EAST CHESHIRE NHS TRUST

MEETING OF THE TRUST BOARD

NOT FOR PUBLICATION BEFORE

Thursday 4th April 2019

3.00 PM

Boardroom 1, New Alderley House, Macclesfield District General Hospital
Our Ref:  LM/FB/Meetings01/TB/Agenda

Date:  28th March 2019

To:  All Directors of East Cheshire NHS Trust

Dear Colleague

TRUST BOARD MEETING

A meeting of the Trust Board will be held at 3.00pm on 4th April 2019 in Board Room 1, New Alderley House, Macclesfield District General Hospital, Victoria Road, Macclesfield, SK10 3BL.

Yours sincerely

Lynn McGill
Chairman

The Board encourages members of the public to attend when Board meetings are taking place. The public are observers of the proceedings not participants, however, the Chairman will provide an opportunity for members of the public to seek clarification on any matter discussed. The Chairman will not allow members of the public to express opinions or arguments which seek to bias or unduly influence the decision-making process of the Board. There are a number of opportunities for members of the public to contribute. If you are unaware of these, please ask a member of staff before or after the Trust Board meeting and they will be happy to advise you.

TRUST BOARD – APRIL 2019 AGENDA

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<tr>
<td>1. Patient Story</td>
<td>Director of Nursing and Quality</td>
<td>10 mins</td>
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<tr>
<td>2. Apologies</td>
<td>Chairman</td>
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### ASSURANCE ITEMS

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<tr>
<td>3. Register of Interests:</td>
<td>The Chairman</td>
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<td>- Declared interest agenda</td>
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<td>- Hospitality and Gifts</td>
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<td>- Register Declaration</td>
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<td>4. Minutes of the March 2019</td>
<td>The Chairman</td>
<td>-</td>
<td>TB 19 (23)</td>
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<td>meeting</td>
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<td>5. Matters Arising</td>
<td>The Chairman</td>
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<td>6. Action Log</td>
<td>The Chairman</td>
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<tr>
<td>7. Verbal update:</td>
<td>Ms A Harrison</td>
<td>10 mins</td>
<td>Verbal</td>
<td>All corporate objectives</td>
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<tr>
<td>SQS Committee</td>
<td>Mr M Wildig</td>
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<td>(supported by formal minutes when available)</td>
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<td>FPW Committee</td>
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### STRATEGIC/GOVERNANCE/ASSURANCE ITEMS

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<tbody>
<tr>
<td>8. Chief Executive’s Report</td>
<td>Chief Executive</td>
<td>15 mins</td>
<td>TB 19 (24)</td>
<td>All corporate objectives</td>
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<tr>
<td>9. Chairman’s Commentary</td>
<td>Chairman</td>
<td>15 mins</td>
<td>TB 19 (25)</td>
<td>All corporate objectives</td>
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<tr>
<td>- Inc. Annual Review of Board</td>
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<td>Members Attendance at Committees</td>
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<td>10. Refresh of ECT’s Clinical</td>
<td>Director of Nursing</td>
<td>10 mins</td>
<td>Presentation</td>
<td>All corporate objectives</td>
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<td>Strategy</td>
<td>and Quality</td>
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<tr>
<td>11. Bi-Annual Report – Safer</td>
<td>Director of Nursing</td>
<td>10 mins</td>
<td>TB 19 (26)</td>
<td>Patients Staff</td>
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<td>Staffing Levels</td>
<td>and Quality</td>
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<tr>
<td>12. Overview of Changes to SFI/SO</td>
<td>Director of Corporate</td>
<td>10 mins</td>
<td>TB 19 (27)</td>
<td>Patients</td>
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<tr>
<td>– Corporate Governance Manual</td>
<td>Affairs and Governance</td>
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<td>14. Draft Quality Strategy Update</td>
<td>Director of Nursing</td>
<td>10 mins</td>
<td>TB 19 (29)</td>
<td>All corporate objectives</td>
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<td></td>
<td>and Quality</td>
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15. Standing Agenda Item: Does the Board wish to add anything to the Assurance Framework or Corporate Risk Register

Chief Executive - Verbal - All corporate objectives

ANY OTHER BUSINESS

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<tr>
<td>16. Public Trust Board Agenda – June 2019</td>
<td>The Chairman</td>
<td>-</td>
<td>TB 19 (30)</td>
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<tr>
<td>17. Any Other Business</td>
<td>The Chairman</td>
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<td>Verbal</td>
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CONSENT ITEMS

(All these items have been read by Board members and the minutes will reflect recommendations, unless an item has been requested to come off the consent agenda for debate; in this instance, any such items will be made clear at the start of the meeting)

<table>
<thead>
<tr>
<th>AGENDA TOPIC</th>
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<th>REASONS FOR PRESENTING</th>
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<tr>
<td>18. Public Trust Board Year at a Glance</td>
<td>TB 19 (31)</td>
<td>For information</td>
<td>All corporate objectives</td>
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<tr>
<td>19. Corporate Governance Manual</td>
<td>TB 19 (32)</td>
<td>For assurance</td>
<td>All corporate objectives</td>
</tr>
<tr>
<td>20. Minutes of the committees of the Board:</td>
<td>TB 19 (33)</td>
<td>For Information</td>
<td>N/A</td>
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<tr>
<td>SQS Committee – February 2019</td>
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<td>FP&amp;W Committee – February 2019</td>
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Date and Time of Next Meeting:

Date: Thursday 6th June 2019
Time: 3.00pm - Venue: Board Room 1, New Alderley House, Macclesfield District Hospital
**PUBLIC TRUST BOARD**

**MINUTES OF MEETING HELD ON:**
Thursday 7th March 2019, 3.00 PM

**Meeting Chair:** Lynn McGill  
**Meeting Secretary:** Bethan Rimmer  
**Venue:** Board Room 1, First Floor, New Alderley House

### Voting Members

<table>
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<tr>
<th>Name</th>
<th>Job Title</th>
<th>Abb.</th>
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<tbody>
<tr>
<td>Mrs Lynn McGill</td>
<td>Chairman</td>
<td>-</td>
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<td>Mr Ian Goalen</td>
<td>Non-Executive Director</td>
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<td>Mr Michael Wildig</td>
<td>Non-Executive Director</td>
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<td>Dr Anthony Coombs</td>
<td>Non-Executive Director</td>
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<td>Ms Ali Harrison</td>
<td>Non-Executive Director</td>
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<tr>
<td>Dr Peter Madden</td>
<td>Non-Executive Director</td>
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<tr>
<td>Mr John Wilbraham</td>
<td>Chief Executive</td>
<td>CEO</td>
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<tr>
<td>Mrs Kath Senior</td>
<td>Director of Nursing and Quality</td>
<td>DNQ</td>
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<td>Dr John Hunter</td>
<td>Medical Director</td>
<td>MD</td>
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<tr>
<td>Ms Rachael Charlton</td>
<td>Director of HR and Organisational Development</td>
<td>DHR</td>
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<tr>
<td>Mr Mark Ogden</td>
<td>Director of Finance</td>
<td>DoF</td>
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### Non-Voting Members

<table>
<thead>
<tr>
<th>Name</th>
<th>Job Title</th>
<th>Abb.</th>
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<tbody>
<tr>
<td>Mrs Julie Green</td>
<td>Director of Corporate Affairs &amp; Governance</td>
<td>DCAG</td>
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<tr>
<td>Mrs Jayne Wood</td>
<td>Chief Operating Officer</td>
<td>COO</td>
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### In Attendance

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Abb.</th>
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<tbody>
<tr>
<td>Mr Peter Goman</td>
<td>Staff Side Chair</td>
<td>SSC</td>
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<tr>
<td>Ms Hazel Power</td>
<td>Integrated Team Performance Support Manager</td>
<td>-</td>
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<tr>
<td>Ms Wendy Barker</td>
<td>Head of Education and Development</td>
<td>-</td>
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<tr>
<td>Ms Katrina Oliver</td>
<td>Integrated Discharge Team Manager</td>
<td>-</td>
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<tr>
<td>Miss Josie Nosworthy</td>
<td>Executive PA / Minutes</td>
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### Agenda Item 1. Staff Story

The DHR welcomed Hazel Power (HP), Integrated Team Performance Support Manager, Wendy Barker (WB), Education Business Manager Katrina Oliver (KO), Discharge Liaison Manager to the Board to share the positive impact of apprenticeships within the organisation.

WB advised that the trust is currently in the second year of the apprenticeship levy, with 77 members of staff on the apprenticeship programme since 2017. The Public Sector target for uptake of apprenticeships is 2.6%; the trust currently has an uptake of 2.3% and is on track to meet the target.

Staff members and managers within the trust are beginning to recognise the benefits of the levy in terms of upskilling and competencies, and support from managers is enabling staff members to sign up to education programmes despite service delivery and operational challenges.

The attendance of staff members on education programmes outside of the organisation provides networking opportunities and sends a positive message to other organisation/people around the behaviours, values and calibre of people.
KO added that during her 20 year employment at the trust, she has been supported by line managers to undergo personal and professional development. As a manager now, KO recognises the importance of supporting and encouraging staff; the apprenticeship levy is a great way to demonstrate investment in staff, leading to motivated and empowered team members, innovation in the workplace and greater staff retention.

HP has worked for the trust since March 2006 and having completed NVQ Levels 3 and 4, is now undertaking the Leaders and Managers Level 5 Apprenticeship. This involves attending college on a monthly basis to cover work units in a learning environment with peers from other organisations. Through the apprenticeship, HP has developed an in depth understanding of planning, policies and communications and the capability to influence decisions and implement change.

HP has recently won the Management Apprentice of the Year Award.

KO thanked HP for her hard work and dedication to her personal development and commitment to driving improved performance within the discharge team.

The Board offered their congratulations to HP and thanked the team for attending the meeting and demonstrating the trust-wide benefits of the apprenticeship levy.

2. **Apologies**

   Jayne Wood, Chief Operating Officer

3. **ASSURANCE ITEMS**

   3. **Register of Interests**

      The Chairman reminded the Board to ensure that all declared interests are noted. There were no interests declared against the agenda.

      The Chairman reminded the Board to declare any hospitality and gifts on the register.

4. **Minutes of the February 2019 meeting**

   The minutes were agreed as a true and accurate record of the previous meeting.

5. **Matters Arising**

   Ms Harrison advised that the final version of the SQS Committee minutes will be added to the full papers prior to uploading on to the trust website.

6. **Action Log**

   - 7342 – Complete, action closed.

7. **Verbal update**

   SQS Committee
### Points for Assurance

- The Committee confirmed agreement to the updated risks on the Board Assurance Framework and Corporate Risk Register.
- The Committee was assured in relation to the Trusts implementation of learning from the external Gosport War Memorial report.
- The Committee endorsed the Freedom to Speak Up Strategic Plan 2019-21.
- The Committee received relevant assurances in relation to Duty Of Candour obligations and ongoing enhancements to associated policy and information documentation.
- The Committee were provided with assurances in relation to the ongoing preparation for future CQC inspections anticipated within the next 6 months.
- The Trust remains positively below trajectory for C. difficile Infections (9 vs max trajectory of 13) and on target to reduce E-Coli infections by 50% by 2022 in line with national targets.
- The Committee received the updated Quality Strategy which is focussed on safe and effective, clinically sustainable person centred care. The strategy will accommodate any future nationally announced targets. Input from Commissioners is being gathered ahead of Board approval of the strategy in April.
- The Committee received a comprehensive spotlight on maternity, confirming that the Trust is well placed in respect of numerous national directives and standards. A nil return was confirmed in relation to any still births or neonatal deaths at the Trust in timeframe covered, in line with reporting requirements of NHS Resolution CNST Maternity incentive scheme.
- The Committee approved the Clinical Audit and Quality Improvement Strategic Plan 2019-22 and will receive further assurances on this area at next SQS (as item deferred from this month).

### Emerging Risks and Mitigating Actions

- Greater focus is being given to improve first time resolution of complaints via emphasis on direct engagement with the complainant and enhanced quality of responses provided. Spotlight on Paediatrics at next months SQS meeting will embrace feedback on any trends and learning from complaints in this area.
- 62 day cancer standard has not been met although this involves small patient number (4). All efforts are being made to improve diagnostic efficiency and future spotlight will be held on local treatment delays or complex treatments where delays are due to the Trust.

### FPW Committee

#### Risks on the BAF and CRR

- Reviewed the report presented by the Director of Corporate Affairs and Governance.
- Reviewed the 2 strategic Risks allocated to FPW, financial stability and people.
- Both have our line of sight and focus for next 3-6 months is appropriate.
- Reviewed our 22 risks on the CRR and no amendments were suggested. It was noted that 2 new risks had been added since the last report.

**Term of Reference**

- The terms of reference for the committee were reviewed and approved.
- They will be in place for the next 12 months.

**Finance**

- £640k positive variance to Plan YTD. Good position overall with 2 months to go.
- The revised Control Total is £17.9m for the year; the Committee continued to be assured that this would be delivered.
- Two directorates continue to be behind plan and we had a discussion about ownership of annual plans and accountability. This is a matter that the executive team are very much focussed on for the new year.
- QIPP schemes, target 5m for 18/19 of which we have delivered £5.9m of Blue schemes, of which £3.2m are recurrent. Given the high level of non-recurrent QIPP we continue to have concerns about the impact of this on next year’s FCT.
- Loans and Cash – Cash, still good control and will draw down the whole of the cash per the Plan by the year-end. Loans of £8.5m due for repayment in Feb 19 have been rolled over for 12 months on the same terms.
- Capital Update – Capex to January is £2.7m against Plan of £2.9m. Total budget for year is now £4m excluding the equipment finance lease which is deferred to next year. The total of £4m will be spent by the end of March.
- Report on the balance sheet at January 2019. No unusual or material variances that are not explained.
- Update on service line reporting to December 2018 – focussing on EBITDA. Discussion around more focus on this next year.

**Performance Targets**

- A&E standard improved slighty to 76.6% in January compared to December (74.5%). It is worth noting that we had 10% higher attendances in January than a year ago with 26.9% admitted which is the highest for 2 years. There were four 12 hour breaches in the month and RCAs will be carried out in line with trust process. Average bed occupancy in the month was over 100% which, as we all know, has a major adverse impact on flow through the hospital. There is a continued focus on transformation programmes to try to improve the position. No assurance given on trajectory through to March.
- RTT achieved 78.6% against the standard of 92% with 10 failing specialties. The patient tracking list is on a trajectory to achieve requirement by March 2019 although there are still some risks involved. Still some first appointments taking far too long.
- The diagnostic standard improved in the month to 86%. The target is expected to be met during Q1 of next FY rather than by the end of March.
- The performance on the cancer standards is generally good however both
of the 62 day standards have been narrowly missed again. There is no reported harm to the patients who were not treated within the period. Back in line by year end.

- Outpatients – Productivity Group still meets bi-weekly to look at driving further efficiencies, a number of which have been identified and will be progressed over next 6 months. Still some specialties with waiting time which are significant. These are receiving additional attention (Cardiology and Rheumatology).
- Community Hubs are continuing to develop with the roll out of locality performance dashboards.

**Workforce**

- **Resourcing** – Overall vacancy rates remain fairly static at 3.8% which compares favourably to the figure of 5.78% for the first 3 months of the year. We are seeing the benefits of focussed attention at areas of recruitment, retention and engagement.
- but we still have relatively high levels of Acute Nursing vacancies at 13% (40 fte)
- Combined nursing and midwifery vacancies are 10.8% which is a much improved position over 6 months ago and is expected to improve further in the coming months.
- **Total pay bill** has increased in January by £80k from December and is due to increased winter staffing. This is almost £250k lower than a year ago.
- Agency spend increased in the month. It remains within the trajectory agreed with NHSI.
- **Engagement and Welbeing** – Staff Survey results are very encouraging with year on year improvements and a positive position compared to national averages. We will look at the details later in this meeting.
- Sickness absence continues to be monitored closely and support is given to line managers. It remains broadly static at just over 5% which is in line with target. Three top reasons for absence remain stress, gastro and musculoskeletal problems.
- **Development** – Annual Clinical Update and Core Clinical e-Learning compliance remains below the in month target because of operational pressures. Revised trajectory is to achieve 84%, rather than 90% by the end of March and even this level will be challenging.
- **Gender Pay Gap Report for 2018/19**. A thorough piece of work which meets the governments requirements and will be filed on time by the end of the month. No major changes from the previous year. Action plan in place.
- **Quarterly Guardian of Safe Working Report** by Chris Smart – Another thorough report which gives good assurance that the role of Guardian is working well and is very supportive of the junior doctors.

**Audit Committee**

- The Committee approved amendments to the Corporate Governance Manual, noting that the draft document has not yet been reviewed.
- Terms of reference were agreed for 2019/20; no changes were made.
- The Conflict of Interest Biannual report was submitted to the Committee; it was noted that a number of decision-makers had not made a disclosure and this will be followed-up as a matter of urgency.
- Proposed changes to the Conflict of Interest Policy were agreed.
- Internal Audit Progress report provided high assurance on key financial systems.
- Limited assurance was provided against the audit of IT continuity, with two high risks identified. A detailed action plan is in place to address this.
- There were no overdue actions on the internal audit tracker and the Committee approved the 2019/20 internal audit plan.
- The Committee approved the Anti-Fraud Workplan 2019/20.
- The external audit 2018/19 report highlighted significant risks around revenue recognition, management over-ride of control, valuation of land and buildings and going concern material uncertainty disclosures.

8. **Chief Executive's Report inc. Staff Survey Presentation**

The CEO presented the Chief Executive’s report, highlighting the following:

- Patient waiting times for diagnostic services has improved
- Waiting times in ED have improved slightly, however remains significantly away from national standard of 95%.

Table 3.1.5 illuminates the scale of benefit to those economies that provide a ‘type 3’ service, with providers showing an improvement of up to 21.9% when reported nationally.

Dr Madden welcomed the benchmarking data included in the report, which offers greater clarity around the comparative position of trust performance.

The CEO emphasised the scale of the difference between the different economies, noting that other providers see a significant increase in performance as a result of providing a type 3 centre.

- The Board are aware that a decision has been taken to temporarily suspend out of area referrals for General Surgery, Cardiology and Gastroenterology. This will remain the case for a further 3 months. CMS will continue to review this position.
- A new risk has emerged around the waiting time for Rheumatology treatment as a result of a period of extended sick leave reducing capacity by 50%. Temporary restriction of e-referrals is in place in order to maintain patient safety.
- Notice has been served on the Orthodontic service with the 6 month notice period taking effect from 1st October 2018.
- The trust has assessed the impact of Brexit as a medium to low risk to the organisation. Work continues around procurement and staffing and this will continue to be monitored.
- The trust continues to be on track to deliver the 2018/19 Financial Control Total following a challenging year. Cost reduction schemes have not met the required recurrent level required for this year.
- No formal contract offer has been received and no offer of assistance for the Winter period has been offered from ECCCG.
**Staff survey**

The DHR presented the results of the staff survey which took place between October and December 2018, highlighting the improved results in comparison to 2017/18.

The following key points/themes were noted:

- There was a good response rate to the survey, being above the national average.
- Thanks was offered to staff side representatives for promotion of the survey throughout the organisation, and to all staff who took the time to complete the survey.
- Overall staff engagement position has improved over the last 5 years. The trust has remained above the national average for the last 3 years and is moving closer towards the best national score year on year.
- It was noted that there are some themes where a low indicator represents a positive result, i.e. bullying and harassment.
- Other areas where the trust performed above the national average include communication, health and wellbeing support and quality of care.
- Actions against specific areas that were below national average in 2017 have been implemented and position has improved in 2018 as a result of this targeted focus.
- The top and bottom 3 key themes for each directorate have been identified and compared to the overall position of the organisation, giving directorates areas of focus for the next 12 month period.
- Work is underway with Associate Directors to develop detailed directorate action plans which will underpin the overall ‘Trust Wide’ plan.
- Results of the survey have been communicated via staff and public briefings. The CEO will produce a podcast and information will also be posted in Staff Matters and on social media.
- The trust has received an invitation to share learning and experience at an NHS Employers event as an example of an NHS organisation performing above the national average.

The Chairman noted that the results of the survey demonstrate that ECT staff continue to demonstrate the trust values and behaviours.

The Chairman referred to the areas of focus, specifically the safety culture within the Planned Care directorate.

The DCAG advised the Board of the work which has been conducted within the directorate over the last 12 months to provide further focus on and support improvements. This includes the implementation of Patient Safety Exchanges, whereby the DNQ visits teams to discuss safety concerns, increase understanding of incidents and complaints and encourages engagement staff.

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<th>9. Board Assurance Framework and Corporate Risk Register</th>
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<td>The DCAG presented the Board Assurance Framework and Corporate Risk Register report which includes additional focus on trajectories over the next 6 months.</td>
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The DCAG sought confirmation from the Board that areas of focus for the report are agreed and that the risks identified are consistent with the information being reported; the Board confirmed their agreement.

10. **Learning from Deaths Report – Quarter 3**

The MD presented the Learning from Deaths Report Quarter 2, highlighting the following:

- The number of deaths within Q3 is within the expected range.
- A comprehensive mortality review is conducted for 20% of all deaths that occur at the trust. In Q3, 32 deaths were reviewed, none of which were deemed to be avoidable.
- No deaths were reported under the Serious Incident Framework.
- One patient with a learning disability died at the trust in Q3; this was thoroughly investigated and deemed as unavoidable.
- Following a Dr Foster Mortality Alert in November 2018, the trust conducted an investigation and provided a comprehensive response to the CQC. No formal feedback has been received to date.
- Positive assurance has been provided that all mortality reviews are conducted in a timely manner, with notes suggesting good communication with patients and relatives.
- Areas for improvement include the consent process for patient’s undergoing fractured neck of femur repair. The mortality review process has identified that consent is not being obtained in line with Mental Capacity Assessments. Consent forms have been modified for patients undergoing this treatment and the Legal Services Manager at the trust has provided further information to the Orthopaedic Department around Mental Capacity Assessment and related obligations.

The DNQ noted the robust processes in place, and the continued added value for reviewing deaths at the trust.

11. **Standing Agenda Item: Does the Board wish to add anything to the Assurance Framework or Corporate Risk Register**

No changes to the risk register were raised.

**ANY OTHER BUSINESS**

12. **Public Trust Board Agenda – April 2019**

The DNQ asked that the April Trust Board agenda include the presentation of the Compassion Award to the nominated staff member; the Board agreed that this would form part of the agenda.

13. **Any Other Business**

The CEO thanked staff for their participation in the annual fundraiser Pancake Race event for the trust charity, ECHO, which received the greatest attendance to date.

The Chairman advised that NHSI have conducted work focused on the development of the new NHS Assembly, for this new appointments will be announced.
Plans for appointments include approximately 50 people representative of national organisations, clinical and patient leaders and staff across the system. In addition to this, an appointment has been made to the position of Chief People Officer.

The Chairman noted the recent agreement between NHSI and NHSE to a shared Chief Executive Officer.

Executive colleagues were asked to express their interest in attendance at the recently advertised ICP Development Network events hosted by NHSI.

### CONSENT ITEMS

<table>
<thead>
<tr>
<th>14.</th>
<th><strong>Public Trust Board Year at a Glance including Agreement of Annual Work Programme for 2019/20</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>The Committee received the Year at a Glance and noted its contents.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>15.</th>
<th><strong>Chairman’s Commentary</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>The Committee received the Chairman’s commentary and noted it contents.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>16.</th>
<th><strong>Safer Staffing Exception Report</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>The Safer Staffing Exception Report was received and its contents noted.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>17.</th>
<th><strong>Freedom to Speak Up Strategic Plan</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>The Committee received the Freedom to Speak Up Strategic Plan and noted it contents.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>15.</th>
<th><strong>Minutes of the Committees of the Board</strong></th>
</tr>
</thead>
</table>
| **SQS Committee**  
The Committee received the SQS Committee minutes for January 2018 and noted the contents. |
| **FP&W Committee**  
The Committee received the FPW Committee minutes for December 2018 and noted the contents. |

### Date and Time of Next Meeting:

Date: Thursday 4\(^{th}\) April 2019  
Time: 3.00pm - Venue: Board Room 1, New Alderley House, Macclesfield District Hospital

Signed: .................................  
Name: .................................  
Date: .................................
### Agenda Item Number 8: TB 19 (24)

#### Report of:
Responsible Officer: Chief Executive  
Accountable Officer: Chief Executive

#### Author of Report:
John Wilbraham, Chief Executive

#### Subject/Title
Chief Executive's commentary for the period ending February 2019

#### Background papers (if relevant)
N/A

#### Purpose of Paper
To highlight performance issues and areas of risk to the delivery of the trust’s objectives

#### Action/Decision required

#### Mitigates Risk Number: (identify)  
On Corporate Risk Register
Links to all risks identified within the Assurance Framework and the Corporate Risk Register

#### Mitigates Risk Number: (identify)  
On Assurance Framework

#### Link to Care Quality Commission Domain
- Safe ✓
- Caring ✓
- Responsive ✓
- Effective ✓
- Well-led ✓

#### Link to:
- Trust’s Strategic Direction
- Corporate Objectives
Links to all strategic objectives

#### Legal implications - (identify)
None

#### Impact on quality
Positive impact on quality

#### Resource impact
None

#### Impact of equality/diversity
None

### Avoid acronyms or abbreviations - if necessary list:
- OSC – Overview & Scrutiny Committee  
- NHS – National Health Service  
- ECT – East Cheshire NHS Trust  
- A&E – Accident & Emergency  
- ED – Emergency Department  
- EPRR – Emergency Preparedness Resilience & Response  
- CCG – Clinical Commissioning Group  
- PbR – Payment by Results  
- QIPP - Quality Innovation Productivity & Prevention  
- GP – General Practitioner  
- FT – Foundation Trust  
- MCFT – NHS Mid-Cheshire Hospitals Foundation
<table>
<thead>
<tr>
<th>Trust</th>
<th>CWP – Cheshire &amp; Wirral Partnership</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICP</td>
<td>Integrated Care Partnership</td>
</tr>
</tbody>
</table>
Chief Executive’s Commentary for the Period Ending February 2019

1 INTRODUCTION

1.1 The paper gives an overview of performance of the trust for the period and provides assurance and areas of risk around the delivery of the Board’s objectives.

1.2 Appendix A summarises the performance of the key indicators.

2 BOARD ACTIONS

2.1 The Board are asked to ratify:

• The submission of the annual plan and the acceptance of the financial control total

2.2 The Board are asked to note:

• The commencement of a major fundraising initiative by The Christie to bring a linear accelerator to the Macclesfield site
• The referral to the Secretary of State for Health concerns from the Overview & Scrutiny Committee (OSC) about the change in service delivery of Oral Surgery and Orthodontics
• Continued pressure on the delivery of waiting times
• Delivery of the 2018/19 financial control total
• Significant changes to leadership in partner organisations/regulators involved in the transformation of services across Cheshire East

3 QUALITY AND COMPLIANCE – PATIENT SAFETY, PATIENT EXPERIENCE AND EFFECTIVENESS

Risk: If quality is not maintained in line with regulatory standards during and after transition then this could impact on services the trust provides and ability to provide services that are caring, safe, and responsive and safeguard the health & wellbeing of the local population

3.1 The Christie Development

3.1.1 It is excellent news that The Christie charity has launched a fundraising programme to build a radiotherapy centre on the Macclesfield site. The development will mean many Cheshire patients who currently travel into Manchester for radiotherapy will be able to receive this treatment in Macclesfield.

3.1.2 The £23m centre will be built in part of the area currently occupied by mental health services in the Millbrook Unit and building work will
Macclesfield site providing care close to home

commence when the mental health service transfer has been completed which is expected to be autumn 2019 with the radiotherapy service commencing in summer 2021.

Whilst sometime away, this development marks a significant investment in the Macclesfield site and assists in the Boards objective of maintaining and developing local services wherever possible. It builds on an excellent relationship with The Christie who currently provides chemotherapy services from the Macclesfield site.

3.1.3

Orthodontics and Oral surgery

The trust agreed to cease delivery of these services however the OSC have decided to refer this decision to the Secretary of State

3.2.1 The Board are aware that the trust served notice to NHS England, as required, that it would cease providing these services during March/April 2019; this is in line with the trusts strategy of moving away from providing specialities with single handed clinicians.

3.2.2 Work has been taking place to transfer patients from ECT to other providers as there has been no single alternative provider commissioned. Patients have been transferred to their most local provider to minimise the impact in terms of travel.

3.2.3 Regrettably, the OSC has felt that the process undertaken for the recommissioning has not been to the standard they would expect and as is their right, they are referring the matter to the Secretary of State.

3.2.4 Whilst we are working closely with NHS England, who would undertake such a consultation, the reputation of the trust has suffered with criticism of the decision in the local press.

3.2.5 I have spoken with the Chair of the OSC who is aware that ECT and NHS England have differing accountabilities and will work with him and NHS England to ensure better processes in the future.

3.2.6 The Board can be assured that whilst patients will be required to travel to alternative providers there have been no patient safety concerns.

3.3 Winter Pressures

Whilst the winter period is coming to a close there is a focus on managing the system over the Easter period with the reduction of the additional capacity for winter, closing on 31st March

3.3.1 Performance over the winter period is generally viewed as being better than the previous year not least because of the proactive steps taken by the trust and its partners.
3.3.2 Pressure in the system was evident however and whilst the elective programme in orthopaedics was planned to cease during January the reality is that we have still not fully returned to a full elective programme. This has led to some activity being undertaken in the private sector to ensure no patients are waiting more than 52 weeks.

3.3.3 The winter plan opened 16 additional beds on Ward 5 and additional medical staff were employed for 3 months to facilitate a surgical ward operating as a medical ward. These changes cease on the 31st March and this will increase pressure on patient flow and performance on the ED standard however this will need to be managed closely to ensure patient safety is maintained.

3.3.4 The A&E Delivery Board will be undertaking a debrief of winter preparedness across the Eastern Cheshire Health Economy to identify what worked well and what can be improved for next year. In addition they will assess readiness for managing over the Easter holiday period.

3.4 **2019/20 Annual Plan**

3.4.1 The trust will submit its annual plan by the 4th April in line with the required deadlines. A presentation will be given to the Board on the 4th April as this is Trust Board day; the presentation will build on previous briefings the Board have received.

3.4.2 In summary the trust will either achieve the national performance standards or will deliver an improved position year on year. An example of the latter is that the trust is unable to commit to achieve the 95% ED 4 hour standard within the next 12 months given the link to the requirement to have bed occupancy of c.92%.

3.4.3 The contract is based on delivering increased non-elective activity of 2%.

3.4.4 The trust has been allocated £750k for winter from a total local NHS financial envelope of £1.6m. This is less than 2018/19. The A&E Delivery Board will need to assess how the 2019/20 winter period is managed.

3.4.5 There are a number of risks to the delivery of the 2019/20 annual plan which will be discussed when it is delivered to the Board for final approval.

3.5 **Operational Performance**

3.5.1 The number of patients receiving their diagnostic procedure has improved again during February to 92.5% (86% at the end of January). This is beneficial for patients on cancer pathways as clearly the earlier the diagnosis is confirmed the more speedy the cancer treatment can take place.
on cancer waiting times

3.5.2 The cancer waiting times have seen improvements in 3 of the standards however there was deterioration on the 2 week standard where performance in the month has dropped to 86.9%.

3.5.3 77 patients waited more than 2 weeks with the major issues in breast surgery where we are seeing an increase in activity.

3.5.4 The trust has seen little improvement in the number of patients being treated within 4 hours within ED however relative performance within the C&M providers remains positive

3.5.5 77.4% of patients were seen within 4 hours in the ED which is a 0.8% improvement over January. When comparing February performance with other type 1 facilities across Cheshire & Merseyside, the trust was the 3rd best performing organisation with 76.7% against a range of between 68.8% to 90.6%.

3.5.6 Whereas the relative position is satisfactory the issue remains that patients are waiting longer than we would wish and clinical and managerial staff are aware of the inherent risk of ED’s which become overcrowded. The Director of Nursing & Quality and the Medical Director continue to work closely with nursing and medical staff to manage the safety of patients.

3.5.7 Even though the pressures exist in ED, the Family & Friends Test for February shows 84.1% of patients stated that they were likely or very likely to recommend the trust. Whilst this is a slight reduction from previous months, it shows that staff are continuing to provide care that is appreciated by its users.

3.5.8 The Board are aware that the trust has signed an undertakings letter with NHS Improvement which has specific reference to the ED standard; this is discussed with NHS Improvement at the monthly performance meeting. NHS Improvement have raised no concerns regarding the delivery of our undertaking.

3.6 Emergency Preparedness, Resilience & Response (EPRR)

The Board reviewed and approved the trusts Major Incident Plan at Private Board which sets out the trusts arrangements for responding to a Major Incident situation. The plan outlines key roles and responsibilities and identifies potential scenarios that could arise that would necessitate the invocation of the plan. It also outlines the requirements of a Category 1 responder under the Civil Contingencies Act (2004).

The Board will note that the self-assessment against EPRR Core Standards was submitted and the required statement has been uploaded to the trusts website.
3.7 **Care Quality Commission Inspection**

3.7.1 I can confirm that the trust remains registered with the Care Quality Commission (CQC) without restrictions. The trust has however deregistered the Fountain’s Centre location based in Chester as we will no longer be providing sexual health services from this location; these services will now be provided by Virgin Health from the 1st April 2019.

3.7.2 The trust was rated “Good” overall following our CQC inspection in 2018 and we have been implementing a quality improvement plan to ensure compliance with three areas highlighted by that inspection.

3.7.3 The Board will have been made aware previously that “Well Led” inspections are expected annually and we have been given notification that they will be undertaking a “Well Led” inspection within the next six months (the exact date is to be confirmed). This will be preceded by unannounced or short notice inspections of some of our core services which is usual practice. Staff focus groups are in the process of being organised and staff have been encouraged to participate in attending.

3.7.4 The trust has also forwarded the requested pre inspection information to CQC.

4 **FINANCIAL STABILITY**

Risk: If the trust cannot meet requisite financial regulatory standards and operate within agreed financial resources and transformation schemes do not deliver sufficient savings, then the proposed health economy wide service model will not be fully or effectively implemented.

4.1 **Income and Expenditure Position**

4.1.1 The trust has a cumulative deficit of £16.3m which is £600k better than the planned position and the Executive Team are confident that the 2018/19 control total will be achieved. The focus has now moved to the 2019/20 financial year.

The tables below show the summarised income and expenditure position.

<p>| Income &amp; Expenditure Statement table: Month 11 2018/19 |
|---------------------------------|-----|-----|-----|-----|</p>
<table>
<thead>
<tr>
<th></th>
<th>Plan</th>
<th>Actual</th>
<th>Variance</th>
<th>Favourable/Adverse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>130,548</td>
<td>141,725</td>
<td>(11,177)</td>
<td>Favourable</td>
</tr>
<tr>
<td>Pay Expenditure</td>
<td>97,922</td>
<td>100,346</td>
<td>2,424</td>
<td>Adverse</td>
</tr>
<tr>
<td>Non-Pay Expenditure</td>
<td>31,571</td>
<td>31,393</td>
<td>178</td>
<td>Favourable</td>
</tr>
<tr>
<td>Total Operating Expenditure</td>
<td>149,493</td>
<td>131,739</td>
<td>4,754</td>
<td>Adverse</td>
</tr>
<tr>
<td>Operating (deficit)/Surplus</td>
<td>(12,947)</td>
<td>(12,324)</td>
<td>623</td>
<td>Favourable</td>
</tr>
<tr>
<td>Interest Rec’d/Paid/Gain on disp.</td>
<td>1,015</td>
<td>872</td>
<td>(143)</td>
<td>Favourable</td>
</tr>
<tr>
<td>Capital Charges &amp; Adjustment for donated assets</td>
<td>3,014</td>
<td>3,134</td>
<td>120</td>
<td>Adverse</td>
</tr>
<tr>
<td>Trust (deficit)/surplus after adjustment for donated assets</td>
<td>16,080</td>
<td>16,130</td>
<td>(50)</td>
<td>Favourable</td>
</tr>
</tbody>
</table>
The trust has agreed a contract with NHS Eastern Cheshire CCG and has committed to achieving the financial control total set by NHS Improvement which brings £18m into the health economy.

4.2 2019/20 Annual Financial Plan

4.2.1 The trust has had a successful negotiation with the CCG in terms of the financial offer however, the Board's attention is drawn to the fact that the contract form has moved from a block arrangement to block on community services and PbR for acute services.

4.2.2 This negotiation has led the trust to committing to delivering a QIPP of £3.4m (1.9%) and committing to achieve the financial control total which will attract additional funding of £17.9m resulting in a final deficit of £5.1m.

4.2.3 A presentation will be made to the Board to outline more of the detail and associated risks however the narrative is attached at Appendix B.

5 WORKFORCE

Risk: If the trust does not attract, develop, and retain a resilient and adaptable workforce with the right capabilities and capacity then there may be an impact on achieving mandatory service standards, and delivering an integrated system.

5.1 Workforce Metrics

The indicators are showing a further reduction in sickness absence and good progress towards achieving training requirements from information governance to appraisals.

5.1.2 The indicators are showing a further reduction in sickness absence and good progress towards achieving training requirements from information governance to appraisals.

5.1.3 The pilot of the Workpal on-line appraisal system has been launched; this builds on the Board's commitment to improve the quality of appraisals. This system will allow staff to engage in continual dialogue with line managers during the year to demonstrate and discuss the achievement of their objectives.

5.1.4 The level of agency expenditure has been managed within planned levels and will not exceed the annual cap set by NHS Improvement.

<table>
<thead>
<tr>
<th>Income &amp; Expenditure Statement table - Month 11 2018/19</th>
<th>Plan</th>
<th>Actual</th>
<th>Variance</th>
<th>Favourable/Adverse</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£'000s</td>
<td>£'000s</td>
<td>£'000s</td>
<td></td>
</tr>
<tr>
<td>Income</td>
<td>136,546</td>
<td>141,720</td>
<td>(5,174)</td>
<td>Favourable</td>
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<tr>
<td>Pay Expenditure</td>
<td>57,922</td>
<td>100,345</td>
<td>2,423</td>
<td>Adverse</td>
</tr>
<tr>
<td>Non-Pay Expenditure</td>
<td>51,571</td>
<td>52,699</td>
<td>1,128</td>
<td>Adverse</td>
</tr>
<tr>
<td>Total Operating Expenditure</td>
<td>249,493</td>
<td>154,044</td>
<td>4,551</td>
<td>Adverse</td>
</tr>
<tr>
<td>Operating (deficit)/Surplus</td>
<td>(12,347)</td>
<td>(12,324)</td>
<td>(23)</td>
<td>Favourable</td>
</tr>
<tr>
<td>Interest Rec’d/Paid/Gain on disp.</td>
<td>3,016</td>
<td>3,072</td>
<td>56</td>
<td>Favourable</td>
</tr>
<tr>
<td>Capital Changes &amp; Adjustment for donated assets</td>
<td>3,016</td>
<td>3,134</td>
<td>118</td>
<td>Favourable</td>
</tr>
<tr>
<td>Trust (deficit)/Surplus after adjustment for donated assets</td>
<td>(16,080)</td>
<td>(16,130)</td>
<td>(50)</td>
<td>Favourable</td>
</tr>
</tbody>
</table>
LEADERSHIP AND STRATEGIC TRANSFORMATION

Risk: If the collective leadership across the integrated care system is not well led and unable to effect the changes required with pace and support of key regulators and stakeholders then there is a risk to the sustainability of the trust and the wider Health and Social Care economy.

6.1 Changes in Wider Economy Leadership

The regulators have formed a north west body which brings together both organisations. It is important that the trust builds relationships with the new leadership team.

6.1.1 There have been a number of appointments made in the newly formed North West Regional regulator structure bringing together NHS England and NHS Improvement.

It is important that where new staff are in post that we forge a strong relationship as quickly as possible to ensure the issues facing the trust are fully understood so that the regulators are able to support the trust in its objectives. The appointments made are shown below.

<table>
<thead>
<tr>
<th>Position</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regional Director</td>
<td>Bill McCarthy</td>
</tr>
<tr>
<td>Chief Nurse</td>
<td>No appointment at this time</td>
</tr>
<tr>
<td>Director of Finance</td>
<td>Jonathan Stephens</td>
</tr>
<tr>
<td>Medical Director &amp; Chief Clinical Information Officer</td>
<td>David Levy</td>
</tr>
<tr>
<td>Director of Workforce &amp; OD</td>
<td>No appointment at this time</td>
</tr>
<tr>
<td>Director of Performance &amp; Improvement</td>
<td>Graham Unwin</td>
</tr>
<tr>
<td>Director of Strategy &amp; Transformation</td>
<td>Clare Duggan</td>
</tr>
<tr>
<td>Director of Commissioning</td>
<td>No appointment at this time</td>
</tr>
</tbody>
</table>

6.1.2 Cheshire & Mersey Health and Care Partnership

The Cheshire & Mersey Health and Care Partnership has commissioned Sir Ian Carruthers and John Bennett to review how the partnership will work with the newly formed NHSE/NHSI regulator team. This will be important for ECT as it will set out the governance arrangements that will be in place to oversee and assist in the transformation of services in Cheshire East.

The creation of a joint regional arm of the regulators means a new relationship is required with the Cheshire and Mersey Health and Care partnership.

6.1.3 The Cheshire East Partnership Board has appointed a new Executive Lead to work alongside the newly appointed Independent Chair.

Mark Palethorpe, Acting Executive Director of People at Cheshire East Council has been appointed as the Executive Lead for the Cheshire East Transformation Board following Tracy Bullock moving to a new role outside of Cheshire East.

Mark will chair the executive group which will be driving the transformation agenda across the Cheshire East footprint.
There are changes to the leadership at NHS Eastern Cheshire

Dr Paul Bowen GP has stepped down from the role as ECCC Chair after holding the position since 2011. Dr Andrew Wilson GP will take over this role on the 1st April; Dr Wilson is a GP in South Cheshire and is Chair of NHS South Cheshire CCG. In effect therefore NHS Eastern Cheshire and NHS South Cheshire now have the same Chair and Accountable Officer.

The appointment process for the shared CCG management team has commenced and I will inform the Board of appointments as they are made.

There are changes to the leadership team at NHS Mid-Cheshire Hospitals FT

There are imminent planned changes being made with the Executive Team at NHS Mid-Cheshire Hospitals FT. The interviews for the replacement Chief Executive took place on 28th and 29th of March; the Board will be updated when the successful candidate is confirmed.

In addition the Director of Finance at MCFT will be leaving.

During this interim period the two executive teams of ECT and MCFT will continue to meet to review how we can best work together to support local service provision within Cheshire East.

A governance process has been agreed which sets out the reporting processes of any decisions; this will be via respective Boards and each organisations existing governance arrangements.

Developing the Care Communities

The development of the Care Communities remains a key foundation stone for the new models of care being developed across Cheshire East. Appendix C is the document which outlines the framework for commissioning these care communities.

East Cheshire staff continue to work with the clinical leads for the 5 care communities on the Eastern Cheshire footprint to influence the development of these teams.

Dr Paddy Kearns GP, who is the overall medical lead for the development of these communities, presented his vision to the Clinical Management Board to strengthen clinical links between our organisations. He identified that there were three key priorities in 2019/20 these being Cardiology, Dermatology and Paediatrics.

Integrated Care Partnership (ICP)

The Cheshire East Partnership Board has appointed Jacqui Wilkes to the post of ICP Development Director. A regular meeting has been established with the Chief Executives of ECT, MCFT and CWP and the medical leads of the two GP alliances to assist in the developing options for the future ICP in Cheshire East for discussion with the Transformation Board in the coming months.

Appendix D is the recently published NHS England publication on contracting arrangements for integrated providers.
### USE OF TRUST SEAL

7.1 The trust seal has been used as below since the last meeting:

<table>
<thead>
<tr>
<th>Date</th>
<th>Seal Number</th>
<th>Name</th>
<th>Document</th>
</tr>
</thead>
<tbody>
<tr>
<td>21st March 2019</td>
<td>460</td>
<td>RVS &amp; ECT</td>
<td>Lease relating to shop at MDGH</td>
</tr>
</tbody>
</table>

**Sign off**

**Role title**

John Wilbraham  
Chief Executive
## Appendix A

<table>
<thead>
<tr>
<th>Metric</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Jan</th>
<th>Feb</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mortality</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk Adjusted Mortality Index 2017 - Latest Peer (86.56)</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Summary Hospital Mortality Indicator (HSCIC)</td>
<td>1.070</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ecoli - includes hospital and community</td>
<td>1</td>
<td>4</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Hospital MRSA bacteraemia</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Hospital Acquired Clostridium Difficile 18/19 Avoidable</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Incidence of newly-acquired cat 3 pressure ulcers - hospital</td>
<td>3</td>
<td>3</td>
<td>5</td>
<td>4</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Incidence of newly-acquired cat 4 pressure ulcers - hospital</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Incidence of newly-acquired cat 3 pressure ulcers - out of hospital</td>
<td>3</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Incidence of newly-acquired cat 4 pressure ulcers - out of hospital</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Infection</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication errors causing serious harm</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Incidents</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Safety: Falls resulting in patient harm per 1000 Occupied bed days</td>
<td>1.7</td>
<td>1.8</td>
<td>1.6</td>
<td>2.2</td>
<td>3.5</td>
<td>4.4</td>
</tr>
<tr>
<td><strong>Complaints</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>No. complaints with HSO Recommendations</td>
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<td>0</td>
<td>0</td>
<td>0</td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>Number of complaints</td>
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<td>41</td>
<td>35</td>
<td>34</td>
<td>11</td>
<td>10</td>
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<tr>
<td>Ward Family and Friends Test % response</td>
<td>44.3%</td>
<td>44.3%</td>
<td>45.9%</td>
<td>42.3%</td>
<td>45.5%</td>
<td>45.5%</td>
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<tr>
<td>ED Family and Friends Test % response</td>
<td>42.5%</td>
<td>40.8%</td>
<td>46.6%</td>
<td>42.3%</td>
<td>45.5%</td>
<td>45.5%</td>
</tr>
<tr>
<td><strong>Access</strong></td>
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<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>18 week incomplete Patients</td>
<td>91.7%</td>
<td>91.7%</td>
<td>82.4%</td>
<td>86.6%</td>
<td>92.5%</td>
<td>89.3%</td>
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<tr>
<td><strong>Cancer</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Referral to Treatment Waiting list Total</td>
<td>89.9%</td>
<td>83.7%</td>
<td>78.6%</td>
<td>76.6%</td>
<td>77.4%</td>
<td>77.0%</td>
</tr>
<tr>
<td>ED: Maximum waiting time of 4 hours</td>
<td>87.0%</td>
<td>80.6%</td>
<td>81.3%</td>
<td>87.6%</td>
<td>87.9%</td>
<td>87.4%</td>
</tr>
<tr>
<td><strong>DTOC</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Weeks maximum wait from urgent referral for suspected cancer</td>
<td>91.3%</td>
<td>98.4%</td>
<td>95.5%</td>
<td>92.8%</td>
<td>86.9%</td>
<td>89.6%</td>
</tr>
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<td>2 Weeks maximum wait from referral for breast symptoms</td>
<td>46.3%</td>
<td>84.1%</td>
<td>73.3%</td>
<td>87.7%</td>
<td>86.3%</td>
<td>86.9%</td>
</tr>
<tr>
<td>31 days maximum from decision to treat to subsequent treatment - Surgery</td>
<td>100.0%</td>
<td>96.8%</td>
<td>100.8%</td>
<td>88.9%</td>
<td>100.0%</td>
<td>93.3%</td>
</tr>
<tr>
<td>31 day wait from cancer diagnosis to treatment</td>
<td>99.4%</td>
<td>100.0%</td>
<td>98.6%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>62 day maximum wait from urgent referral to treatment of all cancers</td>
<td>75.8%</td>
<td>75.6%</td>
<td>81.3%</td>
<td>74.7%</td>
<td>66.7%</td>
<td>68.2%</td>
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<td><strong>Finance</strong></td>
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<tr>
<td>Core Staff in Post (FTE)</td>
<td>2014.5k</td>
<td>2011.8k</td>
<td>2011.8k</td>
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<td>Total Staff (FTE)</td>
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<tr>
<td>Sickness Absence - monthly</td>
<td>5.36%</td>
<td>4.79%</td>
<td></td>
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</tr>
<tr>
<td>Sickness Absence - Rolling year</td>
<td>4.85%</td>
<td>4.71%</td>
<td></td>
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<tr>
<td>Statutory and Mandatory Training - Rolling 3 year period</td>
<td>91.6%</td>
<td>91.4%</td>
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<tr>
<td>Corporate Induction attendance - Rolling year</td>
<td>97.4%</td>
<td>98.8%</td>
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<tr>
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<td></td>
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</tr>
<tr>
<td>Information Governance training</td>
<td>90.52%</td>
<td>93.2%</td>
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<tr>
<td><strong>Safety</strong></td>
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<td>Core Staff in Post (FTE)</td>
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<td>2011.8k</td>
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<td>Total Staff (FTE)</td>
<td>2446.2k</td>
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<tr>
<td>Sickness Absence - Rolling year</td>
<td>4.85%</td>
<td>4.71%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Statutory and Mandatory Training - Rolling 3 year period</td>
<td>91.6%</td>
<td>91.4%</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Corporate Induction attendance - Rolling year</td>
<td>97.4%</td>
<td>98.8%</td>
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<tr>
<td>Appraisals and Personal Development Plans - Rolling year</td>
<td>89.0%</td>
<td>89.1%</td>
<td></td>
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<td>Information Governance training</td>
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<td></td>
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<td>Safeguarding - Level 1 Compliance</td>
<td>91.6%</td>
<td>91.4%</td>
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<tr>
<td>Safeguarding Children - Level 2</td>
<td>93.0%</td>
<td>88.6%</td>
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<td>Safeguarding Adults - Level 2</td>
<td>90.9%</td>
<td>88.6%</td>
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<td>Safeguarding Children - Level 3</td>
<td>93.5%</td>
<td>88.6%</td>
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<tr>
<td><strong>Finance</strong></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Total Pay Expenditure (£000)</td>
<td>£27,047k</td>
<td>£27,357k</td>
<td>£27,324k</td>
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<td>Bank Staff Expenditure (£000)</td>
<td>£1,411k</td>
<td>£1,620k</td>
<td>£1,672k</td>
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<td>Agency Staff Expenditure (£000)</td>
<td>£1,650k</td>
<td>£1,530k</td>
<td>£1,360k</td>
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<td>Cash (£000's)</td>
<td>£7,560k</td>
<td>£10,802k</td>
<td>(£11,232k)</td>
<td>(£12,324k)</td>
<td>(£14,874k)</td>
<td>(£16,330k)</td>
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<tr>
<td>EBITDA (£000)</td>
<td>(£11,232k)</td>
<td>(£12,324k)</td>
<td>(£14,874k)</td>
<td>(£16,330k)</td>
<td>(£18,616k)</td>
<td>(£20,349k)</td>
</tr>
<tr>
<td>Cumulative Deficit</td>
<td></td>
<td></td>
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East Cheshire NHS Trust
2019/20 Final Operational Plan
For Board ratification

4 April 2019
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1 Introduction
This narrative outlines East Cheshire NHS Trust’s operational plans for 2019/20 in line with the national planning guidance published in January 2019 in terms of:

- Activity
- Quality
- Workforce
- Finance
- Links to the local sustainability and transformation plan

2 Approach to Activity Planning
Initially starting from a 2018/19 forecast outturn position, demand and capacity has been reviewed to determine capacity gaps, backlog in higher risk specialties and anticipated changes for 2019/20. The Trust undertakes an integrated annual planning process for quality, workforce, activity and finance, triangulating external drivers with the Trust’s demand and capacity models. This has informed operational plans, contract negotiations and financial planning processes in the lead up to the new financial year.

Plans are based on a reduction in the use of waiting list initiatives by further improving productivity in outpatient services and reducing costs informed by outputs from the Model Hospital, Getting It Right First Time (GIRFT) and the 10 Point Efficiency plan. Specific plans are being developed and tailored for each specialty to ensure effective use of resources and to maximise the use of available capacity in delivery. Plans take account of known activity changes such as the transfer of oral surgery and orthodontic services as summarised in table 1 below:

<table>
<thead>
<tr>
<th>Description</th>
<th>2018/19 FOT</th>
<th>2019/20 Plan</th>
<th>Difference 2019/20 plan to 18/19 FOT</th>
<th>Other Non Recurrent Activity</th>
<th>Underlying Trend and Demographic Growth</th>
<th>Service Changes</th>
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<tr>
<td>GP Referral</td>
<td>33,698</td>
<td>33,169</td>
<td>(529)</td>
<td>0</td>
<td>390</td>
<td>-919</td>
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<td>Other Referral</td>
<td>27,275</td>
<td>27,178</td>
<td>(97)</td>
<td>0</td>
<td>0</td>
<td>-97</td>
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<td>First Appointment</td>
<td>48,606</td>
<td>49,359</td>
<td>753</td>
<td>1,186</td>
<td>537</td>
<td>-971</td>
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<tr>
<td>Follow Up</td>
<td>80,910</td>
<td>82,839</td>
<td>1,929</td>
<td>2,900</td>
<td>669</td>
<td>-1,641</td>
</tr>
<tr>
<td>Procedure</td>
<td>18,386</td>
<td>18,154</td>
<td>(232)</td>
<td>0</td>
<td>91</td>
<td>-323</td>
</tr>
<tr>
<td>Elective Admissions - Day Case</td>
<td>15,209</td>
<td>15,195</td>
<td>(14)</td>
<td>268</td>
<td>44</td>
<td>-326</td>
</tr>
<tr>
<td>Elective Admissions - Ordinary</td>
<td>1,409</td>
<td>1,418</td>
<td>10</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non Elective - 0 LOS</td>
<td>3,059</td>
<td>3,120</td>
<td>61</td>
<td>61</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non Elective - 1+ LOS</td>
<td>12,322</td>
<td>12,568</td>
<td>246</td>
<td>246</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A&amp;E Attendance Total</td>
<td>49,365</td>
<td>49,365</td>
<td>0</td>
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<tr>
<td>A&amp;E Attendance Type 1</td>
<td>47,088</td>
<td>47,088</td>
<td>0</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Table 1: 2018/19 and 2019/20 Activity Plan
The Trust will continue to work in partnership with Cheshire East Council and Eastern Cheshire CCG to minimise Delayed Transfers of Care (DToC) within the 3.5% national target. The DToC trajectory is monitored by all partners through the A&E Recovery Board which is chaired by the Trust’s Chief Executive. In addition, the work programme to reduce the number of stranded and super-stranded (42) patients to target will continue using a change in methodology agreed with NHSI during 2018/19. Focus and monitoring will also continue with the A&E Improvement plan for key indicators such as the use of Red to Green, SAFER and effective Board Rounds to facilitate early daily discharge and enhance flow. The Trust’s Ambulatory Assessment Unit, which operates from 8am until midnight 7 days per week, and integrated frailty service, will support an ongoing focus on Same Day Emergency Care.

East Cheshire NHS Trust plans to deliver the requirements of minimising 52 week RTT breaches and ensuring that the RTT waiting list is no higher in March 2020 than March 2019. Further work will be undertaken in clinical service productivity in key areas such as cardiology, orthopaedics and gastroenterology to maximise productivity and activity for these specialties and also the use of virtual clinics for follow up outpatients. Pathway review and re-design will help support the delivery of the diagnostics target and cancer 62 day standard. Recovery plans are in place for key access targets with the aim of reaching agreed milestones and endpoints as defined within the schedules that accompany this plan.

The Trust will work with colleagues across the eastern Cheshire health and care system and also the Cheshire and Merseyside Health and Care Partnership (C&M HCP) in the development of the system winter plan for 2019/20. This will be initiated through a Q1 joint learning exercise regarding all the schemes implemented during winter 2018/19 along with the use of the 2018/19 system capacity and demand modelling of acute and community bed requirements. Within this plan £1.3m has been identified for the funding of winter 2019/20 to enable the mobilisation of additional capacity as part of the Trust’s internal resilience plan. In addition, Eastern Cheshire CCG has confirmed the continued provision of a number of community beds across the 2019/20 financial year on a recurrent basis. Beds will be flexed to ensure best use of resources as this was found to be material in maintaining the DToC position for the system during winter 2017/18 and similarly in 2018/19.

3 Approach to Quality Planning
The Trust continues to embed quality initiatives that support the improvement of the Emergency Access standard, working with partners to further strengthen clinical outcomes.

3.1 Approach to quality improvement, leadership and governance
A focus on safety and quality has always been central to everything the Trust does. The Board, through its Safety Quality and Standards Committee (SQS), oversees the achievement of the quality standards and challenges the organisation to further improve services and care for the benefit of our patients. The named executive lead for quality improvement (QI) is the Director of Nursing and Quality.

In 2018 following the most recent Care Quality Commission (CQC) Inspection for Well Led and re-Inspection of five of our Core Services the Trust has been rated “Good” overall. The community end of life care was rated Outstanding in “Caring”. The CQC Inspection identified a number of areas of outstanding practice.
The Trust remains “requires improvement” for safety with the following three areas of regulated activity assessed as not being met:

- Regulation 15 of the Health and Social Care Act (HSCA); relating to premises and equipment
- Regulation 12 of the HSCA relating to safe care and treatment
- Regulation 9 of the HSCA relating to person centred care

The Trust has implemented an action plan and audit programme to ensure change is embedded. Assurance is provided to the Board on the action plan via the Trust’s SQS Committee.

### Top three identified risks

- Nurse staffing levels within the acute hospital setting due to availability of qualified staff
- Medical workforce
  - Middle grade cover
  - High risk specialties in relation to delivery of quality standards
- The impact of overcrowding in the Emergency Department during times of peak pressure

The Quality Strategy 2019-2022 details the Quality Improvement Plan (QIP) for the organisation and aligns with the longer term ambitions of the NHS Long Term Plan. The delivery of the Quality Strategy is reviewed on a quarterly basis by the Trust’s SQS Committee and assurance is provided on all elements across the year.

### Summary of the quality improvement plan

The Trust’s QIP encompasses four elements:

- **Harm-free care** - Care that is safe
- **Improving outcomes** - Care that is clinically effective
- **Listening and responding** - Care that provides a positive experience for patients, carers and families
- **Integrated Person Centred Care** - Care that is co-ordinated and based around individual needs

#### 3.2.1 Harm free care

**Mortality Reviews and Serious Incident Investigations**

The mortality nurse undertakes a case note review which is then reviewed by the relevant consultant and members of the multi-disciplinary team. Any learning or actions from reviews are shared with the clinical teams. Overarching data is shared in monthly data packs at service line SQS committees and the Mortality subcommittee.

The Trust adheres to the NHS Serious Incident Framework. To maximise learning from incidents, all reportable serious incidents are robustly investigated using the root cause analysis process. A ‘check and challenge’ meeting is now held, after the report has been written, to ensure all good practice, lapses in care and actions are identified.
Infection Prevention and Control
The Trust is committed to reducing the risk of infections by continuing to educate staff and participating in a health economy approach to reduce avoidable healthcare associated infections, in line with national requirements, including MRSA bloodstream infections, Clostridium Difficile and Gram-negative organisms. This includes learning from post infection reviews to improve practice, reduce the risk of reoccurrence, ensure a 50% reduction in Gram-negative bloodstream infections by 2021 (aligned with wider health economy plans) and ensure that MRSA and Clostridium Difficile remain within agreed trajectories.

Falls
The Trust plan is to improve care for patients by reducing inpatient falls and associated harms by continuing to align falls prevention work with national priorities to support a reduction in falls and harms relating to falls. Through the implementation of the latest evidence based practice, every patient at risk of falls receives appropriate, consistent assessment and has a personalised care plan for in hospital and at home. Assessment documentation will be audited for measurable impact. Falls awareness and education across the Trust will be reviewed and included in statutory and mandatory training. The Trust’s Quality Strategy plans a reduction in injurious falls to less than 2.0 per 1,000 occupied bed days over the term of the strategy.

Management of Sepsis and the Deteriorating Patient
Improvement in the management of sepsis is facilitated through the Trust-wide Sepsis Steering Group. New screening tools for sepsis and a care-bundle approach is delivered Trust-wide in order to achieve best practice and national guidance for the management of sepsis. The Sepsis Steering Group monitors audit data which is escalated to the Board via the Clinical Audit Research and Evaluation (CARE) group. The Trust will continue to embed National Early Warning Scores (NEWS) in all acute wards and work with community staff to embed News 2 into community and GP settings.

Pressure Ulcers
There is a continued focus on the delivery of a year-on-year reduction in avoidable pressure ulcers leading to the elimination of avoidable Grade 3 and 4 pressure ulcers. This is will be delivered through continued implementation of strategic/national initiatives to support a reduction in avoidable harms caused through pressure ulcer development. Quarterly audits of Stage 2 pressure ulcers provides improved information relating to themes, trends, patterns and special areas of variance and concern in order to plan an appropriate response.

3.2.2 Improving Outcomes

National Clinical Audits
The Trust undertakes audits for areas flagged by the Healthcare Quality Improvement Partnership (HQIP). Progress, outcomes and recommendations of National Clinical Audits are reported to service line audit meetings, the Trust’s CARE group and are included in the annual quality account.
Maternity Services
The Trust will continue to embed Saving Babies Lives care bundle by:

- Implementing 36 week CO monitoring for all women
- Ensuring all smokers are commenced on growth scan surveillance pathway
- Ensuring compliance with all areas of reduced foetal movement guidelines including the completion of reduced foetal movements assessment tools
- Developing a Cardiotocography (CTG) competency package to ensure all staff undertake assessment
- Reducing preterm births

The Trust will also begin to implement continuity of care to meet the national ambition to reduce rates of stillbirth, neonatal death, maternal death and brain injury during birth by 20% by 2020 and 50% by 2025.

Four Priority Standards for Seven-day Hospital Services
The Trust is working towards the delivery of the 4 priority standards. Recent audits reveal that the Trust is >90% compliant with standards 5, 6 and 8. The following actions are being undertaken to improve compliance with Standard 2, time to first consultant review for emergency admissions:

- Recruit to a 4th Acute care physician (recruitment is underway)
- Recruit to 2 full time equivalent (FTE) vacant general physician posts
- Review consultant job plans in A&E to extend consultant presence to later in the evening (from 20:00 to 22:00)

Compliance with Standard 5 for access to seven-day access to diagnostics will be improved when the pan-Manchester interventional radiology rota is finalised and agreed between providers.

Although significant progress has been made with attainment of the 7-day service clinical standards it is highly unlikely that all 4 standards will ever be delivered at the Trust with the current configuration of services. Standards 2 and 8 (twice daily consultant review for high dependency patients) are highly dependent on the onsite presence of senior medical staff. Many of the acute services that provided by the Trust are small and have a limited number of consultant staff (e.g. obstetrics and gynaecology, paediatrics, general surgery). The Trust recognises that to fulfil the standards, further networking arrangements and service reconfiguration will be required.

National CQUINs
The Trust will work in partnership to achieve the, as yet unannounced CQUIN indicators, ensuring consistency of delivery and sharing of best practice wherever possible. Progress will be monitored monthly through the Trust’s SQS Committee.

3.2.3 Listening and Responding

End of Life Care
Working with the End of Life Partnership, the Trust is focused on the following key priority areas:

- The utilisation of Electronic Palliative Care Co-ordination Systems (EPaCCS) to share essential end of life information between the hospice, community and hospital settings
- Working with partners to provide a service plan for the delivery of palliative care services seven days a week for community and acute settings
- Working with the End of Life Partnership to promote the use of advanced care planning both within the acute Trust and community
Patient Experience
The Trust focuses on patient experience as a key component of the quality agenda, along with clinical effectiveness and safety. The Trust carries out a wide-ranging, patient feedback programme to include national surveys, peer review, and accreditation. The local survey plan uses a range of methodologies such as focus groups, interviews, real time and online feedback and includes areas where there are changes to services and a duty to involve and consult.

The programme takes account of the requirements of the Equality Act 2010 and compares the experiences of people with protected characteristics against those of the general population. Themes are identified by triangulating feedback from a variety of sources such as national and local surveys, Friends and Family Test and NHS Choices. Work is undertaken to ensure that systems for gathering and utilising patient experience feedback are sustainable. The Trust will be working towards a formal accreditation to support patients with Autism which follows on from the awards presented to the Trust in previous years.

3.2.4 Integrated Person Centred Care
Many people who have complex care needs receive health and social care services from multiple providers and different care settings, without appropriate coordination or in a holistic way. To address this the Trust plans to further develop its care community model to work in a more integrated way to deliver personalised care in the right place, at the right time, by people with the right skills.

3.3 Summary of quality impact assessment process and oversight of implementation
The quality impact assessment (QIA) identifies any potential direct or indirect impact on the quality of care provided to patients through the implementation of individual service developments and Quality, Innovation, Productivity and Prevention (QIPP) schemes. This includes impacts arising from service changes, including workforce capability and capacity, changes to service specification and/or model, estate or accommodation issues.

QIAs are completed for all schemes that will result in one or more of the following;
- A change to skill mix and/or headcount
- Service redesign
- A change to a business process that will directly or indirectly impact quality (safety, patient experience and effectiveness of care), including back office and support services
- Income generation schemes where they are to be provided within existing resources

Responsible Officers (RO) oversee delivery of a scheme and complete the QIA. Finance and Governance teams meet on a regular basis to confirm that QIAs have been developed and approved in line with the agreed process. All QIAs are signed off by the Medical Director and Director of Nursing & Quality, who ensure that risks to patient safety, clinical effectiveness and patient experience are adequately managed. Where impacts and/or risks are deemed unacceptable schemes will be rejected and a rationale provided to the RO.

Once approved, the QIA continues to be monitored for the duration of the scheme and remains open for six months after implementation to allow for any residual impact to be identified. Key performance metrics are identified for each scheme including information such as increase in incidents, complaints and PALS concerns and waiting times.
4 Approach to Workforce Planning
The workforce plan has been developed using a triangulated approach with finance, operations and quality teams. Forecast changes in FTEs have been informed by capacity and demand planning, QIPP project mandates, local intelligence and agreed working assumptions that are utilised in general planning. The Trust Board have agreed the planning assumptions used and have been involved in the sign off prior to submission. The Board are assured that there is effective triangulation between the key components of our business planning (workforce, activity, quality and finance). Delivery of the Trust’s workforce plan will be closely monitored via monthly performance meetings, triangulated with other evidence and indicators. Board assurance is provided through the Finance, Performance, and Workforce Committee.

4.1 Workforce Challenges
Across the system
A holistic approach to workforce is essential to effectively integrating services around patients and populations. With new clinical models, and the need for flexibility and innovation, this requires us to think differently about our workforce – including the skills they will need throughout their careers.

The Trust acknowledges that whilst future models of care are still to be defined it is difficult to understand the full impact on our future workforce. However, it is recognised that in order to deliver care closer to home, our staff will need to work across both professional and organisational boundaries. This will require our workforce to have flexible skill-sets in order to deliver services within the local community. The Trust is playing an active role in defining the plan, the Chief Executive is Senior Responsible Officer (SRO) for the Acute Sustainability work stream and the Director of HR & OD is SRO for the workforce and OD enabling work stream.

The Cheshire East ‘place’ has identified three major workforce priorities that will help achieve transformational change across Health and Care. These are:

- Create a cultural shift to become more system focused. This can be achieved through effective and inclusive systems leadership, talent management and organisational development (OD) – by understanding our workforce drivers we can develop a Cheshire East Workforce & OD Strategy
- Attract, recruit and retain skilled staff within Cheshire East - “Keeping our Cheshire workforce in Cheshire”
- Ensure we make best use of our resources and learning and development opportunities to enable us to grow and develop our workforce, reducing our reliance on national and regional changes in workforce supply.

In order for us to achieve our workforce priorities we recognise there are a number of advantages in our teams collaborating to provide us with a consistent approach to system integration, quality improvement and longer-term system transformation. We have been working with our partner organisations, including Health Education England (HEE) and Skills for Care to understand the size and shape of our local workforce across Health and Care. The outputs of which have created a view of:

- How services are currently delivered to reflect the populations we serve
- The structure and skill mix of our workforce across the place
- Age profiles across all sectors to highlight where staff shortages may occur
The current recruitment challenges and shortage occupations

The number of commissioned training places

Whilst we have made significant progress identifying our workforce priorities we recognise there is further work required to assess the impact our new models of care will have on our workforce shape and size. The next phase of our work will be to look at the future workforce model, specifically the size, structure and skill mix for our Care Community workforce. We will also review how these workforce changes may affect clinical accountability across Cheshire East.

Locally at East Cheshire NHS Trust
Drawing on the above themes and local workforce analysis, we have identified our workforce priorities for the next 12 months. These include:

- **RESOURCING**: Build on 2018/19 progress to attract, recruit, retain and effectively deploy skilled staff.
- **ENGAGEMENT, WELLBEING AND INCLUSION**: Continue to listen to our staff, building on the results from the NHS Staff Survey and focusing on a safe environment, with a supportive and engaging culture
- **DEVELOPMENT**: Ensure we make best use of our resources and learning and development opportunities to enable us to grow and develop our workforce, reducing our reliance on national and regional changes in workforce supply.
- **TRANSFORMATIONAL CHANGE**: Create a cultural shift to become more system focused, supporting the care communities work across Cheshire East Place. This will be achieved through effective and inclusive systems leadership, talent management and organisational development (OD)

The Trust’s workforce priorities align with those within the ‘Cheshire East Place’ and will help achieve transformational change, allowing us to meet our workforce challenges and realise the local ambition of ‘ensuring an affordable workforce with the right number of people with the right skills, values and behaviours to meet the needs of patients both now and in the future’

The next section will describe how we intend to address, manage and mitigate these risks to ensure we can deliver our workforce priorities.

### 4.2 Recruitment and Retention

Over the last 12 months the Trust has focused on the recruitment and retention of nursing and Healthcare Assistant (HCA) staff in order to mitigate supply shortages. This work has included the launch of social media campaigns, attending national and local career events, recruitment open days, introduction of the Flexible Nurse role and participation in the NHSI retention 90 day improvement programme. The Trust currently has 50.32fte qualified nursing vacancies.

The Trust has introduced a new model for nursing family retention which has resulted in a reduction in rolling turnover for Nursing from 12.63% in December 2017 to 9.39% in December 2018 and for HCA staff a reduction from 13.29% in December 2017 to 10.22% in December 2018.

The Trust actively offers employment to all student nurses trained locally, and currently has 10 transitional students in the recruitment pipeline. Over the next 12 months we plan to widen the scope of the model wider to incorporate other staff groups with a view to reducing overall Trust turnover (excluding flexi-retirement and TUPE) and vacancy rates.
4.3 Innovating our workforce model

The Trust is working with partners to actively pursue skill mix solutions including nurse associates and advanced clinical practitioner apprentices. The first cohort of 9fte qualified Nurse Associates commenced work in February 2019 and a second cohort of 5fte have commenced training and are due to qualify in December 2020.

To promote Nursing staff working at the top of their licence the Trust has adopted “buurtzorg” principles to be utilised by its newly formed care community neighbourhood teams. The traditional management structure has been replaced by a coaching model which allows for consensus decision making within the nursing team without having to consult within the traditional nursing hierarchy. This has led to more empowered teams, efficiencies and service improvements within the care communities.

As part of shared delivery plans and in a bid to reach financial balance the Trust continues to explore productivity opportunities with partner organisations. In line with the Lord Carter of Coles report the Trust is working in relation to reducing absence (currently at 4.94%) and aligning transactional middle and back office functions. In April 2019 the Trust is transferring its payroll service to a neighbouring Trust as part of the Cheshire & Wirral Workforce Work stream in line with the Carter at Scale agenda. As part of the transfer the Trust is moving to paperless payroll.

4.4 Taking action to address workforce productivity and reduce agency spend

The Trust is entering the second year of its Workforce Technology Strategy which focuses on improving the availability and deployment of clinical workforce to improve productivity. The focus for year 2 is to further increase the use of e-rostering and e-job planning in line with the NHSI workforce Deployment standard levels. The Trust is working with partners in Cheshire and Merseyside to bid for NHSI capital funds for e-Rostering/e-Job Planning attainment acceleration in line with the Carter at Scale agenda.

The Trust has in place a ‘bank first’ model and is working to reduce reliance on agency staff through improving its ‘flexible workforce’. From a nursing perspective this includes the introduction of the ‘Flexible Nurse’ which is a floating contracted employee managed by the nurse bank who will self-roster their own shifts and be allocated a location of work based on ward need. The Trust is also increasing its Virtual HCA numbers from 25fte to 35fte in order to maintain safe staffing levels across the organisation and ensure adherence to the no HCA agency spend policy. The Trust continues to have in place a strong medical bank that is deployed as an alternative to agency staff and is actively recruiting to strengthen this provision.

As part of an Agency Reduction group the Trust proactively analyses deployment and agency data trends to ensure that staff deployment is being managed effectively to mitigate the need for shifts to be procured at above agency price caps or off-framework where possible. Where there are exceptional patient safety reasons executive approval processes are in place.
4.5 Developing Leadership Capability
The Trust recognises that it needs to develop its leadership capability in order to work across organisational boundaries and support innovation and change. Over the next 12 months the Trust will, in conjunction with partners, introduce a talent management framework that supports system leadership and succession planning across the Integrated Care Partnership. This will be supported by the development of talent boards that use the data to inform what leadership development opportunities, including secondments, shared development programmes, coaching and mentoring are required.

There will also be range of system leadership development programmes to support the development of our Integrated Care Communities. Research carried out by the Kings Fund in 2014 highlights a high level of leadership churn within the NHS and advocates the requirement for targeted leadership programmes and interventions. With this in mind our focus will be on Clinical leadership, Cultural and Behavioural Development and Accelerating Innovation. External funding has been successfully secured to support this programme of work.

Work has already commenced to develop our approach to integrated working, bringing together a range of subject matter experts from across the system to work collaboratively. Our approach has recently been recognised by the North West HPMA Awards as we have been successfully shortlisted in the category of ‘we work across systems’.

4.6 Training and Development
A new e-appraisal tool will be piloted in 2019/20. The focus for staff appraisals will be on meaningful conversations aligning trust objectives, values and behaviours and personal objectives. Additional communications and training for managers will be rolled out to support this.

The Statutory and mandatory training programme recognises the impact of the new three yearly cycle. Communications will focus on the importance of ensuring statutory and mandatory training is completed before winter when staff time is more pressured.

4.7 Impact of the UK’s exit from the EU
The Trust has a workforce European Union exit plan and has analysed the impact on Trust staffing levels. A major part of the plan is to ensure retention of EU staff already working at the Trust via effective communication, support and engagement with affected staff through a series of drop in and celebration events. In regards to future recruitment of EU staff the Trust already has in place systems and processes to support international recruitment which can be mirrored for EU staff.

4.8 Employee Health, Inclusion and Wellbeing
The Trust has long understood that employee wellbeing is intrinsically linked to staff satisfaction and retention and that addressing the needs of the whole person can have a significant, positive impact on sickness levels, vacancy rates and turnover. Failure to address these needs potentially leads to a reduction in the quality and safety of patient care and presents a significant financial cost to the organisation.
In recognition of this, the Trust has developed an annual Engagement, Wellbeing and Inclusion Plan. Wellbeing priorities are identified in the Trusts’ Workforce and Organisational Development Strategy and key performance indicators were developed and articulated at Board level. Wellbeing communication champions reach out to staff and regular wellbeing communications were implemented with a recognisable logo and branding.

Our next steps will be to try and build on the success of last year’s plan and implement more initiatives that focus on delivering sustainable change. In order to have a measurable impact across the Trust we need to scale up the number of participants and the breadth of what we do. However, the Trust has a ready–made group of champions consisting of those who have participated in previous programmes and we will be seeking their help in advocating for our wellbeing programmes and the impact on them personally.

### 4.9 Safe Staffing and Care Hours per Day

The Trust has a robust process in place to ensure safe staffing which is in line with NHSI’s Developing Workforce Safeguards guidance and recommendations. Actual staffing levels are collated for each patient area in liaison with the e-rostering team and information services. Monthly actual and expected average fill rates for registered and unregistered staff are collated and verified by a senior nurse in each Directorate prior to final sign off by the Deputy Director of Nursing and Quality. Care hours per patient day is calculated by the information department daily and escalated appropriately.

In addition, the Trust Board receives a high level exception report on actual fill rates for registered and unregistered staff during the day and night which highlights inpatient areas that fall below a 90% average fill rate threshold. Nurse sensitive indicators and workforce metrics are applied against each inpatient ward area detailing issues such as the total number of slips, trips and falls, pressure ulcers and performance against the Safety Thermometer. A triangulated approach will be adopted to inform staffing decisions that meet National Quality Board (NQB) expectations and reflect any changes in requirements or guidance provided.

### 4.10 Organisational Change

Expected changes in 2019 include a transfer out of the following services in 2019 which are reflected in workforce financial and activity plans:
- Sexual Health West
- Oral Surgery
- Orthodontics
- Parkinson’s service

### 5 Approach to Financial Planning

#### 5.1 Financial Forecasts and Modelling

In 2018/19, the Trust was set a financial control total (FCT) deficit by NHS Improvement of £19.2m, after receipt of £5.7m provider sustainability fund. In September 2018 the Trust confirmed that it could improve its planned deficit by £1.0m. As a result of this additional provider sustainability fund of £2.0m was awarded. The revised 2018/19 planned deficit is £17.9m which reflects the failure to achieve the A&E standard provider sustainability fund. At month 9 2018/19, the Trust is forecast to deliver the revised plan. The Trust is forecast to deliver over £6.5m of savings in 2018/19 against a plan of £5.0m. £3.5m of which are non-recurrent.
NHS Improvement has issued a control total to the Trust for 2019/20 which is a £23.0m deficit excluding provider sustainability fund and financial recovery fund. The finance, information and business planning teams have worked with clinicians, service managers and HR business partners to ensure the financial plan is aligned with the workforce and activity plans. The Trust has assumed 3.4% pay inflation for all non-medical staff and 2.0% from September 2019 onwards for medical staff pay award in line with national guidance. Non-pay expenditure modelling has taken account of known contractual inflation uplifts such as the outsourced soft facilities management provider ISS. The Trust has been notified of a £0.1m increase in CNST premium that has been included in the financial modelling. The Trust has utilised NHS Improvement non-pay inflation assumptions for any remaining material inflation pressures.

The Trust has engaged in meaningful and positive contractual discussions with Eastern Cheshire CCG. Future growth has been factored into the contract and the CCG has offered to divert resources of £750k from its previous winter plan investments into the Trust to support winter pressures. This has resulted in a QIPP requirement of £3.4m (1.9%) to meet the financial control target. NHS Improvement have made a very good offer of additional sustainability and recovery fund monies totalling £17.9m, and the Trust Board has therefore accepted the financial control target for 2019/20. Table 2 below sets out the Trust’s 2018/19 and 2019/20 income and expenditure plan.

<table>
<thead>
<tr>
<th></th>
<th>2018/19 Total Plan £m</th>
<th>2018/19 Actual Outturn £m</th>
<th>2019/20 Total Plan £m</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Income</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Income</td>
<td>135.1</td>
<td>138.8</td>
<td>142.0</td>
</tr>
<tr>
<td>Non-Clinical Income</td>
<td>6.7</td>
<td>7.5</td>
<td>6.4</td>
</tr>
<tr>
<td>PSF</td>
<td>7.7</td>
<td>0.0</td>
<td>3.1</td>
</tr>
<tr>
<td>FRF</td>
<td>0.0</td>
<td>0.0</td>
<td>14.8</td>
</tr>
<tr>
<td><strong>Total Income</strong></td>
<td>149.5</td>
<td>146.3</td>
<td>166.3</td>
</tr>
<tr>
<td><strong>Expenditure</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pay Costs</td>
<td>(108.2)</td>
<td>(109.3)</td>
<td>(110.2)</td>
</tr>
<tr>
<td>Non-Pay Costs</td>
<td>(59.8)</td>
<td>(56.9)</td>
<td>(59.5)</td>
</tr>
<tr>
<td><strong>Total Expenditure</strong></td>
<td>(168.0)</td>
<td>(166.2)</td>
<td>(169.7)</td>
</tr>
<tr>
<td><strong>EBITDA</strong></td>
<td>(18.5)</td>
<td>(19.9)</td>
<td>(3.4)</td>
</tr>
<tr>
<td>Depreciation</td>
<td>(3.4)</td>
<td>(3.4)</td>
<td>(3.9)</td>
</tr>
<tr>
<td>Fixed Asset Impairment</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>PDC</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Financing Costs</td>
<td>(1.0)</td>
<td>(1.1)</td>
<td>(1.2)</td>
</tr>
<tr>
<td><strong>Net Surplus / (Deficit) pre QIPP</strong></td>
<td>(22.9)</td>
<td>(24.4)</td>
<td>(8.5)</td>
</tr>
<tr>
<td><strong>QIPP Requirement/Delivered</strong></td>
<td>5.0</td>
<td>6.5</td>
<td>3.4</td>
</tr>
<tr>
<td><strong>Net Surplus / (Deficit) post QIPP</strong></td>
<td>(17.9)</td>
<td>(17.9)</td>
<td>(5.1)</td>
</tr>
<tr>
<td><strong>Control Total (excluding unmet PSF)</strong></td>
<td>(17.9)</td>
<td>(17.9)</td>
<td>(5.1)</td>
</tr>
</tbody>
</table>

* 2018/19 financial control total was revised in month 6

**Table 2: 2018/19 and 2019/20 Income and Expenditure Plan**
During 2017/18, the Trust reached a net liability position on its Statement of Financial Position. In accordance with guidance from the 2017/18 Department of Health Group Accounting Manual (‘GAM’), the Trust has prepared its 2017/18 accounts on a going concern basis. The Trust continues to extend this assumption to the preparation of the 2019/20 plan submission, in accordance with the draft 2019/20 GAM.

5.2  Efficiency Savings for 2019/20
The Trust has a good track record of delivering its finance savings programme but has been increasingly challenged in the identification of recurrent savings. 2019/20 plans for efficiency savings currently include a level of unidentified QIPP with a number of opportunities requiring further quantification of the level of cash releasing savings that can be delivered either within the financial year or over a longer planning timescale.

Approach to identification of QIPP
The Trust makes extensive use of the model hospital to identify areas of opportunity and in particular examination of peers to consider alternative approaches by best practice organisations. Regular reviews with services using a range of information sources are undertaken to understand opportunities for cost reductions. The Trust makes use of NHSI resources to identify key areas such as theatre efficiency and procurement opportunities. Each opportunity must undergo a QIA process including review by the Directors of Medicine and Nursing prior to being implemented.

The Trust QIPP target is broken down by directorate and its delivery is closely scrutinised in a variety of forums including Directorate performance reporting, Recovery Board and Trust Board sub committees. The range of settings supports QIPP identification and monitoring and an appreciation of its impact across the Trust. QIPP monitoring and delivery is facilitated by the Business and Strategic Planning team through a programme management approach.

Through the Model Hospital, the Trust has identified that in comparison with peers there are opportunities to increase productivity and it has embarked upon a significant programme of changes to outpatient services. Key components include:
- A redesign of the physical outpatient environment to increase clinic room availability and improve patient flow
- The introduction of digitalisation to support improved efficiency and better patient experience
- Improvements to productivity through detailed review of outpatient clinic provision and relationships to consultant job plans
- Detailed reporting of utilisation data to increase visibility of productivity metrics
- Increased provision of ‘non face to face’ options to modernise patient experience and optimise capacity

The Trust has continued to evaluate the efficient use of theatres and theatre staffing and has included in its planning assumptions the flexing of inpatient and outpatient activity plans during winter escalation. The aim is to address the impacts of bed availability on theatre productivity, offset lost consultant capacity with additional outpatient provision and increase work in non bed based specialities such as ophthalmology, thus maintaining levels of organisational productivity during periods of operational pressure.
Positive GIRFT reports for trauma and orthopaedics support the Trust’s aim of ensuring maximum possible repatriation of NHS patients from private providers, supporting organisational sustainability within capped expenditure principles.

Inpatient planned and urgent productivity is being reviewed through ongoing work including the use of benchmarking to understand and reduce length of stay. The Trust is continuing to introduce changes to skill mix including new roles such as that of nursing associate. It has used learning from its peer organisations in tandem with benchmarking and nationally recognised acuity tools to identify areas for workforce redesign.

As part of the C&M HCP the Trust will continue to look to benefit from a number of ‘Carter at scale’ opportunities, particularly in respect of increasing the efficiency of its corporate functions including procurement. For selected products, the Trust will moving to Future Operating Model (FOM) contracts from April 2019 and continues to use the Purchase Price Index and Benchmarking Tool (PPIB) to support its procurement process.

The Trust is currently part of Cheshire Pathology Services and is involved in Cheshire and Mersey radiology network discussions. The Trust is also part of the Greater Manchester Hospital Pharmacy Collaborative and expects to derive financial savings from two collaborations; a proposed single pharmaceutical store collaborative in 2019/20 and a subsequent aseptics workstream.

### 5.3 Agency Spend

The 2018/19 NHSI agency ceiling was set as £7.325m. At month 11 2018/19 the Trust is under plan by £1.4m year to date. The Trust implemented a winter plan in quarter 4 which resulted in increased agency costs but did not exceed the NHSI agency ceiling. The Trust continues to work on schemes to reduce agency expenditure such as increased recruitment of bank staff and nurse pool. NHSI have reduced the agency ceiling to £7.270m for the 2019/20 plan. The Trust is forecasting to achieve the NHSI agency ceiling in 2019/20.

<table>
<thead>
<tr>
<th>2018/19</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; dental</td>
<td>137</td>
<td>128</td>
<td>110</td>
<td>127</td>
<td>138</td>
<td>107</td>
<td>82</td>
<td>94</td>
<td>122</td>
<td>187</td>
<td>184</td>
<td>0</td>
<td>1,408</td>
</tr>
<tr>
<td>Non-medical clinical staff</td>
<td>0</td>
<td>300</td>
<td>322</td>
<td>290</td>
<td>372</td>
<td>356</td>
<td>370</td>
<td>302</td>
<td>330</td>
<td>374</td>
<td>416</td>
<td>0</td>
<td>3,431</td>
</tr>
<tr>
<td>Non-medical non-clinical</td>
<td>55</td>
<td>102</td>
<td>77</td>
<td>59</td>
<td>57</td>
<td>39</td>
<td>31</td>
<td>31</td>
<td>17</td>
<td>17</td>
<td>15</td>
<td>0</td>
<td>531</td>
</tr>
<tr>
<td>Total</td>
<td>236</td>
<td>530</td>
<td>509</td>
<td>473</td>
<td>559</td>
<td>498</td>
<td>483</td>
<td>428</td>
<td>465</td>
<td>574</td>
<td>612</td>
<td>0</td>
<td>5,371</td>
</tr>
</tbody>
</table>

![Figure 1: Actual Agency Spend 2018/19](image1)

![Figure 2: Planned Agency Spend 2019/20](image2)
Table 3: Agency Spend 2018/19 and Planned Spend 2019/20

5.4 Capital
The Trust is operating in a constrained capital environment. The Trust’s internally generated capital resource for 2019/20 is £3.9m. Following the work on asset lives based on the new RICS (Royal Institute of Chartered Surveyors) guidance this may be further updated when the Trust reviews the valuers report. The Trust keeps its estate asset lives under review as part of its valuation process. It is currently utilising a significant number of fully depreciated assets and replaces these on a risk based approach as described above.

NHSI approved ring fencing £2.9m 2017/18 incentive and bonus sustainability and transformation fund cash for capital schemes. £0.9m included in the 2018/19 plan for outpatients with £2m profiled equally in the following two financial years for cancer services investment. The Trust has included £1m of this in 2019/20 to support the LINAC development on the Macclesfield site in conjunction with the Christie. The leads for each area have prioritised and risk rated their planned schemes for 2019/20 and it is proposed that the 2019/20 capital plan is split as follows:

Table 4: Draft capital plan 2019/20

<table>
<thead>
<tr>
<th>£m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estates and accommodation (includes car park £166k &amp; outpatients £450k)</td>
</tr>
<tr>
<td>IT (includes £150k outpatients)</td>
</tr>
<tr>
<td>Equipment and contingency</td>
</tr>
<tr>
<td>Managed equipment service</td>
</tr>
<tr>
<td>Cancer services development</td>
</tr>
<tr>
<td>Equipment - finance lease</td>
</tr>
<tr>
<td><strong>Total</strong></td>
</tr>
</tbody>
</table>

The Trust still intends to progress the extension to the Radiology Managed Equipment Service for a CT scanner, originally planned for 2016/17, and this is included in the capital programme outlined above.

5.5 Loan funding
The plan assumes that the Trust will continue to receive interim revenue loan support from the Department of Health to fund the 2019/20 planned deficit of £5.1m at an interest rate of 1.5%.

In addition, it has been assumed that the interim revenue support loans which fall due for repayment in 2019/20, amounting to £32.7m, will be replaced with a support loan with the same terms and conditions.
6 Link to the local sustainability and transformation plan

C&M HCP has developed four themes of work each containing a number of work programmes. The Place-Based Care Systems work programme includes an ‘Acute Sustainability’ workstream which, during 2018/19, involved both East Cheshire NHS Trust and Southport & Ormskirk Hospital NHS Trust. Both organisations were tasked with producing:

- An evidence-based case for change
- A range of clinically sustainable service change proposals from status quo to radical
- A financial model and high level travel analysis

The Acute Sustainability work stream at the Trust is led by Chief Executive as SRO, reporting into the Cheshire East Place Partnership Board (CEPPB), which in turn reports into the C&M HCP governance process. This work stream forms part of the Cheshire East Place plans and approach for the transformation of NHS and social care services to improve outcomes for our population as well as becoming financially sustainable.
Framework for commissioning care communities in Cheshire

September 2018
1. Introduction

The CCG’s in Cheshire wish to create the culture and conditions for health and care services and staff to deliver the highest standard of care in the community. To ensure that valuable public resources are used effectively to get the best outcomes for individuals, communities and society for now and for future generations. This document outlines the commissioning framework for care communities which will operate across Cheshire from April 2020.

This framework outlines the key features of the services model setting out clear design parameters and the outcomes commissioners seek to improve as a result. This is a joint framework of the following commissioning organisations:

- NHS West Cheshire CCG
- NHS Eastern Cheshire CCG
- NHS South Cheshire CCG
- NHS Vale Royal CCG, and over time
- Cheshire East Council and Cheshire West and Chester Council

This framework will support local commissioning of a person centred outcome based approach to community care; appropriately resourced; to deliver improved health outcomes and cost effectiveness. This will initially encompass all relevant health care with the ambition of expanding to encompass all aspects of health and social care in the time with the agreement of all commissioning bodies.

2. Current context

The Five Year Forward View\(^1\) outlines the challenges faced by the health and social care system in response to an ageing population with increasingly complex and multifaceted health and wellbeing issues. Delivering the strategic vision of the Five Year Forward View and other relevant policies\(^2,3,4,5\) requires a ‘joined up’ approach for effective commissioning and delivery of community health and social care services.\(^6,7\).

The move towards integrated commissioning and integrated service provision spanning health and social care in Cheshire is subject to discussion and agreement with local authority partners (Cheshire East Council and Cheshire West and Chester Council).

The current challenges facing the NHS which impact on community services are well known. There is an ageing population with increased health needs, a growing need for nursing and domiciliary care at or closer to home, a focus on timely and appropriate discharge from hospital and a rise in people with increasingly complex levels of health and social care requirements. Health and

---

1. NHS “Five Year Forward View” (Department of Health 2014)
3. Next Steps on the NHS Five Year Forward View (Department of Health 2017)
4. General Practice Forward View (NHS England 2016)
5. Primary Care Home (NAPC 2016)
6. Commissioning and Contracting for Integrated Care (Kings Fund 2014)
7. Making Sense of Integrated Care Systems (Kings Fund 2018)
social care provision need to respond to these challenges by improving productivity whilst reducing or stabilising the costs of care; providing care closer to the person’s home and reducing episodes of unplanned care. There is a need to develop cost effective and sustainable community services whilst maintaining and improving high quality care. Services will be expected to meet the required statutory and quality standards. The publication of the Five Year Forward View aims to address the health and wellbeing gap, the care and quality gap and the funding and efficiency challenges in the context of rising demand and resources focussed on hospital care.

The development of care communities in Cheshire builds on the learning from the primary care home rapid test sites. There are four key characteristics that make up a primary care home: a combined focus on personalisation of care with improvements in population health outcomes; an integrated workforce, with a strong focus on partnerships spanning primary, secondary and social care; aligned clinical and financial drivers through a unified, capitated budget with appropriate shared risks and rewards; and provision of care to a defined, registered population of between 30,000 and 50,000.

3. Population Health

3.1 Local Population – Cheshire East Place
The Cheshire East Joint Strategic Needs Assessment describes a population of 370,100 people living in the Cheshire East area; the census (2011) shows a 5.2% increase in the population from the figures in 2001 which is 18,300 residents. The age structure is forecast to change significantly with a reduction in the number of children (0-14) with a 28% increase in people aged between 60-74 years of age and a 121% in the number of residents 85 years and older by 2030.

See Appendix 3 - Cheshire East Health Profile 2018 for further information.

3.2 Ageing population
- 50,700 residents are aged between 60-74 years old, which is a larger increase than England and Wales 20% (2011 Census).
- 9,500 residents are over 85 years old; again this is a larger increase than national figures.

3.3 Growing Burden of disease
Key findings from the Cheshire East Joint Strategic Needs Assessment illustrate:
- a significant increase in the number of older and very old people in the population
- Cancer and Cardiovascular disease remain the main causes of death
- Alcohol is the largest emerging lifestyle threat to health with increasing numbers of hospital admissions consequent upon the binge and hazardous drinking of over a quarter of the population

---

8 Primary Care Home (National Association of Primary Care September 2018)
9 Joint Cheshire East Health and Wellbeing Strategy 2018 – 2021
10 Cheshire West and Chester Health and Wellbeing Strategy 2015 – 2010
11 Cheshire East Joint Strategic Needs Assessment
• Smoking remains a significant cause of preventable illness and premature death and is the primary reason for the gap in healthy life expectancy between rich and poor with over a fifth of pregnant women being still recorded as smokers at the time of delivery (2007/08).
• Less than 60% of mothers try to breast feed
• There is good uptake of many immunisations, but low numbers of children having the MMR vaccine which has resulted in a recent outbreak of measles in the community
• The death rate among people with serious mental health illness has worsened over the last 3 years in Cheshire East
• The Census 2011 highlights that the number of cancers have dramatically increased over the past years whilst mortality has fallen
• NHS Health checks are offered to all eligible people aged 40-74, however most LAP areas did not achieve the national target of 10% of the eligible cohort receiving an NHS Health Check by 2011/12

3.4 Local Population – Cheshire West Place
The Cheshire West and Chester Joint Strategic Needs Assessment\textsuperscript{12} describes the population of Cheshire West and Chester as 335,700 and is forecast to increase by about 10% to 367,000 by 2035.
The number of children aged 0-15 is forecast to increase by 8% from 58,600 to 63,400, with the biggest increase in those aged 11-15.
Older age groups will see the biggest increase, with the number of residents aged 65 plus expected to increase by 28% and the numbers of people aged 85 and over forecast to more than double.

See Appendix 4 - Cheshire West and Chester Health Profile 2018 for further information.

3.5 Ageing population
• There are just over 65,000 people aged 65 and over registered with our two Clinical Commissioning Groups.
• The number of people aged 85 and over is around a quarter the number aged 65-74 but they are more likely to need support with around 15% of people aged 85+ living in a residential setting.
• Falls are the largest cause of emergency hospital admissions for older people and significantly impact on long term outcomes such as the need to move from their home into care.

3.6 Growing Burden of disease
Key findings from the Cheshire West and Chester Joint Strategic Needs Assessment illustrate:
• A significant increase in the number of older and very old people in the population
• Life expectancy has been increasing in both deprived and affluent areas but the rate of improvement is slower in more deprived areas. Life expectancy at

\textsuperscript{12} Cheshire West Joint Strategic Needs Assessment
birth is reduced by 10 years in men and 8.7 years in women living in the most deprived areas of Cheshire West and Chester.

- Heart disease and cancer are the key diseases that contribute to the inequality in life expectancy for men. Cancer accounts for the largest proportion of the life expectancy gap for women, particularly lung cancer.
- Smoking levels have fallen markedly in recent decades and are below the England average; however 12.7% of Cheshire West and Chester’s adults are smokers. The prevalence of pregnant mothers smoking at the time of delivery has reduced to slightly lower than the national average.
- The numbers of babies being breastfed has increased, however the numbers remain significantly lower than the England average.
- Cheshire West and Chester population experience an unacceptable level of alcohol related harm which has a negative impact on individuals, local families and communities. Alcohol misuse in Cheshire West and Chester is estimated to cost more than £129 million a year.
- The number of people with dementia in Cheshire West and Chester is forecast to almost double over the next twenty years, from 4,600 in 2012 to around 8,900 in 2032.
- 3.4% of the adult population is in contact with secondary mental health services, lower than the England rate (5.4%).

4. Components of Care Communities

The components for commissioning care communities are illustrated in Figure 1:

![Figure 1: Nine components of Care communities](image-url)
The position of the care communities is illustrated in Figure 2:

**Care Communities within the Care System**

![Diagram of care system](image)

**Figure 2: Where care communities fit within the care system**

5. **Outcome measures**

The outcome framework for integrated community care has a number of purposes including:

- A common set of outcome measures which are shared across the health and care system which are a framework for continuous improvement.
- A common and shared set of goals for all staff/services delivered in the community.
- A means by which teams can target improvement work and tailor care delivery to the specific needs of their local population.
- A common set of goals which the team can communicate with local groups, public, individuals and their carers to achieve together as a wider team.
- A means by which commissioners can measure outcomes, monitor contracts and plan future strategies.

The high level outcomes for this services framework are:

- People’s experience and satisfaction with care and services
- people are supported to recover and stay well through early detection and intervention
- people are supported to manage their condition, and increasing people’s involvement in decisions
- people spend the appropriate time in hospital
A full list of the outcome measures is outlined in the Outcome Framework in Appendix 1.

6. Key characteristics in the development of care communities

6.1 Personalisation
There is widespread support for ending the fragmentation of care, and in keeping with the ethos of the primary care home, more emphasis need to be placed on delivering person centred care. This includes consideration of the wider determinants of health and wellbeing such as employment status, housing, level of financial independence and life chances in general.

6.2 One Team
Front line staff, with carers, should see themselves as ‘One Team’ empowered to work for their population. The integrated community teams are not new teams but rather an alignment of existing community-based care services. This will include physical as well as mental health; social as well as healthcare; primary care as well as community services; and statutory and non-statutory services. There will be integration between physical and mental health, and health care and ultimately social care services. Until such time as services are fully integrated, other related services, e.g. social care, will be aligned to the teams and care communities.

Professional identity or employing organisation should not act as a barrier to integrated working enabling coordination of care and improved outcomes for people.

6.3 Place
The Teams’ focus should be on the ‘place’ and the population they serve. Place is defined geographically and the Teams will serve populations of between 30,000 to 50,000 people. However, some specialist services will need to operate on a larger geographical/population footprint to enable economies of scale and to ensure that all Teams have access to the required specialist knowledge, experience and expertise.

Services should be provided at the most local level possible. Where they are delivered at scale they should be established in a way which integrates with local team arrangements.

It is recognised that from time to time service users will require access to hospital-based services and the transfer between community and hospital based services should be seamless.

It is important that teams can tailor their services to the needs of their communities and innovation and creativity are promoted at the front line. However, there needs to be clear community level design parameters which allow the system to work effectively. In addition, the providers of hospital services need to work seamlessly with community and third sector services.

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13 Buurtzorg Model of Holistic care and Self-Managed Teams
6.4 Flexibility
Not all care needs a multidisciplinary approach, however, it is important that when this is required skills can be brought together easily to ensure effective care planning, management and delivery.

Hitherto services have been designed specifically to target cohorts of people with health conditions. The shift should now be to a flexible multidisciplinary model whereby skills specific to the individual can be drawn from the teams easily. Teams will work to a common set of outcome goals for the local population.

6.5 Equity
It is important that the service offer and outcomes people receive are equitable as far as possible. The One Team model cannot close the outcome equity gap by itself and closing existing gaps in equity will take many years. However, teams should understand and take positive actions to close those gaps and evaluation should identify and measure those as well as possible. The characteristics by which we would seek to ensure equity of offer and outcome are the protected characteristics for Equality: Age, Disability, Gender reassignment, Marriage and civil partnership, Pregnancy and maternity, Race, Religion and belief, Sex (gender), Sexual orientation, Local Protected characteristics, and Deprivation.

This framework and provider proposals will be subject to a full equality impact assessment.

6.6 Growth
We wish to see community place based health and social care grow in terms of its offer to the public and for this to be matched by an increase in resources. This resource can only be directed to the community by a shift from other downstream or more hospital services. Growth in the community offer should be through growing capacity and skills within the care community including individuals and their carers rather than adding new discrete services.

6.7 Proactive care
Growth in community-based care is not about shifting the same care to a new setting. It is focused upon proactive and well-coordinated care which reduces dependency and keeps people well enough not to need hospital-based care or long term care packages. If care is more proactive in its nature, supported by mechanisms for people to increasingly self-care and there are less gaps between professionals and organisations, there will be a reduction in high cost reactive care. This is key to both improving health outcomes and managing public sector finances in a sustainable way.

6.8 Self-Care
Team members will enable residents to maximise self-care so that people are active in the management of their own health and wellbeing. Staff will have the skills to enable self-care including using techniques such as motivational interviewing and shared decision making tools to determine patient priorities and wishes. They will also support individuals with self-care information and other resources. Self-care will form a key component of individual care planning and
care plans. Increasing people's ability and motivation to self-care will lead to better prevention of lifestyle related conditions, better long-term condition management, better medication and treatment compliance and reduced waste and urgent and unplanned care activity.

6.9 Unpaid carers
There are significant numbers of unpaid carers in Cheshire, a high proportion of whom are children. Adopting a workforce planning approach to unpaid carers to allow them to give the most effective care and ensuring that their own wellbeing is supported should be a core part of the model.

6.10 Innovation
Teams need to be given the skills and the permission to innovate within place level design parameters. Care services will need to be tailored to local communities and so front-line staff are best placed to adapt care to the needs of their population. Use of new technologies to support care and care giving is a significantly untapped resource. Innovation will be supported by evaluation as part of a continuous learning approach. A structured means of horizon scanning and sharing learning both positive and negative should be in place between teams.

6.11 Connection
As described in Section 7.3 connections between the teams and providers of hospital based services and specialist services need to be made and maintained to facilitate seamless care.

Teams should also form connections to be able to understand the wider offer to people within their local communities. There are key areas where teams can work with other parts of the public sector such as housing, employment and connected community teams which support people in a more holistic way. Community, voluntary and faith sectors are key players and have a much stronger role to play as part of the wider team. Teams should establish capacity to identify and work with local communities contributing to and benefiting from local assets and different approaches to delivery through co-production.

6.12 Culture
This model relies upon people more than anything else. It is key that teams have ownership of, and commitment to, the vision. A cultural shift to new ways of working as well as practical support to empower teams to work autonomously and effectively is needed as part of organisational development strategies.

6.13 Workforce planning
The more practical aspects of the workforce need to be considered. The skill mix of the health and care system will change as well as all staff needing to develop new ways of working. Some generic skills and developing the 'trusted assessor' role might be incorporated into training. Where implementation has been successful elsewhere investment has been made in workforce training, coaching, co-design and action learning approaches. In defining the workforce this should include the adoption of these approaches. In defining the workforce this should include the independent care market, unpaid carers and volunteers.
6.14 Professional practice
All care professionals will be empowered to work in a more proactive integrated way aligned to the principles and ambition of the care communities but will act within the scope of their professional practice.

6.15 Place Based Estates
Whilst not all staff and services need to be co-located, it is key to forming team working arrangements, to delivering joined up care where a person sees two professionals at the same time and for community care to have a presence and identity within the community. This could be based in an identifiable building where services are delivered for the community. All other premises should be connected to this facility such as local voluntary sector groups. A joint ownership model for estates and IT across partners in the system would allow flexible and joined up working and achieve efficiencies through reduced duplication.

6.16 IT
A key enabler to the team working arrangements is to optimise sharing of clinical and care records either through single care records or shared access to different records. In addition, modernisation of working arrangements for mobile working and use of new technologies should be incorporated into this arrangement. IT infrastructure should be part of a joint asset strategy with estates plans linked to innovative approaches within teams.

6.17 Population served
This model applies to the full population of Cheshire, initially this will be people who are registered with a Cheshire general practitioner (GP) and will expand to residents of Cheshire who are not registered with a local GP as appropriate.

6.18 Funding arrangements
Funding will be aligned to meeting the needs of the population on a care community based allocation (population health model). The level of funding will be commensurate with the services within the scope of the framework at a given point in time. The scope and resources can be varied in year via a contract variation. Service providers will have the flexibility to determine how services will be delivered to meet the specified outcomes at a local level. Other funding streams will be incorporated as and when agreed with other commissioning bodies.

6.19 Contractual arrangements
The Integrated Care Provider (ICP) contract is currently out to national consultation, until 26th October 2018, and it envisaged that this will be the contract adopted locally once finalised. GPs will have the option to either work alongside or be part of any ICP.

The ICP, when formed, will have the freedom to determine the most appropriate configuration of services to meet the needs of the population. The ICP will be able to sub-contract the delivery of services as required and with the agreement and full knowledge of commissioners in accordance with the agreed contractual terms and conditions. Commissioners should give due consideration to the allocation of personal health budgets particularly for people with long term
conditions and disabilities to provide them with more choice and control over the resources spent on meeting their health and wellbeing needs. A personal health budget may be used for a range of things to meet agreed health and wellbeing outcomes.

7. **Next Steps**
Commissioners will agree the scope of services which will be covered under this framework commencing in April 2019 and thereafter on an annual basis until such time as the full ambitions of the framework and ICP are achieved.

The intention is for this commissioning framework is to be adopted by providers from April 2019.

**Appendix 1**
Care Communities Outcome Framework

**Appendix 2**
Example of a Care Community Dashboard

**Appendix 3**
Cheshire East Local Authority Health Profile 2018

**Appendix 4**
Cheshire West and Chester Local Authority Health Profile 2018
<table>
<thead>
<tr>
<th>Caring Together Ambition</th>
<th>Outcome</th>
<th>Care Communities Strategic Outcomes</th>
<th>Sub Outcomes</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Empowered Person</td>
<td>People are empowered to take responsibility for their own health and wellbeing</td>
<td>People have greater understanding of what they can do to live/maintain a healthy lifestyle</td>
<td>Increase in uptake in NHS Health checks</td>
<td>Health Checks: People said LTC supported to manage their condition.</td>
</tr>
<tr>
<td></td>
<td>People are empowered to manage their own health and wellbeing and manage their own support as they wish, so that they are in control of what, how and when support is delivered to match their needs.</td>
<td>People have a greater understanding of how they can manage their long term conditions</td>
<td>Increase of people involved in the development of their care plan</td>
<td>Making Every Contact Count?</td>
</tr>
<tr>
<td>Easy Access</td>
<td>Access that is designed to deliver high quality, responsive services</td>
<td>Consistent access to care services in the community during core hours 7 days a week – 24 hours a day</td>
<td>Access to services, including GP, mental health, social care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Improved access to high quality, responsive services, support and appropriate information that provides everyone with the opportunity to have the best health and wellbeing throughout their life.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appropriate time in Hospital</td>
<td>Improper time in hospital with prompt &amp; planned discharge, well-organised community care</td>
<td>Reduced unplanned care and crises</td>
<td>Reduced A&amp;E Attendances</td>
<td>High quality care: Reduced number of placements to care homes.</td>
</tr>
<tr>
<td></td>
<td>Reducing inappropriate time spent in hospital by increasing planned discharge into co-ordinated community care</td>
<td>Maintaining the quality of care provided in community settings regardless of the time of day or the day of the week.</td>
<td>Avoidable Admissions</td>
<td>Intermediate Care referral and discharge information: Intermediate Care referral and discharge information.</td>
</tr>
<tr>
<td>High quality care</td>
<td>The highest quality care delivered by the right person regardless of the time of day or the day of the week.</td>
<td>Maintain/improve the quality of care provided by the community teams.</td>
<td>Emergency admissions</td>
<td>The proportion of people returning to their usual place of residence following a hospital stay.</td>
</tr>
<tr>
<td></td>
<td>Increasing the quality of care provided in Eastern Cheshire regardless of the time of day or the day of the week.</td>
<td>Maintain/improve the quality of care provided by the community teams.</td>
<td>Emergency care home placements</td>
<td>Care home placements Length of hospital stays: The proportion of people aged 65+ who are at increased risk of hospitalisation, reduced from discharge to hospital Resections.</td>
</tr>
<tr>
<td>Support for carers</td>
<td>Carers feel valued and supported and are able to maintain or improve their desired quality of life.</td>
<td>Carers can balance their caring roles and maintain a desired quality of life.</td>
<td>Maintain/improve the quality of care provided by the community teams.</td>
<td>Avoidable Admissions: Emergency admissions not referred by community teams.</td>
</tr>
<tr>
<td></td>
<td>Carers feel valued and supported and are able to maintain or improve their desired quality of life.</td>
<td>Carers can balance their caring roles and maintain a desired quality of life.</td>
<td>High quality care: Reduced number of emergency placements to care homes.</td>
<td>Emergency care home placements.</td>
</tr>
<tr>
<td>Integrated Care</td>
<td>Staff working together with the person at the centre to proactively manage long term physical and mental health conditions</td>
<td>Enhanced patient experience</td>
<td>Improved co-ordination and alignment of interventions offered by different organisations and professionals.</td>
<td>Case studies: Enhanced patient experience.</td>
</tr>
<tr>
<td></td>
<td>Improving peoples experience and outcomes of Integrated care</td>
<td>Increase in appropriate case finding and proactive management</td>
<td>Improved co-ordination and alignment of interventions offered by different organisations and professions.</td>
<td>Integration survey tool: Enhanced patient experience.</td>
</tr>
</tbody>
</table>

Version: 0.4_20180411
## Care Communities Strategic Outcomes

### Integrated Care

**Accessto Services (ECCCG patients with CEC Social Care)**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Baseline 2017/18</th>
<th>Q1 2018/19</th>
<th>Q2 2018/19</th>
<th>Q3 2018/19</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a. <strong>MENTAL HEALTH</strong> - People entering Treatment &amp; Prescribing (ADULTS)**</td>
<td>55.26%</td>
<td>58.00%</td>
<td>60.89%</td>
<td>63.00%</td>
<td>RAG Parameters to be confirmed</td>
</tr>
<tr>
<td>1b. <strong>MENTAL HEALTH</strong> - Referral to Treatment (ECCCG) - Older People Functional</td>
<td>56.05%</td>
<td>56.65%</td>
<td>57.00%</td>
<td>57.00%</td>
<td>National Standards: GREEN (&lt;3.26)  AMBER (3.26 - 3.76)  RED ( &gt;3.76)</td>
</tr>
</tbody>
</table>

### Outcomes

**Easy Access**

- Access is YTD cumulative. In National Standards: GREEN (<90%)  AMBER (90% - 94.99%)  RED ( >95%)

**Rapid Response**

- Based on a target of 90% for time taken to respond to patients - all providers. Improves access to services, increasing peroples experience and outcomes of integrated care.

**Appropriate Time in Hospital**

- 100% of those accessing IMC - %Step Downs (Beds) 2.31% 2.41% 2.51% 2.61% 2.71% 2.81% 2.91% 3.01% 3.11% 3.21% 3.31%
- 100% of those accessing IMC - %Step Ups (Beds) 1.62% 1.52% 1.42% 1.32% 1.22% 1.12% 1.02% 0.92% 0.82% 0.72% 0.62%

### Appropriate Time in Hospital

- 100% of those accessing IMC - %Step Downs (Home) 75% 75% 75% 75% 75% 75% 75% 75% 75% 75% 75%
- 100% of those accessing IMC - %Step Ups (Home) 25% 25% 25% 25% 25% 25% 25% 25% 25% 25% 25%

### April Satsatisfaction Survey

**Integrated Care**

- Self rating together with the person at the centre to proactively manage long term physical and mental health conditions. Improves patients experience and outcomes of integrated care.

**Appropriate Time in Hospital**

- Appropriate time in hospital with prompt & planned discharge into well organised follow up services. Reducing inappropriate, unplanned hospital stays by increasing planned discharge rates and reducing readmissions.
Cheshire East
Unitary authority
This profile was published on 3 July 2018

Local Authority Health Profile 2018

This profile gives a picture of people’s health in Cheshire East. It is designed to help local government and health services understand their community’s needs, so that they can work together to improve people’s health and reduce health inequalities.

Health in summary
The health of people in Cheshire East is varied compared with the England average. About 10% (6,400) of children live in low income families. Life expectancy for both men and women is higher than the England average.

Health inequalities
Life expectancy is 10.1 years lower for men and 8.9 years lower for women in the most deprived areas of Cheshire East than in the least deprived areas.**

Child health
In Year 6, 15.4% (539) of children are classified as obese, better than the average for England. The rate of alcohol-specific hospital stays among those under 18 is 41*. This represents 31 stays per year. Levels of GCSE attainment are better than the England average.

Adult health
The rate of alcohol-related harm hospital stays is 634*. This represents 2,428 stays per year. The rate of self-harm hospital stays is 207*, worse than the average for England. This represents 730 stays per year. The rate of people killed and seriously injured on roads is worse than average. Rates of sexually transmitted infections and TB are better than average. Rates of statutory homelessness, violent crime, early deaths from cardiovascular diseases and early deaths from cancer are better than average.

For more information on priorities in this area, see:
• www.cheshireeast.gov.uk
• www.cheshireeast.gov.uk/jsna

Visit www.healthprofiles.info for more area profiles, more information and interactive maps and tools.

Local Authority Health Profiles are Official Statistics and are produced based on the three pillars of the Code of Practice for Statistics: Trustworthiness, Quality and Value.

* rate per 100,000 population
** see page 3

© Crown Copyright 2018
Understanding the sociodemographic profile of an area is important when planning services. Different population groups may have different health and social care needs and are likely to interact with services in different ways.

<table>
<thead>
<tr>
<th>Age group</th>
<th>Cheshire East (persons)</th>
<th>England (persons)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population (2016)*</td>
<td>377</td>
<td>55,268</td>
</tr>
<tr>
<td>Projected population (2020)*</td>
<td>382</td>
<td>56,705</td>
</tr>
<tr>
<td>% population aged under 18</td>
<td>20.0%</td>
<td>21.3%</td>
</tr>
<tr>
<td>% population aged 65+</td>
<td>22.2%</td>
<td>17.9%</td>
</tr>
<tr>
<td>% people from an ethnic minority group</td>
<td>2.1%</td>
<td>13.6%</td>
</tr>
</tbody>
</table>

* thousands

Source: Populations: Office for National Statistics licensed under the Open Government Licence

### Deprivation

The level of deprivation in an area can be used to identify those communities who may be in the greatest need of services. These maps and charts show the Index of Multiple Deprivation 2015 (IMD 2015).

#### National

The first of the two maps shows differences in deprivation in this area based on national comparisons, using national quintiles (fifths) of IMD 2015, shown by lower super output area. The darkest coloured areas are some of the most deprived neighbourhoods in England.

The chart shows the percentage of the population who live in areas at each level of deprivation.

#### Local

The second map shows the differences in deprivation based on local quintiles (fifths) of IMD 2015 for this area.

The charts show life expectancy for males and females within this local authority for 2014-16. The local authority is divided into local deciles (tenths) by deprivation (IMD 2015). The life expectancy gap is the difference between the top and bottom of the inequality slope. This represents the range in years of life expectancy from most to least deprived within this area. If there was no inequality in life expectancy the line would be horizontal.

**Trends over time: under 75 mortality**

These charts provide a comparison of the trends in death rates in people under 75 between this area and England. For deaths from all causes, they also show the trends in the most deprived and least deprived local quintiles (fifths) of this area.
The chart below shows how the health of people in this area compares with the rest of England. This area’s value for each indicator is shown as a circle. The England average is shown by the red line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator. However, a green circle may still indicate an important public health problem.

### Indicator names

<table>
<thead>
<tr>
<th>Indicator names</th>
<th>Period</th>
<th>Local count</th>
<th>Local value</th>
<th>Eng value</th>
<th>Eng worst</th>
<th>Eng best</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life expectancy at birth (Male)</td>
<td>2014 – 16</td>
<td>n/a</td>
<td>80.3</td>
<td>79.5</td>
<td>74.2</td>
<td>83.7</td>
</tr>
<tr>
<td>Life expectancy at birth (Female)</td>
<td>2014 – 16</td>
<td>n/a</td>
<td>83.7</td>
<td>83.1</td>
<td>79.4</td>
<td>86.8</td>
</tr>
<tr>
<td>Under 75 mortality rate: all causes</td>
<td>2014 – 16</td>
<td>3,331</td>
<td>303.9</td>
<td>333.8</td>
<td>545.7</td>
<td>215.2</td>
</tr>
<tr>
<td>Under 75 mortality rate: cardiovascular</td>
<td>2014 – 16</td>
<td>730</td>
<td>66.1</td>
<td>73.5</td>
<td>141.3</td>
<td>42.3</td>
</tr>
<tr>
<td>Under 75 mortality rate: cancer</td>
<td>2014 – 16</td>
<td>1,359</td>
<td>122.6</td>
<td>136.8</td>
<td>195.3</td>
<td>99.1</td>
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<tr>
<td>Suicide rate</td>
<td>2014 – 16</td>
<td>106</td>
<td>10.6</td>
<td>9.9</td>
<td>18.3</td>
<td>4.6</td>
</tr>
<tr>
<td>Killed and seriously injured on roads</td>
<td>2014 – 16</td>
<td>590</td>
<td>52.4</td>
<td>39.7</td>
<td>110.4</td>
<td>13.5</td>
</tr>
<tr>
<td>Hospital stays for self-harm</td>
<td>2016/17</td>
<td>730</td>
<td>206.9</td>
<td>185.3</td>
<td>578.9</td>
<td>50.6</td>
</tr>
<tr>
<td>Hip fractures in older people (aged 65+)</td>
<td>2016/17</td>
<td>493</td>
<td>574.6</td>
<td>575.0</td>
<td>854.2</td>
<td>364.7</td>
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<tr>
<td>Cancer diagnosed at early stage</td>
<td>2016</td>
<td>961</td>
<td>55.8</td>
<td>52.6</td>
<td>39.3</td>
<td>61.9</td>
</tr>
<tr>
<td>Diabetes diagnoses (aged 17+)</td>
<td>2017</td>
<td>n/a</td>
<td>75.7</td>
<td>77.1</td>
<td>54.3</td>
<td>96.3</td>
</tr>
<tr>
<td>Dementia diagnoses (aged 65+)</td>
<td>2017</td>
<td>3,833</td>
<td>71.7</td>
<td>67.9</td>
<td>45.1</td>
<td>90.8</td>
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<tr>
<td>Alcohol–specific hospital stays (under 18s)</td>
<td>2014/15 – 16/17</td>
<td>92</td>
<td>40.8</td>
<td>34.2</td>
<td>100.0</td>
<td>6.5</td>
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<tr>
<td>Alcohol–related harm hospital stays</td>
<td>2016/17</td>
<td>2,428</td>
<td>634.3</td>
<td>636.4</td>
<td>1,151.1</td>
<td>388.2</td>
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<tr>
<td>Smoking prevalence in adults (aged 18+)</td>
<td>2016/17</td>
<td>49,490</td>
<td>14.6</td>
<td>14.9</td>
<td>24.8</td>
<td>4.6</td>
</tr>
<tr>
<td>Physically active adults (aged 19+)</td>
<td>2016/17</td>
<td>n/a</td>
<td>69.2</td>
<td>66.0</td>
<td>53.3</td>
<td>78.8</td>
</tr>
<tr>
<td>Excess weight in adults (aged 18+)</td>
<td>2016/17</td>
<td>n/a</td>
<td>59.4</td>
<td>61.3</td>
<td>74.9</td>
<td>40.5</td>
</tr>
<tr>
<td>Under 18 concep tions</td>
<td>2016</td>
<td>98</td>
<td>15.5</td>
<td>18.8</td>
<td>36.7</td>
<td>3.3</td>
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<tr>
<td>Smoking status at time of delivery</td>
<td>2016/17</td>
<td>372</td>
<td>10.4</td>
<td>10.7</td>
<td>28.1</td>
<td>2.3</td>
</tr>
<tr>
<td>Breastfeeding initiation</td>
<td>2016/17</td>
<td>2,285</td>
<td>74.5</td>
<td>37.9</td>
<td>96.7</td>
<td>96.7</td>
</tr>
<tr>
<td>Infant mortality rate</td>
<td>2014 – 16</td>
<td>44</td>
<td>3.9</td>
<td>3.9</td>
<td>7.9</td>
<td>0.0</td>
</tr>
<tr>
<td>Obese children (aged 10–11)</td>
<td>2016/17</td>
<td>539</td>
<td>15.4</td>
<td>20.0</td>
<td>29.2</td>
<td>8.8</td>
</tr>
<tr>
<td>Deprivation score (IMD 2015)</td>
<td>2015/16</td>
<td>n/a</td>
<td>14.1</td>
<td>21.8</td>
<td>42.0</td>
<td>5.0</td>
</tr>
<tr>
<td>Smoking prevalence: routine and manual occupations</td>
<td>2016/17</td>
<td>n/a</td>
<td>35.0</td>
<td>25.7</td>
<td>48.7</td>
<td>5.1</td>
</tr>
<tr>
<td>Children in low income families (under 16s)</td>
<td>2015</td>
<td>6,365</td>
<td>10.1</td>
<td>16.8</td>
<td>30.5</td>
<td>5.7</td>
</tr>
<tr>
<td>GCSEs achieved</td>
<td>2015/16</td>
<td>2,281</td>
<td>62.1</td>
<td>57.8</td>
<td>44.8</td>
<td>78.7</td>
</tr>
<tr>
<td>Employment rate (aged 16−64)</td>
<td>2016/17</td>
<td>170,900</td>
<td>76.4</td>
<td>74.4</td>
<td>59.8</td>
<td>88.5</td>
</tr>
<tr>
<td>Statutory homelessness</td>
<td>2016/17</td>
<td>104</td>
<td>0.6</td>
<td>0.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Violent crime (violence offences)</td>
<td>2016/17</td>
<td>5,710</td>
<td>15.2</td>
<td>20.0</td>
<td>42.2</td>
<td>5.7</td>
</tr>
<tr>
<td>Excess winter deaths</td>
<td>Aug 2013 – Jul 2016</td>
<td>691</td>
<td>19.8</td>
<td>17.9</td>
<td>30.3</td>
<td>6.3</td>
</tr>
<tr>
<td>New sexually transmitted infections</td>
<td>2017</td>
<td>1,176</td>
<td>509.8</td>
<td>793.8</td>
<td>3,215.3</td>
<td>266.6</td>
</tr>
<tr>
<td>Cases of tuberculosis</td>
<td>2014 – 16</td>
<td>47</td>
<td>4.2</td>
<td>10.9</td>
<td>69.0</td>
<td>0.0</td>
</tr>
</tbody>
</table>

For full details on each indicator, see the definitions tab of the Health Profiles online tool: [www.healthprofiles.info](http://www.healthprofiles.info)

### Indicator value types

1. 2 Life expectancy - Years 3, 4, 5 Directly age-standardised rate per 100,000 population aged under 75 6 Directly age-standardised rate per 100,000 population aged 10 and over 7 Crude rate per 100,000 population 8 Directly age-standardised rate per 100,000 population aged 65 and over 10 Proportion - % of cancers diagnosed at stage 1 or 2 11 Proportion - % of cancers diagnosed at stage 3 or 4 12 Proportion - % of cancers diagnosed at stage 5 or more 13 Crude rate per 100,000 population aged under 18 14 Directly age-standardised rate per 100,000 population aged 65 and over 15 Proportion - % of males aged 15 to 19 16 Proportion - % of females aged 15 to 19 17 Proportion - % of males aged 20 to 24 18 Proportion - % of females aged 20 to 24 19 Proportion - % of males aged 25 to 29 20 Proportion - % of females aged 25 to 29 21 Crude rate per 1,000 live births 22 Proportion - % of males aged 15 to 19 23 Index of Multiple Deprivation (IMD) 2015 score 24, 25 Proportion - % of males 26 Proportion - % of females including English & Maths 27 Proportion - % of males 28 Crude rate per 1,000 households 29 Crude rate per 1,000 households 30 Ratio of excess winter deaths to average of non-winter deaths (%) 31 Crude rate per 100,000 population aged 15 to 64 (excluding Chlamydia) 32 Crude rate per 100,000 population

*Regional* refers to the former government regions.

*5* Value not published for data quality reasons

If 25% or more of areas have no data then the England range is not displayed. Please send any enquiries to healthprofiles@phe.gov.uk

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Cheshire West and Chester
Unitary authority

This profile gives a picture of people’s health in Cheshire West and Chester. It is designed to help local government and health services understand their community’s needs, so that they can work together to improve people’s health and reduce health inequalities.

Health in summary
The health of people in Cheshire West and Chester is varied compared with the England average. About 13% (7,600) of children live in low income families. Life expectancy for both men and women is similar to the England average.

Health inequalities
Life expectancy is 9.4 years lower for men and 8.8 years lower for women in the most deprived areas of Cheshire West and Chester than in the least deprived areas.**

Child health
In Year 6, 18.8% (627) of children are classified as obese. The rate of alcohol-specific hospital stays among those under 18 is 34*. This represents 23 stays per year. Levels of breastfeeding initiation are worse than the England average. Levels of GCSE attainment are better than the England average.

Adult health
The rate of alcohol-related harm hospital stays is 632*. This represents 2,134 stays per year. The rate of self-harm hospital stays is 233*, worse than the average for England. This represents 759 stays per year. Estimated levels of adult smoking in routine and manual occupations are better than the England average. The rate of people killed and seriously injured on roads is worse than average. Rates of sexually transmitted infections and TB are better than average. Rates of statutory homelessness and violent crime are better than average.

* rate per 100,000 population
** see page 3

For more information see:
- www.cheshirewestandchester.gov.uk/jsna
- www.valeroyalccg.nhs.uk
- www.westcheshireccg.nhs.uk

Visit www.healthprofiles.info for more area profiles, more information and interactive maps and tools.

Local Authority Health Profiles are Official Statistics and are produced based on the three pillars of the Code of Practice for Statistics: Trustworthiness, Quality and Value.

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Population

Understanding the sociodemographic profile of an area is important when planning services. Different population groups may have different health and social care needs and are likely to interact with services in different ways.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Cheshire West and Chester (persons)</th>
<th>England (persons)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population (2016)*</td>
<td>336</td>
<td>55,268</td>
</tr>
<tr>
<td>Projected population (2020)*</td>
<td>340</td>
<td>56,705</td>
</tr>
<tr>
<td>% population aged under 18</td>
<td>19.8%</td>
<td>21.3%</td>
</tr>
<tr>
<td>% population aged 65+</td>
<td>20.9%</td>
<td>17.9%</td>
</tr>
<tr>
<td>% people from an ethnic minority group</td>
<td>2.0%</td>
<td>13.6%</td>
</tr>
</tbody>
</table>

* thousands

Source:
Populations: Office for National Statistics licensed under the Open Government Licence

Deprivation

The level of deprivation in an area can be used to identify those communities who may be in the greatest need of services. These maps and charts show the Index of Multiple Deprivation 2015 (IMD 2015).

National
The first of the two maps shows differences in deprivation in this area based on national comparisons, using national quintiles (fifths) of IMD 2015, shown by lower super output area. The darkest coloured areas are some of the most deprived neighbourhoods in England.

The chart shows the percentage of the population who live in areas at each level of deprivation.

Local
The second map shows the differences in deprivation based on local quintiles (fifths) of IMD 2015 for this area.


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Health inequalities: life expectancy

The charts show life expectancy for males and females within this local authority for 2014-16. The local authority is divided into local deciles (tenths) by deprivation (IMD 2015). The life expectancy gap is the difference between the top and bottom of the inequality slope. This represents the range in years of life expectancy from most to least deprived within this area. If there was no inequality in life expectancy the line would be horizontal.

![Life expectancy gap for males: 9.4 years](image1)

![Life expectancy gap for females: 8.8 years](image2)

Trends over time: under 75 mortality

These charts provide a comparison of the trends in death rates in people under 75 between this area and England. For deaths from all causes, they also show the trends in the most deprived and least deprived local quintiles (fifths) of this area.

![Under 75 mortality rate: all causes, males](image3)

![Under 75 mortality rate: all causes, females](image4)

![Under 75 mortality: heart disease and stroke](image5)

![Under 75 mortality: cancer](image6)

Data from 2010-12 onwards have been revised to use IMD 2015 to define local deprivation quintiles (fifths), all prior time points use IMD 2010. In doing this, areas are grouped into deprivation quintiles using the Index of Multiple Deprivation which most closely aligns with the time period of the data. This provides a more accurate way of examining changes over time by deprivation.

Data points are the midpoints of three year averages of annual rates, for example 2005 represents the period 2004 to 2006. Where data are missing for local least or most deprived, the value could not be calculated as the number of cases is too small.

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The chart below shows how the health of people in this area compares with the rest of England. This area’s value for each indicator is shown as a circle. The England average is shown by the red line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator. However, a green circle may still indicate an important public health problem.

![Health summary for Cheshire West and Chester](image)

For full details on each indicator, see the definitions tab of the Health Profiles online tool: [www.healthprofiles.info](http://www.healthprofiles.info)

### Indicator names

<table>
<thead>
<tr>
<th>Period</th>
<th>Local count</th>
<th>Local value</th>
<th>Eng value</th>
<th>Eng worst</th>
<th>Eng best</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life expectancy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2014 – 16</td>
<td>n/a</td>
<td>79.7</td>
<td>79.5</td>
<td>74.2</td>
<td>83.7</td>
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<tr>
<td>Life expectancy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2014 – 16</td>
<td>n/a</td>
<td>82.8</td>
<td>83.1</td>
<td>79.4</td>
<td>86.8</td>
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<td>Under 75 mortality rate: all causes</td>
<td>2014 – 16</td>
<td>3,088</td>
<td>328.0</td>
<td>333.8</td>
<td>545.7</td>
</tr>
<tr>
<td>Under 75 mortality rate: cardiovascular</td>
<td>2014 – 16</td>
<td>661</td>
<td>70.2</td>
<td>73.5</td>
<td>141.3</td>
</tr>
<tr>
<td>Under 75 mortality rate: cancer</td>
<td>2014 – 16</td>
<td>1,330</td>
<td>140.2</td>
<td>136.8</td>
<td>195.3</td>
</tr>
<tr>
<td>Suicide rate</td>
<td>2014 – 16</td>
<td>88</td>
<td>9.9</td>
<td>9.9</td>
<td>18.3</td>
</tr>
<tr>
<td>Violent crime (violence offences)</td>
<td>2014 – 16</td>
<td>496</td>
<td>49.5</td>
<td>39.7</td>
<td>110.4</td>
</tr>
<tr>
<td>Hospital stays for self-harm</td>
<td>2016/17</td>
<td>759</td>
<td>232.5</td>
<td>185.3</td>
<td>578.9</td>
</tr>
<tr>
<td>Hip fractures in older people (aged 65+)</td>
<td>2016/17</td>
<td>379</td>
<td>545.4</td>
<td>575.0</td>
<td>854.2</td>
</tr>
<tr>
<td>Cancer diagnosed at early stage</td>
<td>2016</td>
<td>830</td>
<td>51.6</td>
<td>52.6</td>
<td>39.3</td>
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<tr>
<td>Diabetes diagnoses (aged 17+)</td>
<td>2017</td>
<td>n/a</td>
<td>79.7</td>
<td>77.1</td>
<td>54.3</td>
</tr>
<tr>
<td>Dementia diagnoses (aged 65+)</td>
<td>2017</td>
<td>2,789</td>
<td>65.0</td>
<td>67.9</td>
<td>45.1</td>
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<tr>
<td>Alcohol–specific hospital stays (under 18s)</td>
<td>2014/15 – 16/17</td>
<td>68</td>
<td>34.2</td>
<td>34.2</td>
<td>100.0</td>
</tr>
<tr>
<td>Alcohol–related hospital stays</td>
<td>2016/17</td>
<td>2,134</td>
<td>631.7</td>
<td>636.4</td>
<td>1,151.1</td>
</tr>
<tr>
<td>Smoking prevalence in adults (aged 18+)</td>
<td>2017</td>
<td>34,098</td>
<td>12.7</td>
<td>14.9</td>
<td>24.8</td>
</tr>
<tr>
<td>Excess weight in adults (aged 18+)</td>
<td>2016/17</td>
<td>n/a</td>
<td>68.4</td>
<td>66.0</td>
<td>53.3</td>
</tr>
<tr>
<td>Under 18 conceptions</td>
<td>2016</td>
<td>100</td>
<td>18.7</td>
<td>18.8</td>
<td>36.7</td>
</tr>
<tr>
<td>Smoking status at time of delivery</td>
<td>2016/17</td>
<td>409</td>
<td>11.7</td>
<td>10.7</td>
<td>28.1</td>
</tr>
<tr>
<td>Breastfeeding initiation</td>
<td>2016/17</td>
<td>2,306</td>
<td>66.3</td>
<td>74.5</td>
<td>37.9</td>
</tr>
<tr>
<td>Infant mortality rate</td>
<td>2014 – 16</td>
<td>39</td>
<td>3.7</td>
<td>3.9</td>
<td>7.9</td>
</tr>
<tr>
<td>Obese children (aged 10–11)</td>
<td>2016/17</td>
<td>627</td>
<td>18.8</td>
<td>20.0</td>
<td>29.2</td>
</tr>
<tr>
<td>Deprivation score (IMD 2015)</td>
<td>2015</td>
<td>n/a</td>
<td>18.1</td>
<td>21.8</td>
<td>42.0</td>
</tr>
<tr>
<td>Smoking prevalence: routine and manual occupations</td>
<td>2017</td>
<td>n/a</td>
<td>16.8</td>
<td>25.7</td>
<td>48.7</td>
</tr>
<tr>
<td>Children in low income families (under 16s)</td>
<td>2015</td>
<td>7,565</td>
<td>13.1</td>
<td>16.8</td>
<td>30.5</td>
</tr>
<tr>
<td>GCSEs achieved</td>
<td>2015/16</td>
<td>2,058</td>
<td>62.8</td>
<td>57.8</td>
<td>44.8</td>
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<td>Employment rate (aged 16−64)</td>
<td>2016/17</td>
<td>149,400</td>
<td>73.5</td>
<td>74.4</td>
<td>59.8</td>
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<tr>
<td>Statutory homelessness</td>
<td>2016/17</td>
<td>24</td>
<td>0.2</td>
<td>0.8</td>
<td></td>
</tr>
<tr>
<td>Violent crime (violence offences)</td>
<td>2016/17</td>
<td>5,970</td>
<td>17.9</td>
<td>20.0</td>
<td>42.2</td>
</tr>
<tr>
<td>Excess winter deaths</td>
<td>Aug 2013 – Jul 2016</td>
<td>587</td>
<td>18.9</td>
<td>17.9</td>
<td>30.3</td>
</tr>
<tr>
<td>Sexually transmitted infections</td>
<td>2017</td>
<td>1,170</td>
<td>557.8</td>
<td>793.8</td>
<td>3,215.3</td>
</tr>
<tr>
<td>Cases of tuberculosis</td>
<td>2014 – 16</td>
<td>30</td>
<td>3.0</td>
<td>10.9</td>
<td>69.0</td>
</tr>
</tbody>
</table>

For details on each indicator, see the definitions tab of the Health Profiles online tool: [www.healthprofiles.info](http://www.healthprofiles.info)

### Indicator value types

1. Life expectancy:
   - Years 3, 4, 5: Directly age-standardised rate per 100,000 population aged under 75
   - Years 6: Directly age-standardised rate per 100,000 population aged 10 and over
   - %: Proportion of cancers diagnosed at stage 1 or 2

2. Crude rate per 1,000 households: 30
3. Crude rate per 1,000 population: 79
4. Ratio of excess winter deaths to average of non-winter deaths: 11
5. Crude rate per 100,000 population aged 15 to 64: 12

9. Directly age-standardised rate per 100,000 population aged 65 and over
10. Proportion: % of cancers diagnosed at stage 1 or 2
11. Proportion: % of cancers diagnosed at stage 1 or 2
12. Proportion: % of cancers diagnosed at stage 1 or 2
13. Proportion: % of cancers diagnosed at stage 1 or 2
14. Directly age-standardised rate per 100,000 population aged 15 to 64
15. Proportion: % of cancers diagnosed at stage 1 or 2
16. Proportion: % of cancers diagnosed at stage 1 or 2
17. Proportion: % of cancers diagnosed at stage 1 or 2
18. Proportion: % of cancers diagnosed at stage 1 or 2
19. Proportion: % of cancers diagnosed at stage 1 or 2
20. Proportion: % of cancers diagnosed at stage 1 or 2
21. Proportion: % of cancers diagnosed at stage 1 or 2
22. Proportion: % of cancers diagnosed at stage 1 or 2
23. Proportion: % of cancers diagnosed at stage 1 or 2
24. Proportion: % of cancers diagnosed at stage 1 or 2
25. Proportion: % of cancers diagnosed at stage 1 or 2
26. Proportion: % of cancers diagnosed at stage 1 or 2
27. Proportion: % of cancers diagnosed at stage 1 or 2
28. Proportion: % of cancers diagnosed at stage 1 or 2
29. Proportion: % of cancers diagnosed at stage 1 or 2
30. Proportion: % of cancers diagnosed at stage 1 or 2
31. Proportion: % of cancers diagnosed at stage 1 or 2
32. Proportion: % of cancers diagnosed at stage 1 or 2

*Regional* refers to the former government regions.

If 25% or more of areas have no data then the England range is not displayed.

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Contracting arrangements for integrated care providers – response to consultation
Directorate

Medical
Nursing
Finance

Operations and Information
Trans. & Corp. Ops.

Specialised Commissioning
Strategy & Innovation

Publishing Approval Reference: 000292

Document Purpose
Implementation Support

Document Name
Contracting arrangements for integrated care providers – response to consultation

Author
NHS England

Publication Date
March 2019

Target Audience
CCG Clinical Leaders, CCG Accountable Officers, CSU Managing Directors, Foundation Trust CEs, Medical Directors, Directors of PH, Directors of Nursing, Local Authority CEs, Directors of Adult SSS, NHS England Regional Directors, NHS England Directors of Commissioning Operations, Allied Health Professionals, GPs, Communications Leads, Directors of Children’s Services, NHS Trust CEs, Members of the public

Additional Circulation List

Description
The consultation ran over a period of 12 weeks, from 3 August to 26 October 2018. Following the review and analysis of the consultation feedback this response report has been published.

Cross Reference

Superseded Docs (if applicable)

Action Required
For Information

Timing / Deadlines (if applicable)
N/A

Contact Details for further information
NHS England
Primary Care Strategy and NHS Contracts
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Contracting arrangements for integrated care providers: response to consultation

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1 Context and development

1.1 What is the ICP Contract?

1. There is a long-recognised need for health and care services to be better integrated to improve people’s care, reinforced recently by the House of Commons Health and Social Care Committee’s support for improving integration of care. In January 2019, the NHS Long Term Plan highlighted the intention to ‘dissolve the historic divide between primary and community health services’ and further stated:

'The NHS will be more joined-up and coordinated in its care. Breaking down traditional barriers between care institutions, teams and funding streams so as to support the increasing number of people with long-term health conditions, rather than viewing each encounter with the health service as a single, unconnected ‘episode’ of care'.

2. The NHS Long Term Plan sets out the centrality of integrated care systems (ICSs) to achieving this goal. In ICSs, commissioners and providers of NHS services, in partnership with local authorities and others, voluntarily take collective responsibility for managing resources, delivering NHS standards and improving the health of the population they serve. Collaborations will also take place at different levels in the system, including through provider partnerships, such as networks of primary care providers. The NHS Long Term Plan committed to new investment of at least £4.5 billion over the next five years in primary medical and community services to deliver stronger integration and out of hospital care. This will support, for example, expanded community multidisciplinary teams aligned with new primary care networks, and a new offer of urgent community response and recovery support.

3. The health and care services provided to an individual or population are currently arranged via a series of different contracts, awarded by NHS and local authority commissioners to a range of different providers. For example, each GP practice holds a contract of one sort for primary medical services, whilst hospital, mental health or community NHS services are bought using another type of contract, usually independently from each other. In addition, many public health and social care services are delivered by local authorities themselves. A complex set of separate contracts, organisations and funding streams can lead to duplication and lack of coordination, make communication between providers, clinicians and patients more difficult, and risk loss of focus on the overall needs of the person. This affects how people receive their care from the various health and care services across the system, and could adversely affect those services.

4. For this reason, in some areas, commissioners and providers have found it helpful to put in place an overlaying agreement (which can be known as an ‘alliance agreement’), supplementing the providers’ individual contracts with the commissioner and formalising their collaboration. This agreement can describe

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shared processes, goals and incentives, and set up a joint forum for discussion of what is best for the population and for the achievement of the defined goals, and how budgets and resources can best be used to those ends. In these collaborations there can be a sense of shared system accountability for managing separate organisations' resources, quality improvement and population health in a more aligned way.

5. Despite the longstanding aim of improving integration there has never before been a commissioning contract designed specifically to promote an integrated service model including primary care, wider NHS and some local authority services. Though contracts alone do not deliver integration, commissioners want the opportunity to use a contract of this type to ensure contracting, funding and organisational structures all help rather than hinder staff to do the right thing and to define more clearly who has overall responsibility for integrating and co-ordinating care.

6. The development of the NHS Standard Contract (Integrated Care Provider) Contract ('ICP Contract') responds to the demand from some commissioners and providers for a single contract through which general practice, wider NHS services, and in some cases some local authority-funded services, may be commissioned from a single 'lead' provider organisation, responsible for delivering those services in an integrated fashion. We call such a provider an 'Integrated Care Provider' (ICP). ICPs are not new types of legal entity, but rather provider organisations (such as NHS foundation trusts) which have been awarded ICP contracts.

7. The ICP Contract is largely based on the generic NHS Standard Contract, and includes additional provisions specifically designed to:
   - ensure the ICP is required to deliver integrated, population-based care
   - ensure, as far as possible, consistency in terms and conditions in relation to different services, reducing the risk of conflicting priorities or requirements getting in the way of clinicians and care workers doing the right thing for people in their care
   - accommodate a population-based payment approach, allowing flexible deployment of resources to best meet needs and encouraging a stronger focus on overall health and prevention of ill-health, rather than simply paying for activity delivered
   - accommodate aligned incentives across all teams and services.

8. Commissioning services in this way, as we understand many clinicians and staff want to see it, can ensure the sustainability of care redesign – perhaps cementing developments already achieved through looser models of collaboration. It can ensure the benefits of collaboration are not lost over time. In particular, the new contract is designed to facilitate a stronger role for providers of primary medical services, allowing GPs to work at the heart of the system and with colleagues to take on an operational, clinical leadership role in co-ordinating the care that is delivered to their patients, treating them in the most appropriate setting, close to home.
1.2 History of publication and development

9. Engagement on what is now the draft ICP Contract began with six ‘vanguard’ areas working towards implementation of the Multispecialty Community Provider (MCP) care model. A contract development group was established in 2015 which brought together interested clinical commissioning groups (CCGs) with wider stakeholders such as the Royal College of General Practice (RCGP), the British Medical Association (BMA), and the National Association of Primary Care (NAPC). This early co-development period led to a publication of a draft ‘MCP Contract Package’ in December 2016, which began an engagement period in which feedback was invited on the draft.

10. Following its publication, it became clear to NHS England that the draft MCP Contract could in fact have a broader application. The next version of the draft contract was re-named to reflect this and published in August 2017. We published alongside it a summary of the engagement received earlier in the year on its first iteration as the draft MCP Contract.²³

11. Our initial intention had been to consult formally on the draft ICP Contract following testing with early commissioners and providers. In early 2018 however, we committed to bringing our consultation forward to take the opportunity to explain our proposals in more detail, and to dispel misconceptions about what integrated care models might mean for the NHS in England and for the people who rely on it.

12. The consultation began once the High Court had decided two judicial reviews in NHS England’s favour:
   * R (oao Jennifer Shepherd) v NHS England [2018] EWHC 1067 (Admin)⁴, which concerned the lawfulness of the payment approach contemplated by the draft ICP Contract, the whole population annual payment.⁵
   * R (oao Hutchinson & others) v SSHSC and NHS England [2018] EWHC 1698 (Admin)⁶, which concerned, in general terms, the lawfulness of the ICP model and the manner of its introduction.⁷

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² The full draft Contract package published in August 2017, including a summary of the feedback previously received, can be found on the NHS England website: [https://www.england.nhs.uk/new-business-models/publications/](https://www.england.nhs.uk/new-business-models/publications/). This package of documents may be further updated.

³ The previous iteration of this draft ICP Contract was referred to as the draft Accountable Care Organisation (ACO) Contract. At that point in time, we described ICPs as accountable care organisations or ACOs. We have changed our terminology in recognition that, as reported by the House of Commons Health and Social Care Committee, use of the term ‘accountable care’ has generated unwarranted misunderstanding about what is being proposed. We believe that the terms ‘Integrated Care Provider’ and ‘Integrated Care Model’ better describe our proposals – to promote integrated service provision through a contract to be held by a single lead provider.

⁴ The judgment can be viewed here: [https://www.bailii.org/ew/cases/EWHC/Admin/2018/1067.html](https://www.bailii.org/ew/cases/EWHC/Admin/2018/1067.html)

⁵ The Claimsants in the other judicial review challenge did not seek permission to appeal the High Court’s judgment.

⁶ The judgment can be viewed here: [https://www.bailii.org/ew/cases/EWHC/Admin/2018/1698.html](https://www.bailii.org/ew/cases/EWHC/Admin/2018/1698.html)

⁷ Note that following the start of the consultation, the Appellant in the Jennifer Shepherd Judicial review challenge sought to overturn the decision of the High Court in an appeal to the Court of Appeal. Her appeal was unsuccessful in respect of all seven of her pleaded grounds and, for eleven reasons, the decision of the High Court was upheld by the Court of Appeal in its judgment dated 20 December 2018 (citation number: [2018] EWCA Civ 2849). The judgment can be viewed here: [https://www.bailii.org/ew/cases/EWCA/Civ/2018/2849.html](https://www.bailii.org/ew/cases/EWCA/Civ/2018/2849.html).
1.3 Summary of consultation approach

13. The consultation ran over a period of 12 weeks, from 3 August-26 October 2018.

14. In support of the consultation, we published a consultation document setting out our proposals (along with an easy read version), the draft ICP Contract and other supporting materials. These were available on the NHS England website and were available in hard copy format by request. We worked with voluntary sector organisations, patient groups and networks in a variety of ways to raise awareness about the proposals.

15. We held engagement events, open to those who expressed interest in attending, in London, Leeds, Exeter and Birmingham. At each location there were sessions for members of the public and for NHS and other stakeholders. A further event was held specifically for local authority representatives.

16. There were various options for people to give written feedback to the consultation. These included an online survey based on the questions outlined below, and postal responses. We also received a number of responses via email and made available an easy read questionnaire.

17. The consultation document set out 12 questions for feedback. These related to:
   - whether people supported the option of a single contract that promotes the integration of services
   - proposed content in the draft contract aimed at promoting integration
   - the balance between national and local content in the draft content
   - whether an ‘integrated budget’ offers a useful flexibility for commissioners
   - the proposed contractual safeguards about service quality, patient choice, transparency and financial management
   - GP participation in an ICP
   - local authority participation in an ICP
   - proposed contractual safeguards about commissioners’ statutory duties
   - proposed contractual provisions about public accountability
   - proposed contractual provisions about value, quality and effectiveness
   - additional suggestions for the draft ICP Contract
   - the equality and health inequalities impact of the proposed national provisions in the draft ICP Contract.
2 Who responded to the consultation?

18. In total, we received 3,806 written responses to the consultation. These included:
   - 466 responses to our online survey
   - 67 responses to the easy read version of the survey
   - 3,273 responses received by email and post.

19. Of the 3,806 total written responses, we judged that 3,276 (86%) were part of
    organised campaigns, identified through their use of common response templates
    repeating key themes and phrases. Three separate template responses were
    identified – with 3,161 responses on the first, 106 on the second and ten on the
    third.

20. The table below breaks down the responses by different types of respondent,
    based on categories available for selection through the Citizenspace survey:

<table>
<thead>
<tr>
<th>Respondent Type</th>
<th>Number of responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member of the public</td>
<td>3,595</td>
</tr>
<tr>
<td>Other</td>
<td>57</td>
</tr>
<tr>
<td>NHS provider organisation</td>
<td>23</td>
</tr>
<tr>
<td>Clinical Commissioning Group (CCG)</td>
<td>23</td>
</tr>
<tr>
<td>Voluntary organisation or charity</td>
<td>17</td>
</tr>
<tr>
<td>Clinician</td>
<td>14</td>
</tr>
<tr>
<td>Local authority</td>
<td>15</td>
</tr>
<tr>
<td>GP organisation/individual GP</td>
<td>11</td>
</tr>
<tr>
<td>Patient representative organisation</td>
<td>15</td>
</tr>
<tr>
<td>Professional representative body</td>
<td>22</td>
</tr>
<tr>
<td>Not Answered</td>
<td>6</td>
</tr>
<tr>
<td>Other healthcare organisation</td>
<td>6</td>
</tr>
<tr>
<td>Academic</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td><strong>3,806</strong></td>
</tr>
</tbody>
</table>

21. In addition, a petition addressed to NHS England received 31,870 signatures. Its
    content was similar to that of the most common template campaign response.

22. Approximately 250 people attended our engagement events. Those attending
    included members of the public and representatives from provider organisations,
    commissioners, GPs, local authorities, professional representative bodies and
    charities.

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8 One response was identified as using text from two of the campaign templates.
9 Respondents to the Citizenspace survey self-identified their respondent category. We have identified the respondent category
   responses received by post and email, and for the easy read survey.
3 Summary of feedback and response

3.1 Summary of feedback

23. Responses varied considerably across the different types of respondent. NHS providers and commissioners were generally supportive of introducing the ICP Contract as an option for local systems to enable integration. They acknowledged and confirmed the proposed benefits of such a contract, whilst recognising that considerable engagement and strong relationships would be required locally before considering its use. The benefits identified included, for example, the opportunity an ICP would have in removing organisational and other barriers between different parts of the health and social care system, which may currently lead to duplication of work and confusion for patients. It was noted that the contract should provide the flexibility to enable staff and teams to work differently, and enable a stronger focus on preventing ill-health. For example, NHS Clinical Commissioners (a representative body for CCGs) stated:

'A key potential benefit of the ICP Contract is that it is designed to promote an integrated service model, affording the opportunity to commission primary care alongside wider NHS services, public health and social care provision. This has the potential to further integration and the delivery of person-centred care.'

24. An NHS provider stated:

'It is clear that there is a need to move to a new way of working which enables integration of services to be delivered irrespective of provider organisation. The current contracting arrangements make this hard to achieve as organisational barriers will always get in the way of enabling integration of services to occur.'

25. Responses from the small number of individual GPs who responded were mixed. Responses from GP representative bodies (particularly the BMA and the RCGP) raised various issues in their responses, including their concerns about what they refer to as the 'potential marketisation of the NHS' through competition for contracts, and that the likely scale of an ICP would mean only large organisations would be capable of holding the contract, limiting the opportunity for GPs to have leadership opportunities and autonomy. The RCGP and BMA welcomed the aim to deliver greater integration of services, for example the RCGP stated:

'It is widely agreed that there is a need for greater integration of care to improve patient experience, quality of care and outcomes. It is hoped that integration will help address current unsustainable pressures within the NHS and social care, and as the challenge of caring for an ageing population with multiple co-morbidities grows, represent an opportunity to collaborate and improve the patient journey. In order for there to be widespread change, there must be joint working between primary care, secondary care, mental health, social care and the voluntary sector.'

However, these representative bodies raised specific issues about the effectiveness and widespread viability of options proposed to enable GP
integration in an ICP – including around the complexity and viability of elements of the ‘fully integrated’ option, where GPs would be given the option of suspending their current primary medical services contracts for a period of time in order to become an employee or sub-contractor of the ICP. For example, the BMA highlighted that they ‘retain serious doubts about the practicality of the “right of return” proposals, open to practices should they agree to suspend their respective GMS/PMS contract and integrate fully into an ICP.’ The BMA also highlighted their view that collaboration is already occurring effectively through local agreements which do not require new contracts. A small number of responses also queried how emerging forms of collaboration such as primary care networks would relate to ICPs.

26. Local authority responses (including a joint response from the Local Government Association (LGA) and Association of Directors of Adult Social Services (ADASS)) were generally supportive of the option of a contract to support health and social care integration, but raised general questions about how adequately the current version provides for integration of local authority services with healthcare. They also expressed concern about potential barriers to a local authority itself holding an ICP Contract, and we heard some wider views about potential challenges of local authority participation in an ICP model.

27. A significant majority of responses from members of the public, including those related to organised campaigns, were opposed. A widely-held concern expressed in these responses related to the potential for private sector bodies to hold an ICP Contract, and there was considerable support for preventing non-statutory bodies from holding an ICP Contract altogether. Specific related concerns included whether the performance of an independent sector ICP would be sufficiently open to public scrutiny. For example, the petition and responses associated with one campaign stated:

‘This would mean that profit-making companies – who have often failed our NHS – could be responsible for the care of whole areas of the country, even though they’re not a statutory part of the NHS.’

Some associated concerns were raised in the consultation that private providers may prioritise profit which could result in reduced quality of care or access to services, or local or regional monopolistic providers could emerge. Many respondents rejected in general the principle of contracting as the basis for service provision in the NHS.

28. A number of other themes and specific comments were received across the consultation feedback, including:

- Concerns the potential role for sub-contractors in delivering services commissioned through an ICP Contract may lead to duplication between commissioners and the ICP in carrying out provider / contract management activities, which might limit the extent to which an ICP would achieve a meaningful and effective transformation in care
- Concerns about how a CCG would effectively hold an ICP to account
- Whether a provider organisation would have the necessary skills and capability to successfully meet the requirements of an ICP Contract, such as to deliver a population-based approach
• A consensus among many respondents, consistent with statements we had 
made in the consultation pack, that the ICP Contract should not be presented 
as the only option for local systems, but as one of a number of different 
approaches to integration available to commissioners and providers.

29. Further detail about the feedback we received in response to each specific 
consultation question is contained in Annex A.10

3.2 Our response

30. We have analysed and considered in detail the feedback received throughout the 
consultation. There is support across NHS commissioners and providers for 
making the ICP Contract available as an option for local systems, and widespread 
agreement with the proposal set out in the consultation pack that, if adopted, its 
use should be voluntary, recognising the range of options available to systems. 
Many respondents agreed that an ICP Contract has the potential to underpin 
integration of primary medical services and other health and care services. We 
therefore consider that the rationale for asking a lead provider to take responsibility 
for this integration remains strong where the necessary local conditions are in 
place, including buy-in from local GP practices and the wider system.

31. We address below three broad themes which arose from the consultation 
responses. The first of these, expressed in particular by members of the public 
through the campaign-related responses, relates to the potential for an 
independent sector organisation to be awarded an ICP Contract. We then discuss 
the ability for the ICP to achieve successful integration of primary medical services 
and local authority-commissioned services and finally the feedback relating to the 
changes to commissioner and provider roles where an ICP is commissioned.

32. More detailed feedback and responses for each consultation question is provided 
in Annex A.

3.2.1 The benefits of a statutory body holding the ICP Contract

33. The experience of CCGs who have been exploring the possibility of an ICP 
Contract for their area supports the view that a statutory provider is likely to be 
identified as the most capable organisation to hold such a contract. Statutory 
bodies have been selected as preferred bidders in the ongoing procurement in 
Dudley, the area where the first ICP Contract may be awarded. This likelihood 
reflects the need for any organisation which would wish to become an ICP to 
demonstrate wider sign-up and strong relationships with different providers across 
the system, in addition to assuring commissioners that it had the experience, 
resilience and capability to deliver the required services to a high standard.

10 In some cases, similar themes were raised in response to multiple consultation questions. In 
summarising consultation feedback for this report, we have generally sought to ensure that the 
comments for specific themes are included in the summary for one question only in order to reduce 
duplication.
34. However, it should be understood that current NHS law and EU and domestic procurement law prohibits CCGs or NHS England from taking steps, whether through evaluation criteria used in a procurement or otherwise, to disqualify certain categories of provider (e.g., independent sector providers) from bidding for or being awarded commissioning contracts. It is with these rules in mind that we included in the draft ICP Contract package a range of financial safeguards, over and above those already in the generic NHS Standard Contract, that would apply to provide additional assurance to commissioners and the public in the unlikely event that a non-statutory provider should be awarded an ICP Contract. These safeguards have been proposed specifically to recognise the anticipated broader scope and scale of ICP Contracts in comparison with existing NHS commissioning contracts, and to provide security to patients and the public that services will be protected. These safeguards include, as examples:

- requirements to maintain a minimum level of assets
- a restriction on carrying out any business other than that required by the ICP Contract
- a prohibition on distribution of funds unless a range of quality standards and financial conditions have been met
- the expectation that the ICP will secure a guarantee from its parent organisation or a third party, providing financial security for the ICP’s performance of the ICP Contract.

35. In order to provide further assurance regarding financial stability, transparency and accountability we will take the following steps before the ICP Contract is republished:

- We will provide guidance as to the further contractual protection and stringent capitalisation and financial standing and security requirements that an ICP will be required to satisfy, constituting an important safeguard for ongoing delivery of services.
- We will include in the ICP Contract new standards more explicitly requiring ICPs to act in an open and accountable way. These will include:
  - requirements to hold board meetings in public
  - additional transparency standards requiring performance and financial information to be published and made available directly to patients and the public
  - more explicit requirements, in response to specific suggestions in the consultation, for the ICP to work directly with local Healthwatch and other supervisory bodies.

36. Alongside the publication of the ICP Contract, we have considered further legislative steps, part of a package outlined in the NHS Long Term Plan, which if enacted would support commissioners and providers in developing and carrying forward proposals to put in place an ICP more quickly and with less bureaucracy than is possible currently. The proposals have accordingly been designed to facilitate local discussions to identify a suitable public body where this consensus has been reached. The two related proposals:

- provide for the creation of new statutory bodies ('integrated care trusts') which would be fit-for-purpose organisations to perform the role of integrated care provider for a defined population; and
- allow NHS commissioners to decide the circumstances in which they should use procurement, subject to a 'best value' test to secure the best outcomes for
patients and the taxpayer - which would enable local commissioners to award a service contract to an appropriate statutory provider organisation without the need to undertake a process as required by current procurement rules.

37. The agreement of these proposals by Parliament is, at best, some years off. However, if progressed they would support CCGs to act more freely in delivering improved outcomes and integration for patients, and so we will continue to advocate for these changes as we learn from early adoption of the ICP Contract.

3.2.2 The inclusion of GP and local authority funded services

38. We agree with the many respondents, such as the RCGP, who told us the inclusion of primary medical services is vitally important to the delivery of a whole population model of care, given the central role of general practice in every health system. We will continue, in response to concerns raised particularly by the RCGP and the BMA, to reassure GP practices that whether and how they participate in an ICP model is entirely voluntary, noting respondents’ views that the availability of a range of options is important.

39. While GPs would be able to choose whether and how they wish to participate in an ICP, GP responses demonstrate that some are concerned about how reactivation of suspended General Medical Services (GMS)/Personal Medical Services (PMS) contracts (the mechanism for which remains subject to changes in regulations developed through discussions with the BMA and was previously consulted upon by the Department of Health and Social Care in 2017\textsuperscript{11}) will operate in practice for ‘fully integrated’ models. No specific suggestions for further refinement of this mechanism were made by respondents however, we also recognise the potential benefits and opportunities for GPs and other partners in working in closer collaboration within a fully integrated ICP, and are committed to making this an attractive option locally for those GPs who choose it.

40. It will be necessary for us to share learning from ongoing procurements where GPs have demonstrated strong support for the model, and we will further develop the template integration agreement between GPs and the ICP, for use where GPs choose the ‘partially integrated’ option.

41. In addition to the options for individual practices, both the Long Term Plan and subsequent five year framework for GP Contract reform set out the ambition to support the Primary Care Network (PCN) development across the country, enabled by a new PCN Contract from 1 July 2019. PCNs make sense regardless of whether ICPs occur locally. PCNs are a natural development of the localities at the heart of whole population care models. Where practices are partially integrated with an ICP and retain their GMS or PMS contract, an ICP will be in a position to integrate its services with those delivered through networks, in line with expectations of other community providers. Where GPs decide to participate as fully integrated practices, they will similarly be supported to work more effectively\textsuperscript{11} The Department of Health and Social Care’s consultation and response are available at https://www.gov.uk/government/consultations/accountable-care-models-contract-proposed-changes-to-regulations (accessed 12 January 2019).
at scale within an ICP, enabled through the infrastructure and support it will be able to provide.

42. While local authority responses in general welcomed the goal of integration we are seeking to enable through the ICP Contract, responses have demonstrated that barriers remain to the integration of local authority-funded services with healthcare services through an ICP Contract. Although the joint response from the LGA and ADASS highlighted and welcomed changes that we had made to the ICP Contract following engagement with them, many respondents pointed out that the different statutory frameworks underpinning the NHS and local authorities are likely to continue to act as barriers to integration unless and until those frameworks are aligned. We will continue to engage closely with local authority representatives to ensure we both learn from experiences elsewhere where health and social care integration has been successful, and in developing the ICP Contract further in due course to reflect new learning that arises out of its early use and to facilitate integration as far as current legislation allows.

3.2.3 The role of an ICP will require it to take on greater responsibility for some activities such as sub-contracting and population health management

43. The ICP proposals envisage that in order to perform this role properly, the ICP will itself need to take on responsibility for the coordination and management of a wide range of services in the system. In a complementary way, the ICP Contract specifically sets out new standards requiring the ICP to consider more thoroughly the health needs of the population, and ensure it is developing longer term strategies to meet those needs.

44. It is true that the ICP Contract envisages the ICP taking a different role in the system compared to the more traditional role that a provider may currently play in the system, for example where an existing provider may only be responsible for a specific portion of the services to be delivered to any one patient. While many providers already use subcontractors, the ICP Contract represents an attempt to allow a lead provider greater flexibility to join up a wider range of services which any one patient may be required to use over the course of their life. It is unlikely that any single organisation will ever be able deliver all of the services that a population requires. However, it is important that whilst not delivering all services, the provider is held to account properly for their collective delivery, as this provides the incentive for it to think more carefully about the best way to improve quality. Alongside this responsibility, it must have flexibility to achieve this, including through the power to contract with other providers in the system to deliver the desired integration. This is an important power, and complements the payment approach in the ICP Contract, which aims to offer flexibility to the provider holding the ICP Contract to use its available funding to respond to areas of poor performance or target longer term improvements in health outcomes.

45. Whilst we believe these new flexibilities and powers are important to effectively perform the role of an ICP, we also acknowledge that the expanded role of a provider holding this contract necessitates a range of new checks and balances to be in place, supporting any ICP to deliver this role. For example:
• Through appropriate national oversight we will ask whether a potential provider of this type of contract – such as an existing NHS foundation trust – has the capability and capacity to deliver services required under the contract to the highest possible standard. This includes testing through the Integrated Support and Assurance Process (ISAP) 12 that the provider has good relationships with other partners in the system so they have a shared and coherent vision of how to integrate and improve services, or that they have demonstrated sufficient rigour in their approach to health analytics prior to commencing delivery, that there can be confidence they will be able to deliver this role properly and plan carefully to meet the current and future needs of the population.

• Similarly, through ISAP, we will seek assurance from the responsible commissioners that any proposals protect the long-term sustainability of high quality services, irrespective of where and how they are currently provided. This assurance – alongside the engagement and testing which CCGs will already be carrying out – will test whether the ICP will itself take an active role in the delivery of services.

• As outlined in the consultation document, we have given commissioners the ability to intervene effectively in the delivery of an ICP Contract, should this be required. For example, the commissioners have the power to suspend or terminate individual parts of the contract where the provider is not meeting important service requirements, so it can if necessary change how those services are delivered or require their delivery by other providers. A commissioner also has the power to enter into direct agreements with any subcontractors that the ICP has put in place, complementing existing rights to approve such subcontracts in advance, and prevent their alteration without agreement.

46. All of these protections are in place specifically to ensure that a CCG is always able to carry out its role effectively in arranging delivery of services and holding providers to account across the system for their quality and performance.

47. Finally, other national support is being developed, in part through proposals outlined in the NHS Long Term Plan, which will help to develop capability and knowledge that will enable providers to more effectively deliver an ICP Contract. For example, all services will benefit from the ongoing investment in improving population health management techniques, helping systems to identify the greatest areas of unmet need. In addition, the new commitments on tackling health inequalities will lead to a greater awareness and ability to respond to and manage inequalities across different pathways such as cancer, maternity, and long-term conditions, with ICPs and other providers able to benefit from the increased national focus and investment.

12 ISAP provides a co-ordinated approach by NHS England and NHS Improvement to supporting and assuring the procurement and transactions related to complex contracts. Further details can be found in the ISAP documents on the NHS England website: https://www.england.nhs.uk/publication/integrated-support-and-assurance-process/ (Information accessed 12 January 2019)
4 Next steps

48. In response to the feedback received, and including the important steps outlined above to put additional controls in place over ICPs and improve transparency and accountability, we will make a number of changes to the ICP Contract before it can be used by any commissioners.

49. Following these improvements, the ICP Contract will be made available in a controlled and incremental way, conditional on successful completion of NHS England and NHS Improvement assurance through the ISAP, and initially focusing on those commissioners which have already taken steps towards using an ICP Contract prior to our consultation. This incremental approach is in line with the recommendation of the House of Commons Health and Social Care Committee. 13

50. Recognising that much engagement and consultation has taken place in those early frontrunner areas, we intend to publish a revised version of the ICP Contract in due course to support those processes. This will follow the publication of, and reflect, the generic NHS Standard Contract 2019/20. We will ensure the use of the ICP Contract is controlled by making it available only by specific exception to the general mandate to use the generic NHS Standard Contract to commission non-primary care healthcare services. The ICP Contract will continue to develop through a process of co-production with early adopter commissioners and other stakeholders, and further iterations will be published when appropriate. We will also continue to provide guidance to support commissioners and providers that wish to use it.

51. The DHSC will publish Directions (which were subject to a separate consultation during Autumn 2018) later this year. Following the decision to make the ICP Contract available the DHSC laid regulations in Parliament, following the consultation process undertaken in 2017, in support of the ICP Contract on 13 February 2019.

5 Annex A – Overview of responses by question

5.1 Question 1: Option of single contract

We asked...

Should local commissioners and providers have the option of a contract that promotes the integration of the full range of health and, where appropriate, care services? Yes/No/unsure; and please explain your response.

Respondents said...

52. Stakeholders such as NHS commissioners, NHS providers and local authorities generally supported the option of a single contract to promote the integration of services. They saw the potential benefits of such a contract – for example, in offering opportunities to improve alignment and break down organisational barriers, allowing space to work differently, addressing perverse incentives in the current system and enabling a stronger focus on preventing ill-health. For example, NHS Clinical Commissioners (a representative body for CCGs) stated:

‘A key potential benefit of the ICP Contract is that it is designed to promote an integrated service model, affording the opportunity to commission primary care alongside wider NHS services, public health and social care provision. This has the potential to further integration and the delivery of person-centred care.’

53. Most individual public respondents, including through the campaigns and petition, opposed the proposed ICP Contract, often on the basis of fears that it would lead to privatisation of NHS services and lack of accountability to the public.

54. Some associated concerns were that private providers could result in reduced quality of care or access to services, or that local or regional monopolistic providers could emerge. Many respondents rejected in general the principle of contracting as the basis for service provision in the NHS.

55. Respondents also raised other concerns – including expressing a view that the ICP Contract would not address perceived existing problems in the system such as funding and staffing levels, and that the likelihood of subcontracting of services in an ICP model means it would not truly achieve integration of services.

56. There was recognition from many respondents that a contract in itself would not be enough to achieve integrated care, with a strong emphasis on the importance of relationships and culture. Some questioned whether a new form of contract is necessary given the existence of other options for integration, such as alliances and integrated care systems, and noted the importance of ‘system maturity’ – with a view that many areas would not yet be ready to pursue a contractual route to achieve integration. On the other hand, there were some strong views to the contrary, for example, one CCG stated:

‘The option of having a contract which is aligned with the national, regional and local ambition for the transformation of services to meet the needs of local populations would be welcomed by the CCG. It is recognised that health
systems are encouraged to integrate and that despite the presence of alliance arrangements where provider and commissioning organisations have chosen to integrate further, the presence of multiple contracts and other agreements can be challenging. As a result a contractual vehicle that is dedicated to eliminating such complexity and duplication is welcomed even if in some cases it is a way of codifying existing agreements and relationships.

57. There was a strong view that, as proposed during the consultation, if the contract is made available it should be as an option for local commissioners, rather than mandatory.

58. Many respondents suggested the ICP model should be debated in Parliament before being introduced, and if such a model is to be introduced ICPs should be statutory bodies.

Our response...

59. We welcome the support of NHS commissioners, NHS providers and local authorities for our making available a form of contract to encourage the integration of services. This approach has the potential to bring a range of benefits that will better enable organisations to provide more integrated care to people and their families – including, as highlighted in consultation feedback, by providing incentives that are more aligned towards integrated working, breaking down organisational barriers, encouraging a stronger focus on preventing ill-health and managing long-term conditions.

60. We accept that a statutory provider is considered by many as the most suitable vehicle to perform the role of an ICP.

61. We acknowledge the objections expressed by some to the principle of contracting as the basis of service provision in the NHS. The wider structure of the NHS is outside the scope of this consultation.

62. Subcontracting is already an important and widespread part of NHS service delivery. Smaller providers, for example from the voluntary sector, will continue to play a vital role in delivery where an ICP is in place, as they did beforehand. The ability to bring together a range of providers, and deploy flexibly its budget to develop a coordinated set of services, is an important power which an ICP will require to give it the opportunity to achieve better outcomes for its population. This flexibility will in addition be an important safeguard for personalisation of services. Furthermore, it is important to note that while an ICP may not itself deliver all services which are in scope under its contract, it will, under that contract, be held to account for their collective delivery: this provides the incentive for it to think carefully about the best way to improve quality.

63. Various respondents emphasised that the ICP Contract should be made available as one option amongst others available to local system, rather than being mandatory. This remains the position. The ICP Contract should only be used where commissioners decide, following appropriate engagement with providers, staff and local people, that the appropriate conditions (including strong relationships) are in place to do so successfully. Other options to achieve
integration between different providers, such as alliances, will continue to be most suitable in many areas. However, some commissioners, such as in Dudley, believe using the ICP Contract would allow them to go further in fulfilling their ambitions to provide better, more integrated care for people than they have already been able to achieve using existing approaches.

5.2 Question 2: Content to promote integration

We asked…

The draft ICP Contract contains new content aimed at promoting integration, including:

- Incorporation of proposed regulatory requirements applicable to primary medical services, included in a streamlined way within the draft ICP Contract
- Descriptions of important features of a whole population care model, as summarised in paragraph 30 (of the consultation document)

a) Should these specific elements be amended and if so how exactly? Yes/no/unsure; and please explain your response.

b) Are there any additional requirements which should be included in the national content of the draft ICP Contract to promote integration of services? Yes/no/unsure; and please explain your response.

Respondents said…

64. Throughout the consultation there was generally support for integration of services, and many respondents welcomed the inclusion of care model content in the ICP Contract. For example, one CCG employee stated:

‘Health inequalities, provider risk stratification, analysis of population health needs and obligations to develop shared electronic patient records are each features where an ICP provider can play a significant role.’

Some respondents were supportive of the existing content, while others offered suggestions for how it could be further developed.

65. Some respondents – particularly providers and commissioners – also noted the importance of ensuring that providers which would become an ICP had the skills and resources necessary to deliver requirements of a whole population care model. For example, NHS Clinical Commissioners stated:

‘Support will need to be given to enable lead providers to fulfil a new role within an ICP… Many providers will not yet be well equipped to deliver population health management and risk stratification functions that will be delivered by the provider under an ICP – consideration needs to be given as to how best to support the transfer or development of this skill set.’

66. Many responses sought further clarity on the population that would be served by an ICP. Some noted the potential challenges (should local authority-funded services be in-scope for an ICP) where CCG and local authority boundaries are
not coterminous. Others sought information on how people such as out of area patients, travellers and people who are homeless, along with those accessing digital GP services, would be able to access ICP services.

67. Some respondents commented specifically on the contract requirements relating to primary medical services, largely derived from the draft Directions published alongside the consultation. Among these, the BMA, had concerns about the proposals but agreed that ICPs providing primary medical services should be bound by the same regulatory requirements as existing GP practices, and therefore welcomed the consistency between the proposed requirements for ICPs (as set out in draft Directions, and reflected in the draft Contract) and requirements under existing primary medical services contracts.

68. Some respondents, particularly campaign responses, also expressed a concern that the integration of GP services in an ICP could lead to larger-scale less personal primary care provision.

69. We also received suggestions on other matters, including in relation to the importance of:
   - voluntary sector involvement in ICPs
   - data and how it is shared.

Our response...

70. No substantive suggestions were received through the consultation on the drafting of the population health content within the ICP Contract, so we do not at this stage propose making material changes to the existing content in this respect, though the whole contract will be kept under review. It will be for local commissioners and their chosen providers to set out in their locally-developed service specifications what is required of their population health model and how it will be delivered locally.

71. We agree it is important for providers to have the right skills and capabilities in place, and ISAP has been designed to seek assurance from the responsible commissioners and the prospective ICP that it would be able to meet the population health requirements that it will be commissioned to deliver through the ICP Contract. In support of this, we expect local commissioners and providers to also consider the extent to which it may be appropriate to transfer resource from the CCG to an ICP to support these requirements. We also recognise that local systems will want to move to a more outcomes based approach to support a whole population care model, and in light of this feedback, we will consider what further support we can provide to ICSs to help them, and the health and care organisations within them including ICPs, develop the necessary capabilities. This will be in addition to the national programmes identified in the NHS Long Term Plan to raise levels of awareness and capability more generally in relation to tackling health inequalities and undertaking population health analysis.

72. The contract’s definition of the population to be served by an ICP is designed to ensure the ICP has wide responsibilities for providing care to the whole population:
   - For NHS-funded services, the population served will comprise everyone registered with that ICP (or with a GP practice partially-integrated with the ICP) wherever they live, and everyone permanently or temporarily resident within the
ICP's area, unless they are registered with a GP practice which is not part of the ICP

- The ICP would therefore be responsible for providing care for homeless people, travellers and others who live within its area
- If local authority-funded services are within scope for the ICP, the population served by the ICP for those services will be defined so as to cover the population for which the local authority is legally responsible.

73. We welcome the comments from the BMA that the requirements for primary medical services being provided under an ICP Contract should be consistent with those of other GP contracts, whilst recognising other responses about integration dealt with separately under question 6. Most requirements of the ICP Contract relating to primary medical services are linked to the draft Directions developed with the DHSC. Those Directions may be revised as a consequence of the feedback DHSC has received in response to their own recent consultation, and we will update the corresponding provisions of the ICP Contract accordingly as necessary.

74. We agree that the voluntary sector should play a key role in delivering a population-based model of care, focused on the needs and wishes of individuals, which the ICP Contract is designed to support. Voluntary sector organisations bring important and unique expertise, and can enhance the opportunities for patient choice and personalisation. We anticipate that commissioners will require bidders for any ICP Contract to demonstrate how they will involve and work closely with local voluntary sector organisations to deliver choice and person-centred care.

75. We note that some respondents have raised a concern that provision of GP services would move to 'hubs' under an ICP Contract. This is not the intention. The ICP Contract includes a requirement that the ICP must ensure people have a choice of readily-accessible locations at which to receive primary medical care services. In addition, the ICP Contract allows local commissioners to specify, should they choose, the locations of premises from which primary medical (or any other) services must be delivered.

76. We have already included in the ICP Contract requirements to ensure data in respect of service users is collected, managed and used appropriately and lawfully. These include the necessary controls required to protect personal data, to maintain patient health records in systems that enable legitimate sharing between providers for direct care, and to have in place robust and lawful data processing arrangements to enable secondary uses (e.g. risk stratification, targeting of care interventions). NHS England is developing an information governance framework to support integrated care. This will incorporate a data governance tool to help care systems with the lawful, and accessible use of de-identified patient data for these secondary uses.
5.3 Question 3: Balance between national and local content

We asked...

The draft ICP Contract is designed to be used as a national framework, incorporating core requirements and processes. It is for local commissioners to determine matters such as:

- The services within scope for the ICP
- The funding they choose to make available through the contract, within their overall budgets
- Local health and care priorities which they wish to incentivise, either through the locally determined elements of the financial incentive scheme or through additional reporting requirements set out in the contract

Have we struck the right balance in the draft ICP Contract between the national content setting out requirements for providers, and the content about providers' obligations to be determined by local commissioners? Yes/no/unsure; and please explain your response.

Respondents said...

77. Some respondents were supportive of the need to ensure local commissioners have some flexibility to determine the requirements that best meet the needs of their local population. A view was expressed, for example, that a one size fits all approach will not work for all communities and there must be recognition of differences in the way services are delivered across urban and rural populations. Some respondents saw the benefit in the contract providing a consistent national perspective while also enabling local priorities to be identified, while a number of organisations requested greater flexibility to meet local population needs. For example, we heard:

'The best combination and relationship to deliver national priorities within a specific national context should be left to local commissioners. The structure of a national contract is very useful, the detailed content must be predominantly local.' (a CCG)

and

'The Trust would endorse fuller flexibility in contracting arrangements (supported by nationally consistent contract templates) to support new and innovative integrated models of care. We recognise that the release of this contract sends an important signal to enable system-wide working, however believe there is still some way to go before it lands. We feel the contract needs to maintain a suitable degree of flexibility to ensure it can work for all partners in the system.' (an NHS foundation trust)

78. However, others expressed a view that further standardised content is required, based partly on concerns that local decision-making could lead to access variations between different areas. A few respondents suggested additional national guidance that could be developed or changes that could be made to the ICP Contract, such as:

- the development of a template sub-contract to accompany the ICP Contract
• a minimum set of required services and further national standards or quality requirements – for example, the inclusion of the national e-referral standard.

79. Many respondents supported having local flexibility in determining their financial incentive scheme as part of the contracting arrangements – this includes flexibility to set the reward quantum against local population health outcome priorities in a way that is achievable and sustainable for local delivery partners. It was suggested that a wide range of partners should be involved in developing the measures that would be incentivised including local authorities and the voluntary sector. Some respondents would like to see practical examples of how the theory of a financial incentive scheme, including risk sharing arrangements, would translate into practice and to use that learning to help develop and implement suitable arrangements for their localities.

80. Some respondents commented further on specific issues. For example:
• We heard suggestions about the importance of certain types of services being included within the scope of ICP Contracts – such as urgent care services, mental health services, and primary care services (in addition to general practice). Some respondents also queried how specialised services commissioned by NHS England would relate to the scope of an ICP Contract.
• Different views were expressed about potential contract duration – while some agreed that up to ten years is appropriate, some respondents thought this potential term was too long and a counter-view was also expressed that it was too short.

Our response...

81. The ICP Contract does not change the broad discretion commissioners already have about what services to commission to ensure they can meet the needs of their communities. The structure of the ICP Contract is based on that of the generic NHS Standard Contract. Most of its mandatory content is derived from the generic NHS Standard Contract or the Directions, and so reflects established national requirements for in-scope services. We agree that it is important to avoid a one size fits all approach, by ensuring local commissioners are able to determine a lot of the content of their local contracts, supplementing consistent mandatory requirements in such a way as to best meet local requirements.

82. With regard to suggestions for national guidance, we will continue to keep this area under review and we may choose to make additional resources available in due course, in addition to those already published, for example a template subcontract. We will consider on an ongoing basis what further guidance could usefully be developed, particularly building on learning from early users of the ICP Contract.

83. There was support for local flexibility in determining the financial incentive schemes to be incorporated into the contracting arrangements. We agree with those who suggested that a wide range of partners should be involved in determining behaviours to be incentivised locally and in developing metrics against which performance will be assessed. We also agree with those respondents who expressed caution and stressed the importance of using financial incentives in a proportionate and sustainable way, including the need for incentives and their use
being properly thought through to help mitigate unintended consequences. Whilst the nature of the feedback did not suggest that any material changes were needed to the incentives Framework for Integrated Care Providers published alongside our consultation, the feedback will inform our thinking and future policy development around CQUIN and the use of financial incentives frameworks and schemes more generally.

84. All relevant national standards and requirements applicable from time to time to providers of particular services under the generic NHS Standard Contract and/or GP contracts will apply to providers of equivalent services under an ICP model, and will be reflected in the ICP Contract as appropriate. For example, requirements in relation to use of the NHS e-referral system, as updated in the generic NHS Standard Contract for 2019/20, will be reflected in the ICP Contract.

85. We maintain the view that both the duration of local contracts, and the range of services to be commissioned under them, are matters best left for local commissioners to determine, informed by local engagements and based on the needs of their local population and desired care model. We therefore do not propose to set out a minimum set of required in-scope services for ICP Contracts but service scope (and any anticipated extension of that scope during the term of the contract) will be a key element to be considered and assured through ISAP.

86. However, as set out in the consultation materials, where commissioners use the ICP Contract, we anticipate that they may agree a contract term of up to ten years (as could in principle occur with existing contracts). An important idea behind the ICP Contract is that by giving one organisation responsibility for providing health and care services for the whole local population, it will be able to shape services around what really works best. A longer-term contract offers the stability needed to incentivise the provider to improve longer-term outcomes by investing in services to manage and improve treatment and prevent deteriorations in health, rather than being focused solely on meeting short-term targets. It will inevitably take some time for the impact of any new care model to emerge and for the new provider to be able to show improvements in population health outcomes.

5.4 Question 4: Option of single budget

We asked...

Does the bringing together of different funding streams into a single budget provide a useful flexibility for providers? Yes/No/unsure; and please explain your response

Respondents said...

87. The proposal for an integrated budget/whole population annual payment (WPAP) was supported by most providers, commissioners and local authorities. For example, one such respondent thought that it would provide ‘more flexibility for innovation’. Another welcomed the proposed whole population annual payment, stating:

‘It is essential that the contract incentivises investment in prevention and conservative treatment options. Without giving a provider the opportunity to look
at whole pathways, through control of population budgets, this cannot happen to the optimum level.”

88. While there was much support for the integrated budget, some respondents commented on how it would work in practice. For example, some respondents raised concerns about how much funding would be available to the ICP, and how it would be determined by the commissioner. This included some queries about how the budget could respond to changing demands and local demographics over a contract term of up to ten years. A number of stakeholders also commented specifically on how the budget would be managed by an ICP which included comments about:

- how it would be impacted deficits in parts of the local health and care system and whether a flexible budget might effectively be used to ‘plug gaps’
- how the budget would be allocated to different types of services, with some expressing support for ‘ring-fencing’ funding for particular types of service
- relatedly, whether combining funding streams into a single budget might also consolidate financial risk in one organisation.

89. Many individual public respondents expressed concerns about an integrated budget approach. Among these – particularly in campaign responses that specifically responded to this question – there was a view that the proposed integrated budget offered a ‘flexibility’ that would mean ICPs would not be accountable for their decisions, and that a single funding stream flowing through the ICP could create risk and uncertainty for existing local NHS providers. We also heard a concern that managing the budget within financial constraints might lead to rationing of treatment or services to patients. However, some expressed support for a single budget – for example, that it ‘would hopefully allow them to see the bigger picture in allocating funding to a whole local plan and avoid further fragmentation.’

Our response...

90. We note the support expressed in many responses for the flexibility that the whole population budget is designed to offer. It is a key part of the proposals in allowing the provider the ability to design care around the needs of the population. Flexibility in how funding is used is a core feature of the whole-population approach.

91. However, we also note concerns about the ability that an ICP would have to make decisions about resource allocation. Any provider has to operate within the budget it is allocated, and this will continue to be true of a provider holding the ICP Contract. However, given the flexibility which the budgeting approach is designed to enable, we recognise the importance of ensuring all local organisations and services are fully engaged in the development of any ICP model. This engagement will be tested through ISAP, and assurance sought that the wider implications of the proposals have been considered, including the delivery costs of the services to be delivered under the proposed model, to ensure the assumptions are properly tested by partners and have taken into account long term sustainability of services. As set out in our consultation document, we have also included in the ICP Contract a range of safeguards to ensure financial accountability, transparency and service continuity.
92. We also acknowledge the point about whether an integrated budget might mean that financial risk is consolidated in one place. This is why new financial controls have been developed for the ICP Contract, and oversight and assurance over ICPs will be important. However, a consolidated budget for a whole population is a critical part of the rationale in delivering this model effectively, and is part of a wider national move towards greater accountability for delivering whole population healthcare within each system. As outlined in the NHS Long Term Plan, the move to system control totals is designed to enable organisations to jointly manage resources to deliver the best possible care for their population, whilst the system as a whole is held to account for achieving this. This principle is aligned to the ICP proposals, which allow one provider to be held to account directly for the effective management of services, whilst ensuring the oversight and scrutiny provided by the system and national regulators can be more focused and effective.

93. Neither the use of an ICP Contract as the vehicle for commissioning services, nor the proposed WPAP approach under such a contract, will have any bearing on the level of funding allocated to CCGs by NHS England to commission services. The two matters – funding and the choice of contract – are distinct. In determining the proportion of its allocation a CCG would use to fund payments under an ICP Contract (were it to choose to commission services using one) the CCG would need to consider the funding required to safely and effectively deliver the services to be in-scope under that ICP Contract. ISAP requires that local governing bodies and boards provide an effective first line of assurance. Therefore, commissioners and providers should ensure their governing body/board is kept fully informed and given the opportunity to scrutinise, test and challenge the proposals in depth at each stage, including having first-hand access to advisers’ conclusions and recommendations. Funding will be subject to ongoing review at various points throughout the lifetime of the ICP Contract.

94. We will keep under review how we can update our guidance on integrated budgets to provide additional clarity in response to consultation feedback.

95. Finally, we note that the Court of Appeal has confirmed the lawfulness of the WPAP under the ICP Contract. As noted above, in R (aao Jennifer Shepherd) v NHS England [2018] EWCA Civ 2849 the Appellant sought to argue that the pricing mechanism under the contract, the WPAP, was contrary to the relevant provisions of the Health and Social Care Act 2012. In its judgment dated 20 December 2018, all seven of the Appellant’s grounds of appeal were dismissed for eleven reasons. This judgment confirms that the WPAP is lawful under the 2012 Act.\(^{14}\)

\(^{14}\)As at the date of publication, the Appellant has sought permission from the Supreme Court to appeal the Court of Appeal’s decision. The Supreme Court has not yet made a decision on this matter.
5.5 Question 5: Safeguards about service quality, patient choice, transparency and financial management

We asked...

We have set out how the ICP Contract contains provisions to:
- guarantee service quality and continuity
- safeguard existing patient rights to choice
- ensure transparency
- ensure good financial management by the ICP of its resources.

a) Do you agree or disagree with our proposal that these specific safeguards should be included? Agree/Disagree/unsure; and please explain your response
b) Do you have any specific suggestions for additional requirements, consistent with the current legal framework, and if so what are they? Yes/No/unsure; and please explain your response.

Respondents said...

96. The proposals were supported by most commissioners, NHS provider organisations, local authorities and GPs who responded. For example, a local authority Health Scrutiny Committee stated ‘It is important these safeguards are included to ensure that high quality services are provided to communities.’ Responses from members of the public were mixed, although the vast majority of those who disagreed seemed to do so primarily on the basis of their wider concerns about the proposed ICP Contract. Some members of the public who agreed with the inclusion of the safeguards also expressed their wider objections to ICPs, or doubt about whether the safeguards offer sufficient protection. A number of respondents offered suggestions for additional requirements that could be included.

97. There was a strong view, particularly among individual respondents, about the importance of transparency about the performance and finances of ICPs – not only to commissioners, but also to the public. Some respondents offered suggestions about how the transparency provisions in the ICP Contract could be enhanced, while others suggested that commercial confidentiality should not be a reason to ‘deny the public access to information’. However, different views were expressed about the proposed requirements for ICPs to operate ‘open book accounting’ with some commissioners and providers requesting greater clarity about the requirements, or expressing concerns that the proposed requirements may be too burdensome or impact commercial confidentiality. A number of respondents also commented on public accountability, which is covered in further detail later in this document.

98. There was some concern about the impact on choice for patients who do not wish to register with the GP services offered by an ICP, for example where their current GP practice chooses to join an ICP. In addition, some respondents questioned whether being registered to a practice fully or partially integrated with the ICP may affect the places to which they would be referred by a GP. A range of comments were also made about patient choice and access which were not specific to an
ICP Contract, most significantly seeking assurance that the proposals would not affect the existing legal requirements establishing the free availability of NHS services.

Our response...

99. We acknowledge the support for transparency about the finances and performance of ICPs and will include in the ICP Contract additional transparency standards requiring performance and financial information to be published and made available directly to patients and the public.

100. While we acknowledge that some respondents raised concerns about the potential administrative burden of making more detail available (particularly through the proposed requirement for open book accounting), it remains our view that this and other financial reporting requirements are important to ensure financial accountability, transparency and service continuity.

101. These additions would complement the information we would already anticipate being made available, both through the existing draft contractual requirements and more widely – for example, the Care Quality Commission (CQC) would, as part of its regulation of an ICP and its constituent services, publish reports about the quality of care these provide.

102. While some concerns have been raised about preservation of patient choice, we are confident patient choice will be preserved and do not consider that further amendments to the ICP Contract are needed at this time. The ICP Contract has been designed to make sure the commissioning of multiple services through a single contract does not restrict or in any way adversely affect the options people have about how and where they receive care. The ICP Contract not only requires the ICP to ensure the rights of choice people have under the NHS Constitution are respected, but also to offer further choices as to when, where and how people can receive the services they need wherever practicable. As set out in the consultation document, it includes, for example, the requirements that:

- local people are offered choice in where, how and by whom services are delivered to them, wherever possible
- the ICP adheres to the rights of patient choice in respect of secondary and tertiary care services, as set out in the NHS Constitution
- NHS users are offered a choice of GP from those employed or engaged by the ICP
- NHS users have a choice of readily-accessible locations at which to receive GP services
- the ICP offers sufficient pre-bookable and same-day GP appointments to meet the needs of the population, including during evenings and at weekends (we will also consider how the ICP Contract may need to be updated to reflect the Access Review to be undertaken in 2019, as announced in the recent Five-year framework for GP contract reform to implement The NHS Long Term Plan).

These requirements may be supplemented by local requirements as commissioners think appropriate for their local needs. Where a GP practice decides to join an ICP on a ‘fully integrated’ basis, we would expect this to be informed by engagement with their registered patients and patients would also be able to
choose whether they wish to receive primary medical services from the ICP or to register with a different GP practice.

103. With respect to the concern about whether health care services would remain free at the point of use, nothing about the ICP model or the ICP Contract in any way affects the position that, subject to certain exceptions\(^{15}\) determined by law, NHS services are to be provided free at the point of use by an ICP and their subcontractors just as they are by current providers of NHS services. This will be the case regardless of the type of organisation that holds an ICP Contract or sub-contract, and whether or not it is responsible for social care services alongside NHS services.

5.6 Question 6: GP participation in an ICP

We asked...

a) Should we create a means for GPs to integrate their services with ICPs, whilst continuing to operate under their existing primary care contracts? Yes/No/unsure; and please explain your response.
b) If yes, how exactly do you think we should create this?
c) Are there any specific features of the proposed options for GP participation in ICPs that could be improved? Yes/No/unsure; and please explain your response.

Respondents said...

104. There was support from many respondents for primary medical services to be included within any ICP model, given the important role that general practice should play in an integrated health and care system. Most CCGs and NHS provider organisations who responded were supportive of creating means for GPs to integrate their services with ICPs, whilst continuing to operate under their existing primary care contracts. For example, a social enterprise stated:

‘Given its pivotal role within NHS care in determining both health outcomes and in optimising the use of NHS system resources, it is critical that primary care remains front and centre. Under integrated care arrangements, NHSE therefore, has no choice but to create a compelling proposition to GPs to integrate their services with ICPs.’

105. Most responses from GPs also agreed with different options being available, but wanted NHS England to confirm that no one approach would be mandatory. For example, the BMA noted the importance of GPs having options as to how they might participate, despite reservations in general about the need for the contract. A small number of responses also queried how emerging forms of collaboration such as primary care networks (PCNs) would relate to ICPs.

106. In relation to the proposed option for ‘full integration’ (whereby GP practices could, subject to proposed regulatory changes on which DHSC has consulted, choose to suspend their existing GMS or PMS contract to participate in an ICP as

\(^{15}\) Those exceptions being, for example, in relation to NHS charges for overseas visitors under the NHS (Charges to Overseas Visitors) Regulations 2015, statutory charges for prescribed medicines, charges for issue of certain certificates.
an employee or subcontractor), there was some concern from several
respondents, including some GP representative bodies, about the complexity and
practical mechanisms by which GP practices could reactivate their GMS or PMS
contract if they wished to withdraw from full integration with the ICP. For example,
we heard about potential uncertainties regarding the return of the patient list,
estates, and workforce. We also heard a concern about ensuring patients would
have sufficient notice where their GP practice wished to join an ICP, to enable
them to make a choice about whether they wished to receive primary medical
services from the ICP or register with a different GP practice.

107. There was a desire for more information about the partially integrated option,
under which GP practices could maintain their existing contracts but agree to
integrate their services with those delivered under the ICP Contract via an
‘Integration Agreement’. Stakeholders including the BMA and Royal College of
Psychiatrists gave some specific comments on the current draft Integration
Agreement that was published as part of the consultation package.

108. Most individual respondents who responded to this question did not agree that
we should create a means for GPs to integrate their services with ICPs, often on
the basis of their wider objection to the ICP model. Some also expressed a view
that GPs should maintain their independence, and the belief (as mentioned earlier)
that GP participation in an ICP could lead to less personalised care.

Our response...

109. People most commonly access health care through their GP, and integrated
care models therefore rely on GP registered lists as the foundation of a population-
based approach. We continue to believe that wholehearted voluntary GP
participation is fundamental to the success of the care and contractual models.

110. We acknowledge the availability of different options for participation in an ICP
model is important and valued by GPs. We further recognise, in response to
concerns raised particularly by the RCGP and BMA, that we should continue to
make clear, as the consultation did, that participation on any basis in an ICP is
entirely voluntary for practices.

111. For fully integrated models, we agree with the importance of patients being able
to choose the provider from whom they receive primary medical services and have
developed the draft regulations proposed to underpin the suspension and
reactivation of GMS and PMS contracts with this in mind. Outside the formal
requirements set out in the draft regulations, we would anticipate that GP practices
will engage with their patients when deciding whether to join an ICP on a fully
integrated basis.

112. On the matter of reactivation of suspended contracts, no firm proposals for how
to improve this option have been identified through the consultation. However, the
existing proposals – developed during previous discussions with the BMA and
consulted upon by the DHSC in 2017 – will be subject to further review on the
basis of experience from sites, and we remain committed to working with GP
representatives to make it an attractive option locally.
113. It will be necessary for us to share learning from ongoing procurements where GPs have demonstrated strong support for the model, and we will further develop the template integration agreement between GPs and the ICP, for use where GPs choose the ‘partially integrated’ option.

114. PCNs will benefit patients, GPs and the NHS generally regardless of whether ICPs come into being. PCNs are a natural development of the localities at the heart of whole population care models. Where practices are partially integrated with an ICP and retain their GMS or PMS contract, an ICP will be in a position to integrate its services with those delivered through networks, in line with expectations of other community providers. Where GPs decide to participate as fully integrated practices, they will similarly be supported to work more effectively at scale within an ICP, enabled through the infrastructure and support it will be able to provide.

115. We note that some respondents raised concerns about the need to ensure GP participation does not mean less personalised care. Our view remains that GP participation in integrated care models – which the ICP model would facilitate – will improve the care patients receive by, for example, improving access to services. We have previously produced information on what it is like to be a GP in a multispecialty community provider (a type of care model that could be facilitated by the ICP Contract), and which also highlight how GP participation in such models can benefit patients. These videos are available on the NHS England website.

5.7 Question 7: Local authority participation in an ICP

We asked...

a) Do you think that the draft ICP Contract adequately provides for the inclusion of local authority services (public health services and social care) within a broader set of integrated health and care services? Yes/No/unsure; and please explain your response.

b) If not, what specifically do you propose? Please explain your response.

Respondents said...

116. Many respondents were supportive of including local authority-funded services in an ICP where possible, as important to the delivery of a whole population model of care. For example, one respondent stated:

‘As an alliance organisation that counts local authorities as key members, we feel that it is essential that the ICP Contract does provide for the inclusion of local authority services (public health services and social care) within a broader set of integrated health and care services.’

117. However, some respondents felt that the current ICP Contract is NHS-focused and could do more to provide for the inclusion of local authority services. For example, in their shared response the LGA and ADASS argue that certain requirements of the ICP Contract might restrict the ability of a local authority to be a lead provider. Another respondent noted that it is underpinned by an NHS contractual and legal framework.
118. Respondents also shared wider views about local authority participation in an ICP model, such as:
- a view that it might be more feasible to include public health services than social care services within an ICP’s scope
- potential challenges due to differences in how social care and NHS services are funded and in funding levels
- potential challenges due to differences in the governance and structures of local authorities and NHS organisations, including that local authorities may perform commissioning and provider functions, but NHS organisations may not
- comments about how the proposed ICP Contract relates to existing mechanisms for achieving integration with local authority services, including a question about how it would achieve more than arrangements under existing section 75 agreements and a concern from a small number of respondents that a section 75 agreement might still be needed alongside an ICP Contract
- technical barriers, such as VAT, where rules apply differently to local authority services and healthcare services.

119. Some responses suggested that greater clarity was required on how local authorities, including elected members, can be reflected in governance arrangements where a local authority is involved in an ICP. There were also requests for further guidance, such as practical examples of partnerships and local authority integration agreements.

120. Other comments included emphasis on the importance of engagement with local authorities, including that they should be engaged as equal and active partners in commissioning.

Our response...

121. We are committed to ensuring the ICP Contract is fit for purpose, given existing statutory constraints, for commissioning local authority-funded services should this be desired by local authorities locally. We have already worked to achieve this through extensive engagement with the LGA, and following this engagement we made a number of changes to the ICP Contract in response to local authorities’ feedback, particularly as commissioners of services. In Dudley, the local authority has already chosen to commission public health services through this contract.

122. We will consider whether any further amendments can be made to the ICP Contract, within the constraints of the existing legal framework. We will make available a template integration agreement for local authority participation, which would allow local authority-funded and delivered services to be integrated with services commissioned under an ICP Contract, and consider whether any further guidance can be developed.

123. Many of the concerns raised by the LGA and ADASS relate to the implications for a local authority itself of being a potential ICP Contract-holder. We recognise that many of the perceived obstacles to a local authority holding an ICP Contract could only be overcome by legislative changes which are outside the scope of this consultation (for example, in relation to CCG membership and governing body composition), however we are committed to supporting NHS and local authority
commissioners where proposals are being developed that envisage such an outcome.

5.8 Question 8: Safeguards about commissioners’ statutory duties

We asked...

The draft ICP Contract includes safeguards designed to help contracting parties to ensure commissioners’ statutory duties are not unlawfully delegated to an ICP:

- It provides a framework within which decisions can be taken by the ICP, based on a defined scope of services which the commissioners require the ICP to deliver.
- It includes a number of specific protections, outlined in paragraph 83 (of the consultation document), which together prohibit the provider from carrying out any activity which may place commissioners in breach of their statutory duties. Are there any other specific safeguards we should include to help the parties to ensure commissioners’ statutory duties are not unlawfully delegated to an ICP? Yes/No/unsure; and please explain your response.

Respondents said...

124. Most types of stakeholders expressed mixed views in response to this question. There was some support for the proposed safeguards. Several comments were broadly positive, viewing the safeguards proposed in the ICP Contract as adequate to ensure statutory duties are not unlawfully delegated to an ICP. For example, one healthcare partnership stated:

‘The changes proposed in the draft ICP Contract are broadly positive and it provides flexibility for commissioners and providers to strike the right balance depending on the local context. The guidance document ‘CCG roles where ICPs are established’ is helpful in clarifying the extent that ICPs may lawfully undertake activities that are currently undertaken by CCGs, in order to manage whole pathways of care and a capitated budget.’

125. However, some respondents proposed additional safeguards or guidance, including a request for further assurance on the tasks and responsibilities CCGs would be passing over to ICPs – with some CCGs highlighting a related need to be clear on how an ICP would be expected to support the CCG in carrying out its statutory duties and how CCGs could ensure that they do not inadvertently breach requirements.

126. More widely, some respondents highlighted a concern that ICPs and commissioners may have overlapping roles. One provider organisation suggested that further consideration should be given to support greater collaboration between providers and commissioners to avoid duplication.

Our response...

127. In respect of the division of responsibilities between CCGs and providers, we note the comments that suggested the ICP Contract is clear about this distinction.
128. We acknowledge that, while statutory duties of CCGs will not change, some activities – such as population health management – undertaken in support of those duties may change under an ICP model, and indeed the ICP Contract is, in part, designed with the intention of accommodating this change. We would expect, for example, that where an ICP Contract is awarded, CCG and/or commissioning support unit teams currently involved in health analytics and informatics may support the ICP in its role in understanding and mapping population health needs.

129. As part of our consultation package, we published updated guidance on CCG roles where ICPs are established. We will consider whether this can be updated or further guidance developed in future. In particular, in due course, once a contract is commissioned, more practical examples will be made available to help those considering similar proposals.

130. We also think it is helpful to restate the findings of the High Court in one of the judicial review claims referred to above, R (oao Hutchinson) v SSHC and NHS England [2018] EWHC 1698 (Admin). In dismissing that claim, the Court found, amongst other things, that the integration of health and social care via a single provider of care (for example, an ICP), where that provider has a degree of autonomy over how care is delivered and resource allocation:
   • is within the statutory powers of a CCG;
   • does not represent the unlawful delegation to ICPs of non-delegable functions or preclude CCGs from fulfilling their statutory functions; and
   • is not contrary to the commissioner-provider split under the National Health Service Act 2006.

131. An important lesson from the judgment is that commissioners have under the 2006 Act considerable leeway to lawfully commission provision of services in such a way that the relevant provider has a substantial degree of autonomy over how care is delivered and resource allocation. The ICP Contract does not change this. Indeed, as noted by the Court, the ICP model recognises the non-delegable nature of CCG functions and includes measures (for example, monitoring, supervision and enforcement) specifically designed to ensure that ICPs act in a manner consistent with the CCG’s functions.

5.9 Question 9: Provisions about public accountability

We asked…

The draft ICP Contract includes specific provisions, replicating those contained in the generic NHS Standard Contract, aimed at ensuring public accountability, including:
   • Requirements for the involvement of the public as explained in paragraphs 89-93 (of the consultation document)
   • Requirement to operate an appropriate complaints procedure
   • Complying with the ‘duty of candour’ obligation

a) Should we include much the same obligations in the ICP Contract on these matters as under the generic NHS Standard Contract? Yes/No/unsure; and please explain your response.
b) Do you have any additional, specific suggestions to ensure current public accountability arrangements are maintained and enhanced through an ICP Contract? Yes/No/unsure; and please explain your response.

Respondents said...

132. Most types of respondents agreed the ICP Contract should include much the same obligations as the NHS Standard Contract, with one provider organisation stating that it 'provides the necessary obligations for public accountability and is demonstrated to work effectively'. Others thought these standards should be the minimum, with scope for them to be strengthened. Some specific suggestions included requirements to:

- hold board meetings in public
- engage with bodies such as local Health and Wellbeing Boards and local Healthwatch.

133. However, many individual responses highlighted a perception that ICPs would not have a statutory duty to ensure public accountability. For example, some campaign responses stated 'As long as ICPs remain bodies with no statutory legal status, there can be no guarantees they will respect any requirement to ensure public accountability.' Specific concerns focused on the possibility that, despite the contractual responsibilities in the ICP Contract to do so, providers would not comply with their obligations under the "duty of candour", or to operate an appropriate complaints procedure. Some respondents were also concerned about whether ICPs would be subject to freedom of information requirements.

134. Some campaign responses expressed a view that even if the ICP Contract includes the same obligations as under the generic NHS Standard Contract, public accountability would be mediated through the CCG and 'the public will have to rely on the skills and willingness of the CCGs to hold ICPs to account'. Some respondents were concerned about whether CCGs would have the 'necessary staff, skills or willingness to rigorously and robustly manage the ICP Contracts', and some stressed the importance of effective monitoring and KPIs.

135. A small number of CCGs who responded agreed with the desirability of public involvement in service redesign, but did express a concern that it can 'slow and hinder the transformative pace needed to bring together so many organisations, sites and services'.

136. We also received comments about other accountability mechanisms. There were also some questions about how ICP arrangements would be regulated by bodies such as the CQC and NHS Improvement.

Our response...

137. We are committed to ensuring an ICP can be properly held to account for its delivery. Along with the additional transparency requirements outlined in response to question 5 (including in relation to freedom of information requests), we are proposing further standards to more explicitly require ICPs to act in an open and accountable way. These will include:
• Requirements to hold board meetings in public, in line with the requirements that are already in place for statutory providers
• More explicit requirements, in response to specific suggestions in the consultation, for the ICP to work directly with local Healthwatch and other supervisory bodies.

138. It will also continue to be a requirement to ensure adequate public involvement has taken place to inform decisions about service redesign: this is a principle enshrined in legislation and guidance and reflected in the ICP Contract.

139. Whether an ICP has statutory duties, and if so what those duties are, will depend on the nature of the organisation in question. We do not consider it likely that non-statutory organisations will hold ICP Contracts. In any event CCGs are required to hold the ICP to account under their own statutory duties regardless of the type of organisation holding the contract, however the additional controls that have been developed within the ICP Contract have been designed specifically to ensure patients and the wider public can have confidence that commissioners will hold ICPs to account effectively. We believe that, alongside the new protections, the ICP Contract provides a CCG with appropriate and robust levers and performance indicators by which to hold an ICP to account. Under ISAP, a national assurance process run jointly by NHS England and NHS Improvement, it will be for the CCG to provide assurance to NHS England of the robustness of its own locally-determined performance management indicators and of its capability to manage the ICP’s performance, both before any ICP is in place, and subsequently during the lifetime of the contract.

140. Alongside CCGs other system partners, including the CQC and NHS Improvement, will also have important roles in holding ICPs to account for their performance.

141. The CQC is committed to working with and learning alongside new ICPs as they emerge, and is currently considering its approach to ICPs, and other new, integrated models of care. This includes how it will regulate ICPs overall, and how its approach would take into account the different options for GP participation. Within its existing legal powers, the CQC will be able to register an organisation holding an ICP Contract where it is established as a separate legal entity. This will enable the CQC to regulate the ICP overall, as well as its constituent regulated services. Where a sub-contractor carries on an activity that is regulated by the CQC then they would need to register with the CQC.

142. Any organisation holding an ICP Contract would need to hold a licence from NHS Improvement, and so would be subject to NHS Improvement oversight.

143. The requirements on holders of ICP Contracts, for example around the duty of candour, or obligations to operate an appropriate complaints procedure, are in line with those imposed on existing providers of NHS services through their contracts with NHS commissioners. DHSC’s proposed changes to complaints regulations are intended to ensure these requirements would be the same for ICPs as for other providers of similar services.
5.10 Question 10: Provisions about value, quality and effectiveness

We asked...

It is our intention to hold ICPs to a higher standard of transparency on value, quality and effectiveness, and to reduce inappropriate clinical variation. In order to achieve this the draft ICP Contract builds on existing NHS standards by incorporating additional provisions describing the core features of a whole population model of care and new requirements relating to financial control and transparency:

a) Do you think that the draft ICP Contract allows ICPs to be held to a higher standard of value, quality and effectiveness and to reduce inappropriate clinical variation? Yes/No/Unsure; and please explain your response.

b) Do you have any additional, specific suggestions to secure improved value, quality and effectiveness, and reduce inappropriate clinical variation? Yes/No/Unsure; and please explain your response.

Respondents said...

144. Many responses to this question generally drew on those to earlier questions, including the themes expressed in response to related questions on transparency and quality of ICP performance, and accountability – see questions 5 and 9.

145. Other feedback was mixed. A number of respondents suggested it may not be appropriate to hold ICPs to account for meeting a higher standard in the early years of an ICP Contract’s duration due to the time required to develop processes and positively impact quality, efficiency and effectiveness.

146. There were some requests for further guidance – for example, for more detail on the transparency required, the types of outcomes envisaged, and how the features of a population health model would allow ICPs to be held to a higher standard.

147. More widely, some respondents shared views on whether ICPs should be held to a ‘higher standard’ at all: that it is not clear why a higher standard should be expected for ICPs than for other providers of the same services, with an NHS provider suggesting:

“This in itself could result in different standards of health provision dependent on what type of NHS contract that a provider enters into. This could almost act as a perverse incentive encouraging providers not to seek the integration of services.’

Our response...

148. We are seeking to strengthen the controls and assurance over ICPs in a number of ways, both through the imposition of additional financial and transparency requirements, and through the requirement that any proposed award of an ICP Contract must be subject to ISAP. We have proposed elsewhere revisions we may make to the ICP Contract and related requirements to ensure the services delivered by an ICP are of the highest possible quality. We will also draw on wider developments around the availability of system-wide data and
performance metrics to ensure whole population providers can be held accountable for their wider impact on improving outcomes and integration of services.

5.11 Question 11: Additional suggestions for the draft ICP Contract

We asked...

In addition to the areas covered above, do you have any other suggestions for specific changes to the draft ICP Contract, or for avoiding, reducing or compensating for any impacts that introducing this Contract may have? Yes/No/unsure; and please explain your response.

Respondents said...

149. Alongside comments repeating themes expressed elsewhere in the consultation responses, various respondents made suggestions about the importance of ICPs having some responsibility for workforce training. This included a suggestion that the contract should include a requirement for an ICP to contribute to the future supply of trained clinicians to meet NHS needs.

Our response...

150. The ICP Contract contains provisions in relation to workforce training which largely reflect those under the generic NHS Standard Contract and current GP contracts. These include a requirement to cooperate with the LETB and Health Education England in the planning and provision of education and training for healthcare workers.

151. The ICP Contract already contains provisions around conflicts of interest, which include a requirement for the ICP to comply with existing NHS guidance on management of conflicts. We will consider whether supplementary contractual requirements or guidance are warranted. We will also consider how the contract may need to be updated to reflect commitments made in the NHS Long Term Plan.

5.12 Question 12: Equality and health inequalities impact

We asked...

Are there any specific equality and health inequalities impacts not covered by our assessment that arise from the national provisions within the draft ICP Contract? Yes/No/unsure; and please explain your response.

Respondents said...

152. There were mixed views about whether there would be any additional equality and health inequalities impacts arising from the proposed mandatory provisions that were not covered by our draft impact assessment.
153. Many NHS provider organisations and commissioners, along with some other respondents, thought our draft assessment (included with the consultation) covered the likely equality and health inequalities impacts. For example, one integrated care partnership stated:

'The assessment sets out how the draft ICP Contract, and supporting documents, could be utilised to address inequalities, and, as such, we welcome the potential these offer to support our agreed ambitions. As noted in the assessment, it will be imperative that equality and health inequality assessments are completed effectively by commissioners and providers to ensure the potential to reduce inequalities amongst the local population are realised.'

154. Amongst those respondents who disagreed, there were concerns about the impact of ICP arrangements – for example, (as highlighted earlier) about whether the homeless or travellers might be able to access care from an ICP. Others raised concerns, addressed under Question 3, that use of the ICP Contract could result in inequality of access due to a variation of care in different geographical areas.

Our response...

155. The proposed contracting approach for ICPs provides a national framework to enable the integration of care, which could have a positive impact for people with protected characteristics and those that are more likely to experience health inequalities, such as health inclusion groups. Its focus is on ensuring people receive integrated care that is focused on meeting their individual needs. At the whole population level, a key component of the new models of is that they are focused on addressing the wider determinants of health and tackle inequalities. This also complements the existing NHS England policies on equality and health inequalities, assisting in compliance with the Public Sector Equality Duty. Alongside the existing contractual provisions, we will also ensure that the ICP Contract incorporates where appropriate the new national policy and interventions to address health inequalities signalled in the NHS Long Term Plan.

156. However, as set out in our draft Equality and Health Inequalities Analysis, the practical impacts of this national framework will be determined by local commissioners in determining a care model and selecting an appropriate provider. It will be important for local commissioners and providers to undertake their own equality and health inequalities analyses to inform their decision-making, in accordance with legal and contractual requirements.
### Agenda Item Number 9: TB 19 (25)

**Report of: The Responsible & Accountable Officer**  
The Chairman

**Author of Report:**  
Lynn McGill, Chairman

**Subject/Title**  
Chairman’s Commentary

**Background papers (if relevant)**  
None

**Purpose of Paper**  
The purpose of this report is to provide a summary of many of the extra-curricular activities during March 2019 that form part of the network and relationship development which support the trust and its ambassadors in achieving its vision and corporate objectives. It is not intended as an exhaustive summary.

**Action/Decision required**  
Strategy and Objectives for the financial year 2019-20  
To discuss and agree  
The remainder of the report - To Note.

**Link to Care Quality Commission Domain**  
Safe  
Caring  
Responsive  
Effective  
Well-led

**Link to:**  
- Trust’s Strategic Direction  
- Corporate Objectives

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<tr>
<th>Link to:</th>
<th>Patients</th>
<th>People</th>
<th>Partnerships</th>
<th>Resources</th>
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<td>To provide safe, effective personal care in the right place</td>
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<td>People - Build, Value and develop a skilled, motivated and sustainable Workforce</td>
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<td></td>
<td>Partnerships - To build strong relationships with partners in Cheshire East and Greater Manchester to Deliver our vision</td>
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<td>Resources - To deliver services that are clinically and financially sustainable</td>
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**Legal implications - (identify)**  
None

**Impact on quality**  
Positive impact

**Resource impact**  
Linked to the annual plan

**Impact of equality/diversity**  
Positive impact

**Avoid acronyms or abbreviations - if necessary list:**  
NHS – National Health Service  
CCG – Clinical Commissioning Group  
NHSI – NHS Improvement  
NHSE - NHS England  
CQC - Care Quality Commission  
MP – Member of Parliament  
CEP – Cheshire East Place  
HFMA - Healthcare Financial Management Association
1 Introduction

1.1 Collectively, as a means of adding value through effective leadership, these activities provide context and so aid strategic challenge, seeking assurance in a supportive and collegiate manner and may be gained through key meetings of national, regional or local importance, shared learning from each other, from international examples and by making local connections to engender and strengthen relationships, trust and broaden engagement.

Breakfast meeting on system leadership

I was pleased to attend this breakfast event run by one of the leading resource organisations at which a speaker from the Northern Alliance Care NHS Group highlighted key aspects of their journey in transforming care within their Place. This is an example of a large complex partnership, with many similarities to Cheshire East, and which is further along in its development.

2 Cheshire East Partnership

The Programme Board met on Wednesday 6th March 2019. Discussions focused on alignment of local plans with the NHS Plan together with agreement on next steps in order to future proof services for population health and care needs. These updates also provided the opportunity to hear of progress from the Cheshire and Mersey Health and Care Partnership, neighbouring partner regions and a summary of local developments. These are preliminary discussions and any transformation will be part of a much wider conversation and brought to the Board via the Public Trust Board agenda.

The Christie at Macclesfield

I was delighted to attend this unique and exciting launch event on Wednesday 27th March at Adlington Hall, outlining plans to build a new Christie centre on the Macclesfield site. This will bring pioneering research and treatment of cancer to the heart of eastern Cheshire and south Manchester, adding to their progressive portfolio.
2.2 The Community supports ECHO Charity

On Tuesday 5th March, Dr Antony Coombs, Non-executive Director, met with members of Woodside Golf Club whom have chosen ECHO as their charity of the year. He shared how ECHO’s fundraising makes a difference when buying equipment and furniture, together with supporting volunteer coordination that improves patient, visitor and carer experiences. ECHO is the official charity of East Cheshire NHS Trust which undertakes fundraising to benefit patients and staff for a positive experience when in need of our care.

2.3 The Pancake Race wins again

The much loved annual fun pancake race, supported by Silk 106.9 went ahead on Tuesday 5th March, Shrove Tuesday, in the centre of Macclesfield town. Out thanks go to Silk 106.9 and especially to afternoon presenter Darren Antrobus, who brought this event to life. Attended by Cllr Adam Schofield, the Worshipful Mayor of Macclesfield and his Consort, Heather Schofield, we were blessed with a sunny sky, and despite the cold wind we were thrilled to see a record 23 team entries competing for the much coveted trophy, winner of the pancake race. This year that went to the Tytherington School team. Our thanks go to all involved in the preparation prior to the event, those helping with safety on the day including the Macclesfield Rotary Club and for all our energetic competitors.

3 Trust Board Business

3.1 The Trust Board Programme of Work

The programme is largely as planned. Agenda item changes from March 2019 to April 2019 are included within this month’s agenda, specifically

- Overview of changes to the Corporate Governance Manual and Standing Financial Instructions and
- Annual Report on the Carter Review

3.2 Strategic and Annual Objectives

Each year, the Board are required to set strategic objectives and an annual plan and for their delivery. These are proposed below
for the financial year 2019-20 for discussion and approval by the Board.

3.3 **Patients**

We will ensure patients remain safe when under our care, with specific emphasis on meeting the patient safety indicators, with a particular emphasis on pressure ulcers and mortality.

The winter period of 2019/20 is likely to bring pressures once again and we will work with partners to produce an effective winter plan that focuses on patient safety to minimise and mitigate risk.

3.4 **People**

As a priority we will continue to build on successful staff engagement through a period of potential turbulence, clinical strategy development and significant financial challenge.

Developing an inclusion strategy, which continues to embrace diversity, we will prioritise within existing resource the development of staff to deliver transformation within the Place of Cheshire East and develop leaders to translate this into operational reality. Within this broader plan, we will manage short-term workforce challenges by the continued reduction in vacancies and in particular qualified nurses.

3.5 **Partners**

In line with the NHS Long Term Plan, another key priority will be to develop the eight care communities with partners to deliver new care models, providing the right care in the right place and reducing the need for hospital admissions wherever possible. This remains very much in line with the trust’s focus in previous years.

The trust will work with partners to develop services that meet the needs of Cheshire East population and translate these into operational plans and to support the Clinical Commissioning Group in any consultation process which involves the services currently provided by the trust.

This will require:

- The completion of the Acute Clinical strategy alongside the development of the care communities and will lead to
a view of future organisational form as part of the development of an integrated care partnership/provider across Cheshire East, in line with the NHS Long Term Plan.

- To agree a financial strategy for 2020/21 onwards during the financial year to ensure there is clarity around the ongoing financial position.
- To garner the solid support of our partners, the Cheshire and Merseyside Health Care Partnership and regulators to ensure any service changes are part of the wider Place plan and fit within an Integrated Care Partnership.

3.6 **Resources**

Our main priorities are to ensure clinical and other productivity is maximised and savings schemes delivered in order to achieve the benefits that come with the delivery of the financial control target. This will assist in not only achieving the financial objective of the trust but will also maximise the impact on waiting times and other standards for patients.

This means every aspect of our services will come under scrutiny; we will review the ‘Model Hospital’ data to identify opportunities to reduce expenditure, which will be critical in delivering on our dual responsibilities of safe care and meeting our financial objectives. Every proposed change will be scrutinised and assessed for any impact on patient safety.

The trust will undertake a business case for the development of an electronic patient record during the financial year to build on IT investment made in recent years.

3.7 **The Trust Board Programme for 2019-20**

The Board programme for the year 2019-20 is included as a consent agenda item for reference. This is a live document and may therefore be subject to change throughout the year.

3.8 **Board Development Programme**

Board walkabouts continue as planned. A summary of those walkabouts undertaken are appended to this report. Please see appendix 1.

3.9 **Board Attendance**

Each year, the trust publishes Board member attendance at each of its key meetings by way of demonstrating commitment,
commitment of board members

We scrutinise remuneration and reward where these fall outside of national agreements

We recognise and reward clinical excellence that delivers best practice

Celebrating Compassion recognised by our people

Board is assured of membership compliance with the Fit & Proper Persons Test requirements

We scrutinise remuneration and reward where these fall outside of national agreements

We recognise and reward clinical excellence that delivers best practice

Remuneration Committee
I can confirm that the Remuneration Committee met on 7th March 2019.

Clinical Excellence Awards Committee
This committee showcases the very best of clinical excellence and is competitive. It was pleasing to see an increase in both numbers and diversity of applications this year.

I am pleased to note that this committee met on Wednesday 13th March and which reached its recommendations, ratified via members as at Monday 18th March and has therefore discharged its responsibilities in line with policy and good practice.

It is a pleasure to award a further Compassion award to one of our outstanding people. This quarter we celebrate the contribution of Elizabeth Nelson for her contribution to outstanding patient care.

Fit and Proper Persons Test confirmed
All appropriate checks and declarations have been received, confirmed and evidenced as being compliant, meeting the required standards of board members and their deputies; please refer to Appendix 3. This includes sign up to the NHS Code of Conduct and the Nolen Principles.

Lynn McGill
Chairman
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| **Report of:**  
| **Responsible Officer Accountable Officer** | Kath Senior  
| Director of Nursing and Quality |
| **Author of Report:** | Jeanette Sarkar  
| Head of Nursing, Quality |
| **Subject/Title** | Bi-Annual Report: Safer Staffing: Safer Nursing Care Acuity and Dependency Audit |
| **Background papers (if relevant)** | “How to ensure the right people with the right skill are in the right place at the right time”  
Chief Nursing Officer for England & National Quality Board  
November 2013  
| **Purpose of Paper** | The purpose of this paper is to provide assurance on staffing levels and capacity in order to provide safe, sustainable, productive staffing and high quality, patient centred compassionate care across all acute wards at East Cheshire NHS Trust |
| **Action/Decision required** | To note the contents of the report and the assurance provided |
| **Mitigates Risk Number:** (identify)  
| **On Corporate Risk Register** | BAF 2: If the quality of services provided is not at the required standard, then there is a risk that the Trust may fail to safeguard the health and wellbeing of patients which will impact on the Trust’s ability to deliver care which is safe, effective, caring, responsive and well led.  
BAF 5: If the Trust does not have a high quality workforce who are engaged and motivated, then staff behaviours may not be aligned with the Trust values and this will have a negative impact on patient experience  
1406: If there are inadequate core staffing levels on acute in patient wards it will compromise the delivery of high quality care impacting on harm free care and patient safety. This will result in poor patient/carer experience and potential outcomes, recruitment and retention, staff morale, increased sickness and absence rates, non-compliance with statutory and mandatory staff training, an increase in staffing incidents and complaints resulting in financial implications |
| **Link to Care Quality Commission Outcome Number (identify)** | Safe  
Caring  
Responsive  
Effective  
Well Led |
| **Link to:**  
| Trust’s Strategic Direction  
| Corporate Objectives | Provide the best services to our population through improvements to safety, productivity and patient experience  
Getting it right first time |
<p>| <strong>Legal implications - (identify)</strong> | No legal implications |
| <strong>Impact on quality</strong> | May potentially impact upon quality of care, patient experience, patient outcome, recruitment, retention and staff well-being however mitigating actions are put in place to reduce the level of impact |
| <strong>Resource impact</strong> | Identified gaps in funded establishments due to wte substantive and temporary nurse staffing vacancies may impact on an increase in payroll costs in relation to paid additional hours, overtime and bank/agency expenditure in order to mitigate risks associated with patient safety and delivering high quality, compassionate care |</p>
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**Avoid acronyms or abbreviations - if necessary list:**

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Bi-Annual Report: Safer Staffing: Safer Nursing Care Acuity and Dependency Audit

This paper forms the bi-annual review of nurse staffing in line with the commitments outlined by the National Quality Board (NQB 2013) and DoH (2014) ‘Hard Truth’s’ document – The Journey to Putting Patients First. The guidance refers to the optimisation of nursing, midwifery and care nurse staffing capacity and capability. This in turn forms part of CQC’s Intelligent Monitoring for all NHS providers.

1 INTRODUCTION

1.1 This paper describes the Trust’s progress, compliance against national guidance and delivery of safe care. A summary of key actions and recommendations since the last bi-annual report is provided along with the overall results of the SNCT patient acuity and dependency audit undertaken in January 2019.

2 SUMMARY OF KEY ACTIONS AND PROGRESS SINCE JULY 2018 SNCT AUDIT

A plan for both RN and HCA staff groups has been produced for 2019

Monthly recruitment and training meetings scheduled within HR as part of the Trust’s 2019 Recruitment and Training plan for both Registered Nurses (RN) and Healthcare Assistants (HCA) are meeting less frequently due to successful outcomes. This reflects the extensive pre-work undertaken in this area over the past 12 months. Conversations also occur outside of this meeting between group members to ensure that any issues that may arise are being effectively managed.

Simulation and training has been incorporated into induction process

This includes the Be Aware to Care 3 day course, of which the AWARE course is integral at day 2. Professional practice teams also support the commencement of the Care certificate and support with RN and HCA interviews.

Simulation has been incorporated into selection process

The above plan supports HR recruitment teams to identify when influxes of RN’s and HCA’s are expected. This in turn enables Learning and Development teams (L&D) to work more flexibly by ensuring sufficient induction and training dates are available to meet fluctuations in demand.

HCA rolling recruitment campaigns changed to quarterly

Monthly rolling recruitment campaigns for RN’s and substantive staff have remained in place since the last bi-annual report. Interviews for all adverts take place on the same day wherever possible facilitated by staff volunteering to support weekend or evening events from HR, Learning and Development and Senior nurses. Clinical scenarios have been introduced to RN interviews to facilitate and select high quality candidates.

However, due to successful regular recruitment campaigns substantive core HCA vacancies have become minimal. Therefore there has been no requirement to hold monthly HCA recruitment events. Interviews took place in February 2019 with a proposal to hold quarterly HCA recruitment campaigns moving forward. This is dependent on the number of HCA vacancies which will continue to be assessed on a regular basis. A value based recruitment tool has been added to HCA advertisements for applicants to undertake prior to applying to explore if their values are in line with the NHS values.
An RN recruitment pipeline report is provided monthly

2.6 An RN recruitment pipeline database is maintained and updated monthly by designated personnel within HR which in turn supports the monitoring and progress made to date.

2.7 A new Face book page ‘Careers at East Cheshire NHS Trust’ was launched at the end of July 2018 with the aim to advertise hard to fill vacancies under the heading ‘Job of the Week’ increasing the level of advertisement exposure and building on the Trust’s social media presence. This has been further extended to include a Twitter page and good news stories about the Trust

2.8 Implementation of weekly pay for substantive staff undertaking shifts via nurse bank has been successfully applied and extended to pay staff at their current substantive AfC band, capped at Band 7. In addition, the majority of new employees to nurse bank prefer and choose this weekly pay option.

13 International nurses have passed their OSCE examinations

2.9 A total of 13 international nurses from the Philippines successfully passed their OSCE examinations and subsequent NMC registration of which 11 remain employed by the Trust

Reconnect sessions established for newly recruited nurses

2.10 The introduction of reconnect sessions as part of the retention plan for newly recruited nurses to the Trust at 30 days with Senior Sister, 60 days with Matron and 90 days with the Heads of Nursing or Deputy Director of Nursing have been implemented with positive results.

RN turnover rate has reduced to 9.14%

2.11 Staff turnover and year to date retention rates have improved and remained below the NHSI 10% retention plan target for five consecutive months and in January was 9.14%.

Reduction in RN vacancies - currently 43.59 wte within acute care settings

2.12 During the time of January’s SNCT acuity and dependency audit registered nurse vacancies were 43.59 wte compared to 46.96 wte during July’s 2018 audit. Inclusion of RN maternity and long term sickness leave increases the overall gap to 55.7wte which demonstrates an improving position.

9 Nursing Associates successfully achieved NMC registration in January 2019

2.13 Nine trainee nursing associates successfully completed the two year training programme, NMC registration and gained substantive posts according to preference choice and service need.

2.14 All registrants are subject to a period of consolidation, competency based assessment and preceptorship as per national standards and guidance. Robust support mechanisms and governance arrangements have been put in place to support staff through the transition.

2.15 Local and national evaluation of the pilot programme is expected later this year as the role is further understood and skill set embedded in clinical practice. The pilot programme has been led by HoN, Professional Practice with support from Learning and Development teams.

A further 5 Trainee Nursing Associates commenced training in December 2018

2.16 A further cohort of 5 trainee Nursing Associate roles was agreed and commenced training in December 2018 which is being supported through an apprenticeship model to complete their training.

Assistant Practitioner undertaking RN degree programme

2.17 One Assistant Practitioner who applied for TNA programme has successfully been supported to undertake the RN Degree programme instead which will enable them to become a fully qualified RN within 24 months due to accreditation for prior learning.

L&D continue to work in collaboration with Macclesfield College to progress apprenticeship roles and further roll out of the Care Certificate to existing HCA’s. This provides the HCA workforce with a solid foundation developing
a Health Academy with Macclesfield College for 16-18 year olds to undertake a Level 3 extended diploma. The Trust has agreed to provide placements from September 2019 and will support pump priming potential candidates to meet the entry requirements to apply for TNA or RN degree programmes.

The Trust is further investing in Advanced Clinical Practice programmes which are sponsored through apprenticeship routes. 2 RN’s and 1 Allied Healthcare Professional are due to commence training in Q4

3 staff members are due to commence Advanced Clinical Practice programmes in Q4

Since 2012 the Trust has used the validated Shelford Safer Nursing Care Tool (SNCT)

Since 2012 the Trust continues to use the evidence based, validated Shelford Safer Nursing Care Tool recommended by NICE and NQB. Following data collection data analysis is triangulated with professional judgement models in line with national guidance. This underpins and supports a consistent approach to monitor and ensure adult inpatient ward staffing levels remain in line with funded establishments. These tools help to inform and determine optimal nurse staffing levels based upon acuity and dependency.

From Monday 7th January 2019 to Sunday 3rd February 2019 patient acuity and dependency data was collected for each day of the week for a period of 4 weeks across all adult in patient ward areas. In order to maintain consistency data collection and subsequent data extraction from Safe Care Census Check 2 (14.00-15.00 hours) enabled data analysis. Activity was captured and provided daily at ward level.

Inter-reliability assurance audits were also undertaken twice weekly by Senior Sisters and Matrons to ensure that the application of care level category and ‘tasks’ from Safe Care e.g. 1:1 enhanced nursing consistently met the definitions criteria and guidance.

Bed Occupancy across acute inpatient wards remain high–100%

Historically funded establishments have been based on 85% bed occupancy

The daily average number of patients who require Level 1b care demonstrates incremental increases compared to July's 2018 audit

SNCT analysis, metrics triangulation and application of senior nurse professional judgement indicates that January’s 2019 acuity and dependency audit consistently demonstrates 100% bed occupancy and case mix complexities. With the exception of Ward 4, 11 and Aston ward staffing levels on the whole met patient needs although acute medical specialties required a third HCA overnight to support safe staffing levels.

It is recommended that in view of SNCT analysis, emerging trends and patterns that a review of all staffing models and skill mix is undertaken in all areas which have not already been reviewed.

Overall analysis demonstrates that in the majority of inpatient wards case mix and patient care delivery rose in the Level 1b care category compared to previous audits with the exception of Coronary Care and Intensive Care Units which illustrate Level 2 and Level 3 care delivery and provision. This reflects the peaks of acuity and dependency seen throughout January depicting complex case mix and fluctuations seen in operational and capacity pressures.

Overall analysis also demonstrates that in the majority of inpatient wards case mix and patient care delivery in the Level 1a care category compared to previous audits was slightly lower with the exception of Wards 3 and 4. Ward 4 data illustrates a much higher proportion of Level 1a care delivery.

It is important to note that orthopaedic elective activity was cancelled throughout January following NHSE directives to support the management of winter pressures.
On a number of occasions during January it was necessary to flex capacity above the winter plan. This resulted in in-patients residing in AAU or ED and following risk assessment the placement of +1 bed on acute wards as part of the Trust response to Escalation Policy. These areas were de-escalated as quickly as possible to support safe staffing levels, safety and patient experience.

Daily risk assessments and review of staffing levels were maintained during January and overseen within the Trust’s bed capacity meetings to mitigate risks to patient safety and patient experience as far as possible. The ‘matron of the day’ rota remains in place to provide an overview informing staff deployment and mitigation of risks as far as possible utilizing Safe Care and professional judgement.

Since the previous bi-annual report RN shifts requests via nurse bank have increased from 977 to 1,180 to support safe staffing levels during January of which 80 shifts remained unfilled. This places additional pressure on front line staffing and the ability to maintain delivery of high quality person centred care. The rise seen, in part, is explained by the support required to enable the opening of flex capacity and identified shortfall due to the % of nurse vacancies, maternity leave and long term sickness.

A total of 1,180 Registered Nurse shifts were requested during January of which 80 were unfilled

A total of 940 Healthcare Assistant shifts were requested during January of which 398 core shifts remained unfilled

A review of staffing levels and skill mix on Ward 4 is required to support the delivery of safe NIV and high flow oxygen therapy

Wards 3, 4 and 7 current funded establishment do not align with acuity and dependency data during January’s audit

Ward 4 demonstrates the highest proportion of patients that require either Level 1a or Level 2 care. Increases in the provision of NIV and high flow oxygen therapy have significantly increased since the last biannual audit. An urgent review of staffing levels and escalation of care is recommended.

Based on January’s SNCT analysis and application of senior nurses professional judgment it is recommended that a review of core staffing levels and skill mix within CCU is undertaken to build capability and capacity in view of the ageing workforce.

This approach will support wider professional context knowledge, ensuring sustainable staffing levels, appropriate skill mix and alternative roles align
High bed occupancy rates and changing patterns in case mix reflect local population healthcare needs

Increases in the number of patients with a DoLS in place was evident during January

All adult inpatient areas continue to demonstrate a high level of acuity and dependency particularly in Level 1b care

There is an overall upward trend in the daily average of patients who require Level 1b care compared to fluctuating Levels of 1a care

Current funded staffing establishments are considered adequate subject to potential service redesign

Patient acuity and dependency levels continue to demonstrate consistent incremental rises in the daily average of patients who require Level 1b care

With NQB guidance in getting it right first time to deliver the right staff, with the right skills, in the right place at the right time is fully considered.

Data analysis and application of professional judgement suggest that inter-ward transfers are increasing to support operational pressures. This in turn may impact upon patient continuity of care, effective communication, and increased length of stay reducing patient and carer experience.

All medical adult inpatient ward areas continue to demonstrate a high level of patients who require Level 1b care. This coupled with case mix and discharge planning complexities reflects the ageing population within East Cheshire and associated co-morbidities. In addition, a higher than average number of DoLS applications were applied. Bed occupancy throughout January remains equal or greater than 100%.

Staff continue to work flexibly across all areas and are deployed between clinical settings to support patient care based on case mix complexities and maintenance of appropriate staffing levels

PLANNED CARE SERVICES DIRECTORATE - SURGICAL SPECIALTIES Wards 1&1a, Ward 2 (Ward 5) and Ward 10

SNCT analysis demonstrates an overall shift in patient acuity and dependency within the footprint of the surgical and orthopaedic ward areas. It illustrates a lower daily average of patients who require Level 1a care and a significant increase in the daily average of patients who require Level 1b care. This, in part reflects the number of medical outliers residing in surgical specialties and cohort 1:1 nursing within orthopaedics. The daily average of patients requiring Level 0 care remains the same compared to previous audits.

Staff work flexibly across all areas and are deployed between clinical settings to support patient care based on case mix complexities and maintenance of appropriate staffing levels. On the whole the current core staffing establishments are considered adequate when fully recruited to subject to potential changes in service design.

In view of changes to case mix the senior nursing team closely monitor the effects and impact on clinical pathways, skill mix, nurse sensitive metrics, patient experience and clinical outcomes.

A directorate risk assessment is in place with regards to the management of medical outliers, staffing levels and skill mix dilution. This is monitored via the Directorate’s governance assurance framework and exception reporting.

Although recruitment and retention within Orthopaedics has significantly improved compared to previous audits the RN vacancy rate on Ward 10 is 21.35% (5.56 wte) necessitating continued use of bank and agency staff.

Ward 1 & 1A:

For the purposes of this report Ward 1 and Ward 1A’s data is combined. It continues to demonstrate a changing pattern compared to previous SNCT audits over time. Data analysis again illustrates incremental rises seen in patients requiring level 1b care (52%), increasing on average by 2-3 patients daily with fluctuating levels of patients that require 1a care (7%). Surgical benchmarking data suggests that 22% of patients residing in a surgical ward are subject to Level 1b care.
Mitigating actions include staff deployment via Safe Care, utilization of bank/agency staff whilst acknowledging that Ward 1 has a more senior, experienced and stable workforce compared to other areas which at times enables staff to absorb nursing workloads on an ad hoc basis. Current RN vacancy is 9.11% (2.21 wte).

Based on January’s SNCT data analysis the recommended RN and HCA wte requirements and 50/50 split between RN and HCA ratios meet the individual needs of patient care aligning with the current funded staff model.

Ward 2’s large geographical footprint and number of beds coupled with RN vacancy levels 8.91% (1.68 wte) and changes to case mix is a challenging area to co-ordinate to ensure staffing levels and skill mix are appropriate. A high proportion of substantive staff regularly undertakes additional shifts to support safe staffing levels, patient care and their colleagues.

It is important to note that since the last biannual report Ward 2 has been relocated to Ward 5 to facilitate implementation of the winter plan for a period of 3 months. 11 day case and 16 surgical inpatient beds are co-located within the footprint following transfer of the discharge lounge.

**ACUTE AND INTEGRATED COMMUNITY CARE**

**DIRECTORATE - INTEGRATED CARE Wards 9, 11 and Aston**

Integrated care wards SNCT data analysis demonstrates a reduction in Level 1a care on Ward 9, 11 and Aston compared to July’s audit and an overall increase in the daily average number of patients who require Level 1b care were seen during January’s audit. The most significant rises in Level 1b care were seen on Aston Ward whilst Ward 9 and 11 remain comparable to the previous audit.

However, the overall number of patients who are in receipt of Level 1b care denotes the high level of nursing input required to care for these patient cohorts. Throughout January a number of patients required 1:1 enhanced care with additional cohort nursing in place to support challenging behaviours, patient aggression, cognitive impairment, patients living with dementia and complex discharge planning. In addition, Ward 9 flexed capacity to +1 for 3 days during January to support demand and capacity pressures.

Current funded establishments on the whole are considered adequate although a review of Ward 11 staffing establishment followed by Aston Ward is recommended in view of SNCT data analysis and trends. Ward 11 demonstrates a case mix more in keeping with a sub-acute medical ward opposed to intermediate care staffing models.

**Ward 9**

Continues to demonstrate a significant decrease in the daily average of patients who require Level 1a care (from 8.6 to 1.6 to 0.3) compared to previous audits. This proportion is more in keeping with expected levels of care. As such, January’s 2019 audit is more representative of the care mix and care level categories expected – Level 1b (65%) which is comparable to the previous biannual audit.

Application of professional judgement and triangulation of metrics illustrates that acuity and dependency remains demanding due to an altered ratio of patients with behavioural or challenging cognitive aggressive manifestations.
On a few occasions members of staff have been assaulted. 1:1 nursing and cohort nursing is applied as far as possible to support this group of patients. During January the housekeeper was also utilized to support 1:1 enhanced care and ward clerking duties to release nursing time.

Alignment with professional judgement also indicates that a number of patients admitted from residential care or home were too ill to return to their normal place of residence. This impacted on staffing levels and workload as complex discharge planning, 24 hour profiling and multi professional referral, therapeutic interventions and care planning was sought inclusive of DoLS application. It has also been perceived that a reduced service from psychiatric liaison impacts upon the support provided to Ward 9 patients. The senior sister and matron cite their concerns subject to Cheshire and Wirral Partnership re-design of services and subsequent implications. Currently, Ward 9 and Croft ward ‘buddy’ each other to share best practice, care bundles and facilitate training which supports both areas.

Based upon January’s SNCT data analysis it suggests that 17.7wte RN’s and 24wte HCA’s are required to support the delivery of acuity and dependency safely. This is in keeping with the funded establishment. However, application of professional judgment indicates that ‘sun downing’ hours are becoming increasingly challenging from a safe staffing perspective, challenging the late shift. It is therefore recommended as part of the planned ward funded establishment reviews that workforce profiling, roles and infrastructure are considered to enable alignment of patient care needs.

Professional judgement recognises that the use of more reminiscence therapy is required and invaluable for this cohort of patients. In being able to facilitate this on a regular basis may help to reduce the number of 1:1’s required, patient aggression related incidents, offsetting expenditure. Volunteers continue to be utilized as able.

It is anticipated that the introduction of a new 12 month fixed term role from 1st April 2019 in relation to appointment of an Admiral Nurse will facilitate baseline assessment and improvements in this area coupled with the introduction of Nursing Associate roles who may with additional support and specialist training support meaningful activities.

**8 ACUTE AND INTEGRATED COMMUNITY CARE DIRECTORATE - URGENT CARE – MAU and ITU**

**Overall**

Urgent Care analysis demonstrates that on the whole current staffing levels, funded establishments and skill mix is appropriate based on current data, specialty bed configuration and consistency with regional network critical care guidance.

Outputs from the MAU sustainable workforce project continue to utilize dedicated pharmacy technician support to facilitate administration of medications which enables some nursing resource to be re-directed to front facing patient care.

Since the last bi-annual SNCT audit the pilot of additional Band 6 roles to provide senior cover for each shift to support patient safety, clinical practice and enhance patient flow was successfully implemented. However, in order to sustain this staffing model MAU’s funded establishment will require further review and agreement for 7 days per week.
Although a two year rotational staff nurse programme was previously implemented between ITU, ED, AAU and MAU completion of full rotation is sporadic in view of staff preferences to permanently stay in one of the areas opposed to rotating through. Rotational opportunities, however, remain in place to attract and incentivise recruitment, retention and sustainable staffing levels.

Urgent care has also been challenged with high level of vacancies, maternity leave and diluted skill mix within MAU and ITU. However, since the last biannual report this position has improved with RN vacancy % reducing from 50% to 30.51% (6.69 wte) in MAU and 2.41% (0.63 wte) since the last bi-annual report.

Current recruitment trajectories identify further improvements although it is important to note that MAU will be subject to a number of newly qualified nurses over the coming 6 months placing additional pressure on substantive staff.

The pharmacy technician role which supports routine drug administration continues to work well within this area and releases nursing time to facilitate effective utilization of skill sets.

ITU

Demonstrates a comparable position in the daily average number of patients who require Level 2 (34%) care outlined in previous biannual audits. January’s SNCT audit illustrates a slight increase in Level 3 (65%) care provision compared to January’s 2018 audit – on average 3.6 patients daily. The small rise in Level 0 care observed previously has returned to expected normal values.

Application of professional judgement concurs that a general increase in flu cases compared to this time last year placed additional pressures on capacity both locally and across the region. This reflects the increases seen in the daily average number of patients admitted to ITU – 5.6 opposed to 4.7 per day.

On a few occasions during January the step down of patients to specialty wards was dependent upon bed availability and at times delayed patient transfers from the unit. This subsequently impacts upon the management of Same Sex Accommodation returns. Mitigating risks are proactively managed as far as possible by utilizing side room capacity within ITU flexibly dependent upon case mix.

In order to effectively manage and facilitate improvements in patient ‘step down’ it has been agreed that routine screening for VRE will only be undertaken if it is clinically indicated in assessing patients when transferring in our out of the unit. This follows extensive benchmarking and alignment with critical care network guidance. It is anticipated that this will release side room capacity across the organisation in order that infection control and preventative management measures may be optimized for patients who require true isolation.

Staffing levels for ITU are appropriate and reflect critical care network guidance and align to the commissioned service specification. Staffing levels and patient dependency are risk assessed daily to ensure that 4 Level 3 and 2 Level 2 care patients may be accommodated at any one time which reflects their number of commissioned critical care beds.
Since the last biannual report RN substantive vacancies have significantly improved due to successful recruitment.

On a number of occasions additional RN’s have been required to support fluctuating levels of acuity and dependency. However, during January staff have also been deployed to support ward areas or ED when acuity and dependency allows via Safe Care and in discussion with Matron of the Day.

ITU staff are supported to undertake professional development to meet service specification requirements that all 50% of staff must possess a Critical Care Course.

Ward 2 (winter pressures ward)

The new winter pressures ward (ward 2) was established on 31st December 2019

SNCT data analysis demonstrates comparable acuity, dependency and case mix to other acute medical specialty wards.

Staffing levels were supported by deployment of staff from all other inpatient ward areas which also impacted upon existing acute areas.

Skill mix dilution and competency were supported by practice educator facilitators.

Staffing levels have been subject to daily risk assessment and monitoring by the matron team.

A Medical Nurse Practitioner was assigned to Ward 2 to support clinical care and senior decision making.

Since the last SNCT acuity and dependency audit sickness has been more challenging. Gaps in rota have been covered by substantive staff undertaking additional duties, bank or agency utilization. In addition, 7.5 hours of Band 6 supports a Macclesfield after care clinic service which complies with NICE recommendations. RN vacancy level is 2.41% (0.63 wte).

In line with the Trust’s winter plan Ward 2 was opened on the 31st December 2019 as part of the project plan in re-locating the surgical Ward to Ward 5. This enabled the conversion of Ward 2 to open as a 21 bedded acute medical ward to support the management of winter pressures.

As such, there is no SNCT data analysis available to compare to previous biannual audits. However, January’s 2019 audit demonstrates that the daily average number of patients requiring level 0 care was 6.6 (32%), Level 1a was 2.4 (12%) and Level 1b care was 11.7% (56%). Preliminary analysis compared to other acute medical specialty wards with the exception of Ward 4 aligns to the level care categories seen during January’s audit.

The number of daily admissions discharges and inter-ward transfers to and from Ward 2 is also comparable with the footprints of other acute medical wards.

It is important to note that in order to provide staff to facilitate the opening of Ward 2 all acute inpatient areas rotated or released a staff member for 3 months to support safe staffing levels. As such, this impacted upon staffing levels elsewhere given the level of RN vacancies, maternity leave and long term sickness. Identified gaps in the rota were managed via nurse bank and agency requests and on daily review by the matron team. Substantive staff also picked up additional shifts.

Application of professional judgment describes the difficulties of building a new team quickly in addition to supporting competency and a more junior Band 6 and 7 role. In order to mitigate risks and support the team to acquire the skill set and competency required practice educator facilitators and volunteers were utilized throughout. The matron for MAU provided leadership support to the new Band 7.

Although ward clerk and housekeeper support was available for the first couple of weeks it clearly became evident that the support required was unsustainable. Utilization of volunteers to support this function was therefore maximised. Difficulties were also experienced in accessing equipment and stores in the early stages.

To support clinical cover and mitigate risks to patient safety a Medical Nurse Practitioner has been deployed to support clinical decision making and review of diagnostics. Application of professional judgment concurs that although this is essential to support patient safety and flow, perceived fragmented clinical medical cover impacted upon the staff’s ability to effectively manage all aspects of patient management. During January Ward 2’s clinicians also...
supported the review of medical outliers on Ward 1 which further challenged stretched resources.

8.23 Based upon SNCT data analysis it suggests that 15.6wte RN’s and 15.6wte HCA are required to safely care for the level of acuity and dependency elicited during January’s audit.

9 COMMUNITY SETTING

9.1 Work remains ongoing to review community nurse roles to prepare the workforce for the increasing demand and acuity across the community footprint to support the shift from secondary to primary care. This has also been designed to align to the parallel development of the integrated teams across the 5 care communities. Support is being provided to enable and empower front line teams in quality improvement initiatives. Vacancies are minimal.

9.2 A successful ECNT bid has secured 2 places on the Health Education England - Skills for Health Advanced Clinical Practitioner (ACP) apprenticeship programme which commences in Q4. This will support the development of advanced practice roles across the community setting.

10 CURRENT NURSING ESTABLISHMENT – CHANGES TO SERVICE MODEL AND BED BASE

10.1 Since the last SNCT acuity and dependency audit the Trust has embedded a number of service model redesign programmes and progressed transformation projects to support patient flow through winter pressures. Frailty and intermediate discharge teams proactively support patient flow in addition to primary care supporting hospital admission avoidance where possible. Capital estates work to facilitate the completion of essential bed head services and replacement flooring works completed.

10.2 Further review of the provision of specialty services are expected in addition to evaluating the effectiveness and implementation of the winter plan.

10.3 A review of overall bed stock and potential bed reconfiguration is currently being undertaken pending definitive Directorate and Board approval. Strong multiagency, partnership working and improved outputs linked to service transformation will support the Trust’s ability to respond consistently to demand on services.

11 Quality & Safety - delivering safe care

11.1 To support the delivery of safe and effective care the Trust invested in Allocate’s SafeCare software tool which informs real time patient acuity and dependency. This enables appropriate decision making, supports workforce deployment, mitigation of risks and professional judgement to support clinical care. SafeCare was fully implemented within the acute hospital setting in May 2018 and continues to be embedded. Further evaluation and assessment of additional report functionalities are being explored.

11.2 Over the past 6 months the majority of supervisory senior sister ward status has improved and adjusted to either a 70/30 or 60/40 split. However, this is
supporting and managing activity as part of the SAFER project

heavily dependent upon operational pressures, current level of vacancies and skill mix dilution which necessitates senior sisters to regularly step down into core staffing numbers to support patient care as appropriate.

11.3 It is anticipated that following successful recruitment supervisory status will be reinstated where possible to allow closer management and monitoring of quality standards, patient experience, completion of staff appraisal, clinical training and coaching more junior members of staff.

11.4 Equally important is enabling the senior Band 7 sister to have capacity to oversee inpatient flow, pulling through patients requiring admission from MAU/ED into the right specialty. This will support effective patient centred care and facilitate safe discharge.

11.5 The senior sisters continue to spend a significant amount of time in supporting this function and management of activity as part of the SAFER project.

11.6 The SAFER project has also been extended with the support of NHSE to review stranded patients over a 6 week period which commenced mid January utilizing PDSA methodology. This involves a step change in process and is being supported by senior colleagues within the organisation.

11.7 Currently, staffing levels and patient safety continue to be overseen, risk assessed and resolved on a daily basis by the Clinical Matron team and Senior Nurse central to nurse bank staffing. Concerns or risks that remain unresolved are escalated to the corporate nursing team in as real time as possible to facilitate resolution and escalation processes.

11.8 Where ward staffing levels fall below their core funded establishment or below acceptable safe staffing levels in any shift period, a senior professional risk assessment is undertaken based on acuity, patient dependency, skill mix, and levels of enhanced 1:1 care. This overview is supported by reviewing census data from SafeCare to prioritize workforce deployment and aid decision making in order to maintain patient care, professional standards and safety.

11.9 The use of SafeCare and SBAR enables consistent application of care parameters, clear documentation, audit trails in relation to decisions and actions taken to facilitate safe staffing levels. Bed capacity meetings have been strengthened to ensure that staffing, patient safety and subsequent actions are appropriately managed. However, the ability to redeploy staff effectively remains challenging in view of the impact on already stretched staffing levels when carrying a RN vacancy of 43.59 wte and bed occupancy levels exceed 95-100% in addition to flexing capacity above the winter plan.

11.10 Identified nurse staffing shortfalls continue to be discussed daily and escalated as per Trust guidance and policy in conjunction with utilization of SafeCare, patient safety huddles, daily board rounds and professional judgement. A matron of the day rota supports the decisions taken with regards to staff deployment and escalation.

11.11 All reasonable steps and measures with regards to forward planning are proactively managed to support safe staffing levels as far as possible. This includes ensuring that identified gaps are met in the first instance by allocating any unused nursing hours accrued by substantive staff within the roster, cancellation of non-essential study leave, temporary staff utilization via nurse bank, existing ward staff working additional hours, staff redeployment, senior nurses stepping down into core numbers and booking of agency staff in line with staff escalation systems and processes.
Non-clinical front facing staff and additional volunteers continue to support staffing levels at time of peak operational pressures

On occasions during January non-clinical front facing staff and additional volunteers were drafted in to support staffing levels at times of peak operational pressures to mitigate risks to patient safety.

Further recruitment strategies and initiatives for attracting registered nurses to join the Trust substantively or through the nurse bank have been strengthened via social media, refer a friend scheme and access to weekly pay for nurses who work additional shifts or employed by nurse bank in addition to paying substantive staff at their current pay band. This has been capped to Band 7.

A clear focus to further develop and strengthen staff retention in view of the Trust’s demographic profile of the nursing workforce is in progress. This forms part of the NHSi 90 day improvement methodology and early signs demonstrate a reduction YTD in nurse turnover rates. Currently, below the 10% trajectory.

Regular student nurse focus group meetings facilitated by Practice Educator Facilitators and Heads of Nursing are in place to engage with students at an earlier point in their training. This aims to discuss their placement experience and provide strong links to support and convey job opportunities on qualification. A number of student nurses have been secured on successful qualification.

Any adverse clinical incidents relating to nurse staffing levels, patient safety, patient harm, patient complaints or staff concerns are reported and investigated via Datix Clinical Incident Management system. The Trust also actively promotes a designated, named lead in relation to ‘Freedom to Speak Up’ to raise concerns.

The triangulation of nurse sensitive and workforce metric indicators are reported against each individual acute in patient ward and presented monthly via the safe staffing exception Trust Board report, Ward Quality Dashboards and Directorate SQS exception reports. Ward quality dashboards are visible and shared with all in-patient ward teams.

Directorates continue to review risks pertaining to nurse staffing levels

Risks pertaining to nurse staffing levels are reported and form part of the Datix Risk Register which are subject to discussion and regular review within Directorates and form part of the Trust’s Governance assurance frameworks.

In addition, ‘Did You Know’ Boards, Sign up to Safety, Safety Thermometer, Ward Quality Dashboards, RADaR reports, Mortality/Morbidity are closely monitored. Actions are taken as appropriate to support mitigation of risks to patient and staff safety.

Patient experience and patient outcomes are continually monitored and actioned upon through various assurance meetings in addition to PaLS in reach to AED and in patient areas.

TRUST POSITION AGAINST NICE & NATIONAL GUIDANCE

The Trust continues to work and align staffing levels in line with NICE guidance recommendations. Based upon a three shift pattern the Trust is compliant with NICE guidance on acute hospital wards and on Intermediate Care Wards 11 and Aston professional skill mix judgement is used to ensure safe staffing levels within these areas.
‘Red flag events’ which are defined as ‘events that prompt an immediate response by the registered nurse in charge of the ward’ has previously been challenging to robustly record in real time due to the absence of electronic infrastructures and software tools.

However, the implementation of SafeCare provides staff with IT access to robustly and consistently select and apply Red flags. It is important to note that this functionality is not fully embedded as the tool itself remains in the early stages of full implementation. Further training and evaluation is required to fully embed all functionalities to ensure all acuity and dependency activity is captured and accurate. A further software upgrade is expected.

Relatively new NHSI resource guidance and collation of evidence-based tools specifically in relation to Paediatric and Accident and Emergency Departments is available. The new set of resource tools aims to improve and inform safe, sustainable and productive workforces in these clinical areas which are excluded from the SNCT Shelford model. The guidance is currently being appraised to consider the recommendations therein.

**13 CARE CONTACT TIME (CHPPD)**

13.1 In February 2016 the Carter report provided further guidance with regards to improving measures aligned previously to care contact time. It recommends that CHPPD (Care Hours per Patient Day) is calculated to describe both the staff required and staff available in relation to the number of patients requiring direct nursing care to help Trust’s provide high quality care, efficiency savings and improvements in productivity. It is calculated by adding the hours of registered nurses to the hours of healthcare support workers and dividing by the total number of in-patient admissions in a 24 hour period at the midnight bed count for each ward area.

13.2 The Trust is compliant with reporting measures.

13.3 Further data intelligence via the ‘model hospital’ facilitates rigorous interpretation and consistent application of guiding principles with other sources of data such as professional judgement to ensure the complexities of patient care and staffing numbers reflect appropriate skill mix and competency.

**14 CHALLENGES AND MITIGATION**

14.1 European and International recruitment trajectories and start dates have been subject to change which has resulted in a significant decrease in the number of international nurses initially recruited to. This has been compounded by the candidate’s unsuccessful completion of IELTS examination, regulatory requirements, candidate withdrawal or loss to larger peer organisations. The impact of Brexit is currently being worked through. Mitigating actions include partnership working, colleges and universities including closer working with candidates to assess and facilitate their competencies in the clinical setting.

14.2 National indications continue to demonstrate that the removal of student bursaries in England has had a detrimental effect on the number and quality of students who apply to undertake nurse training. Both local and national
trajectories identify a significant workforce shortfall to meet current demand coupled with the impact of lower birth rates in the UK and nurse retention. A number of peer organisations have offered and implemented incentive packages to attract and retain staff which poses ECT with additional challenges. Mitigating actions include developmental opportunities, flexible retirement options, return to practice and the piloting of new roles to support the workforce. Health and well-being continue to work with Directorates and partners in Learning and Development to explore new initiatives.

The trust has an ageing experienced workforce with an increasing number of staff eligible and applying for early retirement

Demographic profiling demonstrates that the Trust has an ageing experienced workforce with an increasing number of staff eligible and applying for early retirement. Over the next 2 years a higher proportion of nurse specialists and senior nurses within the organisation are expected to retire.

Robust workforce development and succession planning is required to ensure that key critical posts are recruited to in order to mitigate risks associated with patient safety and business continuity. Emerging patterns and themes since the last bi-annual report reveal that specialist nurse practitioner and critical care areas are more likely to attract and secure prospective employees than general wards. Mitigating actions to date include HR work stream alignment to recruitment, retention, attraction strategies to facilitate workforce sustainability.

Fluctuating sickness and absence rates within some areas has impacted on safe staffing levels and skill mix dilution. The management of this in addition to a number of gaps due to maternity leave is an additional pressure on an already challenged workforce. Operational pressures continue to be mitigated through agreed escalation processes and managed on a daily basis. All sickness and absence is proactively managed as per Trust policy.

On a number of occasions additional flex capacity or utilization of AAU as an in-patient area to support the management of patient flow, patient safety and operational pressures presented staff with challenges during January and has required staff resilience and flexibility. Mitigating actions include a planned and co-ordinated approach to deploy staff from all other areas to support safe staffing levels and skill mix. However, this coupled with the current level of vacancies and early indications of winter pressures experienced may further impact upon the Trust’s ability to provide adequate staffing levels and skill mix across all in patient ward areas necessitating backfill with bank and agency staff.

Controls to support a reduction in agency expenditure have been consistently applied to ensure a trust wide approach is adopted for all staff groups. The impact of these measures are monitored weekly against nurse sensitive and workforce metrics to ensure patient safety, staff wellbeing and operational delivery is effectively addressed and managed to support safe staffing levels. The Director of Nursing and Quality maintains oversight on all over cap nurse agency requests and a robust approval process is in place in and out of normal working hours. Despite these measures, on a number of occasions throughout January staffing levels have been below core minimum staffing levels due to non-availability of bank or supply of agency staff.

Identified gaps in medical staffing may further impact upon nurse staffing and the delivery of safe patient care. Mitigating actions include review of job plans,
substantive and locum recruitment with clear escalation processes in place.

15 **NEXT STEPS**

15.1 Share outputs from SNCT with Directorates and re-establish a project plan to review all acute adult in patient ward funded establishments over the next 6 months.

15.2 Engage and co-opt key personnel to support establishment reviews and seek sign off approval via Directorates and Board.

15.3 Undertake urgent review of Ward 4 staffing model in view of the rise seen in Level 1a and Level 2 care requirements.

15.4 Agree and build upon the foundations of the Nursing Associate programme which encompasses evaluation of the national pilot informing future practice standards, policy alignment embedding safe clinical practice and preceptorship.

15.5 Revisit nurse bank functions, systems and processes in conjunction with “matron of the day”, bed and site management roles to streamline communication, provide role clarity and prevent duplication of efforts. Monitor and evaluate escalation process.

15.6 Continue to monitor and improve Safe Care and e-rostering compliance by working with ward areas and e-rostering team to reflect accurate templates and resolve anomalies. Pilot Safe Care quality audit tools to capture and provide assurance re: compliance in relation to quality standards.

15.7 Recruit to and implement the recommendations in relation to Ward 10 agreed workforce model.

15.8 Build upon the retention strategies to support workforce development, succession planning and reduce agency expenditure.

15.9 Evaluate MAU Band 6 roles to support 24 hour 7 days a week cover and confirm identified funding stream.

15.10 Request directorate appraisal of NHSI resource information guidance re: Paediatrics and Accident and Emergency in relation to safe, sustainable and productive staffing to help guide workforce planning.

15.11 Progress and embed application of NICE Red Flag reporting via Safe Care to further inform staffing levels based on acuity and dependency, triangulation with nurse sensitive indicators linked to CHPPD ‘model hospital’ intelligence. Agree organisational response to Red Flags.

15.12 A further SNCT acuity and dependency audit will be undertaken in July 2019 to enable regular comparable acuity and dependency data analysis to inform safe staffing levels for acute in patient areas.

15.13 Any exception identified in the interim will be managed appropriately within set timescales, discussed and escalated through the Trust’s established performance and governance assurance frameworks.
15.14 Complete baseline NICE guidance re-assessment

16 RECOMMENDATIONS

16.1 The Board is asked to note the contents and recommendations contained within the report.

Kath Senior
Director of Nursing and Quality
Appendix 1:

Safer Nursing Care Tool Example:

Multipliers can be used to set nursing establishments allied to acuity and dependency measurement. The multipliers agreed for each level of patients on inpatient wards are:

<table>
<thead>
<tr>
<th>Level of Care</th>
<th>Adult Inpatient Wards</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 0</td>
<td>0.99 WTE per bed</td>
</tr>
<tr>
<td>Level 1a</td>
<td>1.39 WTE per bed</td>
</tr>
<tr>
<td>Level 1b</td>
<td>1.72 WTE per bed</td>
</tr>
<tr>
<td>Level 2</td>
<td>1.97 WTE per bed</td>
</tr>
<tr>
<td>Level 3</td>
<td>5.96 WTE per bed (1-1)</td>
</tr>
</tbody>
</table>

Example:

If a 28 bedded ward has 12 patients at Level 0, 7 patients at Level 1a, 8 patients at Level 1b and 1 patient at Level 2, a total of 37.24WTE nursing staff should be required. This figure is a baseline against which to set nurse staffing levels.

Additional factors as outlined in Appendix 1 may also need to be considered as wards have different activity and dependency.

Professional judgment is required to ensure that establishments are adjusted appropriately under these circumstances. Nurse sensitive indicators can also be used at this stage to ascertain the impact of acuity, dependency and activity on quality outcomes.

<table>
<thead>
<tr>
<th>Number of patients/Level of Care</th>
<th>Adult inpatient ward area</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 patients at Level 0</td>
<td>0.99 x 12 = 15.24</td>
</tr>
<tr>
<td>7 patients at Level 1a</td>
<td>1.39 x 7 = 9.73</td>
</tr>
<tr>
<td>8 patients at Level 1b</td>
<td>1.72 x 8 = 13.76</td>
</tr>
<tr>
<td>1 patient at Level 2</td>
<td>1.97 x 1 = 1.97</td>
</tr>
<tr>
<td>Total</td>
<td>37.34 WTE</td>
</tr>
</tbody>
</table>

The tool recommends 22.6% – 25% uplift for annual leave, study leave and sickness.
Report of:  
Responsible Officer:  
Accountable Officer:  
Director of Corporate Affairs & Governance

Author of Report:  
Head of Integrated Governance

Subject/Title:  
Review of Corporate Governance Manual

Background papers (if relevant):  
Full Corporate Governance Manual 2019/20 incorporating:  
- Standing Orders  
- Standing Financial Instructions  
- Reservation of Powers to the Board and Delegation of Powers  
- Terms of Reference  
- Policies and Procedures

Purpose of Paper:  
To present to the Board proposed amendments to the Corporate Governance Manual.

Action/Decision required:  
The Board is asked to:  
- Review the proposed amendments  
- Approve the revised Corporate Governance Manual  
- Note that the Audit Committee has received an update of proposed changes.

Mitigates Risk Number: (identify)  
On Corporate Risk Register

Mitigates Risk Number: (identify)  
On Assurance Framework

This paper relates to the all aspects of the Trust’s operation and therefore is linked to all risks on the Corporate Risk Register and Board Assurance Framework.

Link to Care Quality Commission Domain (identify):  
All domains

Link to:  
- Trust’s Strategic Direction
- Corporate Objectives

All objectives

Legal implications - (identify):  
No legal implications

Impact on quality:  
No impact on quality

Resource impact:  
None

Impact of equality/diversity:  
No impact on equality / diversity

Avoid acronyms or abbreviations - if necessary list:  
- CQC – Care Quality Commission  
- BMA – British Medical Association  
- OJEU - Official Journal of the European Union
1. **PURPOSE**

1.1 The purpose of this report is to present to the Board proposed amendments to the Corporate Governance Manual for approval.

2 **BACKGROUND**

2.1 The Trust’s Corporate Governance Manual incorporates its Standing Orders; Standing Financial Instructions; Reservation of Powers to the Board and Delegation of Powers and Terms of Reference of the Committees of the Board. The Corporate Governance Manual is subject to annual review and amendment where necessary.

3 **SUMMARY OF PROPOSED AMENDMENTS**

3.1 The amendments which have been identified as being required are:

**General Amendments:**
- Inclusion of Document control page
- Correction of errors in cross referencing paragraph numbers
- Reference to Annual Business Plan changed to Annual Plan

**Standing Orders:**
- Sections 3.3 and 3.7 amended to reflect the new Director role as a board member
- Section 7.4.5 reference to recent public inquiries and reviews

**Detailed Scheme of Delegation and Delegated Financial Limits**
- Executive Director Delegated Authority amended to reflect current portfolios
- Detail expanded including Officers with delegated authority for Freedom to Speak up Guardian and Data Protection roles.

**Standing Financial Instructions**
- Removal of reference to Local Delivery Plan (LDP)
- Section 22.1 Include reference to Conflict of Interest Policy (included at C8), which includes declaration of gifts and hospitality

**Terms of Reference**
- Revised Terms of Reference for each of the Committees of the Board

**Policies and procedures**
- C1 – Annual refresh of Anti-Fraud and Corruption policy
- C2 – Amended Freedom to Speak Up (Raising Concerns) policy – updated to reflect Board discussion following completion of the Board Self-assessment tool. This includes strengthening of roles and responsibilities and strategic intent section
- C6 – Fit & Proper Persons process replaced with new Fit & Proper Persons policy
- C8 – New Conflicts of Interest policy
- C9 – New Overpayments policy

4 **RECOMMENDATIONS**

4.1 The is asked to approve the Annual Governance Manual
### Agenda Item Number 13: TB 19 (28)

**Report of:**
Responsible Officer: Mark Ogden, Director of Finance

**Accountable Officer:**

**Author of Report:** Julia Cazalet, Associate Director - QIPP

**Subject/Title**
Implementation of Lord Carters Recommendations for Delivering Improved Productivity

**Background papers (if relevant)**
Operational productivity and performance in English NHS acute hospitals: Unwarranted variations
An independent report for the Department of Health by Lord Carter of Coles.

**Purpose of Paper**
To provide the annual update the Board on the progress made by ECT in delivering the recommendations contained within the report by Lord Carter on improving operational productivity.

**Action/Decision required**
To note

**Mitigates Risk Number: (identify)**
BAF 7

**On Assurance Framework**

**Link to Care Quality Commission Domain**
Choose one of the following:
- Safe
- Effective ✓
- Well-lead

**Link to:**
- Trust’s Strategic Direction
- Corporate Objectives

- Continuously improve quality, safety and the patient experience
- Achieving financial sustainability

**Legal implications - (identify)**
None currently identified

**Impact on quality**
Continuously improve quality, safety and the patient experience

**Resource impact**
Impact on expenditure.
Management, clinical and administrative resource to address the actions.

**Impact of equality/diversity**
NIL

**Avoid acronyms or abbreviations**
WAU – Weighted Activity Unit
| - if necessary list:                                                                 | PACS – Picture Archiving and Communication System |
|                                                                                  | FOM – Future Operating Model                      |
|                                                                                  | GS – Global Standard                              |
|                                                                                  | GIRFT – Get it Right First Time initiative        |
|                                                                                  | HPTP – Hospital Pharmacy Transformation Plan      |
|                                                                                  | MIAA – Mersey Internal Audit                      |
|                                                                                  | IBCF – Improved Better Care Fund                  |
|                                                                                  | ESR – Employee Staff Record                       |
Implementation of Lord Carter’s recommendations for delivering increased productivity

The report below provides the annual update on the Trust’s response to the recommendations made in Lord Carter’s report on operational productivity in the NHS. It highlights what the Trust has done differently and the extent to which implementation of the recommendations has supported improvements in efficiency or productivity.

1 Introduction

Lord Carter identified steps to improve productivity.

1.1 The Carter report identifies the level of productivity opportunity available to the NHS if levels of variation were reduced such that at a granular level all trusts achieved the performance of the average trust.

1.2 This paper highlights a number of initiatives ECT is working on to deliver the productivity opportunity identified by the review.

2 Spotlight on Productivity

The potential for productivity has led to a move to ‘spotlight’ particular areas.

2.1 The Trust has been implementing an increasing number of the actions outlined in the Carter report since its inception. In the previous update it was highlighted that the impact of these actions would be identified from the 2017/18 financial and activity data presented in the model hospital.

2.2 Appendix 1 document documents the relationship between income, expenditure and activity over the last four financial years and includes whole Trust expenditure and that included within reference costs which informs the model hospital financial information. The 2017/18 data indicates that the Trusts costs were better under control than in previous years with an improvement in its ranking, and a reduction in its cost per WAU compared to the previous year. However ECT remains an outlier in terms of productivity.

2.3 The Trust monthly ‘spotlight on productivity’ session to maintain visibility on areas requiring change has ceased but achieving increased productivity has been a key focus of the 2019/20 planning process.
3 Implementation of the recommendations in 2018/19

3.01 The Carter report made recommendations on the type of information that should be gathered and reported to support the provision of national benchmarking data. The data requirements have become more detailed and more defined as NHSI attempts to develop comparability between organisations. These have been extended by Carter Efficiency Guidelines which outline in more detail expected actions Trusts will undertake to deliver QIPP.

3.02 The Trust’s response to the Carter recommendations are set out in more detail below:

3.1 National People Strategy

3.1.1 The national workforce strategy consultation has now been concluded although it remains in draft.

3.1.2 Actions already taken to further effective planning and management of transformational change include:

- A range of leadership development programmes including leadership courses for aspiring managers and 360 appraisal for current managers
- Succession planning process in place at executive, deputy and senior manager levels
- Implementation of a portfolio of mental health support for staff to support staff well-being and reduce sickness rates including: in-house staff counsellor, workplace wellbeing policy supported by departmental stress risk assessments and in-house e-learning packages. In addition, the Trust provides free mental health training, including recognised qualifications in mental health awareness
- The Trust has introduced a RETAIN model for nursing staff in order to improve staff retention. New nurse starters are met with at 30, 60 and 90 days to see how they are settling in. Any issues raised can be dealt with quickly; Turnover has been reducing steadily across the Trust and for Nursing it has reduced from 11.64% in May 18 to 9.14% in January 19.

3.2 Analysing Staff Deployment

3.2.1 The Trust continues to capture and report on nursing care hours per patient day. From August this value was on a par with the national median and lower than that of our peers, having previously been consistently higher.

3.2.2 The data that is collated within the Model hospital relating to nurse staffing has been used to contribute to nursing ward reviews in conjunction with other tools such as safer nursing care and local information systems including ESR and e-roster. The first phase has commenced with initial recommendations due early April and with all wards to be reviewed by the end of July 2019.
3.2.3 In line with Carter recommendations, there has been an increased focus on medical deployment. The Trust has implemented E-job planning for consultants and is in the process of rolling out the software for middle grades. The Trust is also implementing Clinical Activity Manager in Theatres which will provide an overview of rosters and job plans against clinical activity. In line with the NHSI attainment standards for e-rostering and job planning the Trust is working to improve the consistency and quality of the data recorded.

3.2.4 The Trust has a large medical bank to support the management of vacancies. Weekly clinical deployment meetings are held to review agency rates and rates negotiated with agencies on an individual basis. These have reduced the agency spend. Expenditure on agency is currently broadly in line with the maximum threshold, although opening extra winter capacity will breech this.

3.3 Hospital Pharmacy Transformation Programme

ECT are working with the Greater Manchester hospital pharmacy transformation collaborative.

3.3.1 The Trust continues to be part of the Greater Manchester Hospital Pharmacy Collaborative and maintains its involvement in the following work streams:

- **Aseptics** - a review of aseptic services across GM & ECT has now led to the production of a catalogue of products for pre-made items from licensed units. A standardised capacity modelling tool has also been developed and will be implemented across the footprint. This work is on-going and linking into a national aseptic review being led by the Specialist Pharmacy Services.

- **Stores** – significant piece of work being undertaken around this looking at having potentially a single central store to serve all trusts. An Outline Business Case has been developed and agreed at GM board. Resources have been given to take the project forward and next steps are to develop a final business case and tender for the service.

- **ECT** is reviewing the provision of medicines information services, looking to outsource to another trust to focus on having 80% of staff delivering direct clinical activity.

3.3.2 These pieces of work are expected to release QIPP through staff savings in 2019/20. There is a similar piece of work happening across the Cheshire and Merseyside Health and Care partnership looking at hospital pharmacy collaboration which is at an earlier stage.

3.3.3 The continued programme of switching to biosimilar drug treatments will also generate savings across the health economy. The Trust purchase of Define® software will allow benchmarking of prescribing patterns to identify any unwarranted variations and potential QIPP.

3.3.4 Model Hospital data for 2017/18 showed an improvement in pharmacy cost per WAU compared to the previous year with the Trust now ranking as green - in the middle of the second top quartile.
3.4.1 Pathology

**Cheshire Pathology Services** and University Hospital of North Midlands have agreed the strategic outline case for a networked pathology service.

ECT receives its pathology provision from Cheshire Pathology Services led by MCHFT. In collaboration with UHN, Cheshire Pathology Services has been exploring the development of a larger pathology hub. The firm LTS was awarded the tender to produce the strategic plan for a collaborative approach between Cheshire Pathology Services and North Staffordshire. The strategic outline case has been approved by the pathology executive and UHN and the outline business case is now being developed.

In the short-term, ECT has received a share of identified QIPP within the Cheshire Services pathology contract, resulting in a reduced SLA value. The Trust will be seeking support from Cheshire Pathology Services in respect of demand management of testing and to understand whether it has any levels of unwarranted variation which can be addressed.

3.4.2 Imaging

ECT’s model hospital benchmarking report showed that the Trust was generally well placed against other organisations particularly on efficiency metrics including cost per report and percentage of consultant job plans delivering direct clinical care. The service is currently preparing a business case for further radiologists to aid in reporting turn around and support increased demand for reporting in specialist areas.

The model hospital data was used to support a workforce redesign. A skill mix review included ensuring that existing trained Assistant Practitioners are fully utilised to release radiographers for cross sectional scanning.

The Trust is working within the cancer alliance / STP’s to progress the training of a Chest and Abdomen reporting radiographer funded by HEE to further support effective skill mix. Funding was also released from the Cancer alliance enabling retention and productivity gains through home reporting for a radiologist.

Through the procurement arm of C&MHCP / Cancer alliance the Trust has benefitted from group buying power for CT contrast, using economy of scale to get best deals possible resulting in a £30k financial saving to the Trust. Work is also underway within this group to look at the outsourced reporting. Early indications are that ECT’s existing arrangements are more cost effective than the proposed model.

ECT radiology assets were highlighted as good within the model hospital benchmarking data. To ensure this stays that way the service are looking at kit requirements across a 5-10 year timeframe. Working with procurement, the service will review the MES contract and other provision to ensure that the Trust uses reliable equipment within guideline age. The joint PACS procurement process has been stopped and ECT is now procuring PACS as a single entity.
3.4.2.6 The radiology model hospital data submission is being refreshed again in April 2019. The service is working with the information team to ensure that data sources are as accurate as possible with any errors or outliers being identified, reviewed and corrected.

3.5 Procurement

The Trust continues to implement its procurement transformation plan.

3.5.1 The Trust undertakes quarterly reviews of the top 100 products identified by the Procurement Price Index & Benchmarking (PPIB) tool to optimise the selected supply route and to challenge the price paid.

3.5.2 The Trust is fully participating in the Cheshire and Mersey STP procurement network that is looking to maximise saving from collaborative working. A work plan will be in place for the 2019/20 financial year and will focus on high value spend areas such as agency staffing to align charge rates and Future Operating Model (FOM) category tower products to ensure value for money from the FOM is maximised.

3.5.3 The Trust will have a GS1 compliant inventory management system in place by April 2019. The inventory management system will enable the management and tracking of high value orthopaedic prosthesis to optimise stock levels.

3.5.4 The Trust continues to measure and record key procurement metrics and continues to be compliant for the following targets; 80% addressable spend transaction volume on catalogue, 90% addressable spend transaction volume on catalogue, 90% addressable spend transaction volume with a purchase order, 90% addressable spend under contract.

3.6 Operational Productivity – Estates and Facilities

ECT is working with NHSI to review its estates and facilities provision.

3.6.1 The Facilities management team continue to work with NHSi to validate warranted and unwarranted variation contained within Model Hospital. In particular the recording of data via the ERIC return is being reviewed to establish whether costs are being appropriately allocated to the ISS contract. Additionally the team are looking closely at Mid Cheshire Hospitals NHS Foundation Trust as a peer hospital to establish opportunities.

3.6.2 Earlier in 2019, the Facilities department considered the possibility of issuing formal OJEU re-tender for the Soft FM contract which is due to come terminate in October 2019; this would have enabled a bid from Mid Cheshire Hospital FT. Whilst standards have been good, ISS has been regarded as expensive against model hospital peer comparison. MCHFT were interested in submitting a bid but it was decided by their Board that the timing was not right due to organisational changes.
3.6.3 In the interim, ISS reviewed their financial offering for the contractual option to extend services for another 2 year period. ISS offered a reduction in service costs of £140k over the remaining two years; this offer has subsequently been accepted and included in forecasted QIPP delivery.

3.7 Corporate and Administration Functions

A regional review of corporate and administrative functions seeks to identify opportunities through increased collaboration.

3.7.1 A region wide programme is being undertaken to review the opportunities for delivering savings through ‘Corporate Collaboration at Scale’ based on the recommendation made in the Carter report regarding the efficiency gains from standardising these services. The 2017/18 corporate benchmarking return constitutes the base data for the programme.

3.7.2 The Trust continues to be challenged by the costs of its overheads. The 2017/18 review indicated that ECT corporate services continue to benchmark in the lowest quartile for cost per £100m of Trust turnover, particular in finance, IM&T and HR. As a small provider ECT stands to benefit most from opportunities derived from collaborative working and shared benefits realisation and is increasingly engaged in the regional forums reviewing these proposals.

3.7.3 Under the auspices of the Collaboration at scale programme, Mersy Internal Audit Agency (MIAA) in conjunction with NHSI is undertaking an exercise to validate the corporate benchmarking data and support comparability between organisations. PA consulting have been commissioned to use this data to scope out the ‘size of the prize’ in respect of opportunities for NHS organisationsto work collaboratively and the extent of the regional savings that could be delivered as a result. These are likely to range from sharing expertise and knowledge across the region through proposals for a unified approach, to moving to a single provider for services such as occupational health or legal services.

3.7.4 ECT is currently validating its corporate benchmarking with MIAA. The project to switch payroll provider to achieve better value remains on track.

3.8 Joint Clinical Governance

ECT has received feedback from the GIRFT team.

3.8.1 The Trust has received reports from the GIRFT team in respect of orthopaedics and ophthalmology. The Medical Director has held implementation meetings with the service which have reviewed the findings and derived action plans to address the recommendations. GIRFT benchmarking report relating to A&E has also been produced and is in the process of review by the service.
3.9 Digital Information Systems

The Trust does not have all the key digital information systems in place. It is taking steps to develop an electronic health record.

3.9.1 The Trust position on digital information systems is unchanged and is summarised below:

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<th>Requirement for implementation by October 2018</th>
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<th>Significant risk to achievement</th>
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<td>Electronic Health Record - acute</td>
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<td>X</td>
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3.9.2 The Trust is currently pursuing approval of a joint Digital Clinical System with a neighbouring Trust which if approved would provide the Electronic Health record for the acute and e-Prescribing. The Outline Business case is due at the Trust Board in April 2019.

3.10 Local Government Representatives

Collaborative working with local government is in place to reduce delayed transfers of care

3.10.1 Carter recommended that the Department of Health, NHS England and NHS Improvement should work 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 carers. The Trust is working closely with local government to support this aim.

3.10.2 Daily health and social care boards are in place via the Integrated Discharge Team, whereby all those requiring supported transfers out of hospital are discussed and joint actions agreed. Significant progress has been made in the reduction of delayed transfers of care (DToCs) with escalation processes in place when DToC exceed 15.

3.10.3 The development of an alert system which informs community care teams of individuals from existing case loads who have been admitted into the acute setting with a view to community clinicians developing proactive processes to support discharge has been piloted with the Macclesfield team. The value and effectiveness of this scheme will be evaluated as part of the winter plan review.

Chairman: Lynn McGill
Chief Executive: John Wilbraham
Care home beds have been key to supporting discharge from the acute setting over the winter period with care home colleagues being supportive and responsive. Provision across multiple care homes allowed up the spot purchase of up to 58 additional beds into the system during peak demand.

Further work will be required to develop a Trusted Assessor role, potentially funded by the Improved Better Care Fund programme, to support assessment of suitability for the areas nursing and care homes.

### 3.11 Partnership working

...and collaboration across the health economy is continuing.

The Trust is an active participant in the Cheshire East Partnership, with a view to developing improvements in the quality and efficiency of care for the local population through collaboration with its local health Economy partners. The Trust is also part of the Cheshire and Merseyside Health and Care Partnership which has been looking at opportunities for implementing the recommendations of Carter at scale, to support better quality and efficiency across a wider footprint.

The Acute Sustainability work stream at the Trust is led by the Chief Executive as SRO, reporting into the Cheshire East Place Partnership Board (CEPPB), which in turn reports into the C&M HCP governance process. This work stream forms part of the Cheshire East Place plans and approach for the transformation of NHS and social care services, with the aim of improving outcomes for our population as well as becoming financially sustainable.

Six clinical scenarios for the future sustainability of acute services in East Cheshire have been developed. 2019/20 will see further work undertaken to ‘stress test’ these clinical scenarios with clinical partners. Wider stakeholder engagement including patient and public involvement will be essential to further develop the scenarios.

### 3.12 The Model Hospital

Clinicians and managers have identified changes that can be trialled.

The volume and range of data within the model hospital has been considerably expanded. This increases the richness of data available to support comparison with other organisations.

A key purpose of a benchmarking tool is to learn from others who appear to be high performing organisations. Harrogate NHS Trust has been identified as an appropriate peer organisation, based on both its scale, situation and population demographic. In October 2018, clinicians and managers from the acute and integrated care directorate undertook a visit to Harrogate District General Hospital A&E department with objective of understanding what drove their high productivity and performance rankings.
3.12.3 As a result of the visit, significantly different overnight staffing levels were identified. Although highlighting that there are a number of differences between the two A&E departments including the physical environment and in patient bed occupancy rates, the directorate have now drafted a proposal to reduce A&E nurse staffing overnight. The visit also prompted a review of current data capture processes which provided assurance of practices in place and highlighted the need to progress with new data requirements.

3.13 Implementing the recommendations

The Trust continues to progress the recommendations made by Carter and there is some evidence of improvement.

3.13.1 Detailed review of trust information and a focus on outpatient provision appear to have delivered productivity gains evidenced by an improvement in the reference cost value for outpatients from 114 in 2016/17 to 104 in 2017/18. However the overall position of the Trust has only reduced to 111 from 110 to the previous year. This suggests that the improvement in Outpatients has been offset by deterioration in productivity elsewhere.

3.13.2 Appendix 2 indicates where there have been changes to cost per WAU over time. The key significant reduction is on nursing costs per WAU potentially reflecting the ongoing work in respect of skill mix redesign and effective rostering. (although additional agency spend may be influenced by this.) Reductions in AHP are primarily due to technical changes in holding of employment contracts.

3.13.3 The Trust is working through the Carter efficiency guidelines to ensure that it is giving due consideration to each area. This supports the organisation in identifying productivity and efficiency opportunities that ECT can deliver on its own and those which require collaboration and cooperation, particularly in clinical support services such as pharmacy, pathology and radiology and developing proposals for provision of corporate services.

4 Conclusions

...but the rate of productivity improvement needs to increase and changes to Trust practice are still required to deliver better productivity. 4.1 The Trust has addressed the recommendations made in the Carter report and has prioritised the introduction of nationally promoted tools which support increased visibility of information on workforce, procurement of supplies and pharmaceuticals. This has led to the Trust making progress in tackling some underlying issues which impact on productivity including effective monitoring of leave and non clinical commitments.
5 RECOMMENDATION

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

Mark Ogden
Director of Finance
22nd March 2019
### ECT Cost Per WAU By Spend Category from 2014/15 to 2017/18

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<th>Category</th>
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### Local Peers Cost Per WAU By Spend Category from 2014/15 - 2017/18

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<td>1080</td>
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<tr>
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## ECT Cost Per WAU By Spend Category from 2014/15 to 2017/18

<table>
<thead>
<tr>
<th>Category</th>
<th>14/15</th>
<th>15/16</th>
<th>16/17</th>
<th>17/18</th>
<th>Difference between 16/17 - 17/18 (£)</th>
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<tr>
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<tr>
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<td>167</td>
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<td>230</td>
<td>284</td>
<td>54</td>
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<tr>
<td><strong>Healthcare science and Other STT Staff</strong></td>
<td>347</td>
<td>491</td>
<td>461</td>
<td>416</td>
<td>45</td>
</tr>
<tr>
<td><strong>Agency Staff</strong></td>
<td>183</td>
<td>195</td>
<td>230</td>
<td>284</td>
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<tr>
<td><strong>Other non-Substantive Staff</strong></td>
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<td>242</td>
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<td>397</td>
<td>461</td>
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<tr>
<td><strong>Medicines</strong></td>
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<td>285</td>
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<tr>
<td><strong>Corporate, admin and estates Staff</strong></td>
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<td>343</td>
<td>379</td>
<td>416</td>
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<td><strong>Premises, establishment &amp; service charge</strong></td>
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<td><strong>Clinical negligence &amp; Purchase Healthcare</strong></td>
<td>183</td>
<td>195</td>
<td>230</td>
<td>284</td>
<td>54</td>
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<tr>
<td><strong>Depreciation</strong></td>
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<td>230</td>
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### ECT Trust

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<tr>
<th>Category</th>
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<th>17/18</th>
<th>Difference between 16/17 - 17/18 (£)</th>
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### ECT Trust

#### Recommended Peers Cost Per WAU By Spend Category from 2014/15 - 2017/18

<table>
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<tr>
<th>Category</th>
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<th>16/17</th>
<th>17/18</th>
<th>Difference between 16/17 - 17/18 (£)</th>
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<tr>
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<tr>
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</tr>
<tr>
<td>Healthcare science and Other STT Staff</td>
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<tr>
<td>Agency Staff</td>
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<tr>
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<tr>
<td>Supplies and Services</td>
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<td>335</td>
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<td>Medicines</td>
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<td>413</td>
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<td>516</td>
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<td></td>
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<tr>
<td>Premises, establishment &amp; service charge</td>
<td>170</td>
<td>156</td>
<td>172</td>
<td>177</td>
<td></td>
</tr>
<tr>
<td>Clinical negligence &amp; Purchase Healthcare</td>
<td>170</td>
<td>156</td>
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<tr>
<td>Depreciation</td>
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<td>Grand Total</td>
<td>176</td>
<td>156</td>
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<td>177</td>
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</table>

#### Full Meeting Bundle Page 147 of 472
| Report of: | Kath Senior  
Director of Nursing and Quality |
|---|---|
| Responsible Officer: | Kath Senior  
Director of Nursing and Quality |
| Accountable Officer: | Brian Green  
Deputy Director of Nursing and Quality |
| Author of Report: | Kath Senior  
Director of Nursing and Quality  
Brian Green  
Deputy Director of Nursing and Quality |
| Subject/Title | Quality Strategy 2019/22 |
| Background papers (if relevant) | Quality Strategy 2015/19  
Quality Accounts |
| Purpose of Paper | To outline the area of focus and priorities for the ECT Quality Strategy |
| Action/Decision required | Approval of the Quality Strategy 2019/22 |
| Mitigates Risk Number: (identify) On Corporate Risk Register | BAF 2: If quality is not maintained in line with regulatory standards during and after transition then this could impact on services the trust provides and ability to provide services that are caring, safe, and responsive and safeguard the health & wellbeing of the local population. |
| Mitigates Risk Number: (identify) On Assurance Framework | BAF 5: If the Information Technology/Information Systems and Estate infrastructure are not sufficiently invested in and adapted to align with the health economy strategy then there will be an impact on the quality of the delivery of clinically & financially sustainable services |
| Link to Care Quality Commission Domain | Safe✓  
Effective✓  
Caring✓  
Responsive✓  
Well-led✓ |
| Link to: | All corporate objectives |
| Trust’s Strategic Direction |  
Corporate Objectives |
| Legal implications - (identify) | None |
| Impact on quality | Positive impact on patient experience, engagement and clinical outcomes |
| Resource impact | None |
| Impact of equality/diversity | Supports equality and diversity action plan |
| Avoid acronyms or abbreviations - if necessary list: |
Quality Strategy
2019-2022

Listening and responding to deliver high quality person centred care
# Table of Contents

- Foreward 3
- Introduction 4
- 2015-2019 Quality Achievements 5
- Our Quality Improvement Model 9
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Foreword

East Cheshire NHS Trust (ECT) provides hospital and community health care services for the local population of Eastern Cheshire.

Quality improvement at ECT is about continuously improving standards to ensure we provide safe care, better outcomes and positive experiences for the people who access our services.

The NHS 10 year plan sets out a number of ambitions and this Quality Strategy demonstrates our commitment to deliver safe, effective and personal care whilst working in partnership to develop innovative and integrated ways of working that drive quality improvement. This will support the trust in achieving its vision to provide the best care in the right place.

As a trust rated overall GOOD following CQC inspection we will continue to have a strong focus on demonstrating compliance with regulatory safety requirements. Achieving improvement in patient access standards is a key priority for the trust. A culture of continuous learning from incidents, complaints and good practice is fundamental to patient safety, engaging with people for whom we provide care or services.

The Eastern Cheshire area has a high elderly population compared to national average, with a high percentage of people aged over 65 and over 85. This is expected to increase further in the future, which will result in rising demands on health and care services. It is therefore essential that we work with partners to make best use of all available resources. Many patients are living well with one or more long-term conditions and our ability to treat the person rather than their condition is something that has been at the forefront of our work with health, care and third sector partners as we develop our five care communities within our catchment area.

We recognise that the best place for care is often in the person’s own home and enabling people to maintain their independence is a high priority. When people require essential hospital treatment our aim is to provide timely and responsive care and we will continue to ensure that our staff have the necessary knowledge, skills and competence.

We are proud of what has already been achieved and look forward to working with key stakeholders and staff as we further develop and transform services across Eastern Cheshire.

John Wilbraham
Chief Executive

Kath Senior
Director of Nursing and Quality
Introduction

For East Cheshire NHS Trust, quality encompasses four areas of focus:

**Harm-free Care**
Care that is safe and a commitment to deliver a year on year reduction in patient harm

**Improving outcomes**
Care that is clinically effective, providing the best possible evidence based care

**Listening and responding**
Care that provides a positive experience for patients, carers and families, further improving patient experience by listening to feedback and responding to concerns

**Integrated person centred care**
Care which is co-ordinated and based around individual needs through collaboration and co-operation

**Monitoring Quality – How will we know we have achieved**

The Board approves the Quality Strategy and seeks assurance on quality via its Safety Quality and Standards Committee which is chaired by a Non-Executive Director. This Committee receives reports on the quality strategy and triangulates information from:

- Patient Stories
- Clinical Audit and Research Reports
- Review of serious incidents, follow up actions, and deep dive reviews in line with escalating risk
- Safeguarding reports, including infection, prevention and control
- Quality Governance Reports (including complaints, incidents, claims and patient experience)
- Service area to Board reports on quality indicators (RADaR)
- Key Performance Indicator reports relating to Quality
- The Assurance Framework and Corporate Risk Register Reports specifically relating to Quality and Compliance
- Quality impact assessments of QIPP schemes
- External reports on safety and quality and associated action plans, including Freedom to Speak Up (raising concerns) from the Freedom to Speak Up Guardian.
- Staff and Patient Feedback survey results

The Director of Nursing and Quality is the Executive Director with responsibility for quality systems which are also tested annually through the Quality Account external assessment process.
2015-2019 Quality Achievements

In considering our strategic priorities for quality improvement we have considered current context and successes and achievements to date. Below are the highlights over the previous three years:

**Awards and Achievements 2016**

- In January 2016 the trust took the title of ‘most innovative organisation’ at a Haelo conference in Manchester. The award was given for a 90-day improvement programme which focused on the delivery of enhanced care.

- In March 2016 the trust won the National Autistic Society’s Outstanding Health Services award for the trust’s Open 2 Autism project.

- In April 2016, the trust’s GP Out-of-Hours service was rated as ‘Good’ by the CQC – both overall and in each of the five domains the CQC uses.

- The Cheshire Care Record, an IT system that allows hospital, GP and community staff to have access to a single record of patient information, was launched across the trust.

- In September 2016 maternity services at Macclesfield Hospital became the first in Cheshire to sign up to the Royal College of Midwives Caring for You Charter, which aims to improve services for women and babies by improving staff wellbeing.

- In October respiratory medicine at the trust was ranked number one in the country by the General Medical Council (GMC) following a survey of 15 different parameters including satisfaction in the post, workload, senior support and multi-disciplinary team working.

- In November 2016 the trust received an NHS Improvement award for a nurse-led 90 day Infection Prevention and Control programme.

**Awards and Achievements 2017**

- The trust received a strong endorsement as a place to work via the latest NHS Staff Survey, with employees of the trust reporting feeling more engaged and motivated – and more likely to recommend the trust as a place to work or receive treatment.

- The SAFER patient flow bundle – a standardised way of managing patient flow through hospitals was launched and saw a positive impact on specific wards around length of stay.

- The Walking Majors initiative was introduced in A&E in April as an alternative process for streaming majors patients who do not require treatment on a trolley.

- In June 26 staff members completed their Care Certificate at a celebratory event. The Care Certificate equips health and social care support workers with the knowledge and skills needed to provide safe, compassionate care.

- The trust launched #Endpjp paralysis, a social media campaign aimed at enabling hospitalised patients to get up, dressed and moving in order to prevent deconditioning.

- In December, a major redevelopment of Macclesfield Hospital’s Accident and Emergency Department was completed in a move which helps patients access the care they need more efficiently.
Awards and Achievements in 2018/19

- The trust was rated ‘Good’ by the Care Quality Commission with multiple areas of outstanding practice following a major inspection in January 2018.

- Single Sign On was rolled out to all wards at Macclesfield Hospital, removing the need for clinical staff to remember a wide range of user names and passwords.

- Free patient and public Wi-Fi was launched throughout Macclesfield District General Hospital, to allow patients and visitors to go online on their phones, tablets and other devices for free.

- The trust was named one of the top 40 hospital operators in the country for the eighth consecutive year via the CHKS Top Hospitals Programme in May 2018. This year the trust also received the CHKS Most Improved Award.

- The trust’s Maternity Department was one of just four nationally which performed ‘better than expected’ across all labour and birth questions in the CQC’s Maternity Services Survey and received an overall rating of 9/10.

- The trust won the ‘Changing Culture’ category in the HSJ Patient Safety Awards 2018 for our work managing winter pressures in 2017/18, including implementing a ‘runner’ system.

- Our Clinical Simulation Centre was accredited by the North West Simulation Education Network which shows we can deliver multi-professional education to the highest standard.

- The trust launched its prestigious “Compassion Award” where staff nominate colleagues who have shown outstanding compassion in care to our patients and carers and staff.

- The trust has also developed an initiative called ‘Improving Patient Flow (FLO) to free up beds allowing new patients to move to the hospital wards more quickly, rather than these people being delayed in other areas like A&E. The trust produced a video to demonstrate this initiative which went on to win a regional award. video featuring local NHS and social care staff

- In December 2018 training for the trust’s second six-strong cohort of nursing associates commenced.

- In January 2019 the Trust’s first cohort of nine Nurse Associates completed their programme of training and in February 2019 became some of the first Nursing Associates in the country to join the Nursing and Midwifery Council register.
# Quality Strategy Review 2015-2019

## Harm Free Care

Our commitment to deliver a year on year reduction in avoidable patient harm has been achieved

<table>
<thead>
<tr>
<th>Action Focus</th>
<th>Achievements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce injurious falls by 50% from 2015/16 baseline.</td>
<td>• The local target to reduce injurious falls rate to 2.5 per 1000 occupied bed days has been achieved.</td>
</tr>
<tr>
<td>Roll out of skin bundle supporting zero grade 3 or 4 pressure ulcers acquired on caseload or in hospital</td>
<td>• The roll out of the SSKIN bundle has been successfully achieved &amp; fully incorporated into the initial patient assessment document for both hospital and community patients. A key achievement has been a 76% reduction in unstageable pressure ulcers (n=98 in 2015-16 compared to 23 in 2018). The benefits are that more pressure ulcers are being categorised correctly and at an earlier stage which means prompt investigation as well as more timely and appropriate treatment for the patient.</td>
</tr>
<tr>
<td>Reduction of <em>Clostridium difficile</em> infection</td>
<td>• A demonstrable year-on-year reduction of <em>Clostridium difficile</em> infection cases.</td>
</tr>
<tr>
<td>Hospital MRSA bloodstream infections</td>
<td>• A reduction in MRSA bloodstream infections from 2 in 2017/18 to 1 in 2018/19. Since 2015/16, the trust has recorded a total of 4 MRSA bloodstream infections.</td>
</tr>
<tr>
<td>Improved management of the acutely unwell, deteriorating patient and Sepsis</td>
<td>• Good engagement of staff and improved sepsis risk assessment with ongoing AWARE training for non-registered staff. Further work is required to ensure full compliance with the sepsis care bundle. NICE guidance successfully re-audited and 96% compliance achieved.</td>
</tr>
</tbody>
</table>

## Improving Outcomes

Our aim has been to provide the best possible evidence based care

<table>
<thead>
<tr>
<th>Action Focus</th>
<th>Achievements</th>
</tr>
</thead>
</table>
| Embed SAFER flow principles | • Multidisciplinary morning board round implemented with use of expected date of discharge on all wards  
  • #last1000days social media campaign with monitoring on ’red to green days’  
  • #endpjparalysis campaign implemented on all hospital wards and also adopted by community nursing teams |
| Continued with rollout of EMIS web and Clinically Mobile working | • All clinical staff using EMIS have access to the full shared electronic patient record of Nursing, Therapies, Primary Care, Hospice and Cheshire Care Record. These records are shared in real time.  
  • All our Community Nursing Teams have iPads for full access (read and write) anywhere, anytime to all patient-shared records.  
  • Cross-organisation tasking is used in District Nursing teams, replacing the message books in GP surgeries and ensuring any requests are auditable in the patient record. |
| Develop and implement nurse revalidation | • Nurse revalidation process implemented with checks in place to ensure all nurses and midwives have appropriate licence to practice. |
Listening & Responding
We have further improved the patient experience by listening to feedback and responding to concerns

<table>
<thead>
<tr>
<th>Action Focus</th>
<th>Achievements</th>
</tr>
</thead>
<tbody>
<tr>
<td>More patients on the care of the dying pathway cared for in their preferred place of care</td>
<td>• East Cheshire is in the top quartile across England for people to be in a preferred place of care on their death.</td>
</tr>
<tr>
<td>Friends and Family Test</td>
<td>• Overall positive Friends and Family test results throughout the years</td>
</tr>
<tr>
<td>Development of Patient Advice and Liaison Service (PALS) outreach.</td>
<td>• Proactive visiting by PALS officers to patients and relatives in the Emergency Department and on wards has provided the opportunity for them to feedback on their experiences and where required take real time action has been taken to resolve any informal concerns or queries locally. This has resulted in positive feedback.</td>
</tr>
</tbody>
</table>

Integrated Care
We have developed services to ensure they are based around an individual’s needs

<table>
<thead>
<tr>
<th>Action Focus</th>
<th>Achievements</th>
</tr>
</thead>
</table>
| Develop integrated community care teams effectively aligning health and social care professionals | • We have five care communities with established project groups working on developing integrated services using a transformational approach  
• Community dashboard has been successfully developed with key quality metrics |
| Strengthen multidisciplinary working in community services ensuring high risk patients receive timely care coordination | • We developed systems and processes to implement trusted assessor pathways with our private care providers. All seven of the nursing homes who support intermediate care patients in the community now accept assessment completed by an integrated team nurse and do not complete their own assessment whilst the patient is in an acute bed. This has reduced duplication of assessment for patients and reduced delayed transfers of care |
| All specialties to have agreed transparent arrangements for transition of care from hospital to non-acute setting | • All paediatric specialties have arrangements for transition and these are formalised in guidelines. Each speciality has implemented or are in the process of implementing the ‘ready steady go’ pathway for transition. This is a national programme that can be adapted for individuals to ensure transition happens at the right time for that individual not necessarily at a certain age. |
| Develop and implement strategic plan to strengthen paediatric community service provision | • Following the SEND inspection, close links have been formed with the CCG to strengthen and develop the community paediatric service. Delays and quality issues with EHCP (education health care plans) have been resolved and a robust pathway created to ensure all children have a medical report when it is requested. |
| Develop an integrated approach to reduce delayed transfers of care from hospital to non-acute setting for children with complex needs | • Children with complex needs often require care packages to be set up. The children’s community nursing team have developed close links and a good working relationship with the complex care team to ensure that there are clear lines of communication and there is an understanding of who is responsible for which aspect of setting up a package. |
Our Quality Improvement Model provides a framework for high quality person-centred care by ensuring that we listen and respond to patient and staff feedback to improve outcomes and prevent harm. This integrated person-centred approach aims to empower service users and staff with the knowledge and skills needed to lead long and healthy lives.
# Quality Strategy Priorities 2019-2022

## HARM FREE CARE

To deliver a year on year reduction in avoidable patient harm.

A focus on safety is central to everything the Trust does. We will continue to ensure that as we transform services that safety remains our top priority for all age groups.

<table>
<thead>
<tr>
<th>Focus</th>
<th>Ambition 2019-2022</th>
<th>Expected Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Prevention Control</td>
<td>Participation in a Health economy approach to ensure a reduction in avoidable healthcare associated infections in line with national requirements including MRSA Blood stream infections, Clostridium difficile and gram negative organisms. This includes learning from post infection reviews to improve practice and reduce the risk of reoccurrence.</td>
<td>MRSA blood stream infections and Clostridium Difficile remain within agreed trajectories. Reduction in Gram-negative bloodstream infections by 50% by 2021 aligned with wider health economy plans.</td>
</tr>
</tbody>
</table>
| Maternity Services            | Embed Saving Babies Lives care bundle:  
  • Implement 36 week Carbon Monoxide monitoring for all women  
  • Ensure all smokers are commenced on growth scan surveillance pathway  
  • Ensure compliant with all areas of reduced fetal movement guideline – includes completion of reduced fetal movements assessment tools  
  • Develop CTG competency package to ensure all staff undertake assessment  
  • Reduce Preterm Births  
  • Implement continuity of carer to meet the national ambition to reduce rates of stillbirth, neonatal death, maternal death and brain injury during birth by 20% by 2020 and 50% by 2025 | Saving Babies Lives care bundle fully implemented to support national ambition. |
| Falls                         | Improve care for patients by reducing inpatient falls and associated harms:  
  Continue to align Fall prevention work with national priorities to support a reduction in falls and harms relating to falls:  
  • NICE Guidance  
  • The Falls and Fragility Fracture Audit Programme (FFFAP)  
  • National Safety Strategy  
  Create / implement a local integrated (hospital and community) Falls working group designed to improve engagement/collaboration and undertake the improvement work. | Target reduction in injurious falls from 2.5 per 1000 bed days to 1.8 in 2019/20, 1.7 in 2020/21 with a further reduction to 1.6 by 2022. |
<table>
<thead>
<tr>
<th>Focus</th>
<th>Ambition 2019-2022</th>
<th>Expected Outcome</th>
</tr>
</thead>
</table>
| **Pressure Ulcers**       | Continue embedding strategic /national initiatives to support a reduction in avoidable harms caused through pressure ulcer development.  
                             | • Stop the Pressure  
                             | • React to Red approaches  
                             | 10% reduction in number of grade 2 and 3 pressure ulcers from 2018/19 baseline by March 2020.  
                             | Zero avoidable grade 4 pressure ulcers by March 2020  
                             | Participate in the National Pressure Ulcer improvement collaborative and Align Pressure Ulcer strategy /reduction work with the National Safety Strategy  
                             | Rollout of the government initiative to align the terminology and reporting of Pressure Ulcers  
                             | Create of a local integrated Pressure Ulcer working group designed to improve engagement and focus on improvement work to be undertaken.  
                             | **Deteriorating patient NEWS 2**  
                             | Continue to embed National early Warning Score in all acute wards and work with community staff to embed News 2 into community and GP settings  
                             | Continue working with Manchester Patient safety collaborative and AQUA to progress NEWS 2  
                             | Decreased mortality rates.  
                             | Full compliance with sepsis care bundle.  
                             | **Safer Staffing**  
                             | Undertake baseline assessment re: updated NICE guidance  
                             | Review and agree local, organisational response re: NICE red flags  
                             | Monitor Safe Care compliance - Review Nurse Sensitive indicators and ward Quality Dashboards  
                             | Review of all wards WTE funded staff establishments inclusive of skill mix and roles based upon Bi-annual Safer Nursing Care Tool Audit analysis  
                             | Registered Nurse rolling annual turnover to remain less than 10% by 2022.  
                             | Reduction in Registered Nurse vacancies by 10% year on year.  
                             | Skill mix meets the needs of patients and national guidelines  
                             | **Discharge Planning**  
                             | To reduce inappropriate time spent in hospital. Smooth transition of patient discharge:  
                             | • Strengthen Board rounds and long stay patient reviews.  
                             | • Support development of Trusted Assessor across Care Homes  
                             | • Shared decision making framework for complex patient.  
                             | • Trusted Assessor model across all Care Homes  
                             | • Reduce the number of patient moves at night  
                             | Reduction in patients with a prolonged length of stay in hospital bed from 2018/19 baseline.  
                             | Improved National Adult Inpatient Survey results in relation to discharge questions  
                             | To meet the delayed transfers of care trajectory of 3.5% in line with national target  
                             | Improved patient experience and patient survey results |
INTEGRATED PERSON CENTRED CARE

To ensure services are effectively coordinated and based around an individual’s needs by collaboration and cooperation

Many people who have complex care needs receive health and social care services from multiple providers and in different care settings, without appropriate co-ordination or in a holistic way. To address this we aim to further develop our Care Communities to work in a more integrated way to deliver personalised care in the right place at the right time by people with the right skills.

<table>
<thead>
<tr>
<th>Focus</th>
<th>Ambition 2019-2022</th>
<th>Expected Outcome</th>
</tr>
</thead>
</table>
| **Further Development of Care Communities** | To empower people to take responsibility for their own health and wellbeing putting them in control of the support available to meet their needs  
  Establish neighbourhood care team model across East Cheshire building on work in Holmes Chapel  
  Develop and agree vision for Personalised Care including social prescribing across all Care Communities  
  Improved access designed to deliver high quality responsive services, support and appropriate information that provides everyone with the opportunity to have the best health and wellbeing throughout their life  
  Collaborative patient care between the acute and community and mental health care. | An increase in the number of people returning to their usual place of residence following a hospital stay.  
  A reduction in avoidable hospital admissions  
  Improved Patient and Staff satisfaction results  
  Care Communities working in an integrated way to deliver Personalised care  
  Improved patient satisfaction measured via Friends and Family tests  
  30% of staff trained in social prescribing skills year on year  
  Improved collaborative working between partner organisations to ensure seamless transition of care.  
  A reduction in readmissions by 10%. |
| **Social Isolation**          | Improved training for carers, volunteers and third sector  
  Population profiling & identification processes developed  
  To develop a new volunteer role to provide support to patients on the wards and encourage carers to participate where appropriate in supporting care | Community staff have a greater understanding of the range of local initiatives to reduce social isolation  
  Better recognition and understanding of loneliness across all age groups.  
  Greater focus on supporting individuals to access community and voluntary services.  
  Year on year increase of recruited volunteers for this role – 10 in first year.  
  Greater carer involvement in ward-based care |
It is envisaged that Care Communities will continue to bring wider health and social care teams together to deliver a wide range of services that not only treat illness but promote wellness, self-care and behavioural change. This will continue to involve a cohesive and comprehensive response from community services, social and primary care, hospital specialists, mental health and support from public health and preventative services. Input from the voluntary and community sector will be central to the success of this approach.

All the Care Communities are evolving to support the following principles:

- Optimise self-care and family/carers support to enable people to stay at home for as long as possible, independently and safely
- Proactively identify people at high risk of requiring access to services through early intervention and prevention
- Help people live as independently as possible whilst managing one or more long term conditions
- Focus on improved condition management to avoid unnecessary admissions
- Co-ordinate delivery of services from all providers, with teams of multi skilled professionals based in each of the Care Communities
- Help prevent people from having to move to a residential or nursing home (24 hour care) until they really need this level of care
- Move care and support closer to home
- Improve recruitment and retention into General Practice and Community Services
**IMPROVING OUTCOMES**

To provide the best possible evidence-based care

We are a learning organisation that is committed to continuous improvement and our aim is to provide the best possible evidence-based care. In some areas quality outcomes are well developed and understood and national and local indicators are in place. We will continue to benchmark and monitor local performance to ensure we maintain quality outcomes.

<table>
<thead>
<tr>
<th>Focus</th>
<th>Ambition 2019-2022</th>
<th>Expected Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Audit</td>
<td>Develop and implement annual clinical audit programme.</td>
<td>Evidence of service improvements and better outcomes for patients with presentations to directorate SQS meetings and at least two Grand Round audit-based presentations every year.</td>
</tr>
<tr>
<td></td>
<td>Participation in National Falls Audit</td>
<td></td>
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<tr>
<td></td>
<td>Participation in Care of the Dying Audit</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ensure a more streamlined approach to audit to prevent duplication and release time to care.</td>
<td></td>
</tr>
<tr>
<td>Clinical Research</td>
<td>Increase awareness of the benefits of research for patients and the trust by publicising on intranet and induction.</td>
<td>Improved research awareness and implementation of evidence based practice.</td>
</tr>
<tr>
<td></td>
<td>Increase awareness of what research activity is carried out within the trust by informing staff, visitors, patients and the wider public.</td>
<td>Increase the number of participants recruited into NIHR CRN Portfolio studies and increase number of research articles published.</td>
</tr>
<tr>
<td>Implement the UNICEF Baby Friendly Initiative UK</td>
<td>A standardised programme of training and auditing of NHS staff to provide evidence based infant feeding information which includes guidelines, leaflets and practical advice. The overall aim is to increase Breast feeding figures nationally and subsequently increase the health of the Nation.</td>
<td>East Cheshire contribution to increasing national breast feeding rates by maintaining at least 74% 2019-2022</td>
</tr>
<tr>
<td>Releasing Time to Care and better utilisation of IT</td>
<td>Review and refinement of Nursing documentation</td>
<td>More efficient and effective working and more time to care</td>
</tr>
<tr>
<td></td>
<td>Full shared EMIS patient record including interactive care plans for all acute wards and services</td>
<td>Increased productivity</td>
</tr>
<tr>
<td></td>
<td>Implementation of a single clinical digital solution for all service integrated with community and other care partners</td>
<td></td>
</tr>
<tr>
<td>Delivering Clinical Standards</td>
<td>To deliver all clinical standards within the operational plan including RTT, cancer screening and diagnostics</td>
<td>Patients receive timely care, procedures and investigations in line with national standards</td>
</tr>
</tbody>
</table>
LISTENING AND RESPONDING

To further improve patient experience by listening to feedback and responding to concerns

We are committed to further improving patient and staff experience by listening to feedback and responding to concerns. We will continue to shift the focus of our relationships with patients from “what’s the matter?” to “what matters most to you?”

<table>
<thead>
<tr>
<th>Focus</th>
<th>Ambition 2019-2022</th>
<th>Expected Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety Culture</td>
<td>Ensuring a safety culture is fostered, by encouraging and supporting staff to report incidents.</td>
<td>Maintain trust position in top quartile of peer group for incident reporting via the National Reporting and Learning System.</td>
</tr>
<tr>
<td></td>
<td>Ensure the trust is listening and responding to staff concerns through implementation of the Freedom to Speak Up Strategic Plan.</td>
<td>Year on year increase in recruitment of staff Freedom to Speak Up Ambassadors (200 by 2021).</td>
</tr>
<tr>
<td></td>
<td>Further promotion of Excellence reporting</td>
<td>Improved staff survey results in relation to staff confidence in reporting incidents.</td>
</tr>
<tr>
<td>Autism</td>
<td>The trust is working with the National Autistic Society to pilot the autism hospital accreditation standards and aims to achieve accreditation in 2019.</td>
<td>Achievement of autism hospital accreditation standards</td>
</tr>
<tr>
<td></td>
<td>• Achieve accreditation in six areas of Macclesfield hospital</td>
<td>At least 20% of community staff to have received autism and learning disabilities awareness training</td>
</tr>
<tr>
<td>Learning Disabilities</td>
<td>Ensuring that people with disabilities feel involved in decisions about their care and treatment</td>
<td>Parity of esteem for patients with Learning Disabilities.</td>
</tr>
<tr>
<td></td>
<td>Identify reasons via patient interviews carried out by members of the trust’s Disability Equality Group</td>
<td>At least 20% of community staff to have received autism and learning disabilities awareness training</td>
</tr>
<tr>
<td></td>
<td>Ensure that the Accessible Information Standard continues to be implemented</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Measure improvement via national and local surveys</td>
<td></td>
</tr>
<tr>
<td>Patient Representative</td>
<td>To ensure groups of individuals truly reflect the demographic of the local population and improve the representation of people with protected characteristics</td>
<td>Review patient representative groups to become more reflective of the population we serve.</td>
</tr>
<tr>
<td>Groups</td>
<td></td>
<td>Review function and outputs of groups in place</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Introduce feedback groups for people with learning disabilities and/or autism</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ensure mechanism for the involvement of children and young people.</td>
</tr>
<tr>
<td>Focus</td>
<td>Ambition 2019-2022</td>
<td>Expected Outcome</td>
</tr>
<tr>
<td>-------</td>
<td>-------------------</td>
<td>------------------</td>
</tr>
</tbody>
</table>
| Continued work in ensuring patients die in their preferred place, with a focus on more patients dying in their own home. | Strategies to improved care for patients in the community include:  
Better access to domiciliary support for end of life care.  
A review of documentation including care plans for both hospital and community.  
Continued education on End of life care in the community.  
Further roll out of the use of EPACCs to ensure patients’ preferences are recorded and this information is shared. | More patients dying at their preferred place of death.  
Improved percentage of patients who have their care supported by a care plan in both hospital and community settings. |
## Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRSA</td>
<td>Meticillin-resistant Staphylococcus aureus (MRSA) is a type of bacteria that is resistant to several widely used antibiotics. This means infections with MRSA can be harder to treat than other bacterial infections but can usually be treated by antibiotics that work against MRSA.</td>
</tr>
<tr>
<td>PALS</td>
<td>Patient Advice and Liaison Service</td>
</tr>
<tr>
<td>NICE</td>
<td>National Institute for Health and Clinical Excellence (NICE) guidance sets the standards for high quality healthcare and encourages healthy living. The guidance can be used by the NHS, Local Authorities, employers, voluntary groups and anyone else involved in delivering care or promoting wellbeing.</td>
</tr>
<tr>
<td>CQC</td>
<td>The Care Quality Commission (CQC) inspect all hospitals in England to ensure they are meeting care and quality standards and publish their findings with the public.</td>
</tr>
<tr>
<td>NEWS2</td>
<td>National Early Warning Score 2 (NEWS2) is the latest version of the National Early Warning Score (NEWS) first produced in 2012 and updated in December 2017. The tool developed by the Royal College of Physicians improves the detection and response to clinical deterioration in adult patients and is a key element of patient safety and improving patient outcomes.</td>
</tr>
<tr>
<td>FFFAP</td>
<td>The Falls and Fragility Fracture Audit Programme (FFFAP) is a national clinical audit run by the Royal College of Physicians designed to audit care that patients with fragility fractures and inpatient falls in hospital and to facilitate quality improvement initiatives.</td>
</tr>
<tr>
<td>SEND</td>
<td>Special Educational Needs and Disability (SEND) – a statutory code of practice introduced by the Children and Families Act 2014 and relating to children and young people up to the age of 25. Focusing on greater cooperation between education, health and social care and a greater emphasis on the outcomes which make a difference to how they live their lives.</td>
</tr>
<tr>
<td>NIHR CRN</td>
<td>National Institute of Health Clinical Research Network (NIHR CRN) provides the infrastructure to allow high quality clinical research to take place in the NHS.</td>
</tr>
<tr>
<td>EPACC</td>
<td>Electronic Palliative Care Coordination-Systems (EPACC) enable the recording and sharing of people’s care preferences and key details about their care at the end of life.</td>
</tr>
<tr>
<td>RTT</td>
<td>Referral To Treatment (RTT) gives patients the right to access services within maximum waiting times, or for the NHS to take all reasonable steps to offer a range of suitable providers if this is not possible.</td>
</tr>
</tbody>
</table>
Dear Colleague

TRUST BOARD MEETING

A meeting of the Trust Board will be held at 3.00pm on 6th June 2019 in Board Room 1, New Alderley House, Macclesfield District General Hospital, Victoria Road, Macclesfield, SK10 3BL.

Yours sincerely

Lynn McGill
Chairman

The Board encourages members of the public to attend when Board meetings are taking place. The public are observers of the proceedings not participants, however, the Chairman will provide an opportunity for members of the public to seek clarification on any matter discussed. The Chairman will not allow members of the public to express opinions or arguments which seek to bias or unduly influence the decision-making process of the Board. There are a number of opportunities for members of the public to contribute. If you are unaware of these, please ask a member of staff before or after the Trust Board meeting and they will be happy to advise you.

TRUST BOARD – JUNE 2019 AGENDA

<table>
<thead>
<tr>
<th>AGENDA TOPIC</th>
<th>PRESENTED BY</th>
<th>TIME ALLOCATION</th>
<th>REFERENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Patient Story</td>
<td>Director of Nursing and Quality</td>
<td>10 mins</td>
<td>-</td>
</tr>
<tr>
<td>2. Apologies</td>
<td>Chairman</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>
## ASSURANCE ITEMS

<table>
<thead>
<tr>
<th>AGENDA TOPIC</th>
<th>PRESENTED BY</th>
<th>TIME ALLOCATION</th>
<th>REF. NO.</th>
<th>LINKED TO TRUST OBJECTIVE ON:</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Register of Interests:</td>
<td>The Chairman</td>
<td>5 mins</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>- Declared interest agenda</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Hospitality and Gifts</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Register Declaration</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Minutes of the April 2019 meeting</td>
<td>The Chairman</td>
<td>-</td>
<td>TB 19 (35)</td>
<td>-</td>
</tr>
<tr>
<td>5. Matters Arising</td>
<td>The Chairman</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>6. Action Log</td>
<td>The Chairman</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>7. Verbal update:</td>
<td>Ms A Harrison</td>
<td>10 mins</td>
<td>Verbal</td>
<td>All corporate objectives</td>
</tr>
<tr>
<td>SQS Committee</td>
<td>Mr M Wildig</td>
<td></td>
<td>(supported by formal minutes when available)</td>
<td></td>
</tr>
<tr>
<td>FPW Committee</td>
<td></td>
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<td></td>
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</tbody>
</table>

## STRATEGIC/GOVERNANCE/ASSURANCE ITEMS

<table>
<thead>
<tr>
<th>AGENDA TOPIC</th>
<th>PRESENTED BY</th>
<th>TIME ALLOCATION</th>
<th>REF. NO.</th>
<th>LINKED TO TRUST OBJECTIVE ON:</th>
</tr>
</thead>
<tbody>
<tr>
<td>8. Chief Executive’s Report</td>
<td>Chief Executive</td>
<td>15 mins</td>
<td>TB 19 (36)</td>
<td>All corporate objectives</td>
</tr>
<tr>
<td>9. Capital Programme</td>
<td>Director of Finance</td>
<td>10 mins</td>
<td>TB 19 (37)</td>
<td>Resources</td>
</tr>
<tr>
<td>10. Learning from Deaths Report – Quarter 4</td>
<td>Medical Director</td>
<td>10 mins</td>
<td>TB 19 (38)</td>
<td>Patients</td>
</tr>
<tr>
<td>11. Standing Agenda Item:</td>
<td>Chief Executive</td>
<td>-</td>
<td>Verbal</td>
<td>All corporate objectives</td>
</tr>
<tr>
<td>Does the Board wish to add anything to the Assurance Framework or Corporate Risk Register</td>
<td></td>
<td></td>
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</tbody>
</table>

## ANY OTHER BUSINESS

<table>
<thead>
<tr>
<th>AGENDA TOPIC</th>
<th>PRESENTED BY</th>
<th>TIME ALLOCATION</th>
<th>REF. NO.</th>
<th>LINKED TO TRUST OBJECTIVE ON:</th>
</tr>
</thead>
<tbody>
<tr>
<td>12. Public Trust Board Agenda – July 2019</td>
<td>The Chairman</td>
<td>-</td>
<td>TB 19 (39)</td>
<td>-</td>
</tr>
<tr>
<td>13. Any Other Business</td>
<td>The Chairman</td>
<td>-</td>
<td>Verbal</td>
<td>-</td>
</tr>
</tbody>
</table>
CONSENT ITEMS

(All these items have been read by Board members and the minutes will reflect recommendations, unless an item has been requested to come off the consent agenda for debate; in this instance, any such items will be made clear at the start of the meeting)

<table>
<thead>
<tr>
<th>AGENDA TOPIC</th>
<th>REF. NO.</th>
<th>REASONS FOR PRESENTING</th>
<th>LINKED TO TRUST OBJECTIVE ON</th>
</tr>
</thead>
<tbody>
<tr>
<td>14. Public Trust Board Year at a Glance</td>
<td>TB 19 (40)</td>
<td>For information</td>
<td>All corporate objectives</td>
</tr>
<tr>
<td>15. Chairman’s Commentary</td>
<td>TB 19 (41)</td>
<td>For information</td>
<td>All corporate objectives</td>
</tr>
<tr>
<td>16. Annual Report – Infection, Prevention and Control</td>
<td>TB 19 (42)</td>
<td>For information</td>
<td>All corporate objectives</td>
</tr>
<tr>
<td>17. Annual Reports – Committees of the Board</td>
<td>TB 19 (43)</td>
<td>For information</td>
<td>All corporate objectives</td>
</tr>
<tr>
<td>18. Annual Report – Safeguarding</td>
<td>TB 19 (44)</td>
<td>For information</td>
<td>All corporate objectives</td>
</tr>
<tr>
<td>19. Annual Review – Action Plan Equality, Diversity and Human Rights</td>
<td>TB 19 (45)</td>
<td>For information</td>
<td>All corporate objectives</td>
</tr>
<tr>
<td>20. Minutes of the committees of the Board:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SQS Committee</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- March 2019</td>
<td>TB 19 (46)</td>
<td>For Information</td>
<td>N/A</td>
</tr>
<tr>
<td>- April 2019</td>
<td>TB 19 (47)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FP&amp;W Committee</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- March 2019</td>
<td>TB 19 (48)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- April 2019</td>
<td>TB 19 (49)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Date and Time of Next Meeting:

Date: Thursday 4th July 2019
Time: 3.00pm - Venue: Board Room 1, New Alderley House, Macclesfield District Hospital
### Board Objectives

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>PATIENTS</td>
<td>To provide safe, effective personal care in the right place</td>
</tr>
<tr>
<td>PEOPLE</td>
<td>Build, value and develop a skilled, motivated and sustainable workforce</td>
</tr>
<tr>
<td>PARTNERSHIPS</td>
<td>To build strong relationships with partners in Cheshire East and Greater Manchester to deliver our vision</td>
</tr>
<tr>
<td>RESOURCES</td>
<td>To deliver services that are clinically and financially sustainable</td>
</tr>
</tbody>
</table>

### Board Assurance Framework

1. Leadership of Strategic Transformation
2. Quality & Compliance: patient safety, patient experience and effectiveness
3. Financial stability
4. People
5. Infrastructure

### KPIs for strategies will be overseen by committees. The CEO report will contain escalation issues and separate papers will be provided to the Board as appropriate
## Agenda Item Number 19: TB 19 (32)

### Report of:
**Responsible Officer**  
Director of Corporate Affairs & Governance  
**Accountable Officer**

### Author of Report:
Head of Integrated Governance

### Subject/Title
Corporate Governance Manual 2019/20

### Background papers (if relevant)
Summary report presented to Board.

### Purpose of Paper
To present to the Board proposed amendments to the Corporate Governance Manual.

### Action/Decision required
The Board is asked to:
- Review the proposed amendments
- Approve the revised Corporate Governance Manual
- Note that the Audit Committee has received an update of proposed changes.

### Mitigates Risk Number:
(identify)

### On Corporate Risk Register
This paper relates to the all aspects of the Trust’s operation and therefore is linked to all risks on the Corporate Risk Register and Board Assurance Framework.

### Mitigates Risk Number:
(identify)

### On Assurance Framework

### Link to Care Quality Commission Domain (identify)
All domains

### Link to:
- Trust’s Strategic Direction
- Corporate Objectives

### All objectives

### Legal implications - (identify)
No legal implications

### Impact on quality
No impact on quality

### Resource impact
None

### Impact of equality/diversity
No impact on equality / diversity

### Avoid acronyms or abbreviations - if necessary list:
- CQC – Care Quality Commission
- BMA – British Medical Association
- OJEU - Official Journal of the European Union
Corporate Governance Manual

Including:

Standing Orders;
Standing Financial Instructions; and
Scheme of Reservation and Delegation

April 2019
Policy Title: Corporate Governance Manual

Executive Summary: Corporate Governance is the system by which the trust is directed and controlled at its most senior level in order to achieve its corporate objectives and meet the necessary standards of accountability and probity.

This manual pulls together the following documents to set the framework for good governance at the trust:

- Governance Arrangements
- Standing Orders
- Scheme of Reservation and Delegation
- Standing Financial Instructions
- Standards of Business Conduct and codes of conduct
- Terms of Reference
- Key Policies and Procedures

Supersedes: Corporate Governance Manual v7

Description of Amendment(s): Changes to the Corporate Governance Manual include:

- The inclusion of the new Chief Operating Officer role
- Expanded Scheme of Reservation and Delegation to reflect further detail of responsibilities
- Replacement of terms of Reference and policies with latest versions
- Addition of revised conflict of Interest Policy
- Addition of new Overpayments Policy

This policy will impact on: This is a trust wide manual and impacts on all areas.

Financial Implications: There are no financial implications in the implementation of this policy other than training time for senior managers and Executives.

<table>
<thead>
<tr>
<th>Policy Area:</th>
<th>Governance</th>
<th>Document Reference:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Version Number:</td>
<td>V8</td>
<td>Effective Date: April 2019</td>
</tr>
<tr>
<td>Issued By:</td>
<td>Chief Executive Officer</td>
<td>Review Date: April 2020</td>
</tr>
<tr>
<td>Author:</td>
<td>Director of Corporate Affairs and Governance Deputy Director of Corporate Affairs and Governance</td>
<td>Impact Assessment Date: March 2019</td>
</tr>
</tbody>
</table>

**APPROVAL RECORD**

Consultation: Directors March 2019

Approved by: Trust Board April 2019

Received for information: Deputy Directors March 2019
## EAST CHESHIRE NHS TRUST
### CORPORATE GOVERNANCE MANUAL

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<td>3 Policy and Procedural documents</td>
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<td>4 Training</td>
<td>10</td>
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<tr>
<td>5 Risk Management</td>
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Overarching Governance Arrangements
FOREWORD

East Cheshire NHS trust (the trust) is an integrated community and acute NHS trust, employing circa 3,000 people. The trust’s services are managed through three clinical directorates supported by corporate functions. Acute services are managed through a payment by results contract and community services via a block contract.

The trust is a partner of the Health and Care Partnership of Cheshire and Merseyside, which aims to deliver a new integrated care system for the local population.

The trust recognises it has a responsibility to embed a culture of good governance and this manual sets out those arrangements which have been put in place to help manage that process.

Effective governance arrangements will help the trust achieve its objectives and provide better services. In particular it will help deliver improved:

(a) care which is equitable, safe, patient centred, effective, and timely;
(b) strategic management and decision making;
(c) operational management; and
(d) financial management
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7. COMMITTEE STRUCTURE
1 INTRODUCTION

1.1 The trust’s Governance Framework provides assurance from service area to Board through an established “fit for purpose” Committee structure, which is described on page 11. The trust’s risk and assurance processes are audited on an annual basis to ensure that it has robust systems and controls to manage and monitor progress towards the trust’s Vision.

1.2 The trust has adopted an Integrated Governance approach which is defined as:

“Systems, processes and behaviours by which trusts lead, direct and control their functions in order to achieve organisational objectives, safety and quality of service and in which they relate to patients and carers, the wider community and partner organisations”.

1.3 Integrated Governance will better enable the Board to take a holistic view of the organisation and its capacity to meet its legal and statutory requirements and clinical, quality and financial objectives.

1.4 The trust is committed to ensuring its continued high performance through robust systems and processes. The trust will work continuously to deliver high quality safe care and to minimise risk and improve quality at all levels and across all services in the organisation. The trust’s governance arrangements provide a strong basis for which to build upon.

1.5 At an overall level, responsibility for governance is held by the trust Board. The Board is accountable for ensuring that the right culture, systems and procedures are in place to enable appropriate governance, including establishing Committees of the Board as required. The trust will review its governance structure arrangements annually to ensure it is continually improving and minimising overlap to ensure best use of Committee and Board time.

1.6 Good governance is maintained and supported by the following:

(a) Standing Orders, Standing Financial Instructions, Reservation of Powers to the Board and Scheme of Delegation

(b) A clearly defined trust Board; supporting Board Committees; and Sub Committees

(c) A structure of operational business meetings, which provide assurance to the main committees and trust Board

(d) Approved terms of reference for committees and sub committees

(e) Policy and procedural documents available to staff

(f) Codes of conduct and accountability for managers

(g) Access to training programmes

(h) An embedded risk register and assurance framework.

(i) Internal audit plan
(j) Scrutiny by external assessors including the Care Quality Commission, external audit and NHS Improvement

1.7 Further detail on the above is covered within Corporate Governance Manual.

2 ASSURANCE PROCESS

2.1 The role and composition of the Board and Committees of the Board is described within the Standing orders.

2.2 This section describes the process which leads to the Board and its Committees receiving assurance on the processes and operational management across the trust.

2.3 The trust is currently divided into clinical directorates supported by corporate and operational services. Operationally each of the clinical directorates have a Safety Quality and Standards Sub-committee which mirror the content of the trust’s main Safety, Quality and Standards Committee. Safety, Quality and Standards Sub-Committee meetings are required to take place on a regular basis and report upwards by exception and to provide assurance.

2.4 The Corporate Risk Register and Board Assurance Framework are presented to the Board, Committees of the Board and the Clinical Management Board. Further assurance is provided through the reporting of risks identified as a result of business processes established by the trust.

3 POLICY AND PROCEDURAL DOCUMENTS

3.1 The trust has a policy for the production of procedural documents which gives clear guidance on how policies, procedures and strategies should be developed and the process for consultation and approval of those documents.

3.2 All directorates have a responsibility to ensure that policies and procedures are in place so that staff are clear on the processes to be adopted, who to refer to for further guidance and how to escalate any issues.

3.3 Authors of any trust document are required to maintain these so that they are accurate, up to date, reflect known best practice and are reviewed on a regular basis.

3.4 A cascade process is in place to ensure that all members of staff are made aware of new and revised documents.
4 TRAINING

4.1 All employees are required as part of their employment conditions to attend statutory and mandatory training in line with trust Policy:

(a) Corporate Induction should be completed on the first day of employment with the trust

(b) Local induction must be completed within the first 6 weeks of employment with the trust

(c) Statutory and Mandatory training should be completed on the first day of employment and then three yearly unless stated otherwise.

(d) Information Governance training should be completed within 6 weeks of commencement of employment and then annually thereafter

(e) Dependent on the individual employee role there may be further mandatory training which needs to take place which will also include additional Information Governance training.

5 RISK MANAGEMENT

5.1 RISK MANAGEMENT PROCESS

5.1.1 The Chief Executive is accountable for ensuring the trust has a programme of risk management, in accordance with current Department of Health assurance framework requirements. This is approved and monitored by the Board. Responsibility for Risk Management is delegated to the Director of Corporate Affairs and Governance.

5.1.2 The programme of risk management includes:

(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) arrangements to review the risk management programme.

5.1.3 It is the responsibility of all service areas and departments to have a clearly defined process to review and update the risk register to ensure that there is a live system which accurately reflects the risk position of the trust at any time.
5.1.4 The following diagram shows the structure and flow chart for the management of assurance and risk:

5.2 BOARD ASSURANCE FRAMEWORK

5.2.1 The Board Assurance Framework identifies and quantifies all risks that may potentially compromise the organisation’s ability to meet its strategic objectives. These strategic risks to the organisation are identified by the East Cheshire NHS trust Board and recorded on the Board Assurance Framework. Gaps identified in controls or assurances, and the associated treatments to address them, contribute to the trust’s Corporate Risk Register.

5.2.2 These high level risks are monitored by the Executive Directors and reported to the Board and the relevant Board Committees for review and scrutiny.
5.3 CORPORATE RISK REGISTER

5.3.1 The Corporate Risk Register consists of two elements: all risks which cross-cut the organisation, regardless of the level of risk; and any operational risks which have been scored at a level of 15 or more.

5.3.2 An up-to-date position on the significant risks i.e. those risks of a score of 15 and above, is provided 4 times a year to the trust Board, Clinical Management Board and Committees of the Board. The Audit Committee reviews its effectiveness 3 times per year, with an additional review undertaken by Internal Audit. The Clinical Management Board is responsible for the co-ordination of both strategic and significant risks and therefore discusses risks as part of their agenda on a monthly basis. Additionally the Operational Management Team receives and discusses the Corporate Risk Register.

6 ANNUAL GOVERNANCE STATEMENT

6.1 The existence, integration and evaluation of the above risk management process will provide a basis (along with opinions received from Internal and External Audit) to make a statement on the effectiveness of internal control in the form of the Annual Governance Statement, within the Annual Report and Accounts. This is signed by the Chief Executive on behalf of the Board.

7 COMMITTEE STRUCTURE

7.1 The trust Board is supported by the following Formal Committee Structure

(a) Audit Committee – this is one of the two committees that the trust is required to have by statute. Its role is to review, on behalf of the Board, that the trust has effective processes in place to manage and oversee the systems necessary for integrated governance, risk management, internal control (i.e., financial and clinical management). The committee is informed by reports on the trust’s systems and processes prepared by both internal and external auditors;

(b) Finance, Performance & Workforce Committee – this committee provides the trust Board with assurance that standards relating to finance and workforce are being met. It will discuss the integrated performance of the organisation and provide assurance that there is a robust performance management framework in place. Its quality focus will be on systems and processes which underpin sound performance and workforce modeling to deliver a redesigned clinical workforce;
(c) **Remuneration Committee** – this is one of the two committees that the trust is required to have by statute. Its role is to:

(i) oversee and agree the remuneration and terms of service of the Chief Executive and Other Directors who are members of the Board, together with any member of staff employed by the trust whose terms of service are not covered by national agreements,

(ii) provide advice to the Board on a range of employment issues for all staff (i.e., pensions, car schemes, termination of employment);

(d) **Safety, Quality & Standards Committee** – this committee exists to provide the trust Board with assurance that national and local safety, quality and other standards are being met for both clinical and non-clinical activities of the trust. The committee provides the assurance that effective systems, process and training is in place to ensure all employees are aware of their responsibilities for promoting and maintaining the highest standards in everything the trust does;

7.2 In addition the trust Board is supported by two **Operational Reporting Forums**, which are accountable to the Chief Executive. Although these Forums are not formal Committees of the trust Board, they provide a forum for the Chief Executive to ensure clear accountability and gain assurance from the relevant Directors / Clinical Directors and Clinical Leads, which can then be provided to the trust Board:

(a) **Clinical Management Board** – allows the Chief Executive to gain assurance from Directors and Clinical Directors that key objectives are being achieved and risks managed. The QIPP / CIP scheme is managed through this forum;

(b) **Executive Management Team** – allows the Chief Executive to gain assurance from Executive Directors and hold them to account for the delivery of their objectives and recovery, which includes the delivery of the QIPP programme.

7.3 Both the Finance, Performance & Workforce Committee and the Safety Quality and Standards Committee are supported by a range of Sub Committees and Groups.
Standing Orders
FOREWORD

NHS trusts need to agree Standing Orders (SOs) for the regulation of their proceedings and business. Regulation 19 of the NHS trusts (Membership and Procedure) Regulations 1990 (SI(1990)2024) requires the meetings and proceedings of an NHS trust to be conducted in accordance with the rules set out in the Schedule to those Regulations and with Standing Orders made under regulation 19 (2). The Codes of Conduct and Accountability (EL(94)40) require Boards to adopt schedules of reservation of powers and delegation of powers.

The documents, together with Standing Financial Instructions, provide a regulatory framework for the business conduct of the trust. They fulfil the dual role of protecting the trust's interests and protecting staff from any possible accusation that they have acted less than properly.

The Standing Orders, Delegated Powers and Standing Financial Instructions provide a comprehensive business framework. All executive and non-executive directors, and all members of staff, in line with their contractual arrangements, should be aware of the existence of these documents and, where necessary, be familiar with the detailed provisions.

The Standing Orders incorporate provisions of the National Health Service trusts (Membership and Procedure) Regulations 1990 SI(1990)2024 as amended by SI(1990)2160 and SI(1996); such provisions are indicated in italics and are not subject to suspension under SO 4.17.
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1 INTRODUCTION TO STANDING ORDERS

1.1 STATUTORY FRAMEWORK

1.1.1 The East Cheshire NHS trust (the trust) is a body corporate which was established under the National Health Service trust (Establishment) Order 1993 (the Establishment Order).

1.1.2 The principal places of business of the trust are Macclesfield DGH, Knutsford Hospital and Congleton War Memorial Hospital.

1.1.3 NHS trusts are governed by Act of Parliament, mainly the NHS Act 2006 (as amended by the Health and Social Care Act 2012) and the National Health Service and Community Care Act 1990 (as amended and the Health and Social Care Act 2008).

1.1.4 The functions of the trust are conferred by this legislation.

1.1.5 As a statutory body, the trust has specified powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable as well as to the Secretary of State for Health.

1.1.6 The Membership and Procedure Regulations require the trust to adopt Standing Orders for the regulation of its proceedings and business. The trust must also adopt Standing Financial Instructions as an integral part of Standing Orders setting out the responsibilities of individuals.

1.1.7 The trust will also be bound by such other statutes and legal provisions which govern the conduct of its affairs.

1.2 EQUALITY AND HUMAN RIGHTS

1.2.1 The trust recognises that some sections of society experience prejudice and discrimination. The Equality Act 2010 specifically recognises the protected characteristics of age, disability, gender, race, religion or belief, sexual orientation, pregnancy & maternity and transgender. The Equality Act also requires regard to socio-economic factors including pregnancy /maternity and marriage/civil partnership.

1.2.2 The trust is committed to equality of opportunity and anti-discriminatory practice both in the provision of services and in our role as a major employer. The trust believes that all people have the right to be treated with dignity and respect and is committed to the elimination of unfair and unlawful discriminatory practices.

1.2.3 The trust also is aware of its legal duties under the Human Rights Act 1998. Section 6 of the Human Rights Act requires all public authorities to uphold and promote Human Rights in everything they do. It is unlawful for a public authority to perform any act which contravenes the Human Rights Act.
1.2.4 The trust is committed to carrying out its functions and service delivery in line with a Human Rights based approach and the FREDA principles of Fairness, Respect, Equality, Dignity, and Autonomy

1.3 NHS FRAMEWORK

1.3.1 In addition to the statutory requirements, the Secretary of State through the Department of Health issues further directions and guidance. These are normally issued under cover of a circular or letter.

1.3.2 The Code of Accountability requires that, inter alia, Boards draw up a schedule of decisions reserved to the Board, and ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives (a Scheme of Reservation and Delegation). This Code makes various requirements concerning possible conflicts of interest of Board Members.

1.3.3 The Code of Practice on Openness in the NHS sets out the requirements for public access to information on the NHS.

1.4 DELEGATION OF POWERS

1.4.1 The trust has powers to delegate and make arrangements for delegation. The Standing Orders set out the detail of these arrangements. Under the Standing Order relating to the Arrangements for the Exercise of Functions (Standing Orders paragraph 4) the trust is given powers to "make arrangements for the exercise, on behalf of the trust of any of their functions by a committee, sub-committee or joint committee appointed by virtue of Standing Orders paragraph 5 or by an officer of the trust, in each case subject to such restrictions and conditions as the trust thinks fit or as the Secretary of State may direct".

1.4.2 Delegated Powers are covered in a separate document (Scheme of Reservation and Delegation) this sets out the reservation of powers to the Board and the delegation of powers by the Board. This document has effect as if incorporated into the Standing Orders and Standing Financial Instructions.

2 INTERPRETATION AND DEFINITIONS FOR STANDING ORDERS AND STANDING FINANCIAL INSTRUCTIONS

2.1 Save as otherwise permitted by law, at any meeting the Chairman of the trust shall be the final authority on the interpretation of Standing Orders (on which they should be advised by the Chief Executive or trust Secretary).

2.2 Any expression to which a meaning is given in the National Health Service Act 2006 (the “NHS Act 2006”) and in any other Acts of Parliament relating to the NHS or any regulations made under such Acts shall have the same meaning in these Standing Orders and in addition:
2.3 "Accountable Officer" means the NHS Officer responsible and accountable for funds entrusted to the trust. The officer shall be responsible for ensuring the proper stewardship of public funds and assets. For this trust it shall be the Chief Executive.

2.4 "trust" means the East Cheshire NHS trust.

2.5 "Board" means the Chairman, Executive Directors and Non-Executive Directors of the trust collectively as a body.

2.6 "Budget" means a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the trust.

2.7 "Budget holder" means the Executive Director or employee with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisations' budget.

2.8 "Chairman of the Board" is the person appointed by NHS Improvement to lead the Board and to ensure that it successfully discharges its overall responsibility for the trust as a whole. The expression “the Chairman of the trust” shall be deemed to include any Non-Executive Director who is acting as the Chairman during any absence of the Chairman from the meeting or who is otherwise unavailable.

2.9 "Chief Executive" means the accountable officer of the trust.

2.10 "Commissioning" means the process for determining the need for and for obtaining the supply of healthcare and related services for the trust within available resources.

2.11 "Committee" means a committee or sub-committee created and appointed by the Board.

2.12 "Committee members" means persons formally appointed by the Board to sit on or to chair specific committees.

2.13 "Contracting and 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.

2.14 "Executive Director of Finance" means the Chief Financial Officer of the trust.

2.15 "Funds held on trust" shall mean those funds which the trust holds on date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under powers derived under paragraph 14(2) of Schedule 4 on the NHS Act 2006, as amended. Such funds may or may not be charitable.

2.16 "Member" means Executive Director or Non-Executive Director of the Board as the context permits. Member in relation to the Board does not include its Chairman.
2.17 "Membership and Procedure Regulations" means the National Health Service trusts (Membership and Procedure) Regulations (Statutory Instrument Number 1990/2024) and subsequent amendments.

2.18 "Motion" means a formal proposition to be discussed and voted on during the course of a meeting.

2.19 "Nominated officer" means an officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions.

2.20 "Non-Executive Director" means a member of the Board who is not an officer of the trust.

2.21 "Executive Director" means a member of the Board who is an Executive Director or a person to be regarded as an executive director pursuant to Regulation 5 of the Membership and Procedure Regulations.

2.22 "Officer" means an employee of the trust.

2.23 "trust Secretary" means a person appointed to act independently of the Board to provide advice on corporate governance issues to the Board and the Chairman and monitor the trust’s compliance with the law, Standing Orders and Department of Health or other regulatory body guidance.

2.24 "SFI's" means Standing Financial Instructions.

2.25 "SO's" means Standing Orders.

2.26 "Vice-Chairman (deputy)" means the Non-Executive Director appointed by the Board to take on the Chairman’s duties if the Chairman is absent for any reason.

2.27 The following terms have been used in the Scheme of Delegation only (For Finance and HR responsibilities)

<table>
<thead>
<tr>
<th>Level of Authority</th>
<th>Authority Delegated to</th>
</tr>
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<tbody>
<tr>
<td>8</td>
<td>Administrator</td>
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<tr>
<td>7</td>
<td>Budget Holder</td>
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<td>6</td>
<td>Service Manager, including senior finance staff</td>
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<td>5</td>
<td>Associate Director</td>
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<td>4</td>
<td>Deputies (excluding Deputy Director of Finance)</td>
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<td>3</td>
<td>Executive (excluding Director of Finance)</td>
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<tr>
<td>2</td>
<td>Director of Finance and Deputy Director of Finance</td>
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<tr>
<td>1</td>
<td>Chief Executive and Deputy Chief Executive</td>
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3 THE TRUST BOARD [THE BOARD]: COMPOSITION OF MEMBERSHIP, TENURE AND ROLE OF MEMBERS

3.1 CORPORATE ROLE OF THE BOARD

3.1.1 All business shall be conducted in the name of the trust.

3.1.2 All funds received in trust shall be held in the name of the trust as corporate trustee. In relation to funds held on trust, powers exercised by the trust as corporate trustee shall be exercised separately and distinctly from those powers exercised as a trust

3.1.3 The powers of the trust established under statute shall be exercised by the Board meeting in public session except as otherwise provided for in Standing Orders paragraph 4 (Meetings of the Board).

3.1.4 The Board shall define and regularly review the functions it exercises on behalf of the Secretary of State.

3.2 SCHEDULE OF MATTERS RESERVED TO THE BOARD AND SCHEME OF DELEGATION

3.2.1 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These powers and decisions are set out in the ‘Schedule of Matters Reserved to the Board’ and shall have effect as if incorporated into the Standing Orders. Those powers which it has delegated to officers and other bodies are contained in the Scheme of Reservation and Delegation.

3.3 COMPOSITION OF THE MEMBERSHIP OF THE BOARD

3.3.1 In accordance with the Establishment Order and the Membership and Procedure Regulations the composition of the Board shall be:

(a) the Chairman of the Board appointed by NHS Improvement;

(b) no more than 5 Non-Executive Directors appointed by NHS Improvement;

(c) no more than 5 Executive Directors (but not exceeding the number of Non-Executive Directors) including:

   (i) Chief Executive;
   (ii) Director of Finance (the Chief Finance Officer);
   (iii) Medical Director;
   (iv) Director of Nursing and Quality (Deputy Chief Executive);
   (v) Director of Human Resources and Organisational Development and Human Resources.

3.3.2 In addition, there will be two non-voting members

   (a) Chief Operating Officer
   (b) Director of Corporate Affairs and Governance.
3.4 APPOINTMENT OF CHAIRMAN AND MEMBERS OF THE BOARD

3.4.1 The appointment and tenure of office of the Chairman and members are set out in the Membership and Procedure Regulations. The trust shall appoint a committee whose members shall be the Chairman and non-executive directors of the trust whose function will be to appoint the Chief Officer as a director of the trust. The trust shall appoint a committee whose members shall be the Chairman, the non-executive directors and the Chief Officer whose function will be to appoint the executive directors of the trust other than the Chief Officer.

3.5 TERMS OF OFFICE OF THE CHAIRMAN AND MEMBERS

3.5.1 Regulation 7 of the Membership and Procedure Regulations sets out the period of tenure of office of the Chairman and members and Regulations 8 and 9 of the Membership and procedure Regulations set out provisions for the termination or suspension of office of the Chairman and members.

3.6 APPOINTMENT AND POWERS OF VICE-CHAIRMAN (DEPUTY)

3.6.1 Subject to Standing Orders paragraph 3.6.2 below, the Chairman and Members of the Board may appoint one of their numbers, who is not also an Executive Director to be Vice-Chairman (deputy), for such period, not exceeding the remainder of his term as a member of the Board, as they may specify on appointing him.

3.6.2 Any member so appointed may at any time resign from the office of Vice-Chairman (deputy) by giving notice in writing to the Chairman. The Chairman and members may thereupon appoint another member as Vice-Chairman (deputy) in accordance with the provisions of Standing Orders paragraph 3.6.1.

3.6.3 Where the Chairman of the trust has died or has ceased to hold office, or where they have been unable to perform their duties as Chairman owing to illness or any other cause, the Vice-Chairman (deputy) shall act as Chairman until a new Chairman is appointed or the existing Chairman resumes their duties, as the case may be; and references to the Chairman in these Standing Orders shall, so long as there is no Chairman able to perform those duties, be taken to include references to the Vice-Chairman.

3.7 ROLE OF MEMBERS

3.7.1 The Board will function as a corporate decision-making body, Executive Directors and Non-Executive Directors will be full and equal members. Their role as members of the Board will be to consider the key strategic and governance issues facing the trust in carrying out its statutory and other functions.

(a) Non-Executive Directors and Executive Directors

(i) Non-Executive Directors and Executive Directors shall exercise their authority within the terms of these Standing Orders, the Standing Financial Instructions and the Scheme of Reservation and Delegation.
(b) **Chief Executive**

(i) The Chief Executive shall be responsible for the overall performance of the executive functions of the trust. The Chief Executive is the **Accountable Officer** for the trust and shall be responsible for ensuring the discharge of obligations under Financial Directions and in line with the requirements of the Accountable Officer Memorandum for trust Chief Executives.

(c) **Director of Nursing and Quality**

(i) The Director of Nursing and Quality is also the Deputy Chief Executive and as such assumes all responsibilities as per the Chief Executive in his absence.

(ii) The Director of Nursing and Quality is the named lead for Safeguarding and is the Director of Infection, Prevention and Control. She has responsibility for Patient Safety and Quality and is responsible for providing nursing advice to the Board.

(d) **Director of Finance**

(i) The Director of Finance shall be responsible for the provision of financial advice to the trust and to its members and for the supervision of financial control and accounting systems. They shall be responsible along with the Chief Executive for ensuring the discharge of obligations under relevant Financial Directions.

(ii) The Director of Finance is responsible for NHS and Primary Care Contracts and for procurement and the work of the Local Anti-Fraud Specialist, Information and Technology; and Estates & Facilities Management and Security.

(e) **Director of Human Resources and Organisational**

(i) The Director of Human Resources and Organisational Development shall be responsible for Professional Registration; Recruitment; Training and Organisational Development and providing workforce advice to the Board.
(f) **Medical Director**

(i) The Medical Director is responsible for the provision of medical advice to the Board. They are the designated individual for Human Tissue Authority regulations. The Medical Director is responsible for Clinical Medical Risk Clinical Effectiveness and Research has delegated the role of responsible officer for the GMC to the Clinical Lead for Revalidation; the role of Caldicott Guardian to the Associate Medical Director for Clinical Effectiveness and the role of Clinical Lead for Research Lead to the Consultant Colorectal and General Surgeon. The Medical Director is responsible for ensuring clinical engagement in the Clinical Strategy. They are responsible for approving any deviations from the Duty of Candour process.

(g) **Chief Operating Officer**

(i) The Chief Operating Officer is a non-voting Executive Director. They are responsible for organisational operational management ensuring that all operations are carried out line with the NHS Operating Framework, the NHS and Primary Care Contracts. This includes monitoring service risk via performance meetings.

(ii) The Chief Operating Officer is specifically responsible for:

- The delivery of NHS Performance Standards
- Operational Delivery of Patient Safety

(h) **Director of Corporate Affairs & Governance**

(i) The Director of Corporate Affairs & Governance is a non-voting Executive Director. They are responsible for the maintenance of governance arrangements at the trust.

(ii) The Director of Corporate Affairs & Governance is responsible for Clinical and Non-Clinical Risk Management; Health, Safety and Fire, Specialist Security Standards; Complaints and Litigation; Information Governance; and Emergency Preparedness, Communications, and is the Lead for Freedom to Speak Up. They are also the Senior Information Risk Owner at Board level.

(iii) The Director of Corporate Affairs and Governance is the trust Secretary and shall therefore act independently of the Board and monitor the trust's compliance with the law, Standing Orders and observance of guidance to the NHS issued by the relevant statutory bodies and regulators.

(i) **Non-Executive Directors**

(i) The Non-Executive Directors shall not be granted nor shall they seek to exercise any individual executive powers on behalf of the trust. They may however, exercise collective authority when acting as executives of or when chairing a committee of the trust which has delegated powers.
(j) Chairman

(i) The Chairman shall be responsible for the operation of the Board and chair all Board meetings when present. The Chairman has certain delegated executive powers. The Chairman must comply with the terms of appointment and with these Standing Orders.

(ii) The Chairman shall liaise with NHS Improvement over the appointment of Non-Executive Board Members and once appointed shall take responsibility either directly or indirectly for their induction, their portfolios of interests and assignments, and their performance.

(iii) The Chairman shall work in close harmony with the Chief Executive and shall ensure that key and appropriate issues are discussed by the Board in a timely manner with all the necessary information and advice being made available to the Board to inform the debate and ultimate resolutions.

3.8 LEAD ROLES FOR BOARD MEMBERS

3.8.1 The Chairman will ensure that the designation of lead roles or appointments of Board members as required by the Department of Health or as set out in any statutory or other guidance will be made in accordance with that guidance or statutory requirement (for example, appointing a Lead Board Member with responsibilities for Infection Control or Safeguarding etc.).

4 MEETINGS OF THE BOARD

4.1 ADMISSION OF PUBLIC AND THE PRESS

4.1.1 Admission and exclusion on grounds of confidentiality of business to be transacted

(a) The public and representatives of the press may attend all meetings of the Board, but shall be required to withdraw upon the Board resolving as follows:

(i) ‘that representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest’, Section 1(2), Public Bodies (Admission to Meetings) Act 1960;

(ii) Some of the trust’s business is more appropriately considered in private session. The Board will usually consider as unsuitable for discussion in public, issues about the award of contracts, disciplinary matters and matters concerning staff or any identifiable patient. Other issues are harder to identify in advance. In determining which matters should be reserved for private consideration, the trust will consider whether the information to be discussed would be exempt from disclosure under the Freedom of Information Act (FOI) 2000. If information would be exempt then it is likely that it should be considered during the private session of any trust Board meeting.
(iii) A Protocol for Reserving matters to a private Board meeting has therefore been prepared in order to outline the exemptions most likely to apply to material considered by the trust Board and to provide guidance for Directors on those matters which should be reserved for discussion within private session. Guidance should be sought from the NHS trust’s Freedom of Information Lead to ensure correct procedure is followed on matters to be included in the exclusion.

4.1.2 General disturbances

(a) The Chairman (or Vice-Chairman (deputy)) or the person presiding over the meeting shall give such directions as she/he thinks fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Board’s business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Board resolving as follows:

(i) ‘That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Board to complete its business without the presence of the public’. Section 1(8) Public Bodies (Admissions to Meetings) Act 1960

4.1.3 Business proposed to be transacted when the press and public have been excluded from a meeting

(a) Matters to be dealt with by the Board following the exclusion of representatives of the press, and other members of the public, as provided in Standing Orders paragraphs 4.1.1 and 4.1.2 above, shall be confidential to the members of the Board.

(b) Non-Executive Directors and Executive Directors or any employee of the trust in attendance shall not reveal or disclose the contents of papers marked 'In Confidence' or minutes headed 'Items Taken in Private' outside of the trust, without the express permission of the trust. This prohibition shall apply equally to the content of any discussion during the Board meeting which may take place on such reports or papers.

4.1.4 Use of Mechanical or Electrical Equipment for Recording or Transmission of Meetings

(a) Nothing in these Standing Orders shall be construed as permitting the introduction by the public, or press representatives, of recording, transmitting, video or similar apparatus into meetings of the Board or Committee thereof. Such permission shall be granted only upon resolution of the Board.
4.1.5 **Observers at trust Meetings**

(a) The Board will decide what arrangements and terms and conditions it feels are appropriate to offer in extending an invitation to observers to attend and address any of the Board's meetings and may change, alter or vary these terms and conditions as it deems fit.

4.2 **CALLING MEETINGS**

4.2.1 Ordinary meetings of the Board shall be held at regular intervals at such times and places as the Board may determine. These meetings are open to the public to enable staff and members of the public to attend.

4.2.2 The Chairman may call a meeting of the Board at any time.

4.2.3 One third or more members of the Board may requisition a meeting in writing. If the Chairman refuses, or fails, to call a meeting within seven days of a requisition being presented, the members signing the requisition may forthwith call a meeting.

4.3 **NOTICE OF MEETINGS AND THE BUSINESS TO BE TRANSACTED**

4.3.1 Normally before each meeting of the Board, a written notice specifying the business proposed to be transacted, shall be delivered to every member, or sent by post to the usual place of residence of each member, so as to be available to members at least five clear days before the meeting. The notice shall be signed by the Chairman or by an Executive Director authorised by the Chairman to sign on their behalf.

4.3.2 Lack of service of such a notice on any member shall not affect the validity of a meeting.

4.3.3 In the case of a meeting called by members in default of the Chairman calling the meeting, the notice shall be signed by those members. No business shall be transacted at the meeting other than that specified on the agenda, or emergency motions allowed under *Standing Orders* paragraph 4.9 (Emergency Motion).

4.3.4 Before each meeting of the Board a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed at the trust’s principal offices at least five clear days before the meeting, (required by the Public Bodies (Admission to Meetings) Act 1960 Section 1 (4) (a)).

4.3.5 Failure to serve such a notice on more than three directors will invalidate the meeting. A notice shall be presumed to have been served at the time at which the notice would be delivered in the ordinary course of the post.

4.4 **SETTING THE AGENDA AND SUPPORTING PAPERS**

4.4.1 The trust may determine that certain matters shall appear on every agenda for a meeting of the trust and shall be addressed prior to any other business being conducted.

4.4.2 A member desiring a matter to be included on an agenda shall make their request in writing to the Chairman at least 10 clear days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information.
Requests made less than 10 days before a meeting may be included on the agenda at the discretion of the Chairman.

4.5  PETITIONS

4.5.1 Where a petition has been received by the trust, the Chairman shall include the petition as an item for the agenda of the next meeting.

4.5.2 At the discretion of the Chairman 10 minutes will be allocated at the beginning of each public meeting for members of the public to address the Board, providing that prior notification has been made to the trust. Any address by members of the public will not form part of the “minute record” of the trust Board. At the Chairman's discretion any notes taken of the address may be shared to members of the Board meeting.

4.6  CHAIRMAN OF MEETING

4.6.1 At any meeting of the Board the Chairman, if present, shall preside. If the Chairman is absent from the meeting, the Vice-Chairman (deputy) if present, shall preside. If the Chairman and Vice-Chairman (deputy) are both absent, such member (who is not also an Executive Director member of the Board) as the members present shall choose shall preside.

4.6.2 If the Chairman is absent from a meeting temporarily on the grounds of a declared conflict of interest the Vice-Chairman (deputy), if present, shall preside. If the Chairman and Vice-Chairman (deputy) are absent, or are disqualified from participating, such non-executive director as the directors present shall choose shall preside.

4.7  ANNUAL GENERAL MEETING

4.7.1 The trust will publicise and hold an annual public meeting in accordance with the NHS trusts (Public Meetings) Regulations 1991 (SI(1991)482).

4.8  NOTICE OF MOTION

4.8.1 A director of the trust desiring to move or amend a motion shall send a written notice thereof at least 10 clear days before the meeting to the Chairman, who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations. This paragraph shall not prevent any motion being moved during the meeting, without notice on any business mentioned on the agenda subject to Standing Orders paragraph 4.4.

4.9  EMERGENCY MOTIONS

4.9.1 Subject to the agreement of the Chairman, and subject also to the provision of Standing Orders paragraph 4.10 (Motions: Procedure at and during a meeting), a member of the Board may give written notice of an emergency motion after the issue of the notice of meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. If in order, it shall be declared to the Board at the commencement of the business of the meeting as an additional item included in the agenda. The Chairman's decision to include or exclude the item shall be final.
4.10 MOTIONS: PROCEDURE AT AND DURING A MEETING

4.10.1 Who may propose

(a) A motion may be proposed by the Chairman of the meeting or any member present. It must also be seconded by another member.

4.10.2 Contents of motions

(a) The Chairman may exclude from the debate at their discretion any such motion of which notice was not given on the notice summoning the meeting other than a motion relating to:

(i) the receipt of a report;
(ii) consideration of any item of business before the Board;
(iii) the accuracy of minutes;
(iv) that the Board proceed to next business;
(v) that the Board adjourn;
(vi) that the question be now put.

4.10.3 Amendments to motions

(a) A motion for amendment shall not be discussed unless it has been proposed and seconded.

(b) Amendments to motions shall be moved relevant to the motion, and shall not have the effect of negating the motion before the Board.

(c) If there are a number of amendments, they shall be considered one at a time. When a motion has been amended, the amended motion shall become the substantive motion before the meeting, upon which any further amendment may be moved.

4.10.4 Rights of reply to motions

(a) Amendments

(i) The mover of an amendment may reply to the debate on their amendment immediately prior to the mover of the original motion, who shall have the right of reply at the close of debate on the amendment, but may not otherwise speak on it.

(b) Substantive / original motion

(i) The member who proposed the substantive motion shall have a right of reply at the close of any debate on the motion.
4.10.5 **Withdrawing a motion**

(a) A motion, or an amendment to a motion, may be withdrawn.

4.10.6 **Motions once under debate**

(a) When a motion is under debate, no motion may be moved other than:

(i) an amendment to the motion;

(ii) the adjournment of the discussion, or the meeting;

(iii) that the meeting proceed to the next business;

(iv) that the question should be now put;

(v) the appointment of an 'ad hoc' committee to deal with a specific item of business;

(vi) that a member be not further heard;

(vii) a motion under Section 1 (2) or Section 1 (8) of the Public Bodies (Admissions to Meetings) Act 1960 resolving to exclude the public, including the press (see Standing Orders paragraph 4.1).

(b) In those cases where the motion is either that the meeting proceeds to the 'next business' or 'that the question be now put' in the interests of objectivity these should only be put forward by a member of the Board who has not taken part in the debate and who is eligible to vote.

(c) If a motion to proceed to the next business or that the question be now put, is carried, the Chairman should give the mover of the substantive motion under debate a right of reply, if not already exercised. The matter should then be put to the vote.

4.11 **WITHDRAWAL OF A MOTION OR AMENDMENTS**

4.11.1 A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chairman

4.12 **MOTION TO RESCIND A RESOLUTION**

4.12.1 Notice of motion to rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the member who gives it and also the signature of four other members, and before considering any such motion of which notice shall have been given, the Board may refer the matter to any appropriate Committee or the Chief Executive for recommendation. When any such motion has been dealt with by the Board it shall not be competent for any member other than the Chairman to propose a motion to the same effect within six months, however the Chairman may do so if he / she considers it appropriate.
4.13 **CHAIRMAN'S RULING**

4.13.1 Statements of directors made at meetings of the trust shall be relevant to the matter under discussion at the material time and the decision of the Chairman of the meeting on questions of order, relevancy, regularity and any other matters shall be observed at the meeting.

4.13.2 The decision of the Chairman of the meeting on questions of order, relevancy and regularity (including procedure on handling motions) and their interpretation of the *Standing Orders* and *Standing Financial Instructions*, at the meeting, shall be final.

4.14 **VOTING**

4.14.1 Every question put to a vote at a meeting shall be determined by a majority of the votes of members present and voting on the question. In the case of an equal vote, the person presiding (i.e., the Chairman of the meeting) shall have a second and casting vote.

4.14.2 At the discretion of the Chairman all questions put to the vote shall be determined by oral expression or by a show of hands, unless the Chairman directs otherwise, or it is proposed, seconded and carried that a vote be taken by paper ballot.

4.14.3 If at least one third of the members present so request, the voting on any question may be recorded so as to show how each member present voted or did not vote (except when conducted by paper ballot).

4.14.4 If a member so requests, their vote shall be recorded by name (other than by paper ballot).

4.14.5 In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote.

4.14.6 A manager who has been formally appointed to act up for an Executive Director during a period of incapacity or temporarily to fill an Executive Director vacancy shall be entitled to exercise the voting rights of the Executive Director member.

4.14.7 An Officer attending the Board meeting to represent an Executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Executive Director. An Officer’s status when attending a meeting shall be recorded in the minutes.

4.14.8 For the voting rules relating to joint members see *Standing Orders* paragraph 4.16.

4.15 **MINUTES**

4.15.1 The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they shall be signed by the person presiding at it.

4.15.2 No discussion shall take place upon the minutes except upon their accuracy or where the Chairman considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.
4.15.3 Minutes shall be circulated in accordance with Chairman's / directors' wishes. Where providing a record of a public meeting the minutes shall be made available to the public (required by Code of Practice on Openness in the NHS).

4.16 **JOINT MEMBERS**

4.16.1 Where more than one person is appointed jointly to a post mentioned in Regulation 2 of the Membership and Procedure Regulations those persons shall count for the purpose of Standing Orders paragraph 3.3 as one person.

4.16.2 Where the office of a member of the Board is shared jointly by more than one person:

(a) either or both of those persons may attend or take part in meetings of the Board;

(b) if both are present at a meeting they should cast one vote if they agree;

(c) in the case of disagreements no vote should be cast;

(d) the presence of either or both of those persons should count as the presence of one person for the purposes of Standing Orders paragraph 4.20 (Quorum).

4.17 **SUSPENSION OF STANDING ORDERS**

4.17.1 Except where this would contravene any statutory provision or any direction made by the Secretary of State or the rules relating to the Quorum (Standing Orders paragraph 4.20), any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the whole number of the members of the Board are present (including at least one member who is an Executive Director member of the Board and one member who is not) and that a majority of those members present signify their agreement to such suspension.

4.17.2 The reason for the suspension shall be recorded in the Board's minutes.

4.17.3 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Chairman and members of the Board.

4.17.4 No formal business may be transacted while Standing Orders are suspended.

4.17.5 The Audit Committee shall review every decision to suspend the Standing Orders.
4.18 VARIATION AND AMENDMENT OF STANDING ORDERS

4.18.1 These Standing Orders shall not be varied except in the following circumstances:

(a) upon a notice of motion under Standing Orders paragraph 4.8 has been given; and

(b) no fewer than half of the trust’s non-executive directors vote in favour of amendment; and

(c) that at least two thirds of the Board members are present at the meeting where the variation or amendment is being discussed; and

(d) providing that any variation or amendment does not contravene a statutory provision or direction made by the Secretary of State.

4.19 RECORD OF ATTENDANCE

4.19.1 The names of the Chairman and Members present at the meeting shall be recorded.

4.20 QUORUM

4.20.1 No business shall be transacted at a meeting unless at least one third of the whole number of the Chairman and Board Members (including at least one member who is also an Executive Director member of the Board and one member who is a Non-Executive Director member) is present.

4.20.2 An officer in attendance for an Executive Director member but without formal acting up status may not count towards the quorum.

4.20.3 If the Chairman or member has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest (see Standing Orders paragraph 6) that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

4.20.4 The above requirement for at least one executive director to form part of the quorum shall not apply where the executive directors are excluded from a meeting (for example when the Board considers the recommendations of the Remuneration and Terms of Service Committee).
5. ARRANGEMENTS FOR THE EXERCISE OF TRUST FUNCTIONS BY DELEGATION

5.1 DELEGATION OF FUNCTIONS TO COMMITTEES, OFFICERS OR OTHER BODIES

5.1.1 Subject to such directions as may be given by the Secretary of State, the Board may make arrangements for the exercise, on behalf of the Board, of any of its functions by a committee, sub-committee appointed by virtue of Standing Orders paragraph 5, or by an officer of the trust, or by another body as defined in Standing Orders paragraph 4.21.2 below, in each case subject to such restrictions and conditions as the Board thinks fit.

5.1.2 Paragraph 18 of Schedule 4 of the NHS Act 2006 allows the functions of the trust to be carried out jointly with any one or more of the following: NHS trusts, NHS Improvement, Special Health Authorities or any other body or individual including Clinical Commissioning Groups.

5.1.3 Regulation 16 of the Membership and Procedure Regulations permits the trust to make arrangements for the exercise on behalf of the trust of any of its functions by a committee or sub-committee appointed pursuant to Regulation 15 of the Membership and Procedure Regulations.

5.2 EMERGENCY POWERS AND URGENT DECISIONS

5.2.1 The powers which the Board has reserved to itself within these Standing Orders (see Standing Orders paragraph 4.25) may in emergency or for an urgent decision be exercised by the Chief Executive and the Chairman after having consulted at least two Non-Executive Directors. The exercise of such powers by the Chief Executive and Chairman shall be reported to the next formal meeting of the Board in public session for formal ratification.

5.3 DELEGATION TO COMMITTEES

5.3.1 The Board shall agree from time to time to the delegation of executive powers to be exercised by other committees, or sub-committees, or joint-committees, which it has formally constituted in accordance with Regulation 15 of the Membership and Procedure Regulations. The constitution and terms of reference of these committees, or sub-committees, or joint committees, and their specific executive powers shall be approved by the Board in respect of its sub-committees.

5.3.2 When the Board is not meeting as 'the Board' in public session it shall operate as a committee and may only exercise such powers as may have been delegated to it by the Board in public session.

5.4 DELEGATION TO OFFICERS

5.4.1 Those functions of the trust which have not been retained as reserved by the Board or delegated to other committee or sub-committee or joint-committee shall be exercised on behalf of the trust by the Chief Executive. The Chief Executive shall determine which functions shall be performed personally and shall nominate officers to undertake the remaining functions for which they will still retain accountability to the trust Board.
5.4.2 The Chief Executive shall prepare a Scheme of Reservation and Delegation identifying proposals which shall be considered and approved by the Board, subject to any amendment agreed during the discussion. The Chief Executive may periodically propose amendment to the Scheme of Delegation which shall be considered and approved by the Board.

5.4.3 Nothing in the Scheme of Reservation and Delegation shall impair the discharge of the direct accountability to the Board of the Director of Finance to provide information and advise the Board in accordance with statutory or Department of Health requirements. Outside these statutory requirements the role of the Director of Finance shall be accountable to the Chief Executive for operational matters.

5.5 SCHEDULE OF MATTERS RESERVED TO THE BOARD AND SCHEME OF DELEGATION OF POWERS

5.5.1 The arrangements made by the Board as set out in the "Schedule of Matters Reserved to the Board" and “Scheme of Delegation“ of powers shall have effect as if incorporated in these Standing Orders.

5.6 DUTY TO REPORT NON-COMPLIANCE WITH STANDING ORDERS AND STANDING FINANCIAL INSTRUCTIONS

5.6.1 If for any reason these Standing Orders 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 Board for action or ratification. All members of the Board and staff have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

6 APPOINTMENT OF COMMITTEES AND SUB-COMMITTEES

6.1 APPOINTMENT OF COMMITTEES

6.1.1 Subject to such directions as may be given by the Secretary of State for Health, the Board may appoint committees of the trust, consisting wholly or partly of directors of the trust or wholly of persons who are not directors of the trust.

6.1.2 A committee appointed under these Standing Orders may, subject to such directions as may be given by the Secretary of State or the trust appoint sub-committees consisting wholly or partly of members of the committee (whether or not they include directors of the trust or wholly of persons who are not members of the trust committee (whether or not they include directors of the trust).

6.1.3 The Standing Orders of the trust, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees or sub-committees established by the trust. In which case the term “Chairman” is to be read as a reference to the Chairman of other committee as the context permits, and the term “member” is to be read as a reference to a member of other committee also as the context permits. (There is no requirement to hold meetings of committees established by the trust in public.)
6.1.4 Each such committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board), as the Board shall decide and shall be in accordance with any legislation and regulation or direction issued by the Secretary of State. Such terms of reference shall have effect as if incorporated into the Standing Orders.

6.1.5 Committees may not delegate their executive powers to a sub-committee unless expressly authorised by the Board.

6.1.6 The Board shall approve the appointments to each of the committees which it has formally constituted. Where the Board determines that persons, who are neither directors nor officers, shall be appointed to a committee, the terms of such appointment shall be determined by the Board subject to the payment of travelling and other allowances being in accordance with such sums set out in statute or on the advices of the appropriate statutory or regulatory body.

6.1.7 Where the trust is required to appoint persons to a committee and/or to undertake statutory functions as required by the Secretary of State, and where such appointments are to operate independently of the trust such appointment shall be made in accordance with the regulations laid down by the Secretary of State.

6.2 JOINT COMMITTEES

6.2.1 Joint committees may be appointed by the Board by joining together with one or more other trusts consisting of, wholly or partly of the Chairman and members of the Board or other health service bodies, or wholly of persons who are not members of the Board or other health bodies in question (where permitted by regulations).

6.2.2 Any committee or joint committee appointed under this Standing Order may, subject to such directions as may be given by the Secretary of State or the Board or other health bodies in question, appoint sub-committees consisting wholly or partly of members of the committees or joint committee (whether or not they are members of the Board or health bodies in question) or wholly of persons who are not members of the Board or health bodies in question or the committee of the trust or health bodies in question.

6.3 COMMITTEES ESTABLISHED BY THE BOARD

6.3.1 The committees, sub-committees, and joint-committees established by the Board are:

6.3.1.1 Audit Committee

a) In line with the requirements of the NHS Audit Committee Handbook, NHS Codes of Conduct and Accountability, and more recently the Higgs report, an Audit Committee has been established and constituted to provide the trust Board with an independent and objective review on its financial systems, financial information and compliance with laws, guidance, and regulations governing the NHS. The Terms of Reference are approved by the trust Board and reviewed on a periodic basis.
b) The Higgs report recommends a minimum of three non-executive directors be appointed, and the trust is compliant with this recommendation. Higgs also recommends that one member must have significant, recent and relevant financial experience, again the trust has complied with this recommendation.

6.3.1.2 **Remuneration Committee**

a) In line with the requirements of the NHS Codes of Conduct and Accountability, and more recently the Higgs report, a Terms of Service and Remuneration Committee has been established and constituted.

b) The Higgs report recommends the committee be comprised exclusively of Non-Executive Directors, a minimum of three, who are independent of management.

c) The purpose of the Committee is to advise the trust Board about appropriate remuneration and terms of service for the Chief Executive and other Executive Directors 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.

6.3.1.3 **Safety Quality and Standards Committee**

a) The Safety, Quality and Standards Committee exists to provide the trust's Board with assurance that national and local safety, quality and other standards are being met for both the clinical and non-clinical activities of the trust.

b) This Committee provides the Board with assurance on that effective systems, process and training is in place to ensure all employees are aware of their responsibilities for promoting and maintaining the highest standards in everything the trust does.

6.3.1.4 **Finance, Performance and Workforce Committee**

a) This committee provides the trust Board with assurance that standards relating to finance and workforce are being met. It will discuss the integrated performance of the organisation and provide assurance that there is a robust performance management framework in place. Its quality focus will be on systems and processes which underpin sound performance and workforce modelling to deliver redesigned clinical pathways.

6.3.1.5 **Other Committees**

The Board may also establish such other committees as required to discharge the trust's responsibilities.
6.4 OPERATIONAL REPORTING FORUMS

6.4.1 In addition to the committees identified above, the trust Board is supported by two Operational Reporting Forums, which are accountable to the Chief Executive. Although these Forums are not formal Committees of the trust Board, they provide a forum for the Chief Executive to ensure clear accountability and gain assurance from the relevant Directors / Clinical Directors and Clinical Leads, which can then be provided to the trust Board:

6.4.1.1 Clinical Management Board – allows the Chief Executive to gain assurance from Directors and Clinical Directors and clinical Leads that key objectives are being achieved and risks managed. The QIPP scheme is managed through this forum;

6.4.1.2 Executive Management Team – allows the Chief Executive to gain assurance from Executive Directors and hold them to account for the delivery of their objectives and recovery, which includes the delivery of the QIPP programme.

6.5 CONFIDENTIALITY

6.5.1 A member of a committee shall not disclose a matter dealt with by, or brought before, the committee without its permission until the committee shall have reported to the Board or shall otherwise have concluded on that matter.

6.5.2 A committee member, or anybody attending a committee shall not disclose any matter reported to the Board or otherwise dealt with by the committee, notwithstanding that the matter has been reported or action has been concluded, if the Board or committee shall resolve that it is confidential.

6.5.3 All visitors to the trust Private Board or any other Committee of the Board will be required to ensure confidentiality is maintained where the committee shall resolve that it is confidential. Where appropriate confidentiality statement will be signed before attendance at the meeting.

7 DUTIES AND OBLIGATIONS OF BOARD MEMBERS AND SENIOR MANAGERS UNDER THESE STANDING ORDERS

7.1 DECLARATION OF INTERESTS

7.1.1 Requirements for Declaring Interests and applicability to Board Members

7.1.1.1 The NHS Code of Accountability requires Board Members and senior managers to declare any personal or business interest which may influence, or may be perceived to influence, their judgement. All existing Board members should declare such interests. Any Board members and senior managers appointed subsequently should do so on appointment.

7.1.2 Declarable interests

7.1.2.1 Interests which should be declared are:

a) directorships, including Non-Executive Directorships held in private companies or public limited companies (with the exception of those of dormant companies);
b) ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS;

c) majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS;

d) a position of authority in a charity or voluntary organisation in the field of health and social care;

e) any connection with a voluntary or other organisation contracting for NHS services;

f) research funding / grants that may be received by an individual or their department;

g) interests in pooled funds that are under separate management;

h) one party has direct or indirect control over the other party;

i) the parties are subject to common control from the same source;

j) the party having an interest in the entity that gives it significant influence over the entity, where significant influence is defined as being the power to participate in financial and operating decisions;

k) the party is a member of the key management personnel of the entity, or its parent; and

l) the party is a close family member of the other party.

7.1.2.2 Any member of the Board who comes to know that the trust has entered into or proposes to enter into a contract in which they or any person connected with them (as defined in Standing Orders paragraph 6.3 below and elsewhere) has any pecuniary interest, direct or indirect, the Board member shall declare his/her interest by giving notice in writing of such fact to the Chief Executive as soon as practicable.

7.1.3 Advice on interests

7.1.3.1 If Board members have any doubt about the relevance of an interest, this should be discussed with the Chairman or with the trust Secretary and reference made to the Conflict of Interest policy.

7.1.3.2 Financial Reporting Standard No 8 (issued by the Accounting Standards Board) specifies that influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

7.1.3.3 International Accounting Standard 24 indicates that any relationship where control exists should be disclosed, even where there have been no transactions between the parties, in order to enable users of financial statements to form a view about the effects of related party relationships on the entity.

7.1.4 Recording of interests in board minutes

7.1.4.1 At the time Board members’ interests are declared, they should be recorded in the Board minutes.
7.1.4.2 Any changes in interests should be declared at the next Board meeting following the change occurring and recorded in the minutes of that meeting.

7.1.5 Publication of Declared Interests in the Annual Report

7.1.5.1 Board members' directorships of companies likely or possibly seeking to do business with the NHS should be published in the trust's annual report. The information should be kept up to date for inclusion in succeeding annual reports.

7.1.6 Conflicts of interest which arise during the course of a meeting

7.1.6.1 During the course of a Board meeting, if a conflict of interest is established, the Board member concerned should withdraw from the meeting and play no part in the relevant discussion or decision. (See overlap with Standing Orders paragraph 6.3 – Exclusion of Chairman and Board Members in proceedings on account of pecuniary interest).

7.1.7 Interests of spouses or partners

7.1.7.1 There is no requirement for the interests of Board director's spouses or partners to be declared. Note however that Standing Orders paragraph 6.3, which is based on the Membership and Procedure regulations, requires that the interest of directors' spouses, if living together, in contracts should be declared.

7.2 REGISTER OF INTERESTS

7.2.1 The Director of Corporate Affairs and Governance will ensure that a Register of Interests is established to record formally declarations of interests of Board or Committee members. In particular the Register will include details of all directorships and other relevant and material interests (as defined in Standing Orders paragraph 6.1.2 – Declarable Interests) which have been declared by both executive and non-executive Board members.

7.2.2 These details will be kept up to date by means of a review which is carried out at least annually.

7.2.3 The Register will be available to the public and the Chief Executive will take reasonable steps to bring the existence of the Register to the attention of local residents and to publicise arrangements for viewing it.

7.3 EXCLUSION OF CHAIRMAN AND BOARD MEMBERS IN PROCEEDINGS ON ACCOUNT OF PECUNIARY INTEREST

7.3.1 Exclusion in proceedings of the Board

7.3.1.1 Subject to the following provisions of this Standing Order, if the Chairman or a member of the Board has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Board at which the contract or other matter is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.
7.3.1.2 The Secretary of State may, subject to such conditions as they may think fit to impose, remove any disability imposed by this Standing Order in any case in which it appears to them in the interests of the National Health Service that the disability should be removed. (See Standing Orders paragraph 6.3.4 on the ‘Waiver’ which has been approved by the Secretary of State for Health).

7.3.1.3 The Board may exclude the Chairman or a member of the Board from a meeting of the Board while any contract, proposed contract or other matter in which they have a pecuniary interest is under consideration. (Under Regulation 20 of the Membership and Procedure regulations trusts may provide for such exclusion).

7.3.1.4 Any remuneration, compensation or allowance payable to the Chairman or a Board Member by virtue of paragraph 11 of Schedule 4 of the NHS Act 2006 (pay and allowances) shall not be treated as a pecuniary interest for the purpose of this Standing Order.

7.3.1.5 This Standing Order applies to a committee or sub-committee and to a joint committee or sub-committee as it applies to the Board and applies to a member of any such committee or sub-committee (whether or not they are also a member of the Board) as it applies to a member of the Board.

7.3.2 Definition of terms used in interpreting ‘Pecuniary’ interest

7.3.2.1 For the sake of clarity, the following definition of terms is to be used in interpreting this Standing Order:

a) "spouse" shall include any person who lives with another person in the same household (and any pecuniary interest of one spouse shall, if known to the other spouse, be deemed to be an interest of that other spouse);

b) "contract" shall include any proposed contract or other course of dealing.

c) “Pecuniary interest” - subject to the exceptions set out in this Standing Order, a person shall be treated as having an indirect pecuniary interest in a contract if:-

d) they, or a nominee of theirs, is a member of a company or other body (not being a public body), with which the contract is made, or to be made or which has a direct pecuniary interest in the other matter under consideration, or

e) they are a partner, associate or employee of any person with whom the contract is made or to be made or who has a direct pecuniary interest in the other matter under consideration, or in the case of a spouse the interest of one shall, if known to the other, be deemed for the purposes of this Standing Order to be also an interest of the other

7.3.2.2 Exception to Pecuniary interests - a person shall not be regarded as having a pecuniary interest in any contract if:-

a) neither they or any person connected with them has any beneficial interest in the securities of a company of which they or such person appears as a member, or

b) any interest that they or any person connected with them may have in the contract is so remote or insignificant that it cannot reasonably be regarded as likely to influence him/her in relation to considering or voting on that contract.
7.3.2.3 A person shall not be regarded as having a pecuniary interest in any contract if they (or any person connected to them):

   a) has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body, and

   b) the total nominal value of those securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less, and

   c) if the share capital is of more than one class, the total nominal value of shares of any one class in which he/she has a beneficial interest does not exceed one-hundredth of the total issued share capital of that class

   d) This Standing Order shall not prohibit him/her from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it without prejudice however to his/her duty to disclose his/her interest.

7.3.3 Scope

7.3.3.1 Standing Orders section 6 applies to a committee or sub-committee of the trust as it applies to the trust and applies to any member of any such committee or sub-committee (whether or not he/she is also a director of the trust) as it applies to a director of the trust

7.3.4 Powers of the Secretary of State for Health

7.3.4.1 Power of the Secretary of State to remove disability

   a) Under regulation 20(2) of the Membership and Procedure Regulations, there is a power for the Secretary of State to, subject to any conditions the Secretary of State may think fit to impose, remove any disability imposed by Regulation 20, in any case in which it appears to the Secretary of State in the interests of the health service that the disability (which prevents a chairman or a member from taking part in the consideration or discussion of, or voting on any question with respect to, a matter in which he has a pecuniary interest) should be removed.

7.4 STANDARDS OF BUSINESS CONDUCT

7.4.1 trust Policy and National Guidance

7.4.1.1 All trust staff and Board members must comply with the trust’s Conflict of Interest Policy and the national guidance contained in HSG(93)5 on ‘Standards of Business Conduct for NHS staff’ (see Standing Orders paragraph 8.2).

7.4.2 The Committee on Standards in Public Life (the Nolan Committee) - recommended seven principles of conduct that should underpin the work of public authorities. The Nolan principles are:

7.4.2.1 Selflessness

   Holders of public office should take decisions solely in terms of the public interest. They should not do so in order to gain financial or other material benefits for themselves, their family, or their friends.
7.4.2.2 Integrity

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

7.4.2.3 Objectivity

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

7.4.2.4 Accountability

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

7.4.2.5 Openness

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

7.4.2.6 Honesty

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

7.4.2.7 Leadership

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

7.4.3 Standards for Members of NHS Boards and Governing Bodies in England

7.4.3.1 In November 2012 the Professional Standards Authority for Health and Social Care published Standards for members of NHS Boards and governing bodies in England. They put respect, compassion and care for patients at the centre of leadership and good governance of the NHS in England.

7.4.3.2 The standards bring together the essential skills that are expected of all executive and non-executive leaders in the NHS in England across in their personal behaviour, technical competence and business practices. The standards are based on 7 core values:

a) Responsibility
b) Honesty
c) Openness
d) Respect
e) Professionalism
f) Leadership
g) Integrity.
7.4.3.3 The new standards challenge people to take responsibility for their own behaviour, to challenge the behaviour of others, and to recognise and resolve conflicts of interest, and these fit with the expectations of the Nolan principles.

7.4.4 The Health and Social Care Act 2014 (Regulated Activities) Regulations

7.4.4.1 The 2014 Regulations places a duty on NHS providers not to appoint a person, or allow a person to continue to be, an Executive Director or equivalent (this includes the Chief Executive) or a Non-Executive Director (this includes the Chairman) under given circumstances. This means Directors should not be appointed or continue to hold office unless they are:

a) of good character
b) have the necessary qualifications, skills and experience
c) are able to perform the work that they are employed for after reasonable adjustments are made
d) able to supply information as set out in Schedule 3 of the 2014 Regulations when requested by the Care Quality Commission

7.4.4.2 When assessing a person being ‘of good character’ NHS providers are required to take account of Schedule 4 of the 2014 Regulations, namely:

a) whether the person has been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence, and

b) whether the person has been erased, removed or struck off a register of professionals maintained by a regulator of health care or social work professionals.

(See C6 Supporting Policies and Procedures for ‘Fit and Proper Persons Regulation Requirements and Process’).

7.4.5 Francis Report

7.4.5.1 Following the Public Inquiry into Mid Staffordshire NHS Foundation trust, Robert Francis QC published the Francis Report, which set out the need for a new, patient-centred culture within the NHS. The follow areas from the report support the trust’s focus:

a) Foster a common culture shared by all in the service of putting the patient first.

b) Ensure openness, transparency and statutory Duty of Candour throughout the system about matters of concern through implementation of the Being Open – Duty of Candour Policy.

c) Make all those who provide care for patients – individuals and organisations – properly accountable for what they do and to ensure that the public is protected from those not fit to practice.

d) Provide a proper degree of accountability for senior managers and leaders to place all with responsibility for protecting the interests of patients on a level playing field.

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e) Enhance the recruitment, education, training and support of all the key contributors to the provision of healthcare, but in particular those in nursing and leadership positions, to integrate the essential shared values of the common culture into everything they do.

f) Develop and share ever improving means of measuring and understanding the performance of individual professionals, teams, units and provider organisations for the patients, the public and all other stakeholders in the system.

7.4.5.2 In response to the Francis report, a number of high profile reviews into Quality of Care & Treatment, Patient Safety, and complaints have been conducted. These consist of:


b) Keogh review - Review into the Quality of Care and Treatment Provided by 14 Hospital trusts in England

c) Berwick review - Improving the Safety of Patients in England

d) Clwyd Hart review – Putting Patients back in the Picture which related to handling patient complaints

e) Kirkup review - An independent review into the widespread failings by a community health trust

7.4.5.3 The trust has reviewed the content of each of the above reports and produced action plans to ensure that the recommendations are embedded into the culture of the trust.

7.4.5.4 Additionally the CQC report on Winterbourne and learnings from the Speaking up national report; local learning; PHSO; and National Quality Board / NHS Resolve have also been reviewed and used to inform our policies and approach.

7.4.6 Interest of Officers in Contracts

7.4.6.1 Any officer or employee of the trust who comes to know that the trust has entered into or proposes to enter into a contract in which they or any person connected with them (as defined in Standing Orders paragraph 6.3) has any pecuniary interest, direct or indirect, the Officer shall declare their interest by giving notice in writing of such fact to the Chief Executive or trust’s Secretary as soon as practicable.

7.4.6.2 An Officer should also declare to the Chief Executive any other employment or business or other relationship of their, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the trust.

7.4.6.3 The trust will require interests, employment or relationships so declared to be entered in a register of interests of staff.
7.4.7 Canvassing of and Recommendations by Board Members in Relation to Appointments

7.4.7.1 Canvassing of members of the Board or of any Committee of the trust directly or indirectly for any appointment under the trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates.

7.4.7.2 Members of the Board shall not solicit for any person any appointment under the trust or recommend any person for such appointment; but this paragraph of this Standing Order shall not preclude a member from giving written testimonial of a candidate’s ability, experience or character for submission to the trust.

7.4.7.3 Informal discussions outside appointments panels or committees, whether solicited or unsolicited, should be declared to the panel or committee.

7.4.8 Relatives of Members

7.4.8.1 Candidates for any staff appointment under the trust shall, when making an application, disclose in writing to the trust whether they are related to any member or the holder of any office under the trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render them liable to instant dismissal.

7.4.8.2 The Chairman and every member of the Board shall disclose to the Board any relationship between themselves and a candidate of whose candidature that member is aware. It shall be the duty of the Chief Executive to report to the Board any such disclosure made.

7.4.8.3 On appointment, members (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the Board whether they are related to any other member or holder of any office under the trust.

7.4.8.4 Where the relationship to a member of the Board is disclosed, the Standing Order headed ‘Exclusion of Chairman and Board Members in proceedings on account of pecuniary interest’ (Standing Orders paragraph 6.3) shall apply.

8 CUSTODY OF SEAL, SEALING OF DOCUMENTS AND SIGNATURE OF DOCUMENTS

8.1 CUSTODY OF SEAL

8.1.1 The common seal of the trust shall be kept by the Chief Executive in a secure place.

8.2 SEALING OF DOCUMENTS

8.2.1 Where it is necessary that a document shall be sealed, the seal shall be affixed in the presence of two senior managers duly authorised by the Chief Executive, and not also from the originating department, and shall be attested by them.
8.3 WHEN SHOULD THE SEAL BE USED

8.3.1 The following examples should be used as a guide as to when the seal should be used:

8.3.1.1 All contracts for the purchase / lease of land and/ or building

8.3.1.2 All contracts for capital works exceeding £250,000

8.3.1.3 All lease agreements where the annual lease charge exceeds £50,000 per annum and the period of the lease extends beyond 5 years

8.3.1.4 Any other lease agreement where the total payable under the lease exceeds £100,000

8.4 REGISTER OF SEALING

8.4.1 An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. A report of all sealing shall be made to the trust Board at least quarterly. (The report shall contain details of the seal number, the description of the document and date of sealing).

8.5 SIGNATURE OF DOCUMENTS

8.5.1 Where the signature of any document will be a necessary step in legal proceedings involving the trust, it shall be signed by the Chief Executive, unless any enactment otherwise requires or authorises or where appropriate by the trust's Legal Advisers, or the Board shall have given the necessary authority to some other person for the purpose of such proceedings.

8.5.2 The Board delegates signature of responses to Industrial Tribunals to the Director of Human Resources and Organisational Development.

8.5.3 The Chief Executive or nominated officers shall be authorised, by resolution of the Board, to sign on behalf of the trust any agreement or other document (not required to be executed as a deed) the subject matter of which has been approved by the Board or committee or sub-committee to which the Board has delegated appropriate authority.

9 OVERLAP WITH OTHER TRUST POLICY STATEMENTS / PROCEDURES AND REGULATIONS

9.1 POLICY STATEMENTS: GENERAL PRINCIPLES

9.1.1 The Board will from time to time agree and approve Policy statements / procedures which will apply to all or specific groups of staff employed by East Cheshire NHS trust. The decisions to approve such policies and procedures will be recorded in an appropriate Board minute and will be deemed where appropriate to be an integral part of the trust's Standing Orders and Standing Financial Instructions. The Board may delegate the approval of specific policies to its Committees.
9.2 SPECIFIC POLICY STATEMENTS

9.2.1 Notwithstanding the application of Standing Orders paragraph 8.1 (Policy Statement: general principles) above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following Policy statements:

9.2.1.1 the Conflicts of Interest Policy for East Cheshire NHS trust staff;

9.2.1.2 the staff Disciplinary and Appeals Procedures adopted by the trust, both of which shall have effect as if incorporated in these Standing Orders.

9.3 SPECIFIC GUIDANCE

9.3.1 Notwithstanding the application of Standing Orders paragraph 9.1 (Policy Statement: general principles) above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following guidance and any other issued by the Secretary of State for Health:

9.3.1.1 Caldicott Guardian 1997;

9.3.1.2 Human Rights Act 1998;

9.3.1.3 Freedom of Information Act 2000;

9.3.1.4 The Public Contracts Regulations 2006 and 2015;

9.3.1.5 Confidentiality: NHS Code of Practice 2003;

9.3.1.6 The NHS Constitution for England 2013.

10 MISCELLANEOUS

10.1 STANDING ORDERS TO BE GIVEN TO DIRECTORS AND OFFICERS

10.1.1 It is the duty of the Chief Executive to ensure that existing directors and officers and all new appointees are notified of and understand their responsibilities within Standing Orders and Standing Financial Instructions. Updated copies shall be issued to staff designated by the Chief Executive. New designated officers shall be informed in writing and shall receive copies where appropriate of Standing Orders.

10.2 DOCUMENTS HAVING THE STANDING OF STANDING ORDERS

10.2.1 Standing Financial Instructions and the Scheme of Reservation and Delegation adopted by the Board in accordance with the Financial Regulations shall have effect as if incorporated in these Standing Orders.
10.3 INDEMNITY

10.3.1 Members of the trust Board (i.e., the Chair, Non-Executive Directors and Executive Directors) and the trust Secretary who act honestly and in good faith will not have to meet out of their own personal resources the costs associated with any personal civil liability which accrues to them in the execution or purported execution of their functions, save where they have acted recklessly. Any cost arising in this way will be met by the trust. The trust may purchase and maintain insurance against this liability for its own benefit and for the benefit of members of the trust Board and of the trust Secretary.

10.4 JOINT FINANCE ARRANGEMENTS

10.4.1 The Board may confirm contracts to purchase from a voluntary organisation or a local authority using its powers under Section 28A of the NHS Act 1977 (as amended). The Board may confirm contracts to transfer money from the NHS to the voluntary sector or the health related functions of local authorities where such a transfer is to fund services to improve the health of the local population more effectively than equivalent expenditure on NHS services, using its powers under Section 28A of the NHS Act 1977, as amended by section 29 of the Health Act 1999.

10.4.2 See overlap with Standing Financial Instruction No. 10.2.

10.5 REVIEW OF STANDING ORDERS

10.5.1 Standing Orders shall be reviewed annually by the trust. The requirement for review extends to all documents having the effect as if incorporated in Standing Orders.
Reservation of Powers to the Board and Delegation of Powers
CONTENTS

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ROLE OF THE CHIEF EXECUTIVE
CAUTION OVER THE USE OF DELEGATED POWERS
DIRECTORS' ABILITY TO DELEGATE THEIR OWN DELEGATED POWERS
ABSENCE OF DIRECTORS OR OFFICER TO WHOM POWERS HAVE BEEN
DELEGATED

1. RESERVATION OF POWERS TO THE BOARD
GENERAL ENABLING PROVISION
REGULATION AND CONTROL
APPOINTMENTS
POLICY DETERMINATION
STRATEGY AND BUSINESS PLANS AND BUDGETS
DIRECT OPERATIONAL DECISIONS
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AUDIT ARRANGEMENTS

2. DELEGATION OF POWERS
DELEGATION TO COMMITTEES

3. SCHEME OF DELEGATION TO OFFICERS

4. DETAILED SCHEME OF DELEGATION

5. DELEGATED FINANCIAL LIMITS
INTRODUCTION

Standing Orders paragraph 4.1 provides that “subject to such directions as may be given by the Secretary of State, the trust may make arrangements for the exercise, on behalf of the trust, of any of its functions by a committee or sub-committee or by the Chairman or a director or by an officer of the trust, in each case subject to such restrictions and conditions as the Board thinks fit”. The Code of Accountability also requires that there should be a formal schedule of matters specifically reserved to the trust.

The purpose of this document is to provide an example of how those powers may be reserved to the Board - generally matters for which it is held accountable to the Secretary of State, while at the same time delegating to the appropriate level the detailed application of trust policies and procedures. However, the Board remains accountable for all of its functions, even those delegated to the Chairman, 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.

A. Role of the Chief Executive

All powers of the trust which have not been retained as reserved by the Board or delegated to an executive committee or sub-committee shall be exercised on behalf of the Board by the Chief Executive. The Chief Executive shall prepare a Scheme of Delegation identifying which functions he shall perform personally and which functions have been delegated to other directors and officers.

All powers delegated by the Chief Executive can be re-assumed by him should the need arise. As Accountable Officer the Chief Executive is accountable to the Accounting Officer of the NHS Improvement for the funds entrusted to the trust.

The Director of Nursing and Quality is also the Deputy Chief Executive and as such assumes all responsibilities as per the Chief Executive in his absence.

B. 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 matter which in their judgement was likely to be a cause for public concern.

C. Directors’ Ability to Delegate their own Delegated Powers

The Scheme of Delegation shows only the “top level” of delegation within the trust. The Scheme is to be used in conjunction with the system of budgetary control and other established procedures within the trust.

D. 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. If the Chief Executive is absent powers delegated to him may be exercised by the Chairman after taking appropriate advice from the Director of Finance/Director of Corporate Affairs and Governance.
1 RESERVATION OF POWERS TO THE BOARD

1.1 The Code of Accountability which has been adopted by the trust requires the Board to determine those matters on which decisions are reserved unto itself. These reserved matters are set out in paragraphs 1.2 to 1.9 below:

1.2 GENERAL ENABLING PROVISION

1.2.1 The Board may determine any matter it wishes in full session within its statutory powers.

1.3 REGULATION AND CONTROL

1.3.1 The Board reserves the following regulation and control matters, namely the:

(a) Approval of Standing Orders (SOs), a schedule of matters reserved to the Board and Standing Financial Instructions for the regulation of its proceedings and business.

(b) Approval of a scheme of delegation of powers from the Board to officers.

(c) Requiring and receiving the declaration of directors’ interests which may conflict with those of the trust and determining the extent to which that director may remain involved with the matter under consideration.

(d) Requiring and receiving the declaration of interests from officers which may conflict with those of the trust.

(e) Disciplining directors who are in breach of statutory requirements or SOs.

(f) Approval of the disciplinary procedure for officers of the trust.

(g) Receipt of annual reports on key functions of the trust including: Workforce; safeguarding; infection prevention and control; governance and risk management; Equality & Diversity and Human Rights.

(h) Approval and monitoring of the trust’s arrangements for Quality including provision of the annual Quality Account.

(i) Approval and monitoring of the trust’s clinical arrangements.

(j) Approval and monitoring of the trust’s I.T. arrangements.

(k) Approval and monitoring of the trust’s arrangements for nursing and Allied professions.

(l) Approval of arrangements for dealing with complaints.

(m) Approval and monitoring of the trust’s arrangements for the management of risk.

(n) Approval of the trust’s Major incident plan.
(o) Adoption of the organisational structures, processes and procedures to facilitate the discharge of business by the trust and to agree modifications there to.

(p) To receive reports from committees including those which the trust is required by the Secretary of State or other regulation to establish and to take appropriate action thereon.

(q) To confirm the recommendations of the trust's committees where the committees do not have executive powers. To establish terms of reference and reporting arrangements of all sub-committees of the Board (and other committees if required).

(r) Ratification of any urgent decisions taken by the Chairman in accordance with Standing Orders paragraph 4.9.

(s) Approval of the annual governance statement.

(t) Approval of arrangements relating to the discharge of the trust's responsibilities as a bailee for patients' property.

1.4 APPOINTMENTS

1.4.1 The Board reserves the following appointment matters, namely:

(a) The appointment and dismissal of committees.

(b) The appointment, appraisal, disciplining and dismissal of executive directors (subject to Standing Orders paragraph 3.4).

(c) The appointment of members of any committee of the trust or the appointment of representatives on outside bodies.

1.5 POLICY DETERMINATION

1.5.1 The approval of management policies including Human Resource policies incorporating the arrangements for the appointment, dismissal and remuneration of staff. The trust's policy on procedural documents delegate's responsibility for approval of policies to Directors except for those policies specifically stated as reserved for the Board.

1.6 STRATEGY AND BUSINESS PLANS AND BUDGETS

1.6.1 The Board reserves the following strategy, business plans and budgets matters, namely the:

(a) Definition of the strategic aims and objectives of the trust.

(b) Approval of key strategies and Strategic Plans of the trust.

(c) Approval annually of plans in respect of:
   (i) the trust's Plan and Integrated Business Plan
   (ii) trust budgets at service area level.
   (iii) The application of available financial resources.
(d) Overall approval of programmes of investment to guide the letting of contracts for the supply of clinical services.

(e) Approval of business cases over the agreed value determine in the Scheme of Delegation.

1.7 DIRECT OPERATIONAL DECISIONS

1.7.1 The Board reserves the following direct operational decisions, namely the:

(a) Acquisition, disposal or change of use of land and/or buildings.

(b) The introduction or discontinuance of any significant activity or operation. An activity or operation shall be regarded as significant if it has a gross annual income or expenditure (that is before any set off) in excess of £100,000.

(c) Approval of individual contracts (other than NHS contracts) of a capital or revenue nature amounting to, or likely to amount to over £500,000 over a 3 year period or the period of the contract if longer.

(d) Approval of individual compensation payments over £10,000 and

(e) To agree action on litigation against or on behalf of the trust.

1.8 FINANCIAL AND PERFORMANCE REPORTING ARRANGEMENTS

1.8.1 The Board reserves the following financial and performance reporting matters, namely the:

(a) Continuous appraisal of the affairs of the trust by means of the receipt of reports as it sees fit from directors, committees, associate directors and officers of the trust as set out in management policy statements. All monitoring, regulatory and mandated returns required shall be reported, to the trust.

(b) Approval of the opening or closing of any bank or investment account.

(c) Receipt and approval of a schedule of Contracts signed in accordance with arrangements approved by the Chief Executive.

(d) Consideration and approval of the trust's Annual Report including the annual accounts.

(e) Receipt and approval of the Annual Report(s) for funds held on trust.

1.9 AUDIT ARRANGEMENTS

1.9.1 The Board reserves the following audit matters, namely the:

(a) To approve audit arrangements (including arrangements for the separate audit of funds held on trust) and to receive reports of the Audit Committee meetings and take appropriate action.
(b) The receipt of the annual management letter received from the external auditor and agreement of action on the recommendation where appropriate of the Audit Committee.

(c) The receipt of the Director of Audit Opinion received from the internal auditor and the agreement of action on the recommendation where appropriate of the Audit Committee.

2 DELEGATION OF POWERS

2.1 DELEGATION TO COMMITTEES

2.1.1 The Board 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 from time to time taking into account where necessary the requirements of the Secretary of State (including the need to appoint an Audit Committee and a Remuneration and Terms of Service Committee). The Board shall determine the reporting requirements in respect of these committees. In accordance with Standing Orders paragraph 5.1.5, committees may not delegate executive powers to sub-committees and the two Operational Reporting Forums accountable to the Chief Executive (the Clinical Management Board and the Executive Management Team Meeting) unless expressly authorised by the Board.

3 SCHEME OF DELEGATION TO OFFICERS

3.1.1 Standing Orders and model Standing Financial Instructions set out in some detail the financial responsibilities of the Chief Executive, the Director of Finance and other directors. These responsibilities are summarised below.

3.1.2 Certain matters needing to be covered in the scheme of delegation are not covered by SFIs or SOs or they do not specify the responsible officer.

3.1.3 This scheme of delegation covers only matters delegated by the Board to directors and certain other specific matters referred to in SFIs. Each director is responsible for the delegation and production of a scheme of delegation within their scope of responsibility outside of those identified within the Detailed Scheme of Delegation.
4. DETAILED SCHEME OF DELEGATION

Delegated matters in respect of decisions which may have a far reaching effect must be reported to the Chief Executive. **The delegation shown below is the lowest level to which authority is delegated.** Delegation to lower levels is only permitted with written approval of the Chief Executive who will, before authorising such delegation, consult with other Senior Officers as appropriate. All items concerning Finance must be carried out in accordance with Standing Financial Instructions and Standing Orders.

<table>
<thead>
<tr>
<th>Level of Authority</th>
<th>Authority Delegated to</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>Administrator</td>
</tr>
<tr>
<td>7</td>
<td>Budget Holder</td>
</tr>
<tr>
<td>6</td>
<td>Service Manager, including senior finance staff</td>
</tr>
<tr>
<td>5</td>
<td>Associate Director</td>
</tr>
<tr>
<td>4</td>
<td>Deputies (excluding Deputy Director of Finance)</td>
</tr>
<tr>
<td>3</td>
<td>Executive (excluding Director of Finance)</td>
</tr>
<tr>
<td>2</td>
<td>Director of Finance and Deputy Director of Finance</td>
</tr>
<tr>
<td>1</td>
<td>Chief Executive and Deputy Chief Executive</td>
</tr>
<tr>
<td>DELEGATED TO</td>
<td>DUTIES DELEGATED</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>1. STANDING ORDERS AND STANDING FINANCIAL INSTRUCTIONS</td>
<td></td>
</tr>
<tr>
<td>Audit Committee</td>
<td>Review every decision to suspend SOs.</td>
</tr>
<tr>
<td>Board of Directors</td>
<td>Approval of the trust’s Standing Orders for the trust Board, Standing Financial Instructions and Scheme of Reservation and Delegation of Powers (including variations and amendments)</td>
</tr>
<tr>
<td>Chairman</td>
<td>Final authority in interpretation of SOs.</td>
</tr>
<tr>
<td>Chairman and Chief Executive (with two Non Executive Directors)</td>
<td>Use of emergency powers relating to the authorities retained by the trust Board</td>
</tr>
<tr>
<td>Chief Executive</td>
<td>Existing Directors and employees and all new appointees are notified of and understand their responsibilities within Standing Orders / SFIs.</td>
</tr>
<tr>
<td>Chief Executive</td>
<td>Ensuring Standing Orders for the trust Board / Standing Financial Instructions are compatible with Department of Health requirements re building and engineering contracts</td>
</tr>
<tr>
<td>Chief Executive</td>
<td>Disclosure of non-compliance with Standing Orders to the Chief Executive (report to the trust Board)</td>
</tr>
<tr>
<td>Director of Corporate Affairs &amp; Governance</td>
<td>Advice on the interpretation or application of the Scheme of Reservation and Delegation of Powers</td>
</tr>
<tr>
<td>Director of Corporate Affairs and Governance</td>
<td>Disclosure of non-compliance with the Scheme of Reservation and Delegation of Powers to the Director of Corporate Governance and Governance (report to the trust Board via Audit Committee)</td>
</tr>
<tr>
<td>Director of Finance</td>
<td>Advice on the interpretation or application of the Standing Financial Instructions</td>
</tr>
<tr>
<td>Director of Finance</td>
<td>Disclosure of non-compliance with Standing Financial Instructions to the Director of Finance (report to the trust Board via Audit Committee)</td>
</tr>
<tr>
<td>2. MEETINGS</td>
<td></td>
</tr>
<tr>
<td>Chairman</td>
<td>Calling meetings.</td>
</tr>
<tr>
<td>Chairman</td>
<td>Chair all Board meetings and associated responsibilities.</td>
</tr>
<tr>
<td>3. SIGNATURE OF DOCUMENTS</td>
<td></td>
</tr>
<tr>
<td>Chief Executive</td>
<td>Approve and sign all documents which will be necessary in legal proceedings</td>
</tr>
<tr>
<td>Chief Executive (or nominated officers)</td>
<td>Sign on behalf of the trust any agreement or document not requested to be executed as a deed.</td>
</tr>
<tr>
<td>4. PROPERTY AGREEMENTS AND LICENCES</td>
<td></td>
</tr>
<tr>
<td>Director of Finance</td>
<td>Preparation and signature of all tenancy agreements/licenses for all staff subject to trust Policy on accommodation for staff</td>
</tr>
<tr>
<td>Director of Finance</td>
<td>Extensions to existing leases</td>
</tr>
<tr>
<td>Director of Finance</td>
<td>Letting of premises to outside organisations</td>
</tr>
<tr>
<td>Director of Finance</td>
<td>Approval of rent based on professional assessment</td>
</tr>
</tbody>
</table>
### 5. AUDIT ARRANGEMENTS

<table>
<thead>
<tr>
<th>DELEGATED TO</th>
<th>DUTIES DELEGATED</th>
<th>REF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audit Committee</td>
<td>Provide independent and objective view on internal control and probity.</td>
<td>SFI 2.1.1</td>
</tr>
<tr>
<td>Audit Committee</td>
<td>Raise the matter at the Board of Directors meeting where Audit Committee considers there is evidence of ultra vires transactions or improper acts.</td>
<td>SFI 2.1.2</td>
</tr>
<tr>
<td>Audit Committee</td>
<td>Establish a panel to appoint External Auditors. Ensure cost-effective External Audit.</td>
<td>SFI 2.5</td>
</tr>
<tr>
<td>Director of Corporate Affairs and Governance</td>
<td>Implementation of Internal and External Audit Recommendations</td>
<td>SFI 2.3.3 and 2.6.1</td>
</tr>
<tr>
<td>Director of Corporate Affairs and Governance</td>
<td>Commission the investigation of any suspected cases of irregularity not related to fraud or corruption and not covered by work of the local anti-fraud specialist in accordance with NHS Counter Fraud Authority Standards for Providers</td>
<td>SFI 2.6.2</td>
</tr>
<tr>
<td>Director of Corporate Affairs and Governance</td>
<td>Decide at what stage to involve police and other statutory agencies in cases of misappropriation and other irregularities not involving fraud or corruption.</td>
<td>SFI 2.6.2</td>
</tr>
<tr>
<td>Director of Finance</td>
<td>Ensure an adequate internal audit service is provided and involve the Audit Committee in the selection process when an Internal Audit provider is changed.</td>
<td>SFI 2.1.3</td>
</tr>
<tr>
<td>Director of Finance</td>
<td>Ensure compliance in accordance with its contractual requirements under the NHS Standards Contract in respect of Anti-Fraud, Bribery and Corruption as required by NHS Counter Fraud Authority's Standards for Providers</td>
<td>SFI 2.2.1</td>
</tr>
<tr>
<td>Director of Finance</td>
<td>Nominate Individual to carry out the duties of the Local Anti-Fraud Specialist.</td>
<td>SFI 2.2.2</td>
</tr>
<tr>
<td>Director of Finance</td>
<td>The Local Anti-Fraud Specialist will provide a written report, at least annually, on anti-fraud and corruption work within the trust.</td>
<td>SFI 2.2.4</td>
</tr>
<tr>
<td>Director of Finance</td>
<td>Review, appraise and report in accordance with NHS Internal Audit Standards and best practice.</td>
<td>SFI 2.4</td>
</tr>
</tbody>
</table>

### 6. BUDGETS, BUDGETARY CONTROL AND MONITORING

| All Board Directors | Responsible for security of the trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming to Standing Orders, Financial Instructions and financial procedures. | SFI 1.3.8 |
| All Budget Holders | Ensure that:  
- no overspend, or reduction of income that cannot be met from virement (with reference to virement limits), is incurred without prior consent of Board.  
- approved budget is not used for any other than specified purpose subject to rules of virement;  
- no permanent or temporary employees are appointed without the approval of the Chief Executive other than those provided for within available resources and manpower establishment Agency staff are approved as per trust policy | SFI 3.3.2 |
<p>| Chief Executive | Compile and submit to the Board an Annual Plan                                                                                                                          | SFI 3.1.1 |
| Chief Executive | Delegate budget to budget holders, subject to the budgetary total or virement limits set by the Board not being exceeded                                                                                               | SFI 3.2.1 |
| Chief Executive | Responsibility of keeping expenditure within budgets:                                                                                                                   | SFI 3.3.2 |</p>
<table>
<thead>
<tr>
<th>DELEGATED TO</th>
<th>DUTIES DELEGATED</th>
<th>REF</th>
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</thead>
</table>
| Level 1 - 8 | a) For the trust as a whole  
             b) For areas within delegated scope of responsibility |     |
| Chief Executive | Identify and implement cost improvements and income generation activities in line with the trust Plan. | SFI 3.3.3 |
| Chief Executive or Director of Finance | Submit monitoring returns | SFI 3.5.1 |
| Director of Finance | Responsible for implementing the trust’s financial policies and co-ordinating corrective action and ensuring detailed financial procedures and systems are prepared and documented. | SFI 1.3.7 |
| Director of Finance | Maintain & Update on trust Financial Procedures | SFI 1.3.7 |
| Director of Finance | To be satisfied with the form and adequacy of financial records kept and manner in which financial duties discharged in all departments. | SFI 1.3.10 |
| Director of Finance | Submit budgets to the Board for approval. | SFI 3.1.2 |
| Director of Finance | Monitor performance against budget, submit to Board financial estimates and forecasts. | SFI 3.1.3 |
| Director of Finance | Ensure that adequate training is delivered on an on-going basis to budget holders | SFI 3.1.5 |
| Director of Finance | Devise and maintain systems of budgetary control. | SFI 3.3.1 |

7. **ANNUAL ACCOUNTS AND REPORTS**

| Director of Finance | Prepare and submit Annual accounts, reports and returns. | SFI 4.1 |
| Director of Nursing and Quality | Prepare and submit Annual Quality Accounts | SFI 4.3 |

8. **BANK ACCOUNTS**

| Director of Finance | Managing the trust's banking arrangements and advising the trust on the provision of banking services and operation of accounts. | SFI 5.1.1 |
| Director of Finance | Open, Operate and monitor bank accounts | SFI 5.2 |
| Director of Finance | Authorisation of transfers between trust Bank Accounts in accordance with the bank mandate / internal procedures | SFI 5.2 |
| Director of Finance | Authorisation of: BACS schedules; Automated cheque schedules; Manual cheques in accordance with the bank mandate / internal procedures | SFI 5.3 |
| Director of Finance | Nominated staff who can use the trust credit card | SFI 5.4.1 |
| Director of Finance | Prepare detailed instructions on the operation of the bank accounts | SFI 5.3 |
| Director of Finance | Review the banking arrangements of the trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the trust's banking business | SFI 5.4.1 |

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

<p>| Director of Finance | Designing, maintaining and ensuring compliance with income systems for the proper recording, invoicing, collection and coding of all monies due, including prompt banking of monies received. | SFI 6.1.1 |
| Director of Finance | Follow the NHS Payment by Results guidance in setting prices for commissioner contracts. | SFI 6.2.1 |
| Director of Finance | Approval and regular review of level of fees and charges for Private Patient, Overseas Visitors, Income Generation | SFI 6.2.2 |</p>
<table>
<thead>
<tr>
<th>DELEGATED TO</th>
<th>DUTIES DELEGATED</th>
<th>REF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Director of Finance</td>
<td>Duty to follow agreed procedures to recover money due from transactions which they initiate / deal with, for example recording required patient service activity, overseas visitors, private patients</td>
<td>SFI 6.2.3</td>
</tr>
<tr>
<td>Director of Finance</td>
<td>Appropriate recovery action on all debts</td>
<td>SFI 6.3</td>
</tr>
<tr>
<td>Director of Finance</td>
<td>Recovery of an overpayment to staff in the next available payroll run or exceptionally over a period not exceeding three months.</td>
<td>SFI 6.3</td>
</tr>
<tr>
<td>Director of Finance</td>
<td>Approval to extend the recovery period of the overpayment / debt for period greater than 3 months</td>
<td>SFI 6.3</td>
</tr>
<tr>
<td>Director of Finance</td>
<td>Security of cash, cheques &amp; negotiable instruments</td>
<td>SFI 6.4</td>
</tr>
</tbody>
</table>

### 10. CONTRACTING FOR PROVISION OF SERVICES

<table>
<thead>
<tr>
<th>Role</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Executive / Director of Finance</td>
<td>Regular reports provided to the Board on actual and forecast income from contracts, including information on costing arrangements</td>
</tr>
<tr>
<td>Chief Executive with Director of Finance</td>
<td>Negotiating contracts for provision of patient services in accordance with the trust plan.</td>
</tr>
<tr>
<td>Director of Finance</td>
<td>Regular reports of actual and forecast contract income / expenditure.</td>
</tr>
<tr>
<td>Director of Finance</td>
<td>Price of NHS Contracts Charges for all NHS Contracts for Clinical Commissioning Groups or NHS Improvement; including block, cost per case, cost and volume spare capacity</td>
</tr>
<tr>
<td>Director of Finance</td>
<td>Negotiation and approval of Service Level Agreements</td>
</tr>
<tr>
<td>Director of Finance</td>
<td>Costing all SLAs, contract and non commercial contracts</td>
</tr>
<tr>
<td>Director of Finance</td>
<td>Ad hoc costing relating to changes in activity, developments, business cases and bids for funding</td>
</tr>
<tr>
<td>Director of Finance (with Chief Executive’s approval)</td>
<td>Approve and sign the main commissioner contract for patient services</td>
</tr>
</tbody>
</table>

### 11. BUSINESS CASES

<table>
<thead>
<tr>
<th>Role</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Executive</td>
<td>Delegate responsibility for approval of business cases subject to defined limits (refer to delegated financial limits)</td>
</tr>
<tr>
<td>Executive Directors</td>
<td>Development and submission of Business Cases in line with the agreed approval process</td>
</tr>
</tbody>
</table>

### 12. TERMS OF SERVICE AND PAYMENT OF DIRECTORS AND EMPLOYEES

<table>
<thead>
<tr>
<th>Role</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chairman</td>
<td>Establish a Remuneration &amp; Terms of Service Committee</td>
</tr>
<tr>
<td>Chief Executive</td>
<td>Authority to appoint staff to post not on the formal establishment, grant additional increments and re-grade/upgrade staff without a specifically allocated budget</td>
</tr>
<tr>
<td>Chief Executive</td>
<td>Nominate officers to enter into contracts of employment, regrading staff, agency staff or consultancy service contracts.</td>
</tr>
<tr>
<td>DELEGATED TO</td>
<td>DUTIES DELEGATED</td>
</tr>
<tr>
<td>-------------</td>
<td>----------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Chief Executive /  
Director of Human Resources and Organisational Development or Director of Finance | Authority to fill funded post on the establishment with permanent staff.       | SFI 9.3 |
| Chief Executive /  
Director of Human Resources and Organisational Development or Director of Finance | Authority for additional staff to the agreed establishment with specifically allocated finance |       |
| Chief Executive and Director of Finance | Approval of Increase in funded establishment of any department. | SFI 9.2.2 |
| Director of Finance | Authorised Car & Mobile Phone Users  
i) Requests for new posts to be authorised as car users and lease cars  
ii) Requests for approval of mobile phone / smart phone users  
iii) Requests for approval of ipad users |       |
| Director of Finance/  
Director of Human Resources | Ensure that the chosen method for payroll processing is supported by adequate (contracted) 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. | SFI 9.4.4 |
| Director of Human Resources and Organisational Development  
Chief Executive | Removal Expenses, Excess Rent and House Purchases  
Authorisation of payment of removal expenses incurred by officers taking up new appointments (consultants & hard to recruit to posts only - providing consideration was promised at interview and funding sourced from Directorate budgets) - up to £8,500  
i) over £8,500 |       |
| Director of Human Resources and Organisational Development | Staff Retirement Policy  
i) Authorisation of return to work in part time capacity under the flexible retirement scheme |       |
| Director of Human Resources and Pay:  
i) Authority to authorise standing data forms effecting pay, new starters, variations and leavers | SFI 9.4.3 |
<table>
<thead>
<tr>
<th>DELEGATED TO</th>
<th>DUTIES DELEGATED</th>
<th>REF</th>
</tr>
</thead>
</table>
| Organisational Development                           | ii) Authority to authorise positive reporting forms, or recognised alternative, where appropriate  
<p>|                                                       | iii) Authority to authorise overtime                                              |               |
|                                                       | iv) Authority to authorise travel &amp; subsistence expenses                          |               |
| Director of Human Resources and Organisational      | Leave – In line with trust policy                                                | trust policy  |
| Development                                           | i) Approval of annual leave                                                       |               |
|                                                       | ii) Annual leave - approval of carry forward (up to maximum of 5 days or in the case of Ancillary &amp; Maintenance staff as defined in their initial conditions of service). |               |
|                                                       | iii) Annual leave – approval of carry over in excess of 5 days but less than 10 days (to occur only in exceptional circumstances) |               |
|                                                       | iv) Annual leave - approval to carry forward 10 days or more. (to occur only in exceptional circumstances) |               |
|                                                       | v) Compassionate leave between 1 and 5 days                                       |               |
|                                                       | vi) Carers leave (up to a maximum of 3 days)                                     |               |
|                                                       | vii) Leave without pay and career break                                          |               |
|                                                       | viii) Medical Staff Leave of Absence, paid and unpaid                            |               |
|                                                       | ix) Time off in lieu                                                             |               |
|                                                       | x) Maternity Leave                                                              |               |
|                                                       | xi) Paternity Leave                                                             |               |
|                                                       | xii) Adoption Leave                                                             |               |
|                                                       | – paid and unpaid In line with trust policy                                       |               |
| Director of Human Resources and Organisational      | Study Leave – In line with trust policy:                                         | trust policy  |
| Development                                           | i) Study leave outside the UK                                                    |               |
|                                                       | ii) Medical staff study leave (UK)                                               |               |
|                                                       | iii) All other study leave (UK)                                                  |               |
| Director of Human Resources and Organisational      | Grievance Procedure                                                              | trust policy  |
| Development                                           | All grievances cases must be dealt with strictly in accordance with the Grievance Procedure and the advice of a Personnel Manager must be sought when the grievance reaches the level of service area Manager |               |
| Director of Human Resources and Organisational      | Renewal of Fixed Term Contract within agreed budget                              | trust policy  |
| Development                                           |                                                                               |               |
| Director of Human Resources and Organisational      | Ill Health Retirement - Decision to pursue retirement on the grounds of ill-health | trust policy  |
| Development                                           |                                                                               |               |</p>
<table>
<thead>
<tr>
<th>DELEGATED TO</th>
<th>DUTIES DELEGATED</th>
<th>REF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Development</td>
<td>Dismissal</td>
<td>trust policy</td>
</tr>
</tbody>
</table>
| Director of Human Resources and Organisational Development | Payroll:  
- specifying timetables for submission of properly authorised time records and other notifications;  
- final determination of pay and allowances and making payments on agreed dates;  
- agreeing method of payment;  
- issuing instructions. | SFI 9.4.1 |
| Director of Human Resources and Organisational Development | Submit time records and other notifications in line with timetable; Complete time records and other notifications; Submit termination forms | SFI 9.4.3 |
| Director of Human Resources and Organisational Development | 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; and Deal with variations to, or termination of, contracts of employment; and Deal with claims, settlements, compensation, tribunal hearings and disputes generally, arising from contracts of employment. | SFI 9.5.1 |
| Director of Human Resources and Organisational Development & Remuneration Committee | Redundancy / Redeployment  
ii) Authorisation of Redundancy payments  
iii) Redeployment | trust policy |
| Director of Human Resources and Organisational Development or Director of Finance | Sick Leave  
Extension of Sick Leave  
i) Extension of sick leave on half pay up to three months  
ii) Extension of sick leave on full pay | SFI 9.3.1 |
| Executive Directors | Agency staff  
Approval within cap and framework  
Approval outside cap and framework  
Approval of payments over £100 | |
<p>| Chief Executive | | |</p>
<table>
<thead>
<tr>
<th>DELEGATED TO</th>
<th>DUTIES DELEGATED</th>
<th>REF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remuneration &amp; Terms of Service Committee</td>
<td>Advise the Board on and make recommendations on the remuneration and terms of service of the Chief Executive and senior employees to ensure they are fairly rewarded having proper regard to the trust’s circumstances and any national agreements; Monitor and evaluate the performance of individual senior employees as appropriate; Advise on and oversee appropriate contractual arrangements for such staff, including proper calculation and scrutiny of termination payments</td>
<td>SFI 9.1.2</td>
</tr>
<tr>
<td>Remuneration and Terms of Service Committee</td>
<td>Report in writing to the Board its advice and its bases about remuneration and terms of service of directors and senior employees.</td>
<td>SFI 9.1.3</td>
</tr>
</tbody>
</table>

13. NON PAY EXPENDITURE

<table>
<thead>
<tr>
<th>Role</th>
<th>Duties</th>
<th>REF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Executive</td>
<td>Ensure that Standing Orders are compatible with NHS Improvement requirements re building and engineering contracts.</td>
<td>SFI 10.2.7</td>
</tr>
<tr>
<td>Chief Executive/ Director of Finance</td>
<td>Authorise who may use and be issued with official orders.</td>
<td>SFI 10.2.5</td>
</tr>
<tr>
<td>Director Finance</td>
<td>Ensure that they comply fully with the guidance and limits for Non Pay Expenditure as specified by the Director of Finance.</td>
<td>SFI 10.2.6</td>
</tr>
<tr>
<td>Director of Finance</td>
<td>Determine, and set out, level of delegation of non-pay expenditure to budget managers.</td>
<td>SFI 10.1.1</td>
</tr>
<tr>
<td>Director of Finance</td>
<td>Set out procedures on the seeking of professional advice regarding the supply of goods and services.</td>
<td>SFI 10.1.3</td>
</tr>
<tr>
<td>Director of Finance</td>
<td>Prompt payment of accounts.</td>
<td>SFI 10.2.2</td>
</tr>
<tr>
<td>Director of Finance</td>
<td>Advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; Prepare procedural instructions on the obtaining of goods, works and services incorporating the thresholds; Designing and maintaining a system of verification, recording and payment of all amounts payable, including a timetable and system for submission in accordance with cashflow</td>
<td>SFI 10.2.3</td>
</tr>
<tr>
<td>Director of Finance</td>
<td>Prepare procedures in accordance with good practice on payments to local authorities and voluntary organisations.</td>
<td>SFI 10.2.9</td>
</tr>
</tbody>
</table>

14. BORROWING AND INVESTMENT

<table>
<thead>
<tr>
<th>Role</th>
<th>Duties</th>
<th>REF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Director of Finance</td>
<td>Advise Board on borrowing (Public Dividend Capital) and investment needs and prepare procedural instructions.</td>
<td>SFI 11.1.1</td>
</tr>
<tr>
<td>Director of Finance</td>
<td>Any request for temporary borrowing or draw down of Public Dividend Capital must be authorised by two of the nominated signatories</td>
<td>SFI 11.1.2</td>
</tr>
<tr>
<td>Director of Finance</td>
<td>Advise the Board on investments and shall report periodically to the Board concerning the performance of investments held.</td>
<td>SFI 11.2.2</td>
</tr>
<tr>
<td>Director of Finance</td>
<td>Prepare detailed procedural instructions on the operation of investment accounts and on the records to be</td>
<td>SFI 11.2.3</td>
</tr>
<tr>
<td>DELEGATED TO</td>
<td>DUTIES DELEGATED</td>
<td>REF</td>
</tr>
<tr>
<td>--------------------</td>
<td>----------------------------------------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>Director of Finance</td>
<td>Investment of Funds [including Charitable &amp; Endowment Funds]</td>
<td>SFI 11.2</td>
</tr>
<tr>
<td>Director of Finance</td>
<td>Ensure members of the Board are aware of the Financial Framework</td>
<td>SFI 11.3</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Role</th>
<th>Responsibilities</th>
<th>REF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Executive</td>
<td>Issue a scheme of delegation for capital investment management in accordance with &quot;Estatecode&quot; guidance and the trust's Standing Orders</td>
<td>SFI 12.1.4</td>
</tr>
<tr>
<td>Chief Executive</td>
<td>Overall responsibility for fixed assets.</td>
<td>SFI 12.4.1</td>
</tr>
<tr>
<td>Chief Executive / Director of Finance</td>
<td>Responsibility for the management of capital schemes and for ensuring that they are delivered on time and within cost.</td>
<td>SFI 12.1.2</td>
</tr>
<tr>
<td>Director of Finance</td>
<td>Capital investment programme developed which ensures that there is adequate appraisal and approval process for determining capital expenditure priorities and the effect that each has on plans; cost; and that capital investment is not undertaken without availability of resources to finance all revenue consequences.</td>
<td>SFI 12.1.1</td>
</tr>
<tr>
<td>Director of Finance</td>
<td>Business case is produced for each proposal.</td>
<td>SFI 12.1.2</td>
</tr>
<tr>
<td>Director of Finance</td>
<td>Selection of architects, quantity surveyors, consultant engineer and other professional advisors within EU regulations.</td>
<td>N/A</td>
</tr>
<tr>
<td>Director of Finance</td>
<td>Financial Monitoring and reporting on the capital programme.</td>
<td>SFI 12.1.3</td>
</tr>
<tr>
<td>Director of Finance</td>
<td>Issue procedures governing financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.</td>
<td>SFI 12.1.5</td>
</tr>
<tr>
<td>Director of Finance</td>
<td>Demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.</td>
<td>SFI 12.2</td>
</tr>
<tr>
<td>Director of Finance</td>
<td>Maintenance of asset registers.</td>
<td>SFI 12.3.1</td>
</tr>
<tr>
<td>Director of Finance</td>
<td>Approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.</td>
<td>SFI 12.3.5</td>
</tr>
<tr>
<td>Director of Finance</td>
<td>Approval of asset control procedures (including fixed assets, cash, cheques and other negotiable instruments).</td>
<td>SFI 12.4.2</td>
</tr>
<tr>
<td>Director of Finance</td>
<td>Security of property of the trust.</td>
<td>SFI 12.4.4</td>
</tr>
<tr>
<td>Director of Finance</td>
<td>Responsibility for security of trust assets including notifying discrepancies to Director of Finance, and reporting losses in accordance with trust procedure.</td>
<td>SFI 12.4.4</td>
</tr>
<tr>
<td>Director of Finance or nominated deputy</td>
<td>Certify professionally the costs and revenue consequences detailed in the business case for capital investment.</td>
<td>SFI 12.1.2</td>
</tr>
</tbody>
</table>

### 16. STORES AND RECEIPT OF GOODS

<table>
<thead>
<tr>
<th>Role</th>
<th>Responsibilities</th>
<th>REF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Executive / Designated Officer</td>
<td>Identify persons authorised to requisition and accept goods from NHS Supply Chain.</td>
<td>SFI 13.1.8</td>
</tr>
<tr>
<td>Director of Finance</td>
<td>Responsible for systems of control over stores and receipt of goods.</td>
<td>SFI 13.1.2</td>
</tr>
<tr>
<td>DELEGATED TO</td>
<td>DUTIES DELEGATED</td>
<td>REF</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>Director of Finance</td>
<td>Responsible for controls of pharmaceutical stock</td>
<td>SFI 13.1.2</td>
</tr>
<tr>
<td>Director of Finance</td>
<td>Responsible for control of stocks of fuel oil</td>
<td>SFI 13.1.2</td>
</tr>
<tr>
<td>Director of Finance</td>
<td>Security arrangements and custody of keys</td>
<td>SFI 13.1.2</td>
</tr>
<tr>
<td>Director of Finance</td>
<td>Set out procedures and systems to regulate the stores</td>
<td>SFI 13.1.3</td>
</tr>
<tr>
<td>Director of Finance</td>
<td>Agree stocktaking arrangements.</td>
<td>SFI 13.1.4</td>
</tr>
<tr>
<td>Director of Finance</td>
<td>Approve alternative arrangements where a complete system of stores control is not justified.</td>
<td>SFI 13.1.6</td>
</tr>
<tr>
<td>Director of Finance</td>
<td>Approve system for review of slow moving and obsolete items and for condemnation, disposal and replacement of all unserviceable items.</td>
<td>SFI 13.1.7</td>
</tr>
<tr>
<td>Director of Finance</td>
<td>Operate system for slow moving and obsolete stock, and report to Director of Finance evidence of significant overstocking.</td>
<td>SFI 13.1.7</td>
</tr>
</tbody>
</table>

17. **DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS**

| Audit Committee                          | Approve write off of losses within delegated limits.                             | SFI 14.2.4 |
| Chief Executive                          | Determining any items to be sold by sale or negotiation.                         | SFI 20 (a) |
| Director of Finance                      | Prepare detailed procedures for disposal of assets including condemnations and ensure that these are notified to managers. | SFI 14.1.1 |
| Director of Finance                      | Prepare procedures for recording and accounting for losses and special payments and informing NHS Improvement and NHS Counter Fraud Authority of all frauds and informing police in cases of suspected arson or theft. | SFI 14.2.1 |
| Director of Finance                      | Prepare Fraud, Bribery and Corruption response plan                              | SFI 14.2.2 |
| Director of Finance                      | Discovery or suspicion of loss of any kind must be reported immediately to the Chief Executive and Director of Finance or inform an officer charged with responsibility for responding to concerns involving loss or fraud confidentially. This officer will then appropriately inform the Director of Finance and/or Chief Executive | SFI 14.2.2 |
| Director of Finance                      | For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Director of Finance must immediately notify the Audit Committee and the External Auditor. | SFI 14.2.4 |
| Director of Finance                      | Take necessary steps to safeguard trust's interests in bankruptcies and company liquidations | SFI 14.2.6 |
| Director of Finance                      | Consider whether any insurance claim can be made.                               | SFI 14.2.7 |
| Director of Finance in conjunction with Director of Corporate Affairs & Governance | Maintain losses and special payments register                                      | SFI 14.2.8 |

18. **SECURITY MANAGEMENT**

<p>| Director of Finance                      | Ensure compliance with the NHS Standards Contract in accordance with NHS Counter Fraud Authority’s Security Standards for Providers on security management | SFI 14.3.1 |
| Director of Corporate Affairs and Governance | Maintain losses and special payments register                                      | SFI 14.3.1 |</p>
<table>
<thead>
<tr>
<th>DELEGATED TO</th>
<th>DUTIES DELEGATED</th>
<th>REF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Director of Finance</td>
<td>Review, maintain and develop trust policies and procedures for security management</td>
<td></td>
</tr>
<tr>
<td>Director of Finance</td>
<td>Ensure compliance with statutory requirements and trust policies and procedures for security management</td>
<td></td>
</tr>
<tr>
<td>Director of Finance</td>
<td>Compliance with statutory requirements and trust policies and procedures for security management</td>
<td></td>
</tr>
</tbody>
</table>

19. INFORMATION TECHNOLOGY

<table>
<thead>
<tr>
<th>Committee</th>
<th>Role and Responsibilities</th>
<th>REF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audit</td>
<td>Periodically seek assurances that adequate controls are in operation.</td>
<td>SFI 15.1.4</td>
</tr>
<tr>
<td>Chief Executive</td>
<td>Overall responsibility for Information Technology</td>
<td>SFI 15.1.1</td>
</tr>
<tr>
<td>Chief Executive</td>
<td>Satisfy him/herself that systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy and data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists</td>
<td>SFI 15.1.5</td>
</tr>
<tr>
<td>Director of Corporate Affairs and Governance</td>
<td>Ensure that risks to the trust arising from the use of IT are identified, considered and action taken where necessary</td>
<td>SFI 15.4.1</td>
</tr>
<tr>
<td>Director of Finance</td>
<td>Responsible for accuracy and security of computerised financial data.</td>
<td>SFI 15.1.1</td>
</tr>
<tr>
<td>Director of Finance</td>
<td>Satisfy themselves that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation assurances of adequacy must be obtained from them prior to implementation.</td>
<td>SFI 15.1.2</td>
</tr>
<tr>
<td>Director of Finance</td>
<td>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.</td>
<td>SFI 15.1.3</td>
</tr>
</tbody>
</table>

20. PATIENTS' PROPERTY

<table>
<thead>
<tr>
<th>Role</th>
<th>Role and Responsibilities</th>
<th>REF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Executive</td>
<td>Responsible for ensuring patients and guardians are informed about patients' money and property procedures before or at admission.</td>
<td>SFI 16.2</td>
</tr>
<tr>
<td>Director of Finance</td>
<td>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.</td>
<td>SFI 16.3</td>
</tr>
<tr>
<td>Chief Operating Officer</td>
<td>Inform staff of their responsibilities and duties for the administration of the property of patients.</td>
<td>SFI 16.6</td>
</tr>
<tr>
<td>Director of Finance</td>
<td>For deceased patients, issuing property on production of a probate letter of administration</td>
<td>SFI 16</td>
</tr>
</tbody>
</table>

21. RETENTION OF DOCUMENTS (RECORDS)

<table>
<thead>
<tr>
<th>Role</th>
<th>Role and Responsibilities</th>
<th>REF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Director of Corporate Affairs and Governance</td>
<td>Maintaining archives for all records required to be retained in accordance with Department of Health guidelines</td>
<td>SFI 17.1</td>
</tr>
<tr>
<td>Director of Corporate Affairs and Governance</td>
<td>Review the trust's compliance with the Access to Records Act</td>
<td>SFI 17.1</td>
</tr>
<tr>
<td>Medical Director and Director of Corporate Affairs</td>
<td>Development of strategies, policies and procedures for clinical records and non-clinical records</td>
<td>SFI 17.2</td>
</tr>
<tr>
<td>DELEGATED TO</td>
<td>DUTIES DELEGATED</td>
<td>REF</td>
</tr>
<tr>
<td>--------------</td>
<td>------------------</td>
<td>-----</td>
</tr>
<tr>
<td>Affairs and Governance</td>
<td>Ensure compliance with strategies, policies and procedures for clinical records and non-clinical records</td>
<td>SFI 17.2</td>
</tr>
<tr>
<td>Medical Director and Director of Corporate Affairs and Governance</td>
<td>Records are retained and disposed of in accordance with trust records management policies and procedures</td>
<td>SFI 17.2</td>
</tr>
</tbody>
</table>

22. **RISK MANAGEMENT & INSURANCE**

<table>
<thead>
<tr>
<th>Role</th>
<th>Duties</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Executive</td>
<td>Ensure there is a robust risk management programme in place</td>
</tr>
<tr>
<td>Director of Corporate Affairs and Governance</td>
<td>Develop and maintain a risk management strategy and policy</td>
</tr>
<tr>
<td>Director of Corporate Affairs and Governance</td>
<td>Develop systems for the identification and management of risks and incidents across the trust</td>
</tr>
<tr>
<td>Director of Corporate Affairs and Governance</td>
<td>Ensure compliance with the system for identification and management of risks and incidents</td>
</tr>
<tr>
<td>Director of Corporate Affairs and Governance</td>
<td>Comply with the system for identification and management of risks and incidents</td>
</tr>
<tr>
<td>Director of Corporate Affairs and Governance</td>
<td>Develop a system for assessment of performance against the CQC standards and retain evidence</td>
</tr>
<tr>
<td>Deputy Director of Corporate Affairs and Governance</td>
<td>To act as the trust’s Family Liaison Officer</td>
</tr>
<tr>
<td>Director of Finance/Director of Corporate Affairs and Governance</td>
<td>Ensure that insurance arrangements exist in accordance with the risk management programme</td>
</tr>
</tbody>
</table>

23. **STANDARDS OF BUSINESS CONDUCT (INCLUDING REGISTER OF INTERESTS)**

<table>
<thead>
<tr>
<th>Role</th>
<th>Duties</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chairman</td>
<td>Approving the retention of gifts and the receipt of hospitality / sponsorship</td>
</tr>
<tr>
<td>Director of Corporate Affairs &amp; Governance</td>
<td>- For Non Executive Directors</td>
</tr>
<tr>
<td></td>
<td>- For all other employees</td>
</tr>
<tr>
<td>All Board Directors</td>
<td>Declare relevant and material interests</td>
</tr>
<tr>
<td>Role</td>
<td>Responsibility</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Chief Executive</td>
<td>The trust will produce a periodic statement to satisfy the compliance requirements of the Bribery Act.</td>
</tr>
<tr>
<td>Director of Corporate Affairs &amp; Governance</td>
<td>Maintenance of robust governance arrangements over standards of business conduct including a Hospitality Register (Applies to both individual and collective hospitality received in excess of £50.00) and Register of Interests (encompassing trust Board members, all employees and external consultants)</td>
</tr>
<tr>
<td>Director of Corporate Affairs &amp; Governance</td>
<td>Comply with the systems and policies on confidentiality</td>
</tr>
<tr>
<td>Director of Corporate Affairs &amp; Governance</td>
<td>Comply with requirements to not disclose any matter reported to, or dealt with, by the Board or other committee without its permission</td>
</tr>
<tr>
<td>Director of Corporate Affairs &amp; Governance</td>
<td>Monitoring compliance with standards of business conduct (declaration of interests / hospitality and gifts)</td>
</tr>
</tbody>
</table>

24. **TENDERING AND CONTRACTS**

<table>
<thead>
<tr>
<th>Role</th>
<th>Responsibility</th>
<th>Reference(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Executive</td>
<td>Best value for money is demonstrated for all services provided under contract or in- house.</td>
<td>SFI 19.7.9</td>
</tr>
<tr>
<td>Chief Executive</td>
<td>Demonstrate that the use of private finance represents best value for money and transfers risk to the private sector.</td>
<td>SFI 19.8.1</td>
</tr>
<tr>
<td>Chief Executive</td>
<td>Nominate an officer to oversee and manage the contract on behalf of the trust.</td>
<td>SFI 19.9.2</td>
</tr>
<tr>
<td>Chief Executive</td>
<td>Nominate officers with power to negotiate commissioning contracts with providers of healthcare and other authorities.</td>
<td>SFI 19.1.3</td>
</tr>
<tr>
<td>Chief Executive</td>
<td>Designate an officer responsible for receipt and custody of tenders before opening.</td>
<td>SFI 19.4.5</td>
</tr>
<tr>
<td>Executive Directors (X2)</td>
<td>Open tenders.</td>
<td>SFI 19.4.5</td>
</tr>
<tr>
<td>Chief Executive (or nominated officer)</td>
<td>Decide whether any late tenders should be considered.</td>
<td>SFI 19.4.5</td>
</tr>
</tbody>
</table>

25. **COMPLAINTS**

<table>
<thead>
<tr>
<th>Role</th>
<th>Responsibility</th>
<th>Reference(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Director of Corporate Affairs and Governance</td>
<td>Overall responsibility for ensuring that a robust process is in place to ensure that all complaints are dealt with effectively</td>
<td>Complaint Policy</td>
</tr>
<tr>
<td>Director of Corporate Affairs and Governance</td>
<td>Responsibility for ensuring complaints relating to a service area are investigated thoroughly.</td>
<td>Complaint</td>
</tr>
<tr>
<td>Director of Corporate Affairs and Governance</td>
<td>Medico - Legal Complaints – Co-ordination of their management.</td>
<td>Claims Policy</td>
</tr>
<tr>
<td></td>
<td>SEAL</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>----------------------------------------------------------------------</td>
<td>---------------------------------------------------</td>
</tr>
<tr>
<td>26.</td>
<td>Chairman/Chief Executive</td>
<td>Attestation of sealings in accordance with Standing Orders</td>
</tr>
<tr>
<td></td>
<td>Chief Executive</td>
<td>Keep seal in safe place and maintain a register of sealing.</td>
</tr>
<tr>
<td></td>
<td><strong>SPONSORSHIP</strong></td>
<td></td>
</tr>
<tr>
<td>27.</td>
<td>Chief Executive &amp; Medical Director</td>
<td>Develop a policy for the acceptance of commercial sponsorship</td>
</tr>
<tr>
<td></td>
<td>Chief Executive &amp; Medical Director</td>
<td>Authorisation of Sponsorship deals</td>
</tr>
<tr>
<td></td>
<td><strong>RESEARCH &amp; CLINICAL TRIALS</strong></td>
<td></td>
</tr>
<tr>
<td>28.</td>
<td>Chief Executive &amp; Medical Director</td>
<td>Develop strategy on research activity at the trust</td>
</tr>
<tr>
<td></td>
<td>Chief Executive &amp; Medical Director</td>
<td>Authorisation of Research Projects and Clinical Trials</td>
</tr>
<tr>
<td></td>
<td>Director of Corporate Affairs and Governance</td>
<td>Develop policy and procedures on the authorisation of research projects and clinical trials</td>
</tr>
<tr>
<td></td>
<td>Director of Corporate Affairs and Governance</td>
<td>Ensure robust Research Governance processes are in place.</td>
</tr>
<tr>
<td></td>
<td><strong>RELATIONSHIPS WITH PRESS</strong></td>
<td></td>
</tr>
<tr>
<td>29.</td>
<td>Director of Corporate Affairs &amp; Governance</td>
<td>Non-Emergency General Enquiries</td>
</tr>
<tr>
<td></td>
<td>Executive On-Call or Director of Corporate Affairs &amp; Governance</td>
<td>Non-Emergency General Enquiries</td>
</tr>
<tr>
<td></td>
<td>Director of Corporate Affairs &amp; Governance</td>
<td>Emergency</td>
</tr>
<tr>
<td></td>
<td>Director of Corporate Affairs &amp; Governance</td>
<td>- Within Hours</td>
</tr>
<tr>
<td></td>
<td>Executive On-Call</td>
<td>Emergency</td>
</tr>
<tr>
<td></td>
<td>Director of Corporate Affairs &amp; Governance</td>
<td>- Outside Hours</td>
</tr>
<tr>
<td></td>
<td>Executive On-Call</td>
<td>- Outside Hours</td>
</tr>
<tr>
<td></td>
<td><strong>INFECTIOUS DISEASES</strong></td>
<td></td>
</tr>
<tr>
<td>30.</td>
<td>Director of Nursing and Quality</td>
<td>Act as Director of Infection, Prevention and Control</td>
</tr>
<tr>
<td></td>
<td>Director of Nursing and Quality</td>
<td>Introduce robust systems and policies for the control and prevention of infectious diseases &amp; notifiable outbreaks</td>
</tr>
<tr>
<td>Role</td>
<td>Activities</td>
<td>Notes</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------</td>
<td>-------</td>
</tr>
<tr>
<td>Director of Nursing and Quality</td>
<td>Ensure compliance with regulatory requirements of infection, prevention and control, providing an annual assurance report to the Board</td>
<td>N/A</td>
</tr>
<tr>
<td>Director of Nursing and Quality</td>
<td>Provide Leadership working in partnership with the lead Microbiologist on issues relating to infection, prevention and control</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>31. EXTENDED ROLE ACTIVITIES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chief Executive / Director of Nursing and Quality</td>
<td>Approval of Nurses to undertake duties / procedures which can properly be described as beyond the normal scope of Nursing Practice.</td>
<td>N/A</td>
</tr>
<tr>
<td>Chief Operating Officer</td>
<td>Variation of operating and clinic sessions within existing numbers</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Outpatients</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Theatres</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Other</td>
<td></td>
</tr>
<tr>
<td>Chief Executive</td>
<td>All proposed changes in bed allocation and use</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Temporary Change</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Permanent Change</td>
<td></td>
</tr>
<tr>
<td><strong>32. FACILITIES FOR STAFF NOT EMPLOYED BY THE TRUST TO GAIN PRACTICAL EXPERIENCE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Director of Human Resources and Organisational Development</td>
<td>Professional Registration, Honorary Contracts, &amp; Insurance of Medical Staff. Work experience students</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>33. FIRE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Director of Corporate Affairs and Governance</td>
<td>Review and ensure that the trust’s fire precautions and prevention policies and procedures are adequate and that the fire safety and integrity of the estate is intact</td>
<td>N/A</td>
</tr>
<tr>
<td>Deputy Director of Corporate Affairs and Governance</td>
<td>To act as Fire Safety Manager – ensure governance arrangements are in place in relation to the Regulatory Reform (Fire Safety) Order 2005</td>
<td>N/A</td>
</tr>
<tr>
<td>Director of Corporate Affairs and Governance</td>
<td>Develop fire precautions and prevention policies and procedures that comply with statute and guidance.</td>
<td>N/A</td>
</tr>
<tr>
<td>Director of Corporate Affairs and Governance</td>
<td>Ensure compliance with the fire precautions and prevention policies and procedures.</td>
<td>N/A</td>
</tr>
<tr>
<td>Director of Corporate Affairs and Governance</td>
<td>Comply with the fire precautions and prevention policies and procedures.</td>
<td>N/A</td>
</tr>
</tbody>
</table>
### 34. HEALTH & SAFETY

<table>
<thead>
<tr>
<th>Role</th>
<th>Activities</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Director of Corporate Affairs and Governance</td>
<td>Review of all statutory compliance legislation and Health and Safety requirements including control of Substances Hazardous to Health Regulations.</td>
<td>N/A</td>
</tr>
<tr>
<td>Director of Corporate Affairs and Governance</td>
<td>Develop policies and procedures to comply with statutory requirements, including control of Substances Hazardous to Health Regulations</td>
<td></td>
</tr>
<tr>
<td>Health and Safety Adviser</td>
<td>To act as the competent person for Health &amp; Safety (advice)</td>
<td>N/A</td>
</tr>
<tr>
<td>Director of Corporate Affairs and Governance</td>
<td>Ensure compliance with statutory requirements and trust policies and procedures</td>
<td></td>
</tr>
<tr>
<td>Director of Corporate Affairs and Governance</td>
<td>Comply with statutory requirements and trust policies and procedures</td>
<td></td>
</tr>
<tr>
<td>Medical Director</td>
<td>Medical Device safety officer</td>
<td></td>
</tr>
<tr>
<td>Director of Nursing &amp; Quality</td>
<td>Safe staffing (nursing) and skill mix</td>
<td></td>
</tr>
</tbody>
</table>

### 35. MEDICINES INSPECTORATE

<table>
<thead>
<tr>
<th>Role</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Director</td>
<td>Review of Medicines Inspectorate Regulations</td>
</tr>
<tr>
<td>Chief Pharmacist</td>
<td>Discharge the duties of Accountable Officer for Controlled Drugs for the trust</td>
</tr>
<tr>
<td>Chief Pharmacist</td>
<td>Accountable Officer for Controlled Drugs for the trust to designate officers to act as an Authorised Witness for the disposal of Controlled Drugs</td>
</tr>
<tr>
<td>Chief Pharmacist</td>
<td>Ensure trust staff dispose of Controlled Drugs in accordance with statute and trust Policy</td>
</tr>
<tr>
<td>Medical Director</td>
<td>Responsibility for controls of all pharmaceutical stock as used by the trust</td>
</tr>
<tr>
<td>Deputy Chief Pharmacist</td>
<td>Medicines safety officer for the trust</td>
</tr>
</tbody>
</table>

### 36. ENVIRONMENTAL REGULATIONS

<table>
<thead>
<tr>
<th>Role</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Executive</td>
<td>Implement and monitor the trust’s Sustainable Development Management Plan</td>
</tr>
<tr>
<td>Director of Finance</td>
<td>Review of compliance with environmental regulations, for example those relating to clean air and waste disposal</td>
</tr>
<tr>
<td>Director of Finance</td>
<td>Develop and approve a Sustainable Development Management Plan which sets out clear and measurable milestones to measure, monitor and reduce direct carbon emissions</td>
</tr>
</tbody>
</table>

### 37. CONTRACTUAL ARRANGEMENTS

<table>
<thead>
<tr>
<th>Role</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Director of Finance</td>
<td>Monitor proposals for contractual arrangements between the trust and outside bodies</td>
</tr>
</tbody>
</table>

### 38. GENERAL DATA PROTECTION AND REGULATION (GDPR) / INFORMATION GOVERNANCE

<table>
<thead>
<tr>
<th>Role</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Director of Corporate Affairs &amp; Governance</td>
<td>Role of Senior Information Risk Owner (SIRO)</td>
</tr>
<tr>
<td>Role</td>
<td>Task</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Director of Corporate Affairs &amp; Governance</strong></td>
<td>Developing Information Sharing Protocols (as appropriate) with partner agencies including approval of Information Sharing Agreements</td>
</tr>
<tr>
<td><strong>Director of Corporate Affairs and Governance</strong></td>
<td>Establish a system for monitoring compliance against the Data Security and Protection Toolkit</td>
</tr>
<tr>
<td><strong>Director of Corporate Affairs and Governance</strong></td>
<td>Ensure all employees undertake the data security and protection training module on an annual basis</td>
</tr>
<tr>
<td><strong>Director of Corporate Affairs and Governance</strong></td>
<td>Develop, maintain and implement the trust’s Data Protection and Confidentiality policy</td>
</tr>
<tr>
<td><strong>Director of Corporate Affairs and Governance</strong></td>
<td>Review of trust’s compliance with the GDPR and the Data Protection Act</td>
</tr>
<tr>
<td><strong>Director of Corporate Affairs and Governance</strong></td>
<td>Compliance with the requirements of GDPR and the Data Protection Act (including protecting patients / person identifiable data)</td>
</tr>
<tr>
<td><strong>Head of Integrated Governance</strong></td>
<td>Act as the role of Data Protection Officer ensuring the requirements of GDPR and the Data Protection Act (including protecting patients / person identifiable data) is adhered to.</td>
</tr>
<tr>
<td><strong>Medical Director Delegated to Associate Director for Clinical Effectiveness</strong></td>
<td>Act as the role of Caldicott Guardian</td>
</tr>
<tr>
<td><strong>GMC</strong></td>
<td>Responsible Officer for GMC  <a href="https://example.com">click here</a> for full details on the Role and Statutory Responsibilities of the Responsible Officer as set out by the General Medical Council</td>
</tr>
<tr>
<td><strong>NURSING &amp; MEDICAL ADVICE</strong></td>
<td>Provision of Nursing Advice to the Board</td>
</tr>
<tr>
<td><strong>Medical Director</strong></td>
<td>Provision of Medical Advice to the Board</td>
</tr>
<tr>
<td><strong>Medical Director</strong></td>
<td>Designated individual for Human Tissue Authority regulations</td>
</tr>
<tr>
<td><strong>SAFEGUARDING</strong></td>
<td>Comply with statutory requirements and policies and procedures for safeguarding children</td>
</tr>
<tr>
<td><strong>Chief Executive</strong></td>
<td>Comply with statutory requirements and policies and procedures for safeguarding vulnerable adults</td>
</tr>
<tr>
<td><strong>Director of Nursing and Quality</strong></td>
<td>Board Lead for applicable Mental Health Regulations</td>
</tr>
<tr>
<td>****</td>
<td>Board lead for safeguarding children and adults, discharging duties of the Board</td>
</tr>
<tr>
<td>Role</td>
<td>Responsibility</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>-------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Deputy Director of Nursing and Quality</td>
<td>To act as the Local Authority Designated Officer (LADO)</td>
</tr>
<tr>
<td>Director of Nursing and Quality</td>
<td>Ensure compliance with statutory requirements and policies and procedures for safeguarding children</td>
</tr>
<tr>
<td>Director of Nursing and Quality</td>
<td>Ensure compliance with statutory requirements and policies and procedures for safeguarding vulnerable adults</td>
</tr>
<tr>
<td>Deputy Director of Nursing and Quality</td>
<td>To act as the lead for PREVENT</td>
</tr>
</tbody>
</table>

### 42. FREEDOM OF INFORMATION

- **Chief Executive**: Identified as Qualified Person for Freedom of Information Requests
  - **Notes**: N/A

- **Director of Corporate Affairs and Governance**: Set up a system to monitor freedom of information requests received, responded to within timescales and where exemptions apply
  - **Notes**: SFI 15.5.1

- **Director of Corporate Affairs and Governance**: Development of Freedom of Information Act policies and the trust’s Publication Scheme in accordance with statute and guidance
  - **Notes**: SFI 15.5.1

- **Director of Corporate Affairs and Governance**: Publish and maintain a Freedom of Information publication scheme
  - **Notes**: SFI 15.5.2

- **Director of Corporate Affairs and Governance delegated to Claims Manager**: Freedom of Information Appeals Officer

### 43. EDUCATION AND TRAINING

- **Director of Human Resources and Organisational Development**: Responsibility for development and Provision of Education and Training
  - **Notes**: N/A

### 44. RAISING CONCERNS AT WORK (Speaking Up) and Duty of Candour

- **Chief Executive**: To provide the Board with feedback on the Speaking Up process and concerns raised
  - **Notes**: C2

- **Director of Corporate Affairs and Governance**: Executive Lead - ensuring robust processes are in place for concerns to be raised and investigated
  - **Notes**: C2

- **Deputy Director of Corporate Affairs and Governance**: To act as the Freedom to Speak Up Guardian

- **Director of Corporate Affairs and Governance**: Develop and implement a policy relating to Duty of Candour

- **Medical Director**: Approval of any deviations from the Duty of Candour process
### 45. CLINICAL EFFECTIVENESS and Clinical Strategy

<table>
<thead>
<tr>
<th>Role</th>
<th>Responsibility</th>
<th>Lead/Manager</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Director</td>
<td>Develop strategy and policy for clinical audit</td>
<td>N/A</td>
</tr>
<tr>
<td>Medical Director</td>
<td>Develop, Implement and monitor the clinical audit programme</td>
<td>N/A</td>
</tr>
<tr>
<td>Medical Director</td>
<td>Adhering and contributing to the clinical audit policy and programme(s)</td>
<td>N/A</td>
</tr>
<tr>
<td>Director of Nursing &amp; Quality</td>
<td>Quality assurance on key national screening programmes</td>
<td>N/A</td>
</tr>
<tr>
<td>Medical Director</td>
<td>End of Life Care</td>
<td>N/A</td>
</tr>
<tr>
<td>Medical Director</td>
<td>Ensure there is clinical leadership and engagement in the development of the clinical strategy</td>
<td>N/A</td>
</tr>
</tbody>
</table>

### 46. MENTAL HEALTH ACT ADMINISTRATION SERVICE

<table>
<thead>
<tr>
<th>Role</th>
<th>Responsibility</th>
<th>Lead/Manager</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Executive</td>
<td>Responsibility for provision of the Mental Health Act Administration Service</td>
<td>N/A</td>
</tr>
<tr>
<td>Director of Nursing and Quality</td>
<td>Compliance with Mental Health Act regulatory requirements</td>
<td>N/A</td>
</tr>
</tbody>
</table>

### 47. Non Executive Lead Responsibilities

<table>
<thead>
<tr>
<th>Role</th>
<th>Responsibility</th>
<th>Lead/Manager</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr P Madden</td>
<td>Safeguarding</td>
<td>N/A</td>
</tr>
<tr>
<td>Mr I Goalen</td>
<td>Emergency Preparedness, Resilience and Response</td>
<td>N/A</td>
</tr>
<tr>
<td>Mr M Willdig</td>
<td>Procurement</td>
<td>N/A</td>
</tr>
<tr>
<td>Mrs L McGill (Chairman)</td>
<td>Equality &amp; Diversity &amp; Freedom to Speak Up</td>
<td>N/A</td>
</tr>
<tr>
<td>Ms A Harrison</td>
<td>Mortality and Health &amp; Safety</td>
<td>N/A</td>
</tr>
</tbody>
</table>

### 48. FUNDS HELD ON TRUST

<table>
<thead>
<tr>
<th>Role</th>
<th>Responsibility</th>
<th>Lead/Manager</th>
</tr>
</thead>
</table>
| Charitable Funds Committee / Director of Finance | Investments:  
- Nominating deposit taker  
- Placing transactions | N/A          |
| Director of Corporate Services | To ensure safe and appropriate systems are in place to support fundraising for the ECHO Charity | N/A          |
| Director of Finance          | Management:  
- Funds held on trust are managed appropriately  
- Maintenance of authorised signatory list of nominated fund holder  
- Expenditure Limits  
- Dealing with Legacies | N/A          |
| Director of Finance          | Fundraising Appeals:  
- Preparation and monitoring of budget  
- Reporting progress and performance against budget | N/A          |
<p>| Director of Finance          | Operation of Bank Accounts:                                                   | N/A          |</p>
<table>
<thead>
<tr>
<th>Role</th>
<th>Responsibilities</th>
</tr>
</thead>
</table>
| **Director of Finance** | - Managing banking arrangements and operation of bank accounts  
- Opening bank accounts |
| **Charities Commission** | - Registration of fund(s) with the Charity Commission |
| **49. Professional Leadership** |  |
| **Director of Finance** | **Financial Employees**  
- Provide professional leadership in respect of professional standards, education and training for all of the trust’s financial employees |
| **Director of Nursing and Quality** | **Nursing & Midwifery Professionals**  
- Provide professional leadership in respect of professional standards, education and training for all of the trust’s nursing professionals  
- Ensuring compliance with statutory and regulatory arrangements relating to nursing professionals  
- Quality assurance of nursing professionals processes |
| **Director of Nursing and Quality** | **Allied Health Professionals**  
- Provide professional leadership in respect of professional standards, education and training for all of the trust’s allied health professionals  
- Ensuring compliance with statutory and regulatory arrangements relating to allied health professionals  
- Quality assurance of allied health professionals processes |
| **Medical Director** | **Medical Professionals**  
- Provide professional leadership in respect of professional standards, education and training for all of the trust’s medical employees  
- Ensuring compliance with statutory and regulatory arrangements relating to medical professionals  
- Quality assurance of medical professionals processes |
<p>| <strong>50. EMERGENCY PLANNING</strong> |  |
| <strong>Director of Corporate Affairs and Governance</strong> | <strong>Accountable Officer for Emergency Planning</strong> |
| <strong>Director of Corporate Affairs and Governance</strong> | <strong>Deputy Director of Corporate Affairs and Governance</strong> | <strong>Lead for Emergency Planning</strong> |
| <strong>51. VOLUNTEERS</strong> |  |
| <strong>Director of Corporate Affairs and Governance</strong> | <strong>Monitoring of Volunteer Contract</strong> |
| <strong>52. POLICY GOVERNANCE</strong> |  |</p>
<table>
<thead>
<tr>
<th>Director of Corporate Affairs and Governance</th>
<th>To ensure robust processes are in place for policy governance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Director of Corporate Affairs and Governance</td>
<td>Develop policies and procedures to ensure Policies, procedures and plans are in a consistent format, and regularly reviewed / approved.</td>
</tr>
<tr>
<td>53. NHS PERFORMANCE STANDARDS</td>
<td></td>
</tr>
<tr>
<td>Chief Operating Officer</td>
<td>Delivery of the NHS operational key performance standards</td>
</tr>
</tbody>
</table>
## 5. DELEGATED FINANCIAL LIMITS

<table>
<thead>
<tr>
<th>Level of Authority</th>
<th>Authority Delegated to</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>Administrator</td>
</tr>
<tr>
<td>7</td>
<td>Budget Holder</td>
</tr>
<tr>
<td>6</td>
<td>Service Manager, including senior finance staff</td>
</tr>
<tr>
<td>5</td>
<td>Associate Director</td>
</tr>
<tr>
<td>4</td>
<td>Deputies (excluding Deputy Director of Finance)</td>
</tr>
<tr>
<td>3</td>
<td>Executive (excluding Director of Finance)</td>
</tr>
<tr>
<td>2</td>
<td>Director of Finance and Deputy Director of Finance</td>
</tr>
<tr>
<td>1</td>
<td>Chief Executive and Deputy Chief Executive</td>
</tr>
</tbody>
</table>

### AUTHORITY DELEGATED TO | FINANCIAL LIMITS | REFERENCE DOCUMENTS
---|-------------------|------------------|
1. Non Pay Revenue & Capital Expenditure/Requisitioning/Ordering/Payment of Goods & Services

<p>| Level 8 – Administrator | Non Purchase Order invoice, Stock / non stock requisitions up to £1,000 | SFIs Section 9 |
| Level 7 – Budget Holder | Non Purchase Order invoice, Stock / non stock requisitions up to £5,000 | SFIs Section 9 |
| Level 6 – Service Manager, including senior finance staff | Non Purchase Order invoice, Stock / non stock requisitions up to £15,000 | SFIs Section 9 |
| Level 5 – Associate Directors | Non Purchase Order invoice, Stock / non stock requisitions up to £30,000 | SFIs Section 9 |
| Level 4 – Deputies (excluding Deputy Director of Finance) | Non Purchase Order invoice, Stock / non stock requisitions up to £74,999 | SFIs Section 9 |
| Level 3 – Executive (excluding Director of Finance) | Non Purchase Order invoice, Stock / non stock requisitions over £74,999 | SFIs Section 9 |
| Level 2 - Director of Finance and Deputy Director of Finance | Non Purchase Order invoice, Stock / non stock requisitions up to £999,999 | SFIs Section 9 |
| Level 1 - Chief Executive and Deputy Chief Executive | Non Purchase Order invoice, Stock / non stock requisitions over £1,000,000 | SFIs Section 9 |
| Executive Director or Head of Pharmacy | Pharmacy orders up to £74,999 | SFIs Section 9 |</p>
<table>
<thead>
<tr>
<th>AUTHORITY DELEGATED TO</th>
<th>FINANCIAL LIMITS</th>
<th>REFERENCE DOCUMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Executive or Director of Finance</td>
<td>Pharmacy orders over £75,000 to £249,999</td>
<td>SFIs Section 9</td>
</tr>
<tr>
<td>Chief Executive and Director of Finance or Deputy Director of Finance</td>
<td>Non-Pay Expenditure for which no specific budget has been set up and which is not subject to funding under delegated powers of virement. (Subject to the limits specified above)</td>
<td>SFIs Section 9</td>
</tr>
<tr>
<td>Director of Finance or Chief Executive</td>
<td>Orders exceeding 12 month period excluding service and utilities contracts</td>
<td>SFIs Section 9</td>
</tr>
<tr>
<td>Tier 2 budget holder</td>
<td>All contracts for goods &amp; services and subsequent variations to contracts</td>
<td>SFIs Section 9</td>
</tr>
</tbody>
</table>

2. Quotation, Tendering & Contract Procedures

<table>
<thead>
<tr>
<th>Head of Procurement</th>
<th>a) Obtaining price information for goods and services up to £5,000</th>
<th>SFIs Section 18 / Appendix C3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head of Procurement</td>
<td>b) Inviting a minimum of 3 written quotations where appropriate for goods/services £5,000 up to £50,000</td>
<td>SFIs Section 18 / Appendix C3</td>
</tr>
<tr>
<td>Chief Executive or Designated Officer</td>
<td>c) Obtaining written competitive tenders for goods/services over £50,000 up to EU threshold</td>
<td>SFIs Section 18 / Appendix C3</td>
</tr>
<tr>
<td>Chief Executive or Director of Finance, Director of Human Resources as appropriate</td>
<td>d) Waivering of quotations &amp; Tenders subject to SFIS - Also see guidance in C7</td>
<td>SFIs Section 18 / Appendix C3</td>
</tr>
<tr>
<td>Supplies Manager or Deputy Supplies Manager</td>
<td>e) Opening quotations / tenders between the value of £5,001 and £50,000</td>
<td>SFIs Section 18 / Appendix C3</td>
</tr>
<tr>
<td>Two Executive Directors</td>
<td>f) Opening tenders</td>
<td>SFIs Section 18 / Appendix C3</td>
</tr>
</tbody>
</table>

3. Business Case Approval

<table>
<thead>
<tr>
<th>Chief Executive/Deputy CEO</th>
<th>a) Approval of business cases for individual schemes up to £250,000 (It would be expected that decisions are communicated to CMB)</th>
<th>SFIs Section 18 / Appendix C3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Executive</td>
<td>b) Approval of business cases relating to engagement of consultants above £50k prior to submission to NHS Improvement - See C7</td>
<td>SFIs Section 18 / Appendix C3</td>
</tr>
<tr>
<td>Chief Executive in conjunction with Clinical Management Board</td>
<td>c) Approval of business cases for individual schemes between £250,000 and £1m, within the overall capital budget</td>
<td>SFIs Section 18 / Appendix C3</td>
</tr>
<tr>
<td>AUTHORITY DELEGATED TO</td>
<td>FINANCIAL LIMITS</td>
<td>REFERENCE DOCUMENTS</td>
</tr>
<tr>
<td>------------------------</td>
<td>------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>4. <strong>Engagement of Staff Not On the Establishment</strong> To include Management consultants (including professional services) and agency staff Budget holders have a responsibility to manage resources</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Executive Director a) Where aggregate commitment in any one year (or total commitment) is less than £74,999</td>
<td>SFIs Section 8</td>
<td></td>
</tr>
<tr>
<td>Chief Executive or Director of Finance b) Where aggregate commitment in any one year is more than £74,999</td>
<td>SFIs Section 8</td>
<td></td>
</tr>
<tr>
<td>Chief Executive or Executive Director c) Engagement of trust's Solicitors</td>
<td>SFIs Section 8</td>
<td></td>
</tr>
<tr>
<td>As per trust policy d) Booking of Bank, Locums or Agency Staff Medical Locums Nursing Clerical</td>
<td>SFIs Section 8</td>
<td></td>
</tr>
</tbody>
</table>

| 5. **Condemning & Disposal** Items obsolete, redundant or cannot be repaired cost effectively | | |
| In all instances the Estates Manager must be consulted prior to condemnation / disposal. The Asset Register must be updated with changes | | |
| Director of Finance a) Condemnation of equipment | SFIs Section 13 |
| Head of Integrated Governance b) disposal of x-ray films (subject to estimated income of £1,000 per sale) | SFIs Section 13 |
| Head of Estates c) disposal of mechanical and engineering plant (subject to estimated income of less than £1,000 per sale) | SFIs Section 13 |
| Head of Estates d) disposal of mechanical and engineering plant (subject to estimated income exceeding £1,000 per sale) | SFIs Section 13 |

<p>| 6. <strong>Losses, Write-off &amp; Compensation</strong> | | |
| Chief Executive or Director of Finance a) Losses and Cash due to theft, fraud, overpayment &amp; others i) Up to £50,000 | SFIs Section 13 |
| Chief Executive or Director of Finance b) Fruitless Payments (including abandoned Capital Schemes) Up to £250,000 | SFIs Section 13 |
| Deputy Director of Finance c) Bad Debts and Claims Abandoned. Private Patients, Overseas Visitors &amp; Other i) Up to £25,000 ii) £25,001 to 50,000 | SFIs Section 13 |
| Chief Executive or Director of Finance d) Damage to buildings, fittings, furniture and equipment and loss of equipment and property in stores and in use due to: i) Culpable causes (e.g. fraud, theft, arson) or other b. Up to £50,000 | SFIs Section 13 |</p>
<table>
<thead>
<tr>
<th>AUTHORITY DELEGATED TO</th>
<th>FINANCIAL LIMITS</th>
<th>REFERENCE DOCUMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Executive or Director of Finance / Director of Human Resources and Organisational Development (for HR issues)</td>
<td>e) Compensation payments made under legal obligation up to £50,000</td>
<td>SFIs Section 13</td>
</tr>
<tr>
<td>Chief Executive or Director of Finance / Remuneration Committee and Director of Human Resources Organisational Development (for HR issues)</td>
<td>f) Extra Contractual payments to contractors up to £50,000</td>
<td>SFIs Section 13</td>
</tr>
</tbody>
</table>
| Deputy Director of Finance Chief Executive or Director of Finance [Reported to Audit Committee for information] | g) Write off of NHS Debtors  
  i) up to £25,000  
  ii) over £25,000 | SFIs Section 13 |
| Deputy Director of Finance Chief Executive or Director of Finance [Reported to Audit Committee for information] | h) Write off of Non NHS Debtors  
  i) up to £25,000  
  ii) over £25,000 | SFIs Section 13 |
| Director of Corporate Affairs and Governance/Deputy Director of Finance  
Chief Executive or Director of Finance (reported to Audit Committee) | i) Ex-Gratia Payments  
  i) Patients and staff for loss of personal effects up to £50,000  
  ii) Patients and staff for loss of personal effects > £50,000 | SFIs Section 13 |
| 7. Litigation | a) For clinical negligence  
  i. up to £1,000,000 (negotiated settlements)  
  ii. Over £1,000,000 | SFIs Section 13 |
| Chief Executive or Director of Finance Chief Executive | b) For personal injury claims involving negligence where legal advice has been obtained and guidance applied  
  i. Up to £1,000,000 (including plaintiff's costs)  
  ii. Over £1,000,000 | SFIs Section 13 |
<table>
<thead>
<tr>
<th>AUTHORITY DELEGATED TO</th>
<th>FINANCIAL LIMITS</th>
<th>REFERENCE DOCUMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Executive or Director of Finance</td>
<td>c) Other, except cases of maladministration where there was no financial loss by claimant (up to £50,000)</td>
<td>SFI's Section 13</td>
</tr>
</tbody>
</table>

8. Petty Cash Disbursements (not applicable to central Cashiers Office)

<table>
<thead>
<tr>
<th>Senior Finance Staff</th>
<th>a) Expenditure up to £25 per item</th>
<th>SFIs Section 9</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>b) Reimbursement of patients monies up to £100</td>
<td></td>
</tr>
<tr>
<td></td>
<td>c) Reimbursement of patients monies in excess of £100</td>
<td></td>
</tr>
</tbody>
</table>

9. Authorisation of New Drugs

<table>
<thead>
<tr>
<th>Clinical Director/Head of Pharmacy</th>
<th>Estimated total yearly cost up to £25,000</th>
<th>SFI's Section 9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicines Management Committee and Clinical Director and Director of Finance</td>
<td>Estimated total yearly cost above £25,000</td>
<td>SFI's Section 9</td>
</tr>
</tbody>
</table>

10. Virement (in year transfer between budget lines)

<table>
<thead>
<tr>
<th>Deputy Chief Executive or Deputy Director of Finance</th>
<th>Virement within a service area budget up to £10,000 per annum so long as service area budget remains underspent</th>
<th>SOs Section 3.2 and 3.3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Director of Finance</td>
<td>Virement between budgets up to £50,000 so long as the trust budget remains in line with plan</td>
<td>SOs Section 3.2 and 3.3</td>
</tr>
<tr>
<td>Chief Executive with Director of Finance</td>
<td>Virement between budgets over £50,000 so long as the trust budget remains in line with plan</td>
<td>SOs Section 3.2 and 3.3</td>
</tr>
</tbody>
</table>
Standing Financial Instructions
FOREWARD

The Board operates within a statutory framework within which it is required to adopt Standing Orders. The "Directions on Financial Management in England" issued under HSG(96)12 in 1996 states that the Board must adopt Standing Financial Instructions (SFIs) setting out the responsibilities of individuals. NHS trusts are asked to observe the Directions as far as they are relevant as a matter of good practice.

The Code of Accountability for NHS Boards (published by the Department of Health in April 1994, EL(94)40) requires Boards to draw up standing orders, a schedule of decisions reserved to the Board and standing financial instructions. The code also requires Boards ensure that there are management arrangements in place to enable responsibility to be clearly delegated to senior executives. Additionally, Boards will have drawn up locally generated rules and instructions, including financial procedural notes, for use within their organisation. Collectively these must comprehensively cover all aspects of (financial) management and control. In effect, they set the business rules which directors and employees (including employees of third parties contracted to the trust) must follow when taking action on behalf of the Board.

Once SFIs have been adopted by the Board they become mandatory on all directors and employees of the organisation.
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9 TERMS OF SERVICE AND PAYMENT OF DIRECTORS AND EMPLOYEES

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21 IN HOUSE SERVICES

22 ACCEPTANCE OF GIFTS BY STAFF AND LINK TO STANDARDS OF BUSINESS CONDUCT
1 INTRODUCTION

1.1 GENERAL

1.1.1 These Standing Financial Instructions (SFIs) are issued in accordance with the Financial Directions issued by the Secretary of State for Health & Social Care - under the provisions of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) and the National Health Service and Community Care Act 1990 (as amended and the Health and Social Care Act 2008) - for the regulation of the conduct of the trust in relation to all financial matters. They shall have effect as if incorporated in the Standing Orders (SOs) of the trust.

1.1.2 These SFIs detail 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 the law and Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Schedule of Decisions Reserved to the Board and the Scheme of Delegation adopted by the trust.

1.1.3 These SFIs identify the financial responsibilities which apply to everyone working for the trust and its constituent organisations including Trading Units. They do not provide detailed procedural advice. These statements should therefore be read in conjunction with the detailed departmental and financial procedure notes. All financial procedures must be approved by the Director of Finance.

1.1.4 Should any difficulties arise regarding the interpretation or application of any of the SFIs then the advice of the Director of Finance (Must be sought before acting). The user of these SFIs should also be familiar with and comply with the provisions of the trust’s SOs.

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

1.2 TERMINOLOGY

1.2.1 Any expression to which a meaning is given in Health Service Acts, or in the Financial Directions made under the Acts, shall have the same meaning in these instructions; and

(a) "Board" means the Board of the trust;

(b) "Budget" means a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the trust;

(c) "Budget Holder" means the director or employee with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisation; and

(d) "Chief Executive" means the chief officer of the trust;
(e) "Director of Finance" means the chief financial officer of the trust;

(f) "Funds held on trust" shall mean those funds which the trust holds at 1st April 1996 or date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under powers derived under paragraph 14(2) of Schedule 4 on the NHS Act 2006, as amended. Such funds may or may not be charitable.

(g) "Legal Adviser" means the properly qualified person appointed by the trust to provide legal advice.

(h) "trust" means the East Cheshire NHS trust.

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

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

1.3 RESPONSIBILITIES AND DELEGATION

1.3.1 The Board exercises financial supervision and control by:

(a) formulating the financial strategy;

(b) requiring the submission and approval of budgets within approved allocations/overall income;

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

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

1.3.2 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the 'Reservation of Powers to the Board' document.

1.3.3 The Board will delegate responsibility for the performance of its functions in accordance with the Scheme of Delegation document adopted by the trust.

1.3.4 Within the SFIs, it is acknowledged that the Chief Executive is ultimately accountable to the Board and as accountable officer to the Secretary of State for Health & Social Care, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the trust's activities, is responsible to the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the trust's system of internal control.
1.3.5 **The Chief Executive and Director of Finance** will, as far as possible, delegate their detailed responsibilities but they remain accountable for financial control.

1.3.6 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.

1.3.7 **The Director of Finance** is responsible for:

(a) implementing the trust's financial policies and for co-ordinating any corrective action necessary to further these policies;

(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 trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the trust at any time and, without prejudice to any other functions of directors and employees to the trust, the duties of the Director of Finance include:

(d) the provision of financial advice to the trust and its directors 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 reports as the trust may require for the purpose of carrying out its statutory duties.

(g) All directors and employees, severally and collectively, are responsible for:

(h) the security of the property of the trust;

(i) avoiding loss;

(j) exercising economy and efficiency in the use of resources;

(k) conforming with the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation.

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

(m) 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.
2 AUDIT

2.1 AUDIT COMMITTEE

2.1.1 In accordance with Standing Orders the Board shall formally establish an Audit Committee, with clearly defined terms of reference, which will provide an independent and objective view of internal control by:

(a) overseeing Internal and External Audit services;

(b) reviewing financial systems;

(c) review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation’s activities (both clinical and non-clinical), that supports the achievement of the organisation’s objectives;

(d) monitoring compliance with Standing Orders and Standing Financial Instructions;

(e) reviewing schedules of losses and compensations and making recommendations to the Board.

2.1.2 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. Exceptionally, the matter may need to be referred to NHS Improvement. (To the Director of Finance in the first instance where appropriate, advice should be taken from the trust’s Legal Advisers.)

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

2.2 FRAUD AND CORRUPTION

2.2.1 In line with the trust’s contractual liabilities under the NHS Standards Contract, the Chief Executive and Director of Finance shall monitor and ensure compliance with the requirements of NHS Counter Fraud Authority in relation to fraud, bribery and corruption.

2.2.2 The trust shall nominate a suitable person to carry out the duties of the Local Anti-Fraud Specialist as specified by the NHS Counter Fraud Authority Fraud and Corruption manual and guidance.

2.2.3 The Local Anti-Fraud Specialist shall report to the trust Director of Finance and work with staff of NHS Counter Fraud Authority and requirements of the Fraud, Bribery and Corruption Manual.

2.2.4 The Local Anti-Fraud Specialist will provide a written report, at least annually, on anti-fraud and corruption work within the trust.
2.2.5 The Bribery Act came into force in April 2011. The Act made it a criminal offence for commercial organisations to fail to prevent bribes being paid on their behalf. Organisations which fail to take appropriate steps to avoid (or at least minimise) the risk of bribery taking place will face large fines and even the imprisonment of the individuals involved and those who have turned a blind eye to the problem.

2.2.6 The Act covers the following areas:

(a) make it a criminal offence to give or offer a bribe, or to request, offer to receive or accept a bribe, whether in the UK or abroad (the measures cover bribery of a foreign public official);

(b) make it an offence for a director, manager or officer of a business to allow or turn a blind eye to bribery within the organisation; and

(c) introduce a corporate offence of failure to prevent bribery by persons working on behalf of a commercial organisation.

However, organisations will have a defence against prosecution if they can show that they have adequate procedures in place to prevent bribery.

2.2.7 The trust will undertake a periodic assessment of their compliance against the Bribery Act 2010 requirements.

2.3 DIRECTOR OF FINANCE

2.3.1 The Director of Finance is responsible for:

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

(b) ensuring that the internal audit is adequate and meets the NHS mandatory audit standards;

(c) deciding at what stage to involve the police in cases of misappropriation and other irregularities;

(d) ensuring that an annual Director of Audit opinion is prepared for the consideration of the Audit Committee and the Board. The report must cover

i) a clear statement on the effectiveness of internal control, in accordance with guidance issued by the Department of Health (or relevant regulatory body) including for example compliance with control criteria and standards,

j) major internal financial control weaknesses discovered,

k) progress on the implementation of internal audit recommendations,

l) progress against plan over the previous year,

m) strategic audit plan covering the coming three years,

n) a detailed plan for the coming year.
2.3.2 The Director of Finance or designated auditors are 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 or employee of the trust;

c) the production of any cash, stores or other property of the trust under an employee's control; and

d) explanations concerning any matter under investigation.

2.4 ROLE OF INTERNAL AUDIT

2.4.2 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 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) In accordance with guidance from the Department of Health, Internal Audit will independently verify the Assurance Statements.

2.4.3 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 must be notified immediately.

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

2.4.5 The Head of Internal Audit shall be accountable to the Director of Finance. The reporting system for internal audit shall be agreed between the Director of Finance, the Audit Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the Public Sector Internal Audit Standards. The reporting system shall be reviewed at least every 3 years.
2.5 EXTERNAL AUDIT

2.5.2 The external auditor is appointed by the by the trust. The Audit Committee must ensure a cost-efficient service. Should there appear to be a problem, then this should be raised with the external auditor and referred on to the Public Sector Audit Appointments Ltd if the issue cannot be resolved.

2.6 DIRECTOR OF CORPORATE AFFAIRS & GOVERNANCE

2.6.2 The Director of Corporate Affairs & Governance is responsible for monitoring progress on the implementation of internal and external recommendations.

2.6.3 The Director of Corporate Affairs & Governance will investigate any suspected cases of irregularity not related to fraud, bribery or corruption and not covered by work of the local anti fraud specialist, bribery and corruption (in accordance with Department of Health guidance and NHS Counter Fraud Authority).

3 BUSINESS PLANNING, BUDGETS, BUDGETARY CONTROL AND MONITORING

3.3 PREPARATION AND APPROVAL OF BUSINESS PLANS AND BUDGETS

3.3.2 The Chief Executive will compile and submit to the Board an Annual Plan which takes into account financial targets and forecast limits of available resources. The Annual Plan will contain:

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

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

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

   a) be in accordance with the aims and objectives set out in the Annual Plan;

   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; and

   e) identify potential risks.

3.3.4 The Director of Finance shall monitor financial performance against budget and business plan, periodically review them, and report to the Board.

3.3.5 All budget holders must provide information as required by the Director of Finance to enable budgets to be compiled.
3.3.6 The Director of Finance has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage their budgets successfully.

3.4 BUDGETARY DELEGATION

3.4.2 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 virement;
e) achievement of planned levels of service; and
f) the provision of regular reports.

3.4.3 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board.

3.4.4 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

3.4.5 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive.

3.5 BUDGETARY CONTROL AND REPORTING

3.5.2 The Director of Finance will devise and maintain systems of budgetary control. These will include:

a) monthly financial reports to the Board in a form approved by the Board containing:
   i) income and expenditure to date showing trends and forecast year-end position;
   ii) movements in working capital;
   iii) capital project spend and projected outturn against plan;
   iv) explanations of any material variances from plan;
   v) details of any corrective action where necessary and the Chief Executive's and/or Director of Finance'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, workload and manpower budgets;

d) monitoring of management action to correct variances; and

e) arrangements for the authorisation of budget transfers.

3.5.3 Each service area Manager/Head of Department is responsible for ensuring that:

a) any likely overspending or reduction of income within the year which cannot be met by virement is not incurred without the prior consent of the Board;

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

c) no permanent employees are appointed without the approval of the Chief Executive other than those provided for in the budgeted establishment as approved by the Board.

3.5.4 The Chief Executive is responsible for identifying a process for implementing cost improvements and income generation initiatives in accordance with the requirements of the Annual Plan and a balanced budget.

3.6 CAPITAL EXPENDITURE

3.6.2 The general rules applying to delegation and reporting shall also apply to capital expenditure. (The particular applications relating to capital are contained in Chapter 12.)

3.7 MONITORING RETURNS

3.7.2 The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to the requisite monitoring organisation

4 ANNUAL ACCOUNTS AND REPORTS INTRODUCTION

4.3 The Director of Finance, on behalf of the trust, will:

a) prepare financial returns in accordance with the accounting policies and guidance given by the Department of Health and the Treasury, the trust’s accounting policies, and generally accepted accounting practice;

b) prepare and submit annual financial reports to the Department of Health certified in accordance with current guidelines; and

c) submit financial returns to the Secretary of State for Health & Social Care for each financial year in accordance with the timetable prescribed by the Department of Health.
4.4 The trust’s annual accounts must be audited by an auditor appointed by the Public Sector Audit Appointments Ltd. The trust's audited annual accounts must be presented to a public meeting.

4.5 The trust will produce an annual quality report, which will be audited by an auditor appointed by the Public Sector Audit Appointments Ltd and submitted to the Department of Health.

4.6 The trust will publish an annual report, in accordance with guidelines on local accountability, and present it at a public meeting, (See EL(94)40). The document will comply with the Department of Health's Group Manual for Accounts.

5 BANK ACCOUNTS

5.1 GENERAL

5.1.1 The Director of Finance is responsible for managing the trust's banking arrangements and for advising the trust on the provision of banking services and operation of accounts. This advice will take into account guidance/Directions issued from time to time by the Department of Health. In line with ‘Cash Management in the NHS’, trusts should minimise the use of commercial bank accounts and use Government Banking Services for all banking requirements.

5.1.2 The Board shall approve the banking arrangements.

5.2 BANK ACCOUNTS

5.2.1 The Director of Finance is responsible for:

a) bank accounts;

b) establishing separate bank accounts for the trust's non-exchequer funds;

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

d) reporting to the Board all arrangements made with the trust's bankers for accounts to be overdrawn;

e) monitoring compliance with DH guidance on the level of cleared funds.

5.3 BANKING PROCEDURES

5.3.1 The Director of Finance will prepare detailed instructions on the operation of 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 trust's accounts.

5.3.2 The Director of Finance must advise the trust's bankers in writing of the conditions under which each account will be operated.
5.4  TENDERING AND REVIEW

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

5.4.2 Competitive tenders should be sought at least every 5 years. The results of the tendering exercise should be reported to the Board. This review is not necessary for bank accounts prescribed by the Government Banking Service.

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

6.1  INCOME SYSTEMS

6.1.1 The Director of Finance is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due. In terms of prescription charges only the use of a letter is an acceptable method of income collection where it is not cost effective to raise an invoice.

6.1.2 The Director of Finance is also responsible for the prompt banking of all monies received.

6.2  FEES AND CHARGES

6.2.1 The trust shall follow NHS Improvement’s Payment by Results guidance in setting prices for Commissioner contracts, where applicable.

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

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

6.3  DEBT RECOVERY

6.3.1 The Director of Finance is responsible for the appropriate recovery action on all outstanding debts.

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

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

6.4  SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

6.4.1 The Director of Finance 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;

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 trust.

6.4.2 Official money shall not under any circumstances be used for the encashment of private cheques.

6.4.3 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Director of Finance.

6.4.4 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 trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the trust from responsibility for any loss.

6.4.5 Any loss or shortfall of cash, cheques or other negotiable instruments, however occasioned, shall be reported immediately to the Director of Finance. Where there is prima facie evidence of fraud or corruption this should follow the form of the trust’s Anti Fraud, Bribery and Corruption Policy & Response Plan and the guidance provided by the Anti-Fraud Specialist.

Where there is no evidence of fraud or corruption the loss should be dealt with in line with the trust’s Losses and Special Payments Procedures

6.4.6 The Money Laundering Regulations 2007 require that the trust does not, under any circumstances, accept exchequer cash payments in excess of EUR10,000 (2018 regulations) in respect of any single transaction or several transactions which appear to be linked. Any attempts by an individual to effect payment above this amount should be notified immediately to the Director of Finance.

Furthermore, any patient or service user depositing in excess of £500 for safekeeping with the trust will be notified to the Director of Finance in his capacity as Corporate Appointee and Bailee

7 CONTRACTING FOR PROVISION OF SERVICES

7.1 The Chief Executive is responsible for negotiating contracts for the provision of services to patients in accordance with the Business Plan, and for establishing the arrangements for providing extra-contractual services. In carrying out these functions, the Chief Executive should take into account the advice of the Director of Finance regarding:

(a) costing and pricing of services;

(b) payment terms and conditions; and

(c) amendments to contracts and extra-contractual arrangements.
7.2 Contracts should be so devised as to minimise risk whilst maximising the trust's opportunity to generate income. Contract prices shall comply with payment by results and costing for contracting guidance.

7.3 The Director of Finance shall produce regular reports detailing actual and forecast contract income [linked to contract activity] with a detailed assessment of the impact of the variable elements of income.

7.4 Any pricing of contracts at marginal cost must be undertaken by the Director of Finance and reported to the Board.

7.5 All contracts should aim to implement the agreed priorities contained within the trust plan 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:

(a) the standards of service quality expected;
(b) the relevant national service framework (if any);
(c) the provision of reliable information on cost and volume of services;
(d) the NHS National Performance Assessment Framework;

\[1\text{ Statutory Instrument 2007 No. 2157}\]

(e) that contracts build where appropriate on existing Joint Investment Plans;
(f) that contracts are based on integrated care pathways.

7.6 INVOLVING PARTNERS AND JOINTLY MANAGING RISK

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

7.7 REPORTS TO BOARD ON CONTRACTS

7.7.1 The Chief Executive, as the Accountable Officer, will need to ensure that regular reports are provided to the Board detailing actual and forecast income from the contract. This will include information on costing arrangements, which increasingly should be based upon Healthcare Resource Groups (HRGs). Where HRGs are unavailable for specific services, all parties should agree a common currency for application across the range of contracts.
COMPETING FOR CONTRACTS FOR PROVISION OF SERVICES

8.1 CONTRACTS

8.1.1 The Chief Executive, as the Accountable Officer, is responsible for ensuring the trust enters into suitable contracts and considering the extent to which mandatory NHS Standard Contract Conditions (or equivalent) are applicable. In discharging this responsibility, the Chief Executive should take into account:

(a) the standards of service quality expected;
(b) the relevant national service framework (if any);
(c) the provision of reliable information on cost and volume of services;
(d) that contracts build, where appropriate, on existing investment plans.

8.1.2 In carrying out these functions the Chief Executive should take into account the advice of the Executive Director of Finance regarding the costing of services, payment terms and conditions, and amendments to service and financial frameworks and contracts.

8.1.3 Any costing relating to the involvement of the trust in a tender process or bid for additional external income must be undertaken by the Director of Finances’ staff.

8.1.4 In deciding whether to bid for contracts, the Chief Executive shall prepare and regularly review a Standard Operating Procedure (S.O.P.) for ensuring that decisions follow a strategic and logical framework and that bids are made in an appropriate and timely manner (C4 contains the current S.O.P.)

8.2 INVOLVING PARTNERS AND JOINTLY MANAGING RISK

8.2.1 The Chief Executive should ensure that the trust works, within the constraints of the tender process, with all partner agencies/ bodies involved in both the delivery and the commissioning of the service required.

8.2.2 Where partner agencies/bodies are involved the contract should apportion responsibility for handling a particular risk to the party or parties in the best position to influence the event and financial arrangements should reflect this. In this way the trust can jointly manage risk with all interested parties.

8.3 REPORTS TO THE BOARD AND ITS COMMITTEES ON CONTRACTS

8.3.1 The Chief Executive, as the Accountable Officer, will delegate to the Director of Finance, the responsibility to ensure that regular reports are provided to the trust Board or its appropriate committee (currently Finance, Performance & Workforce Committee), detailing the nature of the contract, the forecast income, timescales. The report will also outline potential future tenders expected, as well as recently bid contract
9 TERMS OF SERVICE AND PAYMENT OF DIRECTORS AND EMPLOYEES

9.1 REMUNERATION AND TERMS OF SERVICE

9.1.1 In accordance with Standing Orders the Board shall establish a Remuneration and Terms of Service Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting. (See NHS guidance contained in the Higgs report.)

9.1.2 The Committee will:

(a) advise the Board 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 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 trust - having proper regard to the trust's circumstances and performance and to the provisions of any national arrangements for such staff where appropriate. The Chief Executive will report on the performance of individual Executive Directors.

(c) 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.

9.1.3 The Committee shall report in writing to the Board the basis for its recommendations. The Board 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's meetings should record such decisions.

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

9.1.5 The trust will remunerate the Chairman and Non-executive Directors in accordance with instructions issued by the Secretary of State for Health & Social Care.

9.2 FUNDED ESTABLISHMENT

9.2.1 The manpower plans incorporated within the annual budget will form the funded establishment.

9.2.2 The permanent funded establishment of any department may not be varied without the approval of the Director of Finance.
9.3 STAFF APPOINTMENTS

9.3.1 No director or employee may engage, re-engage, or regrade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration that is outside their approved budget and funded establishment unless authorised to do so by the relevant Executive Director.

9.3.2 The Executive Directors, on behalf of the Board, will approve procedures presented by the Director of Human Resources and Organisational Development or her deputy for the determination of commencing pay rates, condition of service, etc.

9.4 PROCESSING OF PAYROLL

9.4.1 The Director of Human Resources and Organisational Development is responsible for:

(a) specifying timetables for submission of properly authorised time records and other notifications;
(b) the final determination of pay;
(c) making payment on agreed dates; and
(d) agreeing method of payment.

9.4.2 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;
(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 trust.
9.4.3 Appropriately nominated managers have delegated responsibility for:

(a) submitting time records, and other notifications in accordance with agreed timetables;

(b) 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;

(c) 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 Finance must be informed immediately.

9.4.4 Regardless of the arrangements for providing the payroll service, the Director of Finance 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.

9.5 CONTRACTS OF EMPLOYMENT

9.5.1 The Board shall delegate responsibility to the Director of Human Resources and Organisational Development for:

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

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

10 NON PAY EXPENDITURE

10.1 DELEGATION OF AUTHORITY

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

10.1.2 The Director of Finance will set out:

(a) the list of managers who are authorised to place requisitions for the supply of goods and services; and

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

10.1.3 The Director of Finance shall set out procedures on the seeking of professional advice regarding the supply of goods and services.
10.2 CHOICE, REQUISITIONING, ORDERING, RECEIPT AND PAYMENT FOR GOODS AND SERVICES

10.2.1 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 trust. In so doing, the advice of the trust’s adviser on supply shall be sought. Where this advice is not acceptable to the requisitioner, the Director of Finance (and/or the Chief Executive) shall be consulted.

10.2.2 The Director of Finance shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

10.2.3 The Director of Finance will:

(a) advise the Board 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 standing orders and regularly reviewed;

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

(c) be responsible for the prompt 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 certify invoices.

   (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;

       • the account is in order for payment.
(iii) a timetable and system for submission to the Director of Finance of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

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

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

10.2.4 Prepayments are only permitted where exceptional circumstances apply. In such instances:

(a) Prepayments are only permitted where the financial advantages outweigh the disadvantages (i.e., cash flows must be discounted to NPV) and the intention is not to circumvent cash limits;

(b) the appropriate Director 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 trust if the supplier is at some time during the course of the prepayment agreement unable to meet his commitments;

(c) the Director of Finance will need to be satisfied with the proposed arrangements before contractual arrangements proceed; and

(d) the budget holder is responsible for ensuring that all items due under a prepayment contract are received and he/she must immediately inform the appropriate Director or Chief Executive if problems are encountered.

10.2.5 Official Orders must:

(a) be consecutively numbered;

(b) be in a form approved by the Director of Finance;

(c) state the trust's terms and conditions of trade; and

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

10.2.6 Managers must ensure that they comply fully with the guidance and limits specified by the Director of Finance and that:

(a) all contracts [other than for a simple purchase permitted within the Scheme of Delegation or delegated budget], leases, tenancy agreements and other commitments which may result in a liability are notified to the Director of Finance 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 Department of Health;

(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;

(ii) conventional hospitality, such as lunches in the course of working visits;

(e) no requisition/order should be placed for any item or items for which there is no budget provision unless authorised by the Director of Finance on behalf of the Chief Executive;

(f) 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;

(g) 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";

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

(i) goods are not taken on trial or loan in circumstances that could commit the trust to a future uncompetitive purchase;

(j) changes to the list of directors/employees authorised to certify invoices are notified to the Director of Finance;

(k) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Director of Finance; and

(l) petty cash records are maintained in a form as determined by the Director of Finance.

10.2.7 The Director of Finance shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within CONCODE and Part A and Part B of the Health Building Note 00-08. The technical audit of these contracts shall be the responsibility of the relevant Director.

10.2.8 Joint Finance Arrangements with Local Authorities and Voluntary Bodies (see overlap with Standing Order No. 9.4)
10.2.9 Payments to local authorities and voluntary organisations made under the powers of section 28A of the NHS Act 1977 (as amended) shall comply with procedures laid down by the Director of Finance which shall be in accordance with these Acts. (See overlap with Standing Order No. 9.4)

11 BORROWING AND INVESTMENTS

11.1 BORROWING

11.1.1 The Director of Finance will advise the Board of any borrowing arrangements. If the trust experiences cash flow problems it has the option to request a temporary borrowing facility from the Department of Health.

In such circumstances the trust must forecast borrowing requirements in advance and must submit a cash flow forecast for the relevant period.

11.1.2 Any request for temporary borrowing must be authorised by two of the nominated signatories. All such borrowing must be repaid in accordance with the borrowing agreement.

11.1.3 The Director of Finance will advise the Board concerning the trust’s ability to pay dividend on, and repay Public Dividend Capital and any proposed new borrowing, within the limits set by the Department of Health. The Director of Finance is also responsible for reporting periodically to the Board concerning the PDC debt and all loans and overdrafts.

11.1.4 The Board will agree the list of employees (including specimens of their signatures) who are authorised to make short term borrowings on behalf of the trust. This must contain the Chief Executive and the Director of Finance.

11.1.5 The Director of Finance must prepare detailed procedural instructions concerning applications for loans and overdrafts.

11.1.6 All short-term borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position, represent good value for money, and comply with the latest guidance from the Department of Health.

11.1.7 Any short-term borrowing must be with the authority of two members of an authorised panel, one of which must be the Chief Executive or the Director of Finance. The Board must be made aware of all short term borrowings at the next Board meeting.

11.1.8 All long-term borrowing must be consistent with the plans outlined in the current trust plan and be approved by the trust Board.
11.2 INVESTMENTS

11.2.1 Temporary cash surpluses must be held only in such public or private sector investments as notified by the Secretary of State for Health & Social Care and authorised by the Board.

11.2.2 The Director of Finance is responsible for advising the Board on investments and shall report periodically to the Board concerning the performance of investments held.

11.2.3 The Director of Finance will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

11.3 FINANCIAL FRAMEWORK

11.4 The Director of Finance should ensure that members of the Board are aware of the Financial Framework. This document contains directions which the trust must follow. It also contains directions to NHS Improvement regarding resource and capital allocation and funding to trusts. The Director of Finance should also ensure that the direction and guidance in the framework is followed by the trust.

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

12.1 CAPITAL INVESTMENT

12.1.1 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 confirmation of purchaser(s) support where appropriate and the availability of resources to finance all revenue consequences, including capital charges.

12.1.2 For every capital scheme of £0.5m or more the Chief Executive shall ensure:

(a) that a business case (in line with the guidance contained within the Capital Investment Manual) 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; and

(ii) appropriate project management and control arrangements; and
(b) that the Director of Finance has certified professionally to the costs and revenue consequences detailed in the business case.

12.1.3 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of Part A and Part B of the Health Building Note 00-08

The Director of Finance shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

12.1.4 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;
(c) approval to accept a successful tender.
(d) The Chief Executive will issue a scheme of delegation for capital investment management in accordance with Part A and Part B of the Health Building Note 00-08 guidance and the trust's Standing Orders.

12.1.5 The Director of Finance shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.

12.2 PRIVATE FINANCE

12.2.1 The trust should normally test for PFI when considering capital procurement. When the trust proposes to use finance which is to be provided other than through its External Financing Limit, the following procedures shall apply:

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

(b) Where the sum involved exceeds delegated limits, the business case must be referred to the NHS Improvement and/or treated as per current guidelines.

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

12.3 ASSET REGISTERS

12.3.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Director of Finance 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 annually.
12.3.2 The trust shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be as specified in the Group Manual for Accounts as issued by the Department of Health.

12.3.3 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.

12.3.4 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).

12.3.5 The Director of Finance shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

12.3.6 The value of each asset shall be indexed to current values in accordance with methods specified in the Group Manual for Accounts issued by the Department of Health.

12.3.7 The value of each asset shall be depreciated using appropriate methods and rates, consistent with NHS and professional guidance.

12.4 SECURITY OF ASSETS

12.4.1 The overall control of fixed assets is the responsibility of the Chief Executive.

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

12.4.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Director of Finance.

12.4.4 Whilst each employee has a responsibility for the security of property of the 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. Any breach of agreed security practices must be reported in accordance with instructions.

12.4.5 Any damage to the 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.

12.4.6 Where practical, assets should be marked as trust property.

13 STORES AND RECEIPT OF GOODS

13.1.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

(a) kept to a minimum;

(b) subjected to annual stock take;

(c) valued at the lower of cost and net realisable value.

13.1.2 Subject to the responsibility of the Director of Finance 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 him to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Director of Finance. The control of Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of fuel oil to the designated estates manager.

13.1.3 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/Pharmaceutical Officer. Wherever practicable, stocks should be marked as health service property.

13.1.4 The Director of Finance shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

13.1.5 Stocktaking arrangements shall be agreed with the Director of Finance and there shall be a physical check covering all items in store at least once a year.

13.1.6 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Director of Finance.
13.1.7 The designated Manager/Pharmaceutical Officer shall be responsible for a system approved by the Director of Finance 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 any evidence of significant overstocking and of any negligence or malpractice (see also SFI section 13, Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

13.1.8 For goods supplied via the NHS Supply Chain central warehouses, the Chief Executive or nominated officer shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note. Any variation/discrepancy should be notified to the Supplies Department.

14 DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

14.1 DISPOSALS AND CONDEMNATIONS

14.1.1 The Director of Finance must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers.

14.1.2 When it is decided to dispose of a trust asset, the head of department or authorised deputy will determine and advise the Director of Finance of the estimated market value of the item, taking account of professional advice where appropriate.

14.1.3 All unserviceable articles shall be:

(a) condemned or otherwise disposed of by an employee authorised for that purpose by the Director of Finance and duly recorded where the asset has a value.

14.1.4 The Supplies Manager shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Director of Finance who will take the appropriate action.

14.2 LOSSES AND SPECIAL PAYMENTS

14.2.1 The Director of Finance must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments. The Director of finance 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.

14.2.2 Any employee discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Chief Executive and the Director of Finance or inform an officer charged with responsibility for responding to concerns involving loss or fraud confidentially.
This officer will then appropriately inform the Director of Finance and/or Chief Executive. Where a criminal offence is suspected, the Director of Finance must immediately inform the police if theft or arson is involved. In cases of fraud, bribery and corruption or of anomalies which may indicate fraud, bribery or corruption, the Director of Finance must inform the relevant LAFS and NHS Counter Fraud Authority in accordance with its contractual requirements under the NHS Standards Contract.

14.2.3 The Director of Finance must notify the NHS Counter Fraud Authority and the External Auditor of all frauds.

14.2.4 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Director of Finance must immediately notify:

(a) the Audit Committee, and
(b) the External Auditor.

14.2.5 Within limits delegated to it by the Department of Health, the Audit Committee shall approve the writing-off of losses.

14.2.6 The Director of Finance shall be authorised to take any necessary steps to safeguard the trust’s interests in bankruptcies and company liquidations.

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

14.2.8 The Director of Finance shall maintain a Losses and Special Payments Register in which write-off action is recorded.

14.2.9 No special payments exceeding delegated limits shall be made without the prior approval of the Department of Health.

14.2.10 All losses and special payments must be reported to the Audit Committee at every meeting.

14.3 SECURITY MANAGEMENT

14.3.1 In line with their responsibilities, the trust Director of Finance will monitor and ensure compliance with the requirements of the NHS Counter Fraud Authority security standards for providers on NHS security management.

14.3.2 The trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist, as specified by the requirements of the NHS Counter Fraud Authority security standards for providers on NHS Security Management.

14.3.3 The Chief Executive has overall responsibility for controlling and coordinating security. However, key tasks are delegated to the Director of Finance and the appointed Local Security Management Specialist.
15 INFORMATION TECHNOLOGY

15.1 The Chief Executive has overall responsibility for Information Technology. The Director of Finance, who is responsible for the accuracy and security of the computerised financial data of the trust, shall:

(a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the trust’s data, programs and computer hardware for which he/she is responsible and from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998;

(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 an adequate management (audit) trail exists through the computerised system and that such computer audit reviews are being carried out.

15.1.2 The Director of Finance shall satisfy himself that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy will be obtained from them prior to implementation.

15.1.3 The Director of Finance 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.

15.1.4 Where another health organisation or any other agency provides a computer service for financial applications, the Director of Finance shall periodically seek assurances that adequate controls are in operation.

15.1.5 Where computer systems have an impact on corporate financial systems the Director of Finance shall satisfy themselves 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) staff have access to such data; and such computer audit reviews as are considered necessary are being carried out.
15.2 RESPONSIBILITIES AND DUTIES OF OTHER DIRECTORS AND OFFICERS IN RELATION TO COMPUTER SYSTEMS OF A GENERAL APPLICATION

15.2.1 In the case of computer systems which are proposed General Applications (i.e. normally those applications which the majority of trust's in the region wish to sponsor jointly) all responsible directors and employees will send to the Director of Finance:

(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.

15.3 CONTRACTS FOR COMPUTER SERVICES WITH OTHER HEALTH BODIES OR OUTSIDE AGENCIES

15.3.1 The Director of Corporate Affairs and Governance 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.

15.3.2 Where another health organisation or any other agency provides a computer service for financial applications, the Director of Finance shall periodically seek assurances that adequate controls are in operation.

15.4 RISK ASSESSMENT

15.4.1 The Director of Corporate Affairs and Governance shall ensure that risks to the trust arising from the use of IT are effectively identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans.

15.5 FREEDOM OF INFORMATION

15.5.1 The Director of Corporate Affairs and Governance shall ensure that processes for the receipt, assessment and response to Freedom of Information requests are in place, defined and monitored against the requirements of the Freedom of Information Act (2000).

15.5.2 The Director of Corporate Affairs and Governance 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.
16 **PATIENTS PROPERTY**

16.1 The 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.

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

(a) notices and information booklets,

(b) hospital admission documentation and property records,

(c) the oral advice of administrative and nursing staff responsible for admissions,

(d) that the trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

16.3 The Director of Finance 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. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

16.4 Where Department of Health instructions require the opening of separate accounts for patients' moneys, these shall be opened and operated under arrangements agreed by the Director of Finance.

16.5 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.

16.6 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.

16.7 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.
17 RETENTION OF RECORDS

17.1 The Director of Corporate Affairs and Governance shall be responsible for maintaining archives for all records required to be retained in accordance with Department of Health guidelines.

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

17.3 Records held in accordance with the latest Department of Health guidance shall only be destroyed at the express instigation of the Director of Corporate Affairs and Governance, records shall be maintained of documents so destroyed.

18 INSURANCE

18.1 INSURANCE: RISK POOLING SCHEMES ADMINISTERED BY NHS Resolution

18.1.1 The Board shall decide if the trust will insure through the risk pooling schemes administered by NHS Resolution or self-insure for some or all of the risks covered by the risk pooling schemes. If the Board decides 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.

18.2 INSURANCE ARRANGEMENTS WITH COMMERCIAL INSURERS

18.2.1 There is a general prohibition on entering into insurance arrangements with commercial insurers. There are, however, three exceptions when trusts may enter into insurance arrangements with commercial insurers. The exceptions are:

(a) trusts may enter commercial arrangements for insuring motor vehicles owned by the trust including insuring third party liability arising from their use;

(b) where the 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; and

(c) 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 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 Litigation Authority. In any case of doubt concerning a trust’s powers to enter into commercial insurance arrangements the Finance Director should consult the Department of Health.

18.3 ARRANGEMENTS TO BE FOLLOWED BY THE BOARD IN AGREEING INSURANCE COVER

18.3.1 Where the Board decides to use the risk pooling schemes administered by the NHS Litigation Authority the Director of Finance shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Director of Finance shall ensure that documented procedures cover these arrangements.
18.3.2 Where the Board decides 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 shall ensure that the Board is informed of the nature and extent of the risks that are self-insured as a result of this decision. The Director of Finance in conjunction with the Director of Corporate Affairs & Governance 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.

18.3.3 All the risk pooling schemes require Scheme members to make some contribution to the settlement of claims (the ‘deductible’). The Director of Finance should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

19 **TENDERING AND CONTRACT PROCEDURE**

19.1 **DUTY TO COMPLY WITH STANDING ORDERS AND STANDING FINANCIAL INSTRUCTIONS**

19.1.1 The procedure for making all contracts by or on behalf of the trust shall comply with these Standing Orders and Standing Financial Instructions (except where SO 4.17 (Suspension of SOs) is applied).

19.2 **EU DIRECTIVES GOVERNING PUBLIC PROCUREMENT**

19.2.1 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 these Standing Orders and Standing Financial Instructions.

19.2.2 The trust shall comply as far as is practicable with the requirements of the NHS Executive "Capital Investment Manual" and "Part A and Part B of the Health Building Note 00-08". In the case of management consultancy contracts the trust shall comply as far as is practicable with Department of Health guidance "The Procurement and Management of Consultants within the NHS".

19.3 **REVERSE eAUCTIONS**

19.3.1 The trust should have policies and procedures in place for the control of all tendering activity carried out through Reverse eAuctions.

19.4 **FORMAL COMPETITIVE TENDERING**

19.4.1 The 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 DoH); for the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); and for disposals.
19.4.2 Formal tendering procedures may be waived [see Appendix C3 Tendering Procedure] by officers to whom powers have been delegated by the Chief Executive without reference to the Chief Executive.

(a) where the supply is proposed under special arrangements negotiated by the DoH in which event the said special arrangements must be complied with; or

(b) the timescale genuinely precludes competitive tendering. Failure to plan the work properly is not a justification for single tender; or

(c) specialist expertise is required and is available from only one source; or

(d) 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; or

(e) 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; or

(f) where provided for in the Capital Investment Manual.

(i) The limited application of the single tender rules 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.

(ii) Where it is decided that competitive tendering is not applicable and should be waived the reasons should be documented and reported by the Chief Executive to the Board or the Audit Committee in a formal meeting.

19.4.3 Except where SFI 19.4.2, or a requirement under SFI 19.2, applies, the Board shall ensure that invitations to tender are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate, having regard to their capacity to supply the goods or materials or to undertake the services or works required.

19.4.4 The Board shall ensure that wherever possible the organisations invited to tender (and where appropriate, quote) are among those on approved lists.

19.4.5 Tendering procedures are set out in the Appendices.

19.5 BUILDING AND ENGINEERING CONSTRUCTION WORKS

19.5.1 Competitive Tendering cannot be waived for building and engineering construction works and maintenance (other than in accordance with Concode) without Departmental of Health approval.

19.6 ITEMS WHICH SUBSEQUENTLY BREACH THRESHOLDS AFTER ORIGINAL APPROVAL

19.6.1 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 trust record.
19.7 QUOTATIONS

19.7.1 Quotations are required where formal tendering procedures are waived under SO’s or where the intended expenditure or income exceeds, or is reasonably expected to exceed £5,000 but is less than £50,000.

19.7.2 Where quotations are required under SFI 18.6.1 they should be obtained from sufficient number to ensure a minimum of three quotations where possible.

19.7.3 The Supplies Manager should invite written offers from suppliers to be submitted within a specified time. The supplier must be informed of the circumstances in which the offer is being invited, including

(a) A letter of invitation
(b) A product specification or statement of need
(c) Reference to a standard contract and any supplementary conditions
(d) Delivery details

The Supplies Manager may open the written quotations.

19.7.4 Quotations should be in writing unless the Chief Executive or his nominated officer determines that it is impractical to do so in which case quotations may be obtained by telephone. Confirmation of telephone quotation should be obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in a permanent record.

19.7.5 The Contract will be awarded on the basis of the most economically advantageous offer, judged on price, quality of product, service and overall cost effectiveness. When the preferred quotation is other than the lowest, the Supplies Manager must prepare a report and the decision must be authorised by the Chief Executive.

If only one written quotation is received and proves to be acceptable it must be authorised by the Chief Executive

19.7.6 All quotations should be treated as confidential and should be retained for inspection.

19.7.7 The Chief Executive or his nominated officer should evaluate the quotations and select the one which gives the best value for money. If this is not the lowest then this fact and the reasons why the lowest quotation was not chosen should be in a permanent record.

19.7.8 Single source quotations in writing may be obtained for the following purposes:

(a) the supply of goods/services of a special character for which it is not, in the opinion of the Chief Executive or his nominated officer, possible or desirable to obtain competitive quotations;
(b) the goods/services are required urgently.

Acceptance of single quotes must be authorised by the Chief Executive if tendering or competitive quotation is not appropriate.
The trust shall use NHS Contracts for the procurement of all goods and services unless the Chief Executive or nominated officers deem it inappropriate.

19.7.9 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided under contract or in-house. The Board may also determine from time to time that in-house services should be market tested by competitive tendering (SFI's Section 20).

19.8 PRIVATE FINANCE

19.8.1 When the Board 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 £600,000 a business case must be referred to NHS Improvement for approval or treated as per current guidelines.

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

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

19.9 CONTRACTS

19.9.1 The trust may only enter into contracts within its statutory powers and shall comply with:

(a) the trust’s Standing Orders and Standing Financial Instructions;

(b) EU Directives and other statutory provisions;

(c) any relevant directions including the Capital Investment Manual”, “Part A and Part B of the Health Building Note 00-08” 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.

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.

19.9.2 In all contracts made by the trust, the Board shall endeavour to obtain best value for money. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the trust.
19.10 PERSONNEL AND AGENCY OR TEMPORARY STAFF CONTRACTS

19.10.1 The Chief Executive shall nominate officers with delegated authority to enter into contracts for the employment of other officers, to authorise regarding of staff, and enter into contracts for the employment of agency staff or temporary staff.

19.11 HEALTHCARE SERVICES CONTRACTS

19.11.1 Contracts made between two NHS organisations for example with NHS Improvement for the supply of healthcare services, are subject to the provisions of the NHS Act 2006, as amended, and in any other Acts of Parliament relating to the NHS or any regulations. Such contracts do not give rise to contractual rights or liabilities but a dispute may be referred to NHS Improvement. However, a contract with a Foundation trust, being a PBC, is a legal document and is enforceable in law.

19.11.2 Where the trust elects to invite tenders for the supply of healthcare services these Standing Orders and Standing Financial Instructions shall apply as far as they are applicable to the tendering procedure and need to be read in conjunction with Standing Financial Instruction No. 17 and No. 18.

19.11.3 The Chief Executive shall nominate officers with power to negotiate for the provision of healthcare services with purchasers of healthcare.

19.12 CANCELLATION OF CONTRACTS

19.12.1 Except where specific provision is made in model Forms of Contracts or standard Schedules of Conditions approved for use within the National Health Service and in accordance with SFI 19.2, there shall be inserted in every written contract a clause empowering the trust to cancel the contract and to recover from the contractor the amount of any loss resulting from such cancellation, if the contractor shall have offered, or given or agreed to give, any person any gift or consideration of any kind as an inducement or reward for doing or forbearing to do or for having done or forborne to do any action in relation to the obtaining or execution of the contract or any other contract with the trust, or for showing or forbearing to show favour or disfavour to any person in relation to the contracts or any other contract with the trust, or if the like acts shall have been done by any person employed by him or acting on his behalf (whether with or without the knowledge of the contractor), or if in relation to any contract with the trust the contractor or any person employed by him/her or acting on his/her behalf shall have committed any offence under the Bribery Act 2010 and other appropriate legislation.
19.13 DETERMINATION OF CONTRACTS FOR FAILURE TO DELIVER GOODS OR MATERIAL

19.13.1 There shall be inserted in every written contract for the supply of goods or materials a clause to secure that, should the contractor fail to deliver the goods or materials or any portion thereof within the time or times specified in the contract, the trust may without prejudice determine the contract either wholly or to the extent of such default and purchase other goods, or material of similar description to make good:

(a) such default, or

(b) in the event of the contract being wholly determined the goods or materials remaining to be delivered.

19.13.2 The clause shall further secure that the amount by which the cost of so purchasing other goods or materials exceeds the amount which would have been payable to the contractor in respect of the goods or materials shall be recoverable from the contractors.

20 DISPOSALS

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

(a) any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or his nominated officer;

(b) obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the trust;

(c) items to be disposed of with an estimated sale value of less than £5,000, this figure to be reviewed annually;

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

(e) land or buildings concerning which DoH guidance has been issued but subject to compliance with such guidance.
21 IN HOUSE SERVICES

21.1 In all cases where the trust 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(s).

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

(c) Evaluation group, comprising normally a specialist officer, a supplies officer and a Director of Finance representative. For services having a likely annual expenditure exceeding £50,000, a non-executive director should be a member of the evaluation team.

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

21.3 The evaluation group shall make recommendations to the Board.

21.4 The Chief Executive shall nominate an officer to oversee and manage the contract.

22 ACCEPTANCE OF GIFTS BY STAFF AND LINK TO STANDARDS OF BUSINESS CONDUCT (See overlap with Standing Orders)

22.1 The Director of Corporate Affairs and Governance shall ensure that all staff are made aware of the trust Conflicts of Interest policy (see Appendix C8) on acceptance of gifts and other benefits in kind by staff. This policy follows the guidance contained in the Department of Health circular HSG (93) 5 ‘Standards of Business Conduct for NHS Staff’ (see Appendix A1) is also deemed to be an integral part of these Standing Orders and Standing Financial Instructions (see overlap with SO No. 6.4).
APPENDICES

Appendix 1 - Standards of Business Conduct HSG (93)5

Appendix 1b – Updated NHS Standards of Business Conduct

Appendix 2 - Code of Conduct and Accountability for NHS Boards

Appendix 3 - Code of Conduct for NHS Managers
APPENDIX A1 - STANDARDS OF BUSINESS CONDUCT HSG (93)5

BRIBERY ACT 2010 - SUMMARY OF MAIN PROVISIONS

For any relevant activities undertaken prior to 1st July 2011, the Standards state that it is an offence under the Prevention of Corruption Acts 1906 and 1916 for an employee to accept an inducement or reward for doing, or refraining from doing anything in his or her official capacity, or corruptly showing favour or disfavour in the handling of contracts.

From the 1st July 2011, such activities undertaken by anyone associated with the organisation would now be offences under the more extensive Bribery Act 2010.

This Act created a number of specific offences including:
- the offering, promising or giving a bribe;
- the requesting, agreeing to receive or accepting a bribe;
- bribing a foreign public official;
- a new corporate offence for commercial organisations (which includes NHS bodies) where they fail to prevent bribery by those acting on their behalf.

A bribe may be defined as “an inducement or reward offered, promised or provided to someone to perform their functions or activities improperly in order to gain a personal, commercial, regulatory and/or contractual advantage.”

A bribe may take the form of payment, gifts, hospitality, promise of contracts or employment, or some other form of benefit or gain. The individuals engaged in the actual bribery activity do not have to be those who instigate the offence(s), or ultimately benefit from it. All parties involved are potentially subject to prosecution. The bribe may take place prior, to after, the corrupt act or improper function.

Paragraphs 7, 8 and 15 to 19 of Part B of the original Business Standards expressly relate to areas of NHS functions and activity where breaches may lead to prosecution for potential bribery or corruption-related offences.

NHS MANAGEMENT EXECUTIVE (NHSME) - GENERAL GUIDELINES INTRODUCTION

1. These guidelines, which are intended by the NHSME to be helpful to all NHS employers and their employees, re-state and reinforce the guiding principles previously set out in Circular HM(62)21 (now cancelled), relating to the conduct of business in the NHS.

RESPONSIBILITY OF NHS EMPLOYERS

2. NHS employers are responsible for ensuring that these guidelines are brought to the attention of all employees; also that machinery is put in place for ensuring that they are effectively implemented.

RESPONSIBILITY OF NHS STAFF

3. It is the responsibility of staff to ensure that they are not placed in a position which risks, or appears to risk, conflict between their private interests and their NHS duties. This primary responsibility applies to all NHS Staff, i.e. those who commit NHS resources directly (e.g. by the ordering of goods) or those who do so indirectly (e.g. by the prescribing of medicines). A further example would be staff who may have an interest in a private nursing home and who are involved with the discharge of patients to residential facilities.
GUIDING PRINCIPLE IN CONDUCT OF PUBLIC BUSINESS

4. It is a long established principle that public sector bodies, which include the NHS, must be impartial and honest in the conduct of their business, and that their employees should remain beyond suspicion. It is also an offence under the Bribery Act 2010 for an employee corruptly to accept any inducement or reward for doing, or refraining from doing anything, in his or her official capacity, or corruptly showing favour, or disfavour, in the handling of contracts (see PART A). Staff will need to be aware that a breach of the provisions of these Acts renders them liable to prosecution and may also lead to loss of their employment and superannuation rights in the NHS.

PRINCIPLES OF CONDUCT IN THE NHS

5. NHS staff are expected to:
   • ensure that the interest of patients remains paramount at all times;
   • be impartial and honest in the conduct of their official business;
   • use the public funds entrusted to them to the best advantage of the service, always ensuring value for money.

6. It is also the responsibility of staff to ensure that they do not:
   • abuse their official position for personal gain or to benefit their family or friends;
   • seek to advantage or further private business or other interests, in the course of their official duties.

IMPLEMENTING THE GUIDING PRINCIPLES CASUAL GIFTS

7. Casual gifts offered by contractors or others, e.g. at Christmas time, may not be in any way connected with the performance of duties so as to constitute an offence under the Bribery Act 2010. Such gifts should nevertheless be politely but firmly declined.

   Articles of low intrinsic value such as diaries or calendars, or small tokens of gratitude from patients or their relatives, need not necessarily be refused. In cases of doubt staff should either consult their line manager or politely decline acceptance.

HOSPITALITY

8. Modest hospitality provided it is normal and reasonable in the circumstances, e.g. lunches in the course of working visits, may be acceptable, though it should be similar to the scale of hospitality which the NHS as an employer would be likely to offer.

9. Staff should decline all other offers of gifts, hospitality or entertainment. If in doubt they should seek advice from their line manager.

DECLARATION OF INTERESTS

10. NHS employers need to be aware of all cases where an employee, or his or her close relative or associate, has a controlling and/or significant financial interest in a business (including a private company, public sector organisation, other NHS employer and/or voluntary organisation), or in any other activity or pursuit, which may compete for an NHS contract to supply either goods or services to the employing authority.
11. All NHS staff should therefore declare such interests to their employer, either on starting employment or on acquisition of the interest, in order that it may be known to and in no way promoted to the detriment of either the employing authority or the patients whom it serves.

12. One particular area of potential conflict of interest which may directly affect patients, is when NHS staff hold a self-beneficial interest in private care homes or hostels. While it is for staff to declare such interests to their employing authority, the employing authority has a responsibility to introduce whatever measures it considers necessary to ensure that its interests and those of patients are adequately safeguarded. This may for example take the form of a contractual obligation on staff to declare any such interests. Advice on professional conduct issued by the General Medical Council recommends that when a doctor refers a patient to a private care home or hostel in which he or she has an interest, the patient must be informed of that interest before referral is made.

13. In determining what needs to be declared, employers and employees will wish to be guided by the principles set out in paragraph 5 above; also the more detailed guidance to staff contained in Part D.

14. NHS employers should:
   - ensure that staff are aware of their responsibility to declare relevant interests (perhaps by including a clause to this effect in staff contracts)
   - consider keeping registers of all such interests and making them available for inspection by the public.
   - develop a local policy, in consultation with staff and local staff interests, for implementing this guidance. This may include the disciplinary action to be taken if an employee fails to declare a relevant interest, or is found to have abused his or her official position, or knowledge, for the purpose of self- benefit, or that of family or friends.

**PREFERENTIAL TREATMENT IN PRIVATE TRANSACTIONS**

15. Individual staff must not seek or accept preferential rates or benefits in kind for private transactions carried out with companies with which they have had, or may have, official dealings on behalf of their NHS employer. (This does not apply to concessionary agreements negotiated with companies by NHS management, or by recognised staff interests, on behalf of all staff - for example, NHS staff benefits schemes.)

**CONTRACTS**

16. All staff who are in contact with suppliers and contractors (including external consultants), and in particular those who are authorised to sign Purchase Orders, or place contracts for goods, materials or services, are expected to adhere to professional standards of the kind set out in the Ethical Code of the Chartered Institute of Purchasing and Supply (IPS), reproduced at PART E.
FAVORITISM IN AWARDING CONTRACTS

17. Fair and open competition between prospective contractors or suppliers for NHS contracts is a requirement of NHS Standing Orders and of EC Directives on Public Purchasing for Works and Supplies. This means that:
   - no private, public or voluntary organisation or company which may bid for NHS business should be given any advantage over its competitors, such as advance notice of NHS requirements. This applies to all potential contractors, whether or not there is a relationship between them and the NHS employer, such as a long-running series of previous contracts.
   - each new contract should be awarded solely on merit, taking into account the requirements of the NHS and the ability of the contractors to fulfill them.

18. NHS employers should ensure that no special favour is shown to current or former employees or their close relatives or associates in awarding contracts to private or other businesses run by them or employing them in a senior or relevant managerial capacity. Contracts may be awarded to such businesses where they are won in fair competition against other tenders, but scrupulous care must be taken to ensure that the selection process is conducted impartially, and that staff who are known to have a relevant interest play no part in the selection.

WARNINGS TO POTENTIAL CONTRACTORS

19. NHS employers will wish to ensure that all invitations to potential contractors to tender for NHS business include a notice warning tenderers of the consequences of engaging in any corrupt practices involving employees of public bodies.

OUTSIDE EMPLOYMENT

20. NHS employees are advised not to engage in outside employment which may conflict with their NHS work, or be detrimental to it. They are advised to tell their NHS employing authority if they think they may be risking a conflict of interest in this area: the NHS employer will be responsible for judging whether the interests of patients could be harmed, in line with the principles in paragraph 5 above. NHS employers may wish to consider the preparation of local guidelines on this subject.

PRIVATE PRACTICE

21. Consultants (and associate specialists) employed under the Terms and Conditions of Service of Hospital Medical and Dental Staff are permitted to carry out private practice in NHS hospitals subject to the conditions outlined in the consultant contract and BMA guidance. Consultants who have signed new contracts with trusts will be subject to the terms applying to private practice in those contracts.

22. Other grades may undertake private practice or work for outside agencies, providing they do not do so within the time they are contracted to [the NHS, and they observe the conditions in paragraph 20 above. All hospital doctors are entitled to fees for other work outside their NHS contractual duties under "Category 2" (paragraph 37 of the TCS of Hospital Medical and Dental staff), e.g. examinations and reports for life insurance purposes. Hospital doctors and dentists in training should not undertake locum work outside their contracts where such work would be in breach of their contracted hours. Career grade medical and dental staff employed by NHS trusts may agree terms and conditions different from the National Terms and Conditions of Service.
REWARDS FOR INITIATIVE (PLEASE REFER TO HR56 INTELLECTUAL PROPERTY POLICY)

23. NHS employers should ensure that they are in a position to identify potential intellectual property rights (IPR), as and when they arise, so that they can protect and exploit them properly, and thereby ensure that they receive any rewards or benefits (such as royalties) in respect of work commissioned from third parties, or work carried out by their employees in the course of their NHS duties. Most IPR are protected by statute; e.g. patents are protected under the Patents Act 1977 and copyright (which includes software programmes) under the Copyright Designs and Patents Act 1988. To achieve this, NHS employers should build appropriate specifications and provisions into the contractual arrangements which they enter into before the work is commissioned, or begins. They should always seek legal advice if in any doubt in specific cases.

24. With regard to patents and inventions, in certain defined circumstances the Patents Act gives employees a right to obtain some reward for their efforts, and employers should see that this is effected. Other rewards may be given voluntarily to employees who within the course of their employment have produced innovative work of outstanding benefit to the NHS. Similar rewards should be voluntarily applied to other activities such as giving lectures and publishing books and articles.

25. In the case of collaborative research and evaluative exercises with manufacturers, NHS employers should see that they obtain a fair reward for the input they provide. If such an exercise involves additional work for an NHS employee outside that paid for by the NHS employer under his or her contract of employment, arrangements should be made for some share of any rewards or benefits to be passed on to the employee(s) concerned from the collaborating parties. Care should however be taken that involvement in this type of arrangement with a manufacturer does not influence the purchase of other supplies from that manufacturer.
Appendix A1b – Updated NHS Standards of Business Conduct

NHS STANDARDS OF BUSINESS CONDUCT [HSG (93)5] - STAFF GUIDANCE

Scope of Responsibility

This section refers to the requirements contained within the 1993 NHS Standards of Business Conduct [HSG (93)5] which remains in force and which all trust staff and volunteers are expected to familiarise themselves with and adhere to. Indeed, for many NHS bodies, compliance with these standards forms part of the employee’s contract of employment.

It is the responsibility of all trust staff (employees) and volunteers to personally ensure that they are not, by their conduct or actions, placed in a position which risks, or appears to risk, conflict between their private interests and their NHS duties and responsibilities.

Staff and volunteers should also be aware that the behaviour of immediate family members and partners (either personal or business) could also create potential conflicts.

Interests may be financial, or non-financial (i.e. political or religious). Similarly, the receipt of gifts or hospitality may not be conducive to NHS roles and requirements.

Guiding Principle in the Conduct of Public Business

The NHS, along with other public sector bodies, must be fair, impartial and honest in the conduct of business and decision-making and therefore, staff should act with probity, integrity and transparency at all times, remaining beyond suspicion.

Clarifications to the 1993 NHS Standards of Business Conduct

The Business Standards were first issued in 1993 and much has changed in the NHS and beyond since then, not least the introduction of relevant, new legislation relating to Fraud and Bribery. This section updates guidance relating to the original Standards document and makes reference to the new legislation which must also be considered when reviewing compliance against the requirements contained in the Business Standards.

Parts A & B

Bribery Act 2010

For any relevant activities undertaken prior to 1st July 2011, the Standards state that it is an offence under the Prevention of Corruption Acts 1906 and 1916 for an employee to accept an inducement or reward for doing, or refraining from doing anything in his or her official capacity, or corruptly showing favour or disfavour in the handling of contracts.

From the 1st July 2011, such activities undertaken by anyone associated with the organisation would now be offences under the more extensive Bribery Act 2010. This Act created a number of specific offences including:

- the offering, promising or giving a bribe;
- the requesting, agreeing to receive or accepting a bribe;
- bribing a foreign public official;
- a new corporate offence for commercial organisations (which includes NHS bodies) where they fail to prevent bribery by those acting on their behalf.

A bribe may be defined as “an inducement or reward offered, promised or provided to someone to perform their functions or activities improperly in order to gain a personal, commercial, regulatory and/or contractual advantage.”
A bribe may take the form of payment, gifts, hospitality, promise of contracts or employment, or some other form of benefit or gain. The individuals engaged in the actual bribery activity do not have to be those who instigate the offence(s), or ultimately benefit from it. All parties involved are potentially subject to prosecution. The bribe may take place prior, to after, the corrupt act or improper function.

Paragraphs 7, 8 and 15 to 19 of Part B of the original Business Standards expressly relate to areas of NHS functions and activity where breaches may lead to prosecution for potential bribery or corruption-related offences.

**Fraud Act 2006**

In January 2007, the Fraud Act 2006 came into force. This introduced new, specific fraud offences. Consequently, a person is guilty of fraud if he/she is in breach of any of the following, which provide the three main ways of committing the offence:

- Fraud by false representation;
- Fraud by failing to disclose information;
- Fraud by abuse of position.

For example, failing to disclose information (such as a conflicting personal business or outside interest) when under a legal obligation to do so (as may be required by an NHS contract of employment) may constitute a fraud offence. Paragraphs 10 to 14 and 20 of the original Business Standards (Part B) expressly relate to the requirement of NHS staff to declare all relevant interests.

Similarly, as noted in Paragraphs 6 and 29 of Part B, using commercially confidential NHS information for private gain (either by oneself or another) could also constitute a criminal abuse of position offence under the Fraud Act.

Other fraud-related offences exist under the Act, specifically in respect of items (i.e. false documents) used to commit a fraud. There is also a common law offence of conspiracy to commit fraud, where several individuals are involved working together.

**Summary**

Staff should be aware that a breach of any provision of the Acts referred to above renders them potentially liable for prosecution and may also lead to disciplinary action, as well as loss of employment and pension rights in the NHS. Professional body sanctions (where relevant) may also be applied.

Offences under both the Fraud Act 2006 and the Bribery Act 2010 carry sanctions including up to 10 years imprisonment and/or unlimited fines.

In addition, those in the public sector should be mindful that additional sanctions are also occasionally brought under the common law offence of Misconduct in Public Office, which also carries a potential 10 year sentence.

Further advice and guidance on fraud, bribery or corruption may be obtained from the health body’s local Anti-Fraud Specialist and reference may also be made to the organisation’s Anti-Fraud, Bribery and corruption Policy.

The paragraph references in Parts A and B of the original Business Standards referred to above should not be considered definitive or exhaustive and any potential breach of any of the principles and requirements contained in the Standards of Business Conduct should be reviewed on a case-by-case basis to identify which offences (under various Acts) may or may not have been committed.
What Staff Should Do:

- Make sure you understand the guidelines; consult your line manager if you are not sure.
- Adhere to the ethical code of the Institute of Purchasing and Supply if you are involved in any way with the acquisition of goods and services.
- Make sure you are not in a position where your private interests and NHS duties may conflict. Declare to your employer any relevant interests.
- Seek your employer’s permission before taking on other employment which may adversely affect your ability to fulfil your NHS employment obligations or which conflict (or may be seen to conflict) with your obligation to the organisation.
- Refuse and report any gifts or hospitality which are either inappropriate, excessive or which could be seen to compromise or influence your judgement and or NHS duties.
- The organisation maintains Registers of Interests and Gifts/Hospitality and it is the personal responsibility of each member of staff to notify any relevant interests/activities and report any offer of hospitality or gifts accordingly.

If In Doubt, Ask Yourself…

- Am I, or might I be, in a position where, I, or my family/friends/partner, could gain from the connection between my interests and my NHS employment?
- Do I have access to information which could influence purchasing decisions?
- Could my outside interests be in any way detrimental to my employer, the NHS or to patient interests?
- Do I have any other reason to think I may be risking a conflict of interest?
- If I read about my private interest, or my receipt of a gift or hospitality, in a newspaper would I feel embarrassed about it? (The Newspaper Test)
- If you are still unsure – Declare It!

Do Not:

- Accept any inappropriate gift or hospitality. (There may be circumstances where modest hospitality and casual gifts are acceptable – seek advice from your line manager). Staff should refer to the Gifts and Hospitality policy.
- Abuse your NHS position to obtain preferential treatment for yourself, family or friends.
- Unfairly advantage one supplier over another, or show favouritism awarding contracts.
- Misuse, make available or make inappropriate reference to official ‘commercial’ or ‘in confidence’ information.
- Inappropriately disclose any confidential patient information or data to any third party.
INSTITUTE OF PURCHASING AND SUPPLY - ETHICAL CODE
(Reproduced by kind permission of IPS)

INTRODUCTION

1. The code set out below was approved by the Institute's Council on 26 February 1977 and is binding on IPS members (updated September 2013 CIPS).

PRECEPTS

2. Members shall never use their authority or office for personal gain and shall seek to uphold and enhance the standing of the Purchasing and Supply profession and the Institute by:
   a. maintaining an unimpeachable standard of integrity in all their business relationships both inside and outside the organisations in which they are employed;
   b. fostering the highest possible standards of professional competence amongst those for whom they are responsible;
   c. optimising the use of resources for which they are responsible to provide the maximum benefit to their employing organisation;
   d. complying both with the letter and the spirit of:
      i. the law of the country in which they practise;
      ii. such guidance on professional practice as may be issued by the Institute from time to time;
      iii. contractual obligations;
   e. rejecting any business practice which might reasonably be deemed improper.

GUIDANCE

3. In applying these precepts, members should follow the guidance set out below:
   a. Declaration of interest. Any personal interest which may impinge or might reasonably be deemed by others to impinge on a member's impartiality in any matter relevant to his or her duties should be declared.
   b. Confidentiality and accuracy of information. The confidentiality of information received in the course of duty should be respected and should never be used for personal gain; information given in the course of duty should be true and fair and never designed to mislead.
   c. Competition. While bearing in mind the advantages to the member's employing organisation of maintaining a continuing relationship with a supplier, any relationship which might, in the long term, prevent the effective operation of fair competition, should be avoided.
   d. Business Gifts. Business gifts other than items of very small intrinsic value such as business diaries or calendars should not be accepted.
   e. Hospitality. Modest hospitality is an accepted courtesy of a business relationship. However, the recipient should not allow him or herself to reach a position whereby he or she might be deemed by others to have been influenced in making a business decision as a consequence of accepting such hospitality; the frequency and scale of hospitality accepted should not be significantly greater than the recipient's employer would be likely to provide in return.
   f. when it is not easy to decide between what is and is not acceptable in terms of gifts or hospitality, the offer should be declined or advice sought from the member's superior.
APPENDIX A2 - CODE OF CONDUCT AND ACCOUNTABILITY FOR NHS BOARDS

Public service values must be at the heart of the National Health Service. High standards of corporate and personal conduct, based on a recognition that patients come first, have been a requirement throughout the NHS since its inception. Moreover, since the NHS is publicly funded, it must be accountable to Parliament for the services it provides and for the effective and economical use of taxpayers’ money.

There are three crucial public service values which must underpin the work of the health service.

**Accountability** - everything done by those who work in the NHS must be able to stand the test of parliamentary scrutiny, public judgements on propriety and professional codes of conduct.

**Probity** - there should be an absolute standard of honesty in dealing with the assets of the NHS: integrity should be the hallmark of all personal conduct in decisions affecting patients, staff and suppliers, and in the use of information acquired in the course of NHS duties.

**Openness** - there should be sufficient transparency about NHS activities to promote confidence between the NHS authority or trusts and its staff, patients and the public.

**GENERAL PRINCIPLES**

Public service values matter in the NHS and those who work in it have a duty to conduct NHS business with probity. They have a responsibility to respond to staff, patients and suppliers impartially, to achieve value for money from the public funds with which they are entrusted and to demonstrate high ethical standards of personal conduct. The success of this Code depends on a vigorous and visible example from Boards and the consequent influence on the behaviour of all those who work within the organisation. Boards have a clear responsibility for corporate standards of conduct and acceptance of the Code should inform and govern the decisions and conduct of all Board members.

**OPENNESS AND PUBLIC RESPONSIBILITIES**

Health needs and patterns of provision of health care do not stand still. There should be a willingness to be open with the public, patients and with staff as the need for change emerges. It is essential that major changes are consulted upon before decisions are reached. Information supporting those decisions should be made available and positive responses should be given to reasonable requests for information.

NHS business should be conducted in a way that is socially responsible. As a large employer in the local community, NHS trusts and authorities should forge an open relationship with the local community and should conduct a dialogue about the service provided. NHS organisations should demonstrate to the public that they are concerned with the wider health of the population including the impact of the organisation’s activities on the environment.

The confidentiality of personal and individual patient information must of course be respected at all times.
PUBLIC SERVICE VALUES IN MANAGEMENT

It is unacceptable for the Board of any NHS organisation, or any individual within the organisation for which the Board is responsible, to ignore public service values in achieving results. Chairmen and Board members have a duty to ensure that public funds are properly safeguarded and that at all times the Board conducts its business as efficiently and effectively as possible. Proper stewardship of public monies requires value for money to be high on the agenda of all NHS Boards. Accounting, tendering and employment practices within the NHS must reflect the highest professional standards. Public statements and reports issued by the Board should be clear, comprehensive and balanced, and should fully represent the facts.

Annual and other key reports should be issued in good time to all individuals and groups in the community who have a legitimate interest in health issues to allow full consideration by those wishing to attend public meetings on local health issues.

PUBLIC BUSINESS AND PRIVATE GAIN

Chairmen and Board members should act impartially and should not be influenced by social or business relationships. No one should use their public position to further their private interests. Where there is a potential for private interests to be material and relevant to NHS business, the relevant interests should be declared and recorded in the Board minutes, and entered into a register which is available to the public. When a conflict of interest is established, the Board member should withdraw and play no part in the relevant discussion or decision.

HOSPITALITY AND OTHER EXPENDITURE

Board members should set an example to their organisation in the use of public funds and the need for good value in incurring public expenditure. The use of NHS monies for hospitality and entertainment, including hospitality at conferences or seminars, should be carefully considered. All expenditure on these items should be capable of justification as reasonable in the light of the general practice in the public sector. NHS Boards should be aware that expenditure on hospitality or entertainment is the responsibility of management and is open to be challenged by the internal and external auditors and that ill-considered actions can damage respect for the NHS in the eyes of the community.

RELATIONS WITH SUPPLIERS

NHS Boards should have an explicit procedure for the declaration of hospitality and sponsorship offered by, for example, suppliers. Their authorisation should be carefully considered and the decision should be recorded. NHS Boards should be aware of the risks in incurring obligations to suppliers at any stage of a contracting relationship. The NHS Executive has issued guidance to NHS trusts and authorities about standards of business conduct (ref: HSG(93)5). Suppliers should be selected on the basis of quality, suitability, reliability and value for money.

STAFF

NHS Boards should ensure that staff have a proper and widely publicised procedure for voicing complaints or concerns about maladministration, breaches of this Code and other concerns of an ethical nature. The Board and non-executive directors in particular must establish a climate that enables staff to have confidence in the fairness and impartiality of procedures for registering their concerns.
COMPLIANCE

Board members should satisfy themselves that the actions of the Board and its members in conducting Board business fully reflect the values in this Code and, as far as is reasonably practicable, that concerns expressed by staff or others are fully investigated and acted upon. All Board members of NHS authorities and trusts are required, on appointment, to subscribe to the Code of Conduct.

This Code of Practice is the basis on which NHS organisations should seek to fulfill the duties and responsibilities conferred upon them by the Secretary for Health.

STATUS

NHS authorities and trusts are established under statute as corporate bodies so ensuring that they have separate legal personality. Statutes and regulations prescribe the structure, functions and responsibilities of the Boards of these bodies and prescribe the way chairman and members of Boards are to be appointed.

CODE OF CONDUCT

All Board members of NHS authorities and trusts are required, on appointment, to subscribe to the Code of Conduct.

Chairman and non-executive directors of NHS Boards are responsible for taking firm, prompt and fair disciplinary action against any executive director in breach of the Code of Conduct. Breaches of the Code of Conduct by the chairman or non-executive member of the Board should be drawn to the attention of the non-executive regional Policy Board member. All staff should subscribe to the principles of the NHS Code of Conduct and chairmen, directors and their staff should be judged upon the way the code is observed.

STATUTORY ACCOUNTABILITY

The Secretary of State for Health and Social Care has statutory responsibility for the health of the population of England and uses statutory powers to delegate functions to NHS authorities and trusts, who are thus accountable to the Secretary of State for Health & Social Care and to Parliament. The Chief Executive and the NHS Executive are responsible for directing the NHS, ensuring national policies are implemented and for the effective stewardship of NHS resources.

NHS trusts assume responsibility for ownership and management of hospitals or other establishments or facilities defined in an order transferring them by authority of the Secretary of State for Health & Social Care to whom they are accountable through NHS Improvement.

NHS AUTHORITIES are responsible for procuring health services and administering provision of general medical, dental, ophthalmic and pharmaceutical services in accordance with regulations made by the Secretary of State for Health & Social Care and they are subject to oversight through a system of corporate contracts (not contracts in law) to NHS Improvement.

NHS AUTHORITIES’ AND TRUSTS’ FINANCES are subject to external audit by the Public Sector Audit Appointments Ltd. The chairman and Director of Finance are directly responsible for the organisation’s annual accounts.
NHS Boards must continue to co-operate fully with the NHS Executive and the Public Sector Audit Appointments Ltd. when required to account for the use they have made of public funds, the delivery of patient care and other services, and compliance with statutes, directions, guidance and policies of the Secretary of State for Health & Social Care. The Chief Executive of the NHS England, as Accounting Officer for the NHS, is accountable to Parliament through the Committee of Public Accounts.

THE BOARD OF DIRECTORS

NHS Boards comprise executive Board members and part-time non-executive Board members under a part-time chairman appointed by the Secretary of State for Health & Social Care. Together they share corporate responsibility for all decisions of the Board. There is a clear division of responsibility between the chairman and the chief executive: the chairman’s role and Board functions are set out below; the chief executive is directly accountable to the chairman and non-executive members of the Board for the operation of the organisation and for implementing the Board’s decisions. Boards are required to meet regularly and to retain full and effective control over the organisation: the chairman and non-executive Board members are responsible for monitoring the executive management of the organisation and are responsible to the Secretary of State for Health & Social Care for the discharge of these responsibilities.

The NHS Improvement has a key role in maintaining the line of accountability. Regional non-executive members of the Policy Board will always be available to chairmen and non-executive member on matters of grave concern to them relating to the effectiveness of the Board.

NHS Boards have six key functions for which they are held accountable by NHS Improvement:

- to set the strategic direction of the organisation within the overall policies and priorities of the Government and the NHS, define its annual and longer term objectives and agree plans to achieve them,
- to oversee the delivery of planned results by monitoring performance against objectives and ensuring corrective action is taken when necessary,
- to ensure effective financial stewardship through value for money, financial control and financial planning and strategy,
- to ensure that high standards of corporate governance and personal behaviour are maintained in the conduct of the business of the whole organisation,
- to appoint, appraise and remunerate senior executives,
- to ensure that there is effective dialogue between the organisation and the local community on its plans and performance and that these are responsive to the community’s needs.

In fulfilling these functions the Board should:

- specify its requirements in organising and presenting financial and other information succinctly and efficiently to ensure the Board can fully undertake its responsibilities,
- be clear what decisions and information are appropriate to the Board and draw up standing orders, a schedule of decisions reserved to the Board and standing financial instructions to reflect this,
- establish performance and quality targets that maintain the effective use of resources and provide value for money.
- 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 audit and remuneration committees on the basis of formally agreed terms of reference which set out the membership of the sub-committee, the limit to their powers, and the arrangements for reporting back to the main Board
• act within statutory financial and other constraints.

THE ROLE OF THE CHAIRMAN

The chairman is responsible for leading the Board and for ensuring that it successfully discharges its overall responsibility for the organisation as a whole.

It is the chairman's role to:
• provide leadership to the Board,
• enable all Board members to make a full contribution to the Board's affairs and ensure that the Board acts as a team,
• ensure that key and appropriate issues are discussed by the Board in a timely manner,
• ensure the Board has adequate support and is provided efficiently with all the necessary data on which to base informed decisions,
• lead non-executive Board members through a formally-appointed remuneration committee of the main Board on the appointment, appraisal and remuneration of the chief executive and (with the latter) other executive Board members,
• appoint non-executive Board members to an audit committee of the main Board, and
• advise NHS Improvement through the regional member of the Policy Board on the performance of non-executive Board members.

A complementary relationship between the chairman and chief executive is important. The chief executive is accountable to the chairman and non-executive members of the Board for ensuring that its decisions are implemented, that the organisation works effectively, in accordance with Government policy and public service values and for the maintenance of proper financial stewardship. This chief executive should be allowed full scope, within clearly defined delegated powers, for action in fulfilling the decisions of the Board.

NON-EXECUTIVE BOARD MEMBERS

Non-executive Board members are appointed by or on behalf of the Secretary of State for Health & Social Care to bring an independent judgement to bear on issues of strategy, performance, key appointments and accountability through NHS Improvement to Ministers and to the local community.

Non-executive Board members will be able to contribute to Board business from a wide experience and a critical detachment. They have a key role in working with the chairman in the appointment of the chief executive and other Board members. With the chairman, they comprise the remuneration committee responsible for the appraisal and remuneration decisions affecting executive Board members. Non-executive Board members normally comprise the audit committee. In addition, they undertake specific functions agreed by the Board including functions including oversight of staff relations with the general public and the media, participation in professional conduct and competency enquiries, staff disciplinary appeals and procurement of information management and technology.
Members of NHS authority and trust Boards currently play important roles in relation to the handling and monitoring of non-clinical complaints. Being both informed and impartial, non-executives are able to act effectively as lay conciliators or adjudicators in relation to individual complaints. With the chief executive, they can also take responsibility for ensuring that their authority or trust's complaints procedures are operated effectively and that lessons learned from them are implemented.

REPORTING AND CONTROLS

It is the Board's duty to present through the timely publications of an annual report, annual accounts and other means, a balanced and readily-understood assessment of the authority's or trust's performance to:

- NHS Improvement, on behalf of the Secretary of State for Health & Social Care,
- Public Sector Audit Appointments Ltd. and its appointed auditors, and
- the local community

The detailed financial guidance issued by NHS Improvement, including the role of internal and external auditors, must be scrupulously observed. The Standing Orders of Boards should prescribe the terms of which committees and sub-committees of the Board may be delegated functions, and should include the schedule of decisions reserved for the Board.

DECLARATION OF INTERESTS

It is a requirement that chairmen and all Board members should declare any conflict of interests, that arises in the course on conducting NHS business. That requirement continues in force. Chairman and Board members should declare on appointment any business interests, position of authority in a charity or voluntary body in the field of health and social care and any connection with a voluntary or other body contracting for NHS services. These should be formally recorded in the minutes of the Board, and entered into a register which is available to the public. Directorships and other significant interests held by NHS Board members should be declared on appointment, kept up to date and set out in the annual report.

EMPLOYEE RELATIONS

NHS Boards must comply with legislation and guidance from NHS Improvement on behalf of the Secretary of State for Health & Social Care, respect agreements entered into by themselves or in on their behalf and establish terms and conditions of service that are fair to the staff and represent good value for taxpayers' money. Fair and open competition should be the basis for appointment to posts in the NHS.

The terms and conditions agreed by the Board for senior staff should take full account of the need to obtain maximum value for money for the funds available for patient care. The Board should ensure through the appointment of a remuneration and terms of service committee that executive Board members' total remuneration can be justified as reasonable. All Board members' total remuneration for the organisation of which they are a Board member should be published in the annual report.
APPENDIX A3 - CODE OF CONDUCT FOR NHS MANAGERS

As an NHS manager, I will observe the following principles:
- make the care and safety of patients my first concern and act to protect them from risk;
- respect the public, patients, relatives, carers, NHS staff and partners in other agencies;
- be honest and act with integrity;
- accept responsibility for my own work and the proper performance of the people I manage;
- show my commitment to working as a team member by working with all my colleagues in the NHS and the wider community;
- take responsibility for my own learning and development.

This means in particular that:

1) I will:
- respect patient confidentiality;
- use the resources available to me in an effective, efficient and timely manner having proper regard to the best interests of the public and patients;
- be guided by the interests of the patients while ensuring a safe working environment;
- act to protect patients from risk by putting into practice appropriate support and disciplinary procedures for staff; and
- seek to ensure that anyone with a genuine concern is treated reasonably and fairly.

2) I will respect and treat with dignity and fairness, the public, patients, relatives, carers, NHS staff and partners in other agencies. In my capacity as a senior manager within the NHS I will seek to ensure that no one is unlawfully discriminated against because of their religion, belief, race, colour, gender, marital status, disability, sexual orientation, age, social and economic status or national origin. I will also seek to ensure that:
- the public are properly informed and are able to influence services;
- patients are involved in and informed about their own care, their experience is valued, and they are involved in decisions;
- relatives and carers are, with the informed consent of patients, involved in the care of patients;
- partners in other agencies are invited to make their contribution to improving health and health services; and
- NHS staff are:
  - valued as colleagues;
  - properly informed about the management of the NHS;
  - given appropriate opportunities to take part in decision making.
  - given all reasonable protection from harassment and bullying;
  - provided with a safe working environment;
  - helped to maintain and improve their knowledge and skills and achieve their potential; and
  - helped to achieve a reasonable balance between their working and personal lives.

3) I will be honest and will act with integrity and probity at all times. I will not make, permit or knowingly allow to be made, any untrue or misleading statement relating to my own duties or the functions of my employer. I will seek to ensure that:
the best interests of the public and patients/clients are upheld in decision-making and that decisions are not improperly influenced by gifts or inducements;
- NHS resources are protected from fraud and corruption and that any incident of this kind is reported to the NHS Counter Fraud Authority;
- judgements about colleagues (including appraisals and references) are consistent, fair and unbiased and are properly founded; and
- open and learning organisations are created in which concerns about people breaking the Code can be raised without fear.

4) I will accept responsibility for my own work and the proper performance of the people I manage. I will seek to ensure that those I manage accept that they are responsible for their actions to:
- the public and their representatives by providing a reasonable and reasoned explanation of the use of resources and performance;
- patients, relatives and carers by answering questions and complaints in an open, honest and well researched way and in a manner which provides a full explanation of what has happened, and of what will be done to deal with any poor performance and, where appropriate giving an apology; and
- NHS staff and partners in other agencies by explaining and justifying decisions on the use of resources and give due and proper consideration to suggestions for improving performance, the use of resources and service delivery. I will support and assist the Accountable Officer of my organisation in his or her responsibility to answer to Parliament, Ministers and the Department of Health in terms of fully and faithfully declaring and explaining the use of resources and the performance of the local NHS in putting national policy into practice and delivering targets.

For the avoidance of doubt, nothing in paragraphs two to four of this Code requires or authorises an NHS manager to whom this Code applies to:
- make, commit or knowingly allow to be made any unlawful disclosure;
- make, permit or knowingly allow to be made any disclosure in breach of his or her duties and obligations to his or her employer, save as permitted by law.

If there is any conflict between the above duties and obligations and this Code, the former shall prevail.

5) I will show my commitment to working as a team by working to create an environment in which:
- teams of frontline staff are able to work together in the best interests of patients;
- leadership is encouraged and developed at all levels and in all staff groups; and
- the NHS plays its full part in community development.

6) I will take responsibility for my own learning and development. I will seek to:
- take full advantage of the opportunities provided;
- keep up to date with best practice; and
- share my learning and development with others.
IMPLEMENTING THE CODE

1. The Code should be seen in a wider context that NHS managers must follow the ‘Nolan Principles on Conduct in Public Life’, the ‘Corporate Governance Codes of Conduct and Accountability’, the ‘Standards of Business Conduct’, the ‘Code of Practice on Openness in the NHS’ and standards of good employment practice.

2. In addition many NHS managers come from professional backgrounds and must follow the code of conduct of their own professions as well as this Code. In order to maintain consistent standards, NHS bodies need to consider suitable measures to ensure that managers who are not their employees but who
   (i) manage their staff or services; or
   (ii) manage units which are primarily providing services to their patients also observe the Code.

3. It is important to respect both the rights and responsibilities of managers. To help managers to carry out the requirements of the Code, employers must provide reasonable learning and development opportunities and seek to establish and maintain an organisational culture that values the role of managers. NHS managers have the right to be:
   - treated with respect and not be unlawfully discriminated against for any reason;
   - given clear, achievable targets;
   - judged consistently and fairly through appraisal;
   - given reasonable assistance to maintain and improve their knowledge and skills and achieve their potential through learning and development; and
   - reasonably protected from harassment and bullying and helped to achieve a reasonable balance between their working and personal lives.

BREACHING THE CODE

4. Alleged breaches of the Code of Conduct should be promptly considered and fairly and reasonably investigated. Individuals must be held to account for their own performance, responsibilities and conduct where employers form a reasonable and genuinely held judgement that the allegations have foundation. Investigators should consider whether there are wider system failures and organisational issues that have contributed to the problems. Activity, the purpose of which is to learn from and prevent breaches of the Code, needs to look at their wider causes.

5. Local employers should decide whether to investigate alleged breaches informally or under the terms of local disciplinary procedures. It is essential however that both forms of investigation should be, and be seen to be, reasonable, fair and impartial. If Chief Executives or Directors are to be investigated, the employing authority should use individuals who are employed elsewhere to conduct the investigation. The NHS Confederation, the Institute of Healthcare Management and the Healthcare Financial Management Association are among the organisations who maintain lists of people who are willing to undertake such a role.
APPLICATION OF CODE

6. This Code codifies and articulates certain important contractual obligations that apply to everyone holding management positions. These include Chief Executives and Directors who as part of their duties are personally accountable for achieving high quality patient care. The Department of Health will in the next few months issue a proposed new framework of pay and contractual arrangements for the most senior NHS managers. Under this framework the job evaluation scheme being developed as part of the ‘Agenda for Change’ negotiations is likely to be Implementing the Code used as the basis for identifying which other managerial posts (in addition to Chief Executives and Directors) should be automatically covered by the Code. The new framework will also specify compliance with the Code as one of the core contractual provisions that should apply to all senior managers.

7. For all posts at Chief Executive/Director level and all other posts identified as in paragraph 6 above, acting consistently with the Code of Conduct for NHS Managers Directions 2002, employers should:
   - include the Code in new employment contracts;
   - incorporate the Code into the employment contracts of existing postholders at the earliest practicable opportunity.

ACTION

8. Employers are asked to:
   (i) incorporate the Code into the employment contracts of Chief Executives and Directors at the earliest practicable opportunity and include the Code in the employment contracts of new appointments to that group;

   (ii) identify any other senior managerial posts, i.e. with levels of responsibility and accountability similar to those of Director-level posts, to which they consider the Code should apply. (The new framework for pay and contractual arrangements will help more tightly define this group in due course.)

   (iii) investigate alleged breaches of the Code by those to whom the Code applies promptly and reasonably as at paragraphs four to five;

   (iv) provide a supportive environment to managers (see paragraph three above).
Terms of Reference
For Board Committees
# APPENDIX B1 – SAFETY STANDARDS AND QUALITY COMMITTEE TERMS OF REFERENCE

| Title: Safety, Quality and Standards (SQS) Committee | East Cheshire NHS trust |
| Authors Name: Director of Nursing and Quality | |
| Scope: trust Wide | Classification: trust Organisation Structure and Minutes |
| Replaces: Safety Quality and Standards Committee Terms of Reference February 18 | |
| To be read in conjunction with the following documents: The trust’s Standing Orders and other Committee Terms of Reference | |
| Review Date: March 2020 | This document is no longer authorised for use after this date |
| Issue Status: 1 | Issue No: 1 | Issue Date: April 2019 |
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| Document for Public Display: Yes | |

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| Archive: | Date added to Archive: |
| Officer responsible for archive: Committee Secretary | |
1. **Constitution**

The Board hereby resolves to establish a Committee of the Board to be known as the Safety Quality and Standards Committee (the Committee), which is directly accountable to the Board.

2. **Definition**

This Committee is established as a standing Committee of the trust Board of East Cheshire NHS trust in order to provide the trust Board with assurances of clinical and non-clinical safety, quality and standards of practice throughout the trust.

3. **Membership**

- 2 Non-Executive Directors (one of which will Chair)
- All Executive Directors (or nominated deputies)
- Associate Medical Director for Clinical Effectiveness
- Chief Pharmacist
- Deputy Director of Nursing and Quality
- Deputy Director of Corporate Affairs and Governance

4. **Quorum**

- A Non-Executive Director will Chair the meetings and;
- 2 Executives – one of whom is the Medical Director or Director of Nursing & Quality
- If both these 2 Executives are unable to attend, then both the Associate Medical Director for Clinical Effectiveness and Deputy Director of Nursing and Quality must attend

5. **Attendance**

- Members of the Committee should make every effort to attend meetings in person. There may be circumstances where members join by telephone. If members are on annual or sick leave, deputies who have the appropriate level of authority should attend but their attendance will not count towards the member’s attendance levels. The Chair should be notified of members wishing to join by telephone and the attendance of deputies at least 24 hours in advance of the meeting.
- Members of the SQS Committee must achieve a minimum of 75% meeting attendance. Nominated deputies attendance will not count towards the member’s attendance levels.
6. Chairmanship

- The Chair of the Committee will be a Non-Executive Director.
- The Chair may invite other senior employees, particularly when the Committee is discussing an issue that is the responsibility of that employee.

7. Minutes

- The minutes of the meeting shall be drawn up and submitted for agreement at the next ensuing meeting.

8. Frequency of Meetings

- The Committee shall meet each month, a minimum of ten times per annum
- Emergency Powers
  - Where an urgent decision needs to be made in between scheduled meetings, the Chair of the committee can convene an Extra-ordinary meeting to discuss a particular issue, quorum rules as stated in paragraph 3 still apply.
  - If it is not practicable to meet in person, matters can be dealt with through telephone or the exchange of emails.
  - The exercise of such powers shall be reported and minuted at the next Committee meeting.

9. Authority

- Responsibility for all decisions relating to the clinical governance and non-clinical risk management activities lies entirely with the trust Board of East Cheshire NHS trust. The Safety, Quality and Standards Committee may act with such authority delegated to it by the trust Board to oversee, coordinate, review and assess the effectiveness of clinical governance and non-clinical risk management arrangements and activities within the trust. This includes detailed strategies/plans.
- The Committee is authorised by the Board to seek the information it requires from any employee, and all employees are directed to co-operate with any request made by the Committee.

10. General Responsibilities and Principles

- The general responsibilities and principles are:
  - Contribute to and promote the vision, values and culture of governance, safety, quality and standards across the trust;
  - assess and provide assurance on strategic risks in relation to safety, quality and standards and monitor progress
  - oversee an effective system for delivering a safe high quality experience for all patients and service users, including carers, with
particular focus on involvement and engagement for the purposes of learning and making improvement
- ensure that lessons are learned across the organisation from patient feedback;
- oversee an effective system for monitoring clinical outcomes and clinical effectiveness; with particular focus on ensuring patients receive the best possible outcomes of care across the full range of trust activities
- receive and where relevant and appropriate ensure and implement any recommendations from internal and external reports and guidance;
- approve the following strategies/strategic plans, as and when required, for the following areas of service:
  - Risk Management (Maternity)
  - Clinical Audit
  - Records Management
  - Research Governance
  - Quality (agreement prior to presenting to the trust Board for approval)
  - Nursing, Midwifery and Therapies Professional Practice
  - Medicines Optimisation
  - Engagement and Involvement
- to review the annual quality account, and provide assurance on outcomes and priorities to trust Board
- agree an annual programme of work for the committee and produce an annual report on the progress against the work plan for submission to trust Board.

11. Other Matters

The Safety, Quality and Standards Committee seeks assurance from each of the Sub-Committees and in conjunction with the scope of its own work, provides assurance directly to the Board.

The Committee will look to see how safety, quality and standards initiatives align with those of partner organisations.

12. Conduct of Meetings

- The agenda and papers will be prepared and circulated 7 days in advance of a Committee meeting.
- An action log of open and closed actions will be produced.
- Any member may request an item for the agenda through the Chair.
- Any interest in the matter under discussion (as defined in Standing Orders) will be declared. The person declaring an interest will withdraw whilst the issue is being discussed.
In the event of a formal vote, a simple majority will prevail. In the event of a tied vote the Chair will have a deciding vote, provided that nothing in the way business is conducted is prohibited in Standing Orders of the trust.

13. Reporting

- Reports to the Board will be made as follows:
  - Following each Committee meeting, the minutes shall be drawn up and submitted to the Chair in draft format. The draft minutes will then be presented at the next Committee meeting (see 'Minutes' above) for approval. The minutes of the SQS Committee shall be recorded and submitted to the Board.
  - Due to the timing of the Committee, a verbal update, providing items for assurance and emerging risks and mitigating actions will be given to the trust Board following SQS meetings to ensure timely assurance and escalation of risks.

- Reporting arrangements of other Committees and Groups
  - In order to comply with paragraph 2, in that the SQS Committee is responsible for providing assurance on clinical and non-clinical safety, quality and standards of practice throughout the trust, the following Sub-Committees and Groups will provide a written report to the SQS Committee on at least an annual basis, in line with agreed Terms of Reference:
    1. Quality Forum Sub-Committee
    2. Clinical Audit and Research Effectiveness Sub-Committee
    3. Risk Management Sub-Committee
    4. Organ Donation Sub-Committee
    5. Medicines Management Sub-Committee (to include the report of the Controlled Drugs Accountable Officer)
    6. Human Tissue Authority Sub-Committee
    7. Integrated Safeguarding Sub-Committee
    8. Serious Incident Review Sub-Committee
    9. Mortality Review Sub Committee
    10. Infection, Prevention and Control Sub-Committee
    11. Safety Quality & Standards Sub-Committees of Clinical Directorates x3
    12. Radiation Protection Sub-Committee

- The committee will review and provide recommendations to the Board of any changes to the sub committees reporting to SQS. Reports by exception may take place, where necessary, to escalate significant issues / risks outside of the regular scheduled reporting.

- The committee will receive Annual Reports from Sub-Committees, which will include their self-assessments, as appendices to their reports. A schedule will be shared with the Sub-Committee Chairman.
14. **Annual Review of the SQS Committee**

- The Committee will undertake an annual self-assessment on their effectiveness and performance to:
  - Review its own performance to ensure it is operating effectively;
  - Determine whether its planned activities and responsibilities for the previous year have been sufficiently discharged; and
  - Recommend any changes and/or actions it considers necessary, in respect of the above.

- An annual written report will be provided to the Board, via the Audit Committee which details the outcome of the self-assessment.

15. **Monitoring Compliance**

- As part of the annual self-assessment referred to in paragraph 13 which will be reported in the annual report, the Committee will review that the terms of reference have been complied with and whether they remain fit for purpose. As a minimum, the terms of reference must include:
  - Duties
  - Reporting arrangements to the Board
  - Membership, including nominated deputy where appropriate
  - Required frequency of attendance by members
  - Reporting arrangements into the SQS Committee
  - Requirements for a quorum
  - Frequency of meetings
  - Process for monitoring compliance with all of the above

16. **Terms of Reference**

- These will be reviewed in February 2020 (annually) by SQS Committee prior to recommending to the Board, or as required.
### APPENDIX B2 – REMUNERATION COMMITTEE TERMS OF REFERENCE

| Title: Remuneration Committee - Terms of Reference | East Cheshire NHS trust |
| Authors Name: Lynn McGill, Chairman |
| Scope: trust Wide | Classification: trust Organisation Structure and Minutes |
| Replaces: Remuneration Committee - Terms of Reference March 2018 |
| To be read in conjunction with the following documents: |
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| Officer responsible for archive: |
1. Constitution

The Board hereby resolves to establish a Committee of the Board to be known as the Remuneration Committee (the Committee) confirmed by resolution of the Board on 16 December 2004.

2. Definition

The Committee is responsible for overseeing and agreeing the remuneration and Terms of Service of the Chief Executive, Executive Directors and other Directors who are members of the Board, together with any staff employed by the trust whose Terms of Service are not covered by national agreements.

3. Membership

3 Non-Executive Directors.

A minimum of one of the following Executives will be in attendance:

- Chief Executive
- Director of Human Resources and Organisational Development

No Executive will be present whilst his/her own remuneration or any other matter of direct personal interest is under discussion.

4. Quorum

The quorum shall be at least 3 members of the Committee. Those ‘in attendance’ will not count towards the quorum.

5. Attendance

Members of the Committee should make every effort to attend meetings in person. There may be circumstances where members join by telephone. Deputies will not attend, except where the deputy is formally acting-up as defined in trust Standing Orders. The Chair should be notified of members wishing to join by telephone at least 24 hours in advance of the meeting.

The Committee may invite others to attend particular meetings as observers or to speak to a specific item under discussion.

Members of the Remuneration Committee must achieve a minimum of 75% meeting attendance.

6. Chairmanship

The Chair of the Committee will be the Chairman of the trust or in their absence by the Vice-Chairman (deputy) of the trust.

Another Non-Executive Director will act as Chair in the absence of the Chairman or Vice-Chairman (deputy) as agreed amongst the Non-Executive Directors present at the meeting.
7. Minutes

Minutes of the Committee will be presented to the trust Board by the Chair and/or lead Executive of the Committee. In limited circumstances as covered in the Freedom of Information Act, e.g. where confidential personal information is involved, a summary or suitably edited minutes will be presented.

Minutes and papers will be made available to members of the public on request, subject to Freedom of Information arrangements. In limited circumstances as covered in the Freedom of Information Act, e.g. where confidential personal information is involved, suitably edited minutes or papers will be made available.

8. Frequency of Meetings

The Committee shall meet annually in Quarter 1 (as a minimum).

The Chair may, at any time, convene additional meetings of the Committee to consider business that requires urgent attention.

9. Authority

The Committee is authorised by the Board to seek the information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

10. General Responsibilities and Principles

10.1 The general responsibilities of the Committee are to:

- discuss and agree appropriate remuneration and Terms of Service for the Chief Executive, officer members of the Board, and other management staff directly accountable to the Chief Executive not covered by national agreements. Advice to the Board should include all aspects of salary pertaining to the post, provisions for other benefits including pensions and cars, as well as arrangements for the termination of employment and other contractual terms;

- ensure that decisions are made in accordance with local policy and guidelines issued by the NHS TDA and the Treasury, as appropriate;

- review and agree arrangements for termination of employment including proper calculation and scrutiny of termination payments and other contractual terms for staff where Executives see the circumstances as novel or unusual; which could impact on the reputation of the organization, or where the cost of the contractual payments are over £50,000 and all non-contractual severance payments and where exceptional arrangements are made; and

- identify to the Board any unusual trends arising from termination of employment information presented to the Committee.
10.2 Delegated Authority

This committee has the delegated power to act on any decision within its remit, subject to the requirements of Standing Orders and Standing Financial Instructions.

10.3 Establishment of Groups reporting to the Committee

The Committee may establish standing and/or time limited sub-groups as it sees fit for the effective conduct of its business. Such sub-groups will not exercise powers delegated from the trust Board unless they are established by the trust Board as formal Sub-Committees of the Board. Terms of reference of sub-groups which are not established as Sub-Committees of the Board will be approved by the Committee. Terms of reference of formal Sub-Committees of the Board will be approved by the trust Board.

10.4 Responsibilities

For the Chief Executive, officer members of the Board and other management staff directly accountable to the Chief Executive who are not covered by national agreements:

- Using very senior manager pay scale as guidance, to review and agree on all matters relating to the setting of, and any variations to, the terms and conditions of employment and remuneration relating to the post of Chief Executive;

- To receive, discuss and agree recommendations from the Chief Executive on all matters relating to the setting of, and any variation to, the terms and conditions of employment, and remuneration for all staff on senior manager contracts reporting directly to the Chief Executive who are not covered under Agenda for Change or any remaining staff who have not transferred to an Agenda for Change contract;

- Using very senior manager pay scale as guidance, to review and agree the remuneration of each of the above posts at least annually taking into account prevailing norms and national pay agreements and, in the case of officer members, individual performance and comparative information and any other matter the committee considers relevant;

- To determine the appropriate contractual arrangements for these staff including the proper calculation and scrutiny of termination payments, taking account of such national guidance as is appropriate;

- To ensure that the principles pertaining to remuneration packages are applied consistently and are sufficient to recruit, retain and motivate people of high ability at the level of skills appropriate to the proper management of the trust having regard to the affordability and value for money;

- To report annually to the trust Board on the total impact of agreed changes;
• To ensure that the Board members emoluments and the composition of the committee is correctly disclosed in the annual report;

• To receive and consider recommendations from the Chief Executive or Executives on matters relating to the setting of remuneration local terms and conditions for other staff on local contracts; to agree recommendations to the trust Board, e.g. senior managers on local contracts;

• To review termination arrangements for other staff members where Executives identify unusual or novel circumstances which could impact on the reputation of the organisation or where the contractual payments are over £50,000 and all non-contractual severance payments.

11. Conduct of Meetings

Agendas will normally be prepared and circulated 7 days in advance

Any member may request an item for the agenda through the Chair.

In order for the Committee to conduct its business, the Chief Executive will produce an annual report for consideration at the May meeting on the performance of the named executive staff reporting to him/her together with recommendations for any changes to pay or terms and conditions.

The committee will also receive:

• individual contracts/terms and conditions for staff within its remit prior to any offer of appointment and whenever any changes are proposed;
• termination conditions and calculations;
• routine analysis of total pay package of senior executives annually in May, or as required; and
• annual performance reports relating to Chief Executive annually in May, and relating to other senior managers when changes to pay or package are proposed – other than national pay awards.

Members will have the right to speak and if necessary vote at meetings of the Committee. Attendees may speak and their opinions may be sought but they will not participate in any formal vote.

Declarations of interest will be collected at the start of each meeting – there is requirement that members of committee must make annual declarations of interests.

Any interest in the matter under discussion (as defined in Standing Orders) will be declared. The person declaring an interest will withdraw whilst the issue is being discussed.

In the event of a formal vote, a simple majority will prevail. In the event of a tied vote the Chair will have a deciding vote. Provided that nothing in the way business is conducted is prohibited in Standing Orders of the trust.
Minutes of meetings will be prepared by the Director of Human Resources and Organisational Development and will be:

- Approved by the Chair before submission to the trust Board or wider circulation;
- Approved by the Committee at the next meeting of the Committee.

Submission to the trust Board or wider circulation should not be delayed until after approval by the Committee but should be clearly marked as not yet fully approved.

12. Terms of Reference

These Terms of Reference will be presented to the trust Board at its March meeting for ratification. Any variation, including to the membership, will require the approval of the trust Board.

The trust Board may formally change the Terms of Reference at any time, either at its own initiation or following a request for variation submitted by the Committee.

The Committee will review the Terms of Reference annually for resubmission to the trust Board.

The trust Board will review the Terms of Reference submitted in the light of the wider requirements of the trust and may amend them before approval.

These will be reviewed in March 2020.
# APPENDIX B3 – AUDIT COMMITTEE TERMS OF REFERENCE

| Title: Audit Committee - Terms of Reference | East Cheshire NHS trust |
| Authors Name: Ian Goalen - Non Executive Director, Chair of Audit Committee |
| Scope: trust Wide | Classification: trust Organisation Structure and Minutes |
| Replaces: Previous Terms of Reference approved February 2018 |

To be read in conjunction with the following documents:

The trust's Standing Orders and other Committees of the Board Terms of Reference

| Unique Identifier: ECT000668.AudTOR.20090318. Audit CteeTOR | Review Date: February 2020 |
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Archive: Date added to Archive: |

Officer responsible for archive: Head of Integrated Governance
1. Constitution

The Board hereby resolves to establish a Committee of the Board to be known as the Audit Committee (the Committee), which is directly accountable to the Board.

The Terms of Reference shall be as set out below, subject to amendment at future Board meetings. The Committee shall not have executive powers in addition to those delegated in these Terms of Reference.

2. Definition

The Audit Committee will have primary responsibility for monitoring and reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust’s activities (both clinical and non-clinical), that supports the achievement of the Trust’s objectives.

3. Membership

Three Non-Executive Directors will be members of the Audit Committee excluding the Chairman of the Trust, one of which will Chair.

4. Quorum

The quorum shall be a minimum of two members present.

5. Attendance

Members of the Committee should make every effort to attend meetings in person. There may be circumstances where members join by telephone. The Chair should be notified of members wishing to join by telephone at least 24 hours in advance of the meeting.

The Chief Executive should be invited to attend each meeting and other Executive Directors requested to attend, particularly when the committee is discussing areas of risk or operation that are the responsibility of that director.

The Chief Executive shall be invited to attend to discuss with the Audit Committee the process for assurance that supports the Annual Governance Statement and when the Committee considers the draft internal audit plan and the annual accounts.

Representatives from Internal and External Audit, and the local Counter Fraud Service will be invited to attend meetings.

Members of the Audit Committee must achieve a minimum of 75% meeting attendance. Nominated deputies may attend, but their attendance will not count towards the members attendance levels.
6. **Chairmanship**

The Committee will appoint one of the members to be Chair of the Committee. The Chairman of the Trust shall not be a member of the Committee.

7. **Minutes**

The minutes of the meeting shall be drawn up and submitted for agreement at the next ensuing meeting.

8. **Frequency of Meetings**

The Committee shall meet a minimum of four times a year.

8.1 **Emergency Powers**

Where an urgent decision needs to be made in between scheduled meetings, the Chair, External Auditor or Head of Internal Audit can convene an Extraordinary meeting to discuss a particular issue, quorum rules as stated in paragraph 4 still apply. If it is not practicable to meet in person, matters can be dealt with through telephone or the exchange of emails. The exercise of such powers shall be reported and minuted at the next Committee meeting.

9. **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 member of staff and all members of staff are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Board to obtain external legal or other independent professional advice. The Committee is authorised by the Board to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions.

10. **General Responsibilities and Principles**

The duties of the Committee can be categorised as follows:

10.1 **Governance, Risk Management and Internal Control**

The Committee shall seek assurance that an effective system of integrated governance, risk management and internal control, is established and maintained across the whole of the organisation’s activities, both clinical and non-clinical which supports the achievement of the organisation’s objectives.
In particular, the Committee will seek assurance on the adequacy of:

- all risk and control (in particular the Annual Governance Statement) with related disclosure statements, and any accompanying Head of Audit statement, external audit opinion or other appropriate independent assurance, prior to endorsement by the Board;

- the risk management report as part of the Trust’s internal control arrangements contained in the Annual Report

- the management of risks

- the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;

- the policies for ensuring compliance with relevant regulatory, legal, code of conduct and NHSLA requirements and related reporting and self certification; and

- the policies and procedures for all work related to fraud, bribery and corruption as set out within the NHS Standards Contract and as required by NHS Protect’s Standards for Providers.

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

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

10.2 Internal Audit

The Committee shall ensure that there is an effective internal audit function established by management that meets mandatory NHS Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. This will be achieved by:

- consideration of the appointment of the internal audit service, the audit fee and any questions of resignation and dismissal;

- review and approval of the internal audit strategy, operational plan and programme of work in the context of the Assurance Framework;

- consideration of the major findings of internal audit investigations (and management’s response), and ensure co-ordination between the Internal and External Auditors; and
ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation.

• Receipt of an annual review of the effectiveness of Internal Audit

10.3 *External Audit*

The Committee shall seek assurance on the work and findings of the External Auditor and consider the implications and management’s responses to their work. This will be achieved by:

• consideration of the appointment and performance of the External Auditor, as far as the rules governing the appointment permit;

• discussion and agreement with the External Auditor, before the audit commences, the nature and scope of the audit as set out in the Trust Plan (formally Annual Plan), and ensure co-ordination, as appropriate, with other External Auditors in the local health economy; and

• review of all External Audit reports, including the report to those charged with governance and agreement of the annual audit letters before submission to the Board and any work carried out which is outside the Trust Plan (formally Annual Plan), together with the appropriateness of management responses.

10.4 *Other Assurance Functions*

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

These will include, but will not be limited to, any reviews by the Department of Health arm’s length bodies or regulators/inspections for example the Care Quality Commission, NHS Resolution Authority and professional bodies with responsibilities for the performance of staff or functions.

The Committee will review the updated Assurance Framework on 3 occasions during the year, as well as a full annual review, provided by the trust’s Internal Auditors to gain assurance on the robustness of the process.

10.5 *Reporting Arrangements of other Committees and Groups*

In order to comply with the requirement that the Audit Committee is responsible for providing the Board with assurance that an effective system of integrated governance, risk management and internal control, across the whole of the organisation’s activities (both clinical and non-clinical), the following arrangements have been put in place:

Although the Safety, Quality and Standards Committee, and the Finance, Performance and Workforce Committee report directly to the Trust Board, the Audit Committee will receive formal feedback on the work of these committees particularly where their work can provide relevant assurance to the Audit Committees own scope of work.
In receiving feedback on the work of the Safety, Quality and Standards Committee and issues around clinical risk management the Audit Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function.

In addition, the Committee will seek assurance on the work of other committees within the organisation, which fall within the Audit Committee’s own scope of work.

10.6 Anti Fraud

The Committee shall seek assurance that the organisation has adequate arrangements in place for countering fraud, bribery and corruption and shall review the outcomes of the anti-fraud work programme. This will include receipt of the Anti-Fraud Work Plan with progress reports provided on a recurring basis, plus the Anti-Fraud Annual Report, to ensure that the Committee is satisfied with action taken throughout the year and that significant losses have been properly investigated and reported to the internal and external auditors and relevant external bodies including NHS Protect.

10.7 Management

The Committee shall seek assurance through reports and updates from Directors and managers on the overall arrangements for governance, risk management and internal control.

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

Members of the Audit Committee will meet with External Auditors at least once a year.

10.8 Financial Reporting

The Committee shall seek assurance on the integrity of the financial statements of the Trust and any formal announcements relating to the Trust’s financial position.

The Committee should ensure that the systems for financial reporting to the Board, including those of budgetary control are subject to review as to completeness and accuracy of the information provided.
The Committee shall review the Annual Report and Financial Statements before making recommendations for submission to the Board, focusing particularly on:

- changes in, and compliance with, accounting policies and practices;
- major judgmental areas in preparation of the financial statements;
- Un-adjusted mis-statements in the financial statements;
- significant adjustments resulting from the audit;
- letter of representation;
- qualitative aspects of financial reporting; and
- the wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference.

The Committee shall review the quality account before submission to the Board.

10.9 Other Matters

To identify risks arising from the issues before the Committee. The Chair of the Committee will draw to the attention of the Trust Board issues which require disclosure to the full Board or require executive action.

The Committee will report to the Board at least annually on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Assurance Framework, risk management in the organisation, the integrated governance arrangements and the robustness of the processes behind the accounts.

11. Conduct of Meetings

- Agendas will normally be prepared and circulated 5 days in advance.

- Any member or attendee may request an item for the agenda through the Chair.

- Members will have the right to speak and if necessary vote at meetings of the Committee. Attendees may speak and their opinions may be sought but they will not participate in any formal vote.

- Any interest in the matter under discussion (as defined in Standing Orders) will be declared. The person declaring an interest will withdraw whilst the issue is being discussed.

- In the event of a formal vote, a simple majority will prevail. In the event of a tied vote the Chair will have a deciding vote, provided that nothing in the way business is conducted is prohibited in Standing Orders of the Trust.
12. Reporting

Reports to the Board will be made as follows:

- The minutes of Audit Committee meetings shall be formally recorded and submitted to the Trust Board by the Chair and/or lead Executive of the Committee. In limited circumstances as covered in the Freedom of Information Act, e.g. where confidential personal information is involved, a summary or suitably edited minutes will be presented.

- Due to the timing of the Committee meetings, a verbal update, providing items for assurance and emerging risks and mitigating actions will be given to the trust board following meetings on matters that were discussed at Audit Committee meetings.

- An Annual Report of the Audit Committee

- The External Audit Annual Report.

13. Annual Review of the Audit Committee

The Committee will undertake an annual self assessment on their effectiveness and performance to:

- Review its own performance to ensure it is operating effectively;
- Determine whether its planned activities and responsibilities for the previous year have been sufficiently discharged; and
- Recommend any changes and/or actions it considers necessary, in respect of the above.

An annual written report will be provided to the Board which will provide details of the outcome of an annual self-assessment.

14. Monitoring Compliance

As part of the annual self assessment referred to in paragraph 13 which will be reported in the annual report, the Committee will review that the terms of reference have been complied with and whether they remain fit for purpose. As a minimum, the terms of reference must include:

a) Duties
b) Reporting arrangements to the board
c) Membership, including nominated deputy where appropriate
d) Required frequency of attendance by members
e) Reporting arrangements into the Audit Committee
f) Requirements for a quorum
g) Frequency of meetings
h) Process for monitoring compliance with all of the above
15. **Terms of Reference**

These Terms of Reference were approved by the Trust Board at its meeting in February 2019. Any variation, including to the membership, will require the approval of the Trust Board.

The Trust Board may formally change the Terms of Reference at any time, either at its own initiation or following a request for variation submitted by the Committee.

The Committee will review the Terms of Reference annually for resubmission to the Trust Board.

The Trust Board will review the Terms of Reference submitted in the light of the wider requirements of the Trust and may amend them before approval.

The terms of reference will be reviewed in February 2020 by the Audit Committee (unless required to be reviewed earlier).

These terms of reference may be subject to further amendment following a deep dive review of the outcomes of the recent self assessment on committee effectiveness, which is still being worked through.
# Title: Finance, Performance and Workforce Committee

## Authors Name:
Julie Green, Director of Corporate Affairs & Governance

## Scope:
Trust Wide

## Classification:
Trust Organisation Structure and Minutes

## Replaces:
Not Applicable

## To be read in conjunction with the following documents:
The Trust’s Standing Orders and other Committee Terms of Reference

## Unique Identifier:

## Review Date:
March 2020

This document is no longer authorised for use after this date

## Issue Status:
1

## Issue No:
1

## Issue Date:
April 2019

## Authorised by:
The Trust Board

## Authorisation Date:
April 2019

## Document for Public Display:
Yes

After this document is withdrawn from use it must be kept in an archive for 6 years.

## Archive:

Date added to Archive:

## Officer responsible for archive:
1. Constitution

The Board hereby resolves to establish a Committee of the Board to be known as the Finance, Performance and Workforce Committee (the Committee), which is directly accountable to the Board.

2. Definition

This Committee is established as a Standing Committee of the Trust Board of East Cheshire NHS Trust in order to provide the Trust Board with assurance that national and local standards relating to finance, performance and workforce are being met.

3. Membership

Minimum 2 Non-Executive Directors (one of which will Chair)
All Executive Directors

4. Quorum

The quorum shall be at least three members, one of which shall be a Non-Executive Director.

5. Attendance

Members of the Committee should make every effort to attend meetings in person. There may be circumstances where members join by telephone. If members are on annual or sick leave, deputies who have the appropriate level of authority, should attend. The Chair should be notified of members wishing to join by telephone, and the attendance of deputies, at least 24 hours in advance of the meeting.

Other specialists may be co-opted to discuss specific items on the agenda.

Members of the Finance, Performance and Workforce Committee must achieve a minimum of 75% meeting attendance. Nominated deputies attendance will not count towards the member’s attendance levels.

6. Chairmanship

The Chair of the Committee will be a Non-Executive Director.

The Chair will nominate a member of the Committee to Chair the meeting in their absence.

7. Minutes

The minutes of the meeting shall be drawn up and submitted for agreement at the next ensuing meeting.
8. **Frequency of Meetings**

The Committee shall meet a minimum of ten times per annum.

8.1 **Emergency Powers**

Where an urgent decision needs to be made in between scheduled meetings, the Chair of the committee can convene an Extra-ordinary meeting to discuss a particular issue, quorum rules as stated in paragraph 4 still apply. If it is not practicable to meet in person, matters can be dealt with through telephone or the exchange of emails. The exercise of such powers shall be reported and minuted at the next Committee meeting.

9. **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 member of staff and all members of staff are directed to co-operate with any request made by the Committee.

10. **General Responsibilities and Principles**

10.1 **Finance**

- To seek assurance that systems and controls are in place to enable the Trust to meet its financial objectives of sustaining financial balance.

- To seek assurance on the production and implementation of long term financial plans and ensure these are aligned to workforce plans.

- To provide assurance to the Board that Quality, Innovation, Productivity and Prevention (QIPP) schemes are in accordance with national best practice guidance and that clinical leadership is driving performance improvement.

- To seek assurance on the planning and implementation of tenders.

- To seek assurance on the planning and implementation of the capital programme.

- To seek assurance on the performance and associated risks of finance plans and reporting.
10.2 Workforce

- To seek assurance on the continued development and timely delivery of the workforce strategy and its supporting plans and to ensure the workforce plan is aligned with service and financial plans.
- To provide assurance that the Trust is working within legislation and a good employment framework.
- To seek assurance on the development of appropriate learning and development and receive assurance that the trust is meeting its statutory and mandatory requirements.
- To seek assurance on the performance and associated risks of workforce plans and reporting.
- To seek assurance on the production and implementation of long term workforce plans.

10.3 Performance

- To provide assurance that the organisation has quality systems and processes which underpin sound performance and workforce modelling to deliver redesigned clinical pathways.
- To seek assurance on the delivery of the key performance measures of the trust, with a focus on sustained performance and future delivery.
- To seek assurance on the performance and associated risks of performance plans and reporting.

10.4 Other Matters

The Finance, Performance and Workforce Committee seeks assurance from each of the Sub-Committees and in conjunction with the scope of its own work, provides assurance directly to the Board.

This Committee will work closely with the Audit Committee in supporting their assurance function.

The Committee will look to see how finance, workforce and performance initiatives align with those of partner organisations.
11. **Conduct of Meetings**

- Agendas will normally be prepared and circulated 5 days in advance.

- Any member may request an item for the agenda through the Chair.

- Declarations of interest will be collected at the start of each meeting – there is requirement that members of committee must make annual declarations of interests.

- Any interest in the matter under discussion (as defined in Standing Orders) will be declared. The person declaring an interest will withdraw whilst the issue is being discussed.

- All meetings will be minuted and:
  - approved by the Chair before submission to the trust Board or wider circulation
  - approved by the Committee Members at the following meeting of the Committee
  - an Action Log will be updated following each meeting which will include open and closed actions

12. **Reporting**

12.1 Reports to the Board will be made as follows:

12.2 The minutes of Finance, Performance and Workforce Committee meetings shall be formally recorded and submitted to the trust Board by the Chair and/or lead Executive of the Committee. In limited circumstances as covered in the Freedom of Information Act, e.g. where confidential personal information is involved, a summary or suitably edited minutes will be presented.

12.2 Due to the timing of the Committee dates, a verbal update will be given to the trust Board after every meeting on matters that were discussed at Finance, Performance and Workforce Committee meetings.

12.3 An annual report of the Finance, Performance and Workforce Committee

12.4 Reporting Arrangements of other Committees.

The Board may identify sub committees to be established to provide further assurance.

Areas of risk will be escalated in line with the trust Risk Management System.
13. **Annual Review of the Finance, Performance and Workforce Committee**

The Committee will undertake an annual self assessment on their effectiveness and performance to:

- Review its own performance to ensure it is operating effectively;
- Determine whether its planned activities and responsibilities for the previous year have been sufficiently discharged; and
- Recommend any changes and/or actions it considers necessary, in respect of the above.

An annual written report will be provided initially to the Audit Committee before being submitted to the Board. This will provide details the outcome of an annual self-assessment.

14. **Monitoring Compliance**

As part of the annual self-assessment referred to in paragraph 13 which will be reported in the annual report, the Committee will review that the terms of reference have been complied with and whether they remain fit for purpose. As a minimum, the terms of reference must include:

a) Duties  
b) Reporting arrangements to the Board  
c) Membership, including nominated deputy where appropriate  
d) Required frequency of attendance by members  
e) Reporting arrangements into the Finance, Performance and Workforce Committee  
f) Requirements for a quorum  
g) Frequency of meetings  
h) Process for monitoring compliance with all of the above

15. **Terms of Reference**

These Terms of Reference were approved by the trust Board at its meeting in March 2019 and will be reviewed at the meeting in February 2020. Any variation, including to the membership, will require the approval of the trust Board.

The trust Board may formally change the Terms of Reference at any time, either at its own initiation or following a request for variation submitted by the Committee.

The Committee will review the Terms of Reference annually for resubmission to the trust Board.

The trust Board will review the Terms of Reference submitted in the light of the wider requirements of the trust and may amend them before approval.

The terms of reference will next be reviewed in February 2020 (unless required to be reviewed earlier).
# APPENDIX B5 – CLINICAL MANAGEMENT BOARD TERMS OF REFERENCE

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<td></td>
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<tr>
<td>Scope: trust Wide</td>
<td>Classification: trust Organisation Structure and Minutes</td>
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Document for Public Display: Yes

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1. **Definition**

The Clinical Management Board has been established to ensure clinical leaders work alongside executives to manage the business of East Cheshire NHS Trust. It is the overarching forum for managing risks.

2. **Purpose**

The Clinical Management Board will set the expected standard and provide assurance that management plans are in place to deliver the Board objectives and will ensure clinical engagement exists at the highest level of operational decision making by:

- Developing the Clinical Strategy
- Monitoring performance against key objectives
- Ensuring strategic and corporate risks are being actively managed
- To shape annual and strategic plans
- Resolve operational issues, which have been escalated that impact across the trust
- To ensure there is clear linkage with Directorates and other Corporate Functions to deliver the business of the trust

This will facilitate a Leadership Team:

- Working as a team to manage the whole trust by ensuring resources are targeted where they are most needed
- Being up to date with all the issues of the trust and being familiar with benchmarking and good practice
- That challenges itself in striving to be the best
- That is recognised by other senior clinical and managerial colleagues for good communication and clarity of purpose

3. **Annual Work Programme**

Work programme will be developed focusing on the highest risks.

This will include:
- Systematic monitoring of all performance (Quality, Safety, Finance and Corporate Functions)
- Reviewing risks and management thereof
- Issues requiring CMB/Board approval
- Assurance to the Board on key issues via the Chief Executive
- An annual self-assessment of the achievements of the Clinical Management Board.

4. **Powers**

To make operational decisions in line with the Scheme of Delegation.
5. **Frequency of Meetings**

   Bi-monthly.
   Members will be expected to attend for 75% of meetings and attendance registers will be maintained.

6. **Membership**

   - Executive Directors
   - Clinical Directors
   - Clinical Leads

   **In attendance:**
   - Associate Directors
   - Deputy Directors

   Other members may be co-opted to attend depending on the Agenda item.

7. **Reporting Groups**

   The following groups will report to Clinical Management Board: key issues reported are slippage of agreed trajectories or changes/proposed developments, which impact on the business of the trust, which will be mitigated through the corporate risk register. Chairs of the following meetings to provide a Chairman’s brief to CMB twice yearly:

   - Capital & Space Planning
   - Digital Transformation Group
   - Pathology Executive Board
   - Information Governance & Record Management Group (includes assurance requirements)
   - Operational Management Team
   - Emergency Preparedness (includes assurance requirements)
   - **Recovery Programme Board**

   **Partnership Agreements:**
   - ICT Service Level Agreement
   - Pathology Service Level Agreement
   - Cheshire Occupational Health Services
   - SBS Contract

9. **Quorum**

   - 2 Executive Directors
   - 3 Clinical Directors/or agreed representative

10. **Chairmanship**

   The Chair of the CMB will be the CEO or Deputy CEO (or another Executive Director in their absence).
11. **Conduct of Meetings**

- Agendas will normally be prepared and circulated 5 days in advance of a committee meeting.
- An Action Log of open and closed actions will be produced.
- Any member may request an item for the agenda through the chair.
- Any interest in the matter under discussion (as defined in Standing Orders) will be declared. The Person declaring an interest will withdraw whilst the issue is being discussed.
- In the event of a formal vote, a simple majority will prevail. In the event of a tied vote the chair will have the deciding vote, provided that nothing is in the way business is conducted is prohibited in Standing Orders of the trust.

12. **Terms of Reference**

These will be reviewed annually.
Supporting Policies and Procedures
POLICIES AND PROCEDURES

C1 – Local Anti-Fraud, Bribery and Corruption Policy
C2 – Raising Concerns Policy
C3 – Tendering Procedure
C4 – Standard operating procedure for competing for contracts
C5 – Procurement Waiver Process Diagram
C6 - Fit and proper persons policy
C7 - Consultancy spending approval criteria: updated guidance to providers
C8 – Conflicts of Interest Policy
C9 – Overpayments Policy
APPENDIX C1

Local Anti-Fraud, Bribery and Corruption Policy
## Executive Summary:

East Cheshire Trust is committed to reducing the level of fraud and corruption within the NHS to an absolute minimum and keeping it at that level, freeing up public resources for better patient care. This policy has been produced by the Anti-Fraud Specialist (AFS) and is intended as a guide for all employees on anti-fraud work within the NHS.

### Supersedes:

V8

### Description of Amendment(s):

- Removal of references to the NHS CFA national case management system FIRST which is being replaced from 1st April 2019.
- Additional references to the NHS CFA Standards for Providers following feedback from NHS CFA inspections at North West health bodies

### This policy will impact on:

All employees within the Trust.

### Financial Implications:

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<td>Mark Ogden</td>
<td>31 March 2020</td>
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<td></td>
<td>Director of Finance</td>
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<tr>
<td>Roger Causer</td>
<td>March 2019</td>
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<td>Local Anti-Fraud Specialist</td>
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### APPROVAL RECORD

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<td>March 2019</td>
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<td>March 2019</td>
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5 Roles and Responsibilities
   5.1 Role of the Board / Audit Committee
   5.2 Chief Executive
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   5.4 Managers
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   5.6 Anti-Fraud Specialist (AFS)
   5.7 NHS Counter Fraud Authority (NHSCFA)
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1 Introduction

One of the basic principles of public sector organisations is the proper use of public funds. The majority of people who work in the NHS conduct themselves in an honest and professional manner and they believe that fraud, bribery and corruption, committed by a minority, is wholly unacceptable as it ultimately leads to a reduction in the resources available for patient care.

East Cheshire NHS Trust (the ‘Trust) is committed to reducing the level of fraud, bribery and corruption within the NHS to an absolute minimum and keeping it at that level, freeing up public resources for better patient care. The Trust does not tolerate fraud, bribery or corruption and aims to eliminate all such activity as far as possible.

The Trust wishes to encourage anyone having reasonable suspicions of fraud, bribery or corruption to report them. For the purposes of this policy “reasonably held suspicions” shall mean any suspicions other than those which are totally groundless (and/or raised maliciously).

It is the Trust policy that no employee will suffer in any way as a result of reporting these suspicions. This protection is given under the provisions of the Public Interest Disclosure Act which the Trust is obliged to comply with.

The Trust will take all necessary steps to counter fraud, bribery and corruption in accordance with this policy, the NHS Anti-Fraud, Bribery and Corruption Manual, the policy statement ‘Applying Appropriate Sanctions Consistently’ published by NHS Counter Fraud Authority (NHS CFA), formerly known as NHS Protect and in line with the NHS CFA’s strategy ‘Tackling crime against the NHS: A strategic approach’ plus any other relevant guidance or advice issued by the NHS CFA. The Trust will seek the appropriate disciplinary, regulatory, civil and criminal sanctions [as well as referral to professional bodies, where appropriate] against fraudsters and where possible will attempt to recover losses.

Each Trust is required to appoint its own dedicated Anti-Fraud Specialist (AFS) who is accredited by the NHS CFA and accountable to them professionally for the completion of a range of preventative anti-fraud and corruption work in accordance with the NHS CFA Standards for Providers, as well as for undertaking any necessary investigations. Locally, the AFS is accountable on a day-to-day basis to the Trust’s Director of Finance and reports, periodically, to the Trust Audit Committee.

All instances where fraud, bribery and/or corruption is suspected are thoroughly investigated by staff trained by NHS CFA. Any investigations will be undertake in accordance with the NHS Anti-Fraud and Corruption Manual.

[NB. For staff awareness, theft issues are usually dealt with by local security management (LSMS), not the AFS. However, the AFS will be mindful of any potential criminality identified in the course of any investigation and will, with the agreement of the Director of Finance, notify the appropriate investigating authority.

1.1 Objectives

The Trust is committed to taking all necessary steps to counter fraud, bribery and corruption.
Under the NHS Standards Contract all organisations providing NHS services are required to put in place appropriate anti-fraud management arrangements. The NHSCFA approach to tackling fraud and other economic crime against the NHS (‘Leading the fight against NHS fraud: Organisational strategy 2017-20’) is guided by four principles:

- **Inform and involve**: raise awareness of fraud against the NHS, and work with over 1.3 m NHS staff, with stakeholders and the public to highlight those risks and the consequences of fraud against the NHS;
- **Prevent and deter**: provide solutions to identified fraud risks, discourage individuals who may be tempted to commit fraud against the NHS and ensure that opportunities for fraud to occur are minimised;
- **Investigate, sanction and seek redress**: investigate allegations of fraud thoroughly and to the highest professional standards, where appropriate seek the full range of civil, criminal and disciplinary sanctions and seek redress where possible;
- **Continuously review and hold to account**: fraud is constantly evolving and continuous re-evaluation and improvement is needed to ensure that we keep ahead of the problem. Where this does not take place, or where there is a reluctance to do so, then organisations must be held to account for their inaction.

The overall requirement underpinning these principles is effective **strategic governance**, strong leadership and a demonstrable level of commitment to tackling fraud from senior management within organisations.

### 1.2 Scope

This policy has been produced by the Trust’s AFS, and is intended to provide a guide for all employees [regardless of position], contractors, consultants, vendors and other internal and external stakeholders who have a professional or business relationship with the Trust, on fraud and corruption are in the NHS; what everyone’s responsibility are to prevent fraud, bribery and corruption; and also how to report concerns and/or suspicions with the intention of reducing fraud to a minimum within the Trust.

This policy relates to all forms of fraud, bribery and corruption and is intended to provide direction and help to employees who may identify suspected fraud, corruption or bribery. It provides a framework for responding to suspicions of fraud, bribery and corruption, advice and information on various aspects of fraud, bribery and corruption and implications of an investigation. It is not intended to provide a comprehensive approach to preventing and detecting fraud, bribery and corruption.

### 2 Definitions

The definitions applicable to this policy are as follows:

#### 2.1 NHS Counter Fraud Authority

The NHS CFA is a new special health authority dedicated to tackling fraud, bribery and corruption within the health service. The NHS CFA provides a clear focus for both the prevention and investigation of fraud across the health service and works with NHS England and NHS Improvement to properly uncover fraud and tackle it effectively.
2.2 Fraud

The Fraud Act 2006 introduced an entirely new way of investigating and prosecuting fraud. Previously, the word ‘fraud’ was an umbrella term used to cover a variety of criminal offences falling under various legislative acts. It is no longer necessary to prove that a person has been deceived, or for a fraud to be successful. The focus is now on the dishonest behaviour of the suspect and their intent to make a gain either for themselves or another; to cause a loss to another; or, expose another to a risk of a loss.

There are several specific offences under the Fraud Act 2006; however, there are three primary ways in which it can be committed that are likely to be investigated by the AFS;

The offence of fraud can be committed in three ways:

- **Fraud by false representation (s.2)** – lying about something using any means, e.g. falsifying a CV or NHS job application form
- **Fraud by failing to disclose (s.3)** – not saying something when you have a legal duty to do so, e.g. failing to declare a conviction, disqualification or commercial interest when such information may have an impact on your NHS role, duties or obligation and where you are required to declare such information as part of a legal commitment to do so.
- **Fraud by abuse of a position of Trust (s.4)** – abusing a position where there is an expectation to safeguard the financial interests of another person or organisation, e.g. a carer abusing their access to patients monies, or an employee using commercially confidential NHS information to make a personal gain.

It should be noted that all offences under the Fraud Act 2006 occur where the act or omission is committed dishonestly and with intent to cause gain or loss. The gain or loss does not have to succeed, so long as the intent is there. Successful prosecutions under the Fraud Act 2006 may result in an unlimited fine and/or a potential custodial sentence of up to 10 years.

2.3 Bribery and Corruption

Bribery and corruption prosecutions can be brought using specific pieces of legislation:

- Prevention of Corruption Acts 1906 and 1916, for offences committed prior to 1st July 2011
- Bribery Act 2010, for offences committed on or after 1st July 2011.

The Bribery Act 2010 reforms the criminal law of bribery, making it a criminal offence to:

- Give, promise or offer a bribe (s.1), and/or
- Request, agree to receive or accept a bribe (s.2).

Corruption is generally considered to be an “umbrella” term covering such various activities as bribery, corrupt preferential treatment, kickbacks, cronyism, theft or embezzlement. Under the 2010 Act, however, bribery is now a series of specific offences.

Generally, bribery is defined as: an inducement or reward offered, promised or provided to
someone to perform their functions or activities improperly in order to gain a personal, commercial, regulatory and/or contractual advantage.

Examples of bribery in an NHS context could be a contractor attempting to influence a procurement decision-maker by giving them an extra benefit or gift as part of a tender exercise; or, a medical or pharmaceutical company providing holidays or other excessive hospitality to a clinician in order to influence them to persuade their Trust to purchase that company’s particular clinical supplies.

A bribe does not have to be in cash; it may be the awarding of a contract, the provision of gifts, hospitality, sponsorship, the promise of work or some other benefit. The persons making and receiving the bribe may be acting on behalf of others – under the Bribery Act 2010, all parties involved may be prosecuted for a bribery offence.

All staff are reminded to ensure that they are transparent in respect of recording any gifts, hospitality or sponsorship and they should refer to the separate Trust policy, the ‘Conflict of Interest Policy’ covering:

- Acceptance of Gifts and Hospitality
- Declaration of Interests
- Sponsorship.

The Bribery Act 2010 is also extra-territorial in nature. This means that anyone involved in bribery activity overseas may be liable to prosecution in the UK if the bribe is in respect of any UK activity, contract or organisation. To this end, the Bribery Act 2010 also includes an offence of bribing a foreign public official [s.6].

In addition, the Bribery Act 2010 introduces a new ‘corporate offence’ [s.7] of the failure of commercial organisations to prevent bribery. The Department of Health Legal Service has stated that NHS bodies are deemed to be ‘relevant commercial organisations’ to which the Act applies. As a result, an NHS body may be held liable (and punished with a potentially unlimited fine) when someone “associated” with it bribes another in order to get, keep or retain business for the organisation. However, the organisation will have a defence, and avoid prosecution, if it can show it had ‘adequate procedures’ in place designed to prevent bribery.

Finally, under section 14 of the Bribery Act 2010, a senior officer of the organisation (e.g. a Senior Manager, an Executive or Non-Executive Director) would also be liable for prosecution if they consented to or connived in a bribery offence carried out by another. Under such circumstances, the senior officer may be prosecuted for a parallel offence to that brought against the primary perpetrator. Furthermore, the organisation could also be subject to an unlimited fine because of the senior officer’s consent or connivance.

To re-iterate, the Bribery Act 2010 is applicable to NHS organisations including East Cheshire NHS Trust and, consequently, it also applies to (and can be triggered by) everyone “associated” with this Trust who performs services for us, or on our behalf, or who provides us with goods. This includes those who work for and with us, such as employees, agents, subsidiaries, contractors and suppliers (regardless of whether they are incorporated or not). The term ‘associated persons’ has an intentionally wide interpretation under the Bribery Act 2010.
The Trust adopts a ‘zero tolerance’ attitude towards bribery and does not, and will not, pay or accept bribes or offers of inducement to or from anyone, for any purpose. The Trust is fully committed to the objective of preventing bribery and will ensure that adequate procedures, which are proportionate to our risks, are in place to prevent bribery and which will be regularly reviewed. We will, in conjunction with the NHS CFA seek to obtain the strongest penalties – including criminal prosecution, disciplinary and/or civil sanctions – against anyone associated with the Trust who is found to be involved in any bribery or corruption activities.

As with the Fraud Act 2006, a conviction under the Bribery Act 2010 may ultimately result in an unlimited fine and/or a custodial sentence of up to 10 years imprisonment.

3 Other Relevant Procedural Documents

This policy should be read in conjunction with the following documents:

- Disciplinary Policy and Procedure
- Speak Up Policy
- Conflicts of Interest Policy.

4 Codes of Conduct

The Codes of Conduct for NHS boards and NHS managers set out the key public service values. They state that high standards of corporate and personal conduct, based on the recognition that patients come first, have been a requirement throughout the NHS since its inception. These values are summarised as:

**Accountability** - Everything done by those who work in the authority must be able to stand the tests of parliamentary scrutiny, public judgements on propriety and professional codes of conduct.

**Probity** - Absolute honesty and integrity should be exercised in dealing with NHS patients, assets, staff, suppliers and customers.

**Openness** - The health body’s activities should be sufficiently public and transparent to promote confidence between the authority and its staff and the public.

All staff should be aware of and act in accordance with these values. In addition, staff are expected to:

- Act impartially in all their work
- Refuse gifts, benefits, hospitality or sponsorship of any kind that might reasonably be seen to compromise their judgement or integrity; and, to avoid seeking to exert influence to obtain preferential consideration. All such gifts should be returned and hospitality refused
- Declare and register gifts, benefits or sponsorship of any kind, in accordance with limits agreed locally, whether refused or accepted
Declare and record financial, non-financial or personal interest (e.g. company shares, research grant) in any organisation with which they have to deal, and be prepared to withdraw from those dealings if required, thereby ensuring that their professional judgement is not influenced by such considerations.

Make it a matter of policy that offers of sponsorship that could possibly breach the Code be reported to the Board.

Not misuse their official position or information acquired in the course of their official duties, to further their private interests or those of others.

Ensure professional registration (if applicable) and/or status are not used in the promotion of commercial products or services.

Beware of bias generated through sponsorship, where this might impinge on professional judgement or impartiality.

Neither agree to practice under any conditions which compromise professional independence or judgement, nor impose such conditions on other professionals.

All staff are also reminded that every NHS employee, regardless of position or status, must comply with the Conflicts of Interest in the NHS – Guidance for staff and organisations which may be accessed at: https://www.england.nhs.uk/wp-content/uploads/2017/02/guidance-managing-conflicts-of-interest-nhs.pdf

Relevant personnel are also reminded that their professional bodies will also have codes of conduct or standards of behaviour which they will be expected to adhere to.

5 Roles and Responsibilities

Through our day-to-day work, we, i.e. all staff, are in the best position to recognise any specific risks within our own areas of responsibility. We also have a duty to ensure that those risks – however large or small – are identified and eliminated. Where you believe the opportunity for fraud, corruption or bribery exists, whether because of poor procedures or oversight, you should report it to the AFS or the NHS Fraud and Corruption Reporting Line and/or online Fraud Reporting Form.

This section states the roles and responsibilities of employees and other relevant parties in reporting fraud or corruption.

5.1 Role of the Board / Audit Committee

The Trust has a duty to ensure that it provides a secure environment in which to work, and one where people are confident to raise concerns without worrying that it will reflect badly on them. This extends to ensuring that staff feel protected when carrying out their official duties and are not placed in a vulnerable position. If staff have concerns about any procedures or processes that they are asked to be involved in, the Trust has a duty to ensure that those concerns are listened to and addressed.

The Trust Board (via its Audit Committee) has a duty to provide adequate governance and oversight of the Trust to ensure that it’s funds, people and assets are adequately protected against criminal activity, including fraud, bribery and corruption.
5.2 Chief Executive

The Trust's Chief Executive, as the organisation's accountable officer, has overall responsibility for securing funds, assets and resources entrusted to it, including instances of fraud, bribery and corruption.

The Chief Executive must ensure adequate policies and procedures are in place to protect the organisation and the public funds it receives. However, responsibility for the operation and maintenance of controls falls directly to line managers and requires the involvement of all of Trust employees. The Trust therefore has a duty to ensure employees who are involved in or who are managing internal control systems receive adequate training and support in order to carry out their responsibilities. Therefore, the Chief Executive and Director of Finance will monitor and ensure compliance with this policy.

5.3 Director of Finance

The Director of Finance [DoF], in conjunction with the Chief Executive, monitors and ensures compliance with the Trust's contractual requirements regarding fraud, bribery and corruption and adherence to the NHS CFA Standards for Providers.

The DoF has powers to approve financial transactions initiated by directorates across the organisation. The DoF prepares documents and maintains detailed financial procedures and systems; and applies the principles of separation of duties and internal checks to supplement those procedures and systems.

The DoF will report annually to the Board on the adequacy of internal financial controls and risk management as part of the Board's overall responsibility to prepare the annual governance statement for inclusion in the organisation's annual report.

The DoF will, depending on the outcome of investigations (whether on an interim/on-going or concluding basis) and/or the potential significance of suspicions that have been raised, inform appropriate senior management accordingly.

The AFS shall be responsible, in discussion with the DoF, for informing third parties such as external audit or the police at the earliest opportunity, as circumstances dictate.

The DoF will inform and consult the Chief Executive in cases where the loss or where the incident may lead to adverse publicity.

The DoF or the AFS will consult and take advice from the Director of Human Resources and Organisational Development if a member of staff is to be interviewed, suspended or disciplined. The DoF or AFS will not conduct a disciplinary investigation, but the employee may be the subject of a separate investigation by HR.

5.4 Managers

Managers must be vigilant and ensure that procedures to guard against fraud, bribery and corruption are applied and monitored. They should be alert to the possibility that unusual events or transactions could be symptoms of fraud, bribery and corruption. If they have any doubts, they must seek advice from the nominated AFS.

Managers must instil and encourage an anti-fraud, bribery and corruption culture within their team and ensure that information on procedures is made available to all employees. The desktop guide [Appendix A] provides a reminder of the key contacts and a checklist of
the actions to follow if fraud, bribery and corruption, or other illegal acts, are discovered or suspected. Managers are encouraged to copy this to staff and to place it on staff notice boards in their department.

The AFS will proactively assist the encouragement of an anti-fraud, bribery and corruption culture by undertaking work that will raise fraud awareness.

All instances of actual or suspected fraud, bribery and corruption which come to the attention of a manager must be reported immediately. It is appreciated that some employees will initially raise concerns with their manager. However, in such cases, managers must not attempt to investigate the allegation themselves; they have the clear responsibility to refer the concerns to the AFS as soon as possible.

Line managers at all levels have a responsibility to ensure that an adequate system of internal control exists within their areas of responsibility and that controls operate effectively. The responsibility for the prevention and detection of fraud, bribery and corruption therefore primarily rests with managers but requires the co-operation of all employees.

As part of that responsibility, line managers need to:

- Inform staff of the Trust's code of business conduct and anti-fraud, bribery and corruption policy as part of their induction process, paying particular attention to the need for accurate completion of personal records and forms
- Ensure that all employees for whom they are accountable are made aware of the requirements of the policy
- Assess the types of risk involved in the operations for which they are responsible
- Ensure that adequate control measures are put in place to minimise the risks. This must include clear roles and responsibilities, supervisory checks, staff rotation (particularly in key posts), separation of duties wherever possible so that control of a key function is not invested in one individual, and regular reviews, reconciliations and test checks to ensure that control measures continue to operate effectively
- Ensure that any use of computers by employees is linked to the performance of their duties within the Trust
- Be aware of the Trust's anti-fraud, bribery and corruption policy and the rules and guidance covering the control of specific items of expenditure and receipts
- Identify financially sensitive posts
- Ensure that controls are being complied with
- Contribute to their director's assessment of the risks and controls within their business area, which feeds into the Trust's and the Department of Health Accounting Officer's overall statements of accountability and internal control.
5.5 Employees

the Trust's Standing Orders, Standing Financial Instructions, policies and procedures place an obligation on all employees and non-executive directors to act in accordance with best practice.

Employees are expected to act in accordance with the standards laid down by their professional institutes, where applicable, and have a personal responsibility to ensure that they are familiar with them.

Employees also have a duty to protect the assets of the Trust, including information and property.

In addition, all employees have a responsibility to comply with all applicable laws, regulations and Trust policies relating to ethical business behaviour, procurement, personal expenses, conflicts of interest, confidentiality and the acceptance of gifts and hospitality. This means, in addition to maintaining the normal standards of personal honesty and integrity, all employees should always:

- Avoid acting in any way that might cause others to allege or suspect them of dishonesty
- Behave in a way that would not give cause for others to doubt that the Trust's employees deal fairly and impartially with official matters
- Be alert to the possibility that others might be attempting to deceive.

All employees have a duty to ensure that public funds are safeguarded, whether or not they are involved with cash or payment systems, managing budgets or dealing with contractors or suppliers.

If an employee suspects that there has been fraud, corruption or bribery, or has seen any suspicious acts or events, they must report the matter to the nominated AFS.

Mersey Internal Audit Agency (MIAA), an NHS agency, provides the Trust's AFS service under contract. The Trust's nominated AFS is Roger Causer who can be contacted on 0151 285 4675 or 07768 131 806

5.6 Anti-Fraud Specialist (AFS)

The AFS is operationally accountable to the Trust's Director of Finance and reports on the progress of all anti-fraud and corruption activity to the Trust Audit Committee. The AFS is responsible for taking forward all anti-fraud work locally in accordance with national NHS CFA Standards for Providers and regularly reports to the Director of Finance on the progress of the investigation and when/if referral to the police is required.

The AFS liaises with several key stakeholders and key contacts across the Trust and undertakes their duties to the highest possible standards at all times.
The AFS will:

- Ensure that the Director of Finance is informed about all referrals/cases and approves any necessary investigation activity.

- In particular, conduct investigations of all alleged fraud, bribery and corruption in accordance with the NHS Anti-Fraud and Corruption Manual, Investigations Toolkit, NHS Standards for Providers and relevant criminal law.

- Be responsible for the day-to-day implementation of the key principles of anti-fraud, bribery and corruption activity and, in particular, the investigation of all suspicions of fraud, bribery and corruption.

- Investigate all cases of fraud.

- In consultation with the Director of Finance, report any cases to the NHS CFA as agreed and in accordance with the NHS Anti-Fraud and Corruption Manual.

- Report any case and the outcome of the investigation through the NHS CFA national case management system.

- Ensure that other relevant parties are informed where necessary, e.g. Human Resources (HR) will be informed if an employee is the subject of a referral.

- Ensure that the Trust incident and losses reporting system DATIX is followed.

- Ensure that any system weaknesses identified as part of an investigation are followed up with management and reported to internal audit.

- Adhere to the Counter Fraud Professional Accreditation Board (CFPAB)'s Principles of Professional Conduct as set out in the NHS Anti-Fraud and Corruption Manual.

- Not have responsibility for or be in any way engaged in the management of security for any NHS body.

In addition, the AFS will be responsible for the day to day implementation of the generic areas of anti-fraud, bribery and corruption strategy, as agreed in the fraud risk assessed annual work plan.

5.7 NHS Counter Fraud Authority (NHS CFA)

NHS CFA deliver anti-crime work that cannot be carried out by NHS health bodies regionally or in isolation. They use intelligence to identify serious and complex economic crime, reduce the impact of crime and drive improvements in anti-crime work.

Local NHS organisations are primarily accountable for dealing with crime risks in the NHS. NHS CFA provides information and guidance to local AFSs to improve anti-fraud, bribery and corruption work across the NHS.
NHSCFA’s main objectives are:

- to deliver the Department of Health (DH) strategy, vision and strategic plan, and be the principal lead for counter fraud activity in the NHS in England;
- to be the single expert intelligence led organisation providing a centralised investigation capacity for complex economic crime matters;
- to lead, guide and influence the improvement of standards in counter fraud work, in line with HM Government Counter Fraud Professional Standards, across the NHS and wider health group, through review, assessment and benchmark reporting of counter fraud provision across the system;
- to take the lead and encourage fraud reporting across the NHS and wider health group, by raising the profile of fraud and its effect on the health care system.

5.8 Internal and External Audit

The role of internal and external audit includes reviewing controls and systems and ensuring compliance with financial instructions.

Any incident or suspicion of fraud, corruption or bribery that comes to internal or external audit’s attention will be passed immediately to the nominated AFS. The outcome of the investigation may necessitate further work by internal or external audit to review systems.

5.9 Human Resources

HR will liaise closely with managers and the AFS from the outset if an employee is suspected of being involved in fraud, corruption and/or bribery, in accordance with agreed liaison protocols. HR staff are responsible for ensuring the appropriate use of the Trust’s disciplinary procedure. The HR department will advise those involved in the investigation on matters of employment law and other procedural matters, such as disciplinary and grievance procedures, as requested.

Close liaison between the AFS and HR will be essential in respect of any decision as to whether to exclude an employee from the Trust whilst necessary enquiries are on-going, though any final decision to exclude is that of the Trust. Close liaison will also be necessary to ensure that any parallel sanctions (i.e. criminal, civil and disciplinary sanctions) are applied effectively and in a coordinated manner.

HR will take steps at the recruitment stage to establish, as far as possible, the previous record of potential employees, as well as the veracity of required qualifications and memberships of professional bodies, in terms of their propriety and integrity. In this regard, temporary and fixed-term contract employees are treated in the same manner as permanent employees.

5.10 Information Management and Technology

The Head of Information Security (or equivalent) will contact the AFS immediately in all cases where there is suspicion that Trust ICT is being used for fraudulent purposes in accordance with the Computer Misuse Act 1990. Similarly, the Head of Information Security will liaise closely with the AFS to ensure that a subject’s access (both physical and electronic) to Trust ICT resources is suspended or removed where an investigation identifies that it is appropriate to do so.
6 The Response Plan

6.1 Reporting fraud, bribery and/or corruption

This section outlines the action to be taken if fraud, corruption or bribery is discovered or suspected.

All genuine suspicions of fraud, bribery and corruption must be reported directly to the AFS – contact details can be found using the following link:

Anti-Fraud Specialist Roger Causer on 0151 285 4675 or 07768131806

If the referrer believes that the Director of Finance or AFS is implicated, they should notify whichever party is not believed to be involved who will then inform the Chief Executive and Audit Committee Chairperson.

An employee can contact any executive or non-executive director of the Trust to discuss their concerns if they feel unable, for any reason, to report the matter to the AFS or Director of Finance.

If an employee feels unable, for any reason, to report the matter internally, employees can also call the NHS Fraud and Corruption Reporting Line on Freephone 08000 28 40 60 or report their concerns via the NHS Online Fraud Reporting Form [www.cfa.nhs.uk/reportfraud]

This provides an easily accessible route for the reporting of genuine suspicions of fraud, bribery and corruption within or affecting the NHS. It allows NHS staff who are unsure of internal reporting procedures to report their concerns in the strictest confidence. All calls are dealt with by experienced trained staff and any caller who wishes to remain anonymous may do so.

Anonymous letters, telephone calls, etc. are occasionally received from individuals who wish to raise matters of concern, but not through official channels. While the suspicions may be erroneous or unsubstantiated, they may also reflect a genuine cause for concern and will always be taken seriously.

The AFS will make sufficient enquiries to establish whether or not there is any foundation to the suspicion that has been raised. If the allegations are found to be malicious, they will also be considered for further investigation to establish their source.

Staff are encouraged to report reasonably held suspicions directly to the AFS. You can do this by completing the Referral Form [Appendix B] or by contacting the AFS by telephone or email using the contact details supplied on the desktop guide.

The Trust wants all employees to feel confident that they can expose any wrongdoing without any risk to themselves. In accordance with the provisions of the Public Interest Disclosure Act 1998, the Trust has produced a Speak Up Policy. This procedure is intended to complement the Trust’s Anti-Fraud, Bribery and Corruption Policy as well as other relevant Trust policies and ensures there is full provision for staff to raise any concerns with others if they do not feel able to raise them with their line manager/management chain. Corporate policies can be found on the Trust’s infonet site.
6.2 Sanctions and Redress

The Trust’s approach to pursuing sanctions in cases of fraud, bribery and corruption is that the full range of possible sanctions – including criminal, civil, disciplinary and regulatory – should be considered at the earliest opportunity and any or all of these may be pursued where and when appropriate. The consistent use of an appropriate combination of investigative processes in each case demonstrates this organisation’s commitment to take fraud, bribery and corruption seriously and ultimately contributes to the deterrence and prevention of such actions.

This organisation endorses the NHS CFA’s approach and adopts the principles contained within their policy entitled, ‘Parallel Criminal and Disciplinary Investigations’; as well as complying with the provisions of the NHS Anti-Fraud Manual with regard to applying sanctions where fraud, bribery or corruption is proven. The organisation maintains an internal joint-working and data sharing protocol between the AFS and the HR department which also covers their respective investigative duties.

The types of sanction which this organisation may apply when a financial offence has occurred include:

- **Civil Redress** – We will seek financial redress, whenever possible, to recover losses (of money or assets), including interest and costs, to fraud, bribery and corruption. Redress can be sought in various ways. These include confiscation or compensation orders or use of the Proceeds of Crime legislation in the criminal courts, as well as civil legal sanctions such as an order for repayment or an attachment to earnings where appropriate, in addition to any locally agreed voluntary negotiations or repayments. As an organisation, we actively publicise the fact that redress will be sought where applicable to recover monies lost to fraud and corruption, thus creating a further deterrent effect.

- **Criminal Prosecution** – The AFS will work in partnership with NHS CFA, the police and/or the Crown Prosecution Service, where appropriate, to bring a case to court against an alleged offender. Outcomes can range from a criminal conviction to fines and imprisonment.

- **Disciplinary Sanctions** – Disciplinary procedures will also be initiated where an employee is suspected of being involved in a fraudulent or illegal act. The health body’s disciplinary policy can be located on the Trusts infonet.

- **Professional Body Disciplinary Sanctions** – Where appropriate and if warranted, the organisation reserves the right to also report staff to their professional body as a result of a successful investigation and/or prosecution.”

7 Dissemination and Implementation

7.1 Dissemination

This policy will be brought to the attention of all employees and will form part of the induction process for new staff.

This policy will be disseminated Trust wide for all employees to understand and be made aware of via awareness presentations, the Trust’s Bulletin’s and on the Trust’s Anti-Fraud intranet page.
7.2 Implementation

The Trust’s AFS will be responsible for implementing this policy and all Trust managers have a responsibility to ensure all staff are made aware of the policy and understand it. The AFS will provide any training where required.

8 References

NHS Anti-Fraud Manual

NHS Investigations Toolkit

Speak up Policy

Disciplinary Policy

Conflicts of Interest Policy

Standing Financial Instructions, Standing Orders and the Scheme of Delegation

NHS CFA Standards for Providers


NHS Protect ‘Parallel Criminal and Disciplinary Investigations’


| Applicable Statutory, Legal or National Best Practice Requirements | Anti-Fraud and Corruption Manual  
Public Interest Disclosure Act 1998  
NHS Standards Contract  
Fraud Act 2006  
Bribery Act 2010  
NHS Conflicts of Interest Guidance  
NHS Standards for Providers |
A Desktop Guide to Reporting NHS Fraud, Bribery and Corruption

**FRAUD** is the dishonest intent to obtain a financial gain from, or cause a financial loss to, a person or party through false representation, failing to disclose information or abuse of position.

**CORRUPTION/BRIBERY** is the deliberate use of bribery or payment of benefit-in-kind to influence an individual to use their position in an unreasonable way to help gain advantage for another.

**DO**
- Note your concerns
  Record details such as your concerns, names, dates, times, details of conversations and possible witnesses. Time, date and sign your notes.
- Retain or secure evidence
  Retain any evidence that may be destroyed, but do not alter or write on it an in any way.
- Report your suspicion promptly
  Confidentiality will be respected – delays may lead to further financial loss.
- Be discreet
  Don’t discuss your concerns with anyone who doesn’t need to know

**DO NOT**
- Confront the suspect or convey concerns to anyone other than those authorised
  Never attempt to question a suspect yourself; this could alert a fraudster and place you at harm.
- Try to investigate the concern yourself
  Never attempt to gather evidence yourself unless it is about to be destroyed; gathering evidence must take into account legal procedures in order for it to be useful. Your AFS will conduct an investigation in accordance with legislation.
- Be afraid of raising your concerns
  The Public Interest Disclosure Act 1998 protects employees who have reasonable concerns. You will not suffer discrimination or victimisation by following the correct procedures.
- Do nothing!

If you suspect that fraud against the NHS has taken place, you must report it immediately, by:
- directly contacting the Anti-Fraud Specialist, or
- telephoning the freephone NHS Fraud and Corruption Reporting Line, or
- online via the fraud reporting form [www.cfa.nhs.uk/reportfraud](http://www.cfa.nhs.uk/reportfraud) or
- contacting the Director of Finance.

**Report NHS Fraud, Bribery & Corruption – contact details:**

Your Trust AFS: 0151 285 4675 or 0151 285 4500 (MIAA)
NHS Fraud and Corruption Reporting Line: 0800 028 40 60
NHS Online Reporting Form: [www.cfa.nhs.uk/reportfraud](http://www.cfa.nhs.uk/reportfraud)

All calls will be treated in confidence and investigated by professionally trained personnel

Your nominated Anti-Fraud Specialist is Roger Causer, who can be contacted by telephoning 0151 285 4675, or emailing roger.causer@miaa.nhs.uk or r.causer@nhs.net

If you would like further information about NHS Counter Fraud Authority or the work of the AFS, please visit [https://cfa.nhs.uk](https://cfa.nhs.uk)

Protecting your NHS from Fraud, Bribery and Corruption
NHS Fraud, Bribery and Corruption Referral Form

All referrals will be treated in confidence and investigated by professionally trained staff.

Note: Referrals should only be made when you can substantiate your suspicions with one or more reliable pieces of information. Anonymous applications are accepted but may delay any investigation.

1. Date

2. Anonymous application <Delete as appropriate>
   Yes (If ‘Yes’ go to section 6) or No (If ‘No’ complete sections 3–5)

3. Your name

4. Your organisation/profession

5. Your contact details

6. Suspicion

7. Please provide details including the name, address and date of birth (if known) of the person to whom the allegation relates.

8. Possible useful contacts

9. Please attach any available additional information.

Submit the completed form (in a sealed envelope marked ‘Restricted – Management’ and ‘Confidential’) for the personal attention of Roger Causer, the nominated AFS for East Cheshire NHS Trust c/o Mersey Internal Audit Agency, 1829 Building, Liverpool Road, Chester CH2 1UL.
APPENDIX C2

FREEDOM TO SPEAK UP: raising concerns (whistleblowing) policy for the NHS

April 2018
Speak up – we will listen

Speaking up about any concern you have at work is really important. In fact, it’s vital because it will help us to keep improving our services for all patients and the working environment for our staff.

You may feel worried about raising a concern, and we understand this. But please don’t be put off. In accordance with our duty of candour, our senior leaders and entire Board are committed to an open and honest culture. We will look into what you say and you will always have access to the support you need.

This policy

This ‘standard integrated policy’ was one of a number of recommendations of the review by Sir Robert Francis into whistleblowing in the NHS, aimed at improving the experience of whistleblowing in the NHS. This policy (produced by NHS Improvement and NHS England) has been adopted by East Cheshire NHS trust and all NHS organisations in England as a minimum standard to help to normalise the raising of concerns for the benefit of all patients.

Our local process has been integrated into this policy.

What concerns can I raise?

You can raise a concern about risk, malpractice or wrongdoing you think is harming the service we deliver. Just a few examples of this might include (but are by no means restricted to):

(a) unsafe patient care
(b) unsafe working conditions
(c) inadequate induction or training for staff
(d) lack of, or poor, response to a reported patient safety incident
(e) suspicions of fraud (which can also be reported to our local anti-fraud specialist):
   Anti-Fraud Specialist Roger Causer on 0151 285 4675 or 07768131806
(f) a bullying culture (across a team or organisation rather than individual instances of bullying).

For further examples, please see the Health Education England video.

Remember that if you are a healthcare professional you may have a professional duty to report a concern. If in doubt, please raise it.

Don’t wait for proof. We would like you to raise the matter while it is still a concern. It doesn’t matter if you turn out to be mistaken as long as you are genuinely troubled.

This policy is not for people with concerns about their employment that affect only them – that type of concern is better suited to our Grievance and Disputes Policy available via HR Direct or the HR team.
Feel safe to raise your concern

If you raise a genuine concern under this policy, you will not be at risk of losing your job or suffering any form of reprisal as a result. We will not tolerate the harassment or victimisation of anyone raising a concern. Nor will we tolerate any attempt to bully you into not raising any such concern. Any such behaviour is a breach of our values as an organisation and, if upheld following investigation, could result in disciplinary action.

Provided you are acting honestly, it does not matter if you are mistaken or if there is an innocent explanation for your concerns.

Confidentiality

We hope you will feel comfortable raising your concern openly, but we also appreciate that you may want to raise it confidentially. This means that while you are willing for your identity to be known to the person you report your concern to, you do not want anyone else to know your identity. Therefore, we will keep your identity confidential, if that is what you want, unless required to disclose it by law (for example, by the police). You can choose to raise your concern anonymously, without giving anyone your name, but that may make it more difficult for us to investigate thoroughly and give you feedback on the outcome.

Who can raise concerns?

Anyone who works (or has worked) in the NHS, or for an independent organisation that provides NHS services can raise concerns. This includes agency workers, temporary workers, students, volunteers and governors.

Who should I raise my concern with?

In many circumstances the easiest way to get your concern resolved will be to raise it formally or informally with your line manager (or lead clinician or tutor). But where you don’t think it is appropriate to do this, you can use any of the options set out below in the first instance.

If raising it with your line manager (or lead clinician or tutor) does not resolve matters, or you do not feel able to raise it with them, you can contact one of the following people:

1. The difference between raising your concern formally and informally is explained in our local process. In due course NHS England and NHS Improvement will consider how recording could be consistent nationally, with a view to a national reporting system.

2. Annex A sets out an example of how a local process might demonstrate how a concern might be escalated

(a) our Freedom to Speak Up Guardian: Mrs Lorraine Jackman Deputy Director of Corporate Affairs and Governance 01625 663175 or Email ecn-tr.SpeakingUpForSafety@nhs.net

This is an important role identified in the Freedom to Speak Up review to act as an independent and impartial source of advice to staff at any stage of raising a concern, with access to anyone in the organisation, including the chief executive, or if necessary, outside the organisation. See also Infonet page:

http://nww.eastcheshire.nhs.uk/Freedomtospeakup/default.aspx
You can also contact:

(b) our Executive Director with responsibility for whistleblowing:

Mrs Julie Green, Director of Corporate Affairs and Governance
Independent Board Member Tel 01625 661501

John Wilbraham, Chief Executive Tel 01625 661501

Mrs Lynn McGill, Chairman of the trust - Tel 01625 661501

Or email ecn-tr.SpeakingUpForSafety@nhs.net

Concerns regarding the Director of Corporate Affairs and Governance or their deputy may be raised via the Chief Executive or Chairman

All these people have been trained in receiving concerns and will give you information about where you can go for more support.

(c) You can also report your concern via the module on the DATIX system, using the following link:


If for any reason you do not feel comfortable raising your concern internally, you can raise concerns with external bodies, listed on page 7.
Advice and support

Details on the local support available to you can be found via Whistleblowing section of HR Direct. However, you can also contact the Whistleblowing Helpline for the NHS and social care, your professional body or trade union representative.

How should I raise my concern?

You can raise your concerns with any of the people listed above in person, by phone or in writing (including email).

Whichever route you choose, please be ready to explain as fully as you can the information and circumstances that gave rise to your concern.

What will we do?

We are committed to the principles of the Freedom to Speak Up review and its vision for raising concerns, and will respond in line with them (see Annex B).

We are committed to listening to our staff, learning lessons and improving patient care. On receipt the concern will be recorded and you will receive an acknowledgement within two working days. The central record will record the date the concern was received, whether you have requested confidentiality, a summary of the concerns and dates when we have given you updates or feedback.

Investigation

Where you have been unable to resolve the matter quickly (usually within a few days) with your line manager, we will carry out a proportionate investigation – using someone suitably independent (usually from a different part of the organisation) and properly trained – and we will reach a conclusion within a reasonable timescale (which we will notify you of). Wherever possible we will carry out a single investigation (so, for example, where a concern is raised about a patient safety incident, we will usually undertake a single investigation that looks at your concern and the wider circumstances of the incident3). The investigation will be objective and evidence-based, and will produce a report that focuses on identifying and rectifying any issues, and learning lessons to prevent problems recurring.

We may decide that your concern would be better looked at under another process; for example, our process for dealing with bullying and harassment. If so, we will discuss that with you.

3. If your concern suggests a Serious Incident has occurred, an investigation will be carried out in accordance with the Serious Incident Framework.
Any employment issues (that affect only you and not others) identified during the investigation will be considered separately.

**Communicating with you**

We will treat you with respect at all times and will thank you for raising your concerns. We will discuss your concerns with you to ensure we understand exactly what you are worried about. We will tell you how long we expect the investigation to take and keep you up to date with its progress. Wherever possible, we will share the full investigation report with you (while respecting the confidentiality of others).

**How will we learn from your concern?**

The focus of the investigation will be on improving the service we provide for patients. Where it identifies improvements that can be made, we will track them to ensure necessary changes are made, and are working effectively. Lessons will be shared with teams across the organisation, or more widely, as appropriate.

**Board oversight**

The Board will be given high level information about all concerns raised by our staff through this policy and what we are doing to address any problems. We will include similar high level information in our annual report. The Board supports staff raising concerns and wants you to feel free to speak up.

**Review**

We will review the effectiveness of this policy and local process at least annually, with the outcome published and changes made as appropriate.

**Raising your concern with an outside body**

Alternatively, you can raise your concern outside the organisation with:

i. **NHS Improvement** for concerns about:
   - how NHS trusts and foundation trusts are being run
   - other providers with an NHS provider licence
   - NHS procurement, choice and competition
   - the national tariff

ii. **Care Quality Commission** for quality and safety concerns

iii. **NHS England** for concerns about:
    - primary medical services (general practice)
    - primary dental services
    - primary ophthalmic services
    - local pharmaceutical services

iv. **Health Education England** for education and training in the NHS

v. **NHS Counter Fraud Authority** for concerns about fraud and corruption.
Making a ‘protected disclosure’

There are very specific criteria that need to be met for an individual to be covered by whistleblowing law when they raise a concern (to be able to claim the protection that accompanies it). There is also a defined list of ‘prescribed persons’, similar to the list of outside bodies on page 7, who you can make a protected disclosure to. To help you consider whether you might meet these criteria, please seek independent advice from the Whistleblowing Helpline for the NHS and social care, Public Concern at Work or a legal representative.

National Guardian Freedom to Speak Up

The National Guardian can independently review how staff have been treated having raised concerns where NHS trusts and foundation trusts may have failed to follow good practice, working with some of the bodies listed above to take action where needed.
Annex A: trust process for raising and escalating a concern

Step one

If you have a concern about a risk, malpractice or wrongdoing at work, we hope you will feel able to raise it first with your line manager, lead clinician or tutor (for students). This may be done orally or in writing.

Step two

If you feel unable to raise the matter with your line manager, lead clinician or tutor, for whatever reason, please raise the matter with our local Freedom to Speak Up Guardian(s):

Mrs Lorraine Jackman
Deputy Director of Corporate Affairs and Governance
01625 663175 or email ecn-tr.SpeakingUpForSafety@nhs.net

This person has been given special responsibility and training in dealing with whistleblowing concerns. They will:

vi. treat your concern confidentially unless otherwise agreed
vii. ensure you receive timely support to progress your concern
viii. escalate to the Board any indications that you are being subjected to detriment for raising your concern
ix. remind the organisation of the need to give you timely feedback on how your concern is being dealt with
x. ensure you have access to personal support since raising your concern may be stressful.

If you want to raise the matter in confidence, please say so at the outset so that appropriate arrangements can be made.

You can also contact:
(d) our Executive Director with responsibility for whistleblowing:
Mrs Julie Green, Director of Corporate Affairs and Governance
Independent Board Member Tel 01625 661501

John Wilbraham, Chief Executive Tel 01625 661501

Mrs Lynn McGill, Chairman of the trust - Tel 01625 661501

Or email ecn-tr.SpeakingUpForSafety@nhs.net
Step three

You can raise concerns formally with external bodies:

xi. **NHS Improvement** for concerns about:
   - how NHS trusts and foundation trusts are being run
   - other providers with an NHS provider licence
   - NHS procurement, choice and competition
   - the national tariff

xii. **Care Quality Commission** for quality and safety concerns

xiii. **NHS England** for concerns about:
   - primary medical services (general practice)
   - primary dental services
   - primary ophthalmic services
   - local pharmaceutical services

xiv. **Health Education England** for education and training in the NHS

xv. **NHS Counter Fraud Authority** for concerns about fraud and corruption
Annex B: A vision for raising concerns in the NHS

Source: Sir Robert Francis QC (2015) Freedom to Speak Up: an independent report into creating an open and honest reporting culture in the NHS.
Contact us
NHS Improvement Wellington House
133-155 Waterloo Road London
SE1 8UG

T:  020 3747 0000
E:  nhsi.enquiries@nhs.net
W:  improvement.nhs.uk

NHS Improvement is the operational name for the organisation that brings together Monitor, NHS trust Development Authority, Patient Safety, the National Reporting and Learning System, the Advancing Change Team and the Intensive Support Teams.

This publication can be made available in a number of other formats on request. NHS Improvement (April 2016)
Publication code: Policy 01/16
Publications Gateway Reference: 04877
# C3 - TENDERING PROCEDURE (PROCUREMENT OF GOODS AND SERVICES)

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**APPENDIX 1- WAIVER APPLICATION FORM & GUIDANCE NOTES**
1. SUMMARY

The trust’s Policy is to seek to maximise value for money in the procurement of goods and services whilst ensuring that operational requirements are fulfilled and statutory obligations met.

**All trust Officers have a duty to comply with the provisions of this Policy.**

The Policy is a part of trust Standing Orders/Standing Financial Instructions.

This Document states the key rules and process with respect to the above whilst assisting trust Officers to achieve compliance.

For the purposes of this Policy ‘trust Procurement’ will be defined as the trust’s Senior Officer with responsibility for Procurement or his/her delegated Deputy.

2. QUOTATIONS AND TENDERS

trust Officers will as a matter of course seek to use NHS or other Public Body Contracts. The use of these Contracts negates the need for some or all of the trust Quotation and Tender Procedures.

In cases where NHS or other Public Body Contracts are either not available or inappropriate for use the following rules by value apply. All values are for the total procurement value over the life of the goods/services- for capital Equipment purchases please see the Capital Equipment Procurement Procedure:

<table>
<thead>
<tr>
<th>Value Range</th>
<th>Required Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to £5000 incl. VAT</td>
<td>At least one of the following is required:</td>
</tr>
<tr>
<td></td>
<td>1. Single or competitive formal trust quotation</td>
</tr>
<tr>
<td></td>
<td>2. Supplier quotation verified by trust Procurement</td>
</tr>
<tr>
<td></td>
<td>3. Confirmed price either from a published Catalogue or having been agreed with the proposed supplier</td>
</tr>
<tr>
<td>From £5001.00 to £50000.00 incl. VAT</td>
<td>The following is required:</td>
</tr>
<tr>
<td></td>
<td>Minimum of 3 Formal Quotations – these being issued by and returned to the Procurement Team utilising the trust Quotation Form and appropriate NHS Terms and Conditions.</td>
</tr>
<tr>
<td>Over £50001.00 incl. VAT</td>
<td>The following is required:</td>
</tr>
<tr>
<td></td>
<td>Minimum of 3 Formal Tenders issued and received in accordance with trust Policy as detailed in 5 and 6 below.</td>
</tr>
</tbody>
</table>

It should be noted that;

Both quotations and tenders are formal requests from the trust to potential suppliers to provide prices /costs against a defined procurement.

Quotations will usually comprise a single document. The use of quotations provided by potential suppliers to satisfy the requirement for 3 Quotations will be at the discretion of the Procurement Department.

This discretion will be exercised based upon the knowledge of the potential supplier and proposed procurement.

Tenders representing a greater value and potentially more complicated procurements will comprise a range of standard documentation as advised by the Department of Health and Office of Government Commerce.
In cases where the trust, by prior agreement, uses another Public Body to undertake procurement then the Statutory Framework of that Body will apply to the procurement – the trust having agreed and documented this in advance.

In cases where the trust, by prior agreement, undertakes procurement on behalf of another Public Body the trust’s Statutory Framework will apply – all parties having agreed and documented this in advance.

3. **WAIVING ALL OR PART OF THE COMPETITION REQUIREMENTS.**

All trust Officers should seek, wherever possible, to satisfy the requirements for competition as detailed in 2 above. In exceptional cases where this is not deemed possible, trust Officers may seek the approval of the trust to waive these requirements. All proposed Waivers will be requested by means of the attached Form – Appendix A

The following Approval process for the waiving of competition requirements applies:

- The trust Procurement Department will consider all requests and review based upon both the information presented and appropriate research.
- The trust Procurement Department will either approve or decline the request or, if the value is above £50000 either submit to the Director of Finance or decline. In cases of the latter, full reasons will be given to the trust Officer and advice given as to how the procurement can be progressed.

Waiving of tender requirements may be considered in the following circumstances:

i. Where goods or services are only available from one or two sources
ii. Where genuine and unforeseen urgency exists that precludes compliance to the process as identified in 2 above
iii. Where it is in the commercial and/or operational interest of the trust
iv. Where there is clear benefit to be gained from maintaining continuity with an earlier procurement and with the benefits of that continuity outweighing any potential financial advantage which could gained by competitive tendering;

A Waiver Request form (Appendix 1) should be completed and the reasons should be documented and recorded within this form.

Waiver forms still require authorisation in line with the trust’s Scheme of Delegation. This is set out in the table below:

<table>
<thead>
<tr>
<th>Financial Limit (including VAT)</th>
<th>Waiver Authorised by</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Exec/ Director of Finance</td>
<td>Board of Directors</td>
</tr>
<tr>
<td>Over £106,047</td>
<td></td>
</tr>
</tbody>
</table>

It should be noted that European Procurement Law applies at all times and in particular to proposed procurements in excess of the financial threshold appertaining at the time (£106,047 in total value excl VAT as from 1st January, 2016). The prevailing rate can be found - [http://www.ojec.com/thresholds.aspx](http://www.ojec.com/thresholds.aspx) European Procurement Law cannot be waived and the trust Procurement will advise Budget holders as to how compliance can be achieved.
It should be noted that procurements estimated to be below limits set out as above for which formal tendering procedures are not used which subsequently prove to have a value above such limits shall be reported to the appropriate trust Senior Officer.

4. IDENTIFYING POTENTIAL BIDDERS

The trust Procurement Department will support Budget holders in sourcing and identifying potential suppliers. Sources of potential suppliers will include:

- NHS or other Public Body contractors
- Respondents to Notices placed in the Official Journal of the European Union/ Supply2Health
- Respondents to Notices placed in appropriate Journals
- Those advised by trust Officers based upon their operational and technical knowledge

In accordance with Department of Health and Office of Government Commerce Guidance, a pre-selection process will usually be undertaken including, where appropriate, indicative costing methodologies.

A list of the suppliers invited to submit a Tender will be provided for the Chief Executives office and includes the tender reference and the closing date and time for receipt of tenders.

5. TENDERING PROCEDURE

Tender Documents will be issued according to one of Three Methods:

Method One - Electronically via the trust Tender Management (TM) System

This involves giving Tenderers electronic access to Tender Documents and their return electronically.

The trust may also elect to utilise the Electronic Auction option as part of this Method. This involves facilitating an online reverse auction where against an agreed range of products/services Tenderers submit prices within a timescale with an expectation that suppliers submitting the lowest prices will achieve the highest score for the pricing elements of the Tender. The trust may also invite non-price Tender submissions in addition to the Electronic Auction.

Electronic Auctions will be operated in accordance with the protocols of the TM System provider and the trust Procurement/E-commerce Department.

Method Two - Electronically from an approved trust Officer e-mail address

This involves the electronic dissemination of the Tender Documents including the Return label and the return of a paper hard copy.

Method Three - By paper hard copy

This involves the posting of a paper hard copy of the Tender Documents and the return of a paper hard copy.

In all cases an acknowledgement of receipt will be requested usually by electronic means or e-mail. In the case of hard copy Tender Documents an acknowledgement slip will be included in the Tender Pack for completion/return.

Tenders issued electronically as per Method One should be submitted and opened in accordance with the TM System protocols- These protocols having been agreed with the system provider and approved by the trust’s Internal Audit Service prior to implementation.
Tenders issued as per Method Two and Method Three must be returned in accordance with the following requirements:

i. Addressed and delivered to the Chief Executives Office and submitted in accordance with the notified tender deadline. It is the responsibility of the Tenderer to ensure that the documents are delivered directly to the Chief Executives office where the receipt of the documents will be logged and dated.

ii. Submitted in a plain sealed package or envelope bearing a pre-printed return address label that also states the tender reference and return date and time (supplied by the trust);

iii. 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;

iv. Every tender of goods, materials, services or disposals shall embody the relevant NHS Conditions of Contract, as are applicable;

v. 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 for engineering works, the general conditions of contract recommended by the Institution of Mechanical and Electrical Engineers, or another institution of similar standing.

6. RECEIPT OF TENDERS

Tenders issued and returned under Methods two and, three require the Chief Executive or their nominated representative to be responsible for the receipt, endorsement and safe custody of the tenders received until the time appointed for opening.

The date and time of the receipt of each tender shall be endorsed on the tender envelope or package by the person receiving the tenders.

Tenders issued and received under Method One will remain within the TM System under a password controlled and time locked secure electronic environment.

7. OPENING OF TENDERS

The trust will as soon as practicable after the deadline time for the submission of the tenders formally open the Tender.

Tender submissions should be opened by two senior officers/managers (from separate departments) of the trust as designated by the Chief Executive and not from the originating department. The 'originating' department will be taken to mean the department sponsoring or commissioning the tender.

All trust Directors will be authorised to open tenders regardless of whether they are from the originating department provided that the other authorised person is not from the originating department.

Every tender received shall be marked with the date of opening and initialled by those present at the opening. In the case of Tenders under Method One a system based procedure applies.

8. REGISTER OF TENDERS

Tenders received from suppliers should be cross-referenced to the list received from the Procurement and Estates Departments.
Submissions from suppliers other than those listed must be excluded.

A register shall be maintained, showing for each set of tenders dispatched:

i. The name of all firms/individuals invited;

ii. The names of firms/individuals from which tenders have been received;

iii. The date the tenders were opened;

iv. The persons present at the opening;

v. The price shown on each tender;

vi. A note where price alterations have been made on the tender. If the tender has had so many

vii. alterations that it cannot be readily read or understood this should be noted in the register.

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

Incomplete tenders shall be dealt with in the same way as late tenders – see below.

9. ADMISSIBILITY OF TENDERS

If the designated officers are of the opinion that the tenders received are not strictly competitive (e.g. due to insufficiency in numbers or due to alterations on the tender), then the approval of the Director of Finance is required.

Where only one tender is sought/received, the Director of Finance shall (in conjunction with the trust Procurement & Estates Department) review the tender to ensure that the price to be paid is fair and that the trust will be receiving value for money.

Late tenders will only be considered where there are exceptional circumstances:

- Tenders received post submission deadline but prior to the opening of the other tenders may be considered after the designated officers have concluded that the delay was no fault of the Tenderer.

- Only in the most exceptional circumstances will a tender be considered which is received after the opening of the 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 has not started.

All late tenders should be kept in the safe custody of the Chief Executive or nominated officer during the period that the admissibility is considered.

The TM System will require the trust’s authorized officers to approve the opening of Tenders received past the Tender Return date – until this is agreed they will be stored securely online.

10. CRITERIA FOR AWARD OF BUSINESS

The Tender Document will normally state that the award is to be based on the most economically advantageous bid. This will normally include full life cycle costs.

In cases where the EU Thresholds apply, the Award Criteria must be included in either the Notice in the Official Journal of the European Union or in the Tender.
Contract Award criteria are agreed by trust Officers as part of the procurement process. In projects of significant value/risk this will include Budget holders; Finance staff and Procurement officers along with any other appropriate trust Officers.

11.  PRE OFFER AND POST TENDER BIDDER ENGAGEMENT

The procurement process must allow sufficient time for pre-offer (tender) engagement with potential suppliers including the application of indicative pricing methodologies. These will be conducted in accordance with Department of Health / Office of Government Commerce Guidance.

Post tender negotiation/pre contract negotiation is not permitted within the OJEU tendering process.
In exceptional cases at the discretion of trust Procurement it may be undertaken for below OJEU threshold tendering exercises.

Post tender clarification is permissible where it is deemed reasonable to clarify aspects of a tender without fundamentally changing or renegotiating the contents. These clarifications will be conducted in accordance with Department of Health / Office of Government Commerce Guidance.

12.  CAPITAL AND PROPERTY DEVELOPMENT

trust Procurement Policy applies to all activity within this remit albeit that the European Union value threshold for works differs from Goods and Services (£4,104,394 excl VAT as at 1st January, 2016)
The trust will comply with Department of Health and other Public Body Guidance.

13.  FORMAL AWARD OF BUSINESS

Provided all of the above conditions and circumstances set out above have been fully complied with, formal authorisation and award of a contract may be agreed under the authorisation limits defined in Section 3 of the trust’s Scheme of Delegation. In the case of authorisation by the Board of Directors, this shall be recorded in their minutes.

14.  DISPOSALS

Competitive tendering or quotation procedures shall not apply to the disposal of:

(a) Any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Director of Finance or his nominated officer;
(b) Obsolete or condemned articles and stores, which may be disposed of in accordance with appropriate trust Policy;
(c) Items to be disposed of with an estimated sale value of less than £1000, this figure to be reviewed annually;
(d) Items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;
(e) Land or buildings concerning which Department of Health guidance has been issued but subject to compliance with such guidance.
Appendix 1

WAIVER TO STANDING FINANCIAL INSTRUCTIONS

PROCEDURE INSTRUCTIONS FOR THE COMPLETION OF WAIVER FORMS

Please refer to the Waiver Form below (WAIV4) Revised March 2016.
Please be aware that multi-year contracts may result in the requirement of a Waiver

1. The Waiver form is to be used when:
   - The requester wishes the requirement for tender/competitive quotes in the Standing Financial Instructions to be waived.
   
   **Note:** where the reason is urgency resulting from a lack of forward planning, a waiver will not be authorised.

   **Note:** where the reason is the purchase is from a sole supplier of products/services – written evidence must be provided by the Procurement Manager that alternative sources are impractical.

2. All waiver forms should be completed by providing information as required on the form. The form may be completed electronically or in ink and should be legible (authorisation signature should be done in ink).

3. All waiver forms should be completed in full as requested on the form and signed (in ink) by the appropriate budget holder before being sent to the Procurement Manager. Where necessary please provide additional/supporting information on a separate sheet.

   **Note:** waiver forms not completed correctly and with insufficient details will be returned to the originator for completion.

4. Each waiver form will be registered using the Requisition No on the form and will be assessed by the Procurement Manager prior to sign off by departmental Director & approval.

5. All waivers will be recorded on the trust’s waiver log.

6. All waivers will be returned to the Procurement Department, approved waivers will be processed and a Purchase Order will be issued for the purchase of the goods/services. Rejected waivers will be returned to the originator.

7. Waivers are presented each quarter to the Audit Committee meeting. If the Committee feel that insufficient information has been provided, the person responsible for completing the waiver will be required to attend to explain their actions.
PROCEDURE TO COMPLETING WAIVER DOCUMENT (Waiv4)

Completing the Waiver Form

Reason for Waiver – is the Product/Service;

i. Where the goods/services are available from a fewer number of suppliers required by trust Standing Financial Instructions.

ii. Where genuine and unforeseen urgency exists that precluded compliance to the process as identified in trust Policy. Note: where the urgency results from a lack of forward planning, a waiver will not be authorised.

iii. Where it is in the commercial or operational interest of the trust as clearly evidenced.

iv. Where there is a clear benefit to gained from maintaining continuity with an earlier procurement

For Interim Agency Staff:
Where a Waiver concerns an interim member of staff please liaise with your Business Accountant as a full cost analysis will need to accompany the waiver document before being passed for authorisation. (Business Accountant will complete the cost analysis)

Note: the person responsible for completing the Waiver may be required to attend an Audit Committee meeting to explain their actions.

Contact the Procurement Dept. who will arrange to carry out a Quotation/Tender

Yes

No

Raise a Non Catalogue Request in SBS for your request and complete the Waiver Form, providing information as requested on the form. Budget Holder must support the form.

Send the completed Waiver Form to the Procurement Dept. for assessment of the criteria.

Waiver accepted by Procurement

Yes

No

Waiver rejected by Procurement Dept.

Waiver sent to trust HQ for registration, Director’s support sign off and final approval/rejection

Rejected

Approved

Waiver returned to the Procurement Dept. the Waiver will be returned to originator with explanation of rejection

Waiver returned to Procurement Dept for processing. A Purchase Order will be issued for the request and the Waiver Log will be updated with the Purchase Order Number.
APPLICATION TO ACCEPT A NON COMPETITIVE QUOTATION
(Value £10,000.00 TO £25,000.00) OR TENDER (Value exceeding £50,000.00)
Ref: /

Please ensure all sections are fully completed, failure to do so will result in the form being returned

**STAGE ONE**

SBS Requisition No ............................ Purchase Order No ........................................
(Procurement use only)

For the purchase of:

................................................................................................................................................

Ward/Department ................................................................. Division ......................

Price (inc VAT irrespective of application) £ ............................................ p.

Funding Source (please delete as appropriate) Capital / Revenue / Charitable

Proposed supplier ........................................................................................................................................

**STAGE TWO**

| Reasons for non-competitive quotation application (please tick as appropriate) |
| i. Where the goods or services are only available from a fewer number of suppliers than required by trust Standing Financial Instructions |
| ii. Where genuine and unforeseen urgency exists that precludes compliance to the process as identified in the trust Policy. |
| iii. Where it is in the commercial or operational interest of the trust as clearly evidenced. |
| iv. Where there is clear benefit to be gained from maintaining continuity with an earlier procurement and where the benefits of continuity outweigh any potential financial or operational advantage to be gained from competitive tendering. |

| Supporting evidence for reason and demonstration of Value for Money |
| ......................................................................................................................................................... |
| ......................................................................................................................................................... |
| ......................................................................................................................................................... |
| ......................................................................................................................................................... |

| Details of alternatives considered. (where stating Sole Supplier as reason for waiver details of action taken to verify this must be stated). Sole Supplier verified by Procurement Department |
| ......................................................................................................................................................... |
| ......................................................................................................................................................... |
| ......................................................................................................................................................... |

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STAGE THREE

Waiver Requested by

Name .................................................................

Position........................................Signature………………Date........................Ext No.........

“In Signing this Application, I declare I have (1) read the appropriate sections of the Standing Financial Instructions/ Scheme of Reservation & Delegation (2) hold no pecuniary interest in the company/ individual supplying the goods/services described in this Application. I understand that if I breach any of the above I could face disciplinary action.”

Supported by Budget Holder

Name…………………….………Signature……………..………….………Date.............................Ext No…………..…..

I CONFIRM THAT I AM THE BUDGET HOLDER AND THAT I HAVE DOCUMENTARY EVIDENCE TO SUPPORT THIS APPLICATION TO WAIVER TRUST STANDING FINANCIAL INSTRUCTIONS

“In Signing this Application, I declare I have (1) read the appropriate sections of the Standing Financial Instructions/ Scheme of Reservation & Delegation (2) hold no pecuniary interest in the company/ individual supplying the goods/services described in this Application. I understand that if I breach any of the above I could face disciplinary action.”

THIS COMPLETED FORM IS TO BE HANDED TO THE TRUST PROCUREMENT TEAM
– located on the 2nd Floor of New Alderley House

STAGE FOUR

RECEIVED in trust Procurement and acknowledged to originator…………………………………………………….

Procurement

Comments ……………………………………………………………………………………………………………………

………………………………………………………………………………………………………………………………

………………………………………………………………………………………………………………………………

………………………………………………………………………………………………………………………………

………………………………………………………………………………………………………………………………

PROCUREMENT TEAM TO PROGRESS TO TRUST HQ
STAGE FIVE

Supported by Director

Name ........................................Signature……
........................................Date......................Ext No……………..

STAGE SIX  Final Authorisation  /  Rejection

Director of Finance  /  Chief Executive  /  Deputy Chief Executive

Name: ................................................................................................................

Signed: ..............................................................................................................

Date.........................

APPROVED WAIVERS WILL RESULT IN A PURCHASE ORDER BEING ISSUED TO THE SUPPLIER – VISIBLE IN SBS

Reason for Rejection:

..........................................................................................................................
........................................................................
..........................................................................................................................
........................................................................

REJECTED WAIVERS WILL BE RETURNED TO THE REQUESTOR
C4 STANDARD OPERATING PROCEDURE FOR COMPETING FOR CONTRACTS

DECISION TO BID

The decision to bid shall be made by the trust Board, where:

1. The Chief Executive (in conjunction with the Executive Management Team) recommends bidding, and
2. The value of the contract exceeds 1% of trust Turnover

Where the value of the contract is below 1% of trust Turnover then the Chief Executive (in conjunction with the Executive Management Team), will be delegated to make the decision to bid.

Where the trust Board, or the Chief Executive (in conjunction with the Executive Management Team) decide against bidding then their rationale will be captured in the regular report to the trust Board or its appropriate committee (currently Finance, Performance & Workforce Committee).

CRITERIA FOR BIDDING

In order to decide whether to bid for contracts the Chief Executive (in conjunction with the Executive Management Team) will utilise:

1. The potential services fit with the trust’s strategic plan
2. The view of the Service Line, or Corporate Directorate utilising the trust’s Bid/No Bid tool
3. The view of the potential services geographic and strategic fit with existing services
4. The economic case for bidding or not bidding, based on the cost of the bid and the indicative bid value, especially where this is a pass/fail criterion

CONSTRUCTION AND SUBMISSION OF THE BID

The format and construction of the bid will be determined by the Executive Director of Finance and will be prepared by Service Line, Planning and Business Development, Human Resources, Estates & Finance staff in partnership, where appropriate.

The Chief Executive will nominate an Executive Director to sign off and oversee the submission of the bid, by the deadline. The nominated Executive Director will ensure that all advisory functions have supported the service in signing off the bid.
Fit & Proper Persons Policy
**Policy Title:** Fit & Proper Persons Policy

**Executive Summary:** This policy will ensure trust compliance with the Care Quality Commission Regulation 5 requirements of the Fit & Proper Persons Regulations. It outlines the processes the trust has in place and ensures that trust Board members and Deputy Directors (as listed at 1.1) undertake their annual requirement to complete a self-declaration to confirm that they are of good character, possess the right competencies and skills and be physically and mentally fit to do the job in with the Equality Act 2010.

**Supersedes:** Fit & Proper Persons Test – agreed via the Corporate Governance Manual March 2018.

**Description of Amendment(s):** Updated throughout including extending the FPPR test to include Deputy Directors (those listed at 1.1) as well as trust Board members.

**This policy will impact on:**

**Financial Implications:**

<table>
<thead>
<tr>
<th>Policy Area</th>
<th>Document Reference</th>
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</thead>
<tbody>
<tr>
<td>Board members and their deputies</td>
<td></td>
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<table>
<thead>
<tr>
<th>Version Number:</th>
<th>Effective Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.1</td>
<td>28th November 2018</td>
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<tr>
<th>Issued By:</th>
<th>Review Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corporate Affairs &amp; EPRR Manager</td>
<td>28th November 2021</td>
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</tbody>
</table>

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<thead>
<tr>
<th>Author:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Corporate Affairs &amp; EPRR Manager</td>
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**APPROVAL RECORD**

<table>
<thead>
<tr>
<th>Committees / Group</th>
<th>Date</th>
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<tbody>
<tr>
<td>Approved by:</td>
<td>1st November 2018</td>
</tr>
<tr>
<td>Director of Corporate Affairs &amp; Governance</td>
<td></td>
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<table>
<thead>
<tr>
<th>Ratified by:</th>
<th>Date</th>
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<tbody>
<tr>
<td>trust Board</td>
<td>6th December 2018</td>
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<tr>
<th>Received for information:</th>
<th>Date</th>
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</thead>
<tbody>
<tr>
<td>trust Board members and their deputies</td>
<td>6th December 2018</td>
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## Appendices

- **Appendix A** - CQC provision of information
- **Appendix B** - Fit and Proper Persons Test – Self Declaration Form
- **Appendix C** - Fit and Proper Persons Test – Checklist
1. Introduction and Background

1.1 The Fit & Proper Persons Regulation (FPPR) came into force for all NHS trusts and Foundation trusts in November 2014. The regulations require trusts to assure themselves that all trust Board members and individuals who perform the duties of a trust Board member are fit and proper individuals to carry out the important role of Director irrespective of their voting rights.

For East Cheshire NHS trust this means:

**Board members:**
- Non-executive Directors (NEDs) including the Chairman
- Executive Directors

*The following Deputy Directors who represent Executives at Board:*
- Deputy Director of Corporate Affairs & Governance
- Deputy Director of Finance
- Deputy Director of Nursing & Quality
- Deputy Director of Human Resources and Organisational Development

2. Purpose

2.1 The purpose of the FPPR is not only to hold the above to account in relation to their conduct and performance, but also to instil confidence in the public that the individuals leading NHS organisations are suitable to hold their positions.

2.2 As an NHS provider, the trust is required to demonstrate that appropriate processes are in place to confirm that trust Board members and Deputy Directors are of good character; possess the right competencies and skills and be physically and mentally fit to do the job in with the Equality Act 2010.

2.3 East Cheshire NHS trust will undertake a FPPR test on recruitment and thereafter annually.

3. Responsibilities

3.1 **The Chairman** is accountable for discharging the requirement to ensure that all trust Board members meet the fitness test and do not meet any of the ‘unfit’ criteria and for ensuring that the findings of the annual Fit & Proper Persons test are shared in the public domain.

3.2 **The Chief Executive** has overall accountability for ensuring that the trust has appropriate policies and robust monitoring arrangements in place.
3.3 **The Director of Corporate Affairs & Governance** has delegated accountability for ensuring that all newly appointed trust Board members and those Deputy Directors as noted above have undertaken the Fit & Proper Persons test on recruitment and annually thereafter. They have responsibility of discharging the requirement to ensure that Deputy Directors meet the fitness test and do not meet any of the ‘unfit’ criteria. The Director of Corporate Affairs & Governance has accountability for ensuring that the trusts Fit & Proper Persons Policy is in place.

3.4 **trust Board members** are responsible for ensuring that they submit a Fit & Proper Persons self-declaration on an annual basis and that they adhere to the guidelines of this policy.

3.5 **Deputy Directors** namely: Deputy Director of Corporate Affairs & Governance, Deputy Director of Finance, Deputy Director of HR & OD, Deputy Director of Nursing & Quality are responsible for ensuring that they submit a Fit & Proper Persons self-declaration on an annual basis and that they adhere to the guidelines of this policy.

3.6 **The Corporate Affairs Manager** is responsible for ensuring that the Fit & Proper Persons Policy is current and reviewed as necessary including following any new guidance. They are responsible for co-ordinating the annual Fit & Proper Persons test and for ensuring all information is sourced and shared with either The Chairman or the Director of Corporate Affairs & Governance (as appropriate). The Corporate Affairs Manager is responsible for ensuring all relevant information is stored appropriately and in line with trust policies (including the DBS policy).

4. **Fit & Proper Persons Requirements**

4.1 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 places a duty on trusts to ensure that their trust Board members and individuals who perform the duties of a trust Board member (for East Cheshire NHS trust this means those Deputy Directors stated at section 1.1) are not appointed or allowed to continue being employed by the trust unless they can demonstrate the below requirements:

- **Are of good character** – that is
  - Have not been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence; and
  - Have been erased, removed or struck off a register of professionals maintained by a regulator of health care or social work professionals;
  - Have the necessary qualifications, skills and experience;
  - Are able to perform the work that they are employed for after reasonable adjustments are made;
  - Have not been responsible for, privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity;
  - Can supply information as set out in Schedule 3 of the 2014 Regulations when requested by the Care Quality Commission (see **Appendix A**).
4.2 Categories of ‘unfitness’ that would prevent people from holding office or necessitate their removal from their position as a Board Member or Deputy Director, and for whom there is no discretion includes:

- The person is an undischarged bankrupt or a person whose estate has had a sequestration awarded in respect of it and who has not been discharged;
- The person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland;
- The person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986(40);
- The person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it;
- The person is included in the children’s barred list or the adults’ barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland;
- The person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment.

4.3 The regulations stipulate that a trust Board member or Deputy Director would be considered unfit if they were included on a barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006 or on any corresponding list.

5. Breaching the Requirements

5.1 The FPPR may be breached should the trust have in place someone who does not satisfy the FPPR requirements; evidence of this could be if:

- A Board member or Deputy Director is unfit on a ‘mandatory’ ground, such as a relevant undischarged conviction or bankruptcy; the trust will determine this;
- The trust does not have a proper process in place to enable it to make the robust assessments required by the FPPR;
- On receipt of information about a Board member or Deputy Director’s fitness, a decision is reached on the fitness of the individual that is not in the range of decisions that a reasonable person would make; and
- A Board member or Deputy Director has been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere, which if provided in England, would be a regulated activity.

6. Being held to Account

6.1 The CQC holds trusts to account in relation to the FPPR through the well-led key question of its regulatory model; during a well-led inspection the CQC will always consider FPPR issues including whether the trust has a robust system in place to ensure all relevant trust Board members and individuals who perform the duties of a trust Board member meet the requirement at the recruitment stage and subsequently throughout that persons employment. This may involve:

- Checking their personnel files;
- Checking information or records about appraisal rates; and
7. The Fit & Proper Persons Regulation Test

- Checking that the trust is aware of the various guidelines on recruiting trust Board members and Deputy Directors and that the trust has implemented procedures in line with this best practice.

6.2 If the CQC is concerned that a trust is not discharging its FPPR responsibilities properly, it may take enforcement action against the trust such as cancelling the trusts registration or they may consider prosecution.

6.3 It will be the responsibility of the Chairman to discharge the requirement to ensure that all trust Board members meet the fitness test and do not meet any of the ‘unfit’ criteria; it will be the responsibility of the Director of Corporate Affairs & Governance to ensure that all Deputy Directors (as identified in section 1.1) meet the fitness test and do not meet any of the ‘unfit’ criteria.

6.4 **CQC and trust Response to concerns about a trust Board Member or Deputy Director**

6.4.1 CQC guidance sets out how they will respond to concerning information about a trust Board member or those Deputy Directors that perform the duties of a trust Board member from the public or members of staff. The CQC may decide to convene a management review meeting to determine if the information indicates a potential FPPR concern and needs following up with the individual and the trust.

6.4.2 The CQC would then send all information that falls under the FPPR to the trust and ask the trust to respond with regards to intended action (within 10 days).

7.1 During recruitment and annually thereafter, trust Board members and those Deputy Directors listed previously in section 1.1 will:
- Undertake a self-assessment of their fitness to act in their position

7.2 The FPPR test also requires the following to be undertaken during the recruitment stage and annually thereafter:
- The Insolvency, Bankruptcy and Disqualified Directors registers will be checked to ensure no trust Board member of Deputy Director is named on them;
- A review of the trusts Conflict of Interest Database will take place to ensure compliance (on appointment trust Board members and Deputy Directors will be asked to make a declaration within 28 days of appointment);
- Confirmation will be sought that there are no HR or Whistleblowing issues that may deem the trust Board member or Deputy Director unfit for post;
- A review of the professional body will take place if appropriate (ie General Medical Council, Nursing & Midwifery Council); and
- Their current DBS will be reviewed to ensure compliance (it is the responsibility of the individual concerned to ensure that they have a current DBS)

7.3 The self-assessment form used by the trust can be found at Appendix B. Guidance relating to the Fit & Proper Persons test issued by the CQC can be found at Appendix C.

7.4 **Good Character**

7.4.1 While there is no statutory guidance on what constitutes ‘good character’, it names the following features that are ‘normally associated’ with good character that will be
taken into account when assessing an individual under FPPR, these are:

- Honesty;
- Trustworthiness;
- Integrity;
- Openness;
- Ability to comply with the law;
- A person in whom the public can have confidence;
- Prior employment history, including reasons for leaving;
- If the individual has been subject to any investigations or proceedings by a professional or regulatory body;
- Any breaches of the Nolan principles of Public Life;
- Any breaches of the duties imposed on the trust Board member of Deputy Director under the Companies Act;
- The extent to which the trust Board member of Deputy Director has been open and honest with the trust; and
- Any other information which may be relevant, such as disciplinary action taken by an employer.

7.5 Disclosure and Barring Service (DBS):

7.5.1 A DBS provides access to information across England and Wales about criminal convictions and other police records. The check relates to the data held about an individual's criminal history including (in most cases) cautions, convictions, reprimands and final warnings. It may also include traffic offenses such as speeding and drink driving.

7.5.2 A DBS is required for all trust Board members and those Deputy Directors listed at section 1.1; the type of DBS required is dependent on the position held. See below:

- Non-Executive Directors including The Chairman – Standard DBS (via the trusts HR processes);
- Executive Directors – Enhanced DBS without Barred List information or with Children’s and Adult’s Barred List information (via the trusts HR processes) unless that Executive Director undertakes controlled drugs destruction and then the Capita process and application applies; and
- Deputy Directors – Enhanced DBS without Barred List information or with Children’s and Adult’s Barred List information (via the trusts HR processes) unless that Deputy Director undertakes controlled drugs destruction and then the Capita process and application applies.

7.5.3 DBS checks should be completed as part of the trusts recruitment process and then refreshed every 3 years thereafter. It is the trust Board member and the Deputy Directors responsibility to ensure that their DBS remains current.

7.5.4 For further guidance relating to DBS, please refer to the trusts DBS Policy (which can be found on the intranet under policies); the policy explains eligibility for DBS checks and what each level covers.

7.5.5 Once a DBS has been carried out and a certificate obtained, the certificate should be brought into the Chairman’s office so that details such as the unique reference number, type of DBS (ie level) and date it was issued can be recorded. A copy of the certificate is not kept by the trust.
8. Outlining the Process

8.1 Figure 1 below outlines the process to be adopted by the trust in making new appointments to the trust Board and for those Deputy Directors listed at section 1.1. Figures 2 and 3 outline the review process for existing trust Board members and Deputy Directors listed at section 1.1.
Figure 2: Fit and Proper Persons Annual Process for Trust Board Members

Undertake Fit and Proper Persons Test

All Trust Board members: The process is lead by East Cheshire NHS Trust

Self-Assessment

Chairman’s office to check the following:

- Regulatory rules are not broken (where required)
- DBS status is reviewed and renewed if necessary
- Review of audits undertaken for any potential investigations
- Check of disqualified register conduct
- Check of insolvency and bankruptcy register conduct
- HR Director check to see if there are any outstanding HR issues of concern
- FPP process has been undertaken, there are no issues of concern
- Whistleblowing: check with HR, Compliance to see if there are any whistleblowing issues to consider
- Review of trust, Conflict of Interest register conducted to ensure compliance

Corporate Affairs Manager to notify Trust secretary of the outcome of the FPP Test

Trust Secretary to inform Chair/Senior Independent Director of the outcomes of the FPP Test

- No issues
- Confirm FPP test results

- Issues
- Consider continued employment taking into account of issue(s) and regulations

- Confirm FPP test pass noting why exception has been made
- Undertake steps to remove from post

Appeal Process
8.2 Reporting on the FPPR test:

8.2.1 Annual FPPR checks will take place during January each year the outcomes of which will be reported by The Chairman in their March commentary to trust Board.

Appendices

Appendix A - CQC provision of information
Appendix B - Fit and Proper Persons Test – Self Declaration Form
Appendix C - Fit and Proper Persons Test – Checklist
Appendix A

The CQC has the right to require the provision of information set out in Schedule 3 of the 2014 Regulations and such other information as is kept by the organisation that is relevant to the individual as follows:

- proof of identity including a recent photograph;
- where required for the purposes of an exempted question in accordance with section 113A(2)(b) of the Police Act 1997(38), a copy of a criminal record certificate issued under section 113A of that Act together with, after the appointed day and where applicable, the information mentioned in section 30A(3) of the Safeguarding Vulnerable Groups Act 2006 (provision of barring information on request)(39);
- where required for the purposes of an exempted question asked for a prescribed purpose under section 113B(2)(b) of the Police Act 1997, a copy of an enhanced criminal record certificate issued under section 113B of that Act together with, where applicable, suitability information relating to children or vulnerable adults;
- satisfactory evidence of conduct in previous employment concerned with the provision of services relating to:
  - health or social care, or
  - children or vulnerable adults

- where a person (P) has been previously employed in a position whose duties involved work with children or vulnerable adults, satisfactory verification, so far as reasonably practicable, of the reason why P’s employment in that position ended;
- in so far as it is reasonably practicable to obtain, satisfactory documentary evidence of any qualification relevant to the duties for which the person is employed or appointed to perform;
- a full employment history, together with a satisfactory written explanation of any gaps in employment;
- satisfactory information about any physical or mental health conditions which are relevant to the person’s capability, after reasonable adjustments are made, to properly perform tasks which are intrinsic to their employment or appointment for the purposes of the regulated activity;
- for the purposes of this Schedule:
  - ‘the appointed day’ means the day on which section 30A of the Safeguarding Vulnerable Groups Act 2006 comes into force,
  - ‘satisfactory’ means satisfactory in the opinion of the CQC,
  - ‘suitability information relating to children or vulnerable adults’ means the information specified in sections 113BA and 113BB respectively of the Police Act 1997.
Appendix B

Fit and Proper Persons Test – Self Declaration Form

Under Regulation 5 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014 (and subsequent amendments), the following are expected to make a self-declaration on appointment and annually thereafter:

**Trust Board members, Deputy Directors of HR, Corporate Affairs & Governance, Nursing and Quality and Finance.**

<table>
<thead>
<tr>
<th>DECLARATION</th>
<th>Please confirm Yes or No</th>
</tr>
</thead>
<tbody>
<tr>
<td>I can confirm that I am of good character by virtue of the following:</td>
<td></td>
</tr>
<tr>
<td>I have not been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence</td>
<td></td>
</tr>
<tr>
<td>I have not been erased, removed or struck-off a register of professionals maintained by a regulator of health or social care.</td>
<td></td>
</tr>
<tr>
<td>I have not been sentenced to imprisonment for three months or more within the last five years</td>
<td></td>
</tr>
<tr>
<td>I am not an undischarged bankrupt</td>
<td></td>
</tr>
<tr>
<td>I am not the subject of a bankruptcy order or an interim bankruptcy order</td>
<td></td>
</tr>
<tr>
<td>I do not have an undischarged arrangement with creditors</td>
<td></td>
</tr>
<tr>
<td>I am not included on any barring list preventing them from working with children or vulnerable adults</td>
<td></td>
</tr>
<tr>
<td>I have the qualifications, skills and experience necessary for the position I hold at the trust</td>
<td></td>
</tr>
<tr>
<td>I am capable of undertaking the relevant position, after any reasonable adjustments under the Equality Act 2010</td>
<td></td>
</tr>
<tr>
<td>I have not been responsible for any misconduct or mismanagement in the course of any employment with a CQC registered provider</td>
<td></td>
</tr>
<tr>
<td>I am not prohibited from holding the relevant position under any other law (e.g., under the Companies Act or the Charities Act).</td>
<td></td>
</tr>
</tbody>
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Signed & Name:  

Position:  

Date:  

Date of Birth:  

Home Address:
### Appendix C

**Fit and Proper Persons Test - Complying with the regulations**

<table>
<thead>
<tr>
<th>Standard</th>
<th>Assurance process</th>
<th>Evidence</th>
</tr>
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<tbody>
<tr>
<td>At appointment</td>
<td>Employment checks in accordance with NHS Employment Check Standards issued by NHS Employers including:</td>
<td>References; Outcome of other pre-employment checks; DBS checks where appropriate; Register search results; List of referees and sources of assurance for FOIA purposes.</td>
</tr>
<tr>
<td></td>
<td>• two references, one of which must be most recent employer;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• qualification and professional registration checks;</td>
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<td></td>
<td>• right to work checks;</td>
<td></td>
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<tr>
<td></td>
<td>• proof of identity checks;</td>
<td></td>
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<tr>
<td></td>
<td>• occupational health clearance;</td>
<td></td>
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<tr>
<td></td>
<td>• DBS checks (where appropriate);</td>
<td></td>
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<td></td>
<td>• search of insolvency and bankruptcy register;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• search of disqualified directors register.</td>
<td></td>
</tr>
<tr>
<td>1. Providers should make every effort to ensure that all available information is sought to confirm that the individual is of good character as defined in Schedule 4, Part 2 of the regulations.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(Sch.4, Part 2: Whether the person has been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence.</td>
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<tr>
<td></td>
<td>Whether the person has been erased, removed or struck-off a register of professionals maintained by a regulator of health care or social work professionals.)</td>
<td></td>
</tr>
<tr>
<td>2. Where a provider deems the individual suitable despite not meeting the characteristics outlined in Schedule 4, Part 2 of these regulations, the reasons should be recorded and information about the decision should be made available to those that need to be aware.</td>
<td>Report and debate at the nominations committee(s). Report and recommendation at the council of governors (for NEDs) or the Board of directors (for EDs) for foundation trusts, reports to the Board for NHS trusts. Decisions and reasons for decisions recorded in minutes. External advice sought as necessary.</td>
<td>Record that due process was followed for FOIA purposes.</td>
</tr>
<tr>
<td>3. Where specific qualifications are deemed by the provider as necessary for a role, the provider must make this clear and should only employ those individuals that meet the required specification, including any requirements to be registered with a professional regulator.</td>
<td>Requirements included within the job description for all relevant posts. Checked as part of the pre-employment checks and references on qualifications.</td>
<td>Person specification Recruitment policy and procedure</td>
</tr>
<tr>
<td>Standard</td>
<td>Assurance process</td>
<td>Evidence</td>
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<tr>
<td>4. The provider should have appropriate processes for assessing and checking that the individual holds the required qualifications and has the competence, skills and experience required, (which may include appropriate communication and leaderships skills and a caring and compassionate nature), to undertake the role; these should be followed in all cases and relevant records kept. N.B. While this provision most obviously applies to executive director appointments in terms of qualifications, skills and experience will be relevant to NED appointments and to Deputy Directors (as identified in section 1.1)</td>
<td>Employment checks include a candidate’s qualifications and employment references. Recruitment processes include qualitative assessment and values-based questions. Decisions and reasons for decisions recorded in minutes.</td>
<td>Recruitment policy and procedure Minutes of Board of directors.</td>
</tr>
<tr>
<td>5. In addition to 4 above, a provider may consider that an individual can be appointed to a role based on their qualifications, skills and experience with the expectation that they will develop specific competence to undertake the role within a specified timeframe.</td>
<td>Discussions and recommendations by the nominations committee(s). Discussion and decision at Board of directors meeting. Reports, discussion and recommendations recorded in minutes of meetings. Follow-up as part of continuing review and appraisal.</td>
<td>Discussions and recommendations by the nominations committee(s). Discussion and decision at Board of directors meeting. Reports, discussion and recommendations recorded in minutes of meetings. Follow-up as part of continuing review and appraisal.</td>
</tr>
<tr>
<td>6. When appointing relevant individuals the provider has processes for considering a person’s physical and mental health in line with the requirements of the role, all subject to equalities and employment legislation and to due process.</td>
<td>Self-declaration subject to clearance by occupational health as part of the pre-employment process.</td>
<td>Occupational health clearance</td>
</tr>
<tr>
<td>7. Wherever possible, reasonable adjustments are made in order that an individual can carry out the role.</td>
<td>Self-declaration of adjustments required. NHS Employment Check Standards Board decision</td>
<td>Minutes of Board meeting meeting</td>
</tr>
<tr>
<td>Standard</td>
<td>Assurance process</td>
<td>Evidence</td>
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<tr>
<td>8. The provider has processes in place to assure itself that the individual has not been at any time responsible for, privy to, contributed to, or facilitated, any serious misconduct or mismanagement in the carrying on of a regulated activity; this includes investigating any allegation of such potential behaviour. Where the individual is professionally qualified, it may include fitness to practise proceedings and professional disciplinary cases.</td>
<td>Consequences of false or inaccurate or incomplete information included in recruitment packs. Checks set out in 1. Above i.e. Employment checks in accordance with NHS Employers pre-employment check standards including: • self-declarations of fitness including explanation of past conduct/character issues where appropriate by candidates; • two references, one of which must be most recent employer; • qualification and professional registration checks; • right to work checks; • proof of identity checks; • occupational health clearance; • DBS checks (where appropriate); • search of insolvency and bankruptcy register; • search of disqualified directors register. Included in reference requests.</td>
<td>NED Recruitment Information pack Reference Request for ED/NED/Deputy Director</td>
</tr>
</tbody>
</table>

('Regulated activity' means activities set out in Schedule 1, Regulated Activities, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Schedule 1 covers the provision of:

- personal care; accommodation for persons who require nursing or personal care; accommodation for persons who require treatment for substance misuse; treatment of disease, disorder or injury; assessment or medical treatment for persons detained under the 1983 Act; surgical procedures; diagnostic and screening procedures; management of supply of blood and blood derived products etc.; transport services, triage and medical advice provided remotely; maternity and midwifery services; termination of pregnancies; services in slimming clinics; nursing care; family planning services.

'Responsible for, contributed to or facilitated' means that there is evidence that a person has intentionally or through neglect behaved in a manner which would be considered to be or would have led to serious misconduct or mismanagement.

'Privy to' means that there is evidence that a person was aware of serious misconduct or mismanagement but did not take the appropriate action to ensure it was addressed.

'Serious misconduct or mismanagement' means behaviour that would constitute a breach of any legislation/enactment CQC deems relevant to meeting these regulations or their component parts.

N.B. This provision applies equally to executives, NEDs and Deputy Directors.)
<table>
<thead>
<tr>
<th>Standard</th>
<th>Assurance process</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>9.</strong> The provider must not appoint any individual who has been responsible for, privy to, contributed to, or facilitated, any serious misconduct or mismanagement (whether lawful or not) in the carrying on of a regulated activity; this includes investigating any allegation of such potential behaviour. Where the individual is professionally qualified, it may include fitness to practise proceedings and professional disciplinary cases. N.B. The CQC accepts that providers will use reasonable endeavours in this instance. The existence of a compromise agreement does not indemnify the new employer and providers will need to ensure that their Core HR policies address their approach to compromise agreements.</td>
<td>Consequences of false, inaccurate or incomplete information included in recruitment packs. Core HR policies for appointments and remuneration Checks set out in Section 1 above. Included in reference requests.</td>
<td>NED, ED and Deputy Director Recruitment Information packs Core HR policies Reference Request for ED, NED and Deputy Director</td>
</tr>
<tr>
<td><strong>10.</strong> Only individuals who will be acting in a role that falls within the definition of a 'regulated activity' as defined by the Safeguarding Vulnerable Groups Act 2006 will be eligible for a check by the Disclosure and Barring Service (DBS). N.B. The CQC recognises that it may not always be possible for providers to access a DBS check as an individual may not be eligible.</td>
<td>DBS checks are undertaken only for those posts which fall within the definition of a “regulated activity” or which are otherwise eligible for such a check to be undertaken.</td>
<td>DBS policy DBS checks for eligible post-holders</td>
</tr>
<tr>
<td><strong>11.</strong> As part of the recruitment/appointment process, providers should establish whether the individual is on a relevant DBS list. Continuing provisions.</td>
<td>Eligibility for DBS checks will be assessed for each vacancy arising.</td>
<td>DBS policy</td>
</tr>
<tr>
<td><strong>12.</strong> The fitness of trust Board members and Deputy Directors is regularly reviewed by the provider to ensure that they remain fit for the role they are in; the provider should determine how often fitness must be reviewed based on the assessed risk to business delivery and/or the service users posed by the individual and/or role.</td>
<td>Assessment of continued fitness to be undertaken each year. Checks of insolvency and bankruptcy register and register of disqualified directors to be undertaken each year. Chairman/DCAG review checks and agree the outcomes.</td>
<td>Continual to be assessed annually as part of the Board’s Fit &amp; Proper persons checks (January each year) Register checks if necessary Board minutes record that process has been followed.</td>
</tr>
<tr>
<td><strong>13.</strong> If a provider discovers information that suggests an individual is not of good character after they have been appointed to a role, the provider must take appropriate and timely action to investigate and rectify the matter. The provider has arrangements in place to respond to concerns about a person’s fitness after they are appointed to a role, identified by itself or others and these are adhered to.</td>
<td>Core HR policies provides for such investigations. Revised contracts allow for termination in the event of non-compliance with regulations and other requirements. Contracts (for EDs and director-equivalents) and agreements (for NEDs) incorporate maintenance of fitness as a contractual requirement.</td>
<td>Core HR polices Contracts of employment (for EDs and director-equivalents) Service agreements or equivalent (for NEDs)</td>
</tr>
<tr>
<td>Standard</td>
<td>Assurance process</td>
<td>Evidence</td>
</tr>
<tr>
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</tr>
<tr>
<td>14. The provider investigates, in a timely manner, any concerns about a person’s fitness or ability to carry out their duties, and where concerns are substantiated, proportionate, timely action is taken; the provider must demonstrate due diligence in all actions.</td>
<td>Core HR policies include the necessary provisions. Action taken and recorded as required</td>
<td>Core HR policies</td>
</tr>
<tr>
<td>15. Where a person’s fitness to carry out their role is being investigated, appropriate interim measures may be required to minimise any risk to service users.</td>
<td>Core HR policies</td>
<td>Managerial action taken to backfill posts as necessary.</td>
</tr>
<tr>
<td>16. The provider informs others as appropriate about concerns/findings relating to a person’s fitness; for example, professional regulators, CQC and other relevant bodies, and supports any related enquiries/investigations carried out by others.</td>
<td>Core HR policies</td>
<td>Referrals made to other agencies if necessary.</td>
</tr>
</tbody>
</table>
Appendix C7

Consultancy spending approval criteria: updated guidance to providers

Summary

1. NHS providers wishing to commission consultancy services should use the updated template and guidance information.

2. Consultancy contracts over £50,000 require prior approval by NHS Improvement (the £50,000 threshold includes irrecoverable VAT and other costs, eg expenses). This also applies where the threshold would be reached as a result of a contract extension or variation.

3. The approval process applies to contracts that are accounted for as revenue expenditure. It does not currently apply to contracts accounted for as capital expenditure.

4. The criteria below will be used to assess business cases. Having a business case approved

5. Please send business case approval forms to nhsi.businesscases@nhs.net

6. The panel will review each business case against a number of assessment criteria outlined below:

<table>
<thead>
<tr>
<th>Criteria we are assessing</th>
<th>What we are looking for</th>
</tr>
</thead>
</table>
| Ambition to deliver something of value, importance and relevance | • Evidence that the trust’s strategic and operational objectives are supported by this proposed work. We are looking for relevance to your organisation’s business plans and any recovery plans  
• Evidence on how this work aligns with the local health economy strategy, the 5YFV and the Carter Review  
• Specific deliverables that clearly support the overall objectives of the work and the organisation’s business plans  
• Details of the clinical case where the proposed work directly affects the provision of services for patients  
• An explanation as to why the proposed service cannot be resourced internally or sourced from peer organisations. We are also looking for efforts to ensure skills will be transferred to permanent staff, where appropriate  
• An outline of what the impact will be on the trust objectives and business planning, staff and patient care if approval is not given for the business case |
<table>
<thead>
<tr>
<th>Criteria we are assessing</th>
<th>What we are looking for</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clear scope</td>
<td>• Evidence that the scope is clear, defined and well thought through&lt;br&gt;• Detail on how the scope has been developed including any engagement with patients, clinicians, commissioners or suppliers&lt;br&gt;• You should explain the boundaries to the project and mention any key elements that are out of scope. Will this potentially lead to a future phase project?</td>
</tr>
<tr>
<td>Robust contract management</td>
<td>• Evidence that the trust can manage the supplier, control spend and hold the supplier account for delivering value for money&lt;br&gt;• Assurance that the trust can deliver the scope as planned&lt;br&gt;• Details of payment structure, particularly details of approaches to link payment to deliverables, eg arrangements to ensure effective communication between staff approving and processing payments and the project team receiving and evaluating the work</td>
</tr>
<tr>
<td>Capacity to implement findings/recommendations</td>
<td>• Evidence that the trust has the capacity to act on or implement findings/recommendations of the procured work&lt;br&gt;• Examples of previous success in realising benefits</td>
</tr>
<tr>
<td>Timeline of work</td>
<td>• Evidence of a well-thought-through and realistic timeline, with details on when expected outcome will be delivered&lt;br&gt;• Why does the project need to start now and not in say 6 months’ time?</td>
</tr>
<tr>
<td>Robust implementation review proposal</td>
<td>• An outline of how the effectiveness of the consultancy support procured will be reviewed, with particular focus on benefits and value add</td>
</tr>
<tr>
<td>Finance case</td>
<td>• Evidence of the proposed procurement/resourcing method, including how you reached or propose to reach the decision that this is the best way to meet your business requirements (some evidence of options appraisal)&lt;br&gt;• Evidence of sourcing the best value supplier and evidence of negotiation over rates&lt;br&gt;• Details of the basis of payment and why this will achieve best value, eg does the contract propose a fixed fee, contingent fee, etc and how will any risks within the payment structure be managed?&lt;br&gt;• Details of agreed benchmarking rates, referencing where possible agreed framework rates.&lt;br&gt;• Please confirm where funding is coming from, affordability to the trust and the status of the funding approval (eg Board approved/Director of Finance approved)&lt;br&gt;• Please highlight any in-year benefits and overall business case benefits. Does the benefits realisation of this project depend on capital approval, public consultation or other providers or Local Health Economy programmes?</td>
</tr>
<tr>
<td>Wider use of findings</td>
<td></td>
</tr>
<tr>
<td>-----------------------</td>
<td></td>
</tr>
<tr>
<td>• Whether or not there are any contractual restrictions to sharing the outcomes of this work with the wider sector. Where the outcomes are not commercially sensitive, we will expect all future work to be made available for the wider benefit of the NHS, particularly where the advice is technical and likely to be generic to similar situations.</td>
<td></td>
</tr>
<tr>
<td>• We expect this right of access to be written into contracts. You should check that a contract clause is in place allowing for the wider use of any generic technical findings, and also that the deliverables have been scoped so that such technical work is as far as possible separated from any commercially sensitive elements of the scope.</td>
<td></td>
</tr>
</tbody>
</table>
Consultancy expenditure business case approval form

<table>
<thead>
<tr>
<th>For provider completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider name</td>
</tr>
<tr>
<td>Date submitted</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Project description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please give a high level summary of what this project entails (~250 words)</td>
</tr>
</tbody>
</table>

NHS Improvement’s Consultancy Approval Panel will give final approval for all expenditure requested in this business case approval form. This panel exercises the authority of the Executive Director of Resources/Deputy CEO, Executive Director of Regulation/Deputy CEO, Director of Finance and Programme Director – Improvement.

<table>
<thead>
<tr>
<th>For NHS Improvement completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reference number</td>
</tr>
<tr>
<td>Date received</td>
</tr>
</tbody>
</table>
## Reference information

<table>
<thead>
<tr>
<th>Title of the project:</th>
<th>Job role of requestor:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of requestor:</td>
<td></td>
</tr>
<tr>
<td>Email address of requestor:</td>
<td>Date submitted for approval:</td>
</tr>
<tr>
<td>Tel number of requestor:</td>
<td>Total contract value (£) (including expenses and irrecoverable VAT)¹:</td>
</tr>
<tr>
<td>Contract duration (days):</td>
<td>Vanguard project (Y/N):</td>
</tr>
<tr>
<td>Start date:</td>
<td>End date:</td>
</tr>
</tbody>
</table>

### Expenditure type (please tick ✓)

<table>
<thead>
<tr>
<th>New business case</th>
<th>Extension to business case</th>
</tr>
</thead>
<tbody>
<tr>
<td>Management consultancy</td>
<td>✓ [e.g. Strategy]</td>
</tr>
<tr>
<td>Specialist day rate contractors</td>
<td>Interim managers and day rate contractors do not currently require approval</td>
</tr>
<tr>
<td>Interim managers</td>
<td>Interim managers and day rate contractors do not currently require approval</td>
</tr>
</tbody>
</table>

### Authorisation (two internal authorisations required as a minimum)

<table>
<thead>
<tr>
<th>Authorisers²</th>
<th>Please tick (✓)</th>
<th>Name and date</th>
</tr>
</thead>
<tbody>
<tr>
<td>[Specify job role]</td>
<td>By: [Specify name]; Date: [Specify date]</td>
<td></td>
</tr>
<tr>
<td>[Specify job role]</td>
<td>By: [Specify name]; Date: [Specify date]</td>
<td></td>
</tr>
<tr>
<td>[Specify job role]</td>
<td>By: [Specify name]; Date: [Specify date]</td>
<td></td>
</tr>
<tr>
<td>[Specify job role]</td>
<td>By: [Specify name]; Date: [Specify date]</td>
<td></td>
</tr>
</tbody>
</table>

¹ Total contract value stated here should equal total cost in the table on the final page of this document.

² Business case approval forms should be signed off in accordance with your own governance arrangements. Please note that NHS Improvement also expects this form to be authorised by at least two Board level executives. For projects with direct impact on clinical services, authorisation by the Nursing Director or the Medical Director is required.

Note: It is the responsibility of the requestor to ensure that approval information is retained for audit purposes.

Please submit this form via nhsi.businesscases@nhs.net
<table>
<thead>
<tr>
<th>Assessment criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please demonstrate the value of the proposed contract against the following criteria. Please limit answers to max. 350 words per question. Answers should be self-contained within this table, but further evidence and analysis can be submitted as an annex for consideration if absolutely essential.</td>
</tr>
</tbody>
</table>

| Ambition to deliver something of value, importance and relevance | What strategic or operational objectives does this request support?  
*Please provide a short description of how your organisation’s strategic and operational objectives are supported by this procurement, referring where relevant to your operational and five-year strategic plan and any recovery plans. Where appropriate, please also provide assurance that this work aligns with local health economy strategy, the 5YFV and the Carter Review.* |

| | What outputs or specific deliverables are required, and how do they support the overall objectives?  
*Please provide details of the outputs or deliverables required from the consultancy service. Deliverables should be recognisable such as a report, workshop, license, software etc… Avoid combining deliverables to make benchmarking complicated. It’s helpful to know what the supplier is tasked to do and how its linked to the deliverable.* |

| | Please provide details of the clinical case where the proposed work directly affects the provision of services for patients or quality improvement. |

| | Why do you need external resources to deliver these outputs or deliverables?  
*Please explain what other options you considered e.g. work within the resource profile available to you.* |

| | What skills can or will be transferred to permanent staff?  
*Please explain why the services set out above cannot be resourced internally or sourced from peer organisations. What skills will be transferred to permanent staff, and how will this be done?* |

| | Please describe the impact on the your objectives, staff and patient care if approval is not given for this business case.  
*This should be the consequence of non-approval not the fact the project cannot take place.* |

<p>| Clear scope | Please ensure the scope is clear and defined and provide information on how the scope was developed, including any engagement with patients, clinicians, commissioners or suppliers. You should explain the boundaries to the project and mention any key elements that are out of scope. Will this potentially lead to a future phase project? |</p>
<table>
<thead>
<tr>
<th><strong>Robust contract management</strong></th>
<th>Please explain steps you will take to control spend and manage the supplier to deliver value for money, including steps to ensure the delivery of the scope as planned. Please include detail of the payment structure including detail of approaches to link payment to deliverables.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Capacity to implement findings/recommendations</strong></td>
<td>Please demonstrate your capacity to implement findings/recommendations of the procured support including details of steps taken. Please support your response with details of any relevant previous examples, such as specific examples of where benefits have been realised.</td>
</tr>
<tr>
<td><strong>Timeframe of work</strong></td>
<td>Please include when expected outcome will be delivered. Why does the project need to start now and not in say 6 months’ time?</td>
</tr>
<tr>
<td><strong>Robust post- implementation review proposal</strong></td>
<td>Please outline how you will review the effectiveness of the consultancy support procured.</td>
</tr>
<tr>
<td><strong>Wider use of findings</strong></td>
<td>Please confirm that a contract clause is in place allowing for the wider use of any generic technical findings and that the deliverables have been scoped so that such technical work is as far as possible separated from any commercially sensitive elements of the scope.</td>
</tr>
<tr>
<td><strong>Procurement route if relevant</strong> (please tick ✓)</td>
<td></td>
</tr>
<tr>
<td><strong>Framework</strong> [Insert which one if known]</td>
<td>Open tender</td>
</tr>
<tr>
<td><strong>Procurement method and value on price:</strong> Provide details of the proposed procurement/resourcing method, including how you reached the decision that this is the best way to meet your business requirements, evidence of sourcing the best value supplier and evidence of negotiation over rates. The status of any prices quoted – firm or provisional. Please also provide details of the basis of payment (eg details of fixed fee) and why this will achieve best value. If there is a contingent fee element linked to implementation please also highlight it here as this will be given positive consideration.</td>
<td></td>
</tr>
<tr>
<td><strong>Selected provider (if known):</strong></td>
<td>Benchmarking of rates</td>
</tr>
<tr>
<td><strong>Benchmarking of rates</strong></td>
<td>Please provide details of agreed benchmarking rates, referencing where possible agreed framework rates. Where known present the key points from a competitive tender e.g. other supplier names, scores and prices.</td>
</tr>
</tbody>
</table>
Financial case

**What are the key benefits?**
Please highlight any in-year benefits and overall business case benefits. Does the benefits realisation of this project depend on capital approval, public consultation or other providers or LHE programmes?

**What is the expenditure?**
Please provide details of how you have calculated the cost of the product or service, by reference (as relevant) to benchmarked costs, and provide justification for the number of days required and/or mix of resources. Please provide evidence of the market engagement you have undertaken to calculate the financial case. You should also provide details of additional costs.

**What is the source of funding?**
Please confirm where funding is coming from, affordability to the trust and the status of the funding approval (eg Board approved/Director of Finance approved)

<table>
<thead>
<tr>
<th>Product, service, role(s) and grade(s) (or equivalent)</th>
<th>Unit cost or daily rate</th>
<th>Discount agreed (%)</th>
<th>Units required</th>
<th>Financial Year Expenditure Due</th>
<th>Sub Total (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
<td>Expenditure Due</td>
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<td></td>
<td></td>
<td>16/17</td>
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<td>17/18</td>
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<tr>
<td>Contingency Expenses</td>
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</tr>
<tr>
<td>VAT (irrecoverable only)</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total cost</td>
<td></td>
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</table>
Conflicts of Interest Policy
February 2019 – June 2022
**Policy Title:** Conflict of Interest Policy

**Executive Summary:**
This policy outlines the processes followed by East Cheshire NHS Trust in meeting the requirements for any trust ‘Decision Maker’ to declare any actual or potential conflicts of interest that arise in the course of conducting NHS business.

These should be declared on appointment and updated as necessary (at least annually, including a nil return) any potential or actual conflict.

For non ‘Decision Makers’ - this policy expands on the 11 different categories that staff should refer to when considering if a declaration is necessary.

**Supersedes:** Conflict of Interest v5 issued in 1st March 2019

**Description of Amendment(s):**
Additional line in the Introduction section referencing Appendix 1.
Addition of section 16 – Appendix 1 relating to the Bribery Act 2010

This policy will impact on: All staff (including Agency staff) and volunteers of ECT

**Financial Implications:** None

<table>
<thead>
<tr>
<th>Policy Area:</th>
<th>Corporate Affairs and Governance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Version Number:</td>
<td>6</td>
</tr>
<tr>
<td>Effective Date:</td>
<td>20th March 2019</td>
</tr>
<tr>
<td>Issued By:</td>
<td>Director of Corporate Affairs and Governance</td>
</tr>
<tr>
<td>Review Date:</td>
<td>1st June 2022</td>
</tr>
<tr>
<td>Author: (Full Job title)</td>
<td>Corporate Affairs &amp; EPRR Manager</td>
</tr>
<tr>
<td>Impact Assessment Date:</td>
<td>June 2017</td>
</tr>
</tbody>
</table>

**APPROVAL RECORD**

| Consultation | Deputy Director of CAG Director of CAG | February 2019 |
| Approved by: | Director of Corporate Affairs & Governance | February 2019 |
| Ratified by: | Audit Committee | February 2019 |
1 POLICY SUMMARY

Adhering to this policy will help to ensure that we use NHS money wisely, providing best value for taxpayers and accountability to our patients for the decisions we take.

<table>
<thead>
<tr>
<th>As a member of staff you should...</th>
<th>As an organisation we will...</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Use your common sense and judgement to consider whether the interests you have could affect the way taxpayers’ money is spent.</td>
<td>• Identify a team or individual with responsibility for:</td>
</tr>
<tr>
<td>• Regularly consider what interests you have and declare these as they arise. If in doubt, declare.</td>
<td>o Keeping this policy under review to ensure we are in line with the guidance.</td>
</tr>
<tr>
<td>• <strong>NOT</strong> misuse your position to further your own interests or those close to you.</td>
<td>o Provide advice, training and support for staff on how interests should be managed.</td>
</tr>
<tr>
<td>• <strong>NOT</strong> be influenced, or give the impression that you have been influenced by outside interests.</td>
<td>o Maintain register(s) of interests.</td>
</tr>
<tr>
<td>• <strong>NOT</strong> allow outside interests you have to inappropriately affect the decisions you make when using taxpayers’ money.</td>
<td>o Audit this policy and its associated processes and procedures at least once every three years.</td>
</tr>
</tbody>
</table>

• **NOT** avoid managing conflicts of interest.

• **NOT** interpret this policy in a way which stifles collaboration and innovation with our partners.
2 INTRODUCTION

East Cheshire NHS Trust (the ‘organisation’), and the people who work with and for us, collaborate closely with other organisations delivering high quality care for our patients.

These partnerships have many benefits and should help ensure that public money is spent efficiently and wisely; but there is a risk that conflicts of interest may arise.

Providing best value for taxpayers and ensuring that decisions are taken transparently and clearly, are both key principles in the NHS Constitution. We are committed to maximising our resources for the benefit of the whole community. As an organisation and as individuals, we have a duty to ensure that all our dealings are conducted to the highest standards of integrity and that NHS monies are used wisely so that we are using our finite resources in the best interests of patients. Please also refer to Appendix 1 which contains information relating to the Bribery Act 2010.

3 PURPOSE

This policy should be considered alongside the following East Cheshire NHS Trust policies and procedures:

- Corporate Governance Manual (Part D – Standing Financial Instructions, section 22 – Acceptance of gifts by staff)
- Local Anti-Fraud, Bribery and Corruption Policy
- Freedom to Speak-Up – Raising Concerns Policy

This policy will help our staff manage conflicts of interest risks effectively; it:

- Introduces consistent principles and rules
- Provides simple advice about what to do in common situations
- Supports good judgement about how to approach and manage interests

4 KEY TERMS

A ‘conflict of interest’ is defined as:

“A set of circumstances by which a reasonable person would consider that an individual’s ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold."

A conflict of interest may be:

- Actual - there is a material conflict between one or more interests
- Potential – there is the possibility of a material conflict between one or more interests in the future
Staff may hold interests for which they cannot see potential conflict. However, caution is always advisable because others may see it differently and perceived conflicts of interest can be damaging. All interests should be declared where there is a risk of perceived improper conduct.

5 INTERESTS

Interests fall into the following categories:

- **Financial interests:**
  Where an individual may get direct financial benefit\(^1\) from the consequences of a decision they are involved in making.

- **Non-financial professional interests:**
  Where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making, such as increasing their professional reputation or promoting their professional career.

- **Non-financial personal interests:**
  Where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career.

- **Indirect interests:**
  Where an individual has a close association\(^2\) with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest and could stand to benefit from a decision they are involved in making.

6 STAFF

At East Cheshire NHS Trust we use the skills of many different people, all of whom are vital to our work. This includes people on differing employment terms, who for the purposes of this policy we refer to as ‘staff’ and are listed below:

- All salaried employees
- All prospective employees – who are part-way through recruitment
- Contractors and sub-contractors
- Volunteers
- Agency staff; and
- Committee, sub-committee and advisory group members (who may not be directly employed or engaged by the organisation)

NHS England have produced some frequently asked questions for specific staff groups on the issues posed and how the guidance applies to you; for further information this can be found at [www.england.nhs.uk/ourwork/coi](http://www.england.nhs.uk/ourwork/coi).

---

1. This may be a financial gain, or avoidance of a loss.
2. A common sense approach should be applied to the term ‘close association’. Such an association might arise, depending on the circumstances, through relationships with close family members and relatives, close friends and associates, and business partners.
The policy will expand on the 11 different categories that staff should refer to when considering if a declaration is necessary. Should any staff member have an interest to declare in any of the categories they must do so within 28 days of the interest arising. It is only those staff that are classed as Decision Makers of the trust (see below) that also have a requirement to make an annual ‘nil’ declaration.

Please note should you not have any conflicts to declare and you are not a decision maker of the trust, there is no requirement to enter a ‘nil’ declaration on the electronic system.

7 DECISION MAKING STAFF

Some staff are more likely than others to have a decision making influence on the use of taxpayers’ money, because of the requirements of their role. For the purposes of this guidance these people are referred to as ‘decision making staff.’

Decision making staff in this organisation are:

- Trust Board members, Clinical Directors, Clinical Leads, Deputy Directors, Associate Directors;
- Those who are formal members of Decision Making Groups (see 12.1);
- The trusts Procurement team; and
- Those who sit on job matching panels.

Please remember if you are in one of the above categories and have nothing to declare you still have to go onto the system and input a ‘nil’ declaration; this is required each year.

8 IDENTIFICATION & DECLARATION OF INTERESTS

8.1 Identification & declaration of interests (including gifts and hospitality)

All staff should identify and declare material interests at the earliest opportunity (and in any event within 28 days). If staff are in any doubt as to whether an interest is material then they should declare it, so that it can be considered. Declarations should be made:

- On appointment with the organisation;
- When staff move to a new role or their responsibilities change significantly;
- At the beginning of a new project/piece of work; and
- As soon as circumstances change and new interests arise (for instance, in a meeting when interests staff hold are relevant to the matters in discussion).

The trust has an electronic system which is linked to ESR in full.

The responsibility for the management of the trust’s conflict of interest’s process including the review of this policy lies with the Director of Corporate Affairs & Governance. The trusts register is a public facing document and available to view throughout the year.

Should staff members require any further advice or guidance please email the following address: Ecn-tr.conflictofinterest@nhs.net
After expiry, an interest will remain on the register for a minimum of 6 months and a private record of historic interests will be retained for a minimum of 6 years. Please note declarations stay live on the system for 6 months following departure from the trust.

9 RECORDS AND PUBLICATION

9.1 Maintenance
The organisation will maintain the following register:

- One overall Conflict of Interest Register (including a register of gifts and hospitality)

9.2 Publication
We will:

- Ensure the trusts electronic system is accessible to staff and the public all year round
- Compliance rates will be noted annually at Trust Board in April, contained within the Chairman’s Commentary
- An annual Conflict of Interest report and a bi-annual update report will be presented to the Audit Committee

If decision making staff have substantial grounds for believing that publication of their interests should not take place then they should contact either the Director of Corporate Affairs & Governance (Julie.green4@nhs.net) or the Corporate Affairs Manager (fionabaker@nhs.net) to explain why. In exceptional circumstances, for instance where publication of information might put a member of staff at risk of harm, information may be withheld or redacted on public registers. However, this would be the exception and information will not be withheld or redacted merely because of a personal preference.

9.3 Wider transparency initiatives
East Cheshire NHS Trust fully supports wider transparency initiatives in healthcare, and we encourage staff to engage actively with these.

Relevant staff are strongly encouraged to give their consent for payments they receive from the pharmaceutical industry to be disclosed as part of the Association of British Pharmaceutical Industry (ABPI) Disclosure UK initiative. These “transfers of value” include payments relating to:

- Speaking at and chairing meetings
- Training services
- Advisory board meetings
- Fees and expenses paid to healthcare professionals
- Sponsorship of attendance at meetings, which includes registration fees and the costs of accommodation and travel, both inside and outside the UK
- Donations, grants and benefits in kind provided to healthcare organisations

Further information about the scheme can be found on the ABPI website:

http://www.abpi.org.uk/our-work/disclosure/about/Pages/default.aspx

As part of the audit process, the trust regularly reviews the ABPI Disclosure UK initiative and cross references any individuals from East Cheshire NHS Trust to ensure relevant
declarations have been made on the trust’s CoI site. Any anomalies are reviewed to ensure no conflict has arisen.

10 MANAGEMENT OF INTERESTS – GENERAL

If an interest is declared but there is no risk of a conflict arising then no action is warranted. However, if a material interest is declared then the general management actions that could be applied include:

- restricting staff involvement in associated discussions and excluding them from decision making
- removing staff from the whole decision making process
- removing staff responsibility for an entire area of work
- removing staff from their role altogether if they are unable to operate effectively in it because the conflict is so significant

Each case will be different and context-specific, and East Cheshire NHS Trust will always clarify the circumstances and issues with the individuals involved. Staff should maintain a written audit trail of information considered and actions taken.

Staff who declare material interests should make their line manager or the person(s) they are working to aware of their existence.

11 MANAGEMENT OF INTERESTS – COMMON SITUATIONS

This section sets out the principles and rules to be adopted by staff in common situations, and what information should be declared.

11.1 Gifts

- Staff should not accept gifts that may affect, or be seen to affect, their professional judgement
- Gifts from suppliers or contractors:
  - Gifts from suppliers or contractors doing business (or likely to do business) with the organisation should be declined, whatever their value
  - Low cost branded promotional aids such as pens or post-it notes may, however, be accepted where they are under the value of £63 in total, and need not be declared
- Gifts from other sources (e.g. patients, families, service users):
  - Gifts of cash and vouchers to individuals should always be declined
  - Staff should not ask for any gifts
  - Gifts valued at over £50 should be treated with caution and only be accepted on behalf of East Cheshire NHS Trust and then given to the trust’s charity ECHO for fund raising purposes and not by an individual member of staff; any incidents of this should also be declared
  - Modest gifts accepted under a value of £50 do not need to be declared

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3 The £6 value has been selected with reference to existing industry guidance issued by the ABPI:
• A common sense approach should be applied to the valuing of gifts (using an actual amount, if known, or an estimate that a reasonable person would make as to its value)
• Multiple gifts from the same source over a 12 month period should be treated in the same way as single gifts over £50 where the cumulative value exceeds £50

11.1.2 What should be declared
• Staff name and their role with the organisation
• A description of the nature and value of the gift, including its source
• Date of receipt
• Any other relevant information (e.g. circumstances surrounding the gift, action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

11.2 Hospitality
• Staff should not ask for or accept hospitality that may affect, or be seen to affect, their professional judgement
• Hospitality must only be accepted when there is a legitimate business reason and it is proportionate to the nature and purpose of the event
• Particular caution should be exercised when hospitality is offered by actual or potential suppliers or contractors. This can be accepted, and must be declared, if modest and reasonable. Senior approval must be obtained.

Meals and refreshments:
• Under a value of £25 - may be accepted and need not be declared
• Of a value between £25 and £75⁴ - may be accepted and must be declared
• Over a value of £75 - should be refused unless (in exceptional circumstances) senior approval is given. A clear reason should be recorded on the organisation’s register(s) of interest as to why it was permissible to accept
• A common sense approach should be applied to the valuing of meals and refreshments (using an actual amount, if known, or a reasonable estimate)

Travel and accommodation:
• Modest offers to pay some or all of the travel and accommodation costs related to attendance at events may be accepted and must be declared
• Offers which go beyond modest, or are of a type that the trust might not usually offer, need approval by senior staff, should only be accepted in exceptional circumstances, and must be declared. A clear reason would need to be recorded on the organisation’s register(s) of interest as to why it was permissible to accept travel and accommodation of this type. A non-exhaustive list of examples includes:
  o offers of business class or first class travel and accommodation (including domestic travel)
  o offers of foreign travel and accommodation.

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⁴ The £75 value has been selected with reference to existing industry guidance issued by the ABPI
http://www.pmcpa.org.uk/thecode/Pages/default.aspx
11.2.1 What should be declared

- Staff name and their role with the organisation
- The nature and value of the hospitality including the circumstances
- Date of receipt
- Any other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy)

11.3 Outside Employment

- Existing staff should declare any current outside employment (this would be an annual requirement) and for new staff this will be required on appointment
- Where a risk of conflict of interest arises, the general management actions outlined in this policy should be considered and applied to mitigate risks
- Where contracts of employment or terms and conditions of engagement permit, staff may be required to seek prior approval from the organisation to engage in outside employment

The organisation may also have legitimate reasons within employment law for knowing about outside employment of staff, even when this does not give rise to risk of a conflict.

11.3.1 What should be declared

- Staff name and their role with the organisation
- The nature of the outside employment (e.g. who it is with, a description of duties, time commitment)
- Relevant dates
- Other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy)

11.4 Shareholdings and other ownership issues

- Staff should declare, as a minimum, any shareholdings that are material to them (i.e. equivalent of 5% or more of their overall wealth) or material to the organisation and other ownership interests in any publicly listed, private or not-for-profit company, business, partnership or consultancy which is doing, or might be reasonably expected to do, business with the trust
- Where shareholdings or other ownership interests are declared and give rise to risk of conflicts of interest then the general management actions outlined in this policy should be considered and applied to mitigate risks
- There is no need to declare shares or securities held in collective investment or pension funds or units of authorised unit trusts

11.4.1 What should be declared

- Staff name and their role with the organisation
- Nature of the shareholdings/other ownership interest
- Relevant dates
- Other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy)

11.5 Patents

- Staff should declare patents and other intellectual property rights they hold (either individually, or by virtue of their association with a commercial or other organisation), including where applications to protect have started or are ongoing, which are, or
might be reasonably expected to be, related to items to be procured or used by the organisation

- Staff should seek prior permission from the organisation before entering into any agreement with bodies regarding product development, research, work on pathways etc, where this impacts on the organisation’s own time, or uses its equipment, resources or intellectual property
- Where holding of patents and other intellectual property rights give rise to a conflict of interest then the general management actions outlined in this policy should be considered and applied to mitigate risks

11.5.1 What should be declared

- Staff name and their role with the organisation
- A description of the patent
- Relevant dates
- Other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy)

11.6 Loyalty interests

Loyalty interests should be declared by staff where they:

- Hold a position of authority in another NHS organisation or commercial, charity, voluntary, professional, statutory or other body which could be seen to influence decisions they take in their NHS role
- Sit on advisory groups or other paid or unpaid decision making forums that can influence how an organisation spends taxpayers’ money
- Are, or could be, involved in the recruitment or management of close family members and relatives, close friends and associates, and business partners
- Are aware that their organisation does business with an organisation in which close family members and relatives, close friends and associates, and business partners have decision making responsibilities

11.6.1 What should be declared

- Staff name and their role with the organisation
- Nature of the loyalty interest
- Relevant dates
- Other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy)

11.7 Donations

- Donations made by suppliers or bodies seeking to do business with the trust should be treated with caution and not routinely accepted. In exceptional circumstances they may be accepted but should always be declared. A clear reason should be recorded as to why it was deemed acceptable, alongside the actual or estimated value
- Staff should not actively solicit charitable donations unless this is a prescribed or expected part of their duties for the organisation, or is being pursued on behalf of the organisation’s own registered charity or other charitable body and is not for their own personal gain.
- Staff must obtain permission from the organisation if in their professional role they intend to undertake fundraising activities on behalf of a pre-approved charitable campaign for a charity other than the organisation’s own
- Donations, when received, should be made to a specific charitable fund (never to an individual) and a receipt should be issued
• Staff wishing to make a donation to a charitable fund in lieu of receiving a professional fee may do so, subject to ensuring that they take personal responsibility for ensuring that any tax liabilities related to such donations are properly discharged and accounted for.

11.7.1 What should be declared
• The organisation will maintain records in line with the above principles and rules and relevant obligations under charity law.

11.8 Sponsored events
• Sponsorship of events by appropriate external bodies will only be approved if a reasonable person would conclude that the event will result in clear benefit to the organisation and the NHS
• During dealings with sponsors there must be no breach of patient or individual confidentiality or data protection rules and legislation
• No information should be supplied to the sponsor from whom they could gain a commercial advantage, and information which is not in the public domain should not normally be supplied
• At the organisation’s discretion, sponsors or their representatives may attend or take part in the event but they should not have a dominant influence over the content or the main purpose of the event
• The involvement of a sponsor in an event should always be clearly identified
• Staff within the organisation involved in securing sponsorship of events should make it clear that sponsorship does not equate to endorsement of a company or its products and this should be made visibly clear on any promotional or other materials relating to the event
• Staff arranging sponsored events must declare this to the organisation

11.8.1 What should be declared
• The organisation will maintain records regarding sponsored events in line with the above principles and rules.

11.9 Sponsored research
• Funding sources for research purposes must be transparent
• Any proposed research must go through the relevant health research authority or other approvals process
• There must be a written protocol and written contract between staff, the trust, and/or institutes at which the study will take place and the sponsoring organisation, which specifies the nature of the services to be provided and the payment for those services
• The study must not constitute an inducement to prescribe, supply, administer, recommend, buy or sell any medicine, medical device, equipment or service
• Staff should declare involvement with sponsored research to the trust
11.9.1 **What should be declared**

The trust will retain written records of sponsorship of research, in line with the above principles and rules.

Staff should declare:

- Their name and their role with the organisation
- Nature of their involvement in the sponsored research
- Relevant dates.
- Other relevant information (e.g. what, if any, benefit the sponsor derives from the sponsorship, action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy)

11.10 **Sponsored posts**

- External sponsorship of a post requires prior approval from the trust
- Rolling sponsorship of posts should be avoided unless appropriate checkpoints are put in place to review and withdraw if appropriate
- Sponsorship of a post should only happen where there is written confirmation that the arrangements will have no effect on purchasing decisions or prescribing and dispensing habits. This should be audited for the duration of the sponsorship. Written agreements should detail the circumstances under which organisations have the ability to exit sponsorship arrangements if conflicts of interest which cannot be managed arise
- Sponsored post holders must not promote or favour the sponsor’s products, and information about alternative products and suppliers should be provided
- Sponsors should not have any undue influence over the duties of the post or have any preferential access to services, materials or intellectual property relating to or developed in connection with the sponsored posts

11.10.1 **What should be declared**

- The trust will retain written records of sponsorship of posts, in line with the above principles and rules
- Staff should declare any other interests arising as a result of their association with the sponsor, in line with the content in the rest of this policy

11.11 **Clinical private practice**

Clinical staff should declare all private practice on appointment and/or any new private practice when it arises\(^5\) including:

- Where they practise (name of private facility)
- What they practise (specialty, major procedures)
- When they practise (identified sessions/time commitment)

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\(^5\) Hospital Consultants are already required to provide their employer with this information by virtue of Para.3 Sch. 9 of the Terms and Conditions – Consultants (England) 2003: [https://www.bma.org.uk/-/media/files/pdfs/practical advice at work/contracts/consultanttermsandconditions.pdf](https://www.bma.org.uk/-/media/files/pdfs/practical advice at work/contracts/consultanttermsandconditions.pdf)
Clinical staff should (unless existing contractual provisions require otherwise or unless emergency treatment for private patients is needed):

- Seek prior approval of their organisation before taking up private practice
- Ensure that, where there would otherwise be a conflict or potential conflict of interest, NHS commitments take precedence over private work
- Not accept direct or indirect financial incentives from private providers other than those allowed by Competition and Markets Authority guidelines: [https://assets.publishing.service.gov.uk/media/542c1543e5274a1314000c56/Non-Divestment_Order_amended.pdf](https://assets.publishing.service.gov.uk/media/542c1543e5274a1314000c56/Non-Divestment_Order_amended.pdf)

Hospital Consultants should not initiate discussions about providing their Private Professional Services for NHS patients, nor should they ask other staff to initiate such discussions on their behalf.

### 11.11.1 What should be declared

- Staff name and their role with the organisation
- A description of the nature of the private practice (e.g. what, where and when staff practise, sessional activity, etc)
- Relevant dates
- Any other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy)

### 11.12 Roll-Over of declarations

For those declarations in the following categories, once interests have been declared, they will stay ‘live’ on the system from year to year (i.e. roll-over):

- Loyalty Interests
- Outside Employment
- Clinical Private Practice
- Shareholdings and other Ownership Interests

When an interest in any of the above four categories ceases the ‘end’ date of the interest must be entered onto the CoI database.

For clarification, should ‘decision makers’ have an interest declared in any of the above 4 categories and no other interests to declare, their original declaration will roll over on the system and an additional ‘nil’ annual declaration will be required to be made. This is confirming that the staff member has no additional interests requiring declaration.

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6 These provisions already apply to Hospital Consultants by virtue of Paras.5 and 20, Sch. 9 of the Terms and Conditions – Consultants (England) 2003: [https://www.bma.org.uk/-/media/files/pdfs/practicaladviceatwork/contracts/consultanttermsandconditions.pdf](https://www.bma.org.uk/-/media/files/pdfs/practicaladviceatwork/contracts/consultanttermsandconditions.pdf)
12 MANAGEMENT OF INTERESTS– ADVICE IN SPECIFIC CONTEXTS

12.1 Strategic decision making groups
In common with other NHS bodies East Cheshire NHS Trust uses a variety of different groups to make key strategic decisions about things such as:

- Entering into (or renewing) large scale contracts
- Awarding grants
- Making procurement decisions
- Selection of medicines, equipment, and devices

The interests of those who are involved in these groups should be well known so that they can be managed effectively. For this organisation these groups are:

- Trust Board
- Audit Committee
- Safety, Quality and Standards Committee
- Directorate Safety, Quality and Standards sub-committees and Operational Boards
- Finance, Performance and Workforce Committee
- Remuneration Committee
- Clinical Management Board
- Operational Management Team
- Digital Transformation Group
- Capital and Space Planning Group
- Medicines Management Group
- Pathology Executive Board
- A&E Delivery Board
- Operational Resilience Group
- Job Matching Panels

These groups should adopt the following principles:

- Chairs should consider any known interests of members in advance, and begin each meeting by asking for declaration of relevant material interests
- Members should take personal responsibility for declaring material interests at the beginning of each meeting and as they arise
- Any new interests identified should be added to the trusts register(s)
- The vice chair (or other non-conflicted member) should chair all or part of the meeting if the chair has an interest that may prejudice their judgement.

If a member has an actual or potential interest the chair should consider the following approaches and ensure that the reason for the chosen action is documented in minutes or records:

- Requiring the member to not attend the meeting
- Excluding the member from receiving meeting papers relating to their interest
- Excluding the member from all or part of the relevant discussion and decision
- Noting the nature and extent of the interest, but judging it appropriate to allow the member to remain and participate
- Removing the member from the group or process altogether
The default response should not always be to exclude members with interests, as this may have a detrimental effect on the quality of the decision being made. Good judgement is required to ensure proportionate management of risk.

12.2 Procurement

Procurement should be managed in an open and transparent manner, compliant with procurement and other relevant law, to ensure there is no discrimination against or in favour of any provider. Procurement processes should be conducted in a manner that does not constitute anti-competitive behaviour - which is against the interest of patients and the public.

Those involved in procurement exercises for and on behalf of the organisation should keep records that show a clear audit trail of how conflicts of interest have been identified and managed as part of procurement processes. At every stage of procurement steps should be taken to identify and manage conflicts of interest to ensure and to protect the integrity of the process.

The trusts Procurement team are considered decision makers of the trust and as such are required to make as a minimum an annual ‘nil’ declaration if no other declaration has been made in year.

13 DEALING WITH BREACHES

There will be situations when interests will not be identified, declared or managed appropriately and effectively. This may happen innocently, accidentally, or because of the deliberate actions of staff or other organisations. For the purposes of this policy these situations are referred to as ‘breaches’.

13.1 Identifying and reporting breaches

Staff who are aware about actual breaches of this policy, or who are concerned that there has been, or may be a breach, should report these concerns to the Corporate Affairs Manager at fionabaker@nhs.net

To ensure that interests are effectively managed staff are encouraged to speak up about actual or suspected breaches. Every individual has a responsibility to do this. For further information about how concerns should be raised please refer to the trust’s Freedom to Speak-Up – Raising Concerns Policy or the trust’s Local Anti-Fraud, Bribery and Corruption Policy.

The organisation will investigate each reported breach according to its own specific facts and merits, and give relevant parties the opportunity to explain and clarify any relevant circumstances.
13.1 Following investigation the organisation will

- Decide if there has been or is potential for a breach and if so what severity the breach is
- Assess whether further action is required in response – this is likely to involve any staff member involved and their line manager, as a minimum or Associate Director
- Consider who else inside and outside the organisation should be made aware
- Take appropriate action as set out in the next section

13.2 Taking action in response to breaches

Action taken in response to breaches of this policy will be in accordance with the disciplinary procedures of the trust and could involve organisational leads for staff support (e.g. Human Resources), fraud (e.g. Local Counter Fraud Specialists), members of the management or executive teams and organisational auditors.

Breaches could require action in one or more of the following ways:

- Clarification or strengthening of existing policy, process and procedures
- Consideration as to whether HR/employment law/contractual action should be taken against staff or others
- Consideration being given to escalation to external parties. This might include referral of matters to external auditors, NHS Protect, the Police, statutory health bodies (such as NHS England, NHS Improvement or the CQC), and/or health professional regulatory bodies

Inappropriate or ineffective management of interests can have serious implications for the organisation and staff. There will be occasions where it is necessary to consider the imposition of sanctions for breaches.

Sanctions should not be considered until the circumstances surrounding breaches have been properly investigated. However, if such investigations establish wrong-doing or fault then the organisation can and will consider the range of possible sanctions that are available, in a manner which is proportionate to the breach. This includes:

- Employment law action against staff, which might include:
  - Informal action (such as reprimand, or signposting to training and/or guidance)
  - Formal disciplinary action (such as formal warning, the requirement for additional training, re-arrangement of duties, re-deployment, demotion, or dismissal)
- Reporting incidents to the external parties described above for them to consider what further investigations or sanctions might be
- Contractual action, such as exercise of remedies or sanctions against the body or staff which caused the breach
- Legal action, such as investigation and prosecution under fraud, bribery and corruption legislation
13.3 Learning and transparency concerning breaches

Reports on breaches, the impact of these, and action taken will be considered by the Audit Committee on a six monthly basis.

To ensure that lessons are learnt and management of interests can continually improve, anonymised information on breaches, the impact of these, and action taken will be prepared and published as appropriate, or made available for inspection by the public upon request.

14 REVIEW

This policy will be reviewed in June 2022 unless an earlier review is required. This will be led by the Director of Corporate Affairs & Governance.

15 ASSOCIATED DOCUMENTATION

- Freedom of Information Act 2000
- ABHI Code of Business Practice
- NHS Code of Conduct and Accountability (July 2004)
- Corporate Governance Manual (Part D – Standing Financial Instructions, section 22 – Acceptance of gifts by staff)
- Local Anti-Fraud, Bribery and Corruption Policy
- Freedom to Speak-Up – Raising Concerns Policy
Bribery & Corruption – Bribery and corruption prosecutions can be brought using specific pieces of legislation:

- Prevention of Corruption Acts 1906 and 1916, for offences committed prior to 1 July 2011
- Bribery Act 2010, for offences committed on or after 1 July 2011.

The Bribery Act 2010 (‘the Act’) has updated UK law by making it a criminal offence to:

- Offer, promise, or give a bribe (Section 1 of the Act); and/or,
- Request, agree to receive, or accept a bribe (Section 2 of the Act).

Corruption is generally considered to be an “umbrella” term covering such various activities as bribery, corrupt preferential treatment, kickbacks, cronyism, graft or embezzlement.

Under the 2010 Act, however, bribery is now a series of specific offences. Generally, bribery is defined as: **an inducement or reward offered, promised or provided to someone to perform their functions or activities improperly in order to gain a personal, commercial, regulatory and/or contractual advantage.**

Examples of bribery in the NHS context could be a contractor attempting to influence a procurement decision-maker by giving them an extra benefit or gift as part of a tender exercise; or, a medical or pharmaceutical company providing holidays or other excessive hospitality to a clinician in order to influence them to persuade their Trust to purchase that company’s particular clinical supplies.

A bribe does not have to be in cash; it may be the awarding of a contract, the provision of gifts, hospitality or sponsorship, the promise of work or some other benefit. The persons making and receiving the bribe may be acting on behalf of others – under the Bribery Act 2010, all parties involved may be prosecuted for a bribery offence.

The Act is also extra-territorial in nature. This means that anyone involved in bribery activity overseas may be liable to prosecution in the UK if the bribe is in respect of any UK activity, contract or organisation. To this end, the Act also includes **an offence of bribing a foreign public official (Section 6 of the act).**

In addition, the Act introduces a **new ‘corporate offence’ (Section 7 of the act) of the failure of commercial organisations to prevent bribery.** The Department of Health Legal Service has stated that NHS bodies are deemed to ‘relevant commercial organisations’ to which the Act applies. As a result, an NHS body may be held liable (and punished with a potentially unlimited fine) when someone “associated” with it bribes another in order to get, keep or retain business for the organisation. However, the organisation will have a defence, and avoid prosecution, if it can show it had adequate procedures in place designed to prevent bribery.
The trust adopts a ‘zero tolerance’ attitude towards bribery and does not, and will not, pay or accept bribes or offers of inducement to or from anyone, for any purpose. The trust is fully committed to the objective of preventing bribery and will ensure that adequate procedures, which are proportionate to our risks, are in place to prevent bribery and which will be regularly reviewed. We will, in conjunction with the NHS Counter Fraud Authority (NHS CFA) seek to obtain the strongest penalties – including criminal prosecution, disciplinary and/or civil sanctions – against anyone associated with East Cheshire NHS Trust who is found to be involved in bribery or corrupt activities.

As with the Fraud Act, a conviction under the Bribery Act may ultimately result in an unlimited fine and/or custodial sentence of up to 10 years imprisonment.

Sanctions and Redress

Where fraud, bribery or corruption has taken place within or against the NHS, the full range of available sanctions – criminal, civil, disciplinary and/or regulatory – should be considered at the earliest opportunity, and any or all of these may be pursued where and when appropriate.

In deciding the appropriate sanctions and redress in criminal and civil cases against employees, there should be no hesitation on the part of the trust in all but the most exceptional of cases. Those who defraud the trust, be they internal or external to it, must never be allowed to profit from their actions.

The range of available sanctions which may be pursued includes:

- Criminal prosecution (potentially resulting in fine, imprisonment, community penalty, confiscation and/or compensation order) or out-of-court disposal;
- Civil action, including action to preserve assets and recover losses;
- Disciplinary action by the employing body;
- Regulatory action by a relevant regulatory body.

Where possible the trust should adopt a multi-track approach and, if the evidence supports it, there should be no unnecessary barriers to preventing a criminal prosecution, a civil claim and a disciplinary process taking place concurrently.

In deciding the most appropriate sanctions against employees, there should be a consensus of opinion between Human Resources and the Anti-Fraud Specialist (AFS) where possible. In addition, the Director of Finance must agree the action to be taken in respect of sanctions. The AFS is responsible for informing HR of sanctions applied from a criminal case; HR should keep the AFS updated on the application of disciplinary sanctions.

There is case law within the UK to support parallel sanctions, with a general view that different proceedings are distinct and have different purposes. There is no general rule that the criminal process should take precedence over other processes relating to alleged fraud, bribery and corruption. In practice, public protection is paramount. For example, where there is compelling public interest in suspending/excluding or removing an individual from employment, other proceedings may need to take precedence. This approach requires liaison between those undertaking the various
investigations, and certain information may be shared where lawful and at the appropriate time. If required, however, reference should be made to the relevant case law within the NHS CFA publication ‘Applying Appropriate Sanctions Consistently’ (April 2013 Update); as well as, to ‘Parallel Criminal Disciplinary Investigations – Guidance for Anti-Fraud Specialists’ (April 2013).
APPENDIX C9

OVERPAYMENTS POLICY
## Overpayments Policy

### Executive Summary:

The policy and procedure applies to all staff who have received pay, including allowances and expenses, in excess of their entitlement (overpayment).

It is to clarify the roles and responsibility of staff and managers in relation to overpayments.

This policy sets out the steps that the Trust will take to recover any excess of pay.

### Supersedes:

New Policy

### Description of Amendment(s):

Not Applicable

### This policy will impact on:

All employees of the organisation

### Financial Implications:

To ensure that the Trust meets its fiduciary duty to recover overpayments.

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</tr>
<tr>
<td>Version Number:</td>
<td>3</td>
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<td>Effective Date:</td>
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<td>Issued By:</td>
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<tr>
<td>Review Date:</td>
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### APPROVAL RECORD

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<td>6. References</td>
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</table>
1. Introduction

1.1 Overview

Ensuring staff receive the correct pay for their work is of vital importance to East Cheshire NHS Trust (the Trust) to ensure fairness whilst satisfying the Trust’s fiduciary responsibilities.

However, as with any process, errors occur resulting in overpayments / underpayments being made. Overpayments occur when a change in circumstances affecting an employee’s salary is actioned retrospectively or as a result of an administrative error. These include, but are not limited to:

(i) Termination forms not being completed, received and actioned on time
(ii) Contract amendments (such as banding changes, hours changes not being completed, received and actioned on time
(iii) Inaccurate information being supplied by a manager
(iv) Error being made by the Trust’s payroll provider

Recovery of the overpayment will be the standard approach taken when an overpayment is discovered, regardless of how the overpayment came about or the time elapsed since the overpayment was made.

This policy applies to all staff who have received pay, allowances and expenses in excess of their contractual entitlement (overpayment) and sets out the approach that will be taken by the Trust to recover the overpayment.

For the avoidance of doubt, this policy takes precedence over the overpayments policy and procedures of the Trust’s payroll provider and the Trust’s debt recovery provider.

1.2 Key Points of the Policy

The summary below details the main points of the Overpayments Policy that managers and employees of the Trust, as well as the Trust’s payroll provider, should be aware of.

1.2.1 Trust / Management Responsibility

The Trust has the overall responsibility to ensure that employees are paid correctly. This responsibility is delegated to management within the Trust.

If an overpayment occurs, the Trust will recover the overpayment in full, as it is duty bound to do so by the Public Accounts Committee as public monies are involved. Recovery of the overpayment will be over a maximum of THREE months, unless this would cause demonstrable hardship.
1.2.2 Employee Responsibility

The employee has a responsibility to check the payment that they receive from the Trust every month and advise their manager and the Trust’s payroll provider when it is different to their expected contractual entitlement.

1.2.3 Legal Position

The Theft Act 1968 indicates that although an individual may not set out to obtain the additional salary intentionally, by keeping it and treating it as their own (i.e. spending it), they may be guilty of theft.

The Trust, as an employer, has the right to recover a salary overpayment without that deduction constituting an unauthorised deduction from wages. This is in accordance with The Employment Rights Act 1996.

If an overpayment is considered to have been intentionally kept, then the matter will be dealt with in accordance with the Trust’s Disciplinary Policy and Procedure and the matter will be reported to the Trust’s Local Counter Fraud Specialist for criminal investigation.

2. Purpose

The purpose of this policy is to ensure that:

- The Trust and its employees are aware of their respective responsibilities when an overpayment of salary, allowances or benefits (expenses) occurs
- Overpayments are recovered on a timely basis
- A transparent, fair and consistent approach is followed when an incorrect payment is made

‘Overpayment’ within the context of this policy refers to incorrect salary, allowances or benefit (expenses) payment.

This policy applies to all payments made to employees on a permanent, fixed term or bank contract with the Trust.
3. Responsibilities

3.1 Line Manager

It is the responsibility of all staff in managerial positions within the Trust to:

- Ensure compliance with the Trust’s policy on overpayments
- Ensure that their staff are aware of the policy on overpayments
- Ensure that any changes to ESR in relation to pay are completed in an accurate and timely fashion, within the agreed and published timetable. These include, but are not limited, to terminations and change of hours
- Notify employees in writing of any changes to their contract, following any contractual pay-affecting change (e.g. change of hours, change of banding)
- Support the employee in an overpayment situation ensuring that overpayment is recovered in the shortest practical timeframe
- Provide practical advice to employees concerned about financial matters by informing them of the confidential 24/7 Employee Assistance Programme
- Ensure that where their staff have been overpaid and have not received a timely response to the enquiry from the Trust’s payroll provider, that the matter is raised and formally recorded with their HR Manager
- Review the standing payroll data and working arrangements for staff on a periodic basis to ensure that the information held by the Trust is correct
- Support the employee in any hardship claim that they make
- Record details of any known overpayments on the leaver form to ensure that any amounts owing are recovered prior to the employee leaving the Trust

3.2 Employees

All employees are responsible for checking that the payments they receive from the Trust are correct and must bring any anomalies to the attention of the Trust’s payroll provider and their line manager as a matter of urgency as soon as they notice that it is different to their expected contractual entitlement.

It is the responsibility of the individual employee to:

- Ensure that they understand their salary entitlement
- Ensure that their pay is correct and as expected every pay period
- Advise the Trust’s payroll provider and their line manager when it is different to their expected contractual entitlement payment
- Maintain an awareness of compliance with the Trust’s Overpayment Policy
• Be aware that they may need to make repayment to the Trust in a short time frame (i.e. immediately or exceptionally over a maximum of **THREE** months unless this would cause demonstrable hardship)

• Ensure that any pay anomalies raised with the Trust’s payroll provider that do not receive an adequate response within an agreed timeframe are escalated through their line manager

• Provide sufficient evidence in a timely manner in support of any hardship claim to enable the Trust to make an appropriate decision

• Contact the Trust immediately if they cease employment with the Trust but continue to receive payment for which they are not owed

3.3 **The Trust**

It is the responsibility of the Trust to:

• Ensure that employees are paid correctly and receive the monies to which they are entitled

• Recover, in a timely manner, any overpayment made in full where errors occur

• Provide support where identified to managers in dealing with overpayment issues

• Communicate and publish payroll cut off dates in order to minimise overpayments

• Escalate serious overpayment cases to the Local Counter Fraud Service in accordance with the Trust’s Disciplinary Policy and Procedure.

• Ensure co-operation and collaboration with directorates and corporate departments in order to minimise overpayment situations

• Adjudicate and determine the appropriate course of action in hardship claims

3.4 **Human Resources**

It is the responsibility of the Human Resources (HR) teams to:

• Support Finance and operational colleagues to ensure that the Overpayment’s Policy is adhered to

• Attend the monthly operational payroll conference call and take appropriate action in relation to the recovery of overpayments

• Escalate issues as appropriate for case management on a monthly basis

• Refer any areas where there is persistent overpayment for escalation to Directorate Managers.

Managers, staff and staff side representatives may seek advice from HR on all matters relating to overpayment. HR can offer first line advice though the help desk (01625 656500) to support operational managers relating to overpayment. They can also provide assistance with on-going case management. HR will support in overpayment meetings as required on a case by case basis.
3.5 **ESR Support Systems Team**

It is the responsibility of the ESR Support Systems Team to:

- Work in conjunction with the Trust’s payroll provider, Finance, HR and operational teams to ensure that overpayments are recovered in a timely manner, ensuring that key overpayments are highlighted via email to the appropriate manager in each department.
- Ensure that managers and staff are provided with appropriate advice and guidance on application of this policy and procedure.
- Support managers with updating ESR systems.
- Reject any incorrect changes back to the line manager for resubmission.
- Proactively identify any repetitive management errors and highlight to the senior manager concerned.
- Attend the monthly operational payroll conference call / meeting and take appropriate action in relation to the recovery of overpayments.

3.6 **Trust’s Payroll Provider**

It is the responsibility of the Trust’s payroll provider to:

- Work in conjunction with the Trust to ensure that overpayments are recovered in a timely manner.
- Ensure that information is input into ESR in an accurate and timely manner (within agreed Roles and Responsibilities).
- Ensure any payment errors are resolved following agreed payroll procedures.
- Ensure any payment errors are identified and that the employee is advised within 5 working days of discovery.
- Follow this procedure in resolving payment errors.
- Ensure overpayments are recovered over agreed timescales when recovery is through payroll.
- Refer ALL requests for repayment terms over three months to Finance.
- Refer any hardship cases to Finance for consideration.
- Provide the overpayments reports and manage the monthly operational payroll conference call / meeting and take appropriate action in relation to the recovery of overpayments.

3.7 **Finance**

It is the responsibility of the Finance Department to:

- Work in conjunction with the Trust’s payroll provider, ESR Team, HR and operational teams to ensure that overpayments are recovered in a timely manner.
- Maintain a detailed ledger / spreadsheet of overpayment debt, based on information provided by the Trust’s payroll provider.
- Co-ordinate debt collection of overpayments with the Trust’s debt collection managers.
- Review requests recommended by the Trust’s payroll provider for repayment plans in excess of three months to ensure the timely payment of the outstanding overpayment.
• Review hardship claims and obtain approval from Director of Finance or Deputy Director of Finance to extend the recovery period of the overpayment / debt
• Decide to send outstanding overpayment debt to debt collection agencies
• Liaise with managers to keep them updated on any changes to repayment plans for existing employees
• Obtain approval for overpayment write-off / revision from the Chief Executive / Director of Finance in accordance with the Trust’s Scheme of Reservation and Delegation
• Report any overpayment write-off / revision to the Audit Committee
• Attend the monthly operational payroll conference call / meeting and take appropriate action in relation to the recovery of overpayments
• Decide whether there is evidence of theft / fraud and if a referral for investigation to Local Counter Fraud Services is appropriate in accordance with the Trust’s Disciplinary Policy and Procedures. Referral will be made by the Director of Finance / Deputy Director of Finance

3.8 Legal position

3.8.1 Employment Rights Act 1996

Under the Employment Rights Act 1996 (Section 14), the Trust is not entitled to deduct sums from salaries due to an employee without his/ her consent. There is however an exception:

• Overpayment of salary
• Overpayment in respect of benefits (expenses) made / claimed by the employee

Where there is a deduction to recover an overpayment of salary or expenses, the employer does not require a written mandate from the employee. However the Trust considers it good practice to seek to obtain the employee’s agreement, especially if the deduction is more than a small proportion of the total salary due.

Overpayment issues will be dealt with as thoroughly, consistently and promptly as possible in line with the standards agreed with the Trust’s payroll provider.

3.8.2 The Theft Act 1968

The Theft Act 1968 indicates that although an individual may not set out to obtain additional salary intentionally, by keeping it and treating it as their own (spending it) they may be guilty of theft.

3.8.3 NHS Counter Fraud

If an overpayment is considered to have been intentionally kept then the matter will be reported to the Trust’s Local Counter Fraud Specialist for an assessment. Generally, the case will be referred if an overpayment has been made for three months and the employee has not reported this.
All proposed referrals to the Local Counter Fraud Specialist will be approved by the Director of Finance or Deputy Director of Finance prior to submission.

This may result in action being taken via the criminal courts by the Trust’s Local Counter Fraud specialist.

In the event of fraud being suspected, the matter will be dealt with in accordance with the Trust’s Disciplinary Policy and procedures. Referral to the Local Counter Fraud Specialist in respect of overpayments will be through the Director of Finance / Deputy Director of Finance.

4. Processes and Procedures

4.1 Recovery of overpayments – current employees

4.1.1 Recovery process

(i) Recovery of an overpayment will be in the next available payroll run or exceptionally over a period not exceeding THREE months. This is the standard approach, regardless of the reason for the overpayment or the time elapsed since the overpayment was made. For cases where the three month approach would cause an employee undue hardship, the guidance in 4.1.2 should be followed and an individual assessment undertaken.

(ii) On discovery of the overpayment, the Trust’s payroll provider will provide a written explanation to the employee of the overpayment. This will detail, where relevant:
   - How the overpayment occurred
   - Over what period the overpayment occurred
   - The total amount overpaid
   - The net amount to be repaid once deductions for tax and NI contributions are taken into account
   - Contact name and telephone number should any queries arise
   - An indication of the process to be followed in recovering the overpayment (Repayment Plan)

(iii) Meetings to deal with overpayments will be on request. The meeting will involve the employee and their manager, with input from Finance and HR if necessary.

(iv) Whilst legislation does not require written consent, the Trust will endeavour to obtain agreement from the employee in writing for the repayment terms of the overpayment. A form of agreement will be included in the letter to the employee. The form is to be completed by the employee includes a statement ‘I also confirm that should I terminate my employment with East Cheshire NHS Trust before

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completion of recovery, then any balance outstanding will be deducted from my final salary’.

(v) In the first instance, recovery of the overpayment will be through the employee’s salary.

(vi) Employees will also be offered the opportunity to repay the full amount by debit or credit card. Arrangements to do this should be discussed with the Trust’s payroll provider and Finance. Any tax and National Insurance implications will be dealt with by the Trust’s payroll provider.

(vii) No other repayment methods will be accepted.

(viii) All instances where the recovery period exceeds three months **MUST** be managed as per 4.1.2 and referred by the Trust’s payroll provider to Trust Finance (Deputy Financial Accountant) for prior approval by the Director of Finance / Deputy Director of Finance.

(ix) The letter from the Trust’s payroll provider will emphasise that the employee is free to discuss the repayment terms with their manager or another representative. Should the employee want to vary the standing arrangements for recovery of the overpayment, then the ‘hardship’ process detailed in Section 4.1.2 should be followed. Any decision to vary the recovery terms ultimately rests with the Director of Finance.

(x) In any instances where the repayment term is outside the three month policy, these will be reviewed by the Trust on a monthly basis and assessed based on the individual’s circumstances with every effort being made to reduce the payment term, especially if the employee’s circumstances have changed i.e. an increase in hours or pay band. Following confirmation by the employee’s line manager, the Trust’s payroll provider will write to those individuals with a revised repayment plan.

(xi) The Trust will take action to recover the debt, if appropriate, via the civil court process.

### 4.1.2 Hardship

The standard repayment terms in respect of an overpayment are three months. Repayment will only be extended or deferred in exceptional circumstances if it would cause undue hardship. To be required to pay back money to which there was no entitlement does not in itself represent hardship.

Any hardship claim should in the first instance be discussed with the employee’s line manager. The claim should be supported by reasonable evidence that the overpayment recovery action proposed (i.e. to be recovered over three months), after taking into
account day-to-day living expenses, would impact adversely on the welfare of the employee and his/her family.

In order for the Trust to assess the hardship claim, the employee will be required to provide detailed financial information of their personal income and expenditure to support their claim. The hardship claim form can be obtained from Finance. All requests for extension or deferment of repayment should be directed to the Deputy Financial Accountant. The final decision on the acceptance of the hardship case will then be made by the Director of Finance / Deputy Director of Finance.

Where it is accepted by the Director of Finance / Deputy Director of Finance that hardship would be caused by the recovery action proposed by the Trust’s payroll provider / Trust Finance, the recovery period may be extended.

A letter will be sent to the employee by the Trust’s payroll provider / the Trust detailing the outcome of the hardship review.

4.1.3 Collective Overpayment

If a group of employees have all been overpaid as a result of the same error, they should not be treated differently as regards to the degree of recovery required and should thus be invited to repay on the same basis, subject to the hardship definitions above.

4.2 Recovery of Overpayments - Leavers

(i) Recovery of the overpayment by invoice will be the standard approach, regardless of the reason for the overpayment or the time elapsed since the overpayment was made.

(ii) The Trust’s payroll provider will provide a written explanation of the overpayment to the ex-employee.

(iii) This will detail, where relevant:

• How the overpayment occurred
• Over what period overpayment occurred
• The total amount overpaid
• The net amount to be repaid once deductions for tax and NI contributions are taken into account
• Contact name and telephone number should any queries arise
• Contact name and telephone number for the Trust’s debt management provider

(iv) Where possible, an invoice for repayment of the overpayment amount outstanding will be included with the letter noted in (ii) above. Otherwise, the invoice will be sent to the ex-employee within five working days.
(v) Should the overpayment be discovered prior to the employee leaving the Trust, then recovery of the overpayment will be made through the final salary payment.

(vi) The ex-employee will be offered the opportunity to repay the full amount by debit or credit card or standing order. Arrangements to do this should be discussed with the Trust’s payroll provider / Trust Finance.

(vii) When an invoice has been raised it will become due for payment within 14 days. If no contact is received from the ex-employee, a reminder letter will be forwarded one day after the due date with a further reminder 10 days after the due date. A final demand is sent 20 days after the due date, after which information is forwarded by Trust’s debt management provider to an external Debt Collection Agency.

(viii) If the debt remains unpaid, the Trust will take action to recover the debt via its debt recovery process, which includes the use of the civil courts.

(ix) Should the ex-employee want to vary the standing arrangements for recovery of the overpayment, then the ‘hardship’ process detailed in Section 4.1.2 should be followed. Any decision to vary the recovery terms ultimately rests with the Director of Finance and all hardship applications should be accompanied by supporting evidence from the ex-employee.

4.3 Write Off / Reduction of Overpayments

In accordance with the Trust’s Standing Orders and Standing Financial Instructions, all write offs of overpayments must be approved by the Chief Executive or the Director of Finance. For the avoidance of doubt, this also includes any reduction in amounts due.

All write offs / reductions in overpayments will be recorded on the Trust’s ‘Losses and Compensation’ register and reported and reviewed at the quarterly Audit Committee meetings.

4.4 Underpayment of salary

When an underpayment has occurred, arrangements will be made to correct the underpayment and to reimburse the employee in the next payment period following notification to the Trust’s payroll provider and the ESR System Team.

If an earlier payment is required by the individual due to hardship being caused by non-receipt of salary, the ESR System Team and HR should determine, in conjunction with the Trust’s payroll provider, the amount payable and if individual circumstances dictate that an earlier payment being made by faster (same day) payment is justified. Final approval for making the payment lies with the Director of Finance / Deputy Director of Finance.
If the underpayment relates to non-payment of elements in excess of the individual’s basic salary or if any claims are submitted late, then these will be paid in the next payment period and will NOT be paid in advance.

If an employee is paid on a weekly basis, no claim will attract a faster payment and will be paid in the next payment period.

4.5 Appeals

An employee who feels they are being treated unfairly under this policy may invoke the Trust’s Grievance and Disputes Policy at any stage of this process and this will be dealt with at Stage 2 of the grievance policy.

4.6 Employee Support and Assistance

Employees who require advice and support on financial or other matters can access the confidential Employee Assistance Programme (EAP) on 0800 107 6147. The programme gives the employee the opportunity to speak in confidence to a third party with anonymity assured. The service is available twenty-four hours a day, seven days a week, 365 days a year.

5. Monitoring Compliance with the Document

5.1 Policy Performance

The performance of this policy will be measured by:

(i) Reviewing the number of overpayments and time left to recover on a monthly basis

(ii) Reporting and reviewing the number of overpayments per Directorate

Appropriate corrective action will be taken for areas where persistent overpayments of salary occur.

5.2 Internal Audit review

The Trust’s Internal Auditors will review a sample of overpayments as part of the annual payroll audit. A report on the findings will be forwarded to the Director of Finance.

Recommendations made will be reviewed and any actions taken as a result will be reported to the Audit Committee.
6. References

The policy will be reviewed within three years of issue but may be updated within the period if necessary in line with legislative changes and best practice guidelines.
Public Trust Board
Thursday 4th April 2019

Agenda Item Number 20: TB 19 (33)

Safety, Quality and Standards Committee

Meeting Chair: Ali Harrison
Meeting Secretary: Gareth Rydings

Minutes of Meeting
Tuesday 5th February 2019, 12:00 – 14:00

Venue:
Boardroom 1

Committee Members & Contributors

<table>
<thead>
<tr>
<th>Name</th>
<th>Job Title</th>
<th>Abb.</th>
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<tbody>
<tr>
<td>Ali Harrison</td>
<td>Non-Executive Director</td>
<td>Ms Harrison</td>
</tr>
<tr>
<td>Dr Peter Madden</td>
<td>Non-Executive Director</td>
<td>Dr Madden</td>
</tr>
<tr>
<td>John Wilbraham</td>
<td>Chief Executive</td>
<td>CEO</td>
</tr>
<tr>
<td>Julie Green</td>
<td>Director of Corporate Affairs and Governance</td>
<td>DCAG</td>
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<tr>
<td>Rachael Charlton</td>
<td>Director of HR</td>
<td>DHR</td>
</tr>
<tr>
<td>Kath Senior</td>
<td>Director of Nursing, Performance and Quality</td>
<td>DNPQ</td>
</tr>
<tr>
<td>Dr John Hunter</td>
<td>Medical Director</td>
<td>MD</td>
</tr>
<tr>
<td>Brian Green</td>
<td>Deputy Director of Nursing and Quality</td>
<td>DDNQ</td>
</tr>
<tr>
<td>Kashif Haque</td>
<td>Chief Pharmacist</td>
<td>CP</td>
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<tr>
<td>Mark Ogden</td>
<td>Director of Finance</td>
<td>DoF</td>
</tr>
<tr>
<td>Lorraine Jackman</td>
<td>Deputy Director of Corporate Affairs and Governance</td>
<td>DDCAG</td>
</tr>
<tr>
<td>Jayne Wood</td>
<td>Chief Operating Officer</td>
<td>COO</td>
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Agenda Item

19/04 Patient Story

The DNQ presented a story regarding a patient who was admitted with vomiting and slight abdominal pain. The patient had no previous medical history but reported to drinking a minimum of 5 litres of alcohol a day as well as smoking 20 cigarettes a day. The patient was exhibiting signs of withdrawal, agitation and was tremulous. The patient did not want to stay in hospital but agreed to stay for an endoscopy and alcohol detoxification. During this time the patient had capacity to make informed decisions and a referral to the hospital alcohol liaison service was made.

The patient became agitated and aggressive and was unable to recollect the endoscopy earlier that day. The patient's mental capacity was reassessed and the patient was found to lack capacity. The patient was unsafe to discharge and a Deprivation of Liberty application was made. Attempts were made to stop the patient from leaving the ward but the lone security guard was threatened and the patient subsequently ran out of the main entrance onto road. Police were notified immediately and the patient was found. The patient had fallen and was returned to the ward with a large haematoma to his forehead. The patient was very aggressive and agitated.

On call medical staff reviewed the patient and prescribed further medication. The security guard remained with the patient as he was deemed a risk to self and others. A best interest decision was taken to intubate and ventilate the patient so that a head CT could be performed.
The patient was transferred to intensive care for on-going treatment. The results of the scan were normal and required no further intervention. Once detoxification was complete the patient regained mental capacity and was discharged home 48 hours later.

The patient ingested alcohol during hospital admission whilst undergoing a detoxification programme. This resulted in a loss of mental capacity with violent and aggressive behaviour. Staff were unable to prevent him from absconding.

What went well

- The Deprivation of Liberty application was timely and appropriate as was the support from the security guard.
- The site manager was aware of difficulties and documentation was of a very high standard.
- Escalation of issues and appropriate timely onward referrals were made.
- His family were kept up to date throughout and were aware of circumstances leading to ICU admission.

What did not go well

- A one to one Healthcare assistant was requested by the ward staff, but the site manager was unable to provide additional staff.
- Ingesting alcohol whilst on a detoxification programme resulted in a loss of mental capacity. This led to aggressive behaviour, non-compliance with treatment and he declared intention to self-discharge on several occasions.
- The fact that there was one security guard on duty was a contributory factor and it is possible that had there been more available, they may have been able to safely restrain the patient and prevent him from leaving the premises.

Lessons learned and outcomes

- Staff acted appropriately and in line with expected Trust standards, policy, values and behaviours. Staff have used this incident to support reflection on practice for their appraisal and professional portfolios.
- There were no lapses in medical or nursing care that could have prevented this incident and subsequent injury from occurring. The patient made a full recovery although he remembers little of the admission. Wider learning from the investigations will be cascaded to teams across East Cheshire NHS Trust and the Acute & Integrated Care SQS sub-committee.

It was agreed that the DNQ would share this story at the joint ECCCG/ECT Quality Meeting later this month.

The DDCAG informed that a risk assessment has been requested to review lone working for the Security Guards and this will be presented at the March Risk management Sub-Committee.
<table>
<thead>
<tr>
<th>19/05</th>
<th>Apologies</th>
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| 1. John Wilbraham  
2. Dr Susan Knight |

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<tr>
<th>19/06</th>
<th>Conflict of Interest</th>
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<td>None declared.</td>
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<th>19/07</th>
<th>Matters Arising</th>
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a) Update on Community Nursing appraisals and statutory and mandatory training

Focussed support to Community Nursing teams in relation to completion of appraisals and mandatory training has had positive impact, however further improvement is required from the small teams impacted by sickness and maternity absence.

b) Year at a Glance

Agreed as accurate

c) SQS Committee Minutes – January 2019

Agreed as accurate

d) Action Log

- 7175 – Covered under Matters Arising on the agenda. Action closed.

- 7317 – The MD provided assurance that patients with DNACPRs are treated according to their clinical needs. It was noted that clinicians receive DNACPR training as part of the corporate induction process and a yearly DNACPR audit is undertaken. Recent results have provided good assurances against the treatment of patients with DNACPR’s. Actions closed.

It was agreed that further assurance around the WHO process would be provided to the Chair outside the meeting.

e) Collection of Any Other Business

None

f) Formal Request for Removal of Items from Consent Agenda

None

<table>
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<tr>
<th>19/08</th>
<th>Integrated Quality Governance Report including</th>
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<tr>
<td>The DNQ presented the report highlighting the following</td>
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- The number of acute nurse vacancies in December has decreased to 12.6% (38.98 wte) compared to 13.3% (41.06 FTE) in October.
- Due to ongoing ward pressures and a high demand for HCA 121 care due to the increase in DOLS assessments, it has been agreed to increase the HCA pool from 25 to 35 to help address the current |
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<th>Demand for 121 care.</th>
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<td>Recruitment events continue and following the most recent event in December offers have been accepted by all 9 individuals (RN x 4 and HCA x 5)</td>
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<td>The current cohort of 9 trainee Nurse Associates have all accepted substantive employment on completion of their course in January and a second cohort of 5 trainee Nurse Associates commenced their training in December 2018.</td>
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<td>Safety Thermometer Trust performance in November decreased to 93.51%. This was due to an increase in reported prevalence in Pressure Ulcers</td>
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<td>The Trust will cease to collect the Safety Thermometer point prevalence data from end of March 2019 and replace harm free care reporting with incidence data reporting from the 1st April 2019 as the four key areas of harm are already captured through processes that are more accurate.</td>
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<tr>
<td>There were 18 Mixed Sex Breaches in November and 46 in December. It was noted that nationally the number of mixed sex accommodation breaches has continued to rise and the Trust has submitted a briefing to NHS Improvement to provide an explanation for the breaches in East Cheshire and actions being taken reduce the number back to zero.</td>
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<tr>
<td>The national standard for 4hr A&amp;E performance remains 95%. Trust performance declined in December to 74.5% from 84.63% in November.</td>
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<td>There was one 12 hour breach of the A&amp;E admission standard in November and a further two 12 hour breaches in December. Year to date there have been 14 12-hour trolley waits. It was noted that RCAs are being undertaken on all to identify learning and actions for improvement</td>
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Concerns were expressed that 3 of the 12 hour trolley waits were patients with mental health needs. The DNQ informed that assurances have been received that the patients received all the right care and their requirements were met where possible. The DNQ informed that the regulators are sighted on this and further discussion will take place at the A&E Delivery Board later this month.

**Action** - It was agreed that the DNQ will provide feedback on the discussion that takes place at the A&E Delivery Board

- The 6-week diagnostic access standard was not achieved at 81.8% in December. Although performance declined in December with 556 breaches of the 6-week access standard, there were 25 fewer breaches than in November; 261 of these are over 13 weeks. The demand for Echo and Endoscopy is outstripping capacity however a locum Gastroenterologist has just been recruited and has been allocated endoscopy lists to help address the backlog issues.
- Trust processes for learning from external investigations has been implemented and the Trust is well positioned to embrace and respond to recent national developments such as HealthCare Safety Investigation Branch led maternity investigations; learning from the...
Gosport War memorial hospital case and the new national patient safety consultation.

The DCAG highlighted that the Serious Incident Review update had outstanding additional information. It was agreed that the report will be revised and re circulated outside of the meeting.

- Assurance was provided to the Chair that the 62 day Cancer Performance recovery action plan which aims to achieve compliance with the standard by February 2019 is currently being monitored through the relevant directorate SQS and will feed up into Trust SQS. It was noted there have been no complaints received relating to cancer waiting times and there have been no known consequences to clinical outcomes caused by not meeting the target.
- The Symptomatic breast patients 2 week target was achieved in December with 94.8% of patients being seen in 2 weeks against a target of 93%. The committed noted the achievement of meeting target despite recent operational pressures, however the CP informed that there are concerns and the teams have asked to start planning around the Easter and May Bank holidays. It is expected that additional capacity will be required and the Trust is in discussions with Stockport regarding additional support.

Discussion took place regarding the CQUIN for the sepsis summary assessment of antibiotic review between 24-72 hours. It was agreed that the CP would re word the summary to reflect that this is in relation to the recording of documentation rather than the administration of antibiotics.

19/09 **SQS Terms of Reference And Self-Assessment**

The Committee agreed updated SQS terms of reference and completed the annual self-assessment.

19/10 **Quality Strategy Refresh (1st draft) including Quarterly Quality Strategy Update – Harm Free Care**

The DDNQ presented the draft 2019 – 2022 strategy highlighting the following

- The strategy has been aligned with the themes within the national NHS Long Term Plan and integrated care provision within the Cheshire East Place
- It will also continue to focus on Harm Free Care, Improving Outcomes, Listening & Responding and Integrated Care.
- This is the first time the Trust has included a Quality Improvement Model, which will help deliver an integrated person-centred approach, which aims to empower service users and staff with the knowledge and skills needed to lead long and healthy lives.
- The 2019 - 22 priorities were agreed for all four categories further to additional suggestions from the Committee. These were:
  - Partnership working – how can acute providers partner to provide a single service
  - Focussed metrics to improve the discharge process
  - Fundamental roles for carers and the part they play
  - Inclusion of outcomes to indicate effectiveness of treatments & pathways alongside safety
The team were challenged in relation to the ambitions for a number of targets e.g reductions in injurious falls; reduction in A&E admissions.

It was noted that external input has been sought and engagement with staff has assisted with the development of the strategy. The Trust is currently in consultation on the strategy with the CCG.

The Chair was informed that focus on RTT, cancer screening and diagnostics are not included within the strategy as these will all be addressed within the operational plan.

The amended strategy will subsequently be presented to Trust Board for approval.

### 19/11 Quarterly Mortality Report inc. Self-Assessment

The MD presented the report highlighting the following:

- Crude mortality for the January to December 2018. The rate is shown compared to the top 11 peer rate, the crude mortality rate is above the peer rate.
- The 12-month rolling RAMI-17 displays that the Trust is slightly above the peer rate.
- Over the last 10 years there has been relatively little fluctuation in the number of yearly deaths at the Trust whilst there has been a concomitant significant reduction in the number of admissions. This is negatively impacting on the SHMR.
- The Trust has seen reduction in the number of expected deaths, however this is not reflected in the number of discharges. This reflects that only the most seriously unwell patients are being admitted.
- There is no ‘weekend effect’ demonstrated at the Trust.
- Currently no mortality alerts have been received and a comprehensive analysis of the sepsis deaths highlighted by the October mortality alert – sepsis – has been completed and the report has been sent to the Care Quality Commission. The Trust has received no response to date.
- It was noted that the 30 day post chemotherapy mortality is within the expected range.
- The government intends to introduce a system of medical examiners from April 2019 that will deliver a more comprehensive system of assurances for all deaths not referred to the coroner in England and Wales. It was noted that further clarification on how the role of the medical examiner will function at the Trust is awaited.

### ANY OTHER BUSINESS

#### 19/12 Points for Assurance

Rolling nurse turnover rates are below 10% for the 4th consecutive month, due to positive enhanced recruitment and retention strategies employed at the Trust.

Given recent increases in Patients DOLS requiring 1:1 Care, the Trust has increased the HCA pool to provide adaptable resources to maintain safe levels of care during patients stay.
The Committee gave their agreement to the proposal to amend monitoring of national safety thermometer elements to focus on incidence rather than prevalence. Assurance was provided this does not imply any reduction in safety standards which will continue to be thoroughly monitored.

The Quarterly Mortality review was presented and provided assurances that mortality rates remained in line with peers, with no weekend effect seen. In addition, assurances were provided in relation to the recent retrospective case review for sepsis mortality following a Dr Foster alert. The review has been submitted to CQC.

The Committee welcomed the draft Quality Strategy 2019-22. The strategy has been aligned with the themes within the national NHS Long Term Plan and integrated care provision within Cheshire East Place. Further suggestions from the Committee included the provision of clinical pathways and standards for sustainable care provision.

The Committee received and were provided relevant assurances from the annual reports and self-assessments from the Infection, Prevention and Control Sub-Committee and the Serious Incidents Review Sub-Committee. In addition, the Committee agreed updated SQS terms of reference and completed the annual self-assessment.

Focused support to Community Nursing teams in relation to completion of appraisals and mandatory training has had positive impact, however further improvement is required in small teams impacted by sickness and maternity absence.

The Trust is well positioned to embrace and respond to recent national developments such as Health Care Safety Investigation Branch led maternity investigations; learning from the Gosport War Memorial Hospital case and the new National Patient Safety Strategy Consultation.

Emerging Risks and Mitigating actions

There has been continued pressure on the emergency care standard with two patients breaching 12 hours from decision to admit in month bringing the year to date to 14. There have been no reports of patient harm. There are system issues with regard to the timely transfer of patients with mental health needs and the A&E Delivery Board will be taking oversight of mitigating actions.

The trust has not met key performance standards and the committee sought further assurance on actions to mitigate associated clinical risks on RTT, diagnostics and cancer pathways.

**19/13**

**Any Other Business**

No items of any other business.
CONSENT ITEMS
(These items have been read by Committee members and the minutes will reflect recommendations, unless an item has been requested for removal from the consent agenda for debate; in this instance, any such items will be made clear at the start of the meeting)

<table>
<thead>
<tr>
<th>19/14</th>
<th>Infection, Prevention and Control Sub-Committee Annual Report and Self-Assessment</th>
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<tr>
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<td>The Committee received and were provided relevant assurances from the annual reports and self-assessments from the Infection, prevention and control subcommittee and the SIRI subcommittee.</td>
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FOR INFORMATION

Chairman’s Confirmation of Agenda items for March meeting (not standing items):

- Quality Strategy – Final Annual Refresh
- BAF / CRR reports
- Quarterly CARE Report
- SQS Committee Annual Report and Self-Assessment
- Maternity inc Claims & Dashboard Spotlight
- Clinical Audit Spotlight

Date and time of next meeting:
Tuesday 5th March
12:00 – 14:00
Boardroom 1
### Agenda Item 19/01: Apologies
- Ian Goalen

### Agenda Item 19/02: Declarations of interest
None declared

### Agenda Item 19/03: Minutes of meeting held 6th December 2018
The minutes of the previous meeting were agreed as an accurate record.

### Agenda Item 19/04: Matters arising
None

### Agenda Item 19/05: Action points from previous meeting
- 7234 – completed, action closed
- 7235 – completed, action closed

### Agenda Item 19/06: Annual work plan
No changes made. It was noted that the GP Referrals Profile and SLR quarterly update will be included in the papers for the meeting in March 2019.
The COO updated the committee, highlighting that the four key performance standards deteriorated during December

- **ED four hour standard**
  - 74.5%
  - There were two 12 hour trolley waits, both mental health patients; RCAs have been completed
  - A revised urgent care improvement plan is being developed for the A&E Delivery Board.
- **18 Weeks RTT** – 78.8%
  - The oral surgery service is under notice.
  - Some Orthopaedic elective procedures will be carried out at the Spire hospital
  - 2 x 52 week breaches in month
- **6/52 Diagnostics** – 81.8%; it is planned that the trajectory will be achieved end of Quarter 1
- **62/7 Cancer** – 78.4%
  - 1 x 104 breach in Urology – patient choice
  - An improvement in performance is expected in Month 10

It was noted that theatres efficiency performance has been incorrectly reported as having improved.

Emerging risks include:
- Cardiology
- The closure of the oral and orthodontics services
- Continuation of Parkinson’s and Epilepsy services

The Chair asked whether there were expected improvement trajectories for the four key performance areas, in particular A&E. The COO responded that A&E performance is expected to be no more than 85% by the end of March.

The CEO added that he had spoken with the National Urgent & Emergency Care Director at NHSE and provided a trajectory of 82.5% - accepting that this was not where would wish to be but was the most accurate forecast given the challenges.

The DoN added that the trust is participating in weekly calls with the regulator along with other trusts whose performance is either fragile or is below 65% for the previous week; fragility is recognised and support is being offered.

Dr Coombs asked of the consequences of non-achievement and the CEO replied that the trust has already assumed and planned for the financial impact further impacts would be patient experience and reputational.

The COO confirmed that the current system regarding agreeing OPEL status scores is under review as on occasion it does not appear to reflect the actual
position. A recent revision means that to declare OPEL 4 would need NHSE agreement. Currently OPEL 3 is scored when extra beds are open (ie escalation beds on ward 4 which are planned however the trust may be scoring low on other report categories.

The COO reported cautious optimism that diagnostics performance would be on track by end of Quarter 1, with urgent cases priorities and additional support from ECIST has been put in place to assist with development of a sustainability plan.

The CEO added that although WLI spend was a nil forecast at the start of the year, £0.5m will actually have been spent and an additional £150k resource has been made available from ECCCG for Orthopaedics.

The trajectory for 62 day cancer would have been achieved except for two breaches. Dr Coombs asked about the focus and the COO replied that a full hospital pathway review is in place and will be reviewed at Operational Performance Group meetings. The DoN added that a recovery plan is being overseen by the SQS Committee.

The DoN reported an emerging concern around Breast activity later in this quarter. Assistance has been agreed with Stepping Hill’s two week waits but a plan needs to be formulated as they have had an increase in referrals which is not expected to reduce. The DoN is in regular contact with the Director of Strategy and Planning at SFT concerning this.

The Chair asked about Outpatients redesign and the expected efficiency improvements following completion and the CEO acknowledged the challenge but said that the biggest impact would be on improved patient experience. The COO noted that peripheral clinic inefficiencies would be examined as part of QIPP development for 2019/20.

The COO confirmed to the Chair that an acceptable slot utilisation rate is 90-95%. DNAs need to be targeted but the trust is performing well in comparison to peers. Further detail is needed around cancelled clinics and cancellations require a robust rationale which is monitored through performance meetings.

The CEO added that in some specialties clinic templates have been reemphasised and strengthened. It is expected that 82% of clinics are running taking into account annual and study leave.

Future considerations include a 42 week tracker for outpatients and theatres, a ‘care closer to home’ strategy, virtual clinics. To change the delivery of outpatients clinics requires clinicians working closer with GPs to increase the number of patients seen per session.

In respect of Community hubs, Mr Coombs acknowledged the quality of information now available. The DoN remarked that a Community Delivery Group is in place to encourage staff understanding of improvement methodology and initiatives are underway in intermediate care, paediatrics and cardiology. The GP lead for ECCCG is attending the next CMB meeting to present a care community update.
### Workforce Report inclusive of the below appendices

**19/08**
- **Workforce Risk and Mitigation Report – with monthly KPI dashboard**

The DHR presented the report, highlighting:

- **Resourcing and deployment** – vacancies are at 3.51%, the lowest rate since October 2017. This is the result of a focus on recruitment and targeted nurse retention, however some medical staffing gaps remain.
- **Wellbeing** – sickness absence remains a concern; there is a continued focus to support improvement.
- **Development** – operational pressures meant some training was cancelled during December and January, achievement of trajectory (84%) is expected by the end of March 2019.
- **The trust library achieved 100% assessment score in the NHS Library Quality Assurance Framework having demonstrated year-on-year improvement since 2013.**

The Chair referred to 'High Level Risks’ and asked whether agency spend was under control. The DHR confirmed that spend is under plan but remains a concern due to use in January in areas such as ward 5.

The COO cited additional pressures on spend from availability of HCAs, the number of DOLs and 1:1 requirements where trained staff have had to be used. Unfilled shifts are reported weekly and the Safecare model is used at bed meetings daily. Advanced booking has helped achieve a better position.

The trust is piloting a full-time flexible nurse role enabling staff to be deployed to any ward across the hospital as an alternative to bank and agency staff. Five of eight roles have been successfully recruited to.

It was noted that the Intermediate Team is a small team, hence the vacancy rate 29.4% (2.85FTE) and the vacancy rate 9.2% (09.FTE).

The number of staff retiring but returning is four – this is a small number, but the new pension schemes will make flexible retirement work better for individuals.

### Finance Report inclusive of the below appendices

**19/09**
- **Finance risk report**
- **QIPP report (including milestone delivery plan and risk register)**
- **Repeating presentations – Revolving Working Capital facility**
- **Quarterly capital update**

The DoF presented the report, highlighting:

- **£539k better than plan at Month 9; ideally this should be maintained until the end of the year**
- **Income is £1.6m favourable to plan including accrual release but would be £800k better under PBR.**
- **Pay expenditure is £517k adverse**
- **Non-pay adverse by £1,309k.**
- **QIPP has delivered overall against target, but the recurrent target has not been met.**
- **Quarterly capital report – some slippage in a number of areas, some of this**
will be used to create an extra 35 car parking spaces for patients (subject to planning).

It was confirmed that the pay overspend in medical relates to paediatrics, medical specialties, urgent care and theatre service. The overspend in managers and senior managers relates to agency staff covering vacancies and sickness in Finance, HR and IMT.

The COO noted a risk in restarting the elective programme as planned at the end of February and that this will be reassessed during the month. The CEO asked for more clarity as the programme should have restarted at the beginning of February. He added that wards 1,2 and 5 should be reinstated to where they should be from 1st April in line with the plan. The COO confirmed that the plan to close ward 5 in-patient beds had not changed.

Dr Coombs queried the variance for Non-Pay Expenditure – Services under the Trust-wide operational summary and the DoF replied that this is un-met QIPP in part and large overspends in medical. This needs understanding given that activity is down and further clarity will be provided next month.

**Action: DoF to provide further breakdown of spend under Non-Pay Expenditure – Services.**

The Chair referred to the previous meeting’s minutes and asked what progress had been made concerning budget spend and accountability. The CEO replied that this had been discussed at Executive level. There is focus on the top ten overspending budgets, setting out accountability agreements and ensuring there is clear understanding of the Standing Financial Instructions.

The Committee acknowledged that budgets have to be realistic and that if overspend has occurred despite all reasonable steps having been taken, then difficult conversations will take place.

The Chair asked whether there were any concerns moving towards the year end and the DoF stated how soon the elective programme would restart and the level of risk, especially with Orthopaedics demand and capacity issues.

The COO confirmed that a number of referrals have been accepted by the Spire Regency hospital; the financial impact is covered as these are being carried out at tariff.

It was confirmed that the loans totalling £8.5m due for repayment during February have been rolled over on the same terms. Ultimately the recovery plan will look at consolidating loans into public dividend capital rather than continuing to rollover indefinitely. Full cash drawdown will take place and is expected to be offset by late payments.

Appendix 2 of the report summarised capital expenditure; there has been slippage on some schemes.

- The bed replacement scheme has been removed as it can now be allocated to VAT reclaim.
- There is no intention to bring forward any building works likely to cause operational disruption.
- £1.2m has been spent on medical equipment; purchases were brought...
- There is contingency to create an extra 35 spaces for patient car parking. Planning permission is expected to be granted with work scheduled to start 5th March for four weeks.
- There will also be contingency for medical equipment, approximately £200k
- Also further potential income from the sale of Dane ward Estate to CWP.

The DoF gave assurance to the CEO that the work on creating the additional car park spaces would not impact on ambulance access to A&E.

**Action:** It was noted that following receipt of the meeting papers, Mr Goalen had submitted several queries and the DoF confirmed that further detail would be provided at the March meeting.

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For Information

**Date and Time of Next Meeting:**
Thursday 7th March 2019, 08:30-10:30 Boardroom 1 NAH