EAST CHESHIRE NHS TRUST

MEETING OF THE TRUST BOARD

NOT FOR PUBLICATION BEFORE

Thursday, 30th March 2017
15.00 pm

Board Room 1, New Alderley House
Macclesfield District General Hospital

Chairman: Lynn McGill
Chief Executive: John Wilbraham
Our Ref:  LM/FB/Meetings01/TB/Agenda

Date:  23\textsuperscript{rd} March 2017

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 Thursday 30\textsuperscript{th} March 2017 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 – MARCH 2017 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, Performance &amp; Quality</td>
<td>10 mins</td>
<td></td>
</tr>
<tr>
<td>2. Apologies:</td>
<td>Chairman</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Director</td>
<td></td>
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</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 Register Declaration</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Minutes of the January 2017 meeting</td>
<td>The Chairman</td>
<td>-</td>
<td>TB 17 (09)</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. SQS February and March 2017 meetings</td>
<td>Ms A Harrison</td>
<td>10 mins</td>
<td>Verbal (supported by formal minutes when available)</td>
<td>All corporate objectives</td>
</tr>
<tr>
<td>FP&amp;W February and March 2017 meetings</td>
<td>Mr M Wildig</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## STRATEGIC/GOVERNANCE 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 Commentary</td>
<td>Chief Executive</td>
<td>45 mins</td>
<td>TB 17 (10)</td>
<td>All corporate objectives</td>
</tr>
<tr>
<td>9. Corporate Governance Manual – update overview</td>
<td>Director of Corporate Affairs &amp; Governance</td>
<td>10 mins</td>
<td>TB 17 (11)</td>
<td>All corporate objectives</td>
</tr>
<tr>
<td>10. Carter review – annual update</td>
<td>Director of Finance</td>
<td>15 mins</td>
<td>TB 17 (12)</td>
<td>RESOURCES - To deliver services that are clinically and financially sustainable</td>
</tr>
<tr>
<td>11. 2017-18 Budget Setting</td>
<td>Director of Finance</td>
<td>10 mins</td>
<td>TB 17 (13)</td>
<td>RESOURCES - To deliver services that are clinically and financially sustainable</td>
</tr>
<tr>
<td>12. Standing Agenda Item:</td>
<td>Chief Executive</td>
<td>5 mins</td>
<td>Verbal</td>
<td>All corporate objectives</td>
</tr>
<tr>
<td>Does the Board wish to add anything to the Assurance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Framework or Corporate Risk Register

### ANY OTHER BUSINESS

<table>
<thead>
<tr>
<th>AGENDA TOPIC</th>
<th>PRESENTED BY</th>
<th>TIME ALLOCATION</th>
<th>REF. NO.</th>
</tr>
</thead>
<tbody>
<tr>
<td>13. Public Trust Board Agenda – April 17</td>
<td>The Chairman</td>
<td>5 mins</td>
<td>TB 17 (14)</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. Chairman’s Commentary – including agreement of annual work plan and register of gifts and hospitality</td>
<td>TB 17 (15)</td>
<td>Information</td>
<td>All corporate objectives</td>
</tr>
<tr>
<td>15. Corporate Governance Manual</td>
<td>TB 17 (16)</td>
<td>Assurance</td>
<td>All corporate objectives</td>
</tr>
<tr>
<td>16. Board Assurance Framework &amp; Corporate Risk Register</td>
<td>TB 17 (17)</td>
<td>Assurance</td>
<td>All corporate objectives</td>
</tr>
<tr>
<td>17. Staffing Levels bi-annual Report</td>
<td>TB 17 (18)</td>
<td>Assurance</td>
<td>PATIENTS - Provide the best services to our population through improvements to safety, productivity and patient experience</td>
</tr>
<tr>
<td>18. Safer Staffing Exception Report</td>
<td>TB 17 (19)</td>
<td>Assurance</td>
<td>PATIENTS - Provide the best services to our population through improvements to safety, productivity and patient experience</td>
</tr>
<tr>
<td>AGENDA TOPIC</td>
<td>REF. NO.</td>
<td>REASONS FOR PRESENTING</td>
<td>LINKED TO TRUST OBJECTIVE ON</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>STAFF - Empower, develop and value staff in providing innovative patient focused care</td>
</tr>
<tr>
<td>19. Annual review of the Equality, Diversity &amp; Human Rights action plan</td>
<td>TB 17 (20)</td>
<td>Assurance</td>
<td>PATIENTS - Provide the best services to our population through improvements to safety, productivity and patient experience</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>STAFF - Empower, develop and value staff in providing innovative patient focused care</td>
</tr>
<tr>
<td>20. Sub-Committee Minutes: SQS – January 2017 FP&amp;W – January 2017</td>
<td>TB 17 (21) TB 17 (22)</td>
<td>Information</td>
<td>All corporate objectives</td>
</tr>
</tbody>
</table>

**Date and Time of Next Meeting:**

Date: Thursday 27th April 2017
Time: 3.00pm
Venue: Board Room 1, New Alderley House, Macclesfield District Hospital
<table>
<thead>
<tr>
<th>AGENDA No</th>
<th>SUBJECT</th>
<th>ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td><strong>Patient Story:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>DoN presented the patient story and explained that it related to the experience of a lady who attended for an outpatient Gynaecology appointment. The patient made a complaint following issues with administration and booking.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>When the patient arrived at clinic the doctor she should have seen was unavailable and the appointment should have been cancelled, however another doctor was able to see the patient but there was a delay. When she left her appointment she should have been told to contact her GP or the Out of Hours service if she needed advice, but she was given the Gynaecology clinic telephone number in error and subsequently there was no answer when the patient tried to call. Additionally, the Macclesfield District General Hospital letter head was used to confirm the appointment and it wasn’t clear that the appointment was not at this location.</td>
<td></td>
</tr>
</tbody>
</table>
|           | The DoN confirmed that the actions taken as a result of the complaint are:  
  ➢ Relevant information on clinics and clinicians provided to booking office  
  ➢ Reflection and review of procedures  
  ➢ Letterheads reflect the location of the appointment |        |
|           | DoN added that work is on-going on the outpatient services but there is more work to do. The trust has moved to a partially booked service where appointments are made 4 weeks in advance rather than at the end of clinic when it can be 6/9 months in advance. |        |
| 02        | **Apologies:**                   |        |
|           | There were no apologies          |        |
| 03        | **Register of Interests:**       |        |
|           | -Declared interest agenda        |        |
|           | There were no declared interests. |        |
|           | -Hospitality and Gifts Register Declaration |        |
|           | There were no declared receipts of hospitality or gifts. |        |
Minutes of the November 206 meeting TB 17 (01):

The minutes were approved.

Matters Arising

There were no matters arising.

Action Log:

8305 – Closed.
8306 – Not yet due.
8307 – Closed, but updated indicators not included in the papers. CEO to follow up.

SQS December 2016 and January 2017 meetings FP&W December 2016 and January 2017 meetings

The Chairs of the trust’s Committees of the Board gave an overview of the assurances and risks from their recent meetings:

**Safety, Quality & Standards Committee (SQS)**

Ms Harrison, Chair of SQS Committee, gave the following update.

Points for Assurance

- The trust achieved all cancer targets in November and December
- Quarterly mortality report confirms robust mortality governance processes with enhanced clinical engagement. Mortality review processes & depth of coding is steadily improving. In depth analysis has taken place of excess mortality associated with sepsis deaths, alongside mortality review processes for all deaths within trust. No specific negative trends identified from the data, including deaths on/per day of week. AQUA review of 2015-16 Trust mortality data also show no statistical difference in mortality rate for weekend vs weekday
- The Medicines Management Group provided assurance in relation to safe & effective use of medicines across the trust with no 'high' graded incidents and no serious incident requiring investigation related to medication incidents. All procedures relating to use of controlled drugs are fully compliant with relevant legislation
- The trust will respond to actions identified by CQC review of Looked After Children. No major issues identified
- The committee was assured that the trust has robust serious incident procedures, compliant with all mandatory reporting timelines and legislation. Learning has been identified and where appropriate changes made to practice or process.
Emerging Risks & Mitigating Actions

- Overall falls across the trust has fallen for 5th consecutive month however levels of injurious falls have risen and are higher than last year (currently falls resulting in patient harm per 1000 occupied bed days at average rate of 4.3 YTD vs national target 2.5). An updated policy with associated training will be rolled out from Feb 17 and enhanced awareness of falls prevention across all skills groups. Further discussion to be initiated with Commissioners in relation to overall falls pathway.

Finance, Performance & Workforce Committee (FPW)

Mr Wildig, Chair of the FPW Committee, gave the following assurances and update.

Finance

- At the end of month nine, the trust is £354k better than plan, with the forecast deficit reduced in year
- The QIPP target for 2016/17 is £4.1m, of which £4.6m identified – In the year to date £3.1m has been achieved which is ahead of target.
- Cash and loans continue to be in line with plan, with no draw down taking place in month
- Capital expenditure is slightly behind plan but assurance has been received from DoF that this will be in line with plan by year end
- A deep dive took place on service line framework and how this equates to contribution to financial position. This framework will be rolled out to all directorates in the new financial year
- As part of the Carter review work, reference costs which are identified as excessive are being reviewed to identify how they can be reduced.

Performance

- The access targets of 18 weeks (RTT); 4 hour wait in ED; and diagnostics were not achieved in month nine due to the impact of winter pressures. At present, the trust is unable to project the position at year end. Cancellations of elective admissions have taken place which has affected the 18 weeks position although funding has been secured for outsourcing to take place. Penalties to be applied as a result of non achievement of targets have been built into the financial forecast.

Ms Harrison asked whether the outsourcing of activity resulted in the same cost to the commissioners as when the trust completes the activity. DoN confirmed the cost is the same.

The Chairman asked whether the trust knew where the increase in referrals and patient activity came from. The CEO responded that GP referrals overall are down by 1%. Emergency department activity has increased by 1.5% overall, but there has been an increase of 6% at Macclesfield District General Hospital only. CEO added that whilst there has been an increase in
non-elective activity this has been at a slower rate than other organisations.

Workforce

- There has been an improvement in levels of appraisals and statutory and mandatory training and sickness levels have reduced
- Agency spend is better than trajectory but as an additional ward has had to be opened there is a pressure on agency use
- A paper and presentation on apprenticeships was received, which identified there are currently 29 apprentices at the trust but that this is expected to rise to 60 over two years.
- The recent survey of doctors was positive but only 13 responses were received which needs to be improved on in future

08 Chief Executive's Commentary TB 17 (02)

The CEO presented the report and explained that organisational pressure was the focus, with the key issues being:

- Winter pressures
- Opening beds on Ward 5
- Correct number of beds across the Trust

CEO explained that the trust needs to balance availability of staff / agency and the timing of closing beds with clinical risk and needs further discussion in terms of what the correct number of beds should be. The cost of agency is also a risk to the Trust.

Performance

- Pressure in the Emergency Department is recovering at a slower rate than other organisations so focus is securing beds outside of the acute setting
- The trust submitted a £500k bid around the 18 week waiting list target, which has been partly successful
- There has been one 12 hour trolley wait

CEO stated that the level of staff commitment during this challenging period should not be taken for granted.

DoN confirmed that the 12 hour trolley wait is a red flag but there had been no patient harm and their privacy and dignity had been maintained.

Dr Cowan asked how the 48 cancelled operations compared with other organisations. DoN replied that she would confirm the position.

The Chairman asked whether there was a clear de-escalation plan in place around closure of the additional beds. CEO confirmed that there was with executive discussion around continued reduction in bed numbers.

Finance

- Revision of the forecast deficit by £1.5m has been well received by NHS Improvement
The CCG financial position has worsened, which may impact the trust 2017/18 control total not yet agreed, as this would mean 6% QIPP would be needed

Ms Harrison asked why the QIPP figure had increased from 4% to 6%. DoF explained that the increase is due to 50% share of the stranded costs following the South & Vale Royal Community transfer, which equates to £1.9m. CEO added that the trust is hoping that the reduction in planned deficit of £1.5m plus the return of £120k Capital will help with negotiations of the control total. Discussions will continue in quarter 4.

The Chairman asked whether there was any update on the frailty project. CEO responded that it was agreed that we would have clarity on the funding position by the end of the month.

CEO informed members that a never event had occurred within the specialty of Oral Surgery and that a full investigation was underway. The DoN advised the Board that there was no harm to the patient.

CEO advised the board that 10 Nursing Associates had been recruited to date to support qualified registered nurses. DoN added that the roles are regulated and will have real advantages in person centred care within an integrated care organisation.

DoF asked whether they would be included within the safer staffing numbers and will they be classed as nurses. DoN confirmed that they would once trained.

Mr Goman stated that the trust would need to be careful on the descriptions used as they will be qualified but not registered. DoN agreed and added that these roles are different to the Assistant Practitioner roles as these are not regulated.

The Chairman asked about the audit of unlicensed aseptic preparation services and whether the trust was compliant. CEO confirmed that the trust is compliant but there are some actions to be implemented.

<table>
<thead>
<tr>
<th>09</th>
<th>Standing Agenda Item: Does the board wish to add anything to the Assurance Framework or Corporate Risk Register</th>
<th>There was nothing further identified.</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>Public Trust Board Agenda – March 2017</td>
<td>The agenda was agreed.</td>
</tr>
<tr>
<td>11</td>
<td>Chairman’s Commentary TB 17 (04)</td>
<td>The Board received the verbal comments made and members noted the change and that activity would be summarised in the March 17 commentary</td>
</tr>
</tbody>
</table>
The Chairman referred to a recent CQC consultation document on resourcing and well led organisations, which had been circulated to all board members and asked that any comments be forwarded to DCAG by 01 February 2017.

The Chairman, on behalf of the board, sent a message of thanks to all front line and support staff for the great compassion showed over the recent challenging period.

### 12 Risk Management Strategy TB 17 (05)

The amendments to the Risk Management Strategy were noted and the Strategy was approved subject to the addition of the Human Tissue Authority as a risk area which the Medical Director has responsibility for.

### 13 Safer Staffing Exception Report TB 17 (06)

The Board received the December 16 Safer Staffing Exception Report submitted by the DoN. Members noted its content and the following exceptions:

- The Post Natal ward had an average fill rate of 83.2% for healthcare assistants during the day. On-call midwives have been utilised to support activity and maintain clinical safety
- Ward 10 had an average fill rate of 86.3% for registered nurses during the day. This variance is due to day case beds being utilised within Orthopaedics meaning one RGN is not required at present
- There are currently 34.45wte nursing vacancies across the trust with in month turnover being 1.65%. A focus on staff retention continues alongside proactive nurse recruitment campaigns.

### 14 Sub-Committee Minutes:

SQS – November 2016 and December 2016 TB 17 (07)
FP&W – November 2016 and December 2016 TB 17 (08)

The minutes of the November and December 2016 Finance, Performance & Workforce and the Safety, Quality & Standards Committees were shared with Board members.
<table>
<thead>
<tr>
<th>Action Log No</th>
<th>Committee</th>
<th>Date</th>
<th>Paper Reference</th>
<th>Agenda Item</th>
<th>Action Description</th>
<th>Action Owner</th>
<th>Response required by</th>
<th>Comment/Update</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>8305</td>
<td>Trust Board</td>
<td>Nov 16</td>
<td>N/A</td>
<td>Action log</td>
<td>Notes for action 8174 &amp; 8175 to be amended</td>
<td>Fiona Smith</td>
<td>Dec-16</td>
<td>Action log comments amended. Recommend action closed.</td>
<td>Closed</td>
</tr>
<tr>
<td>8306</td>
<td>Trust Board</td>
<td>Nov 16</td>
<td>N/A</td>
<td>Sub Committee verbal updates</td>
<td>A clarified / revised policy was needed, this should be included in the next revision of the Corporate Governance Manual</td>
<td>DoF / DCAG</td>
<td>Mar-17</td>
<td>The policy is currently progressing through the approval process, prior to inclusion in the Corporate Governance Manual</td>
<td>Open</td>
</tr>
<tr>
<td>8307</td>
<td>Trust Board</td>
<td>Nov 16</td>
<td>TB16/79 Estates Strategy</td>
<td>Inclusion of the additional Capital / Estate indicators in the performance report.</td>
<td>DoF</td>
<td>Jan-17</td>
<td>Action complete, Recommend action closed.</td>
<td>Closed</td>
<td></td>
</tr>
<tr>
<td>8667</td>
<td>Trust Board</td>
<td>Jan-17</td>
<td>8</td>
<td>CEO commentary</td>
<td>Dr Cowan asked how the 48 cancelled operations compared with other organisations. DoN replied that she would confirm the position.</td>
<td>DoN</td>
<td>Mar-17</td>
<td>Update at meeting.</td>
<td>Open</td>
</tr>
<tr>
<td>8668</td>
<td>Trust Board</td>
<td>Jan-17</td>
<td>11</td>
<td>Chairmans Commentary</td>
<td>The Chairman referred to a recent CQC consultation document on resourcing and well led organisations, which had been circulated to all board members and asked that any comments be forwarded to DCAG by 01 February 2017.</td>
<td>All Members</td>
<td>Feb-17</td>
<td>Responses received by DCAG. Recommend action closed.</td>
<td>Open</td>
</tr>
<tr>
<td>8669</td>
<td>Trust Board</td>
<td>Jan-17</td>
<td>6</td>
<td>Action Log</td>
<td>CEO to ensure inclusion of Estates Indicators in March board papers</td>
<td>CEO</td>
<td>Mar-17</td>
<td>Indicators included. Recommend action closed.</td>
<td>Open</td>
</tr>
</tbody>
</table>
**TRUST BOARD**
30th March 2017

Agenda Item Number 8: TB 17 (10)

<table>
<thead>
<tr>
<th><strong>Report of:</strong></th>
<th>The Chief Executive</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Author of Report:</strong></td>
<td>John Wilbraham, Chief Executive</td>
</tr>
<tr>
<td><strong>Subject/Title</strong></td>
<td>Chief Executives Report to Trust Board for the Period to 28th February 2017</td>
</tr>
<tr>
<td><strong>Background papers (if relevant)</strong></td>
<td>None</td>
</tr>
<tr>
<td><strong>Purpose of Paper</strong></td>
<td>To highlight performance issues and areas of risk to the delivery of the trusts objectives</td>
</tr>
<tr>
<td><strong>Action/Decision required</strong></td>
<td>No decisions are required</td>
</tr>
<tr>
<td><strong>Mitigates Risk Number: (identify)</strong></td>
<td>Links to all risks identified within the Assurance Framework and the Corporate Risk Register</td>
</tr>
<tr>
<td><strong>On Corporate Risk Register &amp; Assurance Framework</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Link to Care Quality Commission Domain</strong></td>
<td>Safe ✓</td>
</tr>
<tr>
<td></td>
<td>Caring ✓</td>
</tr>
<tr>
<td></td>
<td>Responsive ✓</td>
</tr>
<tr>
<td></td>
<td>Effective ✓</td>
</tr>
<tr>
<td></td>
<td>Well-led ✓</td>
</tr>
<tr>
<td><strong>Link to:</strong></td>
<td>Links to all Strategic Objectives</td>
</tr>
<tr>
<td></td>
<td>➢ Trust’s Strategic Direction</td>
</tr>
<tr>
<td></td>
<td>➢ Corporate Objectives</td>
</tr>
<tr>
<td><strong>Legal implications - (identify)</strong></td>
<td>None</td>
</tr>
<tr>
<td><strong>Impact on quality</strong></td>
<td>Increasing risk to patient experience due to operational pressures</td>
</tr>
<tr>
<td><strong>Resource impact</strong></td>
<td>None</td>
</tr>
<tr>
<td><strong>Impact of equality/diversity</strong></td>
<td>None</td>
</tr>
</tbody>
</table>

**Avoid acronyms or abbreviations - if necessary list:**
- CCG ClinicalCommissioningGroup
- CQC CareQualityCommission
- DH – Department of Health
- ED – Emergency Department
- NHSE – National Health Service England
- NHSI - National Health Service Improvement
- PAYE – Pay as you earn
- TUPE – Trades Union Protection of Employment
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>SAFER</td>
<td>Senior review-Assessment-Flow-Exit-Regular review</td>
</tr>
<tr>
<td>A&amp;E</td>
<td>Accident and Emergency</td>
</tr>
<tr>
<td>STF</td>
<td>Sustainability Transformation Fund</td>
</tr>
<tr>
<td>QIPP</td>
<td>Quality, Innovation, Productivity and Prevention</td>
</tr>
<tr>
<td>HMRC</td>
<td>Her Majesty’s Revenue &amp; Custom’s</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner’s</td>
</tr>
<tr>
<td>STP</td>
<td>Sustainability &amp; Transformation Plans</td>
</tr>
</tbody>
</table>
Chief Executive's Report to the Trust Board
For the Period Ended February 2017

1 PURPOSE

1.1 This report is to inform the Board on the position of the trust as at the end of February 2017 in relation to the strategic risks faced including a view on operational performance against key indicators.

2. KEY ISSUES

2.1 The Board are asked to note:

- Continuing under achievement of the ED 4 hour operational standard despite a number of actions being implemented
- A never event which took place in ED and the fact that no patient harm was incurred
- Improving position on waiting times
- Positive financial performance during February
- The Care Quality Commission’s agreement that the regulated activity of ‘Assessment or medical treatment for persons detained under the Mental Health Act 1983’ can be undertaken at the Macclesfield District General Hospital site
- Positive improvements in the 2016 staff survey results recently published
- Changes to the way temporary staff can be employed from 1st April 2017 and the associated risk of being able to attract staff within these new regulations
- The development of 2 prototype integrated teams bringing together staff from primary care, Cheshire and Wirral Partnership Trust, Cheshire East Council and East Cheshire Trust
## 2.2 Key Metrics

<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>
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</tr>
<tr>
<td>Risk Adjusted Mortality Index 2016 - Latest Peer (96)</td>
<td>1.027</td>
<td>1.089</td>
<td></td>
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<td>100</td>
<td>99</td>
</tr>
<tr>
<td>Summary Hospital Mortality Indicator (HSCIC)</td>
<td>28</td>
<td>45</td>
<td>37</td>
<td>19</td>
<td>5</td>
<td>24</td>
</tr>
<tr>
<td>Hospital MRSA bacteraemia</td>
<td></td>
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<tr>
<td>Hospital Acquired Clostridium Difficile 16/17 Avoidable</td>
<td>7</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>8</td>
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<tr>
<td>Incidence of newly-acquired cat 3 and 4 pressure ulcers - hospital</td>
<td>0</td>
<td>3</td>
<td>3</td>
<td>0</td>
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<td>0</td>
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<tr>
<td>Incidence of newly-acquired cat 3 and 4 pressure ulcers - out of hospital</td>
<td>10</td>
<td>8</td>
<td>12</td>
<td>3</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Medication errors causing serious harm</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Nover Events</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Incident reported rate per 1000 occupied bed days</td>
<td>74.6</td>
<td>70.0</td>
<td>53.5</td>
<td>58.2</td>
<td>52.1</td>
<td>55.3</td>
</tr>
<tr>
<td><strong>Infection</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Number of investigations with Ombudsman</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Number of complaints</td>
<td>37</td>
<td>20</td>
<td>18</td>
<td>9</td>
<td>24</td>
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<tr>
<td>Ward Family and Friends Test % response</td>
<td>41.1%</td>
<td>41.8%</td>
<td>42.4%</td>
<td>43.4%</td>
<td>37.4%</td>
<td>40.6%</td>
</tr>
<tr>
<td>ED Family and Friends Test % response</td>
<td>24.4%</td>
<td>24.3%</td>
<td>22.8%</td>
<td>22.7%</td>
<td>23.8%</td>
<td>23.2%</td>
</tr>
<tr>
<td>Mixed Sex Accommodation breaches per 1000 FCE's</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td><strong>Experience</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18 week - Incomplete Patients</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18 Week - Admitted Backlog</td>
<td>614</td>
<td>490</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ED: Maximum waiting time of 4 hours</td>
<td>65.4%</td>
<td>82.4%</td>
<td>81.4%</td>
<td>71.4%</td>
<td>78.5%</td>
<td>74.7%</td>
</tr>
<tr>
<td>2 Weeks maximum wait from urgent referral for suspected cancer</td>
<td>98.1%</td>
<td>98.2%</td>
<td>98.0%</td>
<td>99.3%</td>
<td>98.7%</td>
<td>99.0%</td>
</tr>
<tr>
<td>2 Weeks maximum wait from referral for breast symptoms</td>
<td>92.6%</td>
<td>93.3%</td>
<td>96.1%</td>
<td>95.4%</td>
<td>97.2%</td>
<td>98.4%</td>
</tr>
<tr>
<td>31 days maximum from decision to treat to subsequent treatment - Surgery</td>
<td>98.8%</td>
<td>100.0%</td>
<td>98.9%</td>
<td>98.0%</td>
<td>98.0%</td>
<td>98.0%</td>
</tr>
<tr>
<td>31 day wait from cancer diagnosis to treatment</td>
<td>98.8%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>98.0%</td>
<td>99.0%</td>
<td>98.0%</td>
</tr>
<tr>
<td>62 day maximum wait from urgent referral to treatment of all cancers</td>
<td>84.5%</td>
<td>80.6%</td>
<td>80.9%</td>
<td>78.7%</td>
<td>79.5%</td>
<td>83.7%</td>
</tr>
<tr>
<td>62 days maximum from screening referral to treatment</td>
<td>100.0%</td>
<td>100.0%</td>
<td>97.7%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td><strong>Access</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average Length of Stay - non elective</td>
<td>5.5</td>
<td>5.1</td>
<td></td>
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<tr>
<td>Average Length of Stay - elective</td>
<td>7.4</td>
<td>8.1</td>
<td></td>
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<tr>
<td>Delayed transfers of care - Acute</td>
<td>11.4%</td>
<td>10.0%</td>
<td>8.43%</td>
<td>6.72%</td>
<td>6.54%</td>
<td>6.6%</td>
</tr>
<tr>
<td>Bed days lost through delays - Acute</td>
<td>2469</td>
<td>2285</td>
<td>1760</td>
<td>541</td>
<td>490</td>
<td>1021</td>
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<tr>
<td>Delayed transfers of care - Non Acute</td>
<td></td>
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<tr>
<td>Core Staff in Post (FTE)</td>
<td></td>
<td></td>
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<tr>
<td>Total Staff (FTE)</td>
<td>2151.4</td>
<td>2141.8</td>
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<tr>
<td>Sickness Absence - monthly</td>
<td>5.31%</td>
<td>5.09%</td>
<td></td>
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<tr>
<td>Sickness Absence - Rolling year</td>
<td>4.60%</td>
<td>4.63%</td>
<td></td>
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<tr>
<td>Statutory and Mandatory Training - Rolling 3 year period</td>
<td>98.3%</td>
<td>98.2%</td>
<td></td>
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<tr>
<td>Corporate Induction attendance - Rolling year</td>
<td></td>
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</tr>
<tr>
<td>Appraisals and Personal Development Plans - Rolling year</td>
<td>85.5%</td>
<td>85.7%</td>
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<tr>
<td>Information Governance training</td>
<td>97.62%</td>
<td>97.9%</td>
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<tr>
<td>Safeguarding - Level 1 Compliance</td>
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<tr>
<td>Safeguarding Children - Level 2</td>
<td>79.7%</td>
<td>78.6%</td>
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<tr>
<td>Safeguarding Adults - Level 2</td>
<td>79.2%</td>
<td>78.9%</td>
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<tr>
<td>Safeguarding Children - Level 3</td>
<td>78.5%</td>
<td>78.4%</td>
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<tr>
<td>Total Pay Expenditure (£000)</td>
<td>£31,414k</td>
<td>£30,642k</td>
<td>£25,906k</td>
<td>£8,876k</td>
<td>£8,845k</td>
<td>£17,721k</td>
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<td>Bank Staff Expenditure (£000)</td>
<td>£1,043k</td>
<td>£1,039k</td>
<td>£918k</td>
<td>£310k</td>
<td>£322k</td>
<td>£632k</td>
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<tr>
<td>Agency Staff Expenditure (£000)</td>
<td>£1,733k</td>
<td>£1,773k</td>
<td>£1,219k</td>
<td>£497k</td>
<td>£666k</td>
<td>£1,163k</td>
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<td>Cash (£000's)</td>
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<tr>
<td>EBITDA (£000)</td>
<td></td>
<td></td>
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<tr>
<td><strong>Finance</strong></td>
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<tr>
<td><strong>Domain 1 - Efficiency - Cost</strong></td>
<td></td>
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</tr>
<tr>
<td>Total Estates and Facilities running costs / Weighted Activity Unit £ / WAU</td>
<td>440.55</td>
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<tr>
<td>Total Estates and Facilities running costs / Area £ / m²</td>
<td>388.33</td>
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<tr>
<td><strong>Domain 2 - Effectiveness - Productivity</strong></td>
<td></td>
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<tr>
<td>Occupied Floor Area / WAU</td>
<td>1.13</td>
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<tr>
<td>Amount of empty space</td>
<td>4.30%</td>
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<tr>
<td>Amount of unutilised space</td>
<td>0.60%</td>
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</tr>
<tr>
<td>Amount of non clinical space</td>
<td>25.50%</td>
<td></td>
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<tr>
<td><strong>Domain 5 - Organisation Governance &amp; Process</strong></td>
<td></td>
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<tr>
<td>Capital investment required to eliminate CIR</td>
<td>£434,227</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Capital investment required to eliminate Backlog</td>
<td>£2,887,311</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capital spend as % of NBV of land and buildings</td>
<td>1.50%</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
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 Access Times

The trust has continued to face pressure in meeting the demand for in-patient care and has continued to provide additional beds staffed through increased agency usage.

3.2 Emergency Department 4 Hour Standard

3.2.1 Despite these additional 24 beds the delivery of the emergency department 4 hour standard for patients to be admitted, discharged or transferred has not been achieved in February with only 78.5% of patients being seen within this time. March looks to be a further improved position but still significantly below the 95% standard.

3.2.2 In terms of activity, overall levels of ED attendances have reduced by 0.5%, there has been a reduction in the use of the minor injuries clinic in Congleton by 35% but with a 4.7% increase in attendances in Macclesfield.

3.2.3 Whilst this position has improved over January’s position the reality is that the trust has not achieved the standard all year and, whilst many Trusts are in this position our relative performance against other organisations is poor.

3.2.4 It is recognised that busy ED’s do present a clinical risk and patient experience can suffer. The Director of Nursing, Performance & Quality continues to review the department to ensure any clinical concerns are being escalated and managed appropriately and the Board’s attention is drawn to a never event which took place in the Department in February. No patient harm occurred as a result of this error and a full Root Cause Analysis is being undertaken in line with trust policy.

3.2.5 There is no single factor that is driving this position and recovery is focused on 5 themes within the recovery plan namely:

- Streaming Patients on Arrival
- Use OF NHS 111 to minimise attendances
- Ambulance Turnaround times
- Improving hospital flow using the SAFER bundle
- Improving Discharge
3.2.6 The Accident and Emergency Delivery Board, comprising senior leadership from all the Statutory Bodies has responsibility to ensure the plan is delivering and whilst some areas are seeing improvement other areas are finding it difficult to make an impact.

3.2.7 The trust has made significant progress internally with the introduction of a “walk-in major” process whereby patients arriving with major conditions are assessed in a new area within the Department where they can be assessed from ambulance trolleys. This improves the speed in which they are assessed as well as freeing up ambulance crews more quickly and therefore increasing ambulance availability for other patients.

3.2.8 There has been progress also with the roll out of the national SAFER bundle on our wards. This acronym stands for Senior review-Assessment-Flow-Exit-Regular review and the aim of this process is to ensure patients are receiving timely care such that there are no delays in their treatment allowing them to leave hospital safely in a quick time as possible. Daily Board rounds take place where multidisciplinary teams review the needs of each patient at the start of the day to ensure plans are in place for their care that day and action taken to ensure the required inputs are organised. This will lead to reduced lengths of stay but equally as important an ambition has been created to discharge a third of the patients from each ward before midday and thereby freeing up beds in advance of the increased demand from ED which occurs from late morning into the afternoon.

3.2.9 The bundle has been introduced first on Wards 3 and 4 and lengths of stay have reduced on these wards. Matrons, Ward Managers and Clinicians are involved in this work and the process is being introduced into all other wards.

3.2.10 The discharge of patients continues to be an obstacle in the flow of patients and whilst the trust and its partners have made progress in reducing the number of patients whose discharge is delayed the position remains above the levels that are expected.

3.2.11 It is clear that the availability of sufficient nursing home and residential care beds at the rates afforded by the NHS is a challenge given a relatively robust private market for these services. This combined with the difficulty in recruiting sufficient staff to provide domiciliary care in people’s homes means that patients are waiting in hospital beds who do not need hospital care.

3.2.12 Again this is a national issue however the position in East Cheshire is more acute and the focus of the Council and CCG needs to bring about solutions to this. The CCG are proposing on widening the geography of nursing homes they use and the Council are reviewing the contracts of the 80+ providers they use for domiciliary care.

3.2.13 The Council will also benefit from the increase in funding for Social Care outlined in the recent budget and the executive team will be seeking to understand how this resource will be used to support the discharge of patients from hospital.
3.2.14 NHSE/NHSI have contacted local health and care economies outlining their requirements for improving the management of demand during the next financial year. They are seeking each A&E Delivery Board to:

- Ensure every hospital implements a comprehensive front-door streaming model by October 2017, so that A&E departments are free to care for the most urgent patients
- Strengthen support to Care Homes so as to ensure that they have direct access to clinical advice, including where appropriate on-site assessment
- Implement the recommendations of the Ambulance Response Programme by October 2017, freeing up capacity for the service to increase their use of Hear & Treat and See & Treat, thereby conveying patients to hospital only when this is clinically necessary
- Proceed with the standardisation of Walk-In-Centres, Minor Injury Units and Urgent Care Centres, so that the current confusing array of options is replaced with a single type of centre which offers patients a consistent, high quality service
- Roll out evening and weekend GP appointments, to 50% of the public by March 2018 and 100% by March 2019
- Increase the number of NHS 111 calls receiving clinical assessment by a third by March 2018, so that only patients who genuinely need to attend A&E, or use the ambulance service, are advised to do this

3.2.15 This will form the work programme of the East Cheshire A&E Delivery Board.

3.3 **Referral to Treatment Times**

3.3.1 It is with regret that the pressure on medical beds continues to require the cancellation of elective operations for patients. Safety is always considered in these cancellations and no life threatening cases have been cancelled but this does not reduce the frustration, anxiety and disruption that is caused by cancelling routine patients.

3.3.2 The trust has been able to utilise the additional resources it successfully bid for to allow operations to be undertaken for patients in private facilities. Approximately 100 patients have received their operations during January and February who would otherwise have remained on the waiting list. These operations have been orthopaedic and ophthalmology patients and the consequence of this has seen the performance on the standard increase from 87.3% in December to 89.2% in January and a further improvement to 91.3% in February.

3.3.3 The trust remains optimistic that the standard will be achieved at aggregate level by 31st March.

3.4 **Cancer Waiting Times**

3.4.1 The trust has achieved 6 of the 7 cancer standards during February missing the 62 day standard.
3.5 **Care Quality Commission (CQC) Registration**

3.5.1 On 15 March 2017 the Care Quality Commission confirmed the trust is now registered for the regulated activity of ‘Assessment or medical treatment for persons detained under the Mental Health Act 1983’ at the Macclesfield District General location. To support this and ensure compliance with the trust’s statutory responsibilities under the Mental Health Act ‘Code of Practice’, a service level agreement has been agreed with Cheshire and Wirral Partnership NHS Foundation Trust to administer trust applications for detention under the Act. This delegated authority is set out within the trust’s Corporate Governance Manual, with detention activity and assurance of compliance will be provided to the Board through the Safety Quality and Standards Committee.

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**

4.1.1 The trusts financial position in February was in line with the planned position recording a cumulative deficit of £16.2m. The Board are aware that the trust committed to NHSI to deliver an improved year end position of £1.5m from its original plan and remains on plan to deliver this commitment.

**Table 1 - Summarised Income and Expenditure Analysis at February 2017**

<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>147,331</td>
<td>149,496</td>
<td>(2,164)</td>
<td>Favourable</td>
</tr>
<tr>
<td>Pay Expenditure</td>
<td>106,041</td>
<td>105,683</td>
<td>(358)</td>
<td>Favourable</td>
</tr>
<tr>
<td>Non-Pay Expenditure</td>
<td>55,255</td>
<td>56,235</td>
<td>980</td>
<td>Adverse</td>
</tr>
<tr>
<td>Total Operating Expenditure</td>
<td>161,296</td>
<td>161,917</td>
<td>621</td>
<td>Adverse</td>
</tr>
<tr>
<td>Operating (deficit)/Surplus</td>
<td>(13,965)</td>
<td>(12,421)</td>
<td>(1,544)</td>
<td>Favourable</td>
</tr>
<tr>
<td>Interest Rec’d/Paid/Gain on disp.</td>
<td>846</td>
<td>804</td>
<td>(42)</td>
<td>Favourable</td>
</tr>
<tr>
<td>Capital Charges &amp; Adjustment for donated assets</td>
<td>3,215</td>
<td>3,035</td>
<td>(180)</td>
<td>Favourable</td>
</tr>
<tr>
<td>Trust (deficit)/Surplus</td>
<td>(18,026)</td>
<td>(16,261)</td>
<td>(1,765)</td>
<td>Favourable</td>
</tr>
</tbody>
</table>

4.1.2 The table above shows that the trust has generated additional income during the year and managed pay expenditure within the budget levels. The pay expenditure has however increased in recent months mainly as a consequence of having additional beds opened to meet the increased medical in-patient demand. Agency expenditure for the year totals £5.9m and the recent increase will not jeopardise the
delivery of the capped level set for 2016/17 of £8.4m however expenditure in February was £666k and if this is not reduced then the ability to meet the cap in 2017/18 will be put at risk.

4.2 **Sustainability and Transformation Funding**

4.2.1 The trust made an application to receive this funding in quarter 2 and 3 despite not achieving the operational standards for ED and waiting times. The trust has received confirmation that the STF performance funding for Q2 will be paid to the trust (£346k) and the outcome of Q3 appeals is awaited.

4.3 **2017/18**

4.3.1 The contracts for the 2017/18 year have been agreed with commissioners and the budget setting process has been overseen by the Director of Finance. The table below shows the high level income and expenditure plans as they currently stand which do not meet the expectations of NHSI in that the control total set for the trust is exceeded with this budgeted plan.

4.3.2 The Recovery Board have discussed how the QIPP should be allocated across the trust and representatives from corporate and clinical areas have agreed that given the reduction in the number of divisions the QIPP level will be applied equally across the trust.

4.3.3 The QIPP level for 2017/18 stands at £3.4m (2%).

4.3.4 At the current time therefore the trust is budgeting for a deficit of £26.8m which exceeds the NHSI control total. The Director of Finance is involved in ongoing discussions with NHSI about this issue and the Board will be updated when these discussions are completed.

4.3.5 The table below shows the budgeted Income and Expenditure Account for 2017/18 but it should be noted that there will be difficulty when comparing to 2016/17 given the significant changes following the exiting of the South Cheshire/Vale Royal community service provision.

<table>
<thead>
<tr>
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<tr>
<td>Non-pay costs</td>
<td>(57)</td>
</tr>
<tr>
<td>EBITDA</td>
<td>(25.4)</td>
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<tr>
<td>Depreciation and financing costs</td>
<td>(4.8)</td>
</tr>
<tr>
<td>Savings</td>
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<tr>
<td>Net Deficit</td>
<td>(26.8)</td>
</tr>
<tr>
<td>Potential STF funding</td>
<td>4.0*</td>
</tr>
</tbody>
</table>

*subject to agreement of financial control target
5 **PEOPLE**

*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 **Staff Survey**

5.1.1 The results of the national staff survey undertaken in October 2016 have been published and it is pleasing to note that the trust score for staff engagement has increased for the third year running and is now above the national average with a score of 3.86 on a rating of 1 - 5.

5.1.2 The overall matrix of scores is being shared with staff through briefings however it is pleasing to see increasing numbers of staff recommending the trust as a place to work or receive treatment as well as high levels of motivation and staff feeling that they are offered equal opportunities for career progression and promotion. In addition the trust is below the national average for staff feeling harassed or bullied.

5.1.3 Whilst overall the results are positive the survey gives the opportunity to focus on where we can improve further. The quality of appraisals (0.7% below national average) and the number of staff reporting that they are working additional hours 2% higher than national average) are areas where we will seek to generate improvement before the next survey

5.1.4 The survey was issued to all of the trust staff and thanks go to the 1,049 (43%) staff who took the time to reply.

5.2 **Locum and Agency Expenditure**

5.2.1 NHSI have issued further guidance for Trusts in terms of payment processes when employing temporary members of staff.

5.2.2 In September 2015 DH stated that senior staff (Board members and senior staff with significant financial responsibility) must be on the payroll unless there are exceptional temporary circumstances. Recent advice from HMRC goes further than this and states that all appointments to “office holders” should be on the payroll regardless of the expected appointment duration. This means PAYE should be deducted at source and should not be engaged using a personal services contract, an employment agency consultancy or other intermediary vehicle.

5.2.3 NHSI have requested this be brought to the attention of Boards and should make no new off-payroll holder appointments

5.2.4 In addition from 1st April, Trusts can only engage staff working additional hours who are already substantively employed by the NHS (including those working for other Trusts) through bank arrangements whereby PAYE is deducted at source.

5.2.5 The trust is seeking to maximise the number of staff on the bank to ensure we can maximise the use of staff outside of normal contractual requirements to maintain service however there is a risk that rotas may be more difficult to fill post April 1st.
5.2.6 NHSI are also aiming to become more transparent on pay rates being paid to assist Trusts in holding the line on these arrangements.

5.2.7 The Director of HR & Workforce will be overseeing the position with input from other executive directors and medical staff.

5.3 **Middle Grade Staffing**

5.3.1 There are a number of middle grade vacancies across specialities within the trust reflecting national and regional workforce shortages. The position has become more difficult recently due to NHSI agency rules, Health Education England requirements relating to doctors in training and HMRC changes pertaining to the way public sector employers engage with off-payroll workers.

5.3.2 There is no easy solution to this workforce gap and whilst in the short term continual close management of rotas and use of temporary staff will be undertaken more medium term solutions will be needed including potential changes to skill mix and partnering arrangements between trusts.

6 **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 **Caring Together**

6.1.1 The Caring Together Board meeting in February agreed to push forward on the development of local teams bringing together primary, community, mental health and social care staff to focus on the health needs of the local population.

6.1.2 The Caring Together vision is based on local teams looking after populations of c.30,000 – 50,000 patients based on the GP practice lists. This would mean 5 teams working across East Cheshire who would focus on the needs of their local population and breaking down organisational barriers allowing all staff to be patient focused.

6.1.3 The Board agreed that 2 prototypes would be established, one in Knutsford and one covering Bollington, Disley and Poynton to test how services can be delivered in a different way. These will be established under the leadership of primary care with a view to having these running within 6 months to allow the other 3 areas within Eastern Cheshire to take forward the learning and establishing their teams in the following 6 months.

6.1.4 There is no agreement to transfer staff formally (TUPE) but it will require managers to allow staff to work across organisational boundaries. The trust has agreed to release one of its senior managers to work alongside other partners to develop these teams as the first step along the route to establishing an accountable care organisation.

6.1.5 Accountable Care Organisations are seen as a route to delivering more sustainable joined up health and social care however there is no clear definition of what would be included or excluded from such an organisation in the future. The ECT Board believe that this is the right model for the local community and are actively working with other
partners to develop the options around the creation of such an organisation whilst recognising more would need to be done to understand how this will improve the financial challenge faced by the economy.

6.1.6 In this regard the Caring Together Programme Executive along with other senior leaders held an externally facilitated workshop about the readiness of the health and care economy to become an accountable organisation and to outline the issues that would need to be addressed. It was concluded that if this were to be the right solution for Eastern Cheshire then a process for assessing the services within such an organisation and the work needed to produce a business case for its creation would mean October 2018 was likely to be a challenging but achievable timeframe.

6.2 **Sustainability and Transformation Plan**

6.2.1 NHSE/I are expected to publish a Five Year Forward View delivery plan setting out expectations about what will be required in the next few years. It is anticipated that this document will initiate a formal process for appointing STP leads and giving STP’s the ability to make recommendations about local organisational governance where there is evidence that an organisation is delaying the implementation of wider plans.

6.2.2 The development of STP governance models has been developing across the country and the guidance is expected to outline these such that best practice can be spread.

6.2.3 The recent budget highlighted that some £325m investment was available for STP’s that are more advanced to allow plans to be introduced. There is no indication at this time about which STP’s are likely to benefit from this but this may signal a change in methodology of moving resources from the centre to front line services. In addition it is anticipated STP’s may receive some revenue funding to support the work they are doing.

6.3 **Back Office Collaboration**

6.3.1 ECT agreed to move forward with a joint collaboration on procurement across Cheshire and Wirral organisations. The other 5 providers have considered this proposition but regrettably only 2 other providers have agreed to work with ECT at this time.

6.3.2 The wider STP however has also been considering this issue and clearly represents a bigger group of providers to work together. It is expected that all Cheshire and Mersey providers will be approached about working together with a view to those who wish to be involved can progress. Clearly this offers an opportunity for increased cost effectiveness and is something we should actively consider.

6.4 **Accountable Care Organisation (ACO)**

6.4.1 The STP has also been considering the formation of ACO’s across Cheshire and Merseyside. There is a potential opportunity for some additional resources to take forward 2 ACO areas across the footprint to act as “exemplars” and to share learning with other economies. It is probable that there would be one in Cheshire and one in Liverpool.
7. **USE OF TRUST SEAL**

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

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<th>Date</th>
<th>Seal Number</th>
<th>Name</th>
<th>Document</th>
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<tr>
<td>13th February 17</td>
<td>453</td>
<td>Fresenius Medical Care Renal Services Ltd and NHS Commissioning Board</td>
<td>Draft deed of variation, Lease of the Rental Treatment Centre, MDGH</td>
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8. **SUMMARY**

8.1 Operational pressures continue to dominate the focus of senior management at the present time and it is a continual challenge meeting the needs of patients needing urgent care safely whilst seeking to minimise the impact on elective patients.

8.2 Further changes to the employment of temporary staffing in April will assist in further financial benefit however there is a risk that staff will not undertake additional hours therefore placing more pressure on operational delivery.

8.3 Despite this operational pressure the trust continues to be ahead of its financial plan and will post a smaller deficit than expected at the start of the year.

8.4 The introduction of integrated teams planned in two areas of the health and care economy is a clear indication of changes being introduced to integrate care in a way that maximises benefits to the patient in line with Caring Together ambitions.

John Wilbraham  
Chief Executive
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):  
Corporate Governance Manual 2016-2017 incorporating:  
Standing Orders  
Standing Financial Instructions  
Reservation of Powers to the Board and Delegation of Powers

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

Action/Decision required:  
The Board is asked to:  
• Approve the proposed amendments to the Corporate Governance Manual

Mitigates Risk Number:  
(identify)  
On Corporate Risk Register

Mitigates Risk Number:  
(identify)  
On Assurance Framework

This paper relates to 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 inform the Board of proposed amendments to the Corporate Governance Manual.

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. **PROPOSED AMENDMENTS**

3.1 The amendments which have been identified are:

**General Amendments:**
- Change of Trust Development Authority to NHS Improvement
- Reference to Counter Fraud changed to Anti-Fraud
- Change of name of Fraud Response Plan to Fraud, Bribery and Corruption Response Plan
- Replace reference to Prevention of Corruption Acts 1889 and 1916 with Bribery Act 2010
- Reference to NHS Executive replaced with NHS Improvement

**Forward:**
- Update of number of employees and revenue income

**Overarching Governance Arrangements:**
- Page 8. Process for Assurance and Escalation – amendment of the names of meetings and processes

**Standing Orders:**
- Section 6.4.4, page 44. Health and Social Care Act 2008 (Regulated Activities) 2008 date amended to 2014

**Detailed Scheme of Delegation:**
- Section 1.9.1(c), page 56. Reference to Internal Audit annual report replace with Director of Audit Opinion
- Section 3, page 58. Reference to “annual statement” to satisfy requirements of the Bribery Act replaced with “periodic statement”
- Section 6, page 59. Wording of duties amended to reflect changes to NHS Protect - 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 Protect's Standards for Providers
- Section 13, page 69 – Removal of duties relating to the approval of terms, conditions and signing the contract with Arvato
- Section 17, page 72. Change Supplies trust Stores to NHS Supply Chain
• Section 18, page 72/73.
  ▪ Inclusion of NHS Protect to be informed of instances of theft and corruption
  ▪ Replace Secretary of State guidance with NHS Standards Contract in accordance with NHS Protect’s Security Standards for Providers
• Section 24, page 76. Removal of Director of Finance delegated duty to keep lists of approved firms for tenders
• Section 39, page 80. Inclusion of Chief Executive as Qualified Person for Freedom of Information Requests.
• Section 47, page 82. Inclusion of Cheshire & Wirral Partnership NHS Foundation trust responsibility for provision of Mental Health Act Administration Service.

Delegated Financial Limits:
• Page 83 – Amendment of description of Tier 2 budget holders to read “Deputy Director / Associate Director level” and Tier 3 budget holders to read “Service Manager level”.
• Section 5b), page 86. Disposal of x-ray films – delegated responsibility changed to Head of Integrated Governance
• Section 10, page 89. Virement between budgets up to £50,000 and virement between budgets over £50,000, so long as the Trust position is in line with plan. Description amended from Trust position underspent.

Standing Financial Instructions
• Amendment to narrative to reflect the above changes to the Detailed Scheme of Delegation and Delegated Financial Limits
• Section 2.3.1d(i), page 96. Removal of reference to current Assurance Framework guidance from the sentence
• Section 6.4.6, page 104. Value of maximum exchequer cash payments which can be accepted amended to EUR 15,000 in line with the 2015 money laundering regulations

Terms of Reference
• Revised Terms of Reference for each of the Committees of the Board

Appendices
• Appendix 1:
  ▪ Page 132. Summary of main provisions amended to better reflect content of the Bribery Act 2010
  ▪ Page 135. A guide to the Management of private practice in the NHS, replaced with the Consultant contract and BMA guidance

Policies and procedures
• Page 182. Amended Local Counter Fraud and Corruption Policy to remove the section on NHS Protect Area Anti-Fraud Specialist, following changes internally within NHS Protect.
• Procedure Instruction for Completion of Waiver Forms:
  ▪ Page 215. Amended Waiver form including additional declaration requirements
  ▪ Page 220. Waiver process diagram amended to reflect change to OJEU limits
• Amendment to Fit and Proper persons process to replace reference to Directors with Board Members and to include regular annual review of fitness
• Amended NHS Improvement guidance on consultancy spending approval criteria
The Overpayment Policy has been written to strengthen controls over recovery and is currently going through the approval process, including consultation with staff side, before being included within the Corporate Governance Manual.

National guidance on Conflicts of Interest has recently been issued by NHS England and will come into effect from June 2017. As a result the Corporate Governance Manual will need to be amended to reflect additional information in the following areas:

- compliance with the NHS Code of Conduct, definition of Conflict of Interests and categorisation of interests; and further Bribery Act information.
- Changes to gifts and hospitality financial limits
- Managing breaches and sanctions
- Managing conflicts of interest at meetings (including raising concerns)
- Outside Employment
- Private Practice
- General Sponsorship including Sponsored events, research and posts
- Shareholdings
- Patents
- Donations
- Loyalty Interests

4 RECOMMENDATIONS

4.1 The Board is asked to:
- Approve the proposed amendments to the Corporate Governance Manual
| **Report of:** | **Responsible Officer:** Mark Ogden  
**Accountable Officer:** Director of Finance |
|-----------------|-------------------------------------------------------------------------------------------------|
| **Author of Report:** | Julia Cazalet  
**Associate Director - QIPP** |
| **Subject/Title** | Lord Carter Report – Progress Report on Actions to Deliver Recommendations. |
| **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 inform the Board on progress.  
To request approval of the East Cheshire NHS Trusts Hospital Pharmacy Transformation Plan |
| **Action/Decision required** | Approval of the East Cheshire NHS Trusts Hospital Pharmacy Transformation Plan. |
| **Mitigates Risk Number: (identify)** | **BAF 3 – Financial Stability** |
| **On Assurance Framework** | 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 |
| **Link to Care Quality Commission Domain** | Choose one of the following:  
Safe  
Effective  
Well-lead ✓  
Caring  
Responsive |
<p>| <strong>Link to:</strong> | Continuously improve quality, safety and the patient experience |
| ➢ <strong>Trust’s Strategic Direction</strong> | Achieving financial sustainability |
| ➢ <strong>Corporate Objectives</strong> | |</p>
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<td>HPTP – Hospital Pharmacy Transformation Plan</td>
</tr>
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<td>- if necessary list:</td>
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1.0 Background

1.1 The key focus of the report by Lord Carter was identification of ‘unwarranted variation’ and the productivity gains that can be achieved by minimising this variation.

1.2 Unwarranted variation is not a new concept – In April 2011 the Kings Fund published a document ‘Variations in Healthcare, the good, the bad and the inexplicable’ which explored possible causes and analysed areas such as different rates of hospital admission. The Carter review focuses on variability in acute hospitals. The review was wide ranging and heavily data based, including a comparison of organisations reported costs at a granular (HRG) level. The output of the review was summarised in fifteen headline recommendations. Beneath each of these, the Carter report sets out a number of explicit actions that it expects organisations to be undertaking in order to deliver the recommendations.

2.0 Update on East Cheshire Trust Progress against Lord Carter’s Recommendations

2.1 The information below provides an update on the Trust’s progress against these recommendations, highlighting where there have been barriers to progress.

1. National People Strategy – The Trust is currently implementing most of the ‘expected actions to deliver recommendations’. These are documented and overseen by the Board through its workforce strategy, which drills down to directorate level workforce action plans. When the ‘National People Strategy’ (overdue from October 2016) is published the HR function will undertake a gap analysis between current delivery and national expectations of actions and outcomes.

2. Analysing Staff Deployment – The Trust has refined the collection of nursing care hours per patient day so that only direct patient care hours are reported to NHSI; for example excluding staff who are supernumerary or involved in non patient care activities such as audit. The data is being reviewed by Senior Nursing Staff to support their understanding of ward staffing and from March 2017 the data is included in the Trust Board Reporting on Safer Staffing. Reporting of medical staffing information is less advanced; consultant annual leave and on call commitments are captured on the e-rostering system but the information contained within job plans in respect of inpatient, outpatient, theatre and other clinical commitments is not currently captured within the e-rostering system.

3. Hospital Pharmacy Transformation Programme - The pharmacy element of Lord Carter’s report was well developed with clear guidelines and explicit gap analysis tools issued to Chief Pharmacists to undertake the required review and planning. All trusts are required to submit a board approved Hospital Pharmacy Transformation Plan (HPTP) to NHS Improvement by April 2017 outlining how they will meet their model hospital metrics and specific recommendations from the Carter report.
An interim plan was submitted in October 2016 which was well received by NHSI. The final version of ECT’s plan developed by the Chief Pharmacist is attached as Appendix A of this paper. It has been agreed by Clinical Management Board in February 2017 and the Board are requested to give formal approval. Delivery of the Pharmacy Transformation Plan requires collaborative working with other trust pharmacy departments (ECT is currently collaborating with GM, Cheshire & Wirral and Cheshire & Merseyside). Successful implementation of the plan will require a workforce review which includes commitment to investing resources in training to develop new pharmaceutical roles, and provision of a weekend service in order to achieve specific Carter metrics.

4. **Pathology and Imaging Benchmarking** – The Countess of Chester hosted some STP based discussions on the future of service provision for these diagnostics. There have been no proposals for change as result of these discussions.

5. **Purchasing Price Index** - The Trust is currently providing its procurement information to NHS Improvement and has streamlined its report production. This is an area of active development, which is being nationally led. The Trust continues to supply its data and will benefit from the national negotiation of prices. One of the first procurements to be implemented is a move to two national providers for paper rolls at a reduced price. The benefit to the Trust is relatively small but is something that it is unlikely to have been achieved as an independent organisation and for which it has not had to incur costs of negotiation. More material gains will be made from the high value items, although these require more clinical input and testing and decisions will potentially be more contentious.

6. **Operational Management** – Estate based metrics are reviewed by the Head of Estates. In February 2017, the national operational productivity team produced guidance and a progress monitoring template to enable it to track progress against each of the Carter recommendations relating to recommendation six and have requested submission of the data by the end of March 2017. Future changes to Trust estate will be influenced by the outcomes of the Caring Together programme.

7. **Corporate and Administration Functions**
The Trust has recently received feedback on its submission to NHSI of benchmarking data on its corporate functions. These compared the Trust costs per £100m of turnover against the lower cost quartile for organisations nationally, by organisation type and by STP. This data indicates that based on the performance of other organisations there are opportunities for improving efficiency across corporate functions.
8. **Joint Clinical Governance**
   Benchmarking data for GIRFT metrics in trauma and orthopaedics has recently been published on the model hospital portal. Further evaluation is required by the clinical community on the most effective way to explore and utilise the data.

9. **Digital Information Systems** - The Trust has not yet had an update on NHSI incentives and standards and the Trust position has not materially changed since the last update to the Trust Board in August 2016.

10. **Local Government Representation** – The recommendation focuses on the national development of a strategy for patient care and recovery out of hospital in collaboration with Local Authorities. ECT continues as an active partner in Caring Together and will shortly be presenting its proposals to the regulator meeting. The extra funding for social services announced in the budget needs to be a focus area for the local economy.

11. **Collaboration across health economies** – The Trust continues to engage both with its STP partners and acute providers outside its STP borders to support safe and effective clinical provision. The level of input into these areas is significant for Executive Directors.

12. **Model Hospital** - The Model Hospital analysis has been refreshed in January 2017 with 2015/16 reference cost data. The Trust is an outlier on its cost per weighted activity unit metric. Disappointingly, attempts to utilise the data to identify opportunities have been frustrated to some extent by issues with the data methodology resulting in a distortion of its value in benchmarking. Examples include inclusion of payroll based staffing costs for services to other bodies without a commensurate adjustment for the income received and incorrect categorisation of the costs of medical staff in training, as they are not on the ECT payroll. However as the tool is refined and these data anomalies are resolved, it is expected that the Model Hospital will provide powerful benchmarking data. Details of the analysis provided by the portal are included in appendix B.

13. **Reporting Framework** – there has been no further update on this recommendation.

14. **Implementing the Recommendations** - The Trust is continuing to undertake actions which aim to deliver the recommendations of the Lord Carter report.

15. **Efficiency and Productivity Improvements** – NHSI Planning returns and the recent STP submissions include opportunities for efficiency plans to be categorised in line with national programmes. These returns support a benefits realisation system that aims to identify efficiency programmes such as Carter and the benefits of collaboration. However these are challenging to identify since efficiency is measured by the financial savings of individual organisations. The Trust has not yet identified efficiency savings for 2017/18 which will be derived from collaborative working.
3.0 Conclusions

3.1 The Trust is engaged in implementing the actions identified within the Lord Carter report as necessary to deliver the fifteen recommendations. The Trust is reporting as one of the least efficient acute Trusts and needs to take advantage of opportunities to identify areas where it can increase productivity.

4.0 Recommendations

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

4.2 The Trust Board is asked to approve the Hospital Pharmacy Transformation Plan included at appendix A

Mark Ogden
Director of Finance
22 March 2017
Appendix A

Hospital Pharmacy Transformation Plan
<table>
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<tr>
<th><strong>Report of:</strong></th>
<th>Kashif Haque, Chief Pharmacist</th>
</tr>
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<td>Kashif Haque, Chief Pharmacist</td>
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</table>
**Executive Summary**

Lord Carter of Coles report on identifying unwarranted variations in the NHS was published in February 2016. Within this report there was a review of hospital pharmacy and medicines optimisation and a number of recommendations made for Trusts to implement by 2020.

One of these recommendations was for Trusts to submit a board-approved hospital pharmacy transformation plan (HPTP) to NHS Improvement by April 2017 outlining how they will meet their model hospital metrics and specific recommendations from the Carter report.

A template for completion was circulated by NHS improvement and a draft report was submitted to NHS Improvement in October 2016. This was rated green by NHS Improvement. Following feedback sessions held in December 2016, NHS Improvement circulated further guidance on what to include in the report and this has been incorporated.

East Cheshire Trust is currently working with Trusts in Greater Manchester and also separately with Trusts in Cheshire and Wirral on reviewing pharmacy infrastructure services with a view to having 80% of pharmacy time devoted to clinical activities.

Areas for collaboration include:

- Procurement and Distribution
- Medicines Information
- Aseptic Services
- Manufacturing
- Digital medicines and Automation

The recommendations from the Carter review need to be implemented by April 2020, the work currently being undertaken will help to achieve implementation by this date.
East Cheshire NHS Trust Hospital Pharmacy Transformation Plan

1. Introduction

Lord Carter of Coles report on identifying unwarranted variations in the NHS was published in February 2016. Within this report there was a review of hospital pharmacy and medicines optimisation and a number of recommendations made for trusts to implement by 2020 (appendix 1).

Trusts are required to submit a board-approved hospital pharmacy transformation plan (HPTP) to NHS Improvement by April 2017 outlining how they will meet their model hospital metrics and specific recommendations from the Carter report.

East Cheshire NHS Trust is an integrated community and acute trust. The acute trust has 350 beds, circa 35,000 admissions, 210,000 out-patient & 53,000 A&E attendances. The pharmacy workforce consists of approximately 65 WTE and deliver dispensary pharmacy services, aseptic services, ward based clinical services as well as a MHRA licensed manufacturing unit and a locally commissioned hospital pharmacy outreach service. The pharmacy services provided are well developed and new innovative ways of working are implemented. We have a paperless ordering of in-patient medications from ward level and have recently introduced a new role with pharmacy staff administering medications to patients, releasing nursing time and reducing delayed and omitted medicines.

Macclesfield hospital is located south of Manchester and has a number of clinical pathways with hospitals within the Greater Manchester (GM) area. The three closest hospitals being Stockport NHS Foundation Trust (11 miles), University Hospital of South Manchester (14 miles) and Central Manchester University Hospitals NHS Foundation Trust (18 miles). East Cheshire NHS Trust however does not fall within the GM Footprint and from a sustainability and transformational plan (STP) perspective East Cheshire sits within Cheshire and Merseyside with the two closest hospitals in this footprint being Mid-Cheshire NHS Foundation trust (22 miles) and the Countess of Chester (43 miles).

Completion of the local assessment and action planning tool and review of the model hospital pharmacy metrics (appendix 2) and NHS Benchmarking submission has identified a number of positives:

- Low cost of pharmacy staff and medicine cost per WAU (in best 25% of Trusts nationally)
- Scoring green nationally for both number of incidents reported and % causing harm/death
- Days stockholding

as well as areas for development:

- Implementation of electronic prescribing
- Medicines reconciliation within 24 hours
- Use of summary care record
- Weekend clinical pharmacy MAU service
- Reduce daily deliveries
With regards to the specific metrics within the Carter report, East Cheshire Trust has identified a number of partners to work with and further investigate potential collaboration. East Cheshire NHS Trust is actively in discussions with the Greater Manchester Hospital Pharmacy Transformation Collaborative (GMHPTC) and also hospitals within Cheshire and Wirral (Mid Cheshire Hospitals NHS Foundation Trust, Countess of Chester Hospital NHS Foundation Trust and Wirral University Teaching Hospital NHS Foundation Trust). There are also initial discussions looking at extending this to the whole of the Cheshire & Merseyside STP footprint. These discussions are focussing on infrastructure services such as procurement/stores, aseptics, manufacturing and Medicines Information (MI).

East Cheshire NHS Trust is also looking at completing an internal pharmacy workforce review to support more pharmacist prescribers and extend the role of the pharmacy technicians and support staff, pushing traditional role boundaries to ensure 80% focus on clinical activity as per the recommendations of the Lord Carter report.

2. Carter Metrics and Model Hospital benchmarks

<table>
<thead>
<tr>
<th>Metric</th>
<th>Current performance</th>
<th>Planned performance</th>
<th>Actions to achieve plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop HPTP plans at a local level with each trust board nominating a lead Director</td>
<td>HPTP sign off process agreed. Medical Director designated as lead director</td>
<td>On track to achieve by March 2017</td>
<td>HTPT draft to be submitted to NHSI Oct 2016. Final plan to go to board March 2017 and submission to NHSI 31st March 2017</td>
</tr>
<tr>
<td>Ensuring that more than 80% of pharmacist resource is on non-infrastructure activities. Review collaboration/partnership for provision of infrastructure services</td>
<td>80% of pharmacist time is currently clinical. No infrastructure services delivered collaboratively</td>
<td>90% of pharmacist time on clinical. Procurement, MI, and other services to be provided through collaboration</td>
<td>MI to be delivered by regional centre/partner trust. Discussions actively underway with other hospitals re: collaboration (see section 3 below)</td>
</tr>
<tr>
<td>Chief Clinical Information Officer moving prescribing and administration from traditional paper charts to Electronic Prescribing and Medicines Administration systems (EPMA)</td>
<td>Electronic prescribing in place for chemotherapy only. Traditional paper prescriptions for in-patient and out-patient prescribing</td>
<td>Full EPMA rolled out across organisation by 2020</td>
<td>Implementation of EPMA is on the trust digital road map for beginning of implementation in 2018</td>
</tr>
<tr>
<td>Finance Director, working with their Chief Pharmacist, ensuring that coding of medicines, particularly high cost drugs, are accurately recorded within NHS Reference Costs</td>
<td>In place</td>
<td>In place</td>
<td>No further action required</td>
</tr>
<tr>
<td>NHS Improvement publishing a list of the top 10 medicines with savings opportunities monthly for trusts to pursue;</td>
<td>Awaiting publication of saving opportunities. Process in place via lead speciality pharmacists/MMG to review</td>
<td>In place</td>
<td>No further action required</td>
</tr>
</tbody>
</table>
from 20 to 15, deliveries to less than 5 per day and ensuring 90% of orders and invoices are sent and processed electronically;

<table>
<thead>
<tr>
<th></th>
<th>22</th>
<th>10</th>
<th>Current pharmacy stock control system does not allow for e-invoicing. New system being procured for roll out July 2017 – e-invoicing to be included.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Electronic orders – 84%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Electronic invoicing – 0%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Electronic orders – 95%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Electronic invoicing – 90%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Weekend ON WARD Clinical Pharmacy Hours of Service (MAU)</th>
<th>0%</th>
<th>100%</th>
<th>Pharmacy workforce review Business case to be submitted to support implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicines Reconciliation within 24 hours of Admission</td>
<td>61%</td>
<td>95%</td>
<td>Pharmacy workforce review Business case to be submitted to support implementation</td>
</tr>
</tbody>
</table>

3. HPTP Plan Summary

In order to meet the recommendations of Lord Carter’s report and the model hospital metrics, East Cheshire NHS Trust will take a dual approach to deliver its hospital pharmacy transformation plan. This approach will consist of an internal service review as well as looking to collaborate with partners on infrastructure services.

The vision for pharmacy is to have clinical pharmacy services based at ward level. This will consist of prescribing pharmacists actively prescribing for in-patients and on discharge supported by clinical technicians doing basic prescription screening, transcribing discharges and drug histories/medicines reconciliation. There will be a pharmacist free dispensary with discharges being actively processed at ward level (if not out-sourced). Patients who may require support post discharge will be referred to the already established hospital pharmacy outreach team (NIMO service) who will visit patients in their homes to review medicines adherence and any other issues. The NIMO service also review high risk patients referred from primary care with a view to preventing admissions to hospital – this will be further supported by clinical pharmacists in the emergency department to deliver a closed loop clinical pharmacy service.

In order to achieve this, the workforce review will need to include a full training needs analysis. The traditional role of the technician will need to be expanded and supported by undertaking a clinical diploma. There will be requirement to access training for both pharmacists (prescribing course/diploma) and technicians.

The second part of this approach is to look at what infrastructure services can be delivered in collaboration with third parties. East Cheshire has previously looked at third party provision of out-patient dispensing services and aseptic services but it was not deemed cost effective to pursue further. There is now an opportunity to revisit these, and other services, on a larger scale with a number of other NHS trusts.

East Cheshire NHS Trust is in discussions with the Greater Manchester Hospital Pharmacy Transformation Collaborative (GMHPTC) which has been established as part of health and social care devolution in Greater Manchester. GMHPTC reports to the GMHSC strategic partnership board and is challenged with delivering hospital pharmacy recommendations form the Carter report.

The collaborative membership, as detailed below, depicts a diverse and all-encompassing participation form healthcare providers across GM and beyond. This level of collaboration ensures unwarranted hospital pharmacy variation can be challenged across a complete GM
healthcare footprint and permits hospital pharmacy efficiency and productivity to be scrutinised across the region as a whole.

**GMHPTC Membership**

5 Boroughs Partnership NHS FT, Bolton NHS FT, East Cheshire NHS Trust, Greater Manchester West NHS FT, Pennine Acute Hospital NHS Trust, Pennine Care NHS FT, Stockport NHS FT, Tameside and Glossop Integrated care NHS FT, University Hospital of South Manchester NHS FT, Wrightington, Wigan and Leigh NHS FT

Reviewing local and regional provision of pharmacy infrastructure services is the focus for GMHPTC and prioritising these reviews was deemed essential. Appendix 3 is a prioritisation matrix which the group developed to enable differentiation into 4 categories—priority, will do, should do and won’t do.

**Variable Infrastructure Services**

**Supply Chain Management**

McKesson, on a consultancy basis, are supporting GMHPTC Trusts in undertaking a comprehensive assessment of the pharmacy supply chain across the region. Data from the collaborative has been provided for review and analysis and detailed visits to Central Manchester NHS Foundation Trust and Stockport NHS Foundation Trust have been conducted. The final report, detailing a summary of McKesson's findings, innovative practice and a series of options for the GMHPTC to consider will direct future supply chain workstreams and will be available in the coming months. Discussions with pharmacy wholesalers to condense and streamline the number of pharmacy deliveries are on-going and Specialist Pharmacy Services Procurement KPI’s are being piloted across three sites within GM with the intention being to adopt and report monthly from April 2017.

**Greater Manchester Patient Own Drug (POD) Campaign**

The use of patients’ own drugs throughout hospital admission is a quality initiative that many Trusts have explored in the past. Launching a GMHPTC campaign across the region will revive historic programmes and will communicate, with consistency, how patients and healthcare professions should manage patient own medication on admission into hospital. Administering PODs can lead to fewer missed doses and reduces patient confusion on discharge as familiarity with medication supports adherence. This campaign also aligns with the NHS financial agenda as medication will not have to be reissued from Hospital pharmacy stock. Reduced inpatient dispensing, supporting Lord Carter’s recommendations, will also create additional workforce capacity to invest in direct medicines optimisation activities.

Scoping exercise for the following areas will commence in the coming months

**Aseptics strategy across GM.**

Initially a scoping exercise will review aseptic resource and capacity across the region. A data request has been developed and dissemination to aseptic service managers is imminent. Data analyses is scheduled for April 2017 and once complete a GM collaborative aseptic strategy can be developed ensuring demand across GM, and potentially beyond, is achieved. Various delivery proposals will be considered as part of this review.
Outpatients and Homecare.

Review current service delivery models across GM identifying potential opportunities to enhance, transform and collaborate.

Education and training programme.

Ensure Trusts across GM are working to common clinical standards, reducing variation in service provision. Training for pharmacists and technicians will be standardised and utilising higher level apprenticeships will be explored. As a priority NMP training for pharmacists will be reviewed to increase the number of actively prescribing pharmacists across the region.

Digital Medicines and automation

The project group will work with GM organisations supporting dm+d / GS1 / PEPPOL compliance and the implementation of electronic prescribing. Promoting the transfer of health data is a priority for the group as is developing and implementing an electronic communications and referrals system with community pharmacy and GP practice pharmacists. Projects within scope include trialling closed loop prescribing and assessing how automation can create efficiencies within services such as aseptics and enhance the transfer and administration of medicines.

Medicines information.

Understand local service provision and then, in conjunction with the ongoing Specialist Pharmacy Services review, explore delivery options across GM.

Research and Development.

A collaborative approach to R&D service provision will be explored.

East Cheshire NHS Trust is also having discussions along similar lines with Mid Cheshire Hospitals NHS Foundation Trust, Wirral University Teaching Hospital NHS Foundation Trust and The Countess of Chester Hospital NHS Foundation Trust on collaborative pharmacy services (Appendix 4). The following areas have been identified as potential areas for collaboration which require further investigation:

- Out-sourced outpatient pharmacy (wholly owned subsidiary/third party provider)
- Aseptic services
- Procurement/stores and distribution
- Homecare services
- Medicines Information (MI)
- Formulary management and application
- Pre-packing/manufacturing units
- Community pharmacy post discharge follow ups
- Education and training

A risk-benefit exercise has started and will report back shortly. There are also very early conversations to look at this collaboration at a wider STP footprint level with some initial comparison of benchmarking data commencing.
East Cheshire NHS Trust also provides a manufacturing/over-labelling service. This is being reviewed as part of the national review of manufacturing units which will come under the Specialist Pharmacy Services umbrella. Discussions are also on-going with other local manufacturing units with East Cheshire NHS Trust actively looking at an exit strategy that will not adversely affect patient services at other NHS Trusts that rely on this service.

4. Risks and mitigations

**Capital risk.**
Insufficient capital to invest in hospital pharmacy transformation solutions has been identified as a risk by the collaborative as restricted funding would impact on identified service improvements. For GMHPTC, the creation of the Finance Executive Group (FEG), by the GMHSC board, helps to mitigate this risk as the FEG will identify and manage financial risks associated with the delivery of the GM Strategic Plan. As East Cheshire Trust is not part of the GM footprint, and transformational money received for the GMHPTC would only be for those Trusts in GM putting a financial pressure on East Cheshire NHS Trust

**Workforce capacity.**
Due to the abundance of initiatives currently taking place across GM (Manchester Single Hospital Service, creating hospital chains across the region, Carter/HoPMOp implementation) there is a risk that some organisations won’t have the capacity to deliver additional transformational work while still meeting local operational demands. Consequently this would impact on agreed transformational deadlines and delay service enhancement.

**Training.**
In order to deliver some of the Carter metrics (increase in the number of pharmacist prescribers), it will be dependent on access to training and the availability of training funds. The East Cheshire NHS Trust also relates to increasing the clinical role of the technician through clinical diploma – again this is dependent on access to training budgets.

5. Issues and mitigations

**Geography.**
East Cheshire NHS Trust is located South of Manchester with a number of clinical pathways/partnerships with GM. The three closest hospitals are all within GM. However, East Cheshire NHS Trust sits within the Cheshire & Merseyside footprint. By collaborating within the STP there will be potential difficulties with certain services (e.g. receiving urgent chemotherapy). As mitigation we are currently collaborating with both STP partners and the GMHPTC.

**Information Management and Technology**
Across GM and Cheshire & Wirral there is recognition that IM&T is a critical dependency which underpins the ability to deliver many of the transformation plans. GMHPTC will initiate discussions with pharmacy IT provider to determine how limitations can be overcome. A similar project will need to take place in Cheshire and Wirral.
**Local Contracts.**

Throughout the collaborative existing provider contracts will impact the delivery of infrastructure reviews and service redesign. Strategically this will need to be taken into consideration whilst project plans are being developed.

**7 Day Services.**

In order to expand the current clinical pharmacy provision to provide a service on MAU 7 days a week, this will require additional investment in the pharmacist WTE. To mitigate for this, any savings that are identified by collaborating on infrastructure services will need to be re-invested in the clinical aspects of the service.
Appendix 1 – Carter Model Hospital Pharmacy Metrics

Lord Carters’ final report contained the following specific recommendations for transforming hospital pharmacy services and medicines optimisation which need to be implemented by NHS trusts

Recommendation 3: Trusts should, through a Hospital Pharmacy Transformation Programme (HPTP), develop plans by April 2017 to ensure hospital pharmacies achieve their benchmarks such as increasing pharmacist prescribers, e-prescribing and administration, accurate cost coding of medicines and consolidating stockholding by April 2020, in agreement with NHS Improvement and NHS England so that their pharmacists and clinical pharmacy technicians spend more time on patient facing medicines optimisation activities. Delivered by:

a) developing HPTP plans at a local level with each trust board nominating a Director to work with their Chief Pharmacist to implement the changes identified, overseen by NHS Improvement and in collaboration with professional colleagues locally, regionally and nationally; with the Chief Pharmaceutical Officer for England signing off each region’s HPTP plans (brigaded at a regional level) as submitted by NHS Improvement;

b) ensuring that more than 80% of trusts’ pharmacist resource is utilised for direct medicines optimisation activities, medicines governance and safety remits while at the same time reviewing the provision of all local infrastructure services, which could be delivered collaboratively with another trust or through a third party provider;

c) each trust’s Chief Clinical Information Officer moving prescribing and administration from traditional paper charts to Electronic Prescribing and Medicines Administration systems (EPMA);

d) each trust’s Finance Director, working with their Chief Pharmacist, ensuring that coding of medicines, particularly high cost drugs, are accurately recorded within NHS Reference Costs;

e) NHS Improvement publishing a list of the top 10 medicines with savings opportunities monthly for trusts to pursue;

f) the Commercial Medicines Unit (CMU) in the Department of Health undertaking regular benchmarking with the rest of the UK and on a wider international scale to ensure NHS prices continue to be competitive, and updating its processes in line with the Department of Health’s NHS Procurement Transformation Programme as well as giving consideration as to whether the capacity and capability of the CMU is best located in the Department of Health or in the NHS, working alongside NHS England’s Specialist Pharmacy Services and Specialised Commissioning functions;

g) consolidating medicines stock-holding and modernising the supply chain to aggregate and rationalise deliveries to reduce stock-holding days from 20 to 15, deliveries to less than 5 per day and ensuring 90% of orders and invoices are sent and processed electronically; and,

h) NHS improvement, building on and working with NHS England commissioned Specialist Pharmacy Services, should identify the true value and scale of the opportunity for rationalisation and integration of hospital pharmacy procurement and production, developing
an NHS Manufactured Medicines product catalogue and possibly moving towards a four region model for these services.

<table>
<thead>
<tr>
<th>CLINICAL SERVICES</th>
<th>VARIABLE INFRASTRUCTURE SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MEDICINES OPTIMISATION</strong></td>
<td>SUPPLY CHAIN</td>
</tr>
<tr>
<td>1 Patient facing; ward pharmacy; medicines reconciliation; medicines discharge; prescribing; Out-patient and Pre-Admission Clinics; specialist Pharmacists; medicines administration and support</td>
<td></td>
</tr>
<tr>
<td>2 Organisational Assurance: Medicines Safety Officer; Governance role of Chief Pharmacist; Audit Programmes</td>
<td></td>
</tr>
<tr>
<td>Store/distribution and procurement; Aseptic; Production QC; Dispensing; Homecare</td>
<td></td>
</tr>
<tr>
<td>Training provided to Pre-Registration Pharmacists and Technicians; NVQ Assistant staff; Post-Registration Pharmacy staff</td>
<td></td>
</tr>
<tr>
<td>Medicines Information; Formulary</td>
<td></td>
</tr>
<tr>
<td>Clinical Trials; Departmental Research</td>
<td></td>
</tr>
<tr>
<td>Community; Mental Health; Hospices; Prisons; Care Homes; GPs</td>
<td></td>
</tr>
</tbody>
</table>
## Appendix 2 – Model Hospital Pharmacy Metrics – East Cheshire NHS Trust

### Money & Resources

<table>
<thead>
<tr>
<th>Metric</th>
<th>Period</th>
<th>Trust Actual</th>
<th>Peer Median</th>
<th>National Median</th>
<th>Info</th>
<th>Variation</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacy Staff &amp; Medicines Cost per APU</td>
<td>2015/16</td>
<td>£273</td>
<td>£311</td>
<td>£350</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicines Cost per APU</td>
<td>2015/16</td>
<td>£320</td>
<td>£284</td>
<td>£322</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Cost Medicines per APU</td>
<td>2015/16</td>
<td>£98</td>
<td>£94</td>
<td>£112</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non High Cost Medicines per APU</td>
<td>2015/16</td>
<td>£134</td>
<td>£170</td>
<td>£196</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Choice of Parenteral Formulations (% IV Parenteral vs Total Spends “NEW”)</td>
<td>-</td>
<td>NOT AVAILABLE</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use of Generic Imipramine (% Generic vs Total Spend (Selected Drugs) “NEW”)</td>
<td>2016</td>
<td>0%</td>
<td>60%</td>
<td>60%</td>
<td></td>
<td>No trendline available</td>
<td></td>
</tr>
<tr>
<td>Use of Infusion Anaesthetics - % Spend on SedoFlurane “NEW”</td>
<td>-</td>
<td>NOT AVAILABLE</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Safe

<table>
<thead>
<tr>
<th>Metric</th>
<th>Period</th>
<th>Trust Actual</th>
<th>Peer Median</th>
<th>National Median</th>
<th>Info</th>
<th>Variation</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Antibiotic Consumption in DDD/1,000 Admissions</td>
<td>2015/16</td>
<td>7.413</td>
<td>4.514</td>
<td>4.549</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Exceedance vs Baseline &amp; Exclusions (Monthly)</td>
<td>-</td>
<td>NOT AVAILABLE</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% ePrescribing Chemotherapy</td>
<td>2014/15</td>
<td>100%</td>
<td>60%</td>
<td>50%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% ePrescribing IV</td>
<td>2015/16</td>
<td>20%</td>
<td>-</td>
<td>50%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% ePrescribing OP</td>
<td>2015/16</td>
<td>0%</td>
<td>-</td>
<td>50%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% ePrescribing Discharge</td>
<td>2014/15</td>
<td>100%</td>
<td>100%</td>
<td>60%</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

### Effective

<table>
<thead>
<tr>
<th>Metric</th>
<th>Period</th>
<th>Trust Actual</th>
<th>Peer Median</th>
<th>National Median</th>
<th>Info</th>
<th>Variation</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Pharmacy Activity [Pharmacist Time Spent on Clinical Pharmacy Activities] “NEW”</td>
<td>2015/16</td>
<td>85%</td>
<td>60%</td>
<td>60%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Pharmacists Activity Prescribing</td>
<td>2015/16</td>
<td>37%</td>
<td>14%</td>
<td>20%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Medicines Reconciliation Within 24 Hours of Admission</td>
<td>2015/16</td>
<td>90%</td>
<td>60%</td>
<td>73%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Use of Summary Care Record (or Local System) per Month</td>
<td>Aug 2015</td>
<td>48.9%</td>
<td>55.3%</td>
<td>52.1%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Scaled Preparations of Total Prescriptions Uptake</td>
<td>-</td>
<td>NOT AVAILABLE</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% ePrescribing of Total Prescriptions Uptake</td>
<td>-</td>
<td>NOT AVAILABLE</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% ePrescribing of Total Prescriptions Uptake (Monthly)</td>
<td>-</td>
<td>NOT AVAILABLE</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Spend on Sterilisation in 2015/16</td>
<td>-</td>
<td>NOT AVAILABLE</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dose-Rated Chemistry (Doses Delivered as Standardised Dose) “NEW”</td>
<td>2015/16</td>
<td>0%</td>
<td>30%</td>
<td>42%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Medication Incidents Reported to MHRA per 100,000 Patients of Hospital Care “NEW”</td>
<td>Mar 2016</td>
<td>37.84</td>
<td>294.5</td>
<td>285.6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Adverse Incidents Reported as Causing Harm or Death/All Medication Errors “NEW”</td>
<td>Mar 2016</td>
<td>9.4%</td>
<td>10.8%</td>
<td>9.7%</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Number of Days Stockholding</td>
<td>2015/16</td>
<td>15.2</td>
<td>20.5</td>
<td>18.8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pharmacy Deliveries per Day (Average Number of Deliveries)</td>
<td>2015/16</td>
<td>22</td>
<td>11</td>
<td>15</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e-Commerce - Ordering (Alliance) “NEW”</td>
<td>2015/16</td>
<td>84.7%</td>
<td>89.9%</td>
<td>90.4%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e-Commerce - Ordering (JAHR) “NEW”</td>
<td>2015/16</td>
<td>81.3%</td>
<td>82.5%</td>
<td>82.6%</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

### Effective

<table>
<thead>
<tr>
<th>Metric</th>
<th>Period</th>
<th>Trust Actual</th>
<th>Peer Median</th>
<th>National Median</th>
<th>Info</th>
<th>Variation</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Quality of NHS England Monthly Data Set Submissions From Providers “NEW”</td>
<td>Sep 2016</td>
<td>23</td>
<td>22</td>
<td>20</td>
<td></td>
<td></td>
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</table>

### Caring

<table>
<thead>
<tr>
<th>Metric</th>
<th>Period</th>
<th>Trust Actual</th>
<th>Peer Median</th>
<th>National Median</th>
<th>Info</th>
<th>Variation</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Inpatients Survey – Medicines Related Questions</td>
<td>2015/16</td>
<td>74.4%</td>
<td>78.6%</td>
<td>78.1%</td>
<td></td>
<td></td>
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</table>
### Responsive

<table>
<thead>
<tr>
<th>Period</th>
<th>Trust Actual</th>
<th>Peer Median</th>
<th>National Median</th>
<th>Info</th>
<th>Variation</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Samary ONWARD Clinical Pharmacy Hours of Service (HCU) EQUIVALENT</td>
<td>2015/16</td>
<td>0.0</td>
<td>-</td>
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</tbody>
</table>

### People, Management & Culture: Well-led

<table>
<thead>
<tr>
<th>Period</th>
<th>Trust Actual</th>
<th>Peer Median</th>
<th>National Median</th>
<th>Info</th>
<th>Variation</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Sickness Absence Rate</td>
<td>2015/16</td>
<td>3.8%</td>
<td>2.8%</td>
<td>3.1%</td>
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<td></td>
</tr>
<tr>
<td>% Staff with Appraisal Completed</td>
<td>2015/16</td>
<td>95%</td>
<td>92%</td>
<td>85%</td>
<td></td>
<td>No trendline available</td>
</tr>
<tr>
<td>% Staff with Statutory and Mandatory Training</td>
<td>2015/16</td>
<td>15%</td>
<td>94%</td>
<td>61%</td>
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<td>No trendline available</td>
</tr>
<tr>
<td>% Staff Turnover Rate</td>
<td>2015/16</td>
<td>15%</td>
<td>12%</td>
<td>14%</td>
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</tr>
<tr>
<td>% Staff Vacancy Rate &quot;NRA&quot;</td>
<td>2015/16</td>
<td>2%</td>
<td>3%</td>
<td>6%</td>
<td></td>
<td>No trendline available</td>
</tr>
</tbody>
</table>

**Indicators for which judgement of performance is not appropriate**
- Indicates where a high value denotes good performance
- Indicates where a low value denotes good performance

**Indicators where your current performance is better than the benchmark**
- 25% of Trusts with the lowest values

**Indicators where your current performance is worse than the benchmark**
- 25% of Trusts with the highest values

**Year Trust**
- Selected lower

**Selected lower**
- Selected lower

---

*East Cheshire NHS Trust*
Appendix 3 – GMHPTC Prioritisation Matrix

**High Priority**
- Store/distribution and procurement
- GM PODs campaign

**Will do**
- Review aseptic production
- Assess OP dispensing
- Assess Homecare
- Mental Health
- Workforce planning
- Digital medicines and automation

**Benefit**
- MI
- Clinical Trials

**Should do**
- Formulary - GMMMG

**Won’t do**
- Support enablers
  - NHSI and the HoPMOp team in developing, testing and implementing GM model hospital metrics across GM.
  - Benchmark MI services across GM.

**High Effort**
- Review aseptic resource and capacity across GM.
- Develop a GM aseptic strategy. In optimising productivity ensuring demand across GM is met. Various delivery proposals will be considered as part of this review.

**Low Effort**
- Ensure that more than 80% of Trusts pharmacy resource operating across 7 days, is utilised for direct medicines optimisation activities. Review pharmacy E&T and explore utilisation of higher level apprenticeships.

**GM Hospital Pharmacy Transformation**

SRO: Joanne Fitzpatrick, Programme Manager Gareth Adams

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Effort</th>
<th>High Priority</th>
<th>Will do</th>
</tr>
</thead>
<tbody>
<tr>
<td>MI</td>
<td></td>
<td>Review aseptic production</td>
<td>Assess OP dispensing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Assess Homecare</td>
<td>Mental Health</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Workforce planning</td>
<td>Digital medicines and automation</td>
</tr>
<tr>
<td>Clinical Trials</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Supporting enablers**

- HR
- INT
- Estates
- Communications
- Finance
- Legal

**Projects to be delivered in line with the recommendations set out in Lord Carter’s ‘Review of Operational Productivity in Hospitals’**

**Supporting enablers**

<table>
<thead>
<tr>
<th>Project SRO:</th>
<th>Project Manager:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mike Parks</td>
<td>Charlotte Skitterall</td>
</tr>
</tbody>
</table>

**Phase 2 of the review 2018-19**

Phase 2 of the project will include the following reviews across GM:

- Medicines Information - to understand local service provision and explore collaboration
- Clinical Trials - to explore the development of standard operating procedures and encourage a collaborative approach to research and development service provision

**Projects to be delivered in line with the recommendations set out in Lord Carter’s ‘Review of Operational Productivity in Hospitals’**

**Supporting enablers**

- Project SRO: Mike Parks
- Deputy SROs: Charlotte Skitterall, Philippa Jones

**Homecare review**

- Review current service delivery models across GM / nationally to identify potential opportunities to enhance, transform and collaborate
- Project SRO: Mike Parks
- Deputy SROs: Charlotte Skitterall, Philippa Jones
- Status: Not commenced (scheduled 2017/18)

**Outpatient dispensing review**

- Review current service delivery models across GM / nationally to identify potential opportunities to enhance, transform and collaborate
- Project SRO: Charlotte Skitterall
- Deputy SROs: Rob Duncombe, Paul Buckley, Mike Parks
- Status: Not commenced (scheduled 2017/18)

**GM POD Campaign**

- Develop and launch a collaborative Patient-Derived Drug campaign across GM. Baseline assessment will be measured as will the quality and financial impact of the campaign
- Project SRO: Collaborative
- Project Manager: Gareth Adams
- Status: Green. Likely launch April 2017

**As per the McKesson review. Consider opportunities identified and implement transformation to deliver Carter’s recommendations**
Appendix 4 – Cheshire and Wirral HPTP Prioritisation Strategy

Priority
- Aseptic services
- Procurement and distribution
- In/Outsourcing outpatients

Will do
- Homecare
- Formulary management & Shared Care
- Work force planning.
- Education and training
- Community pharmacy post discharge follow ups

Consider Future Review
- Medicines information
- Pre-packing
Cheshire and Wirral HPTP Prioritisation Strategy

The prioritisation strategy has been formulated by the Directors of Pharmacy from the three acute Trusts and the Cheshire and Wirral Partnership Mental Health Trust. The group has prioritised aseptics, procurement and distribution and in/outsourcing outpatient dispensing. These services were chosen because the group feels that these are substantial elements of the hospital pharmacy service, have been highlighted nationally as collaboration options and could have service delivery and financial benefits for the organisations involved.

The group have also highlighted some work streams which will run alongside the main projects. These include homecare medicines which will form part of and is dependent on the in/outsourcing outpatient dispensing project.

Formulary management & shared care pathway work stream is a project the group agrees will develop as the Strategy and collaboration develops. This will involve sharing current practice and working together on new developments to promote standardised practise throughout the group.

Work force planning and education and training are work streams which will be evaluated by the group. This will include an evaluation of the key future roles for pharmacy staff and how the profession will best support and develop the NHS over the next 10 years. Areas of interest of this work stream will include non-medical prescribing pharmacists and pharmacy technicians administering medicines. Education and training will focus on the current resources and delivery with an aim to collaborate where appropriate and the future needs of the pharmacy work force.

Community pharmacy post discharge follow ups is a project which 2 of the Acute Trusts have already signed up to pilot, so this will be monitored as part of the work plan.

The Medicines Information (MI) project is being progressed by the Cheshire and Mersey group so will not form part of the Cheshire and Wirral priority.

The pre-packing project will not be considered initially as there are national changes involving supply chains, audit trail and IT systems which may impact of NHS pre-packing units.

The group has decided not to progress outsourcing inpatient dispensing as this looks to have no service delivery or financial benefits to the group.
Enablers for this strategy are education and training, workforce planning and IT systems. Each of these will be substantial elements of the projects and will form part of the project plans.

### Summary table of Strategy

<table>
<thead>
<tr>
<th>Prioritisation</th>
<th>Financial</th>
<th>Practical</th>
<th>Risks</th>
<th>Benefits</th>
<th>Immediate actions and time frame for scoping exercise.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Aseptic services. Lead – Kash Haque (KH).</td>
<td>Very high capital costs for new units but this will be explored. Established units could be utilised. Such units will need investment.</td>
<td>Yes, site for manufacturing can be anywhere. Trusts can retain small facility on site for more urgent items. Or scale up established hospital based aseptics units</td>
<td>Business continuity required in the event of unit failure if unit numbers are reduced.</td>
<td>Avoid cost of managing individual units. Economy of scale may be offset to some extent by need to retain on site small facility.</td>
<td>KH to email out a data collection tool for the Chief Pharmacists to respond to. KH to produce a report following the responses. January 2017</td>
</tr>
<tr>
<td>1. Procurement and distribution. Lead – Pippa Roberts (PR).</td>
<td>Potential to make efficiency savings at individual Trusts. Potential savings from set up and maintenance of one drug catalogue. Chasing out of stocks Shared expiry costs Shared costs of high cost, infrequently used.</td>
<td>Could provide efficiencies in procurement processes. Such a project has been successfully implemented in Scotland</td>
<td>Cost of setting up local system may neutralise or significantly erode savings from setting it up. IT system dependent</td>
<td>Low – moderate</td>
<td>KH to email out a data collection tool for the Chief Pharmacists to respond to. PR to produce a report following the responses. February 2017</td>
</tr>
<tr>
<td>Prioritisation</td>
<td>Financial</td>
<td>Practical</td>
<td>Risks</td>
<td>Benefits</td>
<td>Immediate actions and time frame for scoping exercise.</td>
</tr>
<tr>
<td>----------------</td>
<td>-----------</td>
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<td>---------------------------------------------------</td>
</tr>
<tr>
<td>1. In/Outsourcing outpatients. Lead - Karen Thomas, Chris Green. (KT, CG).</td>
<td>Should generate savings. Moderate setting up costs and staffing costs will offset savings.</td>
<td>Need to evaluate collaboration benefits/risks. If not viable a joint tender may provide better value for money.</td>
<td>Gain share opportunities with local commissioners are uncertain NHSE have suggested they will pay £30 per item dispensed through a VAT free route.</td>
<td>Depends on volume of outpatient spend but should provide additional capacity for busy departments.</td>
<td>KT to email out a variation of the NHSE template for individual Trusts to ascertain if in/outsourcing is a viable option. KT, CG to produce a project plan for viable Trusts and for collaboration for unviable Trusts. March 2017</td>
</tr>
<tr>
<td>2. Homecare. Lead – Karen Thomas, Chris Green. (KT, CG).</td>
<td>Should generate savings.</td>
<td>Eliminates homecare services provided by third party providers, eliminates need for homecare teams and associated governance issues. Dependent on successful implementation of an out/insourced outpatient pharmacy.</td>
<td>Patients will have to collect medicines or hospital to fund a delivery service.</td>
<td>Significant benefits around governance, staff releasing and control.</td>
<td>This will be dependent on the outcome of the In/Outsourcing outpatients’ project.</td>
</tr>
<tr>
<td>2. Formulary management &amp; Shared Care. Lead - Fiona Couper, Chris Green (FC, CG).</td>
<td>Opportunities around consistent prescribing, modest saving of staff time.</td>
<td>Small scale initial collaboration targeting specific areas would be doable with current resources.</td>
<td>Might be hard to get agreement across patch.</td>
<td>Avoids duplication of work.</td>
<td>FC, CG to evaluate each Trusts current system for formulary application and the formulary management. FC, GC to develop a list of shared care agreements in place for each organisation</td>
</tr>
<tr>
<td>Prioritisation</td>
<td>Financial</td>
<td>Practical</td>
<td>Risks</td>
<td>Benefits</td>
<td>Immediate actions and time frame for scoping exercise.</td>
</tr>
<tr>
<td>----------------</td>
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<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>2. Work force planning Lead - Karen Thomas, Kash Haque (KT, KH).</td>
<td>Limited savings. Negate locum costs.</td>
<td>Collaborative work around scoping of key and emerging services/pressures will benefit all members of the group. May need to involve Health Education England.</td>
<td>Long lead time to get trained staff in place. Demand may initially outstrip supply.</td>
<td>Fit for purpose workforce which is in line with the group’s strategy</td>
<td>Underpins strategy. KT, KH to develop a collaborative workforce plan with the group taking in to account future service plans. June 2017</td>
</tr>
<tr>
<td>2. Education and training Lead – Pippa Roberts, Fiona Couper (PR, FC).</td>
<td>Limited savings for individual Trusts in resources allocated to pharmacy and medication related education and training.</td>
<td>Collaborative scoping exercise around current resources utilised in pharmacy and medication related Trust wide training. Opportunities to standardise education and training across the group.</td>
<td>Will need to ensure elements are tailored to individual Trusts needs and practices. May not be applicable to all areas of education and training.</td>
<td>Standardization of education and training. Avoids duplication at individual Trusts.</td>
<td>Underpins strategy. PR, FC to ascertain current provision of education and training and scope any collaboration opportunities. August 2017</td>
</tr>
<tr>
<td>2. Community pharmacy post discharge follow ups Lead - Karen Thomas, Chris Green.</td>
<td>Low set up costs. IT hardware costs. Pharmacy resource to complete referral to community pharmacy</td>
<td>If most efficient IT solution used then this would have limited impact on workload</td>
<td>Hospital and community pharmacy buy-in needed.</td>
<td>Patient’s medications are checked by the community pharmacy post-discharge.</td>
<td>Pilots are being undertaken in 2 acute hospitals as part of an NHSE funded project. The results of the pilots will be fed back to the group.</td>
</tr>
<tr>
<td>Prioritisation</td>
<td>Financial</td>
<td>Practical</td>
<td>Risks</td>
<td>Benefits</td>
<td>Immediate actions and time frame for scoping exercise.</td>
</tr>
<tr>
<td>---------------</td>
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<td>------------------------------------------------------</td>
</tr>
<tr>
<td>3. NHS Pre-packing.</td>
<td>Low cost but high volume. Largely cost neutral at small scale. New legislation around counterfeit medicines, dm &amp; d may make this option non-viable</td>
<td>Benefits could include control over supply chain – more robust. However there changes around medication legislation may make this unpractical for NHS units</td>
<td>New legislation. Lack of interest from local NHS units</td>
<td>Potential improvements in supply chain</td>
<td>For future review.</td>
</tr>
<tr>
<td>4. In/outsourcing Inpatient dispensary.</td>
<td>Unlikely to generate savings as each site will require a dispensary and dispensary staff, and inpatient medicines are not VAT free. Discharge prescriptions could go through an outsourced dispensary</td>
<td>Not really a practical option for collaboration for inpatient supply but is for discharge prescriptions</td>
<td>High for omitted doses and waste</td>
<td>Low (excluding discharge prescriptions)</td>
<td>Will not be progressed further.</td>
</tr>
</tbody>
</table>
Appendix B

Model Hospital Reporting of East Cheshire Trust Position in Comparison with Other NHS Organisations 2015/16

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Dashboard - Model Hospital - Internet Explorer

NHS Improvement Model Hospital Portal

Welcome Julia, please select a provider:
East Cheshire NHS Trust (RUN)

Period: Latest

Cost per WAU (MFF adjusted)

£3,894
2015/16

Potential Productivity Opportunity (PPO) %

15.8%
2015/16

Surplus / Deficit as % of Expenditure

-13.7%
2015/16

Total pay cost per WAU

£2,497
2015/16

Total non-pay cost per WAU

£1,397
2015/16

---
Model Hospital Reporting of East Cheshire Trust Split of Substantive Pay Costs in Comparison with Peer NHS Organisations 2015/16

![Dashboard with data on pay costs](image)

### Test Headline Metrics, Pay

<table>
<thead>
<tr>
<th>Metric</th>
<th>Period</th>
<th>Trust Actual</th>
<th>Lower Quartile</th>
<th>National Median</th>
<th>Upper Quartile</th>
<th>Peer Median</th>
<th>Info</th>
<th>Distribution</th>
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<tbody>
<tr>
<td><strong>All pay costs</strong></td>
<td>2015/16</td>
<td>£2,497</td>
<td>£2,033</td>
<td>£2,146</td>
<td>£2,298</td>
<td>£2,383</td>
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<td><strong>Pay costs by employment type</strong></td>
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<tr>
<td>Substantive staff cost per WAU</td>
<td>2015/16</td>
<td>£2,068</td>
<td>£1,754</td>
<td>£1,858</td>
<td>£1,958</td>
<td>£2,010</td>
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<tr>
<td>Non-Substantive staff cost per WAU</td>
<td>2015/16</td>
<td>£429</td>
<td>£227</td>
<td>£306</td>
<td>£360</td>
<td>£367</td>
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<tr>
<td>Uncapsitalised staff cost %</td>
<td>2015/16</td>
<td>99.5%</td>
<td>99.3%</td>
<td>99.6%</td>
<td>99.8%</td>
<td>100.0%</td>
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<tr>
<td><strong>Substantive staff by type</strong></td>
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<td></td>
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<td></td>
<td></td>
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<tr>
<td>Medical staff cost per WAU</td>
<td>2015/16</td>
<td>£392</td>
<td>£462</td>
<td>£517</td>
<td>£558</td>
<td>£511</td>
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<tr>
<td>Nursing staff cost per WAU</td>
<td>2015/16</td>
<td>£933</td>
<td>£644</td>
<td>£710</td>
<td>£782</td>
<td>£807</td>
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<td>AHP staff cost per WAU</td>
<td>2015/16</td>
<td>£298</td>
<td>£100</td>
<td>£122</td>
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<td>Healthcare science and Other STF staff cost</td>
<td>2015/16</td>
<td>£102</td>
<td>£131</td>
<td>£152</td>
<td>£172</td>
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<td>Corporate, admin, and estates staff cost per WAU</td>
<td>2015/16</td>
<td>£343</td>
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<td>£343</td>
<td>£393</td>
<td>£400</td>
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<tr>
<td>Corporate and admin staff cost as % of income</td>
<td>2015/16</td>
<td>9.4%</td>
<td>7.2%</td>
<td>8.2%</td>
<td>8.6%</td>
<td>8.8%</td>
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</table>
Model Hospital Reporting of East Cheshire Trust Split of Non Substantive Pay Costs in Comparison with Peer NHS Organisations 2015/16

<table>
<thead>
<tr>
<th>Non-Substantive staff by type</th>
<th>Period</th>
<th>Trust Actual</th>
<th>Lower Quartile</th>
<th>National Median</th>
<th>Upper Quartile</th>
<th>Peer Median</th>
<th>Info</th>
<th>Distribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency staff cost per WAU</td>
<td>2015/16</td>
<td>£234</td>
<td>£114</td>
<td>£163</td>
<td>£232</td>
<td>£208</td>
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<tr>
<td>Other Non-Substantive staff cost per WAU</td>
<td>2015/16</td>
<td>£195</td>
<td>£96</td>
<td>£122</td>
<td>£165</td>
<td>£135</td>
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</tbody>
</table>

![Graph showing performance indicators and distribution](image)
Model Hospital Reporting of East Cheshire Trust Split of Non Pay Costs in Comparison with Peer NHS Organisations 2015/16

<table>
<thead>
<tr>
<th>By type of non-pay</th>
<th>Period 2015/16</th>
<th>Trust Actual</th>
<th>Lower Quartile</th>
<th>National Median</th>
<th>Upper Quartile</th>
<th>Peer Median</th>
<th>Info</th>
<th>Distribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supplies and services cost per WAU</td>
<td>£493</td>
<td>£223</td>
<td>£381</td>
<td>£491</td>
<td>£362</td>
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</tr>
<tr>
<td>Medicines cost per WAU</td>
<td>£230</td>
<td>£268</td>
<td>£312</td>
<td>£370</td>
<td>£290</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary, establishment costs, service charges, and rent/pension cost per WAU</td>
<td>£462</td>
<td>£100</td>
<td>£182</td>
<td>£242</td>
<td>£213</td>
<td></td>
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<td></td>
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<tr>
<td>Depreciation and improvements cost per WAU</td>
<td>£143</td>
<td>£96</td>
<td>£125</td>
<td>£167</td>
<td>£103</td>
<td></td>
<td></td>
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<tr>
<td>Clinical negligence and purchased healthcare cost per WAU</td>
<td>£100</td>
<td>£112</td>
<td>£146</td>
<td>£195</td>
<td>£187</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other non-pay cost per WAU</td>
<td>£98</td>
<td>£59</td>
<td>£75</td>
<td>£102</td>
<td>£71</td>
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</tbody>
</table>

Indicators for which judgement of performance is not appropriate:
- Indicators where a higher value is more desirable
- Indicators where a lower value is more desirable
- Indicates when your peer performance is better than the benchmark
- Indicates when your peer performance is worse than the benchmark
| **Report of:**  
| **Responsible Officer:**  
| **Accountable Officer:** | Director of Finance |
| **Author of Report:** | Nicola Greenfield, Deputy Director of Finance |
| **Subject/Title** | 2017-18 Budgets |

**Purpose of Paper**
- Provide a summary of the financial plan for 2017/18 including planned cost reductions;
- Update the Board on the detailed budget-setting outcome;
- Provide further information on the assumptions that underpin the financial plan.

**Action/Decision required**
- Approval

**Mitigates Risk Number: (identify)**
- **On Corporate Risk Register**
  - Corporate Risk 2342:
    - If the planned process and budget control process are not robust then there is a risk that the Trust will not achieve the financial control total.

**Link to Care Quality Commission Domain**
- Choose one of the following:
  - Safe
  - Caring
  - Responsive
  - Effective
  - Well-led ✓

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

**BAF – 3 – Financial Stability**
- 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

**Legal implications - (identify)**
- None

**Impact on quality**
- Positive impact on quality
<table>
<thead>
<tr>
<th>Resource impact</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impact of equality/diversity</td>
<td>None</td>
</tr>
</tbody>
</table>
| **Avoid acronyms or abbreviations - if necessary list:** | NHS I – NHS Improvement  
S&T – Sustainability and Transformation  
CCG – Clinical Commissioning Group  
QIPP - Quality, Innovation, Productivity and Prevention  
SC&VR – South Cheshire & Vale Royal  
NHS – National Health Service  
HR – Human Resources  
CNST – Clinical Negligence Schemes for Trusts  
CQUIN – Commissioning for Quality & Innovation  
STF – Sustainability & Transformation Fund |
### Public Trust Board
#### 30th March 2017

**Agenda Item Number 11: TB 17 (13)**

<table>
<thead>
<tr>
<th>Report of:</th>
<th>Director of Finance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responsible Officer:</td>
<td>Nicola Greenfield, Deputy Director of Finance</td>
</tr>
<tr>
<td>Accountable Officer:</td>
<td>Nicola Greenfield, Deputy Director of Finance</td>
</tr>
</tbody>
</table>

**Subject/Title**

2017-18 Budgets

**Background papers (if relevant)**

**Purpose of Paper**

Provide a summary of the financial plan for 2017/18 including planned cost reductions;

Update the Board on the detailed budget-setting outcome;

Provide further information on the assumptions that underpin the financial plan.

**Action/Decision required**

Approval

**Mitigates Risk Number: (identify)**

**On Corporate Risk Register**

Corporate Risk 2342:

If the planned process and budget control process are not robust then there is a risk that the Trust will not achieve the financial control total.

**Link to Care Quality Commission Domain**

Choose one of the following:

- Safe
- Caring
- Responsive
- Effective
- Well-led

**Link to:***

- Trust’s Strategic Direction
- Corporate Objectives

**BAF – 3 – Financial Stability**

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

**Legal implications - (identify)**

None

**Impact on quality**

Positive impact on quality

**Resource impact**

None
<table>
<thead>
<tr>
<th>Impact of equality/diversity</th>
<th>None</th>
</tr>
</thead>
</table>
| **Avoid acronyms or abbreviations - if necessary list:** | NHS I – NHS Improvement  
S&T – Sustainability and Transformation  
CCG – Clinical Commissioning Group  
QIPP - Quality, Innovation, Productivity and Prevention  
SC&VR – South Cheshire & Vale Royal  
NHS – National Health Service  
HR – Human Resources  
CNST – Clinical Negligence Schemes for Trusts  
CQUIN – Commissioning for Quality & Innovation  
STF – Sustainability & Transformation Fund |
1.0 **Introduction**

1.1 The Trust submitted its Annual Plan for 2017/18 to NHS Improvement (NHSI) on 23rd December 2017 in line with the national timescales. This was much earlier than previously and due to the early shortened timescales, the Trust’s detailed budget-setting processes ran in parallel with this.

1.2 In the Annual Plan submission, the Trust wasn’t able to meet the 2017/18 control total proposed by NHS Improvement (NHSI) as it felt it could not safely reduce costs sufficiently to meet this. Discussions regarding the control total have continued with NHSI.

1.3 The purpose of this paper is to:

- Provide a summary of the financial plan for 2017/18 including planned cost reductions;
- Update the Board on the detailed budget-setting outcome;
- Provide further information on the assumptions that underpin the financial plan.

2.0 **Financial Plans**

2.1 The Trust has still not yet been notified of the 2017/18 pay awards and therefore assumptions have been made regarding this. This is held in a reserve and will be released into individual budgets when confirmed.

2.2 Known service changes such as the full year effect of the South Cheshire and Vale Royal Community transfer have been taken into account in the financial plans. Further details will be given on these later in the paper.

3.0 **2017/18 Financial Position**

3.1 The submitted financial plan for 2017/18 is a deficit of £26.8m, after assuming delivery of a recurrent 2% cost reduction target totalling £3.4m.

3.2 As a result of not accepting the control total, the Trust is not able to assume that it will be eligible for the Sustainability & Transformation (S&T) Funding payment of £4.0m.

3.3 A summary of the movement from the 2016/17 plan and forecast outturn and the position for the next two years is provided in the table below.
3.4 This deficit is £9.1m higher than the control total of £17.7m the Trust has been given.

4.0 Progress since the Annual Plan submission

4.1 The Trust has now signed contracts in place with all main commissioners. The contract with its main commissioner, Eastern Cheshire CCG, was signed on the 1st February 2017 and with the Staffordshire and Derbyshire CCGs at the end of February.

4.2 The Trust has continued discussions with respect to the financial control target with NHSI. These discussions have focussed on whether the control total can be adjusted upwards to take account of the impact on the Trust position arising from the loss of the South Cheshire & Vale Royal Contract.
4.3 The Recovery Board confirmed that services should deliver a 2.4% QIPP target, and these plans are being worked on. Particular focus is on Theatres and Outpatients, where a specific Project Manager has been retained to focus on this.

5.0 **Budget Assumptions**

5.1 **Service Changes**

5.1.1 There have been a number of service changes which have occurred, and which have been included in our financial plan, including:

- The full year effect of losing the SC&VR community services contract, from October 2016;
- The full year effect of the transfer of inpatient stroke rehab to Stockport NHS Foundation Trust from October 2016;
- Our plan submission assumed Health Visiting services would transfer to another service provider. However, it has now been agreed that this will not take place until either later in 2017/18 or 2018/19. Therefore for the purposes of the plan, it has been assumed that Health Visiting will remain with the Trust for all of 2018/19, but will transfer in 2018/19, and both income and expenditure have been amended accordingly;
- Our plan submission assumed the recurrent funding of the newly established Frailty service at £1m. Following negotiations, it is now assumed that the funding level will be £0.7m, and both income and expenditure have been amended accordingly;
- It has not been assumed that Ward 5 will remain open during 2017/18.

5.2 **Basis of the income budgets**

5.2.1 The starting point for the activity plans has been 2016/17 forecast outturn based on Month 5. Detailed conversations with the Directorates involving Clinical Leads, Associate Directors / Heads of Service, Service Managers, Deputy Director of Operations, Finance, HR and planning staff have then taken place to discuss and agree activity plans on a specialty by specialty, and point of delivery basis.

5.2.2 These meetings have considered whether 2016/17 activity is sustainable, with reference to GP referral demand, commissioning intentions, service reconfigurations, and known service and staffing changes. In the main, the 2017/18 activity plans are at 2016/17 forecast outturn.

5.2.3 These activity plans have then been costed according to the national tariff, and are in the process of being signed off by the Clinical Lead and Associate Director.

5.3 **Inflation and other Generic Pressures**

5.3.1 The financial plan is constructed using the Trust’s budget-setting framework. Pay budgets are based on established posts at actual points of scale, with unsocial hours enhancements, mandatory training and sickness allowances built in where appropriate. Vacancies are budgeted at the bottom of scale,
5.3.2 with an allowance in the plan for small variations due to staff experience levels.

5.3.3 There has not yet been a formal announcement regarding a 2017/18 Agenda for Change pay award, however, the plan assumes a 1% pay award payable to all staff. This is held in a reserve until an announcement is made. It also takes into account the known national insurance increase. There is no change to employer’s pension contribution rates in 2017/18.

5.3.4 It has assumed that the impact of the implementation of the junior doctor’s contract changes is managed to a neutral outcome, in line with national guidance.

5.3.5 The financial plan allows for inflation in drugs prices, as calculated by the Chief Pharmacist, using a national model. The plan also allows for £1.2m of both expenditure and income (as it is received directly from Commissioners) for high cost drugs.

5.3.6 It also allows for specific contract inflation such as on the ISS contract. The financial plan takes into account the notified £0.9m increase in CNST premiums.

5.3.7 The financial plan also reflects account activity driven increases in costs relating to diagnostics and matches activity with expenditure in relation to proposed waiting list initiatives and other costs of delivering activity increases. Currently there are no plans to outsource activity, and the plan does not contain any budgets for this.

5.4 **CQUIN**

5.4.1 The Trust has agreed the overall CQUIN value, but has not yet agreed the split between targets or the quarterly profiling of schemes. The budget assumes the Trust will meet the CQUIN targets.

5.5 **Penalties**

5.5.1.1 There is a significant risk that if the Trust is not able to access the STF Funding, and thereby limit its exposure to penalties, that the CCG will be aggressive in its approach to applying penalties.

5.5.1.2 The Trust has made some provision for penalties against quality and access standards in its plan.

5.6 **Residual overspending risks**

5.6.1 During 2016/17 an extensive exercise of reviewing, and agreeing actions to deal with all residual / historical pressures was undertaken. This followed a previous detailed exercise during 2015/16. Therefore it was not anticipated to have a high number or value of issues to deal with as part of the 2017/18 budget-setting process. As such budget holders are expected to deal with pressures arising as part of their budgetary management processes or develop an additional local QIPP to fund these.

5.6.2 It is important to note though, that, not all risks present in the 2017/18 position will be mitigated against, and budget-holders will be required to manage and control their budgets rigorously in 2017/18.
5.6.3 The financial plan does not build in any further provision for winter.

6.0 **QIPP targets for 2017/18**

6.1 The East Cheshire Trust QIPP target for 2017/18 has been set in the original planning submissions as £3.4m, which is just over 2% of Trust expenditure. There are some costs which are excluded from QIPP targets such as capital and financing charges, CNST, pathology contract and the therefore this results in a 2.4% target on individual budget lines. These are shown below:

<table>
<thead>
<tr>
<th>Service Line</th>
<th>QIPP £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allied Health &amp; Clinical Support Services</td>
<td>2.4%</td>
</tr>
<tr>
<td>Acute &amp; Integrated Community Care</td>
<td>(701)</td>
</tr>
<tr>
<td>Planned Care</td>
<td>(1,156)</td>
</tr>
<tr>
<td>Chief exec</td>
<td>(880)</td>
</tr>
<tr>
<td>Corporate Affairs &amp; Governance</td>
<td>(29)</td>
</tr>
<tr>
<td>Estates &amp; Facilities</td>
<td>(38)</td>
</tr>
<tr>
<td>Finance, Information &amp; Planning</td>
<td>(279)</td>
</tr>
<tr>
<td>Human Resources</td>
<td>(86)</td>
</tr>
<tr>
<td>IMT</td>
<td>(110)</td>
</tr>
<tr>
<td>Nursing Performance &amp; Quality</td>
<td>(53)</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td>(67)</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>(3,400)</strong></td>
</tr>
</tbody>
</table>

7.0 **Summary Budgets**

7.1 The summary budgets for each area are provided in the table below. These budgets have been signed off by the appropriate budget holder, and a further break-down is included in Appendix A.

<table>
<thead>
<tr>
<th>Service Line</th>
<th>Pay</th>
<th>Non-pay</th>
<th>Direct Credit Income</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£m</td>
<td>£m</td>
<td>£m</td>
<td>£m</td>
</tr>
<tr>
<td>Allied Health &amp; Clinical Support Services</td>
<td>21.4</td>
<td>14.6</td>
<td>(3.5)</td>
<td>32.5</td>
</tr>
<tr>
<td>Acute &amp; Integrated Community Care</td>
<td>40.5</td>
<td>8.9</td>
<td>(0.6)</td>
<td>48.8</td>
</tr>
<tr>
<td>Planned Care</td>
<td>28.1</td>
<td>9.3</td>
<td>(0.3)</td>
<td>37.2</td>
</tr>
<tr>
<td>Corporate</td>
<td>17.1</td>
<td>29.1</td>
<td>(1.9)</td>
<td>44.2</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>107.2</strong></td>
<td><strong>61.8</strong></td>
<td>(6.3)</td>
<td><strong>162.7</strong></td>
</tr>
</tbody>
</table>

8.0 **Capital**

8.1 A separate capital paper will be brought to the May Board meeting.

9.0 **Recommendations**

9.1 The Board is asked to approve the 2017/18 budgets.

Mark Ogden  
**Director of Finance**  
23rd March 2017
### Appendix A: Directorate budgets

#### Acute & Integrated Community Care Budget 2017/18

<table>
<thead>
<tr>
<th>Category</th>
<th>WTE</th>
<th>£m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contract income</td>
<td></td>
<td>(65.85)</td>
</tr>
<tr>
<td><strong>Expenditure:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Direct credit income</td>
<td></td>
<td>(0.59)</td>
</tr>
<tr>
<td>Pay Substantive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical (including locum)</td>
<td>115.4</td>
<td>11.15</td>
</tr>
<tr>
<td>Nursing Qualified</td>
<td>430.5</td>
<td>18.45</td>
</tr>
<tr>
<td>Nursing Unqualified</td>
<td>217.4</td>
<td>5.75</td>
</tr>
<tr>
<td>Scientific, Therapeutic &amp; Technical</td>
<td>30.3</td>
<td>1.22</td>
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<tr>
<td>Senior Manager</td>
<td>7.8</td>
<td>0.50</td>
</tr>
<tr>
<td>Admin &amp; Clerical bands 1 - 8</td>
<td>66.9</td>
<td>1.69</td>
</tr>
<tr>
<td>Local Authority</td>
<td>0.0</td>
<td>0.60</td>
</tr>
<tr>
<td>Pay - temporary:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bank</td>
<td>18.3</td>
<td>0.65</td>
</tr>
<tr>
<td>Agency</td>
<td>0.0</td>
<td>0.53</td>
</tr>
<tr>
<td>Non pay</td>
<td></td>
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<tr>
<td><strong>Grand Total Expenditure</strong></td>
<td>85.2</td>
<td>48.81</td>
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</table>

#### Contract income Plan 2017/18:

<table>
<thead>
<tr>
<th>Specialty</th>
<th>£m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accident &amp; Emergency</td>
<td>8.99</td>
</tr>
<tr>
<td>Cardiac Rehab</td>
<td>0.20</td>
</tr>
<tr>
<td>Cardiology</td>
<td>2.04</td>
</tr>
<tr>
<td>Clinical Neurophysiology</td>
<td>0.07</td>
</tr>
<tr>
<td>Community Medicine</td>
<td>15.79</td>
</tr>
<tr>
<td>Community Paediatrics</td>
<td>0.77</td>
</tr>
<tr>
<td>Critical Care Medicine</td>
<td>2.80</td>
</tr>
<tr>
<td>Diabetic Medicine</td>
<td>0.01</td>
</tr>
<tr>
<td>Endocrinology</td>
<td>0.11</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>6.59</td>
</tr>
<tr>
<td>General Medicine</td>
<td>13.38</td>
</tr>
<tr>
<td>Genito-Urinary Medicine</td>
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</tr>
<tr>
<td>Geriatric Medicine</td>
<td>0.13</td>
</tr>
<tr>
<td>Intermediate Care</td>
<td>4.62</td>
</tr>
<tr>
<td>Medical Ophthalmology</td>
<td>0.12</td>
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<tr>
<td>Neonatology</td>
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<tr>
<td>Paediatrics</td>
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<tr>
<td>Palliative Medicine</td>
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<td>Respiratory Medicine</td>
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<tr>
<td>Rheumatology</td>
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<td><strong>Grand Total</strong></td>
<td>65.85</td>
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</table>
## Allied Health & Clinical Support Services Budget 2017/18

<table>
<thead>
<tr>
<th>Category</th>
<th>WTE</th>
<th>£m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contract income</td>
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<td>(12.29)</td>
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<tr>
<td>Direct credit income</td>
<td></td>
<td>(3.49)</td>
</tr>
<tr>
<td>Pay Substantive:</td>
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<td></td>
</tr>
<tr>
<td>Medical (including locum)</td>
<td>18.5</td>
<td>2.33</td>
</tr>
<tr>
<td>Nursing Qualified</td>
<td>41.8</td>
<td>1.66</td>
</tr>
<tr>
<td>Nursing Unqualified</td>
<td>35.9</td>
<td>0.80</td>
</tr>
<tr>
<td>Scientific, Therapeutic &amp; Technical</td>
<td>273.0</td>
<td>10.24</td>
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<td>Senior Manager</td>
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<td>0.49</td>
</tr>
<tr>
<td>Admin &amp; Clerical bands 1 - 8</td>
<td>236.7</td>
<td>5.54</td>
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<td>Bank</td>
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<td>0.34</td>
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<tr>
<td>Agency</td>
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<td>0.02</td>
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<tr>
<td>Non pay</td>
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<td>14.58</td>
</tr>
<tr>
<td><strong>Grand Total Expenditure</strong></td>
<td>619.5</td>
<td>32.50</td>
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### Contract income Plan 2017/18:

<table>
<thead>
<tr>
<th>Specialty</th>
<th>£m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audiology</td>
<td>0.72</td>
</tr>
<tr>
<td>Breast Screening</td>
<td>1.19</td>
</tr>
<tr>
<td>Community Medicine</td>
<td>5.12</td>
</tr>
<tr>
<td>Diagnostic Imaging</td>
<td>3.60</td>
</tr>
<tr>
<td>Dietetics</td>
<td>0.01</td>
</tr>
<tr>
<td>MDT</td>
<td>0.26</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>0.10</td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>0.89</td>
</tr>
<tr>
<td>Speech And Language Therapy</td>
<td>0.40</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td>12.29</td>
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## Planned Care Budget 2017/18

<table>
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</tr>
<tr>
<td><strong>Expenditure:</strong></td>
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</tr>
<tr>
<td>Direct credit income</td>
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</tr>
<tr>
<td>Medical (including locum)</td>
<td>115.7</td>
</tr>
<tr>
<td>Nursing Qualified</td>
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<tr>
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<td>134.9</td>
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<td>Scientific, Therapeutic &amp; Technical</td>
<td>27.9</td>
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<tr>
<td>Admin &amp; Clerical bands 1 - 8</td>
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<td>Bank</td>
<td>9.9</td>
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<tr>
<td>Agency</td>
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<td>Non pay</td>
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**Contract income Plan 2017/18:**

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</tr>
</thead>
<tbody>
<tr>
<td>Breast Surgery</td>
</tr>
<tr>
<td>Colorectal Surgery</td>
</tr>
<tr>
<td>ENT</td>
</tr>
<tr>
<td>General Surgery</td>
</tr>
<tr>
<td>Obstetrics</td>
</tr>
<tr>
<td>Ophthalmology</td>
</tr>
<tr>
<td>Oral Surgery</td>
</tr>
<tr>
<td>Orthodontics</td>
</tr>
<tr>
<td>Orthoptics</td>
</tr>
<tr>
<td>Pain Management</td>
</tr>
<tr>
<td>Plastic Surgery</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
</tr>
<tr>
<td>Urology</td>
</tr>
<tr>
<td>Vascular Surgery</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
</tr>
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</table>
### Corporate & Trust Wide Services Budget 2017/18

<table>
<thead>
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<th>WTE</th>
</tr>
</thead>
<tbody>
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<td>Contract income</td>
<td></td>
</tr>
<tr>
<td><strong>Expenditure:</strong></td>
<td></td>
</tr>
<tr>
<td>Direct credit income</td>
<td></td>
</tr>
<tr>
<td>Pay Substantive:</td>
<td></td>
</tr>
<tr>
<td>Nursing Qualified</td>
<td>41.3</td>
</tr>
<tr>
<td>Senior Manager</td>
<td>45.8</td>
</tr>
<tr>
<td>Admin &amp; Clerical bands 1 - 8</td>
<td>151.7</td>
</tr>
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<td>Estates Officer/Maintenance</td>
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</tr>
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<td>Pay other</td>
<td>2.1</td>
</tr>
<tr>
<td>Pay - temporary:</td>
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<tr>
<td>Non pay</td>
<td></td>
</tr>
<tr>
<td><strong>Grand Total Expenditure</strong></td>
<td>271.1</td>
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</tbody>
</table>
Agenda Item Number 13: TB 17 (14)

Our Ref:  LM/FB/Meetings01/TB/Agenda

Date:  20th April 2017

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 Thursday 27th April 2017 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 2017 AGENDA

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<th>REFERENCE</th>
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<td>1.</td>
<td>Patient Story:</td>
<td>Director of Nursing, Performance &amp; Quality</td>
<td>10 mins</td>
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<tr>
<td>2.</td>
<td>Apologies:</td>
<td>Chairman</td>
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# ASSURANCE ITEMS

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<td>3. Register of Interests:</td>
<td>The Chairman</td>
<td>5 mins</td>
<td>-</td>
<td></td>
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<tr>
<td>- Declared interest agenda</td>
<td></td>
<td></td>
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<tr>
<td>- Hospitality and Gifts Register Declaration</td>
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<tr>
<td>4. Minutes of the March 2017 meeting</td>
<td>The Chairman</td>
<td>-</td>
<td>TB 17 (23)</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. SQS April 2017 meetings</td>
<td>Ms A Harrison</td>
<td>10 mins</td>
<td>Verbal (supported by formal minutes when available)</td>
<td>All corporate objectives</td>
</tr>
<tr>
<td>FP&amp;W April 2017 meetings</td>
<td>Mr M Wildig</td>
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# STRATEGIC/GOVERNANCE ITEMS

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<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 Commentary</td>
<td>Chief Executive</td>
<td>45 mins</td>
<td>TB 17 (24)</td>
<td>All corporate objectives</td>
</tr>
<tr>
<td>9. Refresh of East Cheshire Trust’s Clinical Strategy</td>
<td>Medical Director</td>
<td>30 mins</td>
<td>TB 17 (25)</td>
<td>PATIENTS - Provide safe, effective personal care in the right place</td>
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<td>RESOURCES - To deliver services that are clinically and financially sustainable</td>
</tr>
<tr>
<td>10. Standing Agenda Item:</td>
<td>Chief Executive</td>
<td>5 mins</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>
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ANY OTHER BUSINESS

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<tr>
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<th>PRESENTED BY</th>
<th>TIME ALLOCATION</th>
<th>REF. NO.</th>
</tr>
</thead>
<tbody>
<tr>
<td>11. Public Trust Board Agenda – June 17</td>
<td>The Chairman</td>
<td>5 mins</td>
<td>TB 17 (26)</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. Chairman’s Commentary – including Annual review of Board Members attendance at committee’s</td>
<td>TB 17 (27)</td>
<td>Information</td>
<td>All corporate objectives</td>
</tr>
<tr>
<td>15. Safer Staffing Exception Report</td>
<td>TB 17 (28)</td>
<td>Assurance</td>
<td>PATIENTS - Provide the best services to our population through improvements to safety, productivity and patient experience&lt;br&gt;STAFF - Empower, develop and value staff in providing innovative patient focused care</td>
</tr>
<tr>
<td>16. Sub-Committee Minutes: SQS – February &amp; March 2017&lt;br&gt;FP&amp;W – February &amp; March 2017</td>
<td>TB 17 (29 and 30)&lt;br&gt;TB 17 (31 and 32)</td>
<td>Information</td>
<td>All corporate objectives</td>
</tr>
</tbody>
</table>

Date and Time of Next Meeting:
Date: Thursday 29th June 2017<br>Time: 3.00pm<br>Venue: Board Room 1, New Alderley House, Macclesfield District Hospital
<table>
<thead>
<tr>
<th>Report of: The Responsible &amp; Accountable Officer</th>
<th>The Chairman</th>
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<tbody>
<tr>
<td>Author of Report:</td>
<td>Lynn McGill, The Chairman</td>
</tr>
<tr>
<td>Subject/Title</td>
<td>Chairman’s Commentary</td>
</tr>
<tr>
<td>Background papers (if relevant)</td>
<td>None</td>
</tr>
<tr>
<td>Purpose of Paper</td>
<td>For information</td>
</tr>
<tr>
<td>Action/Decision required</td>
<td>To note</td>
</tr>
<tr>
<td>Mitigates Risk Number: (identify) On Corporate Risk Register</td>
<td>Relates to all BAF’s</td>
</tr>
<tr>
<td>Mitigates Risk Number: (identify) On Assurance Framework</td>
<td></td>
</tr>
</tbody>
</table>
| Link to Care Quality Commission Domain        | - Safe  
- Caring  
- Responsive  
- Effective  
- Well-lead |
| Link to:                                      | Supporting and developing staff to enable them to achieve their best Working with our partners to provide an integrated health service for our local population |
| Trust’s Strategic Direction                   | |
| Corporate Objectives                          | |
| Legal implications - (identify)               | None |
| Impact on quality                             | Positive impact |
| Resource impact                               | None |
| Impact of equality/diversity                  | None |
| Avoid acronyms or                             | NHS – National Health Service |
| abbreviations - if necessary list: | NHSI – National Health Service Improvement  
STP – Sustainability & Transformational Plan  
LDS – Local Delivery System  
GM Devolution – Greater Manchester Devolution  
A&E – Accident and Emergency  
ECT East Cheshire NHS Trust  
NWLA – North West Leadership Academy  
CQC – Care Quality Commission  
MP – Member of Parliament  
ECCCG – Eastern Cheshire Clinical Commissioning Group |
1 NATIONAL AND REGIONAL CONTEXT

Regional Leadership Forums

1.1 National Events

Attended the Healthcare Financial Management Association annual conference on Tuesday 17th January 2017, at which we heard from the CQC about new ways of working; NHSI and their work on Carter in reducing variation and the importance of GIFT – Getting It Right First Time; A Business Director on behalf of NHSI looking at how their remit has evolved to provide increasing support to Trusts to deliver financially and clinically sustainable services; the NHS Providers network speaking on behalf of members representing c60% of the annual health budget spend, about the reality of the current system and the importance of working across a wider social perspective of the determinants of health improvement and wellbeing, the voluntary sector and other public bodies. A private sector provider also presented their perspectives on successful brand leadership in retail, banking, airlines, technology and fast food, recognising the importance of people, leadership and how they make their contribution.

1.2 Regional Sustainability Transformation Plan (STP)

Following the helpful meeting with the STP lead for Cheshire and Merseyside with a peer Chair from Cheshire on 17th November 16, met with her again and her Finance Director at the Trust on 4th January 2017 with our Chief Executive Officer to afford a better understanding of the Trust’s journey to date and some of the associated complexities. There was a further meeting of STP members on 18th January 2017 that the Chief Executive attended, bringing all up to date with the progress made on plans to date.

1.3 NHS Improvement

Attended an event on 4th November 2016, together with our Director of Finance, focused on ‘Relentless Delivery’ outlining the wider achievements and challenges nationally and across the North. This also provided some helpful background information which continues to inform our own approach to improvement.

1.4 Breaking Barriers

Attended a summit on 22nd February 2017 led by Hazel Blears MP. This event focused on the Greater Manchester justice system and opportunities for all public organisations to contribute to improvements, including health. Whilst there are many similarities with the pressures affecting health, the event also recognised the significant number of people with a mental health issue caught up in the justice system, including 30% of the 85,000 strong prison population suffer with a learning difficulty, 64% used illicit drugs and the 49% of women and 23% of men whom
suffered from anxiety and depression. This has facilitated early local contact through Cheshire and Wirral Partnership, looking at innovative practice and any joint opportunities.

1.5 Chair to Chair Discussions

I was pleased to lead and contribute to a meeting of the four Cheshire and Wirral hospital provider Chairs on 8th December 2016, where we focused on shared decision making and the opportunities for effective working across the Local Delivery System footprint to make best use of resources. This will lead to specific papers for the Board to consider over the coming months.

1.6 Cheshire East Council

The Chief Executive and I met with Council representatives and the Portfolio Holder for Communities, Health and Security on 22nd November 2016 where we explored the opportunity to contribute with partners to a stronger economic community, how we innovate and use our assets to best advantage. This was also the focus of an Eastern Cheshire-wide strategic leadership conversation which took place at the end of November 2016 and to which our Chief Executive was invited to and attended.

1.7 North West leadership Academy (NWLA)

As an ambassador for the NWLA, and a member of the steering group I attended and contributed to two meetings and discussions on 3rd December 2016 and 2nd February 2017 that have helped shape the leadership agenda for the current and forthcoming year.

1.8 Greater Manchester Chairs Forum

Attended this forum on 14th December 2016, 1st February and 16th March 2017, at which progress on the various work streams was shared, highlighted where the challenges lay and what the national developments with regards to regulation, transformation and financial control meant for Greater Manchester. This was also aligned to commissioning headlines and developments.

Wednesday 26th October 2016, where we were apprised of developments, how barriers were being overcome and how partners were identifying and maximising opportunities. The GM Devolution Programme now benefits from a dedicated lead Director and supporting team. To find out more, please see https://www.greatermanchester-ca.gov.uk/info/20064/about_gmca to view agendas, minutes and video footage of meetings.
1.9 The Chief Executive and I, together with Caring Together partner leaders, attended an informal conversation with the Chief Executive of Greater Manchester Health & Social Care Partnership on Monday 9th January 2017. The purpose of our discussions was to gather a Caring Together perspective on opportunities and approaches afforded by this devolved authority.

2 PARTNERSHIPS

2.1 Caring Together Programme Board

The Caring Together Programme Board (CTPB) met on 14th December 16, 11th January 2017, 8th & 16th February and 8th March 2017. The Programme Board has continued to discuss optimum models of care, what an accountable care organisation might look like and discuss these developments with regulators. There has been a recognition of the amount of work undertaken, together with the complexity of geography and rurality and the impact this has on wider planning footprints. Further discussions are planned for 27th March and 4th April 2017. For regular updates, please see http://www.caringtogether.info

As part of continuing relationships with Caring Together partners, I meet regularly with EC CCG Chair to ensure we take a ‘no surprises’ approach to meetings and developments. A meeting took place on 22nd November 2016, 14th February (by phone) and 21st March 2017.

2.2 Board to Board with Eastern Cheshire CCG Governing Body

23rd November 2016, shared responsibility with CCG for bringing leaders together to gain a shared view of future health commissioning and provision and understand better the different perspectives and expectations. This was a helpful step in the art of the possible and will continue to inform as we meet as a health economy.

2.3 Christmas Service

It was a real pleasure to attend the service held in St Luke’s Chapel on 15th December, with patients attending, the Mayor of Macclesfield and Consort and with the support of local schools.

2.4 Support for Charity, ECHO

It was a very cold, wet and windy day on 28th February 2017 for the annual pancake race, with 18 teams signed up for the event. Contenders valiantly raced to raise funds for our local community and hospital Charity ECHO. For more information and to see who won, visit http://www.eastcheshire.nhs.uk/news/Teams-brave-wintry-weather-action-packed-2017-Macclesfield-Pancake-Race.htm
2.5 **Thank you to our Volunteers**

East Cheshire Trust has a wealth of volunteers whom add significantly to patient and staff experiences. Making time to say thank you is important and an opportunity for volunteers to come together from time to time, to share the ‘volunteer family’ experience. On the afternoon of 20th December, we welcomed many of our volunteers to a coffee and cake afternoon by way of a thank you in recognition of their contribution.

2.6 It was a privilege to attend the **Macclesfield Mayors Breakfast** on Friday 24th February 2017, connecting with the third sector, the churches across Macclesfield and the great work they undertake. Some of these connections have proved invaluable in supporting patients at our Emergency Department front door.

2.7 **Local MPs**

The Chief Executive and I met with the MP for Macclesfield on 9th December, together with CCG and Council colleagues as one of several informal catch up conversations.

It was also with pleasure I welcomed David Rutley MP to the Trust on 23rd December 2016 for his annual Christmas walk about and thank you to staff, recognising the great care they give and recognising the pressures across health locally and nationally.

2.8 **Health Matters**

This month’s topic focused on ‘Sepsis: Why Does It Matter’. Sepsis is a life-threatening condition that arises when the body’s response to infection injures its own tissues and organs and affects c 44,000 people each year in England. Our resident Consultant shared our approach to identifying and managing this condition. Find out more information, please see [http://www.eastcheshire.nhs.uk/News-Events/health-matters-videos.htm](http://www.eastcheshire.nhs.uk/News-Events/health-matters-videos.htm)

3 **TRUST BOARD**

3.1 The **Trust Board programme of work** is largely as planned for this month. Please see the plan on a page confirming the 2016-17 programme which is attached for information (Appendix 1). The plan for the year 2017-18 is also attached (Appendix 2), although may be further developed in light of the changes affecting health nationally.

3.2 I can confirm that the Remuneration Committee met on 20th December 2016 and on 30th March 2017.
3.3 I am pleased to note that I met with an external provider supporting NHSI to promote board diversity on 21st Feb 2017. As a consequence, I have committed some time to mentor future board members from under-represented groups as part of a wider programme in developing the next generation of board directors. This will be launched later this year.

3.4 I can confirm that the Clinical Excellence Awards Committee met and fulfilled its duties during the course of the year.

3.5 Board Development The planned discussions have been held with the exception of February 2017, which was cancelled due to the intense operational pressures we faced and to ensure all hands were available to support service delivery.

3.6 Non-Executive Board Members leadership roles
In addition to their Board Director roles, our Non-Executive Directors have also taken on additional board lead roles. I can confirm that these are as follows:-

- Dr Jane Cowan – Safeguarding lead and Organ Donation sub-committee Chair
- Michael Wildig – Procurement lead and Finance, Workforce and Performance sub-committee Chair, Chair of the trust charity ECHO
- Ali Harrison, lead for Health and Safety and the Safety, Quality and Standards sub-committee Chair
- Ian Goalen, Deputy Chair and Chair of the Audit Committee
- Lynn McGill, Equality and Diversity lead, Chair of the Remuneration Committee
- Dr Tony Coombs, Senior Independent Director

3.7 Board Walkabouts
The programme for Board walkabouts is as planned, with a breadth of visits having taken place across services. These have helped to inform questions and challenge around the board table and bring reports and papers to life. Please find at Appendix 3 the 2016-17 Board Walkabout programme.

3.8 Register of Interests
The Trust Board has a duty to make transparent all Board members registered interests. I have enclosed the report for this year, which has been maintained as a live document throughout the year and which we will continue to do so for the forthcoming year. Please see Appendix 4.

3.9 Gifts and Hospitality Register
The trust also has a duty to make transparent all gifts and hospitality. The attached register has been maintained as a live document throughout the year and which will continue to do so for the forthcoming year. Please see Appendix 5.

Chairman: Lynn McGill
Chief Executive: John Wilbraham
3.10 **Fit and Proper Persons**

I have received assurance that all members of the Trust Board meet the Fit and Proper Persons definition as laid out by the NHS Improvement; I have received signed self-declarations; all required registers have been checked and I can confirm that those Board members who require a DBS have one in place.

Lynn McGill  
Chairman
The Board 2016/17 – a Year at a Glance

Board Objectives

**PATIENTS** – Provide safe, effective personal care in the right place

**PEOPLE** – Build, value and develop a motivated and sustainable workforce

**PARTNERSHIPS** – Work within the Caring Together framework to deliver our vision

**RESOURCES** – To deliver services that are clinically and financially sustainable

Board Assurance Framework

1. Leadership of Strategic Transformation
2. Quality & Compliance: patient safety, patient experience and effectiveness
3. Financial stability
4. People
5. Infrastructure

Standing Board Agenda Items

- The Patient’s Voice (Patient Story)/The Staff Voice (Staff Story)
- Chairman’s Report
- Chief Executive’s Report (inc. Strategy, Performance and Assurance)
- Conflict of Interests
- Committee Assurance via relevant Committee Chairs
- Exception Report – Safer Staffing Levels
### Board Objectives

**PATIENTS** – Provide safe, effective personal care in the right place

**PEOPLE** – Build, value and develop a motivated and sustainable workforce

**PARTNERSHIPS** – Work within the Caring Together framework to deliver our vision

**RESOURCES** – To deliver services that are clinically and financially sustainable

### Board Assurance Framework

1. Leadership of Strategic Transformation
2. Quality & Compliance: patient safety, patient experience and effectiveness
3. Financial stability
4. People
5. Infrastructure

### Standing Board Agenda Items

- The Patient’s Voice (Patient Story)/The Staff Voice (Staff Story)
- Chairman’s Report (inc annual Fit & Proper person test, Rol and Gifts & Hospitality registers)
- Chief Executive’s Report (inc. Strategy, Performance and Assurance and areas to focus as a Deep Dive)
- Conflict of Interests
- Committee Assurance via relevant Committee Chairs
- Exception Report – Safer Staffing Levels

KPI’s for strategies will be overseen by committee’s. The CEO report will contain escalation issues and separate papers will be provided to the Board as appropriate.
### Board Objectives

**PATIENTS** – Provide the best services to our population through improvements to safety, productivity and patient experience

**PEOPLE** – Empower, develop and value staff in providing innovative patient-focussed care

**PARTNERSHIPS** – Actively develop sustainable services through effective partnerships

**RESOURCES** – Effectively provide services that are sustainable both now and in the future

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<tr>
<td>Hospital Walkabout</td>
<td>Hospital Walkabout</td>
<td>Hospital Walkabout</td>
<td>Ward 9</td>
<td>Medical Assessment Unit</td>
<td>Hospital Walkabout</td>
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<td>Hospital Night Walkabout</td>
<td>Surgical Specialties</td>
<td>Macmillan Cancer Resource Centre</td>
<td>Medical Assessment Unit</td>
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<td>SIRI Sub-Committee</td>
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<td>District Nurses, Waters Green Med Centre</td>
<td>District Nurses, Handforth</td>
<td>SIRI Sub-Committee</td>
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<td>SIRI Sub-Committee</td>
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<td>Tissue Viability Team</td>
<td>SIRI Sub-Committee</td>
<td>AHP and Integrated Care Specialties</td>
<td>SIRI Sub-Committee</td>
<td>SIRI Sub-Committee</td>
<td>SIRI Sub-Committee</td>
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<td>Wards 1&amp;2</td>
<td>Dementia Operational Steering Group Meeting</td>
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<td>Ward 3</td>
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<td>Intermediate Care, SC&amp;VR</td>
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<tr>
<td>SIRI Sub-Committee</td>
<td>District Nurses, Handforth</td>
<td>SIRI Sub-Committee</td>
<td>SIRI Sub-Committee</td>
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<tr>
<td>SIRI Sub-Committee</td>
<td>District Nurses, Congleton</td>
<td>Hospital Walkabout</td>
<td>Ward 7/Cardiology</td>
<td>Ward 7/Cardiology</td>
<td>Ward 9</td>
</tr>
<tr>
<td>MAU, Frailty Team</td>
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<td>Emergency Department Bed Management Team</td>
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<tr>
<td>Children’s Community Nursing Team</td>
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<td>Rheumatology</td>
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<td>Ward 5</td>
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<td>Volunteers Service</td>
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<td></td>
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<td>Ward 1</td>
<td>Ward 1</td>
<td>MAU</td>
<td>Legal Services/Subject Access Team</td>
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<td>Ward 10</td>
<td>Ward 10</td>
<td>Ward 2</td>
<td>Maternity Department</td>
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<td>Library/Knowledge Service</td>
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<td>Paediatric Department</td>
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<td>PGME Team</td>
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<td>Orthopaedic Outpatients</td>
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<td>Emergency Department and Discharge Lounge</td>
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<td>Pharmacy</td>
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<td>Pathology</td>
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<td>Customer Care Team</td>
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<td>Clinical Coding Team</td>
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<td>Aston Ward, Congleton</td>
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**Board Walkabouts – A Year at a Glance 2016-17**

**Agenda Item Number 14: TB 17 (15)**

- Appendix 3
<table>
<thead>
<tr>
<th>FIRST NAME</th>
<th>SURNAME</th>
<th>COMMITTEE MEMBERSHIP 2017-2018</th>
<th>DESIGNATION</th>
<th>Apr 17 - Mar 18 Interests</th>
<th>Email address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lynn</td>
<td>McGYLL</td>
<td>Trust Board, Remuneration Committee, ECHO Committee</td>
<td>Chairman</td>
<td>Trustee, Workington and District Village Hall - Charity Registration ref 1115499, Director of Inspire Today Limited. Member of National Leadership Advisory Panel, Penna. Steering group member, NW Leadership Academy.</td>
<td><a href="mailto:lynnmcgill@nhs.net">lynnmcgill@nhs.net</a></td>
</tr>
<tr>
<td>Anthony</td>
<td>COOMBS</td>
<td>Trust Board, FP&amp;W, ECHO Committee</td>
<td>Senior Independent Director and NED</td>
<td>Shareholder in Galenica (Fresenius) and in Astra Zeneca, Trustee of Roy Castle Lung Cancer Foundation. Non Executive Director of Oxford Vaccmedix</td>
<td><a href="mailto:anthony.coombs@nhs.net">anthony.coombs@nhs.net</a></td>
</tr>
<tr>
<td>Ian</td>
<td>GOALEN</td>
<td>Trust Board, Audit Committee, FP&amp;W, ECHO Committee</td>
<td>Vice Chair and NED</td>
<td>Director and shareholder of One to One (North West) Ltd. Director of Dinwoodie Charitable Company Ltd</td>
<td><a href="mailto:ian.goalen@nhs.net">ian.goalen@nhs.net</a></td>
</tr>
<tr>
<td>(Pamela) Jane</td>
<td>COWAN</td>
<td>Trust Board, Audit Committee, SGS, ECHO Committee, Organ Donation Committee</td>
<td>NED</td>
<td>Medical Practitioner Tribunal Service (MPTS) - Tribunal member</td>
<td><a href="mailto:jane.cowan1@nhs.net">jane.cowan1@nhs.net</a></td>
</tr>
<tr>
<td>Mike</td>
<td>WILDIG</td>
<td>Trust Board, FP&amp;W, Audit Committee, Remuneration Committee, ECHO Committee</td>
<td>NED</td>
<td>Director of Alderley Edge Cricket Club</td>
<td><a href="mailto:michael.wildig@nhs.net">michael.wildig@nhs.net</a></td>
</tr>
<tr>
<td>Ali</td>
<td>HARRISON</td>
<td>Trust Board, SQS, Remuneration Committee, ECHO Committee</td>
<td>NED</td>
<td>Board Trustee at Alzheimers Society (Also volunteer local representative role for Cheshire &amp; St Helens)</td>
<td><a href="mailto:ali.harrison@nhs.net">ali.harrison@nhs.net</a></td>
</tr>
<tr>
<td>John</td>
<td>WILBRAHAM</td>
<td>Trust Board, SQS, FP&amp;W, ECHO Committee</td>
<td>CEO</td>
<td>No interests to declare</td>
<td><a href="mailto:john.wilbraham@nhs.net">john.wilbraham@nhs.net</a></td>
</tr>
<tr>
<td>Kathleen</td>
<td>SENIOR</td>
<td>Trust Board, SQS, FP&amp;W, ECHO Committee</td>
<td>Director of Nursing, Performance &amp; Quality</td>
<td>Daughter works as HR BP within trust - Sister works as ICU nurse within trust</td>
<td><a href="mailto:kath.senior@nhs.net">kath.senior@nhs.net</a></td>
</tr>
<tr>
<td>Rachael</td>
<td>CHARLTON</td>
<td>Trust Board, SQS, FP&amp;W, ECHO Committee</td>
<td>Director of HR and Organisational Development</td>
<td>No interests to declare</td>
<td><a href="mailto:rachael.charlton@nhs.net">rachael.charlton@nhs.net</a></td>
</tr>
<tr>
<td>Julie</td>
<td>GREEN</td>
<td>Trust Board, SQS, FP&amp;W, ECHO Committee</td>
<td>Director of Corporate Affairs &amp; Governance</td>
<td>No interests to declare</td>
<td><a href="mailto:julie.green4@nhs.net">julie.green4@nhs.net</a></td>
</tr>
<tr>
<td>Mark</td>
<td>OGDEN</td>
<td>Trust Board, SQS, FP&amp;W, ECHO Committee</td>
<td>Director of Finance</td>
<td>No interests to declare</td>
<td><a href="mailto:mark.ogden3@nhs.net">mark.ogden3@nhs.net</a></td>
</tr>
<tr>
<td>John</td>
<td>HUNTER</td>
<td>Trust Board, SQS, FP&amp;W, ECHO Committee</td>
<td>Medical Director</td>
<td>Spire Regency Hospital, Macclesfield - (on average) weekly elective operating lists performed</td>
<td><a href="mailto:john.hunter4@nhs.net">john.hunter4@nhs.net</a></td>
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<tr>
<td>Date</td>
<td>Gift/ Hospitality from</td>
<td>Received by</td>
<td>Reason for Gift/ Occasion</td>
<td>Accepted/ Declined</td>
<td></td>
</tr>
<tr>
<td>--------------</td>
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<td>----------------------------------------------------------------</td>
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</tr>
<tr>
<td>Feb and July 15 (not previously declared)</td>
<td>Astra Zeneca</td>
<td>Lis Street, Pharmacy</td>
<td>Fee for service and consultancy - £160 and £1400</td>
<td>Accepted</td>
<td></td>
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<tr>
<td>13th April 16</td>
<td>Bayer</td>
<td>Christine Cooper, Pharmacy</td>
<td>Learning at Lunch – Zantus Study, NOAC’s - £25</td>
<td>Accepted</td>
<td></td>
</tr>
<tr>
<td>13th April 16</td>
<td>MDDUS</td>
<td>Grand Round</td>
<td>Sponsorship of £140 (paid to ISS catering)</td>
<td>Accepted</td>
<td></td>
</tr>
<tr>
<td>20th April 16</td>
<td>MDDUS</td>
<td>Grand Round</td>
<td>Sponsorship of £140 (paid to ISS catering)</td>
<td>Accepted</td>
<td></td>
</tr>
<tr>
<td>21st April 16</td>
<td>NHS Providers</td>
<td>Lynn McGill, Chairman</td>
<td>Forum where light lunch was provided</td>
<td>Accepted</td>
<td></td>
</tr>
<tr>
<td>4th May 16</td>
<td>Bristol-Myers Squibb</td>
<td>Grand Round</td>
<td>Sponsorship of £140 (paid to ISS catering)</td>
<td>Accepted</td>
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<tr>
<td>4th May 16</td>
<td>GlaxoSmithKline</td>
<td>Grand Round</td>
<td>Sponsorship of £140 (paid to ISS catering)</td>
<td>Accepted</td>
<td></td>
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<tr>
<td>10th May 16</td>
<td>CHKS</td>
<td>John Wilbraham, Chief Executive</td>
<td>Invitation to receive CHKS top 40 hospitals award, included dinner</td>
<td>Accepted</td>
<td></td>
</tr>
<tr>
<td>11th May 16</td>
<td>Chiesi Ltd</td>
<td>Grand Round</td>
<td>Sponsorship of £140 (paid to ISS catering)</td>
<td>Accepted</td>
<td></td>
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<tr>
<td>11th May 16</td>
<td>Grunenthal Ltd</td>
<td>Grand Round</td>
<td>Sponsorship of £140 (paid to ISS catering)</td>
<td>Accepted</td>
<td></td>
</tr>
<tr>
<td>18th May 16</td>
<td>MDDUS</td>
<td>Grand Round</td>
<td>Sponsorship of £140 (paid to ISS catering)</td>
<td>Accepted</td>
<td></td>
</tr>
<tr>
<td>18th May 16</td>
<td>British Medical Association</td>
<td>Grand Round</td>
<td>Sponsorship of £140 (paid to ISS catering)</td>
<td>Accepted</td>
<td></td>
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<tr>
<td>25th May 16</td>
<td>Amgen Ltd</td>
<td>Grand Round</td>
<td>Sponsorship of £140 (paid to ISS catering)</td>
<td>Accepted</td>
<td></td>
</tr>
<tr>
<td>25th May 16</td>
<td>Astra Zeneca</td>
<td>Grand Round</td>
<td>Sponsorship of £140 (paid to ISS catering)</td>
<td>Accepted</td>
<td></td>
</tr>
<tr>
<td>May 16</td>
<td>Patient AB</td>
<td>Joanne Williams, Therapy Pathway Manager – East</td>
<td>Care given</td>
<td>Declined</td>
<td></td>
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<tr>
<td>May 16</td>
<td>Gilead, Mylan, Allergan, Novartis, Pfizer, Sanofi-Aventis</td>
<td>Kashif Haque, Chief Pharmasist</td>
<td>Pharmacists meeting - £185 hospitality</td>
<td>Accepted</td>
<td></td>
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<tr>
<td>June 16</td>
<td>KPMG</td>
<td>Ian Goalen, Deputy Chair and</td>
<td>Attended dinner (NHS focussed)</td>
<td>Accepted</td>
<td></td>
</tr>
<tr>
<td>Date</td>
<td>Company</td>
<td>Event</td>
<td>Sponsorship Details</td>
<td>Accepted</td>
<td></td>
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<tr>
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</tr>
<tr>
<td>June 16</td>
<td>KPMG</td>
<td>NED</td>
<td>Ian Goalen, Deputy Chair and NED, Attended cocktail party</td>
<td>Accepted</td>
<td></td>
</tr>
<tr>
<td>8&lt;sup&gt;th&lt;/sup&gt; June 16</td>
<td>Lynn Ramsay, Lilly UK</td>
<td>Christine Cooper, Pharmacy</td>
<td>Learning at Lunch - £25</td>
<td>Accepted</td>
<td></td>
</tr>
<tr>
<td>8&lt;sup&gt;th&lt;/sup&gt; June 16</td>
<td>Medical Defence Unit</td>
<td>Grand Round</td>
<td>Sponsorship of £140 (paid to ISS catering)</td>
<td>Accepted</td>
<td></td>
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<tr>
<td>8&lt;sup&gt;th&lt;/sup&gt; June 16</td>
<td>Grunenthal Ltd</td>
<td>Grand Round</td>
<td>Sponsorship of £140 (paid to ISS catering)</td>
<td>Accepted</td>
<td></td>
</tr>
<tr>
<td>14&lt;sup&gt;th&lt;/sup&gt; June 16</td>
<td>Hill Dickinson Solicitors</td>
<td>Rachael Carlton, Director of HR</td>
<td>Invitation to NW HR Directors dinner organised by NHS Employers</td>
<td>Accepted</td>
<td></td>
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<tr>
<td>15&lt;sup&gt;th&lt;/sup&gt; June 16</td>
<td>MDDUS</td>
<td>Grand Round</td>
<td>Sponsorship of £140 (paid to ISS catering)</td>
<td>Accepted</td>
<td></td>
</tr>
<tr>
<td>21&lt;sup&gt;st&lt;/sup&gt; June 16</td>
<td>Allied Health Science Network</td>
<td>Lynn McGill, Chairman</td>
<td>Attended event where light lunch and refreshments were provided</td>
<td>Accepted</td>
<td></td>
</tr>
<tr>
<td>22&lt;sup&gt;nd&lt;/sup&gt; June 16</td>
<td>Medical Defence Unit</td>
<td>Grand Round</td>
<td>Sponsorship of £140 (paid to ISS catering)</td>
<td>Accepted</td>
<td></td>
</tr>
<tr>
<td>22&lt;sup&gt;nd&lt;/sup&gt; June 16</td>
<td>MDDUS</td>
<td>Grand Round</td>
<td>Sponsorship of £140 (paid to ISS catering)</td>
<td>Accepted</td>
<td></td>
</tr>
<tr>
<td>28&lt;sup&gt;th&lt;/sup&gt; June 16</td>
<td>Ernst &amp; Young</td>
<td>Lynn McGill, Chairman</td>
<td>Attended event re Health Tech where light refreshments and snacks were provided</td>
<td>Accepted</td>
<td></td>
</tr>
<tr>
<td>29&lt;sup&gt;th&lt;/sup&gt; June 16</td>
<td>Wesleyan Ltd</td>
<td>Grand Round</td>
<td>Sponsorship of £140 (paid to ISS catering)</td>
<td>Accepted</td>
<td></td>
</tr>
<tr>
<td>29&lt;sup&gt;th&lt;/sup&gt; June 16</td>
<td>Grunenthal Ltd</td>
<td>Grand Round</td>
<td>Sponsorship of £140 (paid to ISS catering)</td>
<td>Accepted</td>
<td></td>
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<tr>
<td>6&lt;sup&gt;th&lt;/sup&gt; July 16</td>
<td>GlaxoSmithKline</td>
<td>Grand Round</td>
<td>Sponsorship of £140 (paid to ISS catering)</td>
<td>Accepted</td>
<td></td>
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<tr>
<td>6&lt;sup&gt;th&lt;/sup&gt; July 16</td>
<td>British Medical Association</td>
<td>Grand Round</td>
<td>Sponsorship of £140 (paid to ISS catering)</td>
<td>Accepted</td>
<td></td>
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<tr>
<td>13&lt;sup&gt;th&lt;/sup&gt; July 16</td>
<td>MDDUS</td>
<td>Grand Round</td>
<td>Sponsorship of £140 (paid to ISS catering)</td>
<td>Accepted</td>
<td></td>
</tr>
<tr>
<td>14&lt;sup&gt;th&lt;/sup&gt; July 16</td>
<td>Roche</td>
<td>Dane Bradwell, Pharmacy</td>
<td>Meal and lecture – free of charge</td>
<td>Accepted</td>
<td></td>
</tr>
<tr>
<td>15&lt;sup&gt;th&lt;/sup&gt; July 16</td>
<td>Lundbeck Ltd</td>
<td>Sally Chartres</td>
<td>Psychotic Drug Directory 2016 - £46 book required for use in MI</td>
<td>Accepted</td>
<td></td>
</tr>
<tr>
<td>21&lt;sup&gt;st&lt;/sup&gt; July 16</td>
<td>NHS Providers</td>
<td>Lynn McGill, Chairman</td>
<td>Forum where light lunch was provided</td>
<td>Accepted</td>
<td></td>
</tr>
<tr>
<td>3&lt;sup&gt;rd&lt;/sup&gt; August 16</td>
<td>PGME</td>
<td>Junior Doctor Induction</td>
<td>Sponsorship of £30 (paid to ISS catering)</td>
<td>Accepted</td>
<td></td>
</tr>
<tr>
<td>3&lt;sup&gt;rd&lt;/sup&gt; August 16</td>
<td>Meda Pharmaceuticals</td>
<td>Junior Doctor Induction</td>
<td>Sponsorship of £70 (paid to ISS catering)</td>
<td>Accepted</td>
<td></td>
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<tr>
<td>3&lt;sup&gt;rd&lt;/sup&gt; August 16</td>
<td>Wesleyan</td>
<td>Junior Doctor Induction</td>
<td>Sponsorship of £120 (paid to ISS catering)</td>
<td>Accepted</td>
<td></td>
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<tr>
<td>3&lt;sup&gt;rd&lt;/sup&gt; August 16</td>
<td>NAPP Pharmaceuticals</td>
<td>Junior Doctor Induction</td>
<td>Sponsorship of £120 (paid to ISS catering)</td>
<td>Accepted</td>
<td></td>
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<tr>
<td>7&lt;sup&gt;th&lt;/sup&gt; September 16</td>
<td>MDDUS</td>
<td>Grand Round</td>
<td>Sponsorship of £140 (paid to ISS catering)</td>
<td>Accepted</td>
<td></td>
</tr>
<tr>
<td>14&lt;sup&gt;th&lt;/sup&gt; September 16</td>
<td>Agmen Ltd</td>
<td>Grand Round</td>
<td>Sponsorship of £140 (paid to ISS catering)</td>
<td>Accepted</td>
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<tr>
<td>Date</td>
<td>Sponsor</td>
<td>Event</td>
<td>Sponsorship (£140) (paid to ISS catering)</td>
<td>Accepted</td>
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<tr>
<td>14th September 16</td>
<td>Mylan</td>
<td>Grand Round</td>
<td>Sponsorship of £140</td>
<td>Accepted</td>
<td></td>
</tr>
<tr>
<td>21st September 16</td>
<td>PGME</td>
<td>Grand Round</td>
<td>Sponsorship of £140</td>
<td>Accepted</td>
<td></td>
</tr>
<tr>
<td>28th September 16</td>
<td>Agmen Ltd</td>
<td>Grand Round</td>
<td>Sponsorship of £140</td>
<td>Accepted</td>
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<tr>
<td>5th October 16</td>
<td>GSK</td>
<td>Grand Round</td>
<td>Sponsorship of £140</td>
<td>Accepted</td>
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<tr>
<td>5th October 16</td>
<td>Pharmacosmos</td>
<td>Grand Round</td>
<td>Sponsorship of £140</td>
<td>Accepted</td>
<td></td>
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<td>12th October 16</td>
<td>GSK</td>
<td>Grand Round</td>
<td>Sponsorship of £140</td>
<td>Accepted</td>
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<tr>
<td>19th October 16</td>
<td>Eumedica SA</td>
<td>Grand Round</td>
<td>Sponsorship of £140</td>
<td>Accepted</td>
<td></td>
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<tr>
<td>19th October 16</td>
<td>BMA</td>
<td>Grand Round</td>
<td>Sponsorship of £140</td>
<td>Accepted</td>
<td></td>
</tr>
<tr>
<td>25th October 16</td>
<td>Karen McLennan, Pharma Cosmos</td>
<td>Christine Cooper, Pharmacy</td>
<td>Learning at Lunch – sandwiches approx. cost £30</td>
<td>Accepted</td>
<td></td>
</tr>
<tr>
<td>28th October 16</td>
<td>Hill Dickinson LLP</td>
<td>Staff Awards</td>
<td>Sponsorship of £2k to the trust's annual staff awards evening held at Mere Hotel (291 staff attended)</td>
<td>Accepted</td>
<td></td>
</tr>
<tr>
<td>28th October 16</td>
<td>Law by Design</td>
<td>Staff Awards</td>
<td>Sponsorship of £1k to the trust's annual staff awards evening held at Mere Hotel (291 staff attended)</td>
<td>Accepted</td>
<td></td>
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<tr>
<td>9th November 16</td>
<td>Wesleyan Financial Services</td>
<td>Grand Round</td>
<td>Sponsorship of £140</td>
<td>Accepted</td>
<td></td>
</tr>
<tr>
<td>9th November 16</td>
<td>Thornton Ross</td>
<td>Grand Round</td>
<td>Sponsorship of £140</td>
<td>Accepted</td>
<td></td>
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<tr>
<td>16th November 16</td>
<td>Wesleyan Financial Services</td>
<td>Grand Round</td>
<td>Sponsorship of £140</td>
<td>Accepted</td>
<td></td>
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<tr>
<td>17th November 16</td>
<td>Kim Russell, Novo</td>
<td>Hayley Bailey, Pharmacy</td>
<td>Learning at Lunch – sandwiches approx. cost £25</td>
<td>Accepted</td>
<td></td>
</tr>
<tr>
<td>23rd November 16</td>
<td>BMA</td>
<td>Grand Round</td>
<td>Sponsorship of £140</td>
<td>Accepted</td>
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<tr>
<td>23rd November 16</td>
<td>Wesleyan Financial Services</td>
<td>Grand Round</td>
<td>Sponsorship of £140</td>
<td>Accepted</td>
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<tr>
<td>30th November 16</td>
<td>MEDA Pharmaceuticals</td>
<td>Grand Round</td>
<td>Sponsorship of £140</td>
<td>Accepted</td>
<td></td>
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<tr>
<td>30th November 16</td>
<td>MDDUS</td>
<td>Grand Round</td>
<td>Sponsorship of £140</td>
<td>Accepted</td>
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<tr>
<td>7th December 16</td>
<td>Cheisi</td>
<td>Grand Round</td>
<td>Sponsorship of £140</td>
<td>Accepted</td>
<td></td>
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<tr>
<td>7th December 16</td>
<td>Lundbeck Limited</td>
<td>Grand Round</td>
<td>Sponsorship of £140</td>
<td>Accepted</td>
<td></td>
</tr>
<tr>
<td>14th December 16</td>
<td>Baxter</td>
<td>Indu Das, Pharmacy</td>
<td>NWAPG – Lunch made at Salford Royal Hospital</td>
<td>Accepted</td>
<td></td>
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<tr>
<td>Date</td>
<td>Event Name</td>
<td>Sponsor</td>
<td>Details</td>
<td>Status</td>
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<tr>
<td>5th January 17</td>
<td>Learning at Lunch – cold buffet approx. £25</td>
<td>Matthew Topping, Astra Zeneca, Christine Cooper, Pharmacy</td>
<td>Sponsored by: Matthew Topping, Astra Zeneca, Christine Cooper, Pharmacy</td>
<td>Accepted</td>
<td></td>
</tr>
<tr>
<td>11th January 17</td>
<td>Grand Round</td>
<td>MDDUS</td>
<td>Sponsorship of £140 (paid to ISS catering)</td>
<td>Accepted</td>
<td></td>
</tr>
<tr>
<td>18th January 17</td>
<td>Grand Round</td>
<td>PGME</td>
<td>Sponsorship of £140 (paid to ISS catering)</td>
<td>Accepted</td>
<td></td>
</tr>
<tr>
<td>25th January 17</td>
<td>Grand Round</td>
<td>MDDUS</td>
<td>Sponsorship of £140 (paid to ISS catering)</td>
<td>Accepted</td>
<td></td>
</tr>
<tr>
<td>25th January 17</td>
<td>Grand Round</td>
<td>PHARMACOSMOS</td>
<td>Sponsorship of £140 (paid to ISS catering)</td>
<td>Accepted</td>
<td></td>
</tr>
<tr>
<td>1st February 17</td>
<td>Grand Round</td>
<td>Medical Financial Solutions</td>
<td>Sponsorship of £140 (paid to ISS catering)</td>
<td>Accepted</td>
<td></td>
</tr>
<tr>
<td>8th February 17</td>
<td>Annual Northern Healthcare Dinner</td>
<td>Odgers Berndtson Annual</td>
<td>Sponsorship of £140 (paid to ISS catering)</td>
<td>Accepted</td>
<td></td>
</tr>
<tr>
<td>8th February 17</td>
<td>Grand Round</td>
<td>Astra Zeneca</td>
<td>Sponsorship of £140 (paid to ISS catering)</td>
<td>Accepted</td>
<td></td>
</tr>
<tr>
<td>8th February 17</td>
<td>Grand Round</td>
<td>Merck Sharp &amp; Dohme Ltd</td>
<td>Sponsorship of £140 (paid to ISS catering)</td>
<td>Accepted</td>
<td></td>
</tr>
<tr>
<td>1st March 17</td>
<td>Grand Round</td>
<td>Bayer Healthcare</td>
<td>Sponsorship of £140 (paid to ISS catering)</td>
<td>Accepted</td>
<td></td>
</tr>
<tr>
<td>1st March 17</td>
<td>Grand Round</td>
<td>Boehringer Ingelheim Ltd</td>
<td>Sponsorship of £140 (paid to ISS catering)</td>
<td>Accepted</td>
<td></td>
</tr>
<tr>
<td>15th March 17</td>
<td>Grand Round</td>
<td>Astellas</td>
<td>Sponsorship of £140 (paid to ISS catering)</td>
<td>Accepted</td>
<td></td>
</tr>
<tr>
<td>15th March 17</td>
<td>Grand Round</td>
<td>Wesleyan Ltd</td>
<td>Sponsorship of £140 (paid to ISS catering)</td>
<td>Accepted</td>
<td></td>
</tr>
<tr>
<td>22nd March 17</td>
<td>GP Update Event</td>
<td>British Medical Association</td>
<td>Sponsorship of £90 + VAT (paid to ISS catering)</td>
<td>Accepted</td>
<td></td>
</tr>
<tr>
<td>22nd March 17</td>
<td>GP Update Event</td>
<td>Chiesi Ltd</td>
<td>Sponsorship of £50.50 + VAT (paid to ISS catering)</td>
<td>Accepted</td>
<td></td>
</tr>
<tr>
<td>22nd March 17</td>
<td>GP Update Event</td>
<td>Bristol-Myers Squibb</td>
<td>Sponsorship of £140 (paid to ISS catering)</td>
<td>Accepted</td>
<td></td>
</tr>
<tr>
<td>22nd March 17</td>
<td>GP Update Event</td>
<td>Flynn Pharma</td>
<td>Sponsorship of £140 (paid to ISS catering)</td>
<td>Accepted</td>
<td></td>
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</tbody>
</table>
### Report of:
**Responsible Officer**
Director of Corporate Affairs & Governance

**Accountable Officer**

### Author of Report:
Head of Integrated Governance

### Subject/Title
Review of Corporate Governance Manual

### Background papers (if relevant)
- Corporate Governance Manual 2016-2017
- Incorporating:
  - Standing Orders
  - Standing Financial Instructions
  - Reservation of Powers to the Board and Delegation of Powers

### Purpose of Paper
To present the revised Corporate Governance manual

### Action/Decision required
The Board is asked to:
- Approve the revised Corporate Governance Manual

### 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

March 2017
## EAST CHESHIRE NHS TRUST
CORPORATE GOVERNANCE MANUAL

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Overarching Governance Arrangements
FOREWARD

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 a block contract.

The Trust is a partner of the Caring Together programme, 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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2. ASSURANCE PROCESS
   COMMITTEE STRUCTURE

3. POLICY AND PROCEDURAL DOCUMENTS

4. TRAINING

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   i. RISK MANAGEMENT PROCESS
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   iii. CORPORATE RISK REGISTER

6. ANNUAL GOVERNANCE STATEMENT

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:

1.3 ‘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’.

1.4 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.

1.5 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 current governance arrangements provide a strong basis for which to build upon.

1.6 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 regularly to ensure it is continually improving and minimising overlap to ensure best use of Committee and Board time.

1.7 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, and 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 the NHS Improvement

1.8 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 service areas supported by corporate and operational services. Operationally each of the service areas 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 diagram below represents the flow of information and assurance from service areas to the Board

---

**The Process for Assurance & Escalation**

**TRUST BOARD**

- Minutes from Board Committees
- Scored Assurance Framework
- Papers from Executives to the Board

**Papers / reports / minutes sent to the Board**

- Clinical Management Board (via the Chief Executive, Overarching Risk Forum)
- Executive Management Team (via the Chief Executive, Risk Forum)
- Audit Committee (Risk Forum)\*  
- Finance, Performance & Workforce Committee (Risk Forum)\*  
- Safety, Quality & Standards Committee (Risk Forum)\*

**Papers / reports sent to the various Board committees & Clinical Management Board**

- Action Plans
- Unscored Assurance Framework
- Corporate Risk Register

**Risks identified as result of the business processes established by the Trust**

- Directorate Performance Review Mts
- Incidents Reporting
- Staff Objectives \& Review
- Sub-committees & Working Groups
- Performance Management Systems
- Implementing NICE Guidance
- Developing / Reviewing Policies
- Other Reporting Mechanisms

---

The Board may also identify risks for inclusion in the Assurance Framework

---

- Low Risks (Score 1 – 8) Managed Locally
- Moderate Risks (Score 9 – 12) Managed at Directorate level
- High Risks (Score 15 – 25) Clinical Management Board Informed

---

8
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 service areas 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.

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 shall include:

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

(b) engendering among all levels of staff a positive attitude towards the control of risk;
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, 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 Meeting** – 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 cost improvement 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, 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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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 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**). The **Code of Conduct** 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 5) 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 6 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 the 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" 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

(a) "Tier 1 budget holders" means Executive Director level

(b) "Tier 2 budget holders" means Deputy level and posts that report directly to Executive directors

(c) "Tier 3 budget holders" means all other budget holders

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 the 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, Performance and Quality (Deputy Chief Executive);
   (v) Director of Organisational Development and Human Resources.

3.3.2 In addition, there will be one non-voting member

(a) 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**

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, 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 by giving notice in writing to the Chairman. The Chairman and members may thereupon appoint another member as Vice-Chairman 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 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, Performance and Quality**
The Director of Nursing, Performance and Quality is also the Deputy Chief Executive and as such assumes all responsibilities as per the Chief Executive in his absence.

The Director of Nursing, Performance and Quality is the named lead for Safeguarding and is the Director of Infection, Prevention and Control. She has responsibility for the Operating Framework delivery, Patient Safety and Quality and is responsible for providing nursing advice to the Board.

(d) Director of Finance

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.

The Director of Finance responsible for the NHS and Primary Care Contracts and for procurement and the work of the Local Security Management Specialists, Local Anti-Fraud Specialist, and Estates Management.

(e) Director of Organisational Development and Human Resources

The Director of Organisational Development and Human Resources shall be responsible for Professional Registration; Recruitment; Training and Organisational Development and providing workforce advice to the Board.

(f) Medical Director

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 and Clinical Effectiveness and has delegated the role of responsible officer for the GMC to the Clinical Lead for Revalidation and the role of Caldicott Guardian to the Associate Medical Director for Clinical Effectiveness.

(g) Director of Corporate Affairs & Governance

The Director of Corporate Affairs & Governance is a non voting Director. They are responsible for the maintenance of governance arrangements at the Trust.

The Director of Corporate Affairs & Governance is responsible for Clinical and Non-Clinical Risk Management; Health, Safety and Fire; Complaints and Litigation; Information Governance; and Emergency Preparedness. They are also the Senior Information Risk Owner at Board level.
(iii) The Director of Corporate Affairs and Governance shall be 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.

(a) **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.

(b) **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 the 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 (e.g. appointing a Lead Board Member with responsibilities for Infection Control or Child Protection Services 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) 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
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 if present, shall preside. If the Chairman and Vice-Chairman 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, if present, shall preside. If the Chairman and Vice-Chairman 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 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 A 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 7) 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).
ARRANGEMENTS FOR THE EXERCISE OF TRUST FUNCTIONS BY DELEGATION

4.21 Delegation of Functions to Committees, Officers or other bodies

4.21.1 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 6, or by an officer of the Trust, or by another body as defined in Standing Orders paragraph 5.1.2 below, in each case subject to such restrictions and conditions as the Board thinks fit.

4.21.2 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.

4.21.3 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.

4.22 Emergency Powers and Urgent Decisions

4.22.1 The powers which the Board has reserved to itself within these Standing Orders (see Standing Orders paragraph 5.5.1) 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.

4.23 Delegation to Committees

4.23.1 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.

4.23.2 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.

4.24 Delegation to Officers

4.24.1 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
4.24.2 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.

4.24.3 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.

4.25 **Schedule of Matters Reserved to the Board and Scheme of Delegation of Powers**

4.25.1 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*.

4.26 **Duty to report non-compliance with Standing Orders and Standing Financial Instructions**

4.26.1 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.

5 **APPOINTMENT OF COMMITTEES AND SUB-COMMITTEES**

5.1 **Appointment of Committees**

5.1.1 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.

5.1.2 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).

5.1.3 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
5.1.4 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.

5.1.5 Committees may not delegate their executive powers to a sub-committee unless expressly authorised by the Board.

5.1.6 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.

5.1.7 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.

5.2 Joint Committees

5.2.1 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).

5.2.2 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.

5.3 Committees established by the Board

5.3.1 The committees, sub-committees, and joint-committees established by the Board are:

(a) **Audit Committee**

   (i) 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.

(ii) 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.

(b) Remuneration and Terms of Service Committee

(i) 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.

(ii) The Higgs report recommends the committee be comprised exclusively of Non-Executive Directors, a minimum of three, who are independent of management.

(iii) 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:

- all aspects of salary (including any performance-related elements / bonuses);
- provisions for other benefits, including pensions and cars;
- arrangements for termination of employment and other contractual terms.

(c) Safety Quality and Standards Committee

(i) 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.

(ii) 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.

(d) Finance, Performance and Workforce Committee

(i) 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
(e) **Other Committees**

(i) The Board may also establish such other committees as required to discharge the Trust's responsibilities.

5.4 **Operational Reporting Forums**

5.4.1 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, 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 scheme is managed through this forum;

(b) **Executive Management Team Meeting** – 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 cost improvement programme.

5.5 **Confidentiality**

5.5.1 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.

5.5.2 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.

5.5.3 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.
6 DUTIES AND OBLIGATIONS OF BOARD MEMBERS AND SENIOR MANAGERS UNDER THESE STANDING ORDERS

6.1 Declaration of Interests

6.1.1 Requirements for Declaring Interests and applicability to Board Members

(a) 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.

6.1.2 Declarable Interests –

(a) Interests which should be declared are:

   (i) directorships, including Non-Executive Directorships held in private companies or public limited companies (with the exception of those of dormant companies);
   (ii) ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS;
   (iii) majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS;
   (iv) a position of authority in a charity or voluntary organisation in the field of health and social care;
   (v) any connection with a voluntary or other organisation contracting for NHS services;
   (vi) research funding / grants that may be received by an individual or their department;
   (vii) interests in pooled funds that are under separate management;
   (viii) one party has direct or indirect control over the other party;
   (ix) the parties are subject to common control from the same source;
   (x) 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;
   (xi) the party is a member of the key management personnel of the entity, or its parent; and
   (xii) the party is a close family member of the other party.
(b) 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 8.3 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.

6.1.3 **Advice on Interests**

(a) If Board members have any doubt about the relevance of an interest, this should be discussed with the Chairman or with the Trust Secretary.

(b) 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.

(c) 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.

6.1.4 **Recording of Interests in Board Minutes**

(a) At the time Board members' interests are declared, they should be recorded in the Board minutes.

(b) Any changes in interests should be declared at the next Board meeting following the change occurring and recorded in the minutes of that meeting.

6.1.5 **Publication of Declared Interests in the Annual Report**

(a) 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.

6.1.6 **Conflicts of interest which arise during the course of a meeting**

(a) 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 7.3 – Exclusion of Chairman and Board Members in proceedings on account of pecuniary interest).
6.1.7 **Interests of spouses or partners**

(a) There is no requirement for the interests of board director's spouses or partners to be declared. Note however that *Standing Orders* paragraph 7.3, which is based on the Membership and Procedure regulations, requires that the interest of directors' spouses, if living together, in contracts should be declared.

6.2 **Register of Interests**

6.2.1 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 7.1.2 – Declarable Interests) which have been declared by both executive and non-executive Board members.

6.2.2 These details will be kept up to date by means of a review which is carried out at least annually.

6.2.3 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.

6.3 **Exclusion of Chairman and Board Members in proceedings on account of pecuniary interest**

6.3.1 **Exclusion in proceedings of the Board**

(a) 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.

(b) 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 7.3.3 on the ‘Waiver’ which has been approved by the Secretary of State for Health).

(c) 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)

(d) 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.

(e) 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.

6.3.2 **Definition of terms used in interpreting ‘Pecuniary’ interest**

(a) For the sake of clarity, the following definition of terms is to be used in interpreting this Standing Order:

(i) "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);

(ii) "contract" shall include any proposed contract or other course of dealing.

(iii) “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:-

- 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

- 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 same, and 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

(b) Exception to Pecuniary interests - a person shall not be regarded as having a pecuniary interest in any contract if:-

(i) 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

(ii) 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.

(c) A person shall not be regarded as having a pecuniary interest in any contract if they (or any person connected to them)
(i) 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

(ii) 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

(iii) 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

(iv) 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.

6.3.3 **Scope**

(a) **Standing Orders** section 7 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

6.3.4 **Powers of the Secretary of State for Health**

(a) Power of the Secretary of State to remove disability

(i) 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.

6.4 **Standards of Business Conduct**

6.4.1 **Trust Policy and National Guidance**

(a) All Trust staff and Board members must comply with the Trust’s **Standards of Business Conduct Policy** and the national guidance contained in HSG(93)5 on ‘Standards of Business Conduct for NHS staff’ (see **Standing Orders** paragraph 9.2).
6.4.2 *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:

(a) **Selflessness**

(i) 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.

(b) **Integrity**

(i) 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.

(c) **Objectivity**

(i) 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.

(d) **Accountability**

(i) 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.

(e) **Openness**

(i) 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.

(f) **Honesty**

(i) 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.

(g) **Leadership**

(i) Holders of public office should promote and support these principles by leadership and example.

6.4.3 *Standards for Members of NHS Boards and Governing Bodies in England* –

(a) 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.
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:

(i) Responsibility
(ii) Honesty
(iii) Openness
(iv) Respect
(v) Professionalism
(vi) Leadership
(vii) Integrity.

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.

6.4.4 **The Health and Social Care Act 2014 (Regulated Activities) Regulations** –

(a) 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:

(i) of good character
(ii) have the necessary qualifications, skills and experience
(iii) are able to perform the work that they are employed for after reasonable adjustments are made
(iv) able to supply information as set out in Schedule 3 of the 2014 Regulations when requested by the Care Quality Commission

(b) When assessing a person being ‘of good character’ NHS providers are required to take account of Schedule 4 of the 2014 Regulations, namely:

(i) 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
(ii) 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’)

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6.4.5 **Francis Report** –

(a) 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:

(i) Foster a common culture shared by all in the service of putting the patient first.

(ii) 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.

(iii) 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.

(iv) 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.

(v) 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.

(vi) 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.

(b) 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

(i) Cavendish review - An Independent Review into Healthcare Assistants and Support Workers in the NHS and Social Care Settings.

(ii) Keogh review - Review into the Quality of Care and Treatment Provided by 14 Hospital Trusts in England

(iii) Berwick review - Improving the Safety of Patients in England

(iv) Clwyd Hart review – Putting Patients back in the Picture which related to handling patient complaints

(c) 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.
6.4.6 **Interest of Officers in Contracts**

(a) 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 7.3) 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.

(b) 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.

(c) The Trust will require interests, employment or relationships so declared to be entered in a register of interests of staff.

6.4.7 **Canvassing of and Recommendations by Board Members in Relation to Appointments**

(a) 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.

(b) 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.

(c) Informal discussions outside appointments panels or committees, whether solicited or unsolicited, should be declared to the panel or committee

6.4.8 **Relatives of Members**

(a) 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.

(b) 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.

(c) 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.
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 7.3) shall apply.

7 CUSTODY OF SEAL, SEALING OF DOCUMENTS AND SIGNATURE OF DOCUMENTS

7.1 Custody of Seal

7.1.1 The common seal of the Trust shall be kept by the Chief Executive in a secure place.

7.2 Sealing of Documents

7.2.1 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.

7.3 When should the Seal be Used

7.3.1 The following examples should be used as a guide as to when the seal should be used:

(a) All contracts for the purchase / lease of land and/ or building

(b) All contracts for capital works exceeding £250,000

(c) All lease agreements where the annual lease charge exceeds £50,000 per annum and the period of the lease extends beyond 5 years

(d) Any other lease agreement where the total payable under the lease exceeds £100,000

7.4 Register of Sealing

7.4.1 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).

7.5 Signature of documents

7.5.1 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.
7.5.2 The Board delegates signature of responses to Industrial Tribunals to the Director of Human Resources and Organisational Development.

7.5.3 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.

8 OVERLAP WITH OTHER TRUST POLICY STATEMENTS / PROCEDURES AND REGULATIONS

8.1 Policy Statements: General Principles

8.1.1 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.

8.2 Specific Policy Statements

8.2.1 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 Policy statements:

(a) the Standards of Business Conduct Policy for East Cheshire NHS Trust staff;
(b) the staff Disciplinary and Appeals Procedures adopted by the Trust, both of which shall have effect as if incorporated in these Standing Orders.

8.3 Specific Guidance

8.3.1 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:

(a) Caldicott Guardian 1997;
(b) Human Rights Act 1998;
(c) Freedom of Information Act 2000;
(d) The Public Contracts Regulations 2006 and 2015;
(e) Confidentiality: NHS Code of Practice 2003;
9 MISCELLANEOUS
(see overlap with Standing Financial Instructions paragraph 9.3)

9.1 Standing Orders to be given to Directors and Officers

9.1.1 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.

9.2 Documents having the Standing of Standing Orders

9.2.1 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.

9.3 Indemnity

9.3.1 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.

9.4 Joint Finance Arrangements

9.4.1 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.

9.4.2 See overlap with Standing Financial Instruction No. 9.3.

9.5 Review of Standing Orders

9.5.1 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.
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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
FINANCIAL AND PERFORMANCE REPORTING ARRANGEMENTS
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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 Executive for the funds entrusted to the Trust.

The Director of Nursing, Performance 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.
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 3.3).

(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 (formally Annual 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 6.1.5, 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.

**Tier 1 budget holders** – Executive Director level  
**Tier 2 budget Holders** – Deputy Director / Associate Director Level  
**Tier 3 budget holders** – service manager level

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<thead>
<tr>
<th>REFERENCE</th>
<th>DELEGATED TO</th>
<th>DUTIES DELEGATED</th>
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<tbody>
<tr>
<td><strong>1. STANDING ORDERS AND STANDING FINANCIAL INSTRUCTIONS</strong></td>
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</tr>
<tr>
<td>SO 2.1</td>
<td>Chairman</td>
<td>Final authority in interpretation of SOs.</td>
</tr>
<tr>
<td>SO 4.17.5</td>
<td>Audit Committee</td>
<td>Review every decision to suspend SOs.</td>
</tr>
<tr>
<td>SO 9.1.1 and SFI 1.3.6</td>
<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>
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<tr>
<td><strong>2. MEETINGS</strong></td>
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<tr>
<td>SO 4.2/4.4</td>
<td>Chairman</td>
<td>Calling meetings.</td>
</tr>
<tr>
<td>SO 4.6</td>
<td>Chairman</td>
<td>Chair all board meetings and associated responsibilities.</td>
</tr>
<tr>
<td><strong>3. REGISTER OF INTERESTS</strong></td>
<td></td>
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</tr>
<tr>
<td>SO 6.1 and 6.4.6</td>
<td>All Board Directors</td>
<td>Declare relevant and material interests</td>
</tr>
<tr>
<td>SO 6.2.1 and 6.4.6</td>
<td>Director of Corporate Affairs and Governance</td>
<td>Maintain a register(s) of interests.</td>
</tr>
<tr>
<td>REFERENCE</td>
<td>DELEGATED TO</td>
<td>DUTIES DELEGATED</td>
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<tr>
<td>SFI 2.2.7</td>
<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>SO 7.5.1</td>
<td>Chief Executive</td>
<td>Approve and sign all documents which will be necessary in legal proceedings</td>
</tr>
<tr>
<td>SO 7.5.3</td>
<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>
</tbody>
</table>

### 5. PROPERTY AGREEMENTS AND LICENCES

<table>
<thead>
<tr>
<th>SO 7.2.1</th>
<th>Director of Finance / Director of Human Resources and Organisational Development</th>
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<tr>
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<td>SO 7.2.1</td>
<td>Director of Human Resources and Organisational Development</td>
</tr>
</tbody>
</table>

- Preparation and signature of all tenancy agreements/licenses for all staff subject to Trust Policy on accommodation for staff
- Extensions to existing leases
- Letting of premises to outside organizations
- Approval of rent based on professional assessment

### 6. AUDIT ARRANGEMENTS

<table>
<thead>
<tr>
<th>SFI 2.1.1</th>
<th>Audit Committee</th>
<th>Provide independent and objective view on internal control and probity.</th>
</tr>
</thead>
<tbody>
<tr>
<td>SFI 2.1.2</td>
<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>
</tr>
<tr>
<td>REFERENCE</td>
<td>DELEGATED TO</td>
<td>DUTIES DELEGATED</td>
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</tr>
<tr>
<td>SFI 2.1.3</td>
<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>
</tr>
<tr>
<td>SFI 2.2.1</td>
<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 Protect’s Standards for Providers</td>
</tr>
<tr>
<td>SFI 2.2.2</td>
<td>Director of Finance</td>
<td>Nominate Individual to carry out the duties of the Local Anti-Fraud Specialist.</td>
</tr>
<tr>
<td>SFI 2.3.3 and 2.6.1</td>
<td>Director of Corporate Affairs and Governance</td>
<td>Implementation of Internal and External Audit Recommendations</td>
</tr>
<tr>
<td>SFI 2.6.2</td>
<td>Director of Corporate Affairs and Governance</td>
<td>Investigate any suspected cases of irregularity not related to fraud or corruption and not covered by work to counter fraud and corruption in accordance with S of S Directions.</td>
</tr>
<tr>
<td>SFI 2.2.4</td>
<td>Director of Finance</td>
<td>The Local Anti-Fraud Specialist will provide a written report, at least annually, on counter fraud work within the Trust.</td>
</tr>
<tr>
<td>SFI 2.6.2</td>
<td>Director of Corporate Affairs and Governance</td>
<td>Decide at what stage to involve police in cases of misappropriation and other irregularities not involving fraud or corruption.</td>
</tr>
<tr>
<td>SFI 2.4</td>
<td>Director of Finance</td>
<td>Review, appraise and report in accordance with NHS Internal Audit Standards and best practice.</td>
</tr>
<tr>
<td>SFI 2.5</td>
<td>Audit Committee</td>
<td>Establish a panel to appoint External Auditors. Ensure cost-effective External Audit.</td>
</tr>
</tbody>
</table>

**7. BUDGETS, BUDGETARY CONTROL AND MONITORING**

<p>| SFI 1.3.7       | 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. |</p>
<table>
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<tr>
<th>REFERENCE</th>
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<tr>
<td>SFI 1.3.7</td>
<td>Director of Finance</td>
<td>Maintain &amp; Update on Trust Financial Procedures</td>
</tr>
<tr>
<td>SFI 1.3.8</td>
<td>All Directors and Employees</td>
<td>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.</td>
</tr>
<tr>
<td>SFI 1.3.10</td>
<td>Director of Finance</td>
<td>To be satisfied with the form and adequacy of financial records kept and manner in which financial duties discharged in all departments.</td>
</tr>
<tr>
<td>SFI 3.1.1</td>
<td>Chief Executive</td>
<td>Compile and submit to the Board an annual business plan</td>
</tr>
<tr>
<td>SFI 3.1.2</td>
<td>Director of Finance</td>
<td>Submit budgets to the Board for approval.</td>
</tr>
<tr>
<td>SFI 3.1.3</td>
<td>Director of Finance</td>
<td>Monitor performance against budget, submit to Board financial estimates and forecasts.</td>
</tr>
<tr>
<td>SFI 3.1.5</td>
<td>Director of Finance</td>
<td>Ensure that adequate training is delivered on an on-going basis to budget holders</td>
</tr>
<tr>
<td>SFI 3.2.1</td>
<td>Chief Executive</td>
<td>Delegate budget to budget holders, subject to the budgetary total or virement limits set by the Board not being exceeded</td>
</tr>
<tr>
<td>SFI 3.3.1</td>
<td>Director of Finance</td>
<td>Devise and maintain systems of budgetary control.</td>
</tr>
</tbody>
</table>
| SFI 3.3.2 | 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 employees are appointed without the approval of the Chief Executive other than those provided for within available resources and manpower establishment |
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<tbody>
<tr>
<td>SFI 3.3.2</td>
<td>Chief Executive</td>
<td>Responsibility of keeping expenditure within budgets</td>
</tr>
<tr>
<td></td>
<td></td>
<td>a) For the Trust as a whole</td>
</tr>
<tr>
<td></td>
<td>Tier 1, Tier 2 and Tier 3 Budget Holder</td>
<td>b) For areas within delegated scope of responsibility</td>
</tr>
<tr>
<td>SFI 3.3.3</td>
<td>Chief Executive</td>
<td>Identify and implement cost improvements and income generation activities in line with the Trust Plan (formally annual Plan).</td>
</tr>
<tr>
<td>SFI 3.5.1</td>
<td>Chief Executive or Director of Finance</td>
<td>Submit monitoring returns</td>
</tr>
</tbody>
</table>

8. ANNUAL ACCOUNTS AND REPORTS

| SFI 4.1   | Director of Finance | Prepare and submit Annual accounts, reports and returns. |
| SFI 4.3   | Director of Nursing, Performance and Quality | Prepare and submit Annual Quality Accounts |

9. BANK ACCOUNTS

| SFI 5.1.1 | Director of Finance | Managing the Trust's banking arrangements and advising the Trust on the provision of banking services and operation of accounts. |
| SFI 5.2   | Director of Finance | Operate and monitor bank accounts |
| SFI 5.3   | Director of Finance | Prepare detailed instructions on the operation of the bank accounts |
| SFI 5.4.1 | 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 |

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

<p>| SFI 6.1.1 | 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. |</p>
<table>
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<tr>
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<tbody>
<tr>
<td>SFI 6.2.1</td>
<td>Director of Finance</td>
<td>Follow the NHS Payment by Results guidance in setting prices for commissioner contracts.</td>
</tr>
<tr>
<td>SFI 6.2.2</td>
<td>Director of Finance</td>
<td>Approval and regular review of level of fees and charges for Private Patient, Overseas Visitors, Income Generation and other patient related services.</td>
</tr>
<tr>
<td>SFI 6.2.3</td>
<td>All Employees</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>
</tr>
<tr>
<td>SFI 6.3</td>
<td>Director of Finance</td>
<td>Appropriate recovery action on all debts</td>
</tr>
<tr>
<td>SFI 6.4</td>
<td>Director of Finance</td>
<td>Security of cash, cheques &amp; negotiable instruments</td>
</tr>
</tbody>
</table>

### 11. CONTRACTING FOR PROVISION OF SERVICES

<table>
<thead>
<tr>
<th>SFI 7.1</th>
<th>Chief Executive with Director of Finance</th>
<th>Negotiating contracts for provision of patient services in accordance with the Trust plan.</th>
</tr>
</thead>
<tbody>
<tr>
<td>SFI 7.1</td>
<td>Director of Finance with Chief Executive’s approval</td>
<td>Approve and sign the main commissioner contract for patient services</td>
</tr>
<tr>
<td>SFI 7.3</td>
<td>Director of Finance</td>
<td>Regular reports of actual and forecast contract expenditure.</td>
</tr>
<tr>
<td>SFI 7.2 / SFI 6.2.1</td>
<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>SFI 7.7.1</td>
<td>Chief Executive</td>
<td>Regular reports provided to the Board on actual and forecast income from contracts, including information on costing arrangements</td>
</tr>
<tr>
<td></td>
<td>Deputy Director of Finance</td>
<td>Approval of Service Level Agreements</td>
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</tbody>
</table>

### 12. BUSINESS CASES

<p>| Tier 2 and Tier 3 Budget Holders | Development and submission of Business Cases in line with the agreed approval process |</p>
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<tr>
<td></td>
<td>Chief Executive</td>
<td>Delegate responsibility for approval of business cases subject to defined limits (refer to delegated financial limits)</td>
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</tbody>
</table>

### 13. TERMS OF SERVICE AND PAYMENT OF DIRECTORS AND EMPLOYEES

<table>
<thead>
<tr>
<th>Reference</th>
<th>Role</th>
<th>Duties</th>
</tr>
</thead>
<tbody>
<tr>
<td>SFI 9.1.1</td>
<td>Chairman</td>
<td>Establish a Remuneration &amp; Terms of Service Committee</td>
</tr>
</tbody>
</table>
| SFI 9.1.2 | Remuneration & Terms of Service Committee | 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 |
| SFI 9.1.3 | Remuneration and Terms of Service Committee | Report in writing to the Board its advice and its bases about remuneration and terms of service of directors and senior employees. |
| SFI 9.2.2 | Chief Executive and Director of Finance | Approval of Increase in funded establishment of any department.                                                                          |
| SFI 9.3   | 2nd Tier Budget Holders | a) Authority to fill funded post on the establishment with permanent staff.                                                             |
|           | 2nd Tier Budget Holders | b) Authority for additional staff to the agreed establishment with specifically allocated finance                                          |
|           | Director of Human Resources and Organisational Development or Director of Finance | In addition to a) and b)  
c) Authority to appoint staff to post not on the formal establishment, grant additional increments and re-grade / upgrade staff without a specifically allocated budget |
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<th>REFERENCE</th>
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<th>DUTIES DELEGATED</th>
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| SFI 9.4.3 | 3rd Tier Budget Holders | d) Pay  
   i) Authority to complete standing data forms effecting pay, new starters, variations and leavers  
   ii) Authority to complete and authorise positive reporting forms, or recognised alternative, where appropriate  
   iii) Authority to authorise overtime |
|           | Line/Departmental Manager  
   3rd Tier Budget Holders  
   2nd Tier Budget Holders  
   1st Tier Budget Holders | e) Leave  
   In line with trust policy |
|           | Consultant/Medical Director and CE | Leave (continued)  
   In line with trust policy  
   ix) Medical Staff Leave of Absence, paid and unpaid |
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<th>REFERENCE</th>
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<tbody>
<tr>
<td>3rd Tier Budget Holders</td>
<td>Automatic approval with guidance</td>
<td>f) Sick Leave</td>
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<tr>
<td>Director of Human Resources and Organisational</td>
<td></td>
<td>Extension of Sick Leave</td>
</tr>
<tr>
<td>Development</td>
<td></td>
<td>i) Extension of sick leave on half pay up to three</td>
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<td></td>
<td>months</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ii) Extension of sick leave on full pay</td>
</tr>
<tr>
<td></td>
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</tr>
<tr>
<td>CE/Medical Director</td>
<td></td>
<td>g) Study Leave – In line with trust policy</td>
</tr>
<tr>
<td>Clinical Director/Medical Director</td>
<td></td>
<td>i) Study leave outside the UK</td>
</tr>
<tr>
<td>2nd Tier Budget Holder</td>
<td></td>
<td>ii) Medical staff study leave (UK)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>iii) All other study leave (UK)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Director of Human Resources and Organisational</td>
<td></td>
<td>h) Removal Expenses, Excess Rent and House Purchases</td>
</tr>
<tr>
<td>Development</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>i) Authorisation of payment of removal expenses</td>
</tr>
<tr>
<td></td>
<td></td>
<td>incurred by officers taking up new appointments</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(consultants &amp; hard to recruit to posts only -</td>
</tr>
<tr>
<td></td>
<td></td>
<td>providing consideration was promised at interview)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>i) up to £8,500</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ii) over £8,500</td>
</tr>
<tr>
<td>REFERENCE</td>
<td>DELEGATED TO</td>
<td>DUTIES DELEGATED</td>
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</tr>
</tbody>
</table>
| Director of Human Resources and Organisational Development | i) Grievance Procedure  
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 |  |
| Tier 2 Budget Holders | j) Authorised Car & Mobile Phone Users  
i. Requests for new posts to be authorised as car users  
ii. Approval of mobile phone / smart phone users  
iii. Approval of ipad users |  |
| Tier 3 Budget Holders | k) Renewal of Fixed Term Contract within agreed budget |  |
| Director of Human Resources and Organisational Development | l) Staff Retirement Policy  
i) Authorisation of extensions of contract beyond normal retirement age in exceptional circumstances  
ii) Authorisation of return to work in part time capacity under the flexible retirement scheme |  |
<p>| Director of Human Resources and Organisational Development &amp; Remuneration Committee | m) Redundancy and/or Redeployment |  |
| | n) Ill Health Retirement |  |</p>
<table>
<thead>
<tr>
<th>REFERENCE</th>
<th>DELEGATED TO</th>
<th>DUTIES DELEGATED</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Director of Human Resources and Organisational Development</td>
<td>Decision to pursue retirement on the grounds of ill-health</td>
</tr>
<tr>
<td></td>
<td>Dismissing Officers with advice from Director of Human Resources and Organisational Development</td>
<td>o) Dismissal</td>
</tr>
<tr>
<td>SFI 9.3.1</td>
<td>Executive Directors</td>
<td>Engage, re-engage, or regrade employees, either on a permanent or temporary nature, hire agency staff, agree changes in remuneration outside departmental approved budget and funded establishment.</td>
</tr>
</tbody>
</table>
| SFI 9.4.1 | 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 9.4.3 | Nominated Managers | Submit time records and other notifications in line with timetable;  
Complete time records and other notifications;  
Submit termination forms |
<p>| SFI 9.4.4 | Director of Finance | 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. |</p>
<table>
<thead>
<tr>
<th>REFERENCE</th>
<th>DELEGATED TO</th>
<th>DUTIES DELEGATED</th>
</tr>
</thead>
<tbody>
<tr>
<td>SFI 9.5.1</td>
<td>Director of Human Resources and Organisational Development</td>
<td>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.</td>
</tr>
<tr>
<td>SFI 19.9.1</td>
<td>Chief Executive</td>
<td>Nominate officers to enter into contracts of employment, regrading staff, agency staff or consultancy service contracts.</td>
</tr>
</tbody>
</table>

### 14. NON PAY EXPENDITURE

<table>
<thead>
<tr>
<th>REFERENCE</th>
<th>DELEGATED TO</th>
<th>DUTIES DELEGATED</th>
</tr>
</thead>
<tbody>
<tr>
<td>SFI 10.1.1</td>
<td>Director of Finance</td>
<td>Determine, and set out, level of delegation of non-pay expenditure to budget managers.</td>
</tr>
<tr>
<td>SFI 10.1.3</td>
<td>Director of Finance</td>
<td>Set out procedures on the seeking of professional advice regarding the supply of goods and services.</td>
</tr>
<tr>
<td>SFI 10.2.2</td>
<td>Director of Finance</td>
<td>Prompt payment of accounts.</td>
</tr>
<tr>
<td>REFERENCE</td>
<td>DELEGATED TO</td>
<td>DUTIES DELEGATED</td>
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</tr>
<tr>
<td>SFI 10.2.3</td>
<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>
</tr>
<tr>
<td>SFI 10.2.5</td>
<td>Chief Executive</td>
<td>Authorise who may use and be issued with official orders.</td>
</tr>
<tr>
<td>SFI 10.2.6</td>
<td>All Managers</td>
<td>Ensure that they comply fully with the guidance and limits for Non Pay Expenditure as specified by the Director of Finance.</td>
</tr>
<tr>
<td>SFI 10.2.7</td>
<td>Chief Executive</td>
<td>Ensure that Standing Orders are compatible with NHS Improvement requirements re building and engineering contracts.</td>
</tr>
<tr>
<td>SFI 10.2.9</td>
<td>Director of Finance</td>
<td>Prepare procedures in accordance with good practice on payments to local authorities and voluntary organisations.</td>
</tr>
</tbody>
</table>

### 15. BORROWING AND INVESTMENT

<table>
<thead>
<tr>
<th>REFERENCE</th>
<th>DELEGATED TO</th>
<th>DUTIES DELEGATED</th>
</tr>
</thead>
<tbody>
<tr>
<td>SFI 11.1.1</td>
<td>Director of Finance</td>
<td>Advise Board on borrowing and investment needs and prepare procedural instructions.</td>
</tr>
<tr>
<td>SFI 11.1.2</td>
<td>Two nominated signatories</td>
<td>Any request for temporary borrowing must be authorised by two of the nominated signatories</td>
</tr>
<tr>
<td>SFI 11.2.2</td>
<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>
</tr>
<tr>
<td>SFI 11.2.3</td>
<td>Director of Finance</td>
<td>Prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained</td>
</tr>
<tr>
<td>REFERENCE</td>
<td>DELEGATED TO</td>
<td>DUTIES DELEGATED</td>
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</tr>
<tr>
<td>SFI 11.2</td>
<td>Director of Finance</td>
<td>Investment of Funds [including Charitable &amp; Endowment Funds]</td>
</tr>
<tr>
<td>SFI 11.3</td>
<td>Director of Finance</td>
<td>Ensure members of the Board are aware of the Financial Framework</td>
</tr>
<tr>
<td><strong>16. CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SFI 12.1.1</td>
<td>Director of Finance</td>
<td>Capital investment programme developed which ensures that there is adequate</td>
</tr>
<tr>
<td></td>
<td></td>
<td>appraisal and approval process for determining capital expenditure priorities and</td>
</tr>
<tr>
<td></td>
<td></td>
<td>the effect that each has on plans; cost; and that capital investment is not</td>
</tr>
<tr>
<td></td>
<td></td>
<td>undertaken without availability of resources to finance all revenue consequences.</td>
</tr>
<tr>
<td>SFI 12.1.2</td>
<td>Director of Finance</td>
<td>Business case is produced for each proposal</td>
</tr>
<tr>
<td>SFI 12.1.2</td>
<td>Director of Finance or</td>
<td>Certify professionally the costs and revenue consequences detailed in the business</td>
</tr>
<tr>
<td></td>
<td>nominated deputy</td>
<td>case for capital investment</td>
</tr>
<tr>
<td>N/A</td>
<td>Director of Finance</td>
<td>Selection of architects, quantity surveyors, consultant engineer and other</td>
</tr>
<tr>
<td></td>
<td></td>
<td>professional advisors within EU regulations</td>
</tr>
<tr>
<td>SFI 12.1.3</td>
<td>Director of Finance</td>
<td>Financial Monitoring and reporting on the capital programme.</td>
</tr>
<tr>
<td>SFI 12.1.4</td>
<td>Chief Executive</td>
<td>Issue a scheme of delegation for capital investment management in accordance with</td>
</tr>
<tr>
<td></td>
<td></td>
<td>&quot;Estatecode&quot; guidance and the Trust's Standing Orders</td>
</tr>
<tr>
<td>SFI 12.1.5</td>
<td>Director of Finance</td>
<td>Issue procedures governing financial management, including variations to contract,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>of capital investment projects and valuation for accounting purposes.</td>
</tr>
<tr>
<td>SFI 12.2</td>
<td>Director of Finance</td>
<td>Demonstrate that the use of private finance represents value for money and</td>
</tr>
<tr>
<td></td>
<td></td>
<td>genuinely transfers significant risk to the private sector.</td>
</tr>
<tr>
<td>SFI 12.3.1</td>
<td>Director of Finance</td>
<td>Maintenance of asset registers.</td>
</tr>
<tr>
<td>REFERENCEx</td>
<td>DELEGATED TO</td>
<td>DUTIES DELEGATED</td>
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</tr>
<tr>
<td>SFI 12.3.5</td>
<td>Director of Finance</td>
<td>Approve procedures for reconciling balances on fixed assets accounts in ledgers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>against balances on fixed asset registers.</td>
</tr>
<tr>
<td>SFI 12.4.1</td>
<td>Chief Executive</td>
<td>Overall responsibility for fixed assets.</td>
</tr>
<tr>
<td>SFI 12.4.2</td>
<td>Director of Finance</td>
<td>Approval of asset control procedures (including fixed assets, cash, cheques and</td>
</tr>
<tr>
<td></td>
<td></td>
<td>other negotiable instruments.</td>
</tr>
<tr>
<td>SFI 12.4.4</td>
<td>All employees</td>
<td>Security of property of the Trust</td>
</tr>
<tr>
<td>SFI 12.4.4</td>
<td>All senior staff</td>
<td>Responsibility for security of Trust assets including notifying discrepancies to</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Director of Finance, and reporting losses in accordance with Trust procedure.</td>
</tr>
</tbody>
</table>

### 17. STORES AND RECEIPT OF GOODS

<table>
<thead>
<tr>
<th>SFI 13.1.2</th>
<th>Director of Finance</th>
<th>Responsible for systems of control over stores and receipt of goods.</th>
</tr>
</thead>
<tbody>
<tr>
<td>SFI 13.1.2</td>
<td>Designated Pharmaceutical</td>
<td>Responsible for controls of pharmaceutical stock</td>
</tr>
<tr>
<td>Officer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SFI 13.1.2</td>
<td>Designated Estates Manager</td>
<td>Responsible for control of stocks of fuel oil</td>
</tr>
<tr>
<td>SFI 12.3</td>
<td>Nominated Managers/</td>
<td>Security arrangements and custody of keys</td>
</tr>
<tr>
<td>Pharmaceutical Officer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SFI 13.1.3</td>
<td>Director of Finance</td>
<td>Set out procedures and systems to regulate the stores.</td>
</tr>
<tr>
<td>SFI 13.1.4</td>
<td>Director of Finance</td>
<td>Agree stocktaking arrangements.</td>
</tr>
<tr>
<td>SFI 13.1.6</td>
<td>Director of Finance</td>
<td>Approve alternative arrangements where a complete system of stores control is not</td>
</tr>
<tr>
<td></td>
<td></td>
<td>justified.</td>
</tr>
<tr>
<td>SFI 13.1.7</td>
<td>Director of Finance</td>
<td>Approve system for review of slow moving and obsolete items and for condemnation,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>disposal and replacement of all unserviceable items.</td>
</tr>
<tr>
<td>REFERENCE</td>
<td>DELEGATED TO</td>
<td>DUTIES DELEGATED</td>
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<tr>
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<td>-----------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>SFI 13.1.7</td>
<td>Designated Officer</td>
<td>Operate system for slow moving and obsolete stock, and report to Director of Finance evidence of significant overstocking.</td>
</tr>
<tr>
<td>SFI 13.1.8</td>
<td>Chief Executive / Designated Officer</td>
<td>Identify persons authorised to requisition and accept goods from NHS Supply Chain.</td>
</tr>
</tbody>
</table>

### 18. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

<table>
<thead>
<tr>
<th>SFI 14.1.1</th>
<th>Director of Finance</th>
<th>Prepare detailed procedures for disposal of assets including condemnations and ensure that these are notified to managers.</th>
</tr>
</thead>
<tbody>
<tr>
<td>SFI 14.2.1</td>
<td>Director of Finance</td>
<td>Prepare procedures for recording and accounting for losses and special payments and informing NHS Improvement and NHS Protect of all frauds and informing police in cases of suspected arson or theft.</td>
</tr>
<tr>
<td>SFI 14.2.1</td>
<td>Director of Finance</td>
<td>Prepare Fraud, Bribery and Corruption response plan.</td>
</tr>
<tr>
<td>SFI 14.2.2</td>
<td>All employees</td>
<td>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</td>
</tr>
<tr>
<td>SFI 14.2.4</td>
<td>Director of Finance</td>
<td>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.</td>
</tr>
<tr>
<td>SFI 14.2.4</td>
<td>Audit Committee</td>
<td>Approve write off of losses within delegated limits.</td>
</tr>
<tr>
<td>SFI 14.2.6</td>
<td>Director of Finance</td>
<td>Take necessary steps to safeguard Trust’s interests in bankruptcies and company liquidations.</td>
</tr>
<tr>
<td>REFERENCE</td>
<td>DELEGATED TO</td>
<td>DUTIES DELEGATED</td>
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</tr>
<tr>
<td>SFI 14.2.7</td>
<td>Director of Finance</td>
<td>Consider whether any insurance claim can be made.</td>
</tr>
<tr>
<td>SFI 14.2.8</td>
<td>Director of Finance in conjunction with Director of Corporate Affairs &amp; Governance</td>
<td>Maintain losses and special payments register</td>
</tr>
<tr>
<td>SFI 20 (a)</td>
<td>Chief Executive</td>
<td>Determining any items to be sold by sale or negotiation.</td>
</tr>
<tr>
<td>SFI 14.3.1</td>
<td>Director of Finance</td>
<td>Ensure compliance with the NHS Standards Contract in accordance with NHS Protect’s Security Standards for Providers on security management</td>
</tr>
<tr>
<td>SFI 143.3.2</td>
<td>Director of Finance</td>
<td>Identify an individual to carry out the functions of the Local Security Management Specialist</td>
</tr>
</tbody>
</table>

### 19. INFORMATION TECHNOLOGY

<table>
<thead>
<tr>
<th>REFERENCE</th>
<th>DELEGATED TO</th>
<th>DUTIES DELEGATED</th>
</tr>
</thead>
<tbody>
<tr>
<td>SFI 15.1.1</td>
<td>Chief Executive</td>
<td>Overall responsibility for Information Technology</td>
</tr>
<tr>
<td>SFI 15.1.1</td>
<td>Director of Finance</td>
<td>Responsible for accuracy and security of computerised financial data.</td>
</tr>
<tr>
<td>SFI 15.1.2</td>
<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>
</tr>
<tr>
<td>SFI 15.1.3</td>
<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>
</tr>
<tr>
<td>SFI 15.1.4</td>
<td>Audit Committee</td>
<td>Periodically seek assurances that adequate controls are in operation.</td>
</tr>
<tr>
<td>SFI 15.1.5</td>
<td>Chief Executive</td>
<td>Satisfy him/herself that systems acquisition, development and maintenance are in line</td>
</tr>
<tr>
<td>REFERENCE</td>
<td>DELEGATED TO</td>
<td>DUTIES DELEGATED</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>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>
</tr>
<tr>
<td>SFI 15.6.1</td>
<td>Director of Corporate Affairs and Governance</td>
<td>Review of Trust's compliance with the Data Protection Act</td>
</tr>
<tr>
<td>SFI 15.6.2</td>
<td>All employees</td>
<td>Compliance with Data Protection Act</td>
</tr>
<tr>
<td>SFI 15.4.1</td>
<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>
</tr>
</tbody>
</table>

20. **PATIENTS’ PROPERTY**

| SFI 16.2 | Chief Executive | Responsible for ensuring patients and guardians are informed about patients' money and property procedures before or at admission. |
| SFI 16.3 | Director of Finance | 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. |
| SFI 16.6 | Departmental or Senior Managers | Inform staff of their responsibilities and duties for the administration of the property of patients. |

21. **RETENTION OF DOCUMENTS (RECORDS)**

<p>| SFI 17.1 | Director of Corporate Affairs and Governance | Maintaining archives for all records required to be retained in accordance with Department of Health guidelines |
| SFI 17.1 | Director of Corporate Affairs and Governance | Review the Trust's compliance with the Access to Records Act |
| SFI 17.2 | Medical Director and Director of | Development of strategies, policies and procedures for clinical records and non-clinical |</p>
<table>
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<tr>
<th>REFERENCE</th>
<th>DELEGATED TO</th>
<th>DUTIES DELEGATED</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Corporate Affairs and Governance</td>
<td>records</td>
</tr>
<tr>
<td>SFI 17.2</td>
<td>Medical Director and Director of Corporate Affairs and Governance</td>
<td>Compliance with strategies, policies and procedures for clinical records and non-clinical records</td>
</tr>
<tr>
<td>N/A</td>
<td>Associate Medical Director for Clinical Effectiveness</td>
<td>Has the role of Caldicott Guardian</td>
</tr>
<tr>
<td>N/A</td>
<td>Director of Corporate Affairs &amp; Governance</td>
<td>Has role of Senior Information Risk Owner (SIRO)</td>
</tr>
</tbody>
</table>

**RISK MANAGEMENT & INSURANCE**

<p>| SFI 18.1.2 | Director of Finance/Director of Corporate Affairs and Governance | Ensure that insurance arrangements exist in accordance with the risk management programme |
| OGA 5.1.1  | Chief Executive | Risk management programme |
| OGA 5.1.2  | Director of Corporate Affairs and Governance | Develop and maintain a risk management strategy and policy |
| OGA 5.1.3  | Director of Corporate Affairs and Governance | Develop systems for the identification and management of risks and incidents across the Trust |
| OGA 18.1.2 | All employees | Comply with the system for identification and management of risks and incidents |
| N/A        | Director of Corporate Affairs and Governance | Develop a system for assessment of performance against the NHSLA standard and retain evidence |
| N/A        | Director of Corporate Affairs and Governance | Develop a system for assessment of performance against the CQC standards and retain evidence |</p>
<table>
<thead>
<tr>
<th>REFERENCE</th>
<th>DELEGATED TO</th>
<th>DUTIES DELEGATED</th>
</tr>
</thead>
<tbody>
<tr>
<td>23. STANDARDS OF BUSINESS CONDUCT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SFI 22.1</td>
<td>Director of Corporate Affairs &amp; Governance</td>
<td>Maintenance of robust governance arrangements over standards of business conduct including a Hospitality Register</td>
</tr>
<tr>
<td>SFI 22.1 / APPENDIX A1</td>
<td>All employees</td>
<td>Declaration of Hospitality received (Applies to both individual and collective hospitality receipt items. In excess of £25.00 per item received, declaration required in Trust’s Hospitality Register)</td>
</tr>
<tr>
<td>N/A</td>
<td>All employees</td>
<td>Comply with the systems and policies on confidentiality</td>
</tr>
<tr>
<td>SO 5.5</td>
<td>All employees</td>
<td>Shall not disclose any matter reported to, or dealt with, by the Board or other committee without its permission</td>
</tr>
<tr>
<td>24. TENDERING &amp; CONTRACTS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SFI 19.7.9</td>
<td>Chief Executive</td>
<td>Best value for money is demonstrated for all services provided under contract or in-house.</td>
</tr>
<tr>
<td>SFI 19.8.1</td>
<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>
</tr>
<tr>
<td>SFI 19.9.2</td>
<td>Chief Executive</td>
<td>Nominate an officer to oversee and manage the contract on behalf of the Trust.</td>
</tr>
<tr>
<td>SFI 19.1.3</td>
<td>Chief Executive</td>
<td>Nominate officers with power to negotiate commissioning contracts with providers of healthcare and other authorities.</td>
</tr>
<tr>
<td>SFI 19.4.5</td>
<td>Chief Executive</td>
<td>Designate an officer responsible for receipt and custody of tenders before opening.</td>
</tr>
<tr>
<td>SFI 19.4.5</td>
<td>Two Executive Directors</td>
<td>Open tenders.</td>
</tr>
<tr>
<td>SFI 19.4.5</td>
<td>CE or nominated officer</td>
<td>Decide whether any late tenders should be considered.</td>
</tr>
<tr>
<td>REFERENCE</td>
<td>DELEGATED TO</td>
<td>DUTIES DELEGATED</td>
</tr>
<tr>
<td>-----------</td>
<td>--------------</td>
<td>------------------</td>
</tr>
<tr>
<td><strong>25. COMPLAINTS</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| N/A | Director of Corporate Affairs and Governance 2nd Tier Budget Holder | a) Overall responsibility for ensuring that all complaints are dealt with effectively  
b) Responsibility for ensuring complaints relating to a service area are investigated thoroughly.  
c) Medico - Legal Complaints - Coordination of their management. |
| | Deputy Director of Corporate Affairs and Governance | |
| **26. SEAL** | | |
| SO 7.1.1/7.4.1 | Chief Executive | Keep seal in safe place and maintain a register of sealing. |
| SO 7.2.1 | Chairman/Chief Executive | Attestation of sealings in accordance with Standing Orders |
| **27. SPONSORSHIP** | | |
| N/A | Chief Executive & Medical Director | Authorisation of Sponsorship deals |
| **28. RESEARCH & CLINICAL TRIALS** | | |
| N/A | Chief Executive & Medical Director | Authorisation of Research Projects |
| N/A | Chief Executive & Medical Director | Authorisation of Clinical Trials |
| **29. RELATIONSHIPS WITH PRESS** | | |
| N/A | Director of Corporate Affairs & Governance | a) Non-Emergency General Enquiries  
Within Hours |

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<table>
<thead>
<tr>
<th>REFERENCE</th>
<th>DELEGATED TO</th>
<th>DUTIES DELEGATED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive On-Call or Director of Corporate Affairs &amp; Governance</td>
<td>. Outside Hours</td>
<td></td>
</tr>
<tr>
<td>Director of Corporate Affairs &amp; Governance</td>
<td>b) Emergency</td>
<td></td>
</tr>
<tr>
<td>Executive On-Call or Director of Corporate Affairs &amp; Governance</td>
<td>. Within Hours</td>
<td></td>
</tr>
<tr>
<td></td>
<td>. Outside Hours</td>
<td></td>
</tr>
</tbody>
</table>

### 30. INFECTIOUS DISEASES

| N/A | Director of Nursing, Performance and Control | Act as Director of Infection, Prevention and Control |
| N/A | Director of Nursing, Performance and Quality | Introduce robust systems and policies for the control and prevention of Infectious Diseases & Notifiable Outbreaks |
| N/A | All employees | Comply with the requirements of the policies and systems introduced over infectious diseases |

### 31. EXTENDED ROLE ACTIVITIES

| N/A | Chief Executive or Director of Nursing, Performance and Quality | Approval of Nurses to undertake duties / procedures which can properly be described as beyond the normal scope of Nursing Practice. |

### 32. PATIENT SERVICES

| N/A | a) Variation of operating and clinic sessions within existing numbers |

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<table>
<thead>
<tr>
<th>REFERENCE</th>
<th>DELEGATED TO</th>
<th>DUTIES DELEGATED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service area Manager or Clinical Director</td>
<td>Outpatients</td>
<td></td>
</tr>
<tr>
<td>Service area Manager or Clinical Director</td>
<td>Theatres</td>
<td></td>
</tr>
<tr>
<td>Service area Manager or Clinical Director</td>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>Bed Manager / On Call Manager</td>
<td>Temporary Change</td>
<td></td>
</tr>
<tr>
<td>Director of Nursing Performance and Quality</td>
<td>Permanent Change</td>
<td></td>
</tr>
<tr>
<td>33. FACILITIES FOR STAFF NOT EMPLOYED BY THE TRUST TO GAIN PRACTICAL EXPERIENCE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N/A</td>
<td>Clinical Director or Director of Human Resources and Organisational Development</td>
<td>Professional Recognition, Honorary Contracts, &amp; Insurance of Medical Staff. Work experience students</td>
</tr>
<tr>
<td>34. FIRE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N/A</td>
<td>Director of Corporate Affairs and Governance</td>
<td>Review of fire precautions</td>
</tr>
<tr>
<td>N/A</td>
<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>
</tr>
<tr>
<td>35. HEALTH &amp; SAFETY</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N/A</td>
<td>Director of Corporate Affairs</td>
<td>Review of all statutory compliance legislation and Health and Safety requirements</td>
</tr>
<tr>
<td>N/A</td>
<td>Ms A Harrison</td>
<td>Non Executive lead for Health &amp; Safety</td>
</tr>
<tr>
<td>REFERENCE</td>
<td>DELEGATED TO</td>
<td>DUTIES DELEGATED</td>
</tr>
<tr>
<td>-----------</td>
<td>------------------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>36.</td>
<td>MEDICINES INSPECTORATE</td>
<td></td>
</tr>
<tr>
<td>N/A</td>
<td>Medical Director</td>
<td>Review of Medicines Inspectorate Regulations</td>
</tr>
<tr>
<td>37.</td>
<td>ENVIRONMENTAL REGULATIONS</td>
<td></td>
</tr>
<tr>
<td>N/A</td>
<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>38.</td>
<td>CONTRACTUAL ARRANGEMENTS</td>
<td></td>
</tr>
<tr>
<td>N/A</td>
<td>Director of Finance</td>
<td>Monitor proposals for contractual arrangements between the Trust and outside bodies</td>
</tr>
<tr>
<td>39.</td>
<td>INFORMATION GOVERNANCE</td>
<td></td>
</tr>
<tr>
<td>N/A</td>
<td>Chief Executive</td>
<td>Identified as Qualified Person for Freedom of Information Requests</td>
</tr>
<tr>
<td>N/A</td>
<td>Director of Corporate Affairs and Governance</td>
<td>Set up a system for monitoring compliance against the Information Governance Toolkit</td>
</tr>
<tr>
<td>N/A</td>
<td>All employees</td>
<td>Undertake the information governance training module on an annual basis</td>
</tr>
<tr>
<td>N/A</td>
<td>Director of Corporate Affairs and Governance</td>
<td>Review of the Trust's compliance code of Practice for handling confidential information in the contracting environment and the compliance with &quot;safe haven&quot; per EL 92/60</td>
</tr>
<tr>
<td>N/A</td>
<td>Director of Corporate Affairs and Governance (SIRO)</td>
<td>Develop robust systems and policies to ensure patient confidentiality and confidentiality of person identifiable data</td>
</tr>
<tr>
<td>40.</td>
<td>GMC</td>
<td></td>
</tr>
<tr>
<td>N/A</td>
<td>Reporting to Medical Director</td>
<td>Responsible Officer for GMC click here 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>41.</td>
<td>NURSING &amp; MEDICAL ADVICE</td>
<td></td>
</tr>
<tr>
<td>REFERENCE</td>
<td>DELEGATED TO</td>
<td>DUTIES DELEGATED</td>
</tr>
<tr>
<td>-----------</td>
<td>--------------</td>
<td>------------------</td>
</tr>
<tr>
<td>N/A</td>
<td>Director of Nursing, Performance and Quality</td>
<td>Provision of Nursing Advice to the Board</td>
</tr>
<tr>
<td>N/A</td>
<td>Medical Director</td>
<td>Provision of Medical Advice to the Board</td>
</tr>
<tr>
<td>N/A</td>
<td>Medical Director</td>
<td>Designated individual for Human Tissue Authority regulations</td>
</tr>
</tbody>
</table>

### 42. SAFEGUARDING

<table>
<thead>
<tr>
<th>REFERENCE</th>
<th>DELEGATED TO</th>
<th>DUTIES DELEGATED</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td>Director of Nursing, Performance and Quality</td>
<td>Lead for Safeguarding</td>
</tr>
<tr>
<td>N/A</td>
<td>Dr J Cowan</td>
<td>Non Executive Lead for Safeguarding</td>
</tr>
</tbody>
</table>

### 43. FREEDOM OF INFORMATION

| SFI 15.5.1 | Director of Corporate Affairs and Governance | Set up a system to monitor freedom of information requests received, responded to and where exemptions apply |
| SFI 15.5.2 | Director of Corporate Affairs and Governance | Publish and maintain a Freedom of Information publication scheme |

### 44. EDUCATION AND TRAINING

<table>
<thead>
<tr>
<th>REFERENCE</th>
<th>DELEGATED TO</th>
<th>DUTIES DELEGATED</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td>Director of Human Resources and Organisational Development</td>
<td>Responsibility for development and Provision of Education and Training</td>
</tr>
</tbody>
</table>

### 45. RAISING CONCERNS AT WORK (Speaking Up)

<table>
<thead>
<tr>
<th>REFERENCE</th>
<th>DELEGATED TO</th>
<th>DUTIES DELEGATED</th>
</tr>
</thead>
<tbody>
<tr>
<td>C2</td>
<td>Director of Corporate Affairs and Governance</td>
<td>To ensure robust processes are in place for concerns to be raised and investigated</td>
</tr>
<tr>
<td>C2</td>
<td>Chief Executive</td>
<td>To provide the board with feedback on the Speaking Up process and concerns raised</td>
</tr>
<tr>
<td>REFERENCE</td>
<td>DELEGATED TO</td>
<td>DUTIES DELEGATED</td>
</tr>
<tr>
<td>-----------</td>
<td>--------------</td>
<td>------------------</td>
</tr>
<tr>
<td>46. CLINICAL EFFECTIVENESS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N/A</td>
<td>Medical Director</td>
<td>Develop strategy and policy for clinical effectiveness</td>
</tr>
<tr>
<td>N/A</td>
<td>Medical Director</td>
<td>Develop, Implement and monitor the clinical audit programme</td>
</tr>
<tr>
<td>47. MENTAL HEALTH ACT ADMINISTRATION SERVICE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N/A</td>
<td>Cheshire and Wirral Partnership NHS Foundation trust</td>
<td>Responsibility for provision of the Mental Health Act Administration Service</td>
</tr>
<tr>
<td>48. MORTALITY</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N/A</td>
<td>Ms A Harrison</td>
<td>Non Executive lead for Mortality</td>
</tr>
<tr>
<td>49. EQUALITY &amp; DIVERSITY</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N/A</td>
<td>Mrs L McGill (Chairman)</td>
<td>Non Executive lead for Equality &amp; Diversity</td>
</tr>
</tbody>
</table>
**Tier 1 budget holders** – Executive Director level  
**Tier 2 budget Holders** – Deputy Director / Associate Director Level  
**Tier 3 budget holders** – service manager level

## 5. DELEGATED FINANCIAL LIMITS

<table>
<thead>
<tr>
<th>FINANCIAL LIMITS</th>
<th>AUTHORITY DELEGATED TO</th>
<th>REFERENCE DOCUMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Non Pay Revenue &amp; Capital Expenditure/Requisitioning/Ordering/Payment of Goods &amp; Services</td>
<td></td>
<td>SFIs Section 9</td>
</tr>
<tr>
<td>Stock / non stock requisitions up to £10,000</td>
<td>Tier 3 budget holders</td>
<td></td>
</tr>
<tr>
<td>Stock / non stock requisitions up to £29,999</td>
<td>Tier 2 budget holders</td>
<td></td>
</tr>
<tr>
<td>all requisitions from £30,000 to £74,999</td>
<td>Tier 1 budget holders (plus any other specified named individuals agreed with the Director of Finance)</td>
<td></td>
</tr>
<tr>
<td>All requisitions from £75,000 to £999,999</td>
<td>Chief Executive, Director of Finance or Deputy Director of Finance</td>
<td></td>
</tr>
<tr>
<td>All requisitions over £1,000,000</td>
<td>Chief Executive</td>
<td></td>
</tr>
<tr>
<td>Pharmacy orders up to £74,999</td>
<td>Head of Pharmacy or Executive Director</td>
<td></td>
</tr>
<tr>
<td>FINANCIAL LIMITS</td>
<td>AUTHORITY DELEGATED TO</td>
<td>REFERENCE DOCUMENTS</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------------</td>
<td>----------------------------------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>Pharmacy orders over £75,000 to £249,999</td>
<td>Chief Executive or Director of Finance</td>
<td></td>
</tr>
<tr>
<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>Chief Executive and Director of Finance or Deputy Director of Finance</td>
<td></td>
</tr>
<tr>
<td>Orders exceeding 12 month period excluding service and utilities contracts</td>
<td>Director of Finance or Chief Executive</td>
<td></td>
</tr>
<tr>
<td>All contracts for goods &amp; services and subsequent variations to contracts</td>
<td>Tier 2 budget holder</td>
<td></td>
</tr>
</tbody>
</table>

2. **Quotation, Tendering & Contract Procedures**

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Authority</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Obtaining price information for goods and services up to £5,000</td>
<td>Tier 3 Budget Holder</td>
</tr>
<tr>
<td>b) Obtaining a minimum of <strong>3 written quotations</strong> where appropriate for goods/services from £5,000 to £25,000</td>
<td>£5,000 - £15,000 Tier 3&lt;br&gt;£15,000 to £25,000 Tier 2</td>
</tr>
<tr>
<td>c) Obtaining <strong>written competitive tenders</strong> for goods/services over £25,000 up to EU threshold</td>
<td>Chief Executive or Designated Officer</td>
</tr>
<tr>
<td>d) Waivering of quotations &amp; Tenders subject to SFIS - Also see guidance in C7</td>
<td>Chief Executive or Director of Finance, Director of Human Resources as appropriate</td>
</tr>
<tr>
<td>e) Opening quotations between the value of £5,001 and £50,000</td>
<td>Supplies Manager or Deputy Supplies Manager</td>
</tr>
<tr>
<td><strong>FINANCIAL LIMITS</strong></td>
<td><strong>AUTHORITY DELEGATED TO</strong></td>
</tr>
<tr>
<td>-----------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>f) Opening tenders</td>
<td>Two Executive Directors</td>
</tr>
<tr>
<td>3. <strong>Business Case Approval</strong></td>
<td></td>
</tr>
<tr>
<td>a) Approval of business cases for individual schemes up to £250,000, within the overall capital budget</td>
<td>Chief Executive</td>
</tr>
<tr>
<td>b) Approval of business cases relating to engagement of consultants above £50k prior to submission to the NHS Improvement - See C7</td>
<td>Chief Executive</td>
</tr>
<tr>
<td>c) Approval of business cases for individual schemes between £250,000 and £1m, within the overall capital budget</td>
<td>Chief Executive in conjunction with Clinical Management Board</td>
</tr>
<tr>
<td>4. <strong>Engagement of Staff Not On the Establishment</strong></td>
<td><strong>Budget holders have a responsibility to manage resources</strong></td>
</tr>
<tr>
<td>To include Management consultants (including professional services) and agency staff</td>
<td></td>
</tr>
<tr>
<td>a) Where aggregate commitment in any one year (or total commitment) is less than £74,999</td>
<td>Executive Director</td>
</tr>
<tr>
<td>b) Where aggregate commitment in any one year is more than £74,999</td>
<td>Chief Executive or Director of Finance</td>
</tr>
<tr>
<td>c) Engagement of Trust's Solicitors</td>
<td>Chief Executive or Executive Director</td>
</tr>
<tr>
<td>d) Booking of Bank, Locums or Agency Staff</td>
<td>Tier 2 budget holder (in line with NHS Improvement agreed caps)</td>
</tr>
<tr>
<td>• Medical Locums</td>
<td>Executive Director (where agreed Caps are exceeded)</td>
</tr>
<tr>
<td>• Nursing</td>
<td></td>
</tr>
<tr>
<td>• Clerical</td>
<td></td>
</tr>
</tbody>
</table>
### FINANCIAL LIMITS

<table>
<thead>
<tr>
<th>5. Condemning &amp; Disposal</th>
<th>AUTHORITY DELEGATED TO</th>
<th>REFERENCE DOCUMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Items obsolete, redundant or cannot be repaired cost effectively</td>
<td>In all instances the Estates Manager must be consulted prior to condemnation / disposal. The Asset Register must be updated with changes</td>
<td>SFIs Section 13</td>
</tr>
<tr>
<td>a) Condemnation</td>
<td>Tier 2 or Tier 3 budget holder</td>
<td></td>
</tr>
<tr>
<td>b) disposal of x-ray films (subject to estimated income of £1,000 per sale)</td>
<td>Head of Integrated Governance</td>
<td></td>
</tr>
<tr>
<td>c) disposal of mechanical and engineering plant (subject to estimated income of less than £1,000 per sale)</td>
<td>Estates Manager</td>
<td></td>
</tr>
<tr>
<td>d) disposal of mechanical and engineering plant (subject to estimated income exceeding £1,000 per sale)</td>
<td>Estates Manager/Director of Finance</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>6. Losses, Write-off &amp; Compensation</th>
<th></th>
<th>SFIs Section 13</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Losses and Cash due to theft, fraud, overpayment &amp; others</td>
<td>Chief Executive or Director of Finance</td>
<td></td>
</tr>
<tr>
<td>a. Up to £50,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) Fruitless Payments (including abandoned Capital Schemes) Up to £250,000</td>
<td>Chief Executive or Director of Finance</td>
<td></td>
</tr>
<tr>
<td>FINANCIAL LIMITS</td>
<td>AUTHORITY DELEGATED TO</td>
<td>REFERENCE DOCUMENTS</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>c)  Bad Debts and Claims Abandoned. Private Patients, Overseas Visitors &amp; Other</td>
<td>Deputy Director of Finance</td>
<td></td>
</tr>
<tr>
<td>a) Up to £25,000</td>
<td>Chief Executive or Director of Finance</td>
<td></td>
</tr>
<tr>
<td>b) £25,001 to £50,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d)  Damage to buildings, fittings, furniture and equipment and loss of equipment</td>
<td>Chief Executive or Director of Finance</td>
<td></td>
</tr>
<tr>
<td>and property in stores and in use due to:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Culpable causes (e.g. fraud, theft, arson) or other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Up to £50,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e)  Compensation payments made under legal obligation up to £50,000</td>
<td>Chief Executive or Director of Finance / Director of Human Resources and Organisational Development (for HR issues)</td>
<td></td>
</tr>
<tr>
<td>f)  Extra Contractual payments to contractors up to £50,000</td>
<td>Chief Executive or Director of Finance / Director of Human Resources and Organisational Development (for HR issues)</td>
<td></td>
</tr>
<tr>
<td>g)  Write off of NHS Debtors</td>
<td>Deputy Director of Finance</td>
<td></td>
</tr>
<tr>
<td>a) up to £25,000</td>
<td>Chief Executive or Director of Finance</td>
<td></td>
</tr>
<tr>
<td>b) over £25,000</td>
<td>[Reported to Audit Committee for information]</td>
<td></td>
</tr>
<tr>
<td>h)  Write off of Non NHS Debtors</td>
<td>Deputy Director of Finance</td>
<td></td>
</tr>
<tr>
<td>a) up to £25,000</td>
<td>Chief Executive or Director of Finance</td>
<td></td>
</tr>
<tr>
<td>b) over £25,000</td>
<td>[Reported to Audit Committee for information]</td>
<td></td>
</tr>
<tr>
<td>FINANCIAL LIMITS</td>
<td>AUTHORITY DELEGATED TO</td>
<td>REFERENCE DOCUMENTS</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>-------------------------------------------------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>i) <strong>Ex-Gratia Payments</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Patients and staff for loss of personal effects up to £50,000</td>
<td>Chief Executive or Deputy Director of Finance</td>
<td></td>
</tr>
<tr>
<td>ii. Patients and staff for loss of personal effects &gt; £50,000</td>
<td>Chief Executive or Director of Finance (reported to Audit Committee)</td>
<td></td>
</tr>
<tr>
<td>7. Litigation</td>
<td></td>
<td>SFIs Section 13</td>
</tr>
<tr>
<td>a) For clinical negligence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. up to £1,000,000 (negotiated settlements)</td>
<td>i. Chief Executive or Director of Finance</td>
<td></td>
</tr>
<tr>
<td>ii. Over £1,000,000</td>
<td>ii. Chief Executive</td>
<td></td>
</tr>
<tr>
<td>b) For personal injury claims involving negligence where legal advice has been obtained and guidance applied</td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Up to £1,000,000 (including plaintiff's costs)</td>
<td>i. Chief Executive or Director of Finance</td>
<td></td>
</tr>
<tr>
<td>ii. Over £1,000,000</td>
<td>ii. Chief Executive</td>
<td></td>
</tr>
<tr>
<td>c) Other, except cases of maladministration where there was no financial loss by claimant (up to £50,000)</td>
<td>Chief Executive or Director of Finance</td>
<td>SFIs Section 13</td>
</tr>
<tr>
<td>8. Petty Cash Disbursements (not applicable to central Cashiers Office)</td>
<td></td>
<td>SFIs Section 9</td>
</tr>
<tr>
<td>a) Expenditure up to £25 per item</td>
<td>Petty Cash Holder</td>
<td></td>
</tr>
<tr>
<td>b) Reimbursement of patients monies up to £100</td>
<td>Tier 3 budget holder</td>
<td>Tier 3 budget holder</td>
</tr>
<tr>
<td>c) Reimbursement of patients monies in excess of £100</td>
<td>Tier 2 budget holder</td>
<td>Tier 2 budget holder</td>
</tr>
<tr>
<td>FINANCIAL LIMITS</td>
<td>AUTHORITY DELEGATED TO</td>
<td>REFERENCE DOCUMENTS</td>
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<td>----------------------------------</td>
<td>------------------------------------------------</td>
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</tr>
<tr>
<td>9. Authorisation of New Drugs</td>
<td>Estimated total yearly cost up to £25,000</td>
<td>SFI's Section 9</td>
</tr>
<tr>
<td></td>
<td>Clinical Director/Head of Pharmacy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Estimated total yearly cost above £25,000</td>
<td>Medicines Management Committee and Clinical Director and Director of Finance</td>
</tr>
<tr>
<td>10. Virement</td>
<td>Virement within a service area budget up to £10,000 per annum so long as service area budget remains underspent</td>
<td>Deputy Chief Executive or Deputy Director of Finance with Deputy Director of Operations</td>
</tr>
<tr>
<td>(in year transfer between budget lines)</td>
<td>Virement between budgets up to £50,000 so long as the Trust budget remains in line with plan</td>
<td>Deputy Chief Executive with Deputy Director of Finance</td>
</tr>
<tr>
<td></td>
<td>Virement between budgets over £50,000 so long as the Trust budget remains in line with plan</td>
<td>Chief Executive with Director of Finance</td>
</tr>
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</table>
Standing Financial Instructions
FOREWORD

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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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 - 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;
"Director of Finance" means the chief financial officer of the Trust;

"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

"Legal Adviser" means the properly qualified person appointed by the Trust to provide legal advice.

"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 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; and

(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) reviewing 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 the 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 Protect 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 Protect 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 Protect 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 counter fraud 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,

(ii) major internal financial control weaknesses discovered,
(iii) progress on the implementation of internal audit recommendations,
(iv) progress against plan over the previous year,
(v) strategic audit plan covering the coming three years,
(vi) 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

2.4.1 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.
2.4.2 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.

2.4.3 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.

2.4.4 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

2.5.1 The external auditor is appointed by the Public Sector Audit Appointments Ltd and paid for 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

2.6.1 The Director of Corporate Affairs & Governance is responsible for monitoring progress on the implementation of internal and external recommendations.

2.6.2 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 to counter fraud, bribery and corruption (in accordance with Department of Health guidance and NHS Protect).

3 BUSINESS PLANNING, BUDGETS, BUDGETARY CONTROL AND MONITORING

3.1 PREPARATION AND APPROVAL OF BUSINESS PLANS AND BUDGETS

3.1.1 The Chief Executive will compile and submit to the Board an annual business plan which takes into account financial targets and forecast limits of available resources. The annual business 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.

3.1.2 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 business 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.

3.1.3 The Director of Finance shall monitor financial performance against budget and business plan, periodically review them, and report to the Board.

3.1.4 All budget holders must provide information as required by the Director of Finance to enable budgets to be compiled.

3.1.5 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 successfully.

3.2 BUDGETARY DELEGATION

3.2.1 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.

3.2.2 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board.

3.2.3 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.

3.2.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive.

3.3 BUDGETARY CONTROL AND REPORTING

3.3.1 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.

3.3.2 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.

3.3.3 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 Business Plan and a balanced budget.

3.4 CAPITAL EXPENDITURE

3.4.1 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.)

3.5 MONITORING RETURNS

3.5.1 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

4.1 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 each financial year in accordance with the timetable prescribed by the Department of Health.

4.2 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.

4.3 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.

4.4 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 the NHS Improvement's Payment by Results guidance in setting prices for Commissioner contracts.

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:

- approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;
- ordering and securely controlling any such stationery;
- the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and
- prescribing systems and procedures for handling cash and negotiable securities on behalf of the 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\(^1\) require that the Trust does not, under any circumstances, accept exchequer cash payments in excess of EUR15,000 (2015 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 Local Delivery Plan (LDP) 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;
(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.

8 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
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.

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; and
(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; and

(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. 10.4)
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 LDP 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 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 the 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 EFL, 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 Protect in accordance with its contractual requirements under the NHS Standards Contract.

14.2.3 The Director of Finance must notify the NHS Protect 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 Protect 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 Protect 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 NHSLA

18.1.1 The Board shall decide if the Trust will insure through the risk pooling schemes administered by the NHS Litigation Authority or self-insure for some or all of the risks covered by the risk pooling schemes. If the Board 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.

18.1.2 The Director of Corporate Affairs will ensure robust governance arrangements are in place over the existence of policies and evidence collection to ensure compliance against the NHSLA standards.

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 Trust’s may enter into insurance arrangements with commercial insurers. The exceptions are:

(a) Trust’s 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 (SFIs 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 the 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 the 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 policy 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) and 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 1 - 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 advance 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 [he 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 1b – 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 [or 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 2 - 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 it 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 consequential 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 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 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 to whom they are accountable through the 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 and they are subject to oversight through a system of corporate contracts (not contracts in law) to the 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. 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. 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 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 the 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:
• a 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 to bring an independent judgement to bear on issues of strategy, performance, key appointments and accountability through the 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,
• Public Sector Audit Appointments Ltd. and its appointed auditors, and
• the local community

The detailed financial guidance issued by the 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 the NHS Improvement on behalf of the Secretary of State, 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 3 - 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 Protect;
- 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.

2 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

3 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.

4 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

5 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 9 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.

6 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

7 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
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 & Performance.
- 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. 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.

12. 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 8, 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

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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 Service Lines/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

13. 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.

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:
  - 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

15. Terms of Reference

- These will be reviewed in February 2018 (annually) or as required.
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 of the Trust.

Another Non-Executive Director will act as Chair in the absence of the Chairman or Vice-Chairman 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 NHS Improvement 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. The Chairman has delegated authority to take Chair’s actions for urgent decisions up to a maximum value of £50k. All such agreements must be reported to the next Remuneration Committee meeting for ratification.

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 Quarter 1, or as required; and
- annual performance reports relating to Chief Executive annually in Quarter 1, 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.

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 February 2018.
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

3 Non-Executive Directors will be members of the Audit Committee excluding the Chairman of the Trust.

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 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 about 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 Litigation 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 these 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 March 2016. 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 2017 (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.
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 meets its statutory duty 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.

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 risks associated with 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.

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.

• 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:

- 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.

- 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.

- An annual report of the Finance, Performance and Workforce Committee

12.2 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 2015 and will be reviewed at the meeting in February 2016. 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 2018 (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.
1. **Definition**

   - The Clinical Management Board has been established 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

• Monthly
• Members will be expected to attend for 75% of meetings and attendance registers will be maintained

6. Membership

• Executive Directors
• Clinical Directors of Directorates
• Clinical Leads

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:

- 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)
- Improvement Sub-Committee

Partnership Agreements:-
- HR Service Level Agreement
- ICT Service Level Agreement
- Pathology Service Level Agreement
- Cheshire Occupational Health Services

8. Executive Management Team meeting

This is the forum where Executive Directors are held to account by the CEO for delivery of objectives, recovery, which includes the delivery of the QIPP schemes. The Executive Management Team meeting is held weekly and supports timely decision making on business cases subsequently noted at the CMB.

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 minority 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
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 process
Local Anti-Fraud, Bribery and Corruption Policy
Policy Title: 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 Local Anti-Fraud Specialist (LAFS) and is intended as a guide for all employees on counter fraud work within the NHS.

Supersedes: V6

Description of Amendment(s): Removal of NHS Protect Area Anti-Fraud Specialist section following changes internally within NHS Protect.

This policy will impact on:
All employees within the Trust.

Financial Implications:

Policy Area: Trust
Document Reference: Version Number: V7
Effective Date: April 2017
Issued By: Mark Ogden
Director of Finance
Review Date: 31 March 2018
Author: Kerry Wheat
Local Anti-Fraud Specialist
Impact Assessment Date: March 2017

APPROVAL RECORD

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1 Introduction

1.1 General

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 are honest and professional and they find that fraud committed by a minority is wholly unacceptable as it ultimately leads to a reduction in the resources available for patient care.

NHS Protect is a business unit of the NHS Business Services Authority. It has responsibility for all policy and operational matters relating to the prevention, detection and investigation of fraud, corruption and bribery. All instances where fraud is suspected are properly investigated until their conclusion by staff trained by NHS Protect. Any investigations will be handled in accordance with the *NHS Counter Fraud and Corruption Manual*.

East Cheshire NHS Trust is committed to reducing fraud, bribery and corruption in the NHS and will seek the appropriate disciplinary, regulatory, civil and criminal sanctions against fraudsters and where possible will attempt to recover losses.

This policy has been produced by the Local Anti-Fraud Specialist (LAfS), Kerry Wheat Tel: 0161 206 1911, kerry.ann.wheat@miaa.nhs.uk, and is intended as a guide for all employees on anti-fraud work within the NHS. All genuine suspicions of fraud and corruption can be reported to the LAfS or through the NHS Fraud and Corruption Reporting Line (FCRL) on Freephone 0800 028 40 60 or www.reportnhsfraud.nhs.uk

This policy is supported and endorsed by senior management.

1.2 Aims and Objectives

This policy relates to all forms of fraud and corruption and is intended to provide direction and help to employees who may identify suspected fraud. It provides a framework for responding to suspicions of fraud, advice and information on various aspects of fraud and implications of an investigation. It is not intended to provide a comprehensive approach to preventing and detecting fraud, corruption and bribery. The overall aims of this policy are to:

- improve the knowledge and understanding of everyone in East Cheshire NHS Trust irrespective of their position, about the risk of fraud, corruption and bribery within the organisation and its unacceptability
- assist in promoting a climate of openness and a culture and environment where staff feel able to raise concerns sensibly and responsibly
- set out East Cheshire NHS Trust’s responsibilities in terms of the deterrence, prevention, detection and investigation of fraud, corruption and bribery
- ensure the appropriate sanctions are considered following an investigation, which may include any or all of the following:
  - criminal prosecution
  - civil prosecution
  - Internal/external disciplinary action.
1.3 Scope

This policy applies to all employees of East Cheshire NHS Trust, regardless of position held, as well as consultants, vendors, contractors, and/or any other parties who have a business relationship with East Cheshire NHS Trust. It will be brought to the attention of all employees and form part of the induction process for new staff.

2 Definitions

2.1 NHS Protect

NHS Protect leads on work to identify and tackle crime across the health service. The aim is to protect NHS staff and resources from activities that would otherwise undermine their effectiveness and their ability to meet the needs of patients and professionals. Ultimately, this helps to ensure the proper use of valuable NHS resources and a safer, more secure environment in which to deliver and receive care. The organisation’s strategy covers three main objectives:

- To educate and inform those who work for or use the NHS about crime in the health service and how to tackle it;
- To prevent and deter crime in the NHS by removing opportunities for it to occur or to re-occur; and,
- To hold to account those who have committed crime against the NHS by detecting and prosecuting offenders and seeking redress where viable. Any investigations will be handled in accordance with NHS Protect guidance. *NHS Protect strategy “tackling crime against the NHS: A strategic approach.”*

2.2 Fraud

The Fraud Act 2006 represents an entirely new way of investigating and prosecuting fraud. It is no longer necessary to prove that a person has been deceived. The focus is now on the dishonest behaviour of the suspect and their intent to make a gain 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; however, there are three primary ways in which it can be committed that are likely to be investigated in the NHS:

1) Fraud by false representation (s.2) – lying about something using any means, e.g. lying on a CV or NHS job application form.
2) 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 obligations and where you are required to declare these as part of your employment conditions.
3) Fraud by abuse of a position (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 patient 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

The Bribery Act 2010 came into effect on 1st July 2011. Bribery and corruption involves offering, promising or giving a payment of benefit-in-kind in order to influence others to use their position in an improper way to gain some form of personal, financial or commercial advantage for oneself or another.

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 (i.e. a bribe) 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 health body 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 – The bribe itself can occur either before or after the corrupt act.

Staff are reminded to ensure that they are transparent in respect of recording any gifts, hospitality or sponsorship. They should refer to the separate health body policies covering;

- Acceptance of Gifts and Hospitality
- Declaration of Interests
- Sponsorship

In addition the Act introduces a new ‘corporate offence’ of failing to prevent bribery by an organisation not having adequate preventative procedures in place. The Trust may avoid conviction if it can show that it had procedures and protocols in place to prevent bribery. The corporate offence is not a stand-alone offence, but always follows from a bribery and/or corruption offence committed by an individual associated with the company or organisation in question.

As the Bribery Act is applicable to all NHS organisations, it also applies to (and can be triggered by) everyone “associated” with this health body 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).

This health body 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. We are 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 it and these will be regularly reviewed. We shall, in conjunction with NHS Protect, seek to obtain the strongest penalties – including criminal prosecution, disciplinary and/or civil sanctions – against anyone associated with this organisation who is found to be involved in any bribery or corruption 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.

2.4 Employees
For the purposes of this policy, ‘employees’ includes NHS Protect and East Cheshire NHS Trust staff, as well as board, executive and non-executive members (including co-opted members) and honorary members.

3 Roles and responsibilities

Through our day-to-day work, we 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 exists, whether because of poor procedures or oversight, you should report it to the LAFS or the NHS Fraud and Corruption Reporting Line.

This section states the roles and responsibilities of employees and other relevant parties in reporting fraud or other irregularities.

East Cheshire NHS Trust will take all necessary steps to counter fraud, bribery and corruption in accordance with this policy, the *NHS Counter Fraud and Corruption Manual*, the policy statement ‘Applying Appropriate Sanctions Consistently’ published by NHS Protect and any other relevant guidance or advice issued by the NHS Protect.

3.1 Chief Executive

The Chief Executive has the overall responsibility for securing funds, assets and resources entrusted to it. This includes 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.

3.2 Director of Finance

The Director of Finance (DOF) has powers to approve financial transactions initiated by directorates across the organisation.

The DOF prepares documents, maintains detailed financial procedures and systems and that they apply the principles of separation of duties and internal checks to supplement those procedures and systems.

The DOF will report annually to the Board and, where applicable, the Council of Governors on the adequacy of internal financial controls and risk management as part of the Board’s overall responsibility to prepare a statement of internal control for inclusion in the NHS body’s annual report.

The DOF will, depending on the outcome of initial investigations, inform appropriate senior management of suspected cases of fraud, bribery and corruption, especially in cases where the loss may be above an agreed limit or where the incident may lead to adverse publicity.

3.3 Internal and External Audit

The role of internal and external audit includes reviewing controls and systems and ensuring compliance with financial instructions. Internal and External Audit have a duty to pass on any suspicions of fraud, bribery or corruption to the Local Anti-Fraud Specialist (LAFS).

3.4 Human Resources

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HR will liaise closely with managers and the LAFS from the outset if an employee is suspected of being involved in fraud, bribery or corruption, in accordance with agreed liaison protocols. HR staff are responsible for ensuring the appropriate use of East Cheshire NHS Trust’s disciplinary procedure. HR will advise those involved in the investigation on matters of employment law and other procedural matters, such as disciplinary and complaints procedures, as requested. Close liaison between the LAFS and HR will be essential 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.

3.5 Local Anti-Fraud Specialist

The LAFS’s role is to ensure that all cases of actual or suspected fraud, bribery and corruption are notified to the Director of Finance and reported accordingly.

The LAFS will regularly report to the Director of Finance on the progress of the investigation and when/if referral to the police is required.

The LAFS will:

- ensure that the Director of Finance is informed about all referrals/cases, including any regional NHS Protect investigations which may impact upon the organisation
- be responsible for the day-to-day implementation of counter fraud, bribery and corruption activity, as agreed in the fraud annual work plan and, in particular, the investigation of all suspicions of fraud
- investigate all cases of fraud
- report any case and the outcome of the investigation through the NHS Protect national case management system (FIRST)
- 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
- conduct risk assessments in relation to their work to prevent fraud, bribery and corruption
- ensure that any system weaknesses identified as part of an investigation are followed up with management and reported to internal audit
- to adhere to NHS Protect standards to ensure that the organisation has appropriate anti-fraud, bribery and corruption arrangements in place and that the LAFS will look to achieve the highest standards possible, as per Counter Fraud Professional Accreditation Board (CFPAB)’s Principles of Professional Conduct.

3.6 Managers
Managers must be vigilant and ensure that procedures to guard against fraud and corruption are followed. They should be alert to the possibility that unusual events or transactions could be symptoms of fraud and corruption. If they have any doubts, they must seek advice from the nominated LAFS.

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 LAFS will proactively assist the encouragement of an anti-fraud culture by undertaking work that will raise fraud awareness.

All instances of actual or suspected fraud, bribery or 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 LAFS 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 East Cheshire NHS 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
- to be responsible for the enforcement of disciplinary action for staff who do not comply with policies and procedures
- to report any instances of actual or suspected fraud, bribery or corruption brought to their attention to the LAFS immediately.

**It is important that managers do not investigate any suspected financial crimes themselves.**

- to conduct risk assessments and to mitigate identified risks, within 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 East Cheshire NHS Trust
- be aware of East Cheshire NHS Trust’s Anti-Fraud and Corruption Policy and the rules and guidance covering the control of specific items of expenditure and receipts
- identify financially sensitive posts
- contribute to their director’s assessment of the risks and controls within their business area, which feeds into East Cheshire NHS Trust’s and the Department of Health Accounting Officer’s overall statements of accountability and internal control.

**3.7 All Employees**
East Cheshire NHS 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 and resources of the Trust, including information, goodwill and property.

In addition, all employees have a responsibility to comply with all applicable laws and regulations 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 East Cheshire NHS 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, receipts or dealing with contractors or suppliers.

If an employee suspects that there has been fraud or corruption, or has seen any suspicious acts or events, they must report the matter to the nominated LAFS.

3.8 Information Management and Technology

The Head of Information Security (or equivalent) will contact the LAFS immediately in all cases where there is suspicion that IT is being used for fraudulent purposes (Computer Misuse Act 1990).

4 The Response Plan

4.1 Bribery and Corruption

East Cheshire NHS Trust has conducted risk assessments in line with Ministry of Justice guidance to assess how bribery and corruption may affect the organisation. As a result, proportionate procedures have been put in place to mitigate identified risks.

East Cheshire NHS Trust's procedures in relation to declarations of interest and the hospitality/gifts register may be found in the corporate governance manual.

4.2 Reporting Fraud, Bribery or Corruption

This section outlines the action to be taken if fraud, bribery or corruption is discovered or suspected.
If an employee has any of the concerns mentioned in this document, they must inform the nominated LAFS or East Cheshire NHS Trust's Director of Finance immediately, unless the Director of Finance or LAFS is implicated. If that is the case, they should report it to the chair or Chief Executive, who will decide on the action to be taken.

An employee can contact any executive or non-executive director of East Cheshire NHS Trust to discuss their concerns if they feel unable, for any reason, to report the matter to the LAFS or Director of Finance.

Suspected fraud, bribery and corruption can also be reported to NHS Protect using the NHS Fraud and Corruption Reporting Line on Freephone 0800 028 40 60 or by filling in an online form at www.reportnhsfraud.nhs.uk, as an alternative to internal reporting procedures and if staff wish to remain anonymous.

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 LAFS 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 should always be encouraged to report reasonably held suspicions directly to the LAFS. You can do this by contacting the LAFS by telephone or email using the contact details supplied in Appendix 1.

East Cheshire NHS 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, East Cheshire NHS Trust has produced a Whistleblowing Policy. This procedure is intended to complement East Cheshire NHS Trust's Anti-Fraud, Bribery and Corruption policy and Code of Business Conduct 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.

4.3 Sanctions and Redress

The NHS Protect 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 Protect 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 Protect 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 Protect, 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. It should be noted, however, that the duty to follow disciplinary procedures will not override the need for legal action to be taken (e.g. consideration of criminal action). In the event of doubt, legal statute will prevail.

- **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.

- **Police Involvement** - In accordance with the NHS Counter Fraud and Corruption Manual, the Director of Finance, in conjunction with the LAFS, will decide whether or not a case should be referred to the police. Any referral to the police will not prohibit action being taken under the local disciplinary procedures of East Cheshire NHS Trust.

## 5 Review

### 5.1 Monitoring and Auditing of Policy Effectiveness

Monitoring is essential to ensuring that controls are appropriate and robust enough to prevent or reduce fraud. Arrangements might include reviewing system controls on an ongoing basis and identifying weaknesses in processes.

Where deficiencies are identified as a result of monitoring, The Trust should explain how appropriate recommendations and action plans are developed and how any recommendations made should be implemented.

### 5.2 Dissemination of the Policy

The Anti-Fraud, Bribery and Corruption Policy will be made available to all staff, via a variety of forms of communications, including the Trust’s intranet.

It is highly important that all staff understand and are aware of the policy.
5.3 Review of the Policy

The Trust's Anti-Fraud, Bribery and Corruption Policy will be reviewed as per East Cheshire NHS Trust's Policy on Policies? The LAFS will review the policy on behalf of the Trust before ratification.
**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** 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. **BRIBERY** is to give promise to offer a bribe, and to request, agree to receive or accept a bribe.

### **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 evidence**
  Retain any evidence that may be destroyed, or make a note and advise your LCFS.
- **report your suspicion**
  Confidentiality will be respected – delays may lead to further financial loss.

### **DO NOT**
- **confront the suspect or convey concerns to anyone other than those authorised, as listed below**
  Never attempt to question a suspect yourself; this could alert a fraudster or accuse an innocent person.
- **try to investigate, or contact the police directly**
  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 LAFS can 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.

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If you suspect that fraud against the NHS has taken place, you must report it immediately, by:
- directly contacting the Local Anti-Fraud Specialist, or
- telephoning the Freephone NHS Fraud and Corruption Reporting Line, or
- online [www.reportnhsfraud.nhs.uk](http://www.reportnhsfraud.nhs.uk) or,
- contacting the Director of Finance.

### **Do you have concerns about a fraud taking place in the NHS?**
If so, any information can be passed to the NHS Fraud and Corruption Reporting Line: **0800 028 40 60**
All calls will be treated in confidence and investigated by professionally trained staff.

Your nominated Local Anti-Fraud Specialist is **Kerry Wheat**, who can be contacted by telephoning **0161 206 1911, 07825 456 226**, or emailing **kerry.ann.wheat@miaa.nhs.uk**

If you would like further information about the NHS Counter Fraud Service, please visit [www.nhsbsa.nhs.uk](http://www.nhsbsa.nhs.uk)/fraud

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### Protecting your NHS
Freedom to speak up: raising concerns (whistleblowing) policy for the NHS

April 2016
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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):

(e) unsafe patient care
(f) unsafe working conditions
(g) inadequate induction or training for staff
(h) lack of, or poor, response to a reported patient safety incident
(i) suspicions of fraud (which can also be reported to our local anti-fraud specialist):

    Local Anti-Fraud Specialist, Kerry Ann Wheat. Tel 0161 206 1911 Mobile 07825 456 226 or by using the email address kerry.ann.wheat@miaa.nhs.uk or kwheat@nhs.net

(j) 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:

(k) 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

(1) 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.

You can also contact:

(m) 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

All these people have been trained in receiving concerns and will give you information about where you can go for more support.

If for any reason you do not feel comfortable raising your concern internally, you can raise concerns with external bodies, listed on page 7.

8. 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.

9. Annex A sets out an example of how a local process might demonstrate how a concern might be escalated.
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.

10. 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 Protect** 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 new National Guardian (once fully operational) 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:

(n) 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 Protect** 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>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to £5000.00 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>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>£50001.00 to £106,047</td>
<td>Chief Exec/ Director of Finance</td>
</tr>
<tr>
<td>Over £106,047</td>
<td>Board of Directors</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

European Procurement Law cannot be waivered 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

Note: the person responsible for completing the Waiver may be required to attend an Audit Committee meeting to explain their actions.

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)

Contact the Procurement Dept. who will arrange to carry out a Quotation/Tender

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

Waiver sent to Trust HQ for registration, Director’s support sign off and final approval/rejection

Rejected

Waiver returned to originator with explanation for rejection

Approved

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.
WAIVER –

APPLICATION TO ACCEPT A NON COMPETITIVE QUOTATION
(Value £5,000.00 TO £25,000.00) OR TENDER (Value exceeding £25,000.00)

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

..............................................................................................................................................................................
..............................................................................................................................................................................
..............................................................................................................................................................................

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.”

217
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…………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………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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.
C5 WAIVER PROCESS DIAGRAM

Note OJEU threshold changes biannually the current rate is £106,047 excluding VAT – current thresholds can be located at- http://www.ojec.com/thresholds.aspx
Background

In direct response to failing at the Winterbourne View Hospital and the Francis Inquiry into Mid Staffordshire NHS Hospital Trust, Regulation 5 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (referred to as the 2014 Regulations) has been introduced.

All NHS providers are required to demonstrate that appropriate processes are in place to confirm that Directors (and Non-executive Directors) are of good character; hold the required qualifications and have the competence, skills and experience required which may include appropriate communication and leadership skills, as well as a caring and a compassionate nature.

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 Board members should not be appointed or continue to hold office unless they are:

- of good character
- have the necessary qualifications, skills and experience
- are able to perform the work that they are employed for after reasonable adjustments are made
- able to supply information as set out in Schedule 3 of the 2014 Regulations when requested by the Care Quality Committee (see Appendix A).

When assessing a person being ‘of good character’ NHS providers are required to take account of Schedule 4 of the 2014 Regulations, namely:

- 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
- 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.

The CQC’s definition of good character is not the objective test of having no criminal convictions but instead rests upon a judgement as to whether the person’s character is such that they can be relied upon to do the right thing under all circumstances. This implies discretion for Boards in reaching a decision and allows for the fact that people can and do change over time.

The regulations list categories of persons who are prevented from holding the office and for whom there is no discretion:

- 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;

• the person 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 discharging any functions relating to any office or employment with a service provider.

It will be the responsibility of the Chairman to discharge the requirement to ensure that all Board members meet the fitness test and do not meet any of the ‘unfit’ criteria.

In its guidance the CQC makes references to associate directors and persons irrespective of their voting rights. To avoid any doubt, the trust regards the following posts as subject to the 2014 regulations as they are members of the Trust Board:

Chairman
Non-Executive Directors
Chief Executive
Director of Nursing, Performance and Quality (Deputy Chief Executive)
Director of Finance
Medical Director
Director of Human Resources and Organisational Development
Director of Corporate Affairs and Governance

Given that East Cheshire Trust is an NHS Trust, on appointment the process will differ for the Chairman and Non-Executive Directors; the duty to ensure compliance with the 2014 Regulations rests initially with NHS Improvement for the Chairman and Non-Executive Directors.

The following diagrams outline the process to be adopted by the trust in making new appointments and the review process for existing Board members.
For Directors not covered by NHS Improvement the trust will use its existing recruitment and HR policies, which incorporate processes such as the **NHS Employment Check Standards** and **Disclosure & Barring Service (DBS)** checks, to undertake the fit and proper persons tests. In addition checks will need to be made against insolvency / bankruptcy registers and disqualified director registers.
When undertaking the regular annual review of Board members fitness, the trust will extend the principles outlined within its recruitment and HR policies to undertake these reviews, as well as taking account of other information available to the trust (e.g., following the outcome of whistleblowing cases).

To assist with this review process the trust has developed a Self-Declaration Form to be completed and submitted annually (see Appendix B). To ensure the trust complies with the 2014 Regulations the standard checklist will also be adopted (see Appendix C).

For Directors not covered by NHS Improvement, any appointments will be led by the HR Directorate, and the self-declaration process will be led by the Corporate Affairs and Governance Directorate.

For all Directors, irrespective if they undertook a DBS check on appointment, a fresh DBS check will be required every 3 years. Directors should be registered with the DBS Update Service which will automatically update their DBS status without further checks having to be completed and provides portability between NHS employers. There will be a cost of the DBS Update Service which is £13 per annum per person. Support will be available from the Corporate Affairs and Governance Directorate.
CONSEQUENCES OF NOT TAKING ACTION

The CQC will take enforcement action, using their existing regulatory powers, for breaches of the fit and proper person requirement, namely having someone in place who does not satisfy the 2014 Regulations. Evidence of this could be:

- a director is unfit on a ‘mandatory’ ground, such as a relevant conviction or bankruptcy (determined by the provider);
- a provider does not have a proper process in place to enable it to make the assessments required for the fit and proper persons test;
- on receipt of information about a director’s fitness, a decision is reached on the fitness of the director that is not in the range of decisions that a reasonable person would make.
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

In line with the requirement for Board members of NHS provider organisations to be a fit and proper person, as required under Regulation 5 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (and subsequent amendments), I hereby declare:

<table>
<thead>
<tr>
<th>DECLARATION</th>
<th>CONFIRMED (YES / NO)</th>
</tr>
</thead>
<tbody>
<tr>
<td>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</td>
<td></td>
</tr>
<tr>
<td>been convicted elsewhere of any offence which, if committed in any</td>
<td></td>
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<tr>
<td>part of the United Kingdom, would constitute an offence</td>
<td></td>
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<tr>
<td>• I have not been erased, removed or struck-off a register of professionals</td>
<td></td>
</tr>
<tr>
<td>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</td>
<td></td>
</tr>
<tr>
<td>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</td>
<td></td>
</tr>
<tr>
<td>children or vulnerable adults</td>
<td></td>
</tr>
<tr>
<td>I have the qualifications, skills and experience necessary for the position</td>
<td></td>
</tr>
<tr>
<td>I hold on the Board</td>
<td></td>
</tr>
<tr>
<td>I am capable of undertaking the relevant position, after any reasonable</td>
<td></td>
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<tr>
<td>adjustments under the Equality Act 2010</td>
<td></td>
</tr>
<tr>
<td>I have not been responsible for any misconduct or mismanagement in the</td>
<td></td>
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<tr>
<td>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</td>
<td></td>
</tr>
<tr>
<td>law (e.g., under the Companies Act or the Charities Act).</td>
<td></td>
</tr>
</tbody>
</table>

Signed: 

Name: 

Position: 

Date:
## Appendix C

### Fit and Proper Persons Test – Checklist, which covers NHS trusts and Foundation trusts

<table>
<thead>
<tr>
<th>Standard</th>
<th>Assurance process</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>At appointment</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 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. | Employment checks in accordance with NHS Employment Check Standards issued by NHS Employers including:  
- 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;  
- search of insolvency and bankruptcy register; | References;  
Outcome of other pre-employment checks;  
DBS checks;  
Register search results;  
List of referees and sources of assurance for FOIA purposes. |
| 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. | Report and debate at the remuneration committee.  
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. | Record that due process was followed for FOIA purposes. |
<table>
<thead>
<tr>
<th>Standard</th>
<th>Assurance process</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<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>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.</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. 360 degree appraisal (in line with Board development process) 360</td>
<td>Recruitment policy and procedure Values-based questions Minutes of board of directors.</td>
</tr>
<tr>
<td>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.</td>
<td>Discussed and recommendations by the nominations committee(s). Discussion and decision at board of directors meeting. Reports, discussion and recommendations recorded in minutes. Follow-up as part of continuing review and appraisal.</td>
<td>Minutes of committee, NED appraisal framework NED competence framework Notes of ED appraisals</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. Follow-up as part of continuing review and appraisal.</td>
<td>Minutes of committee, NED appraisal framework NED competence framework Notes of ED appraisals</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>
</tbody>
</table>

229
<table>
<thead>
<tr>
<th>Standard</th>
<th>Assurance process</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<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</td>
</tr>
</tbody>
</table>
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 practice proceedings and professional disciplinary cases.

(‘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 and NEDs.

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.

NED Recruitment Information pack
Reference Request for ED/NED
<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 practice proceedings and professional disciplinary cases. N.B. The CQC accepts that providers will use reasonable endeavors 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 and ED Recruitment Information packs Core HR policies Reference Request for ED/NED</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.</td>
<td>Eligibility for DBS checks will be assessed for each vacancy arising.</td>
<td>DBS policy</td>
</tr>
</tbody>
</table>

**Continuing provisions**

<table>
<thead>
<tr>
<th>Standard</th>
<th>Assurance process</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>12.</strong> The fitness of 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 as part of appraisal process. Checks of insolvency and bankruptcy register and register of disqualified directors to be undertaken each year as part of the appraisal process. Board reviews checks and agrees the outcome.</td>
<td>Continual to be assessed as part of appraisal process Register checks if necessary Board minutes record that process has been followed.</td>
</tr>
<tr>
<td>Standard</td>
<td>Assurance process</td>
<td>Evidence</td>
</tr>
<tr>
<td>----------</td>
<td>-------------------</td>
<td>----------</td>
</tr>
<tr>
<td>13. 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>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 policies Contracts of employment (for EDs and director-equivalents) Service agreements or equivalent (for NEDs)</td>
</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>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>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>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>Assessment criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criteria we are assessing</td>
</tr>
<tr>
<td>Ambition to deliver something of value, importance and relevance</td>
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<tr>
<td></td>
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</tr>
<tr>
<td>Criteria we are assessing</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
</tr>
</tbody>
</table>
| Clear scope                                   | • Evidence that the scope is clear, defined and well thought through  
• Detail on how the scope has been 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? |
| Robust contract management                    | • Evidence that the trust can manage the supplier, control spend and hold the supplier account for delivering value for money  
• Assurance that the trust can deliver the scope as planned  
• 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 |
| Capacity to implement findings/recommendations | • Evidence that the trust has the capacity to act on or implement findings/recommendations of the procured work  
• Examples of previous success in realising benefits |
| Timeline of work                               | • Evidence of a well-thought-through and realistic timeline, with details on when expected outcome will be delivered  
• Why does the project need to start now and not in say 6 months’ time? |
| Robust implementation review proposal          | • An outline of how the effectiveness of the consultancy support procured will be reviewed, with particular focus on benefits and value add |
| Finance case                                  | • 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)  
• Evidence of sourcing the best value supplier and evidence of negotiation over rates  
• 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?  
• Details of agreed benchmarking rates, referencing where possible agreed framework rates.  
• 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)  
• 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? |
| Wider use of findings | • 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  
• 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 |
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>
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<tbody>
<tr>
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<table>
<thead>
<tr>
<th>Name of requestor:</th>
<th>Date submitted for approval:</th>
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<tbody>
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<table>
<thead>
<tr>
<th>Email address of requestor:</th>
<th>Total contract value (£) (including expenses and irrecoverable VAT)¹:</th>
</tr>
</thead>
<tbody>
<tr>
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<table>
<thead>
<tr>
<th>Tel number of requestor:</th>
<th>Vanguard project (Y/N):</th>
</tr>
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<tbody>
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<table>
<thead>
<tr>
<th>Contract duration (days):</th>
<th>Start date:</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>End date:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

## Expenditure type (please tick ✓)

<table>
<thead>
<tr>
<th>Expenditure type</th>
<th>Details (Please select one of the following: strategy; finance; organisational and change management; IT; property and construction; procurement; legal services; marketing and communications; human resources, training and education; programme and project management; technical, other (specify))</th>
</tr>
</thead>
<tbody>
<tr>
<td>New business case</td>
<td></td>
</tr>
<tr>
<td>Extension to business case</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Management consultancy</th>
<th>✓</th>
</tr>
</thead>
<tbody>
<tr>
<td>[e.g. Strategy]</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Specialist day rate contractors</th>
<th>Interim managers and day rate contractors do not currently require approval</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Interim managers</th>
<th>Interim managers and day rate contractors do not currently require approval</th>
</tr>
</thead>
</table>

¹ Total contract value stated here should equal total cost in the table on the final page of this document.

## 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>

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>

<table>
<thead>
<tr>
<th>Ambition to deliver something of value, importance and relevance</th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>Please provide details of the clinical case where the proposed work directly affects the provision of services for patients or quality improvement.</td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>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?</td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
</tr>
</tbody>
</table>

| 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? |
### Robust contract management

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.

### Capacity to implement findings/recommendations

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.

### Timeframe of work

Please include when expected outcome will be delivered. Why does the project need to start now and not in say 6 months’ time?

### Robust post-implementation review proposal

Please outline how you will review the effectiveness of the consultancy support procured.

### Wider use of findings

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.

### Procurement route if relevant

(please tick ✓)

<table>
<thead>
<tr>
<th>Framework</th>
<th>Open tender</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>[Insert which one if known]</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Procurement method and value on price:

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.

### Selected provider (if known):

### Benchmarking of rates

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.
## 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>Breakdown of expenditure (expand as necessary)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Product, service, role(s) and grade(s) (or equivalent)</strong></td>
</tr>
<tr>
<td>-------------------------------------------------</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Contingency</strong></td>
</tr>
<tr>
<td><strong>Expenses</strong></td>
</tr>
<tr>
<td><strong>VAT (irrecoverable only)</strong></td>
</tr>
<tr>
<td><strong>Total cost</strong></td>
</tr>
</tbody>
</table>
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 & Performance.

- 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. **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.

12. **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 8, 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 Service Lines/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

13. **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.

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:
  - 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

15. **Terms of Reference**

- These will be reviewed in February 2018 (annually) or as required.
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 of the Trust.

Another Non-Executive Director will act as Chair in the absence of the Chairman or Vice-Chairman 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 NHS Improvement 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. The Chairman has delegated authority to take Chair’s actions for urgent decisions up to a maximum value of £50k. All such agreements must be reported to the next Remuneration Committee meeting for ratification.

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 Quarter 1, or as required; and
- annual performance reports relating to Chief Executive annually in Quarter 1, 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.

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 initiative 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 February 2018.
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**

3 Non-Executive Directors will be members of the Audit Committee excluding the Chairman of the Trust.

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 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 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.

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 about 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 Litigation 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 Committee’s 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 these 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 March 2016. 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 2017 (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.
### 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.

### 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 meets its statutory duty 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.

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 risks associated with 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.

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.

• 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:

- 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.

- 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.

- An annual report of the Finance, Performance and Workforce Committee

12.2 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
15. Terms of Reference

These Terms of Reference were approved by the Trust Board at its meeting in March 2015 and will be reviewed at the meeting in February 2016. 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 initiative 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 2017 (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.
1. **Definition**

   - The Clinical Management Board has been established 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**

• Monthly
• Members will be expected to attend for 75% of meetings and attendance registers will be maintained

6. **Membership**

• Executive Directors
• Clinical Directors of Directorates
• Clinical Leads

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:

- 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)
- Improvement Sub-Committee

Partnership Agreements:-
- HR Service Level Agreement
- ICT Service Level Agreement
- Pathology Service Level Agreement
- Cheshire Occupational Health Services

8. Executive Management Team meeting

This is the forum where Executive Directors are held to account by the CEO for delivery of objectives, recovery, which includes the delivery of the QIPP schemes. The Executive Management Team meeting is held weekly and supports timely decision making on business cases subsequently noted at the CMB.

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 minority 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
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 process
Local Anti-Fraud, Bribery and Corruption Policy
**Policy Title:** 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 Local Anti-Fraud Specialist (LAFS) and is intended as a guide for all employees on counter fraud work within the NHS.

**Supersedes:** V6

**Description of Amendment(s):** Removal of NHS Protect Area Anti-Fraud Specialist section following changes internally within NHS Protect.

**This policy will impact on:**

All employees within the Trust.

**Financial Implications:**

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<th>Policy Area:</th>
<th>Trust</th>
<th>Document Reference:</th>
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<tbody>
<tr>
<td>Version Number:</td>
<td>V7</td>
<td>Effective Date: April 2017</td>
</tr>
<tr>
<td>Issued By:</td>
<td>Mark Ogden Director of Finance</td>
<td>Review Date: 31 March 2018</td>
</tr>
<tr>
<td>Author:</td>
<td>Kerry Wheat Local Anti-Fraud Specialist</td>
<td>Impact Assessment Date: March 2017</td>
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**APPROVAL RECORD**

<table>
<thead>
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<th>Committees / Group</th>
<th>Date</th>
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<tbody>
<tr>
<td>Consultation:</td>
<td>Deputy Director of Corporate Affairs and Governance Audit Committee March 2017</td>
</tr>
<tr>
<td>Approved by Director:</td>
<td>Mark Ogden, Director of Finance March 2017</td>
</tr>
<tr>
<td>Approved by:</td>
<td>Trust Board March 2017</td>
</tr>
<tr>
<td>Received for information:</td>
<td>Operational Management Team May 2017</td>
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1 Introduction

1.1 General

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 are honest and professional and they find that fraud committed by a minority is wholly unacceptable as it ultimately leads to a reduction in the resources available for patient care.

NHS Protect is a business unit of the NHS Business Services Authority. It has responsibility for all policy and operational matters relating to the prevention, detection and investigation of fraud, corruption and bribery. All instances where fraud is suspected are properly investigated until their conclusion by staff trained by NHS Protect. Any investigations will be handled in accordance with the NHS Counter Fraud and Corruption Manual.

East Cheshire NHS Trust is committed to reducing fraud, bribery and corruption in the NHS and will seek the appropriate disciplinary, regulatory, civil and criminal sanctions against fraudsters and where possible will attempt to recover losses.

This policy has been produced by the Local Anti-Fraud Specialist (LAFS), Kerry Wheat Tel: 0161 206 1911, kerry.ann.wheat@miaa.nhs.uk, and is intended as a guide for all employees on anti-fraud work within the NHS. All genuine suspicions of fraud and corruption can be reported to the LAFS or through the NHS Fraud and Corruption Reporting Line (FCRL) on Freephone 0800 028 40 60 or www.reportnhsfraud.nhs.uk

This policy is supported and endorsed by senior management.

1.2 Aims and Objectives

This policy relates to all forms of fraud and corruption and is intended to provide direction and help to employees who may identify suspected fraud. It provides a framework for responding to suspicions of fraud, advice and information on various aspects of fraud and implications of an investigation. It is not intended to provide a comprehensive approach to preventing and detecting fraud, corruption and bribery. The overall aims of this policy are to:

- improve the knowledge and understanding of everyone in East Cheshire NHS Trust irrespective of their position, about the risk of fraud, corruption and bribery within the organisation and its unacceptability
- assist in promoting a climate of openness and a culture and environment where staff feel able to raise concerns sensibly and responsibly
- set out East Cheshire NHS Trust’s responsibilities in terms of the deterrence, prevention, detection and investigation of fraud, corruption and bribery
- ensure the appropriate sanctions are considered following an investigation, which may include any or all of the following:
  - criminal prosecution
  - civil prosecution
  - Internal/external disciplinary action.
1.3 Scope

This policy applies to all employees of East Cheshire NHS Trust, regardless of position held, as well as consultants, vendors, contractors, and/or any other parties who have a business relationship with East Cheshire NHS Trust. It will be brought to the attention of all employees and form part of the induction process for new staff.

2 Definitions

2.1 NHS Protect

NHS Protect leads on work to identify and tackle crime across the health service. The aim is to protect NHS staff and resources from activities that would otherwise undermine their effectiveness and their ability to meet the needs of patients and professionals. Ultimately, this helps to ensure the proper use of valuable NHS resources and a safer, more secure environment in which to deliver and receive care. The organisation's strategy covers three main objectives:

- To educate and inform those who work for or use the NHS about crime in the health service and how to tackle it;
- To prevent and deter crime in the NHS by removing opportunities for it to occur or to re-occur; and,
- To hold to account those who have committed crime against the NHS by detecting and prosecuting offenders and seeking redress where viable. Any investigations will be handled in accordance with NHS Protect guidance. NHS Protect strategy “tackling crime against the NHS: A strategic approach.”

2.2 Fraud

The Fraud Act 2006 represents an entirely new way of investigating and prosecuting fraud. It is no longer necessary to prove that a person has been deceived. The focus is now on the dishonest behaviour of the suspect and their intent to make a gain 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; however, there are three primary ways in which it can be committed that are likely to be investigated in the NHS:

1) Fraud by false representation (s.2) – lying about something using any means, e.g. lying on a CV or NHS job application form.
2) 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 obligations and where you are required to declare these as part of your employment conditions.
3) Fraud by abuse of a position (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 patient 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

The Bribery Act 2010 came into effect on 1st July 2011. Bribery and corruption involves offering, promising or giving a payment of benefit-in-kind in order to influence others to use their position in an improper way to gain some form of personal, financial or commercial advantage for oneself or another.

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 (i.e. a bribe) 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 health body 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 – The bribe itself can occur either before or after the corrupt act.

Staff are reminded to ensure that they are transparent in respect of recording any gifts, hospitality or sponsorship. They should refer to the separate health body policies covering:
- Acceptance of Gifts and Hospitality
- Declaration of Interests
- Sponsorship

In addition the Act introduces a new ‘corporate offence’ of failing to prevent bribery by an organisation not having adequate preventative procedures in place. The Trust may avoid conviction if it can show that it had procedures and protocols in place to prevent bribery. The corporate offence is not a stand-alone offence, but always follows from a bribery and/or corruption offence committed by an individual associated with the company or organisation in question.

As the Bribery Act is applicable to all NHS organisations, it also applies to (and can be triggered by) everyone “associated” with this health body 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).

This health body 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. We are 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 it and these will be regularly reviewed. We shall, in conjunction with NHS Protect, seek to obtain the strongest penalties – including criminal prosecution, disciplinary and/or civil sanctions – against anyone associated with this organisation who is found to be involved in any bribery or corruption 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.

2.4 Employees
For the purposes of this policy, ‘employees’ includes NHS Protect and East Cheshire NHS Trust staff, as well as board, executive and non-executive members (including co-opted members) and honorary members.

3 Roles and responsibilities

Through our day-to-day work, we 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 exists, whether because of poor procedures or oversight, you should report it to the LAFS or the NHS Fraud and Corruption Reporting Line.

This section states the roles and responsibilities of employees and other relevant parties in reporting fraud or other irregularities.

East Cheshire NHS Trust will take all necessary steps to counter fraud, bribery and corruption in accordance with this policy, the *NHS Counter Fraud and Corruption Manual*, the policy statement ‘Applying Appropriate Sanctions Consistently’ published by NHS Protect and any other relevant guidance or advice issued by the NHS Protect.

3.1 Chief Executive

The Chief Executive has the overall responsibility for securing funds, assets and resources entrusted to it. This includes 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.

3.2 Director of Finance

The Director of Finance (DOF) has powers to approve financial transactions initiated by directorates across the organisation.

The DOF prepares documents, maintains detailed financial procedures and systems and that they apply the principles of separation of duties and internal checks to supplement those procedures and systems.

The DOF will report annually to the Board and, where applicable, the Council of Governors on the adequacy of internal financial controls and risk management as part of the Board’s overall responsibility to prepare a statement of internal control for inclusion in the NHS body’s annual report.

The DOF will, depending on the outcome of initial investigations, inform appropriate senior management of suspected cases of fraud, bribery and corruption, especially in cases where the loss may be above an agreed limit or where the incident may lead to adverse publicity.

3.3 Internal and External Audit

The role of internal and external audit includes reviewing controls and systems and ensuring compliance with financial instructions. Internal and External Audit have a duty to pass on any suspicions of fraud, bribery or corruption to the Local Anti-Fraud Specialist (LAFS).

3.4 Human Resources
HR will liaise closely with managers and the LAFS from the outset if an employee is suspected of being involved in fraud, bribery or corruption, in accordance with agreed liaison protocols. HR staff are responsible for ensuring the appropriate use of East Cheshire NHS Trust’s disciplinary procedure. HR will advise those involved in the investigation on matters of employment law and other procedural matters, such as disciplinary and complaints procedures, as requested. Close liaison between the LAFS and HR will be essential 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.

3.5 Local Anti-Fraud Specialist

The LAFS’s role is to ensure that all cases of actual or suspected fraud, bribery and corruption are notified to the Director of Finance and reported accordingly.

The LAFS will regularly report to the Director of Finance on the progress of the investigation and when/if referral to the police is required.

The LAFS will:

- ensure that the Director of Finance is informed about all referrals/cases, including any regional NHS Protect investigations which may impact upon the organisation
- be responsible for the day-to-day implementation of counter fraud, bribery and corruption activity, as agreed in the fraud annual work plan and, in particular, the investigation of all suspicions of fraud
- investigate all cases of fraud
- report any case and the outcome of the investigation through the NHS Protect national case management system (FIRST)
- 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
- conduct risk assessments in relation to their work to prevent fraud, bribery and corruption
- ensure that any system weaknesses identified as part of an investigation are followed up with management and reported to internal audit
- to adhere to NHS Protect standards to ensure that the organisation has appropriate anti-fraud, bribery and corruption arrangements in place and that the LAFS will look to achieve the highest standards possible, as per Counter Fraud Professional Accreditation Board (CFPAB)’s Principles of Professional Conduct.

3.6 Managers
Managers must be vigilant and ensure that procedures to guard against fraud and corruption are followed. They should be alert to the possibility that unusual events or transactions could be symptoms of fraud and corruption. If they have any doubts, they must seek advice from the nominated LAFS.

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 LAFS will proactively assist the encouragement of an anti-fraud culture by undertaking work that will raise fraud awareness.

All instances of actual or suspected fraud, bribery or 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 LAFS 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 East Cheshire NHS 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
- to be responsible for the enforcement of disciplinary action for staff who do not comply with policies and procedures
- to report any instances of actual or suspected fraud, bribery or corruption brought to their attention to the LAFS immediately.

It is important that managers do not investigate any suspected financial crimes themselves.

- to conduct risk assessments and to mitigate identified risks, within 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 East Cheshire NHS Trust
- be aware of East Cheshire NHS Trust's Anti-Fraud and Corruption Policy and the rules and guidance covering the control of specific items of expenditure and receipts
- identify financially sensitive posts
- contribute to their director’s assessment of the risks and controls within their business area, which feeds into East Cheshire NHS Trust's and the Department of Health Accounting Officer’s overall statements of accountability and internal control.

3.7 All Employees
East Cheshire NHS 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 and resources of the Trust, including information, goodwill and property.

In addition, all employees have a responsibility to comply with all applicable laws and regulations 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 East Cheshire NHS 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, receipts or dealing with contractors or suppliers.

If an employee suspects that there has been fraud or corruption, or has seen any suspicious acts or events, they must report the matter to the nominated LAFS.

3.8 Information Management and Technology

The Head of Information Security (or equivalent) will contact the LAFS immediately in all cases where there is suspicion that IT is being used for fraudulent purposes (Computer Misuse Act 1990).

4 The Response Plan

4.1 Bribery and Corruption

East Cheshire NHS Trust has conducted risk assessments in line with Ministry of Justice guidance to assess how bribery and corruption may affect the organisation. As a result, proportionate procedures have been put in place to mitigate identified risks.

East Cheshire NHS Trust’s procedures in relation to declarations of interest and the hospitality/gifts register may be found in the corporate governance manual.

4.2 Reporting Fraud, Bribery or Corruption

This section outlines the action to be taken if fraud, bribery or corruption is discovered or suspected.
If an employee has any of the concerns mentioned in this document, they must inform the nominated LAFS or East Cheshire NHS Trust’s Director of Finance immediately, unless the Director of Finance or LAFS is implicated. If that is the case, they should report it to the chair or Chief Executive, who will decide on the action to be taken.

An employee can contact any executive or non-executive director of East Cheshire NHS Trust to discuss their concerns if they feel unable, for any reason, to report the matter to the LAFS or Director of Finance.

Suspected fraud, bribery and corruption can also be reported to NHS Protect using the NHS Fraud and Corruption Reporting Line on Freephone 0800 028 40 60 or by filling in an online form at www.reportnhsfraud.nhs.uk, as an alternative to internal reporting procedures and if staff wish to remain anonymous.

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 LAFS 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 should always be encouraged to report reasonably held suspicions directly to the LAFS. You can do this by contacting the LAFS by telephone or email using the contact details supplied in Appendix 1.

East Cheshire NHS 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, East Cheshire NHS Trust has produced a Whistleblowing Policy. This procedure is intended to complement East Cheshire NHS Trust’s Anti-Fraud, Bribery and Corruption policy and Code of Business Conduct 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.

4.3 Sanctions and Redress

The NHS Protect 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 Protect 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 Protect 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 Protect, 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. It should be noted, however, that the duty to follow disciplinary procedures will not override the need for legal action to be taken (e.g. consideration of criminal action). In the event of doubt, legal statute will prevail.

- **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.

- **Police Involvement** - In accordance with the *NHS Counter Fraud and Corruption Manual*, the Director of Finance, in conjunction with the LAFS, will decide whether or not a case should be referred to the police. Any referral to the police will not prohibit action being taken under the local disciplinary procedures of East Cheshire NHS Trust.

## 5 Review

### 5.1 Monitoring and Auditing of Policy Effectiveness

Monitoring is essential to ensuring that controls are appropriate and robust enough to prevent or reduce fraud. Arrangements might include reviewing system controls on an ongoing basis and identifying weaknesses in processes.

Where deficiencies are identified as a result of monitoring, The Trust should explain how appropriate recommendations and action plans are developed and how any recommendations made should be implemented.

### 5.2 Dissemination of the Policy

The Anti-Fraud, Bribery and Corruption Policy will be made available to all staff, via a variety of forms of communications, including the Trust’s intranet.

It is highly important that all staff understand and are aware of the policy.
5.3 Review of the Policy

The Trust’s Anti-Fraud, Bribery and Corruption Policy will be reviewed as per East Cheshire NHS Trust’s Policy on Policies? The LAFS will review the policy on behalf of the Trust before ratification.
### 6 Policy appendices

**Appendix 1**

**Anti-fraud, bribery and corruption: dos and don’ts**

**A desktop guide for East Cheshire NHS Trust staff**

**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** 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. **BRIBERY** is to give promise to offer a bribe, and to request, agree to receive or accept a bribe.

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<th><strong>DO</strong></th>
<th><strong>DO NOT</strong></th>
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| • 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 evidence  
Retain any evidence that may be destroyed, or make a note and advise your LCFS.  
• report your suspicion  
Confidentiality will be respected – delays may lead to further financial loss. | • confront the suspect or convey concerns to anyone other than those authorised, as listed below  
Never attempt to question a suspect yourself; this could alert a fraudster or accuse an innocent person.  
• try to investigate, or contact the police directly  
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 LAFS can 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. |

If you suspect that fraud against the NHS has taken place, you must report it immediately, by:
- directly contacting the **Local Anti-Fraud Specialist**, or  
- telephoning the **Freephone NHS Fraud and Corruption Reporting Line**, or  
- online [www.reportnhsfraud.nhs.uk](http://www.reportnhsfraud.nhs.uk) or,  
- contacting the **Director of Finance**.

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**Do you have concerns about a fraud taking place in the NHS?**

If so, any information can be passed to the **NHS Fraud and Corruption Reporting Line: 0800 028 40 60**

All calls will be treated in confidence and investigated by professionally trained staff.

Your nominated Local Anti-Fraud Specialist is **Kerry Wheat**, who can be contacted by telephoning **0161 206 1911, 07825 456 226**, or emailing kerry.ann.wheat@miaa.nhs.uk

If you would like further information about the NHS Counter Fraud Service, please visit [www.nhsbsa.nhs.uk/fraud](http://www.nhsbsa.nhs.uk/fraud)

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**Protecting your NHS**
Freedom to speak up: raising concerns (whistleblowing) policy for the NHS
April 2016
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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):

(e) unsafe patient care

(f) unsafe working conditions

(g) inadequate induction or training for staff

(h) lack of, or poor, response to a reported patient safety incident

(i) suspicions of fraud (which can also be reported to our local anti-fraud specialist):

Local Anti-Fraud Specialist, Kerry Ann Wheat. Tel 0161 206 1911 Mobile 07825 456 226 or by using the email address kerry.ann.wheat@miaa.nhs.uk or kwheat@nhs.net

(j) 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:

(k) 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.

You can also contact:

(m) 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

All these people have been trained in receiving concerns and will give you information about where you can go for more support.

If for any reason you do not feel comfortable raising your concern internally, you can raise concerns with external bodies, listed on page 7.

8. 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.

9. Annex A sets out an example of how a local process might demonstrate how a concern might be escalated.
**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 incident\(^3\)). 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.

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10. 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 Protect** 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 new National Guardian (once fully operational) 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:

(n) 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 Protect** 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
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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>Requirements</th>
</tr>
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<tbody>
<tr>
<td>Up to £ 5000.00 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>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>
<td></td>
</tr>
<tr>
<td>Over £50001.00 incl. VAT</td>
<td>the following is required:</td>
</tr>
<tr>
<td>Minimum of 3 Formal Tenders issued and received in accordance with Trust Policy as detailed in 5 and 6 below.</td>
<td></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>
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<tbody>
<tr>
<td>£50001.00 to £106,047</td>
<td>Chief Exec/ Director of Finance</td>
</tr>
<tr>
<td>Over £106,047</td>
<td>Board of Directors</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 1\textsuperscript{st} January, 2016). The prevailing rate can be found - http://www.ojec.com/thresholds.aspx

European Procurement Law cannot be waivered 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:
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 gain 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)

Contact the Procurement Dept. who will arrange to carry out a Quotation/Tender

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

Waiver sent to Trust HQ for registration, Director’s support sign off and final approval/rejection

Waiver returned to Originator with explanation for rejection

Rejected

Approved

Waiver returned to originator with explanation for 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.

Note: the person responsible for completing the Waiver may be required to attend an Audit Committee meeting to explain their actions.
WAIVER –

APPLICATION TO ACCEPT A NON COMPETITIVE QUOTATION
(Value £5,000.00 TO £25,000.00) OR TENDER (Value exceeding £25,000.00)
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

……………………………………………………………………………………………………………………………………………………

……………………………………………………………………………………………………………………………………………………

……………………………………………………………………………………………………………………………………………………

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.”

217
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
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.
C5 WAIVER PROCESS DIAGRAM

Note OJEU threshold changes biannually the current rate is £106,047 excluding VAT – current thresholds can be located at: http://www.ojec.com/thresholds.aspx
Fit and Proper Persons Regulation Requirements and Process

Background

In direct response to failing at the Winterbourne View Hospital and the Francis Inquiry into Mid Staffordshire NHS Hospital Trust, Regulation 5 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (referred to as the 2014 Regulations) has been introduced.

All NHS providers are required to demonstrate that appropriate processes are in place to confirm that Directors (and Non-executive Directors) are of good character; hold the required qualifications and have the competence, skills and experience required which may include appropriate communication and leadership skills, as well as a caring and a compassionate nature.

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 Board members should not be appointed or continue to hold office unless they are:

• of good character
• have the necessary qualifications, skills and experience
• are able to perform the work that they are employed for after reasonable adjustments are made
• able to supply information as set out in Schedule 3 of the 2014 Regulations when requested by the Care Quality Committee (see Appendix A).

When assessing a person being ‘of good character’ NHS providers are required to take account of Schedule 4 of the 2014 Regulations, namely:

• 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
• 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.

The CQC’s definition of good character is not the objective test of having no criminal convictions but instead rests upon a judgement as to whether the person’s character is such that they can be relied upon to do the right thing under all circumstances. This implies discretion for Boards in reaching a decision and allows for the fact that people can and do change over time.

The regulations list categories of persons who are prevented from holding the office and for whom there is no discretion:

• 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;
• the person 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 discharging any functions relating to any office or employment with a service provider.

It will be the responsibility of the Chairman to discharge the requirement to ensure that all Board members meet the fitness test and do not meet any of the ‘unfit’ criteria.

In its guidance the CQC makes references to associate directors and persons irrespective of their voting rights. To avoid any doubt, the trust regards the following posts as subject to the 2014 regulations as they are members of the Trust Board:

Chairman
Non-Executive Directors
Chief Executive
Director of Nursing, Performance and Quality (Deputy Chief Executive)
Director of Finance
Medical Director
Director of Human Resources and Organisational Development
Director of Corporate Affairs and Governance

Given that East Cheshire Trust is an NHS Trust, on appointment the process will differ for the Chairman and Non-Executive Directors; the duty to ensure compliance with the 2014 Regulations rests initially with NHS Improvement for the Chairman and Non-Executive Directors.

The following diagrams outline the process to be adopted by the trust in making new appointments and the review process for existing Board members.
For Directors not covered by NHS Improvement the trust will use its existing recruitment and HR policies, which incorporate processes such as the *NHS Employment Check Standards* and *Disclosure & Barring Service* (DBS) checks, to undertake the fit and proper persons tests. In addition checks will need to be made against insolvency / bankruptcy registers and disqualified director registers.
When undertaking the regular annual review of Board members fitness, the trust will extend the principles outlined within its recruitment and HR policies to undertake these reviews, as well as taking account of other information available to the trust (e.g., following the outcome of whistleblowing cases).

To assist with this review process the trust has developed a Self-Declaration Form to be completed and submitted annually (see Appendix B). To ensure the trust complies with the 2014 Regulations the standard checklist will also be adopted (see Appendix C).

For Directors not covered by NHS Improvement, any appointments will be led by the HR Directorate, and the self-declaration process will be led by the Corporate Affairs and Governance Directorate.

For all Directors, irrespective if they undertook a DBS check on appointment, a fresh DBS check will be required every 3 years. Directors should be registered with the DBS Update Service which will automatically update their DBS status without further checks having to be completed and provides portability between NHS employers. There will be a cost of the DBS Update Service which is £13 per annum per person. Support will be available from the Corporate Affairs and Governance Directorate.
CONSEQUENCES OF NOT TAKING ACTION

The CQC will take enforcement action, using their existing regulatory powers, for breaches of the fit and proper person requirement, namely having someone in place who does not satisfy the 2014 Regulations. Evidence of this could be:

- a director is unfit on a ‘mandatory’ ground, such as a relevant conviction or bankruptcy (determined by the provider);
- a provider does not have a proper process in place to enable it to make the assessments required for the fit and proper persons test;
- on receipt of information about a director’s fitness, a decision is reached on the fitness of the director that is not in the range of decisions that a reasonable person would make.
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

In line with the requirement for Board members of NHS provider organisations to be a fit and proper person, as required under Regulation 5 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (and subsequent amendments), I hereby declare:

<table>
<thead>
<tr>
<th>DECLARATION</th>
<th>CONFIRMED</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am of good character by virtue of the following:</td>
<td>(YES / NO)</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>
</tbody>
</table>

I have the qualifications, skills and experience necessary for the position I hold on the Board

I am capable of undertaking the relevant position, after any reasonable adjustments under the Equality Act 2010

I have not been responsible for any misconduct or mismanagement in the course of any employment with a CQC registered provider

I am not prohibited from holding the relevant position under any other law (e.g., under the Companies Act or the Charities Act).

Signed: 

Name: 

Position: 

Date: 

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## Appendix C

### Fit and Proper Persons Test – Checklist, which covers NHS trusts and Foundation trusts

<table>
<thead>
<tr>
<th>Standard</th>
<th>Assurance process</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>At appointment</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 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. | Employment checks in accordance with NHS Employment Check Standards issued by NHS Employers including:  
- 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;  
- search of insolvency and bankruptcy register; | References;  
Outcome of other pre-employment checks;  
DBS checks;  
Register search results;  
List of referees and sources of assurance for FOIA purposes. |
| 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. | Report and debate at the remuneration committee.  
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. | Record that due process was followed for FOIA purposes. |
<table>
<thead>
<tr>
<th>Standard</th>
<th>Assurance process</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<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>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.</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. 360 degree appraisal (in line with Board development process) 360</td>
<td>Recruitment policy and procedure Values-based questions 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>Minutes of committee, NED appraisal framework NED competence framework Notes of ED appraisals</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>Standard</td>
<td>Assurance process</td>
<td>Evidence</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>--------------------------------------------------------</td>
<td>-----------------------------------------------</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</td>
</tr>
<tr>
<td>Standard</td>
<td>Assurance process</td>
<td>Evidence</td>
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</tbody>
</table>
| 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 practice proceedings and professional disciplinary cases. ('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 and NEDs. | 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. | NED Recruitment Information pack Reference Request for ED/NED |
<table>
<thead>
<tr>
<th>Standard</th>
<th>Assurance process</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>9. 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 practice proceedings and professional disciplinary cases. N.B. The CQC accepts that providers will use reasonable endeavors 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 and ED Recruitment Information packs Core HR policies Reference Request for ED/NED</td>
</tr>
<tr>
<td>10. 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>11. As part of the recruitment/appointment process, providers should establish whether the individual is on a relevant DBS list.</td>
<td>Eligibility for DBS checks will be assessed for each vacancy arising.</td>
<td>DBS policy</td>
</tr>
</tbody>
</table>

**Continuing provisions**

<table>
<thead>
<tr>
<th>Standard</th>
<th>Assurance process</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>12. The fitness of 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 as part of appraisal process. Checks of insolvency and bankruptcy register and register of disqualified directors to be undertaken each year as part of the appraisal process. Board reviews checks and agrees the outcome.</td>
<td>Continual to be assessed as part of appraisal process Register checks if necessary Board minutes record that process has been followed.</td>
</tr>
<tr>
<td>Standard</td>
<td>Assurance process</td>
<td>Evidence</td>
</tr>
<tr>
<td>----------</td>
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<td>----------</td>
</tr>
<tr>
<td>13. 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>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 policies Contracts of employment (for EDs and director-equivalents) Service agreements or equivalent (for NEDs)</td>
</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>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>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>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>Assessment criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criteria we are assessing</td>
</tr>
<tr>
<td>Ambition to deliver something of value, importance and relevance</td>
</tr>
<tr>
<td></td>
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<td></td>
</tr>
<tr>
<td>Criteria we are assessing</td>
</tr>
<tr>
<td>----------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Clear scope                                                    | • Evidence that the scope is clear, defined and well thought through  
• Detail on how the scope has been 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? |
| Robust contract management                                    | • Evidence that the trust can manage the supplier, control spend and hold the supplier account for delivering value for money  
• Assurance that the trust can deliver the scope as planned  
• 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 |
| Capacity to implement findings/recommendations                 | • Evidence that the trust has the capacity to act on or implement findings/recommendations of the procured work  
• Examples of previous success in realising benefits |
| Timeline of work                                               | • Evidence of a well-thought-through and realistic timeline, with details on when expected outcome will be delivered  
• Why does the project need to start now and not in say 6 months’ time? |
| Robust implementation review proposal                          | • An outline of how the effectiveness of the consultancy support procured will be reviewed, with particular focus on benefits and value add |
| Finance case                                                   | • 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)  
• Evidence of sourcing the best value supplier and evidence of negotiation over rates  
• 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?  
• Details of agreed benchmarking rates, referencing where possible agreed framework rates.  
• 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)  
• 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? |
| Wider use of findings | • 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
• 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 |
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><em>Please give a high level summary of what this project entails (~250 words)</em></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></th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of requestor:</td>
<td>Job role of requestor:</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):</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>
</table>

### Expenditure type

<table>
<thead>
<tr>
<th>Management consultancy</th>
<th>[e.g. Strategy]</th>
</tr>
</thead>
<tbody>
<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>

1. Total contract value stated here should equal total cost in the table on the final page of this document.

### 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>

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
| **Assessment criteria** | **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. |
|------------------------|--------------------------------------------------------------------------------------------------------------------------|
| **Ambition to deliver something of value, importance and relevance** | **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>| <strong>Clear scope</strong> | <strong>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?</strong> |</p>
<table>
<thead>
<tr>
<th>Robust contract management</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>Capacity to implement findings/recommendations</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>Timeframe of work</td>
<td>Please include when expected outcome will be delivered. Why does the project need to start now and not in 6 months’ time?</td>
</tr>
<tr>
<td>Robust post-implementation review proposal</td>
<td>Please outline how you will review the effectiveness of the consultancy support procured.</td>
</tr>
<tr>
<td>Wider use of findings</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>
</tbody>
</table>

### Procurement route if relevant
(please tick ✓)

<table>
<thead>
<tr>
<th>Framework [Insert which one if known]</th>
<th>Open tender</th>
<th>Other</th>
</tr>
</thead>
</table>

**Procurement method and value on price:**

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.

<table>
<thead>
<tr>
<th>Selected provider (if known):</th>
<th>Benchmarking of rates</th>
</tr>
</thead>
</table>

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.
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>
<td></td>
<td></td>
<td></td>
<td>16/17</td>
<td>17/18</td>
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<tr>
<td>Contingency</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expenses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>VAT (irrecoverable only)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total cost</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Report of:</td>
<td></td>
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<td>----------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Responsible Officer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Director of Corporate Affairs and Governance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Author of Report:</th>
<th>Head of Integrated Governance</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Subject/Title</th>
<th>Review of Assurance Framework and Corporate Risk Register</th>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Background papers (if relevant)</th>
<th>Assurance Framework and Corporate Risk Register</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Purpose of Paper</th>
<th>This report is to provide the Board with an opportunity to review and discuss the Board Assurance Framework and actions which have taken place since the previous meeting</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Action/Decision required</th>
<th>The Board is asked to:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Note the content of the Board Assurance Framework and Corporate Risk Register</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mitigates Risk Number: (identify) On Corporate Risk Register</th>
<th>This paper relates to the Assurance Framework and Corporate Risk Register and therefore is linked to all risks.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Mitigates Risk Number: (identify) On Assurance Framework</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Link to Care Quality Commission domain</th>
<th>All domains</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Link to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust’s Strategic Direction</td>
</tr>
<tr>
<td>Corporate Objectives</td>
</tr>
<tr>
<td>All Objectives</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Legal implications - (identify)</th>
<th>There are no legal implications</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Impact on quality</th>
<th>This review ensures that appropriate systems are in place for the Board to understand the controls relating to any impact on the quality of services</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Resource impact</th>
<th>There are no resource implications</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Impact of equality/diversity</th>
<th>There is no impact on equality/diversity</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Avoid acronyms or abbreviations - if necessary list:</th>
<th></th>
</tr>
</thead>
</table>
1. PURPOSE

This report is to provide the Board with an opportunity to review and discuss the Board Assurance Framework and Corporate Risk Register and to note the key areas of focus for the next 3 months to reduce the level of risk.

2. BACKGROUND

The Board has accountability to ensure there are effective systems and processes in place to manage risk and East Cheshire NHS Trust has set this out within its Risk Management Strategy 2017 to 2018. This was approved by the Board at its January 2017 meeting.

The assurance framework and corporate risk register forms part of the Risk Management Strategy and has been developed to identify risks which could significantly impact on the organisation's ability to deliver its organisational objectives and key work-streams.

Reflecting current thinking and good practice over the management of the Board Assurance Framework the overall number of risks within its Board Assurance Framework have been reduced to provide a more strategic focus on risk.

3. STRATEGIC RISKS

At the April 2016 meeting of the Board, the following Strategic risks were reviewed and approved:

1. 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.
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.
3. If the trust cannot meet its 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. 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. 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
4. POSITION REPORT

Assurance Framework

The following table shows how the Strategic Risks included in the Board Assurance Framework were split using the Red, Amber, Green (RAG) rating. The target level for those Strategic Risks has also been included to show how the risks are expected to move over time.

<table>
<thead>
<tr>
<th>RAG rating</th>
<th>Risk Rating without controls</th>
<th>Current Risk Rating</th>
<th>Target Risk Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Red</td>
<td>5 (2x25; 1x20; 2x16)</td>
<td>3 (1x25; 1x20; 1x16)</td>
<td>1 (1x15)</td>
</tr>
<tr>
<td>Amber</td>
<td>0</td>
<td>2 (2x12)</td>
<td>1 (1x10)</td>
</tr>
<tr>
<td>Yellow</td>
<td>0</td>
<td>0</td>
<td>3 (3x8)</td>
</tr>
<tr>
<td>Green</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

The table below shows the key areas of focus within each strategic risk area, which aim to reduce the level of risk:

<table>
<thead>
<tr>
<th>Strategic Risk</th>
<th>Target Date</th>
<th>Areas of Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Leadership of Strategic Transformation</td>
<td>June 2017</td>
<td>• Identification of future Senior Workforce requirements and organisational form</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Pace at which required transformational change is undertaken</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Alignment of Caring Together with LDS and STP 5 year plans</td>
</tr>
<tr>
<td>2. Quality &amp; Compliance: patient safety, patient experience and effectiveness</td>
<td>June 2017</td>
<td>• Engagement and commitment from Partners to improve the 4 hour access standard.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Improve patient flow</td>
</tr>
<tr>
<td>3. Financial stability</td>
<td>June 2017</td>
<td>• Identification of QIPP schemes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Delivery of agreed financial plan</td>
</tr>
<tr>
<td>4. People</td>
<td>June 2017</td>
<td>• Recruitment, Retention and Sickness absence</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Continued focus on the use of temporary workforce and sustainability of middle-grade cover.</td>
</tr>
<tr>
<td>5. Infrastructure</td>
<td>June 2017</td>
<td>• Prioritisation of capital plan</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Completion of Server 2003 project</td>
</tr>
</tbody>
</table>
The Board should note that there are some gaps in control linked to patient flow - the decommissioning of the HITS service; and the lack of a Community Alcohol service; and delayed transfers of care. The trust is currently working with partners to improve services for patients.

The monitoring of each of the Strategic Risks has been delegated as follows:

<table>
<thead>
<tr>
<th>Committee / Board</th>
<th>Number of Strategic Risks</th>
<th>Current Risk Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety, Quality and Standards Committee</td>
<td>1</td>
<td>1 x 12</td>
</tr>
<tr>
<td>Finance, Performance and Workforce Committee</td>
<td>2</td>
<td>1 x 25; 1 x 16</td>
</tr>
<tr>
<td>Clinical Management Board</td>
<td>2</td>
<td>1 x 20; 1 x 12</td>
</tr>
</tbody>
</table>

The Safety Quality and Standards Committee and Finance, Performance and Workforce Committee reviewed their risks at their February 2017 meetings. Clinical Management Board also reviewed its risks in March 2017.

Corporate Risk Register

The 39 red rated Corporate Risks have been delegated as follows (5 risks are monitored by more than one committee):

<table>
<thead>
<tr>
<th>Committee / Board</th>
<th>Number of Red Rated Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety, Quality and Standards Committee</td>
<td>28 (includes 13 incidents which have been reported on the National Strategic Executive Information System (StEIS))</td>
</tr>
<tr>
<td>Finance, Performance and Workforce Committee</td>
<td>8</td>
</tr>
<tr>
<td>Clinical Management Board</td>
<td>8</td>
</tr>
</tbody>
</table>

All red rated risks in the holding area have been reviewed and approved.

The red rated Corporate Risks are included at Appendix 2. The Corporate Risks which are scored between 9 and 12 are reviewed through the risk Management Sub-committee and Operational Management Group and escalated accordingly to the relevant identified committee.

The Clinical Management Board reviewed its risks in March 2017.

Since the previous risk report presented to Committees of the Board the following changes have taken place:

Additions to the Report

Seven new risks have been added, five of which are Serious Incidents:

- 2465 - Impact of opening ward 5 on the financial position of the Trust
- 2486 – Gaps in middle grade rota in Emergency Department

Three risks have had their current risk scores increased:
• 1766 – Reverse Osmosis water plant
• 2112 – Availability of beds during bed reconfiguration programme
• 1698 – Gaps in Middle Grade Paediatricians

Risks Removed from the Report
Three risks have been closed:

• 2383 – South & Vale Royal community services transfer
• 1806 – Handforth X-Ray facilities
• 2303 – Vacancies in administrative posts for Tissue Viability

Five risks have had their current risk scores reduced:

• 1785 – Maintenance of operating theatres
• 2388 – Pharmacy stock control system not being supported
• 1694 – 18 week backlog
• 1765 – Hospital Sterilisation and Decontamination Department (HSDU) water disinfectors
• 2090 – Midazolam register

5. RECOMMENDATIONS

The Board is asked to:

• Note the content of the Board Assurance Framework and Corporate Risk Register
• Note the key areas of focus for the next 3 months to reduce the level of risk
Report of:
Responsible Officer
Accountable Officer

Kath Senior
Director of Nursing, Performance and Quality

Author of Report:
Jeanette Sarkar
Head of Nursing, Quality

Subject/Title
Bi Annual Report : Safer Staffing, Dependency and Acuity Tools

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, high quality, 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 lead.

Mitigates Risk Number: (identify)
On Assurance Framework
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
<table>
<thead>
<tr>
<th>Link to:</th>
<th>Provide the best services to our population through improvements to safety, productivity and patient experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legal implications - (identify)</td>
<td>No legal implications</td>
</tr>
<tr>
<td>Impact on quality</td>
<td>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</td>
</tr>
<tr>
<td>Resource impact</td>
<td>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</td>
</tr>
<tr>
<td>Impact of equality/diversity</td>
<td>No impact on equality and diversity</td>
</tr>
</tbody>
</table>
| Avoid acronyms or abbreviations - if necessary list: | NQB National Quality Board  
NICE National Institute for Health and Care Excellence  
DoH Department of Health  
CQC Care Quality Commission  
CHPPD Care Hours Per Patient Day  
L&D Learning and development  
SNCT Safer Nursing Care Tool  
NMC Nursing and Midwifery Council  
WTE whole time equivalent  
HR Human Resources  
HCA Health care Assistant  
SBAR Situation, background, assessment, recommendation  
RCN Royal College of Nursing  
JAG Joint Advisory Group on GI Endoscopy  
SAFER Senior review/All patients/Flow/Early discharge/Review  
IELTS International English language testing system  
MAU Medical Assessment Unit |
1.0 Executive Summary

1.1 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 staffing capacity and capability. This in turn forms part of CQC’s Intelligent Monitoring for all NHS providers.

1.2 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 and high level narrative with regards to the results of the SNCT audit undertaken in January 2017.

1.3 The SNCT analysis has been triangulated with performance metrics and senior nurse professional judgement and indicates that the January’17 audit on the whole aligns with the expected funded establishment, appropriate skill mix and staff competency required to enable the delivery of high quality safe patient care for in patient adults.

2.0 Summary of key actions and progress since September 2016

- The agreed Nurse recruitment strategy continues and includes:
  - 12 month recruitment campaign timetable for both registered and unregistered staff. As part of the 12 month recruitment campaign, open days/evenings are now booked quarterly.
  - Vacant ward HCA posts are now recruited via the virtual pool, this allows staff to move into substantive posts who have received full induction, mandatory training and have a level of experience.
  - Successful recruitment of HCA to the substantive pool, there is a target of 20wte with 15wte currently in post
  - A recruitment stand was held at the national 2 day RCN jobs fair in Manchester February 2017.
  - A relaunch of the weekly pay initiative for nurse bank staff, this commenced in April’16 and is now available for further staff to sign up to.
  - The cohort of overseas nurses recruited from the Philippines has reduced to 20 in total. 3 nurses from the Philippines joined the Trust at the beginning of March 2017, with a further 3 due at the beginning of May
  - The Trust is part of the Nursing Associate Pilot. 10 nursing associate roles have commenced training and bespoke placements.
  - The Trust is exploring the potential to increase HCA apprenticeship roles during 2017 in collaboration with Macclesfield College.

- Following the initial benefits seen in the reduction of registered nurse vacancies after the service changes relating to Stroke and the bed reconfiguration, substantive registered nurse vacancies have increased from 26wte to 37.66wte. If long term sickness and maternity leave are included in the overall wte identified shortfall this increases to 54.87wte in total. The trust is therefore utilising temporary staff from Bank and Agency to maintain safe staffing levels in line with planned rotas.
3.0 Methodology: Safer Nursing Care Tool (SNCT) See Appendix 1

3.1 The four week period 9th January 2017 was used to collect the patient dependency and acuity data from all ward areas.

4.0 Acute and Integrated Community Care Directorate

Medical Specialties (wards 3, 4, 7, CCU):

4.1 Overall:
Current funded establishments, staffing levels and review of skill mix are appropriate for the medical specialty wards based on current bed configuration and SNCT analysis. All areas continue to demonstrate a high level of acuity and dependency coupled with case mix complexities.

Integrated Care (wards 11 & Aston):

4.2 Overall:
The Integrated care SNCT analysis demonstrates fluctuations in case mix, complex discharges and an improved position in terms of the number of discharges seen during January compared to previous audits. Current funded establishments, staffing levels and review of skill mix are considered appropriate based on current bed configuration and level of care required. However, further work is recommended to review Ward 11 core establishment and skill mix if 30 beds remain open because of the challenges this poses in terms of the ward footprint and restricted patient observation.

Urgent Care (MAU & A&E)

4.3 Overall:
Urgent Care SNCT analysis has demonstrated that current staffing levels, funded establishment and review of skill mix are appropriate based on current data, specialty bed configuration and consistent with regional network guidance.

5. Planned Care Services Directorate - Surgical Specialties:

5.1 Overall:
SNCT analysis demonstrates a shift in patient dependency and acuity within the footprint of the surgical and orthopaedic ward areas. This, in part reflects changes made to the relocation of orthopaedic Wards 5 and 6 to the Ward 10 footprint, the management and placement of medical outliers in surgical beds, the prevalence of orthopaedic trauma and an increased throughput via the day case unit to support elective activity. This change in case mix is being closely monitored by the clinical matrons and rotas are being flexed to meet dependency.

Recruitment and retention within orthopaedics remains challenged. It is anticipated that further workforce modelling and evaluation will be undertaken during the next financial year using the 90 day improvement methodology.

6. Community Setting:

6.1 Although SNCT data collection and preliminary analysis as part of a pilot project was undertaken by community teams the tool is no longer recommended nationally.
6.2 New guidance from NQB; ‘An improvement resource for district nursing services’ is being developed to help providers of NHS services to implement NQB expectation national programme to develop setting specific safe, sustainable and productive staffing.

6.3 The national consultation and engagement period for the community and mental health improvement resources begins on 15th March and ends on 28th April 2017. It is anticipated that these resources will align with the NQB improvement resource, ‘supporting NHS providers to deliver the right staff, with the right skills, in the right place and the right time’, published in July 2016.

6.4 The consultation document will be presented and discussed with District Nurse Team Leaders and feedback collated to further inform and engage with the consultation process inclusive of a caseload management approach.

7. Current Nursing Establishment – changes to service model and bed base

7.1 Since the last SNCT acuity and dependency audit the Trust has been subject to a number of service changes (transfer of stroke and relocation of orthopaedics) which has resulted in some service model redesign and bed reconfiguration.

In addition, work is currently being undertaken to relocate the medical day case area and the surgical admission lounge to facilitate full compliance with JAG accreditation for endoscopy.

8. Quality & Safety - delivering safe care

8.1 The supervisory status of the senior sisters was adjusted for them to provide a 50/50 split working clinically within the rotas. In order to support the SAFER initiative supervisory status of the band 7’s was reinstated on wards 3 and 4, this has proved pivotal to the achievements in these areas. It is anticipated that following successful recruitment supervisory status will be reinstated to all areas as this will support the scale up plan for SAFER.

8.2 Staffing levels and patient safety continue to be overseen on a daily basis by the Clinical Matron team and escalated to Senior Nurse Managers as required. The agreed staffing escalation process is followed to support decision making and mitigate risk. The use of SBAR provides an audit trail in relation to decisions taken. In addition, the bed capacity meetings have been strengthened to ensure that staffing, patient safety and subsequent actions are appropriately recorded.

8.3 Work has commenced to scope the impact in relation to the IR35 legislation and the new NHS guidance that does not allow staff with a substantive contract to work for another NHS employer via an agency from April’17. This is monitored at the weekly Paybill meeting.

8.4 Any adverse clinical incidents relating to nurse staffing are reported and investigated via Datix Clinical Incident Management system or HR policy. These are monitored monthly via the safe staffing exception Trust Board report and Directorate SQS meetings.

8.5 Risks relating to nurse staffing levels are reported and form part of the Datix Risk Register, these are reviewed within Directorates and form part of the Trust’s Governance assurance framework.
8.6 In addition, ‘Did You Know’ Boards, Sign up to Safety, Safety Thermometer, ‘Open and Honest’ Care, Ward Quality Dashboards, RADaR reports, Mortality/Morbidity data and development of red flags are monitored monthly and actions taken as appropriate to mitigate risks to patient safety.

9. **Trust Position against NICE guidance**

9.1 The Trust has declared partial compliance with the guidance against the full implementation of the ‘red flag events’ which are defined to as events that prompt an immediate response by the registered nurse in charge of the ward. The absence of electronic infrastructure and software presents frontline staff with a challenge to collate accurate and robust data with regards to missed breaks and staff working over the duration of their rostered shift. Further work is required to evaluate and embed pilots undertaken.

10. **Care Contact Time (CHPPD)**

10.1 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) may be 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 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.

10.2 The Trust is compliant with reporting measures (see appendix 1)

10.3 Further work is required to provide a process that will show on a daily basis the actual level of acuity so that staffing levels can reflect this in terms of numbers and skill mix. This is being supported at STP level.

11. **Challenges and Mitigation**

11.1 International recruitment trajectories and start dates have been subject to change. This is due to delays in completion of IELTS exams, regulatory requirements, and candidate withdrawing from the process.

Mitigating actions include partnership working with the agency, colleges and universities including closer working with student nurses during their placements at ECT.

11.2 The removal of student bursaries in England may potentially have a detrimental effect on the number and quality of students who apply to undertake nurse training which may impact upon the Trust’s recruitment and attraction strategy. Early indications from higher education organisations are that applications have indeed reduced but there are still more applicants for training than places available so concern at this stage is minimal.
11.3 Demographic profiling demonstrates that the Trust has an ageing workforce with an increasing number of staff eligible and applying for early retirement. A number of staff have also secured flexible retirement options supporting maintenance of key skill sets.

11.4 Increased sickness and absence rates within some areas has impacted on skill mix and in addition to a number of gaps due to maternity leave is an additional pressure on the workforce.

11.5 Year to date long term sickness across the adult inpatient areas is 7.14wte and maternity leave is 10.07 wte

11.6 The opening of additional flex bed capacity to support patient flow and operational pressures during January has presented staff with many challenges and staff have worked flexibly to support this. Mitigating actions included a planned and co-ordinated approach to deploy staff from wards to support skill mix in the flexed area. However, this has impacted upon overall skill mix across all areas and additional backfill with bank and agency staff has been required.

11.7 Controls to support a reduction in agency expenditure have been applied to ensure a consistent, trust wide approach 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. The DNP&Q maintains oversight on all “over cap” nurse agency requests.

11.8 Agency expenditure further reduced during quarter 3 but due to the opening of additional beds has increased since early January.

11.9 The Trust is part of the first wave of Nursing Associate training and is currently supporting 10 staff in their transition from Health Care Assistant to Nursing Associate; it has been agreed that this role will be regulated by the NMC and will form part of the nursing establishment structure going forward.

12. **Next Steps:**

12.1 Review core staffing establishments in the context of learning from new emerging roles such as Nursing Associates, which will support workforce development plans and sustainability.

12.2 Within orthopaedics (Ward 10) review staffing models, skill mix and productivity using 90-day service improvement methodology to facilitate proactive recruitment and staff development

12.3 Develop and establish a caseload management approach within community services

12.4 Progress application of CHPPD to further inform staffing levels based on acuity and dependency and triangulation with nurse sensitive indicators

12.5 The SNCT will be undertaken during July 2017 to enable regular comparable acuity and dependency data analysis to inform safe staffing levels for acute in patient areas. This will be reported to the Board in September.
12.6 Any exception to safe staffing identified in the interim will be managed appropriately within set timescales, discussed and escalated through the Trust’s established performance and governance assurance frameworks.

13. Recommendation

The Board are asked to note the contents of the report.
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><strong>Total</strong></td>
<td><strong>37.34 WTE</strong></td>
</tr>
</tbody>
</table>

The tool recommends 22.6% – 25% % uplift for annual leave, study leave and sickness.
| Report of: Responsible Officer Accountable Officer | Kath Senior  
Director of Nursing, Performance & Quality |
| Author of Report: | Jeanette Sarkar  
Head of Nursing, Quality |
| Subject/Title | EXCEPTION REPORT – SAFE STAFFING LEVELS |
| 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 | To provide the Trust Board with an interim exception report in line with the requirements of: “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 |
| 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 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 and wellbeing of the local population |
| Mitigates Risk Number: (identify) On Assurance Framework | BAF 4: 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 |
| Link to Care Quality Commission Domain | Safe  
Caring  
Responsive  
Effective  
Well Led |
| Link to: | Provide the best services to our population through improvements to safety, productivity and patient experience |
| Trust’s Strategic Direction  
Corporate Objectives | No legal implications |
| Legal implications - (identify) | Impact on Quality | May potentially impact upon the quality of care, patient experience, patient outcomes and staff well being |
| Resource impact | Identified gaps in funded establishments due to wte substantive and temporary nurse staffing vacancies will necessitate 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 quality of care |
| Impact on equality/diversity | No impact on equality and diversity |
| Avoid acronyms or abbreviations - if necessary list: | DoH  Department of Health | ED  Emergency Department | KPI  Key Performance Indicator | wte  Whole time equivalent | NQB  National Quality Board | CNO  Chief Nursing Officer | UK  United Kingdom | HCA  Healthcare Assistants |
1. **Background**

1.1 This report provides a high level summary of Safe Staffing levels on all inpatient wards across the Trust. It provides a high level exception report in relation to the actual fill rate for registered and unregistered staff during the day and night and highlights where this falls below a 90% threshold using a RAG system.

1.2 Actual staff numbers compared to planned staffing numbers are collated for each adult and paediatric inpatient area. This is collected in line with the requirements of the DoH Unify reporting process and the data extract is attached (Appendix 1). Nurse sensitive indicators and workforce metrics have been applied against each inpatient ward area to further inform and provide assurance in terms of adequate staffing levels and harm free care.

2. **February 2017 Position – Exception by RAG status only**

2.1 **Ward Staffing:**

2.1.1 Postnatal and labour ward illustrates an average fill rate of 78.2% registered midwives during the day and 87.6% overnight. The reason for this variance is to in month sickness and absence of 6.4% and 7.2% maternity leave. Mitigating risks include use of on call Midwife/supervisor.

2.1.2 Post-natal and labour ward illustrates an average fill rate of 76% for healthcare assistant during the night. The reason for this variance is due to 6.4% in month sickness and absence rates.

2.1.3 Two new staff members are due to commence in April 2017 (1.5wte) with a further 1.0 wte post under offer.

3. **Recruitment and Retention**

3.1 **Recruitment:**

3.1.1 Proactive, rolling nurse recruitment campaigns continue to secure substantive and temporary staff in line with funded establishments. The Trust secured a stand at the RCN Job Fair in Manchester during February 2017 and a further recruitment evening was held in January.

3.1.2 Currently there are 37.66 wte registered nurse vacancies within the Acute Trust excluding maternity leave and long term sickness.

3.1.3 Currently there are 4.57 wte registered nurse vacancies within the Community excluding maternity leave and long term sickness.
3.2 **Retention:**

A focus on staff retention and succession planning continues to be developed via workforce development project groups. With the support of HR services staff who resign are identified to the corporate nursing team in order to facilitate discussions, elicit themes and potentially identify development opportunities to support staff retention. The alignment of information requires further work to enable the senior nursing team to arrange exit interviews.

3.3 **Staff turnover:**

3.3.1 In month staff turnover is 0.29%. YTD nursing turnover is 12.46% excluding staff TUPE.

3.3.2 Please refer to appendix 1 for a breakdown of each individual in-patient ward area metrics which includes the total number of slips, trips and falls, pressure ulcer and injurious falls incidence in month.

4. **Recommendation**

4.1 The Board is asked to note the content of the report.
Appendix 1 – Safer Staffing Metrics:
### Monthly Safe Staffing Report - February 17

<table>
<thead>
<tr>
<th>Serviceline</th>
<th>Specialty</th>
<th>Ward</th>
<th>Expected RN</th>
<th>Actual RN</th>
<th>Expected HCA</th>
<th>Actual HCA</th>
<th>Percent RN</th>
<th>Actual RN</th>
<th>Expected HCA</th>
<th>Actual HCA</th>
<th>Percent HCA</th>
<th>Total Number of slips, trips &amp; falls</th>
<th>Falls (mod and above)</th>
<th>Calff</th>
<th>MRSA</th>
<th>ST</th>
<th>Pressure Ulcers grade 2-4</th>
<th>Sickness &amp; Absence</th>
<th>% Stat &amp; Mand</th>
<th>% IPR</th>
</tr>
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<tbody>
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<td>Integrated Care</td>
<td>Rehabilitation</td>
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<td>616</td>
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<tr>
<td>Medical Specialties</td>
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Note: Ward 10 moved to Ward 11 1st October 2016, Ward 5 moved to Ward 10 1st November 2016
**Agenda Item Number 19: TB 17 (20)**

| Report of: | Lorraine Jackman: Deputy Director of Corporate Affairs and Governance  
Julie Green: Director of Corporate Affairs and Governance |
<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Author of Report:</td>
<td>Lyn Bailey, Equality &amp; Patient Experience Manager</td>
</tr>
<tr>
<td>Subject/Title</td>
<td>Equality and Human Rights Update</td>
</tr>
<tr>
<td>Background papers (if relevant)</td>
<td></td>
</tr>
<tr>
<td>Purpose of Paper</td>
<td>To provide assurance to the Board in relation to trust compliance with the requirements of the Equality Act (2010), the Equality Delivery System, the Workforce Race Equality Standard (WRES) and progress on learning disabilities and autism.</td>
</tr>
<tr>
<td>Action/Decision required</td>
<td>The Board is asked to note the report, the assurance provided, and the planned action regarding the Workforce Race Equality Standard</td>
</tr>
<tr>
<td>Mitigates Risk Number: (identify) On Corporate Risk Register</td>
<td>CRR 320 – score 9 - If we do not comply with Health &amp; Social Care 2008 Regulations 2014 (Part 3)(Regulation 10: dignity and respect - You must be treated with dignity and respect at all times while you’re receiving care or treatment, including: privacy when you need and want it; everybody is treated as equals; given support you need to help you remain independent and involved in your local community) then this could lead to restrictions on service provision and financial penalty.</td>
</tr>
<tr>
<td>Mitigates Risk Number: (identify) On Assurance Framework</td>
<td>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 &amp; wellbeing of the local population.</td>
</tr>
<tr>
<td>Link to Care Quality Domain</td>
<td>Responsive and Well-led</td>
</tr>
</tbody>
</table>
| Link to: | Board Objective:  
- Provide safe, effective personal care in the right place |
<p>| Trust’s Strategic Direction | |
| Corporate Objectives | |
| Legal implications - (identify) | The trust has a duty to remain compliant with requirements under the Equality Act (2010) |
| Impact on quality | Provides positive assurance in relation to compliance with the NICE Quality Standard for Patient Experience 2012 including requirements around learning disabilities |
| Resource impact | None |</p>
<table>
<thead>
<tr>
<th>Impact of equality/diversity</th>
<th>Assurance around the Equality Delivery System Service Improvements for people with Autism and/or Learning Disabilities Actions developed following WRES analysis.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avoid acronyms or abbreviations - if necessary list:</td>
<td>WRES – Workforce Race Equality Standard</td>
</tr>
</tbody>
</table>
1. EXECUTIVE SUMMARY

1.1 The trust remains focused on the delivery of accessible services for all, delivered in a non-discriminatory way. The commitment to developing a workforce which is valued and diverse will enable the trust to deliver the best possible healthcare to the communities it serves.

1.2 The trust is compliant with the requirements of the Equality Act 2010 and on track to deliver the equality components of the Quality Schedule.

1.3 The 2016 analysis against the Workforce Race Equality Standards (WRES) demonstrated a greater response rate and some improvements in relation to pay, however engagement with Black and Minority Ethnic (BME) staff remains an area for improvement. Following review of communication methods with BME staff targeted action to understand and address the findings is being taken, including focus groups, quarterly newsletters, an inclusion event and staff networking opportunities.

2. PURPOSE

2.1 To provide assurance to the Board on the trust’s compliance with statutory requirements for equality and diversity as a provider of health services and as an employer.

3. BACKGROUND

3.1 The trust’s Equality and Human Rights Policy was reviewed and approved by the Director of Corporate Affairs and Governance in March 2017 following consultation through the Partnership Forum and external stakeholders.

4. PROGRESS UPDATE

4.1 The Safety Quality and Standards Committee approved the trust’s Equality Action Plan and has received an assurance report on progress. The key objectives of the plan were:

- Any significant\(^1\) redesign of services needs to include an equality analysis report and evidence that it has been considered by decision makers
- Black and minority ethnic groups (BME): Analysis of interpretation usage undertaken demonstrating usage in line with demography
- Assessment of equality performance is undertaken by stakeholders using the Equality Delivery System framework
- Improved information for lesbian, gay and bisexual groups/individuals via the trust’s website
- Further work around pathways of care for patients with Autism and/or Learning Disabilities in order to achieve a consistent approach to patient needs
- Implementation of the WRES action plan to improve the trust’s position in relation to WRES indicators.

\(^1\) Significant change is where a service could be reduced, removed or criteria changed so that it impacts on patients.
4.2 All key performance indicators in terms of the Quality Schedule requirements have been assessed as met for Quarter 2 and 3 and are on track for delivery of requirements for Quarter 4.

4.3 The Finance, Performance and Workforce Committee has also received positive assurance reports in respect of equality and diversity as part of their oversight remit for workforce. The 2016 analysis against the Workforce Race Equality Standard demonstrated a greater response rate than 2015 and some improvements in relation to pay, however engagement with BME staff remains requires improvement. The trust has reviewed communication methods with BME staff and is taking targeted action to understand and address the findings. This includes focus groups, a quarterly newsletter, an inclusion event and developing further opportunities for staff networks.

During 2016, the trust has also:

- Strengthened and communicated the trust’s mental health pathway, developing a new Workplace Stress and Wellbeing Policy, describing a positive and proactive approach to mental health
- Signed up to the new Disability Confident scheme (replacing two ticks)
- Implemented a fast-track staff physiotherapy service and strengthened support to staff and managers with long term and disability related absence.

4.4 The trust met the requirement for an annual assessment of equality performance undertaken by stakeholders using the Equality Delivery System framework in March 2016. Although a minimum threshold of five outcomes to be assessed was set by Eastern Cheshire CCG, the trust exceeded this and was assessed in 12 of 18 outcomes. The trust was assessed as “achieving” in 10 outcomes and “developing” in two, these being:

- Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed
- Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations

Highlights of the assessment included winning outstanding health services award in the National Autistic Society (NAS) Autism Professionals Awards, retaining the Access Award, participation in PRIDE, developments in training for learning disabilities, autism and mental health and positive language in complaints.

4.5 The trust continues to perform favourably in terms of compliance with the learning disabilities compliance framework based on recommendations set out in Healthcare for All (DH, 2008).

Areas of good practice are:

- Flagging system in place connected to an email alert system
- Trust website information includes easy read photo journeys
- Transition information developed for parents and for young people with learning disabilities in easy read format
• Training opportunities continue via the learning disabilities and autism e-learning package
• Representation of people with learning disabilities and their carers – regular learning disability and autism meetings continue involving local organisations
• Auditing practice – patient and carer stories gathered and online survey available.

4.6 In relation to autism, the Open 2 Autism approach continues with Macclesfield being the first hospital to pilot the hospital accreditation standard in conjunction with the NAS.

5. NEXT STEPS

• Produce Quarter 4 Quality Schedule report
• Hold the Equality Delivery System stakeholder assessment in March 2017
• Continue with the pilot of the National Autistic Society Autism Accreditation for Hospitals (replacing the Access Award)
• Implement the actions following the WRES analysis
• Achieve Disability Confident level 3
• Prepare for the introduction of the new Workforce Disability Equality Standard (WDES) due in 2018.

6. RECOMMENDATION

The Board is asked to note the contents of the report, the positive assurance with regard to the trust meeting its statutory and mandatory obligations in relation to equality and the next steps required.
Patient Story

The ATM-IDT attended the meeting to share a thank you card received by the Integrated Discharge Team from the daughter of a patient who experienced one of the longest discharge delays at 62 days. The delay for this patient was due to a number of complex challenges. The patient had dementia and had had a fall resulting in a broken neck. It was decided to treat the patient conservatively through the use of a neck brace. Unfortunately due to the patient’s dementia, they required constant 1:1 care as the patient kept attempting to remove the brace. The patient was reviewed by 6 nursing homes before a suitable home was located in Chester. The daughter was engaged at all stages and the team supported the family throughout the process.

The DNPQ noted this patient story is a good example of patient centred care and shows the steps taken to actively manage this patient’s individual needs. The DNPQ requested clarity in terms of why the various nursing homes declined to take the patient. The ATM-IDT advised that as the patient had a broken neck, another fall could potentially have caused her death. Due to the constant supervision required and this patient’s particular needs the nursing homes felt it was too much of a risk to take the patient despite additional funding being offered. A nursing home in Chester assessed the patient and felt they could meet the patient’s needs. It is for Nursing Home Management to determine whether they accept and can meet the level of risk.

Dr Cowan queried whether the patient will require a neck brace for the rest of her life. The ATM-IDT advised this was not known at the time of discharge but there is a continuing healthcare plan in place which will be reviewed as treatment progresses.

The DCAG congratulated the Integrated Discharge Team on the management of this
complex case and the gratitude of the family was noted by members of the committee.

**Apologies**

1. Kash Haque – Annual Leave  
2. Sue Knight – Annual Leave  
3. Rachael Charlton – External Meeting  
4. John Wilbraham – External Meeting

The Chair welcomed Ms Curtis as an observer from Eastern Cheshire CCG.

**Matters Arising**

**Year at a Glance**  
The Year at a Glance was reviewed and confirmed as an accurate record.

**Action Log**

<table>
<thead>
<tr>
<th>Number</th>
<th>Description</th>
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<tbody>
<tr>
<td>7857</td>
<td>On agenda. Action Closed.</td>
</tr>
<tr>
<td>7858</td>
<td>On agenda. Action Closed.</td>
</tr>
<tr>
<td>8316</td>
<td>Following discussion with ENT surgeon, the number of biopsies and FNAs per annum will be approximately 260. University Hospital South Manchester (UHSM) are considering whether they can take this level of activity. The MD agreed to confirm further clarity on what is happening with the service and take through CMB if pathways are to be changed. Action Closed.</td>
</tr>
<tr>
<td>8317</td>
<td>The audit on non-diagnostic FNA’s from ECT and processed by Mid-Cheshire has now been presented at UHSM. Following discussion with ENT surgeon the audit was not conclusive in determining whether non-diagnostic results were due to inadequate sampling or laboratory techniques. UHSM have agreed to share the audit. The MD noted there appears to be no flaw identified in the current system. The Chair queried whether the committee are assured in relation to robust procedures. The MD confirmed that where an inconclusive result is provided, a biopsy is undertaken so there is no gap or patient safety issue within the process. The MD agreed to speak with the ENT surgeon who originally raised this issue to ensure they are assured by this outcome. Action Closed.</td>
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**Action:** The MD agreed to speak with the ENT surgeon who raised concerns about the FNA non-diagnostic results to ensure they are assured by the results of the undertaken audit.  

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<thead>
<tr>
<th>Number</th>
<th>Description</th>
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<tbody>
<tr>
<td>8422</td>
<td>The Midazolam Policy has been amended and will be circulated to the consultant body to ensure staff are aware of the changes. Action Closed.</td>
</tr>
<tr>
<td>8423</td>
<td>The Policy has been amended to state that ‘Midazolam should not be prescribed or administered for conscious sedation by junior doctors, (FY1&amp;2, ST1-4, with the exception of trainee Anaesthetists), unless under direct supervision of a Consultant certified to administer midazolam.’ The change in policy will negate the need to have a register that needs to be updated regularly. The policy will be approved at the Medicines Management Group in February 2017 and the risk will be reviewed with a view to reducing the score. Action Closed.</td>
</tr>
<tr>
<td>8425</td>
<td>To update under Weekend Mortality Report agenda item. Action Closed.</td>
</tr>
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</table>

**Collection of Any Other Business**  
The Chair reminded members to complete their Self-Assessment and return to BR for compilation and inclusion with the Annual Report at February’s meeting.
<table>
<thead>
<tr>
<th>SQS Committee Minutes from December 2016 Meeting</th>
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<tbody>
<tr>
<td>The Chair noted an amendment to agenda item 16/173 following the Trust Board meeting. Under points for Assurance, the third bullet should read:</td>
</tr>
<tr>
<td>• Quarterly mortality report confirms robust mortality governance processes with enhanced clinical engagement with mortality review processes &amp; depth of coding is steadily improving. In depth analysis of excess mortality associated with sepsis deaths, alongside mortality review processes for all deaths within trust. No specific negative trends identified from the data, including deaths on/per day of week. AQUA review of 15-16 Trust mortality data also show no statistical difference in mortality rate for weekend versus weekday admission.</td>
</tr>
<tr>
<td>Following this amendment, the minutes were agreed as an accurate record.</td>
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<table>
<thead>
<tr>
<th>Infection, Prevention and Control Sub-Committee Annual Report and Self-Assessment</th>
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<tr>
<td>The Chair confirmed this item has been deferred to the February meeting.</td>
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<table>
<thead>
<tr>
<th>Quality Governance Report</th>
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<tr>
<td>The committee received the Quality Governance Report and noted its contents and recommendations.</td>
</tr>
<tr>
<td>The DCAG highlighted the CQC Consultation documents advising these have been circulated separately to Board members requesting comments. The DCAG and DDCAG will draft the response on behalf of the trust. Dr Cowan noted the consultation document doesn't take account of the transformation agenda. It was noted that communication with staff needs to be strengthened to ensure they are aware of the trust strategy. The DCAG advised for Caring Together work, a regular newsletter is produced and a staff survey is currently running. In addition the Communications Team are visiting staff to complete a face to face survey to determine level of staff awareness of Caring Together, level of interest and to offer opportunities for them to be involved at different levels e.g. kept informed, be involved etc.. The DNPQ noted the CQC assessment is difficult as it is done in a ‘silo’ outside of other work taking place with other organisations. The Chair requested that feedback from the Board is provided to DDCAG by the end of the week.</td>
</tr>
<tr>
<td>The DNPQ highlighted the Neonatal and New-born Screening Action plan and noted reporting will be led through Maternity Clinical Governance meetings by the Head of Midwifery and updated through the Quality Governance Report. The DDNQ noted on the action plan the deadline for recommendation 10 as November 2017, highlighting the length of time for this to be completed. The DDCAG noted this was a low risk when the assessment took place, however agreed to discuss with the Head of Midwifery and clarify in the Governance Report going forward.</td>
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<tr>
<td>The committee noted and accepted all recommendations of the Quality Governance Report.</td>
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<tr>
<td>The committee received the Quality Dashboard and noted its contents.</td>
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The DDNQ noted the positive work relating to length of stay highlighting the work completed using the SAFER bundle has shown a reduction in length of stay on Wards 3 and 4. The DDNQ noted previous issues with non-admitted patients having a longer than expected Length of Stay (LOS) on AAU as a ward attender have been resolved from the beginning of January by admitting onto PAS any patients still on the unit past midnight. The DDNQ noted for Harm-Free Care (in acute areas), the trust has achieved 95% in January. However community is still slightly below trajectory.

The Chair highlighted GP Correspondence targets. The DNPQ advised there is an improving trajectory and this is discussed at service line performance review meetings. The DDNQ noted the challenge for the transcription suite in relation to the volume of ad hoc additional activity in some high volume specialties which is difficult to plan for. The team are working with specialties to plan ahead for these instances.

The DNPQ noted the falls data and queried how to capture the detail in relation to whether risk assessments and care plans were in place at the time of the fall. The data is showing an increase in the number of injurious falls; information is required on whether this relates to lapses of care, if care plans were in place, if the patient was risk assessed and whether some instances relate to the same patient falling more than once. The DCAG suggested working with the governance team to review falls and to undertake a weekly safety review on falls and pressure ulcers. The DDNQ and DDCAG agreed to discuss this outside of the meeting.

**Action:** DDNQ and DDCAG to discuss safety review of falls and pressure ulcers and how to present the narrative through the Quality Dashboard.

Dr Cowan queried length of stay. The DNPQ advised a piece of work is taking place as part of the SAFER bundle which is looking to include an option on the CRIS system to include each patient’s expected length of stay, based on provisional diagnosis and consultant judgement noting this would be more difficult for some of the more complex medical patients. Benchmarking will be implemented on the system and will be locally refined and managed by clinicians in each specialty. At present the estimated date of discharge is determined from the post take board round.

The DoF queried which patients are classified as non-acute Delayed Transfers of Care (DTOCs). The DNPQ advised these were patients on Ward 11 and the Aston Ward in intermediate care beds. The DDNQ noted clarity is required in terms of patients on Ward 5 determining levels of acute and intermediate patients. The Chair noted overall improvements on DTOCs for acute patients.

### Risk Assessed Data Report (RADaR) – December 2016 Data

The committee received the RADaR report and noted its contents and recommendations.

The DDCAG noted section 3 of the report highlights that data collected in November contained errors for Sexual Health West and GP Out of Hours due to a change in staff and misinterpretation of the data. This has been amended.

The DDCAG highlighted a change in definition on Appendix 2 for identifier 2.04 which relates to monthly documentation audits not undertaken. The DDCAG noted some areas complete quarterly audits and the definition will be amended to relate to compliance with the document audit schedule.
The DDCAG noted on section 4.2 of the report relating to the Knutsford Community Nursing Team that the current risk score was 12, and that 16 related to the risk without controls in place.

The Chair noted the Sexual Health East Team appears to have been without a team leader for a considerable length of time and queried progress. The DDNQ advised that a new structure is in place. The DNPQ advised a new manager has been appointed and interim arrangements have been in place prior to this appointment.

**Action:** The DNPQ agreed to confirm the team leader appointment within the Sexual Health East Team.

Dr Cowan noted good progress but raised concerns regarding community areas triggering when the plan is to provide further services in the community in the future. The DCAG advised in comparison to the previous year, there has been a reduction in community areas flagging through RADaR. Where there are areas consistently flagging, the DNPQ and her team meet with the relevant team leader and members of the community team. The DNPQ advised a review of the services and potential different roles to support new ways of working is underway but not yet finalised. The DNPQ advised of a meeting with the lead GP to discuss current issues and challenges with Knutsford community teams with a view to developing a more integrated approach across acute and mental health and social care. The DNPQ advised where teams are flagging as Red, corporate teams are providing additional support.

The Chair summarised that the committee has noted the data quality issues, reviewed and noted the remedial actions and noted the action plans for areas such as Congleton and Knutsford. Where there are ongoing challenges, this is being reviewed through the service line SQS meetings and corporate teams are providing additional support to teams.

**Infection Control ISS Implementation Plan Update**

The committee received the Infection Control ISS Implementation Plan Update and noted its contents.

The DNPQ advised management and teams are in a position where they are assured of the processes addressed by the implementation plan. The areas still noting concern are within community, predominately the Aston Ward and Knutsford, though the Aston Ward is at 92% following additional support. The DNPQ has passed management of audits to the Infection Control Lead Nurse who will continue to meet with the Head of Estates and ISS regularly. The DNPQ recommended that the risk be reduced to 12 with further action to take place within community areas.

The DoF noted the length of time taken to reduce the risk, highlighting improvement has been seen since August 2016. The DNPQ noted that there were managerial and supervisor role changes within ISS and therefore it was deemed appropriate to ensure that oversight was maintained during the transition.

The committee noted assurance and positive progress made and agreed the reduction of the risk score to 12. This will be managed through the Infection Control Committee going forward.

**Weekend Mortality Update Report**

The MD noted an error on the front sheet of the report under the Purpose of Paper
section; should read ‘to assure SQS that patients admitted during weekends are at no greater risk of dying than those admitted on weekdays.’

The MD noted it has been nationally identified that there is an increase in mortality for patients admitted at weekends and the reasoning for this has been widely debated. The emerging consensus is that one of the principle reasons for this increase is patients admitted at the weekend are more critically ill.

The MD noted the AQuA report included in the paper for mortality within the trust for 2015-16 data. The crude mortality for the weekend is slightly higher (though not statistically significant) but when risk adjusted using the SHMI model there is no statistical difference in mortality rates between weekdays and weekends for the trust. The MD noted there is a higher rate recorded for the North West and England. The MD advised while there is an increase nationally for weekend mortality, this is not being reflected at this trust.

The Chair noted the positive outcome of the AQuA review provided and advised that the Board are aware of this information. The Chair confirmed assurance that the trust shows no difference in mortality between patients admitted at weekends and on weekdays.

Deep Dive: Outpatients Backlog Update

The DDO attended the meeting to present the deep dive on the Outpatients Backlog following previous discussions at the committee. The Chair noted this work is also being reviewed at the FPW Committee in terms of theatre utilisation. The work is being reviewed at this committee in terms of safety and quality. The DDO highlighted the following:

- **Description of Risk** – Risk 411 regarding the potential impact on patient care for the outpatient backlog.
- **July 2016 SQS** – at the previous SQS committee meeting there were a number of issues highlighted including underlying issues, current performance, controls, gaps, assurance and ongoing actions. **The brief from that meeting was to provide a review of the backlog data along with trends and potential improvements.**
- **July 2016 Ongoing Actions** – Specialties are managing the risk of their backlog, a review of specialty improvement plans with trajectories are completed at operational performance and Service Line SQS meetings, the annual review of job plans is reviewing clinic utilisation and there is a review of the management of outpatient productivity via the project group.
- **Achievements 2016** – governance arrangements, outpatient performance, and instigation of the Outpatient Utilisation Productivity group which reports to the Improvement Sub-Committee. There has been an improvement in terms of assessment with an improved, robust model for information data collections. An independent review of the backlog was undertaken by a company called FourEyes which have provided recommendations for areas of improvement.
- **Achievements 2016: Patient Portal** – an online portal has been created for patients to receive their patient information electronically to expand choice and reduce paperwork. For reducing cancellations, there is some variation in adherence to the policy for 6 weeks absence/vacation notice which is being reviewed through CMB and the Clinical Directors. A partial booking process is being piloted which places patients on a waiting list and they are booked in closer to the due date.
- **Partial Booking Example** – the partial booking system has been piloted for Gynaecology and there has been a reduction in patient cancellations since...
implementing the process. The intention is to roll out to other departments/specialties. The DDNQ noted there has been a reduction in comments/complaints relating to cancellations for this specialty.

- **Follow Ups: Wait in Month** – the DDO noted the amount of work taking place to understand the issues relating to the outpatient backlog. Data was presented which identified the maximum wait in month beyond the patient due date for each specialty over the last 12 months with some areas showing improvement and others highlighting concerns, which are being addressed.

- **Follow Up: Backlog** – data was presented indicating the number of patients waiting longer than their due date for each specialty. The DDO noted the improved position for Ophthalmology.

- **Follow Up Chart: Maximum Wait** – The DDO noted Urology and Orthopaedics have increased for their maximum wait over the last 12 months.

- **New Charts** – The DDO noted actions taken to improve the Ophthalmology backlog position have not impacted on the management of new appointments.

- **Issues and Actions** – The rationale for the **ENT deterioration** is due to capacity, with a gap in service provision from the University Hospital of South Manchester for 4 months which has impacted performance. For **Ophthalmology**, new clinics have been converted to follow ups. There are a number of middle grades supporting follow up appointments and a new consultant has been employed with a focus on glaucoma. For **Orthopaedics** the backlog numbers have reduced but the maximum wait has increased. The service has lost a consultant during the year and other consultants have taken on this work. There are measures in place to resolve this by the end of January. For **Urology** there is an SLA in place with Stepping Hill and the trust have had to take a number of patients during the year to cover annual leave at Stepping Hill which has impacted on numbers. For **Gastroenterology**, a new fibrescan service has been introduced this year which has increased the workload and this is being addressed. For **Respiratory**, the backlog has increased over the year and an additional consultant is being recruited. For **Cardiology**, there has been a small increase and additional SpR sessions have been allocated to resolve. For **Rheumatology**, the service has lost a consultant during the year and it has been difficult to replace those sessions. Trust consultants and visiting clinicians are now providing additional clinics. The aim is to improve this position over the next quarter. The Chair queried the notice period required for consultants. The MD confirmed this is 3 months. The Chair queried whether the turnover for consultants is higher than in other trusts. The MD advised the turnover isn’t any higher and noted some of the consultants that have left this year have retired.

- **Summary** – the DDO noted progress made in 2016 in governance arrangements, information systems, process changes including partial booking, additional focus on challenged specialties. A formal improvement process such as the rapid improvement methodology is to be implemented going forward.

The DNPQ noted that the trust has received its reference costs and outpatients is currently higher in relation to peer group providers. Work is underway to benchmark, improve and reduce costs.

The DNPQ raised concerns relating to Paediatrics having a 12 month maximum wait after due date. The DDO advised this is being addressed within the service by the Matron. The DDNQ advised there will be greater focus in terms of the clinic PAS process, reducing variation in practice and the Matron is undertaking benchmarking with other organisations.

The DCAG queried, from a patient safety and quality perspective, whether there are any trends around safety concerns. The DDO advised there have been no trends
highlighted and confirmed the ABC criteria used on referrals by consultants is now embedded in the system. The DNPQ queried how assurance is being obtained that patients waiting on the backlog are not coming to any harm. The DDO advised there is an audit process in place to manage this.

Dr Cowan noted concerns around clinical variation. The DNPQ advised follow up rates are reviewed for each specialty and queried whether there are any outliers. The DDO noted that follow ups are lower for outliers. The DDO noted for Orthopaedics, there service is looking into the use of virtual clinics and learning from this will be embedded and shared with other specialties.

The DoF queried the policy for DNAs (Did Not Attend). The DDO noted the policy is reasonably stringent and there is a process agreed with GPs though this can be overridden by a consultant. The DoF recommended validation should be undertaken. The DDO agreed validation would assist in reducing the backlog and closing a number of RTT pathways. The Chair queried what forum for revalidation. The DDO advised this can be taken through the Outpatient Productivity Group and managed against the Access Policy. Following a query from the Chair, SR confirmed there is no GP representative on the Group. The DNPQ advised GPs are keen to be involved, it is a matter of capacity. The DoF requested a validation of work be provided by year end.

**Action:** The DDO agreed to undertake a revalidation of the outpatients backlog and provide an update to the DoF by year end.

The Chair summarised that some progress has been made and action plans are in place to reduce the backlog and maximum wait. The DDO has been requested to undertake revalidation on the backlog. There have been no trends highlighted relating to the delays. The intention is to improve the position and reduce the risk score following review of the January data. The Chair confirmed that based on data to date the deep dive provided appropriate assurance to the committee on the impact of the backlog on patient safety and experience. This must continue to be monitored.

**Key Items for the Chair to be reported to the Board**

**Points for Assurance**

- Audit of the Trust’s aseptic preparation of chemotherapy doses by Specialist Pharmacy Services gave an overall positive 'low' rated safety risk rating with just one 'major deficiency' which has already been completed. The remaining actions will be completed by due date November 2017 and assurance provided to SQS by the Chief Pharmacist.
- Duty of Candour: Positive assurance received that all duty of candour cases were responded to within defined timelines, facilitated by processes being embedded in practice and implementation of 'Being Open' principles by clinical staff.
- The Committee were asked to contribute to CQC consultation on future regulation for monitoring, inspecting and rating of adult health and care services & for the CQC/NHSI consultation on approaches to leadership and use of resources. The Trusts response will be made by the deadline of 14 February 2017.
- Following the external Quality Assurance team assessment of the Trusts newborn and antenatal screening, a prioritised action plan has been identified which will be monitored by Maternity SQS and assurances on completion provided by the monthly Quality Governance report.
- The committee received appropriate assurances in relation to the progress being
made against the Trusts' Equality Objective Plan 2016/17

- Sustainable improvement on the ISS cleaning programme has been demonstrated allowing the risk level to be lowered from 16 to 12 with ongoing monitoring by Infection Prevention sub-committee. Future focus will also now be on Community areas to achieve consistent cleanliness audit results.
- AQUA review of 15-16 Trust mortality data indicate there is no statistically significant difference in mortality outcome for patients admitted at weekend vs weekday.

Emerging risks and mitigating actions

- Quality Dashboard (QD): The committee requested that as part of the ongoing improvement work on injurious falls that assessment/analysis is made (where possible) of 'avoidable/unavoidable' falls, or falls where lapses of care have been identified. Any key themes should be identified and reported ahead of the next requested Falls Strategy update to SQS due August 2017.
- QD: whilst delays in transfer of care for acute patients has seen improvement, delays in non-acute continue to worsen with largest reason for delay being 'social service local care package'. DTOC rapid improvement programme in place with trajectory for improvement and focus on medically optimised patient delays.
- RADAR data indicates ongoing triggering of Congleton & Holmes Chapel Community Nursing and Sexual Health team East. Senior Management visits and support is being offered and new line management very recently in place to help address the key triggers.
- Outpatient delays (quality and safety aspects) - ongoing deep dive work into outpatient delays has indicated further work is required in relation to clarity of SLA outpatient agreements (e.g. urology) in terms of expectations of both parties; ongoing reference costs (monitor via FPW); interface with Primary care colleagues in relation to clinical value of Follow up appointment vs referral back to GP. Partial booking system has assisted and Progress has been made in relation to ophthalmology waits and plans in place for other specialities. No moderate or severe incidents have been reported as a consequence of delays. PALS processes address concerns in relation to delays with no formal complaints since July 2016.

Any Other Business

There were no items of Any Other Business.

Chairman’s Confirmation of Agenda items for February’s meeting (not standing items):

1. SQS Committee Annual Report and Self-Assessment
2. Quality Strategy – Annual Refresh
3. Quarterly CARE Report
4. Sepsis Audit (via CARE Report)
5. Assurance Framework and Risk Register
8. Infection, Prevention and Control Sub-Committee Annual Report and Self-Assessment

Date and time of next meeting:
Tuesday 28th February 2017, 12:00 – 14:00
Boardroom 1, First Floor, New Alderley House

Paper Deadline: Monday 20th February 2017
Agenda Item Number 20: TB 17 (22)

FINANCE, PERFORMANCE & WORKFORCE COMMITTEE

MINUTES OF MEETING HELD:
26th January 2017

MEETING CHAIR: Mike Wildig
MEETING SECRETARY: Gareth Rydings

PRESENT:
Mike Wildig  Non-Executive Director  Mr Wildig
Ian Goalen  Non-Executive Director  Mr Goalen
Tony Coombs  Non-Executive Director  Dr Coombs
John Wilbraham  Chief Executive  CEO
John Hunter  Medical Director  MD
Kath Senior  Director of Nursing, Performance and Operations  DNPQ
Julie Green  Director of Corporate Affairs and Governance  DCAG
Mark Ogden  Director of Finance  DoF
Rachael Charlton  Director of HR  DHR

IN ATTENDANCE:
Gareth Rydings  Meeting Secretary  GR
Steve Redfern  Deputy Director of Operations  DDoO
Anne Marriott  Associate Director of Acute and Integrated Community Care Services  ADAICCS

APOLOGIES:

AGENDA ITEM | SUBJECT | ACTION
--- | --- | ---
17/01 | Minutes of meeting held December | Amendments:
• Page 2 – CEO awards should say ‘CEA’ awards
• Need to amend the Deputy Director of Operations abbreviation to ‘DDoO’
• Page 3 – Amend the ‘average cost of an elective’ to ‘average income of an elective’
• QIPP – Amend sentence to include ‘this will be undertaken following appropriate QIAs’ at the end of ‘The DoF believes Clinical Support needs to give up vacancies within their position and confirmed this would be resolved by month 12’
Minutes agreed as accurate after the above amends have been made.
17/02 | Matters arising |
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| 17/03  | Action points from previous meeting | 7844 – The CEO has concluded conversations with the CCG. At an impasse in terms of about £200k. The CEO agreed not to argue the £200k that hadn’t been allocated. NHSE and NHSI are aware that ECT has assisted the CCGs financial position. In terms of the CQUIN itself, the schemes are in place, there is a range of underperformance. The trust has accrued the worst case scenarios in the financial trajectories. Action Closed  
8400 – On the meeting agenda – Action closed  
8401 – Amendment made to the work plan. Action closed  
8402 – The DoF has taken out the references to the named organisations to which ECT have debts. Action closed  
8403 – Amendment made to the work plan. Action closed  
8405 – The DNPQ confirmed that the Frailty team has moved. Action Closed  
8406 – The DNPQ confirmed that this action has now been superseded regarding the recovery plans. The DNPQ updated the committee that an offer of external funding has been received from NHSE to assist with addressing the backlog. Action Closed  
8408 – Figures have been altered and corrected. Action Closed  
8409 – Process has been agreed for review through the Deputy Director of Nursing and the Education Manager. To report back to FPW in March 2017. Action remains open. |
| 17/04  | Annual work plan                 | There were no changes noted for the work plan.                                                                                                                                                                                                                                                                                           |
| 17/05  | Performance                      | The meeting took the paper as read with questions only.  
The DNPQ informed the committee that the A&E department continues to be under pressure but has showed some improvements in length of stay and DTOCs have held a good position, especially in acute.  
The draft ECIP report has been received. The DNPQ confirmed that this is now helping with the actions being taken around the SAFER programme and site management.  
The DDNQ informed the committee that Cheshire East Council held a
DTOC event which was attended by the DDoO and senior managers. Each organisation presented what they were doing to improve the DTOC situation. Currently adjourned and awaiting feedback and recommendations.

The CEO confirmed in terms of out of hospital beds that the A&E Delivery Board is going to spend most of the next meeting addressing the bed capacity from a social care perspective and a CCG perspective. The A&E Delivery Board will discuss what capacity is available now and what capacity is needed moving forward.

The DNPQ highlighted that there is a reduction in acute DTOCs but still not achieving non-acute trajectories and this due to intermediate beds being taken up by patients not waiting for intermediate care.

The CEO informed the group that the CCG plan to take the beds out in next year’s QIPP plan. Discussions are taking place and the CEO is challenging this proposal.

The Chair asked if ECT know how many beds are required in the hospital to address the flow in A&E.

The DNPQ informed the Chair that the issue lies in Medicine. A deep dive is currently in progress to identify the bed based needed and will be discussed at the Executive Management Meeting next week.

The CEO has challenged the DNPQ and the team to provide how many beds are needed and what LOS can be achieved in order to address the challenge required. Results to be brought back to FP&W at next meeting.

The Chair asked what would have happened if Ward 5 was not available? The DNPQ stated that if ward 5 was not available then a high amount of 12 hour trolley waits would have been triggered. The DNPQ confirmed it’s the surges that cause the challenges, as they are unexpected. The CEO asked the DNPQ whether this means that the
trust doesn’t have capacity to respond to surges. The DNPQ confirmed that the trust has always struggled to respond to surges and this is on the risk register.

The CEO asked if the trust discharged patients earlier in the day then this would help with handling the surges. The DDoO responded that it wouldn’t help to the extent that was required.

The CEO asked what flex is in the system to cope with surges?

The DNPQ confirmed there was no additionality for the winter. There are more respiratory conditions arriving, there was a flu outbreak and more elderly patients are attending A&E. Generally there is just more pressure this time of year.

Dr Coombs asked what the plan is for Ward 5. The DNPQ confirmed that she would like to have it available as a decamp ward to allow for the movement of patients to enable infection control cleaning. Discussions have also been held and there is a proposal around using ward 5 for 5 months to help with the backlog of electives that have built due to cancellations caused by the recent pressures.

The Committee welcomed the ADAICCS to the meeting.

The ADAICCS informed the committee that community metrics have been reported since March 2016. ECT have benchmarked against other organisations to see what community services are being reported on.

The ADAICCS talked the committee through the following community metrics.

Intermediate care services are bed based services. A dependency rating assessment (Barthal Score) is done for all patients and this looks at a patient’s score on admission and discharge from hospital. The Barthal is a functional assessment score that looks at how independent patients are on admission and then when discharged. 81% of patients who were discharged from the service went home. The intermediate care dependency score shows how independent these patients were. 98% of the patients that were discharged home were more independent.

The Acute Visiting Service is a GP visiting service that works alongside the GPs out of hour’s service. The idea is to have a GP visit an acutely ill patient at home to avoid an admission to hospital. The score for this is based on clinical judgement.

Mr Goalen referred to the December figure of 145. The ADAICCS confirmed this figure represents the number of cases of admission avoidance and confirmed the percentage of 54.4% represents the percentage of people the Acute Visiting Service believe they avoided an admission for.
The CEO asked whether the other 46.4% percent meant that these patients were seen by AVS or admitted to hospital. The ADAICCS confirmed this to be correct. Patients will have either been admitted or had to have further investigations.

Mr Goalen asked if Vernova have sight of the statistics and do the GPs recognise the numbers not going through their books due to community services avoiding admission. The DNPQ informed Mr Goalen that there have been discussions with the GPs and AVS are represented at the locality meetings, however the DNPQ is not sure what format the GPs receive the information.

The Gold Standard Framework – End of Life Care. The framework enables good practice to be available to all people nearing end of life care. The ADAICCS confirmed that the numbers are low due to lack of reporting. The ADAICCS informed the committee that she has spent a lot of time highlighting the importance of capturing data to the community nurses and that they need to code their information on EMIS as well as the Gold Standard Framework to enable accurate reporting.

The committee thanked the ADAICCS for her contribution to the meeting.

The DDoO presented to the committee a presentation on Outpatient Productivity. The DDoO informed the committee that the purpose of the presentation is to update the committee on the progress made against outpatient productivity measures.

The DDoO highlighted the following:
- Risks and associated plans and trajectories to be owned by each specialty
- Improvement Sub-Committee and Directorate SQS meetings will monitor ongoing review of improvement plans
- Outpatient productivity will be reviewed and managed via the outpatient project group
- Lack of information output has been successfully addressed by the development and implementation of the ‘Outpatient Monitoring Tool’ which gives service managers a more detailed overview and understanding of outpatients
- Partial booking has been implemented for all ‘challenged specialties’ and is a means of avoiding unnecessary cancellations. This has resulted in less cancellations from RTT perspective
- Patient portal has been successfully received – giving patients option of receiving information electronically resulting in cost savings and reinforcing cancellation implications. This links into the FourEyes Insight Review which highlighted the issue of cancellations
- KPIs have been developed to ensure progress is effectively measured
• Peer comparison information from the Better Care Better Value website shows ECT is performing well against DNA and First to Follow up rates.

• Reference costs have been a disappointment and are being reviewed.

The MD queried whether the issue was due to clinics not being utilised? The DDoO confirmed that concerns around remote clinics and the level of efficiency gained from those clinics due to consultant time regarding travel costs and travel time.

The DNPQ confirmed that there is a struggle to get patients to attend remote clinics.

The CEO asked how quickly remote clinics that are not utilised can be stopped?

The DNPQ confirmed that conversations are taking place with the specialties.

The DoF highlighted a window of opportunity to sort this before April 1st before the property leases have to be renewed.

The DDoO informed the committee of a programme the CCG are leading on relating to RTT outsourcing. ECT will transfer the responsibility of patients to a provider identified by the CCG. Both operationally and financially this will benefit ECT.

The committee thanked the DDoO for his contribution to the meeting.

Theatres metrics to be discussed at the April meeting.

17/06 Workforce

The meeting took the paper as read with questions only.

The DHR took the opportunity to highlight the Improvement in the number of workforce metrics.

The Paper provides assurance on the actions driving the improvements further.

The DHR highlighted the risk to the January financial position given operational pressures and the impact on agency spends.

The DCAG enquired whether ECT is on a 3 year stat and mandatory training programme.

The DHR confirmed this.

The DCAG highlighted how positive this is due to operational pressures and the current position.

The DHR informed the committee that since October 2016; appraisals and stat and mandatory training have improved. Appraisals are up by 10% and stat and mandatory training is up by 6%.

Dr Coombs asked the DHR what has been done to assist with this improvement.

The DHR informed that weekly monitoring meetings now take place.
instead of monthly. Directors have been challenged and discussions have been had in the performance management meetings. A lot of work on sickness has been done over the last few months with the focus on supporting managers with reducing long term sickness.

The DHR confirmed that this level of focus is not sustainable in the long term but a number longer term developments are in place.

The Chair enquired about the trajectory for the e-rostering trust hours owed?
The DHR highlighted her disappointment with the figures. The DHR has had conversations with the matrons and has been given assurance that the trajectory will get back on track.
Mr Goalen enquired that why due to Christmas; do staff owe us more time?
The DNPQ confirmed that because the trust doesn’t allow annual leave over the Christmas and New Year period, for staff to pay the time back they are used supernumerary.

The Chair enquired the meaning behind ‘Corporate only version’ engagement metrics.
The DHR confirmed that this related to the corporate teams like Governance, Finance and Human Resources. The DHR informed the committee that the results of the national staff survey are expected in February and will be included in the March report.

The Chair referred to 3.1 – Medical training post occupancy data released, urgent meeting requested.
The DHR confirmed this related to ECT being assured every month that we didn’t receive any fewer trainees than other organisations. In the December data released by HCE it was clear for November ECT had significantly less trainees pro rata than any other organisation in the North West.
The DHR has asked for the data to be provided on a monthly basis.
The DHR has requested to meet the Dean and challenge the situation.
The DHR has asked the CEO to draft a letter on behalf of ECT.
Dr Coombs referred to Appendix 3 of the report and the workforce total gap numbers for qualified nurses.
The DHR confirmed that the vacancy number is 30 total gaps. In addition to this is Ward 5 which is staffed mainly by agency or by moving staff around. 50 shifts a week are covered by agency.

The DHR informed the committee about the apprenticeship strategy. The government strategy comes in to effect in April.
The MD talked the committee through the BMA Mersey survey. The MD highlighted that the results are not a true reflection as the response rate to the survey is low.
The MD informed the committee that when the survey started in 2004 ECT were ranked bottom. Since then a number of actions have been
taken to address the situation. The trust appointed an ED doctor to become the SAS representative and funding from Health Education has become available for SAS doctors to improve training.

The DNPQ highlighted two low scoring areas both linked to development and queried if this shows a need for the trust to offer more support towards their development?

The CEO asked if the contribution the SAS doctors do is recognised. The MD to send a letter acknowledging contribution at the end of the year.

The DHR confirmed to the group that the ARVATO move is still on track for the 1st April.

17/07 Finance

The meeting took the paper as read with questions only.

The DoF informed the committee that the year-end forecast has been improved by £1.5 million which allows the trust to attract £1.5 million extra funding due to month 9 being £2 million underspent.

The DoF confirmed that a paper will be tabled at the Private Board regarding NHSI offering trusts who have hit their financial control target to convert their working capital facility from 3.5% to a loan of 1.5%. This reduces loan interest’s rates by £360k a year for the trust.

Mr Goalen asked the DoF whether there was any indication from NHSI or NHSE that the loans will be capitalised next year. The DoF confirmed that currently there is no indication of the loans being capitalised.

The CEO informed the committee that the trust has been asked by NHSI to assess its capital expenditure requirements for the rest of 2016/17. The CEO has responded to NHSI by informing them that ECT will undershoot by £120k. The CEO has written to the CEO of NHSI informing him that ECT has offered up £1.5 million on revenue accounts and £100k on capital accounts trying to assist the national position.

Dr Coombs enquired about the final QIPP expectations. The DoF confirmed that the current position will be close to where ECT finishes the year. The schemes still being identified currently will be implementable for the 17/18 position. The DoF confirmed that the current position is £4.5 million against the £4.1 million forecasted.

Mr Goalen referred to areas over performing on QIPP and any extra identified now could go towards next year’s QIPP. The DoF confirmed this to be correct.

Mr Goalen referred to paragraph 4.2 on page 90 of the report. ‘Provisions being £806k higher than planned’. The DoF confirmed that this was due to redundancy provisions made
and also that ECT has been accruing penalties for not achieving the RTT and A&E targets.

The DoF updated the committee on the service line reporting. The DoF highlighted two areas. The first being an analysis on the changes of cost category and changes in specialties. The second being the reference cost position which shows deterioration. The DoF focussed on the importance of this as it could affect reputation. The deterioration will also have an impact on the trust’s Carter position.

The Chair referred to 8.1 on page 97 of the report and asked what the status was around Eastern Cheshire CCG having submitted a contract performance query to the Trust. The DoF confirmed that the trust has replied to the query and informed the Committee that the data forming the basis of the claim is legitimate. Currently awaiting a response.

The DoF believes that the Service Line Reporting data is as accurate as we can get it and can now be used to start asking the questions about what can be done to support the next phase of development.

In response to a question from the Chair, the DoF confirmed that the capital programme (adjusted for the £100k given up) will be spent by end of year.

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For Information

Future Meetings:

- Thursday, 30th March 2017, 8.30am – 10.30am
- Thursday 27th April 2017, 8.30am – 10.30am
- Thursday 25th May 2017, 8.30am – 10.30am