EAST CHESHIRE NHS TRUST

MEETING OF THE TRUST BOARD

NOT FOR PUBLICATION BEFORE

Thursday, 29th March 2018
15.00 – 17:00

Board Room 1, New Alderley House
Macclesfield District General Hospital

Chairman: Lynn McGill
Chief Executive: John Wilbraham
Dear Colleague

TRUST BOARD MEETING

A meeting of the Trust Board will be held at 3.00pm on 29th March 2018 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 2018 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</td>
<td>10 mins</td>
<td></td>
</tr>
<tr>
<td>2. Apologies:</td>
<td>Chairman</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## ASSURANCE ITEMS

<table>
<thead>
<tr>
<th>AGENDA TOPIC</th>
<th>PRESENTED BY</th>
<th>TIME ALLOCATION</th>
<th>REF. NO.</th>
<th>LINKED TO TRUST OBJECTIVE ON:</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Register of Interests:</td>
<td>The Chairman</td>
<td>5 mins</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>- Declared interest agenda</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Hospitality and Gifts Register Declaration</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Minutes of the January 2018 meeting</td>
<td>The Chairman</td>
<td>-</td>
<td>TB 18 (11)</td>
<td></td>
</tr>
<tr>
<td>5. Matters Arising</td>
<td>The Chairman</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>6. Action Log</td>
<td>The Chairman</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>7. Verbal update:</td>
<td>Ms A Harrison</td>
<td>20 mins</td>
<td>Verbal (supported by formal minutes when available)</td>
<td>All corporate objectives</td>
</tr>
<tr>
<td>SQS</td>
<td>Mr M Wildig</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FP&amp;W</td>
<td>Mr I Goalen</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Audit</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## STRATEGIC/GOVERNANCE/ASSURANCE ITEMS

<table>
<thead>
<tr>
<th>AGENDA TOPIC</th>
<th>PRESENTED BY</th>
<th>TIME ALLOCATION</th>
<th>REF. NO.</th>
<th>LINKED TO TRUST OBJECTIVE ON:</th>
</tr>
</thead>
<tbody>
<tr>
<td>8. Chief Executive’s Commentary</td>
<td>Chief Executive</td>
<td>40 mins</td>
<td>TB 18 (12)</td>
<td>All corporate objectives</td>
</tr>
<tr>
<td>9. Corporate Governance Manual Update</td>
<td>Director of Corporate Affairs &amp; Governance</td>
<td>15 mins</td>
<td>TB 18 (13)</td>
<td>All corporate objectives</td>
</tr>
<tr>
<td>10. Financial Update (budgets)</td>
<td>Director of Finance</td>
<td>15 mins</td>
<td>TB 18 (14)</td>
<td>RESOURCES - To deliver services that are clinically and financially sustainable</td>
</tr>
<tr>
<td>11. Annual Review – Carter</td>
<td>Director of Finance</td>
<td>15 mins</td>
<td>TB 18 (15)</td>
<td>RESOURCES - To deliver services that are clinically and financially sustainable</td>
</tr>
<tr>
<td>12. Learning from Deaths</td>
<td>Medical Director</td>
<td>10 mins</td>
<td>TB 18 (16)</td>
<td>PATIENTS - Provide the best services to our population through improvements to safety, productivity and patient experience</td>
</tr>
</tbody>
</table>
13. GIRFT Update

<table>
<thead>
<tr>
<th>AGENDA TOPIC</th>
<th>PRESENTED BY</th>
<th>TIME ALLOCATION</th>
<th>REF. NO.</th>
</tr>
</thead>
<tbody>
<tr>
<td>GIRFT Update</td>
<td>Medical Director</td>
<td>10 mins</td>
<td>TB 18 (17)</td>
</tr>
</tbody>
</table>

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

14. Board Assurance Framework & Corporate Risk Register

<table>
<thead>
<tr>
<th>AGENDA TOPIC</th>
<th>PRESENTED BY</th>
<th>TIME ALLOCATION</th>
<th>REF. NO.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Board Assurance Framework &amp; Corporate Risk Register</td>
<td>Director of Corporate Affairs &amp; Governance</td>
<td>10 mins</td>
<td>TB 18 (18)</td>
</tr>
</tbody>
</table>

All corporate objectives

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

<table>
<thead>
<tr>
<th>AGENDA TOPIC</th>
<th>PRESENTED BY</th>
<th>TIME ALLOCATION</th>
<th>REF. NO.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standing Agenda Item: Does the Board wish to add</td>
<td>Chief Executive</td>
<td>5 mins</td>
<td>Verbal</td>
</tr>
</tbody>
</table>

All corporate objectives

---

**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>Public Trust Board Agenda – April 18</td>
<td>The Chairman</td>
<td>5 mins</td>
<td>TB 18 (19)</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>Chairman’s Commentary</td>
<td>TB 18 (20)</td>
<td>Information</td>
<td>All corporate objectives</td>
</tr>
<tr>
<td>Corporate Governance Manual</td>
<td>TB 18 (21)</td>
<td>Assurance</td>
<td>All corporate objectives</td>
</tr>
<tr>
<td>Safer Staffing Exception Report</td>
<td>TB 18 (22)</td>
<td>Assurance</td>
<td><strong>PATIENTS</strong> - 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><strong>STAFF</strong> - Empower, develop and value staff in providing innovative patient focused care</td>
</tr>
<tr>
<td>Minutes of the committees of the Board:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AGENDA TOPIC</td>
<td>REF. NO.</td>
<td>REASONS FOR PRESENTING</td>
<td>LINKED TO TRUST OBJECTIVE ON</td>
</tr>
<tr>
<td>----------------------</td>
<td>---------------</td>
<td>------------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>SQS – December 17, Jan 18</td>
<td>TB 18 (22, 24)</td>
<td>Information</td>
<td></td>
</tr>
<tr>
<td>FP&amp;W –November 17, Jan 18</td>
<td>TB 18 (25, 26)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Audit - November 17</td>
<td>TB 18 (27)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Date and Time of Next Meeting:**

Date: Thursday 26th April 2018  
Time: 3.00pm - Venue: Board Room 1, New Alderley House, Macclesfield District Hospital
Agenda item 4: TB 18 (11)

MINUTES OF A MEETING OF
THE PUBLIC TRUST BOARD MEETING
HELD ON THURSDAY 25TH JANUARY 2018
BOARDROOM 1, MDGH, MACCLESFIELD SK10 3BL

Voting Members

<table>
<thead>
<tr>
<th>NAME</th>
<th>TITLE</th>
<th>ABBREVIATION</th>
<th>PRESENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mrs L McGill</td>
<td>Chairman</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Ms A Harrison</td>
<td>Non-Executive Director</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Mr M Wildig</td>
<td>Non-Executive Director</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Dr A Coombs</td>
<td>Non-Executive Director</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Mr I Goalen</td>
<td>Non-Executive Director</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Dr J Cowan</td>
<td>Non-Executive Director</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Mr J Wilbraham</td>
<td>Chief Executive</td>
<td>CEO</td>
<td>Yes</td>
</tr>
<tr>
<td>Mrs K Senior</td>
<td>Director of Nursing, Performance and Quality</td>
<td>DoN</td>
<td>Yes</td>
</tr>
<tr>
<td>Mrs J Green</td>
<td>Director of Corporate Affairs and Governance</td>
<td>DCAG</td>
<td>Yes</td>
</tr>
<tr>
<td>Dr J Hunter</td>
<td>Medical Director</td>
<td>MD</td>
<td>Yes</td>
</tr>
<tr>
<td>Ms R Charlton</td>
<td>Director of HR &amp; Workforce</td>
<td>DHR</td>
<td>Yes</td>
</tr>
<tr>
<td>Mr M Ogden</td>
<td>Director of Finance</td>
<td>DoF</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Non-Voting Members

<table>
<thead>
<tr>
<th>NAME</th>
<th>TITLE</th>
<th>ABBREVIATION</th>
<th>PRESENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mrs J Green</td>
<td>Director of Corporate Affairs &amp; Governance</td>
<td>DCAG</td>
<td>Yes</td>
</tr>
</tbody>
</table>

In Attendance

<table>
<thead>
<tr>
<th>NAME</th>
<th>TITLE</th>
<th>ABBREVIATION</th>
<th>PRESENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Miss J Crook</td>
<td>Meeting Secretary</td>
<td>JC</td>
<td>Yes</td>
</tr>
</tbody>
</table>

DECISIONS MADE BY THE BOARD AT TODAY’S MEETING

1. The Board approved the Major Incident Plan
2. The Board Approved the Risk Management Strategy
<table>
<thead>
<tr>
<th>AGENDA No</th>
<th>SUBJECT</th>
<th>ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Patient Story</td>
<td>DNPQ presented a patient story received by the CEO from the patient's husband in relation to the care a patient had received from the District Nursing Team. The patient had become unwell over the Christmas period and after assurance provided by the GP and a referral to the District Nurses, the patient deteriorated. A phone call was made to the District Nurses on Boxing Day and a home visit took place two hours later that day. A dressing was placed on the patient wounds and a prescription was left for further dressings which the patient could collect when convenient. The immediate action of the District Nurses resulted in the patient receiving care on the day and the avoidance of any grade pressure ulcer developing. The patient and partner were extremely grateful of the service provided and requested that their appreciation was shared with the team.</td>
</tr>
</tbody>
</table>

| 2.        | Apologies | None noted |

<table>
<thead>
<tr>
<th>3.</th>
<th>Register of Interests:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Declared interest agenda</td>
<td>None declared</td>
</tr>
<tr>
<td></td>
<td>Hospitality and Gifts Register Declaration</td>
<td>None declared</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4.</th>
<th>Minutes of the November 2017 meeting</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>TB 18 (01)</td>
<td>Amendment to the previous minutes to be documented as:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Section 9; 'of which one was thought to be avoidable' this is to be amended to 'of this, one was thought to be avoidable'</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The minutes of the November 2017 Trust Board meeting, with the amendment documented above, were declared a true and accurate record and duly signed by the Chairman</td>
<td></td>
</tr>
</tbody>
</table>

| 5.        | Matters Arising | The Chairman confirmed the junior doctor forum in March was cancelled therefore the Chairman was unable to attend. A future date has been booked for 6th March 2018 at the next forum meeting. |
6. **Action Log**

9495 – “MD To provide further clarity re review process for patient deaths within 30 days of discharge”. The MD confirmed all patients are discharged unless there are any concerns raised by the family in relation to the care provided. If no issues are raised, the death is not routinely investigated. Unable to confirm if this is a current standard adopted by surrounding Trusts however this is East Cheshire NHS Trust policy. Recommend action close.

7. **Verbal update:**

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

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

AH presented SQS update and highlighted the following:

**Points for Assurance**

- The Trust is on track to achieve end of year target of 200 or less formal complaints. PALS outreach is undertaken daily with real time local action taken to resolve any identified concerns
- The Committee ratified the updated Duty of Candour and Being Open policy
- The trust responded in a timely manner with all requisite data to the CQC Chief Inspector of Hospitals national request regarding reporting of radiological examinations
- Freedom to Speak Up - The trusts guardian provided the committee with the trusts position and commentary following the recent findings at the Southport & Ormskirk NHS Trust where good practice was not followed in relation to concerns regarding bullying and discrimination
- Learning from 'near misses' - using the principles of 'appreciative enquiry', all near misses are being analysed in order to identify positive measures implemented which will contribute to improvement in patient and carer experience and links with NHS Resolution which aims to reduce clinical claims
- The committee received assurances from the biannual SIRI report in terms of the trusts responsiveness and governance arrangements for serious incidents, including use of check & challenge process; executive sign off of investigation reports & action plans and attendance of non-executive directors at SIRI sub committees. The Committee approved the updated Terms of Reference
- The Committee received Q3 update on Harm Free Care component of our quality strategy. Improvements in achievement of safety thermometer in Community were noted compared with last year. Ongoing improvement work relating to pressure ulcer identification and documentation also noted both in community and hospital together with
ongoing work to roll out frailty training package across health & social care economy including private sector.

Emerging Risks & Mitigating actions

- A spotlight on Risk 2272 relating to ED overcrowding was presented and clinical risks arising from Patient Flow & Overcrowding discussed. Appropriate Control and Escalation measures were seen to be in place (including system wide OPEL and Full Capacity protocol measures). Governance structures including Operational Resilience Group & A&E Delivery Board and SQS/Trust Board were noted. Continued focus on developing out of hospital capacity; deployment of additional winter funding schemes; new patient screening on arrival processes and ongoing intensive leadership proactive engagement resulting in real time action to assure ongoing safety. Risk 2272 wording has subsequently been reviewed and list of controls updated, with current risk score adjusted to likelihood 3, impact 5, total =15 (reduced from 16).

- Following the issuance of the 2016 Children and Young People's in patient and day case surgery, the trust has developed an action plan which will be monitored by SQS committee.

Mortality reviews have identified that the end of life care plan documentation is not being consistently completed however an End of Life Facilitator is now in post to work alongside nursing and medical staff to improve compliance.

DNPQ confirmed there are a number of controls in place to support staff when ED overcrowding occurs alongside strengthened polices, working collaboratively and ensuring the check and challenge process is robust.

Finance, Performance & Workforce Committee (FPW)

MC presented FPW update and highlighted the following:

Finance

It was confirmed FPW December 2017 meeting was rescheduled early as a virtual meeting therefore not all information was available and minutes are awaiting full approval.

The following was noted:

- £368k better than plan at Month 9
- A £665k non-recurrent reserve was released for drugs and data challenges
- The revised forecast deficit including STF is £19.5m
- Receipt of the additional £430k STF funding is now unlikely therefore the forecast will be amended
- Capital expenditure is behind plan. £380k of this relates to the Endoscopy scheme which is delayed but due to finish during February and the full expenditure will be achieved by year end
- Blue QIPP schemes are on target; however, Acute and Integrated
Community Care (AICC) and Planned Care (PC) have a large number of high risk red schemes

- The QIPP targets set are realistic however identifying ways to take costs out is a challenge for AICC and no new schemes have been added since September. An operational manager has been put in place to assist with this
- The CIP for 2018/19 is £5m and is to be discussed at a future Executive Management Team meeting as few schemes have been identified for next year
- Loans due for repayment during February 2019 are likely to be rolled over to the following year, however the associated planning guidance has yet to be issued
- Cancellation of electives will have an adverse effect on finance however controlled target will be achieved.
- Risks are noted with elective surgery and ED performance.

Performance:

- ED 4 hour standard - compliance during December was 72.73% and 81.5% for Q3 against trajectory of 90%. This is due to an increase in complexity of cases and work is ongoing within the CCG to reduce attendance through communication with the public. Delayed Transfers Of Care (DTOC) numbers have improved against year-end trajectory of 15
- RTT – 89.35% against 92% standard
- Diagnostics – achieved 87% however a robust plan is in place with assurance provided to achieve March 2018.
- Cancer 62 day - below standard of 85% at 82.35%. Actions to mitigate.
- RTT achieved 89% with elective surgery deferred into January and first part of February 2018.
- No 52 week breaches are noted however if continuing with deferred surgery and procedures; breaches will occur in April 2018.
- There is work to be done around Expected Date of Discharge in terms of improving management and agreeing more meaningful actions
- One 12 hour trolley wait was reported in December, however, 38 have been reported in January so far
- GP streaming, Acute Visiting Service (AVS) and Alcohol Service are working well
- Risk are noted with ED 4 hour target, Waiting List Initiatives (WLI) and deferred electives

Workforce

- Metrics improved overall during December, however, areas such as booked training and appraisals have been cancelled due to operational pressures, which will have a negative impact during January
- Agency and bank spend decreased during December but is
expected to rise again during January

- Acute nursing vacancy gaps remain a concern at 14% (49 staff) and are under regular review; this position is compounded by maternity and sick leave. Work is underway with Cavendish Hospital in Buxton to promote ECT vacancies to staff at risk there.
- Executives have been completing walkabouts with various departments and offering support.
- ECT has achieved accreditation for simulation training, one of only five centres across the North West.
- Sickness has increased across the workforce however this remains below target. A new staff wellbeing programme is due to be launched within the next few months and advertising will be circulated.
- Staff survey has now been concluded with response rate noted as 41% and compares favourably with national average.

DNQP raised concerns with pressures on junior doctors as they are now required to complete part of their training within the community, GP surgery and hospice setting. This will impact on ward rota as there will be no back fill for cover however this is being closely monitored and noted as an area of issue.

**Audit (November 17)**
No Audit meeting had taken place since the Board last met.

<table>
<thead>
<tr>
<th>STRATEGIC/GOVERNANCE/ASSURANCE ITEMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>8. Chief Executive’s Commentary</td>
</tr>
</tbody>
</table>

**TB 18 (02)**

The CEO presented the report and highlighted the following points:

- Significant operational pressure during December and January due to the volume and complexity of patients being admitted however patient satisfaction has remained stable and positive praise has been received for the staff.
- This pressure has resulted in cancellations for patients both in outpatient and elective services as well as increased waiting times. 1 patient waited more than 12 hours from the decision to admit to them being admitted in December and 38 in January.
- The financial position in December remains ahead of plan however this is due to non-recurrent benefits and the reduction in elective and outpatient services in recent weeks increases pressure on the ability to achieve the control target.
- The Care Quality Commission (CQC) as expected have undertaken a number of short notice inspections prior to the Well Led assessment planned for the end of January.
- The disestablishment of the Caring Together Board due to the formation of a wider Transformation Board covering east and south Cheshire together with Vale Royal.
Flu staff vaccination uptake is noted as 70% with 15 confirmed inpatient flu cases confirmed.

Single sign on is now available in ED for all staff which has received positive feedback from all nurses and doctors.

The Board noted staff engagement and dedication throughout the winter pressures with additional workload throughout the months. The Board asked the Chief Executive to convey thank you to all.

With the aim to cancel all elective activity nationally, East Cheshire NHS Trust has been able to maintain a segment of day case activity.

£600k winter pressure funding has been received with all schemes in place. Extra beds are documented as 30 extra with DToCs noted at 19.

IG raised a concern in relation to a never event in December as there is no mention of this within the commentary. DCAG confirmed a Root Cause Analysis (RCA) has been completed and awaiting outcome. The RCA relates to a wrong site surgery and there was an impact on the patient. DoF advised the financial impact results of the elective programme will be submitted in February for the Board to note.

The Board discussed the ad hoc temporary closure of minor injuries at Congleton War Memorial Hospital (CWMH) Minor Injuries Unit and the actions taking place between East Cheshire NHS Trust and East Cheshire CCG.

**Action:** CEO & DoN to liaise with CEC and CCG regarding Congleton War Memorial minor injuries unit and decisions around temporary closure.

IG requested assurance to be provided surrounding falls as 3 falls were reported as severe in November and 2 in December. DoN confirmed these were all fractured neck of femur (#NOF) and will be subject to a RCA.

The Board approved the Major Incident Plan.

DoN presented safe staffing report which highlighted there was 14% of vacancies within acute nurses. The document has reported shifts which are planned and are showing as over 100% however this is due to HCA 1:1s. Staffing has remained challenging with the redeployment of staff to all areas taking place on a daily basis.

DHR raised concerns with 3 nurses not achieving their accreditation through national recruitment. There has been some push back on the English test and this is due to be revised. The NMC has responded quoting the following:

> ‘Last year there were a number of meetings with the Nursing and Midwifery Council (NMC), and national nursing leads from across the system, to consider your concerns about language testing for nurses trained outside...’
The NMC responded to these concerns by introducing alternative routes to evidencing language competence, including the option to take the Occupational English Test (OET) instead of the International English Language Testing System (IELTS).

Following a discussion with NMC colleagues today, Wednesday 24 January, I am pleased to feedback that early indications show an increase of overseas nurses both applying to the NMC and sitting the OET in December. While the number of nurses sitting and passing IELTS has decreased slightly, the results show that there is now significant additional talent in the system eligible to pass to the next stage in the process, which is welcome news.'

DoN confirmed a meeting is due to take place with the NMC to discuss the above and feedback will be provided.

CEO advised CQC have been present within the last 3 weeks and Well Led Assessments are due to take place on 30th January, 31st January and 1st February 2018.

The Board noted the dissolution of Caring Together and Connecting Care Programme Boards and the formation of the new Joint Programme Board which unites both. The first meeting is due to be held on 7th February and the Chair and CEO will be in attendance. CMB will be briefed on 26th January.

<table>
<thead>
<tr>
<th>9. Learning from Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TB 18 (03)</strong></td>
</tr>
<tr>
<td>The MD presented the Q.2 Learning from Deaths report highlighting the following:</td>
</tr>
<tr>
<td>• The trust measures mortality in order to reduce mortality rates, improve patient safety and reduce avoidable variation in care and outcome</td>
</tr>
<tr>
<td>• Mortality is measured in two ways – crude mortality and standardised mortality. The standardised mortality ratios used at the trust are RAMI (Risk adjusted mortality index) and SHMI (Summary hospital mortality indicator)</td>
</tr>
<tr>
<td>• When considering standardised mortality the difference between the expected number of deaths and the observed number is termed ‘excess’ deaths. This does not mean that these deaths were avoidable (i.e. that they should not have happened at all), unexpected or attributable to failings in care.</td>
</tr>
<tr>
<td>• All deaths at the trust undergo a two stage retrospective case record review. Consultants are asked to apportion an ‘avoidability of death’ score for every death</td>
</tr>
<tr>
<td>• The standardised mortality ratios for Q2 were within the expected range – SHMI 1.06 and RAMI 73</td>
</tr>
<tr>
<td>• During Q2 there were 156 in–patient deaths. All deaths underwent a two stage retrospective case note review and none of the deaths were felt to be attributable to any failings in care.</td>
</tr>
</tbody>
</table>
The learning from the Q2 mortality reviews included issues around the completion of end of life care plans, accurate note keeping to assist with accurate clinical coding and gaps in clinical documentation. Actions to address issues raised from mortality reviews included the appointment of an end-of-life care facilitator, introduction of a new cellulitis pathway and additional coding teaching for junior medical staff. Multiple instances of good practice were also identified by the mortality reviews.

MD confirmed all patients have had a completed review and where lessons have been learnt, these have been shared with the relevant staff. Dr Cowan queried an ongoing issue with coding and whether there was a plan in place to support this. Additional coders are now available and coding training is provided at local induction of new doctors. Action cards have also been developed to fit onto the staff lanyards and to assist with coding and these have been rolled out.

### 10. Risk Management Strategy

**TB 18 (04)**

DCAG presented the Risk Management Strategy highlighting the following:

- The strategy is aimed at supporting all our staff in the process of managing risk.
- The document has been strengthened and this provides a clear requirement to upload all evidence to Datix and ensuring all risk assessments and business cases are confined within one area.
- The Chair noted that when a serious risk is raised and needs to be visible at Board level quickly, this is done via an SBAR report, a Situation, Background, Assessment, Recommendation report. A flow chart will be included. In addition the Chief Executive would include this in the report to the Trust Board.

The Board discussed Duty of Candour and 3 incidents where this was not appropriate. DCAG confirmed every patient is reviewed and Duty of Candour will be implemented unless there is high sensitive of the family or the timeframe is delayed.

The Board approved the Risk Management Strategy.

### 11. Standing Agenda Item:

**Does the Board wish to add anything to the Assurance Framework or Corporate Risk Register**

DoF presented the delegation of annual accounts and asked the Board for approval of the account to be submitted to the Audit Committee. The Board agreed for the annual account to be submitted to the Audit Committee due to be held on 22 May 2018 for final sign off.
ANY OTHER BUSINESS

12. Public Trust Board Agenda – March 18
   TB 18 (05) No comments

CONSENT ITEMS

13. Chairman’s Commentary:
   TB 18 (06) The Board received and noted the content of the Chairman’s commentary.

14. Safer Staffing Exception Report:
   TB 18 (07) The Board received the December 2017 Safer Staffing Exception Report submitted by the DoN. Members noted its content

15. Minutes of the committees of the Board:
   TB 18 (08,09) SQS – October, November 17
                 The minutes of the December 2017 Safety, Quality & Standards Committee were shared with Board members and the content noted.
   TB 18 (10) FP&W – October 17
               The minutes of the December 2017 Finance, Performance & Workforce Committee were shared with Board members and the content noted.

Date and Time of Next Meeting:

Date: Thursday 29th March 2018
Time: 3.00pm - Venue: Board Room 1, New Alderley House, Macclesfield District Hospital

Signed: ..............................................

Name: ..................................................

Date: ..................................................
<table>
<thead>
<tr>
<th>Action Log No</th>
<th>Committee</th>
<th>Date Presented</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>9508</td>
<td>Trust Board</td>
<td>25/01/2018</td>
<td>8</td>
<td>8</td>
<td>Chief Executive’s Commentary</td>
<td>John Wilbraham / Kath Senior</td>
<td>Feb-18</td>
<td>CEO has written to Jerry Hawker and currently awaiting a response</td>
<td>Open</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>CEO &amp; DoN to liaise with CEC and CCG regarding MiU at Congleton War Memorial</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Report of:
Responsible Officer: Chief Executive
Accountable Officer:

Author of Report: John Wilbraham, Chief Executive

Subject/Title
Chief Executives Report to Trust Board for the Period to 28th February 2018

Background papers (if relevant) N/A

Purpose of Paper
To highlight performance issues and areas of risk to the delivery of the trusts objectives

Action/Decision required
The Board are asked to confirm acceptance of the deficit control total of £19.2m for 2018/19.

Mitigates Risk Number: (identify)

On Corporate Risk Register
Links to all risks identified within the Assurance Framework and the Corporate Risk Register

On Assurance Framework

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

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

Legal implications - (identify) None

Impact on quality
Increasing risk to patient experience due to operational pressures

Resource impact None

Impact of equality/diversity None

Avoid acronyms or abbreviations - if necessary list:
ED Emergency Department
NHS National Health Service
NHSI NHS Improvement
NHSE NHS England
CCG Clinical Commissioning Group
CQC Care Quality Commission
A&E Accident and Emergency
HR Human Resource
DWP Department for Work and Pensions
Chief Executives Commentary for the Period Ending 28th February 2018

1  INTRODUCTION

1.1 The paper gives an overview of performance of the Trust for the period and provides assurance and areas of risk around the delivery of the Boards objectives.

2  KEY ISSUES

The Board are asked to accept the 2018/19 financial control total

2.1 The Board are asked to accept the deficit control total for 2018/19 of £19.2m accepting that there is £1.9m of QIPP yet to be identified

The Board are asked to note the following issues

2.2 • The Trust continues to underperform against the 4 hour operational standard for emergency care and has received a letter of undertakings from NHSI. There remains an implied clinical risk associated with busy ED's and long waiting times in the department.

• Continued pressure on urgent care has continued to necessitate the cancelation of elective in-patient operations with a resultant deterioration in waiting times.

• The agreement of a block contract with NHS Eastern Cheshire for 2018/19.

• The delivery of the 2017/18 financial position as at the end of February.

• The commencement of engaging clinical and non-clinical staff in developing service proposals for consideration in July.

3  2018/19 ANNUAL PLAN

The Trust is on line to agree contracts with commissioners by the 23 March and is continuing to finalise the submission of the 2018/19 plan to NHSI by 30th April 2018.

3.1 The Annual Planning cycle for the next financial year is coming to a close. The plan for 2018/19 is a refresh of the two year plan that was submitted to NHSI at the outset of the 2017/18 financial year.

There have been a number of national assumptions which have been included in the East Cheshire plan however the Executive team have reflected minor changes in some of these assumptions to reflect the local situation and the plans of our partners.
The Board are required to confirm that it will accept the financial control total for 2018/19 of £19.2m.

The Executive Team have been in discussion with the main commissioner about moving to a block contract arrangement during the 2018/19 year and move away from cost and volume Payment by results tariff for acute activity. This gives certainty of income to the trust (and commissioner) but forces the trust to improve productivity to meet its financial control total.

This approach supports the Capped Expenditure principles and seeks to move away from passing cost pressures between organisations within the health and care economy.

There are risks to the block arrangement and the key one is the management of waiting times for patients should referrals increase as additional activity would not generate increased income.

The Executives believe the use of a block on balance is the correct course of action but it does require the CCG to manage referrals to the Trust.

The Trusts quality plan needs to be finalised before the end of April however the key themes being proposed are:

**Harm Free Care**
- Pressure ulcer and falls prevention
- Management of IV lines
- Sepsis bundle
- Improved risk assessment/care planning

**Improving Outcomes**
- Personalised Care Plans
- Medication side effects
- In patient flow and discharge planning

**Listening and Responding**
- Ward Environments
- Out Patient Clinic cancellation rates
- Safer staffing and skill mix

**Integrating Care**
- Community hub outcomes framework
- Nursing home provider partnerships
- End of life care
These will be reviewed when the CQC report is published to ensure these outcomes remain the key issues facing the Trust.

**The Trust is not using all of the national activity assumptions**

3.3 The key activity assumptions in the national guidance are that there will be:

- Elective growth of 3.6%
- Non-elective growth of 2.3%
- Accident and emergency attendances will grow by 1.1%
- Out-patient Growth of 4.5%

The trust is planning on forecast outturn for 2017/18 with the above assumptions except that we are assuming slower growth in outpatients (2%) and elective activity (1%) as the CCG are aiming to manage referrals down by up to 8% across all its contracts.

The planning guidance requires Trusts to achieve the same cancer standards as the current year, it will need to agree a phased trajectory for ED recovery to 95% by March 2019 and have no increase in the number of patients waiting for treatment at March 2019 compared to March 2018.

**The workforce plan has little material change in the plan**

The need to reduce cost will impact on some posts with skill mix changes and some overall reduction within the Trust but it is the intention to manage any workforce changes without redundancies.

There will be a need to further reduce sickness absence to reduce bank and agency costs and the Trust has been set a maximum spend on agency during 20118/19 of £7.3m.

**The financial assumptions assume fully funded pay awards and the need to deliver £5m of efficiency savings**

3.4 The financial plan of the Trust is based on a block contract offer from Eastern Cheshire CCG which is based on outturn for 2017/18 and increased for the national activity assumptions.

At this time the pay awards have not been finalised and an assumption of 1% has been used both in terms of income and expenditure. Negotiations continue at national level and the position is that an award greater than 1% is being discussed. The plan will be amended when the discussions are completed however the underlying assumption is that the cost of pay awards for all staff will be financially neutral during the year.

The plan requires £5m of efficiency savings during the year and given the block arrangement this must be found by cost reduction and challenges the trust to improve productivity. At the start of the year there is relative confidence in achieving £3.1m of savings but there is a risk of £1.9m at the start of the year.
A large element of the savings opportunity is the cessation of waiting list sessions with this work being undertaken within core hours by increasing productivity. This will impact on the income of some members of staff and as such there is a risk that there may be some resistance to this plan.

Should the Board agree to the financial control total of £19.2m deficit it will be able to access £5.2m of additional funding providing it delivers both the ED trajectory and its financial targets.

The Board are asked to note that there is risk in achieving both of these targets however if the Board does not agree to its control total it is possible it will not be able to bid for monies that may become available during the year.

There are some risks inherent in accepting the Block contract and Financial Control total

There are a number of risks:

- Should the CCG not manage referral volumes to the Trust the waiting times for patients may grow.

- Should productivity gains not be sufficient to offset the cessation of waiting list activity waiting times for patients may grow.

- The financial control total is at risk at the current time with £1.9m of QIPP unidentified.

- Clinical engagement will be key in delivering improved productivity of patient activity and this will challenge some senior members of staff.

4 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.

Patients accessing the emergency department are continuing to experience longer waiting times than the national operational standard of 4 hours. Whilst no explicit issues of patient safety have occurred there is

The Trust has not achieved the operational standard of 95% of patients being admitted, transferred or discharged within 4 hours. During February the Macclesfield department treated 3,755 patients with 1,118 patients waiting more than 4 hours. At the end of February the performance for quarter 4 of the financial year was 70.2% and the Board are advised that the plan submitted to NHSI for the year has not been achieved.

In addition during February, 9 patients waited more than 12 hours from the decision that they needed inpatient treatment and them actually getting into a bed on the ward.
Healthwatch visited the Department on 22 January and interviewed patients within the Department. Whilst the sample size was relatively small the key messages were consistent with the internal information generated but clearly external assurance is beneficial.

Overall people were largely satisfied with the care they had received although this was slightly lower that the survey undertaken last year.

There was some insight to the number of people in the department who had come to ED having been in contact with other providers however it was not possible to tell if this was an appropriate redirection or if there were still some patients coming to ED who could have been treated in other settings.

The visit was conducted alongside visits to ED's at Leighton and the Countess of Chester.

The Trust’s performance has triggered an enforcement undertakings letter from NHSI about its performance however comparative performance with other trusts is reasonable

4.2 NHSI have issued the trust with a letter of undertakings that I have signed which commits the Trust to making every endeavour to achieve the national standard. The planning guidance for 2018/19 requires Trusts to see 90% of patients within 4 hours for the first half of the year rising to 95% in the second half of the year.

Whilst the Trust has failed to achieve the operational standard it is clear that many other trusts have also under achieved against the standard.

During February the Trust did not always operate the minor injury unit at Congleton as the staff were deployed into the main ED at Macclesfield. The Macclesfield ED is classed as a “type 1 ED” and the Congleton MIU as a “type 3”. Type 3 departments see less complex patients and therefore patients are more easily treated within 4 hours.

East Cheshire is untypical in that the majority of patients treated are within a type 1 facility where as other trusts have a balance of activity. Information from neighbouring trusts shows that they are achieving c. 70% for the performance in their type one facilities which is consistent with East Cheshire.

It should be fully understood that the Trust continues to strive for improvement to the 95% standard and will continue to work with partners to this end.

Whilst the Trust has not met the standard there have been improvements made in processes over the
16.6%. By enabling more patients to wait for ongoing care out of the hospital this has effectively increased the number of beds for patients needing acute care. Despite this a number of patients have been “bedded” within the department which is not the experience we would wish to provide for patients.

The opening of the primary care facility at the front entrance to ED has also assisted in managing demand and the number of patients with minor conditions who have waited more than 4 hours during February totalled and many days there are no patients waiting more than 4 hours.

The Trust held a “Multi Agency Discharge” event over 2 days during February where every ward was visited to assess processes in place to identify if there was anything that could be changed to speed the discharge of patients. This involved staff from the Trust, CCG and social care. There were a number of areas where it was felt further improvements could be made and these areas are being actively followed up and the A&E Delivery Board will be overseeing implementation.

The flu vaccination programme was successful in that 70.6% of staff having received the vaccination. By the end of February the Trust has treated 41 patients with confirmed flu.

The medical staffing position within ED has also improved. A new fulltime ED consultant has joined the Trust with another (locum) consultant starting on 1st April. These two full time posts will more than offset the two part-time consultants who will leave the trust in April. An appointment has also been made to the middle grade rota. The need to use bank and agency staff continues however the number of uncovered shifts is now minimal albeit that the rates being paid are above the capped rates.

With the exception of the 62 cancer waiting standard all cancer waiting time standards have been met. The 62 day standard was achieved for 24 patients (78.7%) against the standard of 85% (2 more patients would have needed to have been treated within 62 days to achieve the standard).

The referral to treatment time has further deteriorated during February as a direct consequence of the pressure on emergency care has necessitated inpatient elective treatment to be cancelled. The Trust has continued to treat elective patients with cancer and has maintained the day case activity on the day case unit.

There has been a deterioration in waiting times

The number of beds for medical care and surgical care appears to be out of balance and the Executive Team are reviewing this position

As noted earlier, during the winter period a number of patients have been bedded in the ED and there have been a number of medical patients nursed on surgical wards. These “outliers” often experience longer lengths of stay and their use of surgical beds leads to cancellation of elective patients. Also the wide spread of medical patients across the site means the medical staff are less efficient as they have to visit more wards when assessing patients on a daily
basis.

The Executive team are assessing the compliment of beds needed for patients in line with planning assumptions for 2018/19 but it is recognised that any change in bed compliment will have staffing and financial implications. This work needs to be completed in time for the submission of plans to NHSI by the end of April.

4.5 Further to work undertaken within the Trust led by the HR team the Trust has been awarded the highest level (3) of accreditation of the DWP Disability Confident Scheme “Leader”.

This award is made by the DWP and only 6 other health organisations have leader status and the Trust is the first in Cheshire and Merseyside.

The assessment looks at whether the Trust is taking all of the core actions how it supports others to be disability confident employers.

4.6 The Specialised Commission team from NHSE visited the Trust on 31st January to undertake a peer review of the services provided by the Trust.

The visiting team acknowledged the good work undertaken by the Trust and confirmed there were no immediate risks or serious concerns identified which provides external assurance on the service.

The report will be received in the near future and will be managed through the relevant SQS Committee.

5 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.

5.1 The financial position of the Trust is a deficit of £18.3m which is a favourable variance to the planned position of £18.8m deficit and with one month left to run the Trust is well placed to deliver the financial control total for the year.

QIPP delivery for the year has been successful with the full year total of £6.3m being delivered against £6m target.

The table below shows the summarised Income and Expenditure Account for the period ended 28th February 2018.
<table>
<thead>
<tr>
<th></th>
<th>Plan</th>
<th>Actual</th>
<th>Var</th>
<th>Fav/Adv</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>£</td>
<td>£</td>
<td>£</td>
<td></td>
</tr>
<tr>
<td>Pay Expenditure</td>
<td>134,563</td>
<td>135,339</td>
<td>(776)</td>
<td>Fav</td>
</tr>
<tr>
<td>Non-Pay Expenditure</td>
<td>97,522</td>
<td>98,577</td>
<td>1,055</td>
<td>Adv</td>
</tr>
<tr>
<td>Total Operating Expenditure</td>
<td>52,104</td>
<td>51,227</td>
<td>(877)</td>
<td>Fav</td>
</tr>
<tr>
<td>Operating (deficit)/Surplus</td>
<td>(149,626)</td>
<td>149,804</td>
<td>179</td>
<td>Adv</td>
</tr>
<tr>
<td>Interest Rec'd/Paid/Gain on disp.</td>
<td>£764</td>
<td>£671</td>
<td>(93)</td>
<td>Fav</td>
</tr>
<tr>
<td>Capital Charges &amp; Adjustment for donated assets</td>
<td>£2,989</td>
<td>£2,989</td>
<td>0</td>
<td>Fav</td>
</tr>
<tr>
<td>Adjustment for 2016/17 additional sustainability &amp; transformation funding</td>
<td>£0</td>
<td>£189</td>
<td>189</td>
<td>Adv</td>
</tr>
<tr>
<td>Trust (deficit)/Surplus</td>
<td>(18,816)</td>
<td>(18,314)</td>
<td>(502)</td>
<td>Fav</td>
</tr>
</tbody>
</table>

The position by Service line is summarised below

<table>
<thead>
<tr>
<th>Income &amp; Expenditure Statement by Service Line</th>
<th>Contract Income</th>
<th>Direct Income</th>
<th>Pay</th>
<th>Non Pay</th>
<th>Total</th>
<th>Fav/Adv</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute and Integrated Care</td>
<td>(1,280)</td>
<td>(307)</td>
<td>2,237</td>
<td>1,200</td>
<td>1,850</td>
<td>Adv</td>
</tr>
<tr>
<td>Allied Health and Clinical Support Services</td>
<td>(283)</td>
<td>(42)</td>
<td>(699)</td>
<td>(156)</td>
<td>(1,181)</td>
<td>Fav</td>
</tr>
<tr>
<td>Planned Care Services</td>
<td>2,364</td>
<td>(84)</td>
<td>1,485</td>
<td>714</td>
<td>4,479</td>
<td>Adv</td>
</tr>
<tr>
<td>Contract Income</td>
<td>(202)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>(202)</td>
<td>Fav</td>
</tr>
<tr>
<td>Corporate Services</td>
<td>0</td>
<td>(220)</td>
<td>(307)</td>
<td>(501)</td>
<td>(1,028)</td>
<td>Fav</td>
</tr>
<tr>
<td>Trust wide</td>
<td>26</td>
<td>(747)</td>
<td>(1,661)</td>
<td>(2,134)</td>
<td>(4,516)</td>
<td>Fav</td>
</tr>
<tr>
<td>Sub Total</td>
<td>624</td>
<td>(1,399)</td>
<td>1,055</td>
<td>(878)</td>
<td>(598)</td>
<td>Fav</td>
</tr>
</tbody>
</table>
The Trust has received additional capital funding for IT investment.

The Trust made a bid for central funding associated with strengthening systems following the recent cyber-attacks on NHS and other services.

The Trust has now received £570k for infrastructure strengthening which was planned for next year. This resource will be spent in 2017/18 and therefore frees up capital resources in the Trusts 2018/19 capital programme.

The capital planning group will decide which other schemes can now be delivered in 2018/19 at its next meeting.

6 WORKFORCE

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

6.1 The national staff survey was undertaken during October 2017 and 41% of ECT staff responded to the survey which is slightly higher than the national average.

The Trust’s staff engagement score was 3.83 which is above the national average for the second year. The table below summarises the survey results over the last few years and the results will be discussed in detail at the finance, performance and workforce committee in April.

There has been continued pressure on staffing cover and costs during February. Sickness absence has improved marginally in February at 6.1% from 6.9% in January but remains high in comparison to last winter.

This has impacted on the use of bank and agency staff which identified through increased costs in both of these areas and the monthly spend on agency of £805k is above the monthly trajectory plan however the annual position will be
achieved.

The Board set an objective to have fewer vacancies at the end of the financial year than the start and this is being achieved with a vacancy rate of 4.39% at the end of February compared to 5.86% in April 2017.

7 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.

7.1 The aims and ambitions of the Caring Together programme aligned well with the ambitions of our partners in South Cheshire and Vale Royal and indeed many organisations were represented on both Boards.

By combining the programmes it is anticipated that duplication will be removed and by working across a larger population base there will be improved service sustainability. This forms one of the 9 “places” that are the building blocks of the Health and Care Partnership of Cheshire and Merseyside (HCPC&M).

The programme has developed a number of key work streams to identify how services will be sustained into the future and these cover care in hospital, care out of hospital, prevention and system development in terms of integrated care.

The Trust is actively involved in this work and in the supporting groups such as finance, workforce and estates.

Part of the work of the new Transformation Board is to build on the work done within the Trust and Eastern Cheshire economy about seeking to find clinically sustainable and financially affordable services.

The Trust has a reputation for providing good quality services but clearly has a significant financial challenge.

The trust has therefore embarked on a 22 week programme of work to identify options for the future delivery of services. These proposals will be just that, i.e. there will be no decisions made at the end of the programme but there will be some tangible proposals that can be discussed with partners and if considered viable then discussed with the public in 2019. The proposals must be:
• Clinically Sustainable
• Operationally practical
• Financially Affordable

The HCPC&M have provided resources to the trust in terms of KPMG and the NHS Transformation Unit to work alongside the Trust over during this period and that brings access to the Kings Fund and The Nuffield Trust and the national work they have been undertaking about the future of small hospitals.

This work will build on the current principles of Caring Together which is about clinically sustainable and quality services provided as close to home as possible.

I am leading this work personally and the first few weeks have been taken up with agreeing the processes and governance of the work. It is crucial this work is clinically led and Clinical Management Board have been briefed on the work and a launch event with senior clinical and no- clinical leaders will take place on 23rd March which will be followed by 3 clinical engagement sessions during May and June.

There is a lack of capacity to deliver this work

7.2 The Board have discussed previously the increased workload on the management of the trust and this very important work will add further pressure.

The Executive Team has discussed this and are agreed that more capacity is needed however there is no financial resources for this. It has been agreed that the CEO, Medical Director and Director of Nursing Quality and Performance be the key executive leaders of this work.

Discussions are ongoing about how further support is given to operational delivery whilst this transformation work takes place.

8 USE OF TRUST SEAL

The Trust Seal has not been used since the last Board meeting

9 SUMMARY

9.1 The operational pressures continue to challenge the organisation and staff continue to work under pressure to provide good care to our patients. Despite
this pressure the Trust is on target to achieve its financial duties.

The plan for 2018/19 is close to completion and will be presented to the Board in April in line with national timelines. This will see the commencement of a focused work programme with clinical staff about options for sustaining quality services into the future.
<table>
<thead>
<tr>
<th>Report of:</th>
<th>Responsible Officer</th>
<th>Director of Corporate Affairs &amp; Governance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Accountable Officer</td>
<td></td>
</tr>
<tr>
<td>Author of Report:</td>
<td></td>
<td>Head of Integrated Governance</td>
</tr>
<tr>
<td>Subject/Title</td>
<td></td>
<td>Review of Corporate Governance Manual</td>
</tr>
</tbody>
</table>
| Background papers (if relevant) | Corporate Governance Manual 2017-2018 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 committee is asked to:  
• Review the proposed amendments  
• Recommend the Board 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: | All objectives |
| • Trust’s Strategic Direction |
| • Corporate 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 as being required are:

General Amendments:
- Reference to NHS Protect changed to NHS Counter Fraud Authority

Forward:
- Update of number of employees and revenue income

Overarching Governance Arrangements:
- Page 8. Replace Process for Assurance and Escalation with committee governance structure diagram

Detailed Scheme of Delegation and Delegated Financial Limits
- Changes to hierarchy tiers and associated budgetary control levels, as approved at the November 2017 Audit Committee meeting

Standing Financial Instructions
- Section 13 - Changes to hierarchy tiers and associated budgetary control levels, as approved at the November 2017 Audit Committee meeting
- Section 22.1 Include reference to Conflict of Interest Policy (included at C8), which includes declaration of gifts and hospitality

Terms of Reference
- Revised Terms of Reference for each of the Committees of the Board
- Amendment of Terms of Reference to include statement that declarations of interest will be collected at the start of each meeting and setting out the requirement that members of decision making groups must make annual declarations of interests.

Policies and procedures
  C1 – Amended Anti Fraud, Bribery and Corruption Policy to reflect:
  - Change of contact point
  - Changes from NHS Protect to NHS Counter Fraud Authority along with changes to the links and national policy changes
  - Amend reference to Statement of Internal Control to annual governance statement
- Correct role name to Anti-Fraud Specialist to link back to progress and annual reports to Audit Committee.

C2 – Raising Concerns – Speaking Up policy to include a link to the electronic reporting system

C5 - Procedure Instruction for Completion of Waiver Forms:
- Page 215. Amended Waiver form

C8 - Conflict of Interest Policy
- Section 7 – Revision to the trusts Decision Making Staff
- Section 12 – Revision to the trusts Decision Making Groups

4 RECOMMENDATIONS

4.1 The Board is asked to:
- Review the proposed amendments
- Approve the changes to the Corporate Governance Manual
## Report of:
**Responsible Officer:**
**Accountable Officer:**

| Director of Finance |

## Author of Report:

**Kara Mason, Deputy Director of Finance**

## Subject/Title

**2018-19 Budgets**

## Background papers (if relevant)

## Purpose of Paper

Provide a summary of the draft financial plan for 2018/19 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.

### Mitigates Risk Number: (identify)

**On Assurance Framework**

### 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:** | NHSI – NHS Improvement  
S&T – Sustainability and Transformation  
CCG – Clinical Commissioning Group  
QIPP - Quality, Innovation, Productivity and Prevention  
NHS – National Health Service  
CNST – Clinical Negligence Schemes for Trusts  
CQUIN – Commissioning for Quality & Innovation |
1.0 Introduction

1.1 The Trust submitted its draft Annual Plan for 2018/19 to NHS Improvement (NHSI) on 8th March 2018 in line with the national timescales. In the submission, the Trust has stated it is able to meet the 2018/19 control total proposed by NHS Improvement (NHSI). The Trust’s detailed budget-setting processes ran in parallel with this.

1.2 The purpose of this paper is to:

- Provide a summary of the financial plan for 2018/19 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 2018/19 pay awards have not yet been announced and therefore assumptions have been made regarding this. This is held in a pay reserve (1%) along with incremental drift, and will be released into individual budgets when confirmed.

2.2 Known service changes such as the full year effect of the health visitor service transfer have been taken into account in the financial plans. Further details will be given on these later in the paper.

2.3 Patient activity contract income plan was based on forecast outturn 2017/18 at month 10 plus growth and tariff inflation.

2.4 National growth assumptions were applied to 2018/19 planned activity:

- Elective 3.6%
- Non elective 2.3%
- A&E 1.1%
- Outpatients 4.9%

For ECCCG elective activity was reduced to approximately 1% growth and outpatient activity reduced to 2% to reflect their referral management scheme.
3.0 **2018/19 Financial Position**

3.1 The submitted financial plan for 2018/19 is a deficit of £19.2m, after assuming delivery of a recurrent 3.5% cost reduction target totalling £5.0m. The Trust had previously accepted a target of £19.4m in September 2017 and this is therefore only a small change.

3.2 As a result of accepting the control total, the Trust is able to assume that it will be eligible for the Sustainability & Transformation (S&T) Funding payment of £5.7m; £4m for financial achievement and £1.7m for A&E delivery.

3.3 A summary of the movement from the 2017/18 plan and forecast outturn and the position for 2018/19 is provided in the table below.

<table>
<thead>
<tr>
<th></th>
<th>2017/18 Total Plan £m</th>
<th>2017/18 Forecast Outturn £m</th>
<th>2018/19 Total Plan £m</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Income</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Income</td>
<td>136.7</td>
<td>136.6</td>
<td>135.8</td>
</tr>
<tr>
<td>Non-Clinical Income</td>
<td>6.3</td>
<td>7.8</td>
<td>6.7</td>
</tr>
<tr>
<td>S&amp;T Fund - General</td>
<td>4.0</td>
<td>4.0</td>
<td>5.7</td>
</tr>
<tr>
<td>Total Income</td>
<td>147.1</td>
<td>148.4</td>
<td>148.2</td>
</tr>
<tr>
<td><strong>Expenditure</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pay Costs</td>
<td>(107.4)</td>
<td>(107.4)</td>
<td>(108.2)</td>
</tr>
<tr>
<td>Non-Pay Costs</td>
<td>(61.1)</td>
<td>(61.8)</td>
<td>(59.8)</td>
</tr>
<tr>
<td>Total Expenditure</td>
<td>(168.5)</td>
<td>(169.2)</td>
<td>(168.0)</td>
</tr>
<tr>
<td><strong>EBITDA</strong></td>
<td>(21.5)</td>
<td>(20.8)</td>
<td>(19.8)</td>
</tr>
<tr>
<td>Depreciation</td>
<td>(3.4)</td>
<td>(3.4)</td>
<td>(3.4)</td>
</tr>
<tr>
<td>PDC</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Financing Costs</td>
<td>(1.4)</td>
<td>(0.9)</td>
<td>(1.0)</td>
</tr>
<tr>
<td><strong>Net Surplus / (Deficit) pre QIPP</strong></td>
<td>(26.2)</td>
<td>(25.1)</td>
<td>(24.2)</td>
</tr>
<tr>
<td><strong>QIPP Requirement</strong></td>
<td>6.0</td>
<td>6.0</td>
<td>5.0</td>
</tr>
<tr>
<td><strong>Net Surplus / (Deficit) post QIPP</strong></td>
<td>(20.2)</td>
<td>(19.1)</td>
<td>(19.2)</td>
</tr>
<tr>
<td><strong>Control Total</strong></td>
<td>(20.2)</td>
<td>(20.2)</td>
<td>(19.2)</td>
</tr>
</tbody>
</table>
4.0 **Progress required before the final Annual Plan submission**

4.1 The Trust is negotiating block contracts with its main commissioner, Eastern Cheshire CCG, and aiming for the same with the Staffordshire and Derbyshire CCGs for 2018/19. These should be signed before the final plan submission on 30th April 2018.

4.2 Focus is required to further develop deliverable QIPP schemes. It is envisaged that productivity gains will support this process and be informed by the Model Hospital information.

5.0 **Budget Assumptions**

5.1 **Service changes**

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

- Health visiting services transferred to another service provider in October 2017. Both income and expenditure have been amended accordingly
- The draft plan assumes dental services contract will be extended while discussions with Commissioners continue

5.2 **Basis of the income budgets**

5.2.1 The starting point for the activity plans has been 2017/18 forecast outturn based on Month 10. Detailed conversations with the Directorates involving Associate Directors, Service Managers, Deputy Director of Operations and Finance 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 2017/18 activity is sustainable, with reference to GP referral demand, commissioning intentions, service reconfigurations, and known service and staffing changes.

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, with an allowance in the plan for small variations due to staff experience levels.

5.3.2 There has not yet been a formal announcement regarding a 2018/19 Agenda for Change pay award, however, the plan assumes a 1% pay award payable to all staff and that is the amount included in tariff. 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 2018/19.

5.3.3 The financial plan allows for inflation in drugs prices. The plan also allows for £6.2m of both expenditure and income (i.e. pass through drugs as it is received directly from Commissioners) for high cost drugs.

5.3.4 It also allows for specific contract inflation such as on the ISS contract. The financial plan takes into account the notified £1.87m increase in CNST premiums.

5.4 CQUIN

5.4.1 The Trust will agree the overall CQUIN value within the anticipated block contract. The split between targets or the quarterly profiling of schemes has not yet been agreed. The budget and block contract offer with ECCCG assumes the Trust will meet the CQUIN targets.

5.5 Residual overspending risks

5.5.1 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 2018/19 budget-setting process. As such budget holders are expected to deal with day to day pressures arising as part of their budgetary management processes or develop an additional local QIPP to fund these.

5.5.2 The financial plan does not build in any further provision for winter, as this would require additional QIPP to be delivered and increasing this above the £5m was not considered deliverable.

6.0 QIPP targets for 2018/19

6.1 The East Cheshire Trust QIPP target for 2018/19 has been set in the draft planning submissions as £5.0m, which is approximately 3.5% of Trust expenditure. Where there is 2017/18 over achieved or unmet QIPP this has been carried forward to 2018/19. There are some costs which are excluded from QIPP targets such as capital, financing charges, CNST. These targets are shown below:
7.0 **Summary Budgets**

7.1 The summary budgets for each area are provided in the table below. Detailed budgets underpinning these have been signed off by the appropriate budget holder, and a further break-down is included in Appendix 1.

<table>
<thead>
<tr>
<th>Directorate or Corporate Area</th>
<th>Recurrent under/(over) achievement as at month 11 to be carried forward</th>
<th>Remaining QIPP as 2.7% of budget</th>
<th>Revised QIPP target based on allocation plus carried forward</th>
<th>Amended target based on increase to contract income</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£m</td>
<td>£m</td>
<td>£m</td>
<td>£000s</td>
</tr>
<tr>
<td>Acute &amp; Integrated Community Care</td>
<td>0.53</td>
<td>1.26</td>
<td>1.78</td>
<td>1.30</td>
</tr>
<tr>
<td>Allied Health &amp; Clinical Support Services</td>
<td>0.16</td>
<td>0.78</td>
<td>0.99</td>
<td>0.74</td>
</tr>
<tr>
<td>Planned Care Services</td>
<td>0.47</td>
<td>0.98</td>
<td>1.43</td>
<td>1.06</td>
</tr>
<tr>
<td>Chief Executive</td>
<td>0.00</td>
<td>0.04</td>
<td>0.04</td>
<td>0.04</td>
</tr>
<tr>
<td>Corporate Affairs &amp; Governance</td>
<td>(0.01)</td>
<td>0.04</td>
<td>0.04</td>
<td>0.04</td>
</tr>
<tr>
<td>Facilities &amp; Estates</td>
<td>0.12</td>
<td>0.31</td>
<td>0.43</td>
<td>0.43</td>
</tr>
<tr>
<td>Finance, BSU, Information and Clinical Coding</td>
<td>(0.00)</td>
<td>0.10</td>
<td>0.10</td>
<td>0.10</td>
</tr>
<tr>
<td>Human Resources</td>
<td>(0.00)</td>
<td>0.12</td>
<td>0.12</td>
<td>0.12</td>
</tr>
<tr>
<td>Information Mgt and Tech</td>
<td>0.04</td>
<td>0.08</td>
<td>0.10</td>
<td>0.10</td>
</tr>
<tr>
<td>Nursing Performance &amp; Quality</td>
<td>(0.01)</td>
<td>0.07</td>
<td>0.06</td>
<td>0.06</td>
</tr>
<tr>
<td>Trustwide</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>1.00</td>
</tr>
<tr>
<td><strong>Net Surplus/ Deficit</strong></td>
<td><strong>1.23</strong></td>
<td><strong>3.77</strong></td>
<td><strong>5.00</strong></td>
<td><strong>5.00</strong></td>
</tr>
<tr>
<td><strong>QIPP as % of budget</strong></td>
<td><strong>0.9%</strong></td>
<td><strong>2.7%</strong></td>
<td><strong>3.5%</strong></td>
<td><strong>3.5%</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 2018/19 budgets.

Mark Ogden  
Director of Finance  
22nd March 2018
Appendix 1: Directorate budgets

**Acute & Integrated Community Care Budget 2018/19**

<table>
<thead>
<tr>
<th>Category</th>
<th>WTE</th>
<th>£m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contract income</td>
<td></td>
<td>62.98</td>
</tr>
<tr>
<td>Expenditure:</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>118.2</td>
<td>11.99</td>
</tr>
<tr>
<td>Nursing Qualified</td>
<td>408.9</td>
<td>19.18</td>
</tr>
<tr>
<td>Nursing Unqualified</td>
<td>206.6</td>
<td>5.89</td>
</tr>
<tr>
<td>Scientific, Therapeutic &amp; Technical</td>
<td>1.0</td>
<td>0.05</td>
</tr>
<tr>
<td>Senior Manager</td>
<td>5.8</td>
<td>0.42</td>
</tr>
<tr>
<td>Admin &amp; Clerical bands 1 - 8</td>
<td>84.3</td>
<td>2.52</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>0.0</td>
<td>0.71</td>
</tr>
<tr>
<td>Agency</td>
<td>0.0</td>
<td>0.36</td>
</tr>
<tr>
<td>Non pay</td>
<td></td>
<td>8.02</td>
</tr>
<tr>
<td>Grand Total Expenditure</td>
<td>824.8</td>
<td>49.16</td>
</tr>
</tbody>
</table>

**Contract income Plan FY 2018/19**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>£m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accident &amp; Emergency</td>
<td>8.61</td>
</tr>
<tr>
<td>Cardiac Rehab</td>
<td>0.19</td>
</tr>
<tr>
<td>Cardiology</td>
<td>2.10</td>
</tr>
<tr>
<td>Clinical Neurophysiology</td>
<td>0.06</td>
</tr>
<tr>
<td>Community Medicine</td>
<td>0.12</td>
</tr>
<tr>
<td>Community Paediatrics</td>
<td>0.77</td>
</tr>
<tr>
<td>Critical Care Medicine</td>
<td>2.76</td>
</tr>
<tr>
<td>Endocrinology</td>
<td>0.27</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>5.81</td>
</tr>
<tr>
<td>General Medicine</td>
<td>15.01</td>
</tr>
<tr>
<td>Genito-Urinary Medicine</td>
<td>0.49</td>
</tr>
<tr>
<td>Geriatric Medicine</td>
<td>0.05</td>
</tr>
<tr>
<td>Intermediate Care</td>
<td>5.10</td>
</tr>
<tr>
<td>Neonatology</td>
<td>0.87</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>4.60</td>
</tr>
<tr>
<td>Palliative Medicine</td>
<td>0.17</td>
</tr>
<tr>
<td>Respiratory Medicine</td>
<td>2.33</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>2.43</td>
</tr>
<tr>
<td>Block contracts</td>
<td>11.22</td>
</tr>
<tr>
<td>Grand Total</td>
<td>62.98</td>
</tr>
</tbody>
</table>
### Allied Health & Clinical Support Services Budget 2018/19

<table>
<thead>
<tr>
<th>Category</th>
<th>WTE £m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contract income</td>
<td>19.09</td>
</tr>
<tr>
<td>Expenditure:</td>
<td></td>
</tr>
<tr>
<td>Direct credit income</td>
<td>(3.49)</td>
</tr>
<tr>
<td>Pay Substantive:</td>
<td></td>
</tr>
<tr>
<td>Medical (including locum)</td>
<td>18.5</td>
</tr>
<tr>
<td>Nursing Qualified</td>
<td>41.7</td>
</tr>
<tr>
<td>Nursing Unqualified</td>
<td>33.2</td>
</tr>
<tr>
<td>Scientific, Therapeutic &amp; Technical</td>
<td>237.6</td>
</tr>
<tr>
<td>Senior Manager</td>
<td>7.8</td>
</tr>
<tr>
<td>Admin &amp; Clerical bands 1 - 8</td>
<td>280.6</td>
</tr>
<tr>
<td>Pay - temporary:</td>
<td></td>
</tr>
<tr>
<td>Bank</td>
<td>0.0</td>
</tr>
<tr>
<td>Agency</td>
<td>0.0</td>
</tr>
<tr>
<td>Non pay</td>
<td>14.06</td>
</tr>
<tr>
<td><strong>Grand Total Expenditure</strong></td>
<td><strong>619.4</strong></td>
</tr>
</tbody>
</table>

### Contract income Plan FY 2018/19

<table>
<thead>
<tr>
<th>Specialty</th>
<th>£m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audiology</td>
<td>0.71</td>
</tr>
<tr>
<td>Breast Screening</td>
<td>1.13</td>
</tr>
<tr>
<td>Clinical Haematology</td>
<td>4.31</td>
</tr>
<tr>
<td>Clinical Oncology</td>
<td>0.01</td>
</tr>
<tr>
<td>Dental</td>
<td>1.32</td>
</tr>
<tr>
<td>Diagnostic Imaging</td>
<td>3.95</td>
</tr>
<tr>
<td>Dietetics</td>
<td>0.01</td>
</tr>
<tr>
<td>MDT</td>
<td>0.28</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>0.18</td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>1.47</td>
</tr>
<tr>
<td>Speech And Language Therapy</td>
<td>0.48</td>
</tr>
<tr>
<td>Block contracts</td>
<td>5.23</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>19.09</strong></td>
</tr>
</tbody>
</table>
### Planned Care Budget 2018/19

<table>
<thead>
<tr>
<th>Category</th>
<th>WTE</th>
<th>£m</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Contract income</strong></td>
<td></td>
<td>47.93</td>
</tr>
<tr>
<td><strong>Expenditure:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Direct credit income</td>
<td></td>
<td>(0.26)</td>
</tr>
<tr>
<td>Pay Substantive:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical (including locum)</td>
<td>110.6</td>
<td>11.95</td>
</tr>
<tr>
<td>Nursing Qualified</td>
<td>212.3</td>
<td>9.92</td>
</tr>
<tr>
<td>Nursing Unqualified</td>
<td>121.6</td>
<td>3.46</td>
</tr>
<tr>
<td>Scientific, Therapeutic &amp; Technical</td>
<td>3.4</td>
<td>0.22</td>
</tr>
<tr>
<td>Senior Manager</td>
<td>7.0</td>
<td>0.48</td>
</tr>
<tr>
<td>Admin &amp; Clerical bands 1 - 8</td>
<td>82.2</td>
<td>2.48</td>
</tr>
<tr>
<td>Pay - temporary:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bank</td>
<td>0.0</td>
<td>0.38</td>
</tr>
<tr>
<td>Agency</td>
<td>0.0</td>
<td>0.62</td>
</tr>
<tr>
<td>Non pay</td>
<td></td>
<td>8.79</td>
</tr>
<tr>
<td><strong>Grand Total Expenditure</strong></td>
<td></td>
<td>537.1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>38.05</td>
</tr>
</tbody>
</table>

### Contract income Plan FY 2018/19

<table>
<thead>
<tr>
<th>Specialty</th>
<th>£m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Surgery</td>
<td>1.97</td>
</tr>
<tr>
<td>Colorectal Surgery</td>
<td>0.11</td>
</tr>
<tr>
<td>ENT</td>
<td>1.03</td>
</tr>
<tr>
<td>General Surgery</td>
<td>7.69</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>2.96</td>
</tr>
<tr>
<td>Obstetrics</td>
<td>8.19</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>4.92</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>2.03</td>
</tr>
<tr>
<td>Orthodontics</td>
<td>0.07</td>
</tr>
<tr>
<td>Orthoptics</td>
<td>0.11</td>
</tr>
<tr>
<td>Pain Management</td>
<td>0.28</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>0.16</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>12.62</td>
</tr>
<tr>
<td>Urology</td>
<td>0.90</td>
</tr>
<tr>
<td>Vascular Surgery</td>
<td>0.23</td>
</tr>
<tr>
<td>Block contracts</td>
<td>4.67</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td>47.93</td>
</tr>
</tbody>
</table>
Corporate & Trust Wide Services Budget 2018/19

<table>
<thead>
<tr>
<th>Directorate</th>
<th>WTE</th>
<th>Contract income</th>
<th>Pay</th>
<th>Non-pay</th>
<th>Direct credit income</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Business Support Unit</td>
<td>3.85</td>
<td>0.00</td>
<td>0.26</td>
<td>0.00</td>
<td>0.00</td>
<td>0.27</td>
</tr>
<tr>
<td>Chief Executive</td>
<td>6.28</td>
<td>0.00</td>
<td>1.30</td>
<td>0.18</td>
<td>0.00</td>
<td>1.49</td>
</tr>
<tr>
<td>Corporate Affairs &amp; Governance</td>
<td>39.84</td>
<td>0.00</td>
<td>1.41</td>
<td>7.63</td>
<td>(0.37)</td>
<td>8.68</td>
</tr>
<tr>
<td>Facilities &amp; Estates</td>
<td>44.81</td>
<td>0.00</td>
<td>1.89</td>
<td>10.83</td>
<td>(1.07)</td>
<td>11.66</td>
</tr>
<tr>
<td>Finance, Information &amp; Clinical Coding</td>
<td>67.27</td>
<td>0.00</td>
<td>2.76</td>
<td>5.92</td>
<td>(0.59)</td>
<td>8.20</td>
</tr>
<tr>
<td>Human Resources</td>
<td>92.36</td>
<td>0.00</td>
<td>3.83</td>
<td>1.35</td>
<td>(0.31)</td>
<td>4.87</td>
</tr>
<tr>
<td>Information Mgt and Tech</td>
<td>3.15</td>
<td>0.00</td>
<td>0.18</td>
<td>2.03</td>
<td>0.00</td>
<td>2.20</td>
</tr>
<tr>
<td>Nursing Performance &amp; Quality</td>
<td>39.87</td>
<td>1.64</td>
<td>1.96</td>
<td>0.91</td>
<td>(0.02)</td>
<td>2.86</td>
</tr>
<tr>
<td>Trustwide</td>
<td>0.00</td>
<td>9.82</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td>297.43</td>
<td>11.46</td>
<td>13.60</td>
<td>28.87</td>
<td>(2.36)</td>
<td>40.21</td>
</tr>
</tbody>
</table>

Contract income mainly consists of sustainability and transformation funding, health education funds, continence, safeguarding and tissue viability block contracts.
<table>
<thead>
<tr>
<th><strong>Report of:</strong></th>
<th>Mark Ogden, Director of Finance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Responsible Officer:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Accountable Officer:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Author of Report:</strong></td>
<td>Julia Cazalet, Associate Director - QIPP</td>
</tr>
<tr>
<td><strong>Subject/Title</strong></td>
<td>Implementation of Lord Carters Recommendations for Delivering Improved Productivity</td>
</tr>
<tr>
<td><strong>Background papers (if relevant)</strong></td>
<td>Operational productivity and performance in English NHS acute hospitals: Unwarranted variations An independent report for the Department of Health by Lord Carter of Coles. Estates Strategy Update November 2017</td>
</tr>
<tr>
<td><strong>Purpose of Paper</strong></td>
<td>To update the Board on the progress made by ECT over the last twelve months in delivering the recommendations contained within the report by Lord Carter on improving operational productivity.</td>
</tr>
<tr>
<td><strong>Action/Decision required</strong></td>
<td>To note</td>
</tr>
<tr>
<td><strong>Mitigates Risk Number:</strong></td>
<td>BAF 7</td>
</tr>
<tr>
<td><strong>On Assurance Framework</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Link to Care Quality Commission Domain</strong></td>
<td>Choose one of the following: Safe Effective Well-lead</td>
</tr>
<tr>
<td><strong>Link to:</strong></td>
<td>Continuously improve quality, safety and the patient experience Achieving financial sustainability</td>
</tr>
<tr>
<td>➢ Trust’s Strategic Direction</td>
<td></td>
</tr>
<tr>
<td>➢ Corporate Objectives</td>
<td></td>
</tr>
<tr>
<td><strong>Legal implications - (identify)</strong></td>
<td>None currently identified</td>
</tr>
<tr>
<td><strong>Impact on quality</strong></td>
<td>Continuously improve quality, safety and the patient experience</td>
</tr>
<tr>
<td><strong>Resource impact</strong></td>
<td>Impact on expenditure. Management, clinical and administrative resource to address the actions.</td>
</tr>
<tr>
<td><strong>Impact of equality/diversity</strong></td>
<td>NIL</td>
</tr>
</tbody>
</table>
| Avoid acronyms or abbreviations - if necessary list: | GIRFT – Get it Right First Time initiative  
HPTP – Hospital Pharmacy Transformation Plan  
LDS – Local Delivery System  
PQAD - Pathology Quality Assurance Dashboard |

Chairman: Lynn McGill  
Chief Executive: John Wilbraham
Implementation of Lord Carter’s recommendations for delivering increased productivity

The report below provides the annual update on the Trust’s response to the recommendations made in Lord Carter’s report on operational productivity in the NHS. It highlights where the Trust has used the model hospital to identify areas of opportunity and the extent to which implementation of the recommendations has supported improvements in efficiency or productivity.

1 Introduction

The Carter report identifies the level of productivity opportunity available to the NHS if level of variation were reduced such that at a granular level all trusts achieved the performance of the average trust.

The report sets out a series of recommendations which it states are all required to deliver the productivity opportunity identified by the review.

The Trust began to actively engage the model hospital and took steps to deliver the Carter recommendations during the early part of 2016/17 financial year.

A number of these relied on initiating activities by the NHSI and in several cases there was slippage on the timescales for delivering this. At the beginning of this financial year there was significant progress made on many of these recommendations.

The report below describes the actions taken in the last financial year. However the information immediately below relates to the prior year which is the latest currently available within the model hospital.

2 Productivity in 2016/17

A large aspect of the model hospital data is based on reference costs. The 2016/17 update of the reference costs data has been released in stages between December and the current period.
Analysis of the three years of data held in the model hospital indicated a deterioration in ECT productivity between 2014/15 and 2016/17 (Appendix 1). Whilst the national mean cost per weighted activity unit stayed almost unchanged across the three years, ECT clinical output fell and cost per weighted activity unit rose.

3 Implementation of the recommendations in 2017/18

Since 2016/17, the Trust has made significant progress on a number of recommendations and the report sets out the way in which they have or are expected to impact on the productivity of the organisation. The remainder of this section highlights progress on these.

3.1 National People Strategy

The national workforce strategy has been issued as a consultation document which ends on 23rd March 2018. This will be reviewed once the final strategy has been published.

To support development of management practices to gain a better understanding of the reasons for levels of staff attrition, the Trust has been selected to participate in the NHSI retention programme in June 2018, led by the Deputy Director of Nursing.

Actions already taken to further effective planning and management of transformational change include:

- drafting of a leadership development programme, due for launch in April 2018
- ‘Bullying and Harassment’ group established with key members including staff side and freedom to speak up lead
- succession planning process in place at Executive and Deputy levels
- roll out of succession planning to senior manager and medical consultant level
- establishment of a policy framework to ensure that all policies are reviewed and updated on time
- provision of detailed sickness information to directorates; targeted sickness absence work is underway for hot spot areas with high sickness
rates.

3.2 Analysing Staff Deployment

The Trust is implementing systems and processes which support increased visibility of staff deployment.

The Trust continues to capture and report on nursing care hours per patient day and e-rostering is key to this. The position shows that combined nursing care hours per patient day are above the national mean, comprising a higher than average use of unregistered staff and a slightly lower than average use of registered staff.

There has been an increased focus on medical deployment. An E-job planning system has been implemented and is being utilised in the current job planning round. The clinical director is involved in medical deployment meetings as part of the process for approval of annual and study leave. The annual leave policy is undergoing a review process to support consistency across the workforce.

The Trust has access to a medical bank to support the management of vacancies. Weekly clinical deployment meetings are held to review agency rates and rates negotiated with agencies on an individual basis. These have reduced the agency spend at a greater rate than the national mean. Expenditure on agency continues to be below our maximum target.

3.3 Hospital Pharmacy Transformation Programme

ECT has been working with the GM hospital pharmacy transformation collaborative.

The Trust has been involved in the following work streams:

- Aseptics - a review of the capacity across GM&ECT, producing a catalogue of products, looking at infrastructure. This work has been superseded by a national aseptic review being led by the Specialist Pharmacy Services
- Workforce – on-going review to see what duplication of roles there are within trusts (e.g. education & training) and if this can be streamlined
- Stores – significant piece of work being undertaken around this looking at having potentially a single central store to serve all trusts. An Outline Business Case has been developed and the collaborative is now aiming to progress towards a final Business
case. These pieces of work are expected to release QIPP through staff savings in 2018/19.

The utilisation of benchmarking data from the model hospital supports an increase in the pace of plans to switch to biosimilar treatments, deriving savings for the health economy as a whole.

### 3.4.1 Pathology

Lord Carter’s recommendations included the introduction of a Pathology Quality Assurance Dashboard (PQAD) hosted by NHSI to provide assurance that the pathology services provided are of appropriate quality and safety. At March 2018, Cheshire pathology services scored on the 16 indicator references as follows:

- 8 indicator references - fully compliant
- 6 indicator references - partially compliant
- 2 indicator references – not compliant

However, Cheshire Pathology Services has full UKAS accreditation for all departments across both sites, indicating a high quality and safe service.

A national directive was received from NHSI during September 2017 to develop a pathology network between University Hospital of North Midlands, Mid Cheshire Hospitals NHS Foundation Trust and East Cheshire NHS Trust. At a steering group meeting in February it was decided that the network were to look at short, medium and long term plans to achieve the £1.5m savings proposed by NHSI.

For short-term plans, workgroups from each pathology speciality are currently identifying cost savings for any potential ‘quick-wins’ which may include send away tests being repatriated to one of the sites within the network. The steering group will then decide on the next steps for medium and long term plans. It will also review risks such as possible I.T. investment requirements to facilitate further networking.

### 3.4.2 Imaging
The Trust is awaiting the outcome of productivity benchmarking for imaging services.

NHSI have been developing imaging metrics that describe relative departmental productivity related to the use of equipment and workforce activity. The Trust completed a detailed data collection on radiology spend, activity, workforce and asset base and is awaiting feedback and benchmarking information.

The Trust is a member of the Cheshire & Merseyside radiology five year forward view programme, which is exploring the potential opportunity for partnership working particularly in areas such as out of hours reporting. It should be noted that the Trust is currently engaged in joint procurement with Greater Manchester for a replacement PACs.

### 3.5 Procurement

The Trust continues to implement the procurement transformation plan. The submission of Procurement Purchasing Information Benchmark (PPIB) data is ongoing. Purchase order data is submitted monthly and this data is used to benchmark the price paid for key items and support negotiation of reduced prices. In 2017/18 there have been a number of examples of effective price reduction achieved by procurement which have been used to offset price rises within directorate budgets.

In line with Carter recommendations, ECT is working on collaborative savings with other trusts through the development of aggregate sourcing work plans. The Trust’s detailed work plan will be in place by May 2018.

During 2017/18 ECT has been monitoring its performance against prescribed model hospital procurement metrics, with the majority of these currently scoring as green or amber against target.

The service is working with NHS Supply Chain to install an electronic demand capture (EDC) ‘Gold Inventory Management’ system into key areas across the Trust to support effective system control and compliance with an expected completion date of March 2019. The development of staff capacity has been supported by achievement of level 1 accreditation of the NHS Standards of Procurement in October 2017, with a view to achievement of level 2 accreditation by October 2018.
3.6 Operational Productivity – Estates and Facilities

ECT is using benchmarking data from the model hospital to review its estates and facilities provision.

The Trust has utilised the model hospital to benchmark its operational productivity. The Trust generally performs well against model hospital metrics relating to the estate.

In 2017/18 savings have been achieved in utilities. There are potentially some opportunities for savings in the provision of facilities and ECT is in the early stages of discussions with other NHS Trusts to explore whether it would be beneficial to undertake a joint procurement of contracts and services. The findings from the model hospital have been presented in more detail as part of the Estate Strategy update to the Board.

3.7 Corporate and Administration Functions

Benchmarking indicates that ECT corporate services are high cost.

ECT currently benchmarks poorly for the cost per £100m of trust turnover. The Trust will review all its back office functions with a view to benefits to be obtained from collaborative working. In 2018/19 the Trust is switching its payroll provision from Shared Business Services (SBS) to Countess of Chester Hospital (COCH) to achieve better value. It has brought its human resources provision back in-house to avoid sharp increases in cost and will develop a revised lower cost provision. A number of other corporate functions have or are due to be restructured to move the organisation closer to comparator benchmarks.

3.8 Joint Clinical Governance

Operational pressures are impacting on the Trusts ability to implement the “Get it right first time” (GIRFT) standards.

During the course of the year, the Trust has hosted sessions on GIRFT by Professor Briggs in which he highlighted the impact of unwarranted variation on orthopaedic operational productivity and quality of care including aspects such as numbers of joints undertaken on all day lists, price variance on identical prosthetics and the importance of minimising surgical infection rates to support high quality, lower cost care.

Clinicians identified the desirability of implementing the proposals, although highlighting that the prioritisation of emergency non elective provision impacted on their ability to benchmark favourably against national
standards.

The national general surgery report and the vascular surgery report have been issued. The GIRFT programme of work includes 35 surgical and medical specialties of which 25 have commenced, along with 6 cross cutting work streams.

3.9 Digital Information Systems

Carter recommended that all trusts should have certain key digital information systems in place, fully integrated and utilised by October 2018.

The Trust has had some of these systems in place during 2017/18 and these are set out below. The Trust continues to develop its digital maturity with the introduction of further digital clinical support systems in 2018/19.

<table>
<thead>
<tr>
<th>Requirement for implementation by October 2018</th>
<th>On target</th>
<th>Significant risk to achievement</th>
</tr>
</thead>
<tbody>
<tr>
<td>e-Rostering</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>e-Prescribing</td>
<td>×</td>
<td></td>
</tr>
<tr>
<td>Radio Frequency Identification (RFID)</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Patient level costing and accounting</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>e-Catalogue and inventory for procurement</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>Electronic Health Record - community</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>Electronic Health Record - acute</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

3.10 Local Government Representatives

The Trust has a fully integrated discharge service in place working collaboratively with social care to proactively manage patients with complex needs to help prevent delayed transfers of care. The Integrated Discharge Team has permission to spot purchase care home facilities as part of the discharge process. This supports care in the most appropriate setting and facilitates productive use of acute hospital beds. The CCG has made a significant increased investment in this area over winter which resulted in a large reduction in the number of delayed transfers of care (DTOCs)
3.11 Trust Board

...and collaborating across the health economy to meet the clinical needs of the community.

The Trust Board has identified that ECT needs to work with partners to identify the best models of care going forward. This work is under the remit of the Central and Eastern Cheshire Partnership Board under the Health and Care Partnership, Cheshire and Merseyside. Over time this work is expected to generate quality and efficiency opportunities.

3.12 The Model Hospital

Clinicians and managers are engaging with the model hospital initiative.

Over the last twelve months, managers and clinicians within the Trust have increasingly engaged with the model hospital as a source of information on potential opportunities for efficiency. Additional reporting at specialty level and the increasing richness of data including quality indicators has enhanced its relevance. The model hospital has been presented at a range of forums to clinicians and managers; and staff have accessed webinars provided by the NHSI operational productivity team. Clinicians and managers are reviewing the benchmarked data to identify potential opportunities to improve the metrics for their service.

The model hospital has reinforced the work undertaken on outpatient productivity through its reflection of opportunity in outpatients across the Trust.

3.13 Implementing the recommendations

The Trust is progressing well with the implementation of the recommendations made by Carter.

The majority of the recommendations within the control of the Trust have either been implemented or there is a dated action plan by when activities will commence. For specific proposals such as those requiring IT investment, there is no short term prospect of the recommendation happening. The Trust is increasingly beginning to utilise the results to make changes which genuinely impact on productivity.

4 Conclusions

...but many of these are enablers and still require changes to Trust practice to deliver better productivity.

The benchmarking information contained within the model hospital has highlighted the extent to which ECT is an outlier in terms of productivity. Benchmarking data
indicates that there are opportunities to improve the cost profile of the organisation in its current organisational form. But implementation of the recommendations do not achieve this in their own right. They are an enabler for delivering productivity through improved deployment of staff and resources.

### 4.2

This will continue to result in some areas not benchmarking favourably as the benefits of economies of scale cannot be realised in both clinical and corporate areas. But even in that context, ECT is relatively high cost or low productivity compared to other small hospitals. The focus on 2018/19 is on increasing productivity, i.e. delivering more within the existing capacity, particularly the elective and outpatient areas.

### 4.3

The agreement of a block contract minimises the opportunity for improving sustainability through additional income generation; the focus must be on reducing cost and increasing productivity. In line with its developing clinical strategy, ECT has assessed that some of these opportunities can only be fully realised by working collaboratively with other partners to achieve economies of scale and support a critical mass of expertise.

### 5 RECOMMENDATION

The Board is asked to note the contents of this report.
## Appendix A

### East Cheshire Cost per WAU in Comparison with the National Mean between 2014/15 and 2016/17

<table>
<thead>
<tr>
<th></th>
<th>Cost per Weighted Activity Unit (WAU)</th>
<th>Annual output in Weighted Activity Units</th>
<th>Productivity Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ECT</td>
<td>National Median</td>
<td>Variance</td>
</tr>
<tr>
<td>14/15</td>
<td>£3,598</td>
<td>£3,487</td>
<td>£111</td>
</tr>
<tr>
<td>15/16</td>
<td>£3,894</td>
<td>£3,484</td>
<td>£410</td>
</tr>
<tr>
<td>16/17</td>
<td>£3,938</td>
<td>£3,480</td>
<td>£458</td>
</tr>
</tbody>
</table>

### ECT Cost per Weighted Activity Unit (WAU) by category

<table>
<thead>
<tr>
<th>Expenditure Category</th>
<th>14/15</th>
<th>15/16</th>
<th>16/17</th>
<th>% change 2014/15 to 2016/17</th>
<th>14/15</th>
<th>15/16</th>
<th>16/17</th>
<th>% change 2014/15 to 2016/17</th>
<th>ECT Cost per WAU variance to National Mean Cost per WAU</th>
<th>Net % variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>371</td>
<td>392</td>
<td>450</td>
<td>21.3%</td>
<td>523</td>
<td>517</td>
<td>526</td>
<td>0.6%</td>
<td>-152</td>
<td>-125</td>
</tr>
<tr>
<td>Nursing</td>
<td>945</td>
<td>933</td>
<td>938</td>
<td>-0.7%</td>
<td>730</td>
<td>710</td>
<td>718</td>
<td>-1.6%</td>
<td>215</td>
<td>223</td>
</tr>
<tr>
<td>AHP</td>
<td>284</td>
<td>298</td>
<td>246</td>
<td>-13.4%</td>
<td>123</td>
<td>122</td>
<td>127</td>
<td>3.3%</td>
<td>161</td>
<td>176</td>
</tr>
<tr>
<td>Healthcare Science</td>
<td>107</td>
<td>102</td>
<td>113</td>
<td>5.6%</td>
<td>159</td>
<td>152</td>
<td>153</td>
<td>-3.8%</td>
<td>-52</td>
<td>-50</td>
</tr>
<tr>
<td>Agency</td>
<td>175</td>
<td>234</td>
<td>143</td>
<td>-18.3%</td>
<td>149</td>
<td>163</td>
<td>137</td>
<td>-8.1%</td>
<td>26</td>
<td>71</td>
</tr>
<tr>
<td>Other</td>
<td>200</td>
<td>195</td>
<td>230</td>
<td>15.0%</td>
<td>120</td>
<td>122</td>
<td>131</td>
<td>9.2%</td>
<td>80</td>
<td>73</td>
</tr>
<tr>
<td>Supplies and Services</td>
<td>474</td>
<td>493</td>
<td>397</td>
<td>-16.2%</td>
<td>386</td>
<td>381</td>
<td>375</td>
<td>-2.8%</td>
<td>88</td>
<td>112</td>
</tr>
<tr>
<td>Medicines</td>
<td>183</td>
<td>230</td>
<td>369</td>
<td>101.6%</td>
<td>298</td>
<td>312</td>
<td>320</td>
<td>7.4%</td>
<td>-115</td>
<td>-82</td>
</tr>
<tr>
<td>Corporate and Estates</td>
<td>342</td>
<td>343</td>
<td>379</td>
<td>10.8%</td>
<td>357</td>
<td>343</td>
<td>352</td>
<td>-1.4%</td>
<td>-15</td>
<td>0</td>
</tr>
<tr>
<td>Premises, Establishment and Ser</td>
<td>222</td>
<td>242</td>
<td>285</td>
<td>28.4%</td>
<td>187</td>
<td>183</td>
<td>184</td>
<td>-1.6%</td>
<td>35</td>
<td>59</td>
</tr>
<tr>
<td>CNST</td>
<td>144</td>
<td>190</td>
<td>205</td>
<td>42.4%</td>
<td>127</td>
<td>146</td>
<td>161</td>
<td>26.8%</td>
<td>17</td>
<td>44</td>
</tr>
<tr>
<td>Dpn</td>
<td>54</td>
<td>62</td>
<td>62</td>
<td>0%</td>
<td>96</td>
<td>90</td>
<td>90</td>
<td>0%</td>
<td>0</td>
<td>-42</td>
</tr>
<tr>
<td>Other</td>
<td>185</td>
<td>122</td>
<td>111</td>
<td>15.0%</td>
<td>111</td>
<td>116</td>
<td>116</td>
<td>0%</td>
<td>0</td>
<td>74</td>
</tr>
<tr>
<td>Total</td>
<td>3,447</td>
<td>3,891</td>
<td>3,939</td>
<td></td>
<td>3,159</td>
<td>3,358</td>
<td>3,390</td>
<td></td>
<td>288</td>
<td>533</td>
</tr>
</tbody>
</table>

Variance in 2014/15 arises due to exclusion of Depreciation and Other in this year.
The productivity unit have noted that variance arises between the national mean by expenditure category and the national mean for cost per weighted activity unit through calculation methods used.
**Report of:**

**Responsible Officer:**

**Accountable Officer:**

| Medical Director |

**Author of Report:**

Dr John Hunter, Medical Director

Andy Chambers, Head of Safety, Risk and Resilience

**Subject/Title**

Learning from Deaths – Quarterly Mortality Report

**Background papers (if relevant)**

N/A

**Purpose of Paper**

To provide assurance that the trust is learning from deaths and using that learning to support quality improvement

**Action/Decision required**

To note the contents of the report

**Mitigates Risk Number:**

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.

**Link to Care Quality Commission Domain**

Choose one of the following:

- Safe
- Caring
- Effective
- Responsive
- Well led

**Link to:**

➢ Trust’s Strategic Direction

➢ Corporate Objectives

- To ensure our patients receive the best care in the right place
- Commit to quality of care
- Improve lives

**Legal implications -**

None

**Impact on quality**

None

**Resource impact**

None

**Impact of equality/diversity**

None

**Avoid acronyms or abbreviations - if necessary list:**

| SMR | Standardised Mortality Ratio |
| RAMI | Risk Adjusted Mortality Index |
| SHMI | Summary Hospital Mortality Index |
| SBAR | Situation, Background, Assessment, Recommendations |
| RCA | Root Cause Analysis |
The CQC published its report *Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England* in December 2016, making recommendations about how the approach to learning from deaths could be standardised across the NHS. The publication of the *Learning from Deaths* framework placed a number of new requirements on trusts, including an imperative to publish information on deaths, reviews and investigations via a quarterly agenda item and paper to the Public Trust Board. This report includes information on the following:

- Background on measurement of mortality metrics and their utility
- Mortality metrics for the quarter including the mortality dashboard
- Themes identified from the review of deaths
- Actions being undertaken in response to learning

## 1 INTRODUCTION

1.1 The aim of this paper is to provide assurance to the Board of the work underway across the organisation to implement the National Quality Board’s (NQB) National Guidance on Learning from Deaths.

## 2 CONTEXT

2.1 Over the last few years, monitoring deaths in hospital has become a standard part of assessing the performance of our hospitals and the quality of their care.

2.2 There are a number of different ways in which this can be done, the most common of which involves calculating standardised mortality ratios (SMRs).

2.3 Regular examination and better understanding of hospital mortality can potentially improve the way care is delivered by identifying problems with the quality of care and help focus the hospital’s quality improvement work.

2.4 In general terms, the rationale for calculating death rates in hospital is that they can be used to measure hospital quality in some way, and therefore help trusts:

- Reduce mortality rates
- Improve patient safety
- Reduce avoidable variation in care and outcomes

2.5 A hospital mortality ratio is calculated by counting the number of actual (observed) deaths in a trust and comparing it with the number of expected deaths. The difference between the expected number of deaths and the observed number is often called ‘excess deaths’. In this case the word *excess* is a technical term, but is sometimes interpreted by the media as deaths which were avoidable (i.e. that they should not have happened at all), unexpected, or attributable to failing in quality of care. None of these can be directly inferred from an SMR – it can only signal that further investigation
may be required.

2.6 It is likely that the frequency of risk groups (populations grouped by age / gender / diagnoses / admission type / deprivation) vary widely between trusts and local weightings may therefore be very different. While hospital standardised mortality ratios, for example, are valid for comparing trusts to the national average (the standard population) they are less useful for comparing between trusts. This means that ranking hospitals on the basis of their SMRs is misleading.

2.7 Hospitals are required to estimate the number of ‘preventable deaths’ – deaths that were reviewed / investigated and as a result considered more likely than not to be due to problems in care - based on case record reviews of deceased patients. Failing to prevent an avoidable death or, worse, contributing to its occurrence, has obvious intuitive appeal as a basic quality problem. Despite the intuitive appeal of this concept, there are significant limitations to using preventable deaths to gauge the quality and safety of healthcare. First, death is an uncommon outcome for many specialties including obstetrics, psychiatry and surgical specialties such as ophthalmology. Gauging performance with any indicator related to death serves little purpose in these settings and draws attention away from the much larger pool of failures leading to harm that affect patients discharged alive. Relatively small numbers of deaths for many specialties mean that random variation can have a large influence on trends or differences across organisations. Second, nearly a quarter of all NHS hospital admissions are aged over 75 years, and more than 40% of deaths occur in those older than 80 years. Moreover, half the UK population end their lives in hospital, with the actual number varying substantially between hospitals depending on local alternatives for provision of end of life care. Thus, expected deaths as a result of underlying disease account for a large proportion of mortality, making it difficult to identify a signal of preventable deaths due to problems with care. Even when errors of commission or omission do occur, establishing the degree to which healthcare has contributed to death amongst very elderly, frail patients with serious illness and multiple comorbidities towards the end of their natural lifespan and with just days or hours to live is difficult.

2.8 The principal approach to measuring preventable deaths involves detailed retrospective case record review (RCRR) by trained reviewers. This has clinical credibility in terms of taking account the complexity of patients’ conditions and care and indicating whether or not poor care was responsible for any death. However data generated from case record review and investigation, for example estimates of the number of deaths thought more likely than not to be due to problems in care, are subjective and so not useful for making external judgements about the safety of trusts.

2.9 Case record review assessment is finely balanced and subject to significant inter-reviewer variation. It does not support comparison between organisations and should not be used to make external judgements about the quality of care provided.

2.10 Research has shown that when case record review identifies a death that may have been caused by problems in care, that death tends to be due to a series of problems, none of which would be likely to have caused the death in isolation but which in combination can contribute to the death of a patient.
2.11 The largest RCRR study of deaths in England identified a preventable death rate of 3.6% and no significant variation in the proportion of avoidable deaths between hospitals.

3 SITUATION

The trust has a robust mortality governance process.

3.1 The National Guidance on Learning from Deaths: National Quality Board 2017 stipulated that as from April 2017 all NHS trusts and foundation trusts must collect and publish, on a quarterly basis, specified information on deaths, including those that are assessed as more likely than not to be due to problems in care, and evidence of learning and action that is happening as a consequence of this information.

3.2 All patients who die at the trust undergo a two stage retrospective case record review as detailed in the Mortality Policy.

3.3 Reviewers are asked to judge whether there were any problems in care that had contributed to the patient’s death.

3.4 Problems in care are defined as patient harm resulting from acts of omission (inactions such as failure to diagnose and treat according to evidence based guidelines), acts of commission (affirmative action such as incorrect treatment or management) and harm as a result of unintended or unexpected complications of healthcare.

4 MORTALITY DASHBOARD FOR QUARTER

There were no deaths in Quarter 3 that were judged to have been more likely than not to have been due to problems in care.

4.1 During Quarter 3, 203 patients died at the trust. All deaths underwent a two stage retrospective case record review; no deaths were thought to have been avoidable (Appendix 1).

4.2 Two patients with learning disabilities died at the trust during Quarter 3. These deaths were reviewed using LeDeR methodology and found to be unavoidable.

4.3 The average crude mortality for Quarter 3 is 2.1%.

4.4 The standardised mortality ratios for the quarter are as follows:
   - Summary hospital mortality index - 1.05 (as expected range)
   - Risk adjusted mortality index (RAMI) – 82.2

5 OUTCOMES OF REVIEWS

Although the majority of care provided was of high quality, a number of areas for improvement were identified.

5.1 Positive:
   - All deaths of patients with learning disabilities were thoroughly reviewed using the LeDER methodology
   - No deaths were identified as avoidable
   - Good input from the palliative care team
   - Evidence throughout the reviews of good communication with relatives and patients at the end of life
   - No deaths were reported under the serious incidents framework
Improvements required:
- Accuracy of coding could be improved with more robust note keeping
- Gaps in clinical documentation often preclude assessment of whether care bundles (e.g. sepsis) are being followed appropriately
- Inconsistent use of the end of life care plans

6 ACTIONS UNDERWAY IN RESPONSE TO LEARNING

6.1 A new cellulitis pathway was introduced at the trust in December 2017 as recommended by the investigation into the excess mortality associated with skin and soft tissue infections highlighted by the mortality alert from the Dr Foster Unit at Imperial College London.

6.2 The trust has appointed a practice educator and facilitator for end of life care in partnership with the End of Life partnership. The role will facilitate ongoing education surrounding end of life care within the trust which will include support regarding the use of individualised end of life care plan as well as helping to drive the end of life agenda forward within the trust.

6.3 The guidelines and paperwork supporting anticipatory prescribing for patients at the end of life in the community (‘the blue booklet’) have been extensively revised and updated.

6.4 A task and finish group has been convened to review the end of life care pathway. Work commenced in January 2018.

6.5 Additional teaching sessions have been organised for junior doctors to raise awareness of how to document in the notes to assist with accurate clinical coding.

6.6 Clinical coders have been working with a number of consultants to improve clinical coding in their specialty.

6.7 The sepsis group is continually refining the sepsis pathway to optimise the management of patients with suspected sepsis. An inpatient sepsis screening and action tool – which was developed in collaboration with the Colleges and NICE – was rolled out across the trust during November 2017.

7 SUMMARY

7.1 All patient deaths at the hospital are subject to retrospective case record review using a two stage process.

7.2 Lessons learned from these reviews are shared with the teams.

7.3 Recurrent themes identified from the mortality reviews are used to identify areas for quality improvement.
## 8 RECOMMENDATIONS

8.1 The Board is asked to note the contents of this report and be aware of the actions taken to further reduce avoidable harm.

<table>
<thead>
<tr>
<th>Sign off</th>
<th>Dr John Hunter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Role title</td>
<td>Medical Director</td>
</tr>
</tbody>
</table>
Appendix 1 – Learning from Deaths Dashboard

Summary of total number of deaths and total number of deaths reviewed under the Structured Judgement Review Methodology

| Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable (does not include patients with identified learning disabilities) | Time Series: Start date 2017-01 End date 2018-03 Q4 |
|---|---|---|
| Total Number of Deaths in Scope | Total Deaths Reviewed | Total Number of deaths considered to have been potentially avoidable (RCP<3) |
| This Month | Last Month | This Month | Last Month | This Month | Last Month |
| This Quarter (Q1) | Last Quarter | This Quarter (Q1) | Last Quarter | This Quarter (Q1) | Last Quarter |
| This Year (YTD) | Last Year | This Year (YTD) | Last Year | This Year (YTD) | Last Year |

<table>
<thead>
<tr>
<th>Score 1</th>
<th>Score 2</th>
<th>Score 3</th>
<th>Score 4</th>
<th>Score 5</th>
<th>Score 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Defining avoidable</td>
<td>Strong evidence of avoidability</td>
<td>Probably avoidable (more than 50%)</td>
<td>Probably avoidable but not likely</td>
<td>Slight evidence of avoidability</td>
<td>Definitely not avoidable</td>
</tr>
<tr>
<td>This Month</td>
<td>0</td>
<td>0.1%</td>
<td>0</td>
<td>0.1%</td>
<td>0</td>
</tr>
<tr>
<td>This Quarter (Q1)</td>
<td>0</td>
<td>0.1%</td>
<td>0</td>
<td>0.1%</td>
<td>0</td>
</tr>
<tr>
<td>This Year (YTD)</td>
<td>0</td>
<td>0.1%</td>
<td>0</td>
<td>0.1%</td>
<td>0</td>
</tr>
</tbody>
</table>

Total Deaths Reviewed by RCP Methodology Score

Summary of total number of learning disability deaths and total number of deaths reviewed under the LeDeR methodology

| Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable for patients with identified learning disabilities | Time Series: Start date 2017-01 End date 2018-03 Q4 |
|---|---|---|
| Total Number of Deaths in Scope | Total Deaths Reviewed Through the LeDeR Methodology (or equivalent) | Total Number of deaths considered to have been potentially avoidable |
| This Month | Last Month | This Month | Last Month | This Month | Last Month |
| This Quarter (Q1) | Last Quarter | This Quarter (Q1) | Last Quarter | This Quarter (Q1) | Last Quarter |
| This Year (YTD) | Last Year | This Year (YTD) | Last Year | This Year (YTD) | Last Year |

<table>
<thead>
<tr>
<th>Score 1</th>
<th>Score 2</th>
<th>Score 3</th>
<th>Score 4</th>
<th>Score 5</th>
<th>Score 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Defined as avoidable</td>
<td>Indeterminate</td>
<td>Non-avoidable</td>
<td>Indeterminate</td>
<td>Non-avoidable</td>
<td>Definitively non-avoidable</td>
</tr>
<tr>
<td>This Month</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>This Quarter (Q1)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>This Year (YTD)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Report of:</td>
<td>Responsible Officer: Medical Director</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------</td>
<td>--------------------------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Accountable Officer: John Hunter, Medical Director</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subject/Title</td>
<td>An update on the Getting It Right First Time (GIRFT) programme at the trust.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Background papers (if relevant)</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Purpose of Paper</td>
<td>To inform the Board on the GIRFT process and summarise the issues highlighted for the inspected services</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Action/Decision required</td>
<td>To note the contents of the report</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mitigates Risk Number: (identify)</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 and wellbeing of the local population</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mitigates Risk Number: (identify)</td>
<td>On Corporate Risk Register</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mitigates Risk Number: (identify)</td>
<td>On Assurance Framework</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Link to Care Quality Commission Domain</td>
<td>Safe Caring Responsive Effective Well-led</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Link to:</td>
<td>Trust’s Strategic Direction</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Corporate Objectives</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Provide safe effective personal care in the right place. To deliver services that are clinically and financially stable.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Legal implications - (identify)</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Impact on quality</td>
<td>Positive impact on quality</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resource impact</td>
<td>Unquantified</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Impact of equality/diversity</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Avoid acronyms or abbreviations - if necessary list:</td>
<td>GIRFT Getting It Right First Time LOS Length of stay</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Getting It Right First Time (GIRFT) Update

The purpose of the paper is to provide Board members with an update on the Getting It Right First Time (GIRFT) programme and how the trust is engaging in this national initiative to reduce unwarranted variation and improve patient outcomes. This report includes information on the following:

- GIRFT background
- GIRFT methodology
- Key points from recent GIRFT visits

1 INTRODUCTION

Getting It Right First Time (GIRFT) is a national programme designed to improve medical care within the NHS by reducing unwarranted variations. By tackling variations in the way services are delivered across the NHS, and by sharing best practice between trusts, GIRFT identifies changes that will help improve care and patient outcomes, as well as delivering efficiencies such as the reduction of unnecessary procedures and cost savings.

GIRFT is led by frontline clinicians who are expert in the areas they are reviewing. This means the data that underpins the GIRFT methodology is being reviewed by people who understand those disciplines and manage those services on a daily basis. The GIRFT team visit every trust carrying out the specialties they are reviewing, investigating the data with their peers and discussing the individual challenges they face.

GIRFT began as a pilot within orthopaedic surgery led by orthopaedic surgeon Professor Tim Briggs and hosted by NHS Royal National Orthopaedic Hospital Trust (RNOH). Following the success of the pilot the GIRFT methodology was rolled out to more than 30 medical specialties and is now a partnership between the RNOH and the Operational Productivity Directorate of NHS Improvement (NHSI).

There is also widespread unwarranted variation which affects patient outcomes, service costs and overall productivity. In February 2016, Lord Carter’s report on unwarranted variation in acute NHS trusts was published. It highlighted the opportunity to save up to £5bn if unwarranted variation can be tackled and all providers’ cost bases were at the median level.

2 METHODOLOGY

The GIRFT process is set out in Appendix 1. The programme is made up of a series of more than 30 medical work streams, each led by a prominent clinician chosen from the specialty they are reviewing.
with all those concerned with a service – not only clinicians, but also clinical and medical directors, managers and chief executives – and monitors the changes that are implemented.

Each clinician heads a project to compile a data and insight driven report into their specialty, combining publicly available information, including Hospital Episode Statistics (HES), other relevant registry or professional body data, and the results of a questionnaire issued to all the trusts being reviewed. The report will look at a wide range of factors, from length of stay to patient mortality, and individual service costs through to overall budgets.

2.2 A report is produced and issued to every trust being reviewed, which is then followed by a meeting at the trust with medical staff and senior trust managers. At each meeting the clinical leads review the findings with their peers, which provides more context to unwarranted variations and opens up a discussion around individual practice and any challenges the trusts face. It is also an opportunity to share best practice and any solutions that have already helped reduce variations.

2.3 After at least 40 trust reviews have been completed, the clinical lead oversees the creation of a national GIRFT report into their specialty. The report presents the original data, GIRFT’s findings, examples of best practice and suggestions for improvements. To date three national GIRFT reports have been published: orthopaedics (2015), general surgery (2017) and vascular services (2017).

3 KEY POINTS FROM GIRFT VISITS

3.1 To date 4 specialties have been visited by the GIRFT team over the past year: orthopaedics, general surgery, ophthalmology and obstetrics and gynaecology. Engagement has been excellent at all the meetings with consistent presence of senior managers, consultants, nursing staff and the medical director.

Orthopaedics 3.2 Positive Assurance:

- Hip and knee revision rate within expected range
- Elective mortality within expected range
- Length of stay (LOS) for knee replacement significantly lower than national average
- LOS for major shoulder procedures significantly shorter than average
- All surgeons performing well in excess of the minimum number of operations required to maintain their skills
- Emergency readmission rate after surgery within expected range
- Cemented hips only performed on those >70 years of age in line with national guidelines
- Universal agreement amongst surgeons on a limited number of prosthesis which limits variation and reduces cost
- Deep infection rate lower than national average

Areas for Improvement:

- Length of stay for elective hip replacement significantly longer than national average
• Access targets not being met – RTT standard 73%
• Average length of stay for fractured neck of femur significantly higher than average
• 4 elective joint replacements should be performed on an all-day theatre list. 3 or less is currently the norm

**General Surgery**

**Positive Assurance:**
• Significantly lower readmission rate after colorectal surgery
• Mortality rate within expected range
• Stoma reversal rate after anterior resection within expected range
• Colorectal cancer specific mortality rate 2 years after operation within expected range
• Day case cholecystectomy rate significantly higher than national average
• Cholecystectomy rate after admission for pancreatitis or cholecystitis within expected range
• Proportion of patients who received a CT scan which was reported by a consultant radiologist before surgery is significantly higher than average
• Proportion of emergency patients reviewed by consultant within 14 hours of admission in expected range

**Areas for Improvement:**
• Achievement of 18 weeks (87%)
• LOS after elective colonic surgery significantly longer than average
• The proportion of patients in whom a risk assessment was performed pre-operatively is significantly below expected range

**Obstetrics and Gynaecology**

**Positive Assurance:**
• Length of stay for elective gynaecological procedures within expected range
• Very few emergency readmissions
• Rate of spontaneous unassisted vaginal deliveries as expected
• Rate of instrumental delivery within expected range
• Caesarean section rate within expected range
• Obstetric litigation costs per delivery in line with national average
• Gynaecology litigation costs per patient in lowest centile

**Areas for Improvement:**
• Episiotomy rate significantly higher than average

**Ophthalmology**

**Positive Assurance:**
• Reviewers concluded that East Cheshire NHS Trust is a very good provider of ophthalmology services which has undergone extensive development and change over the past 3 years.
• 7 cataract cases per 4 hour list in line with national guidelines
Employment of optometrist and nurse practitioner to release consultant time commended
Good cataract conversion rate of circa 80%
Development of virtual glaucoma clinics
Corneal graft activity and outcomes good
Good relationship between managers and clinicians

Areas for Improvement:
- Significant backlog of patients requiring review
- Coding of cataract procedures
- Utilisation of space for clinics and procedures e.g. some procedures currently being performed in operating theatre which could be performed elsewhere

4 SUMMARY

To date, clinical and managerial engagement in GIRFT has been good.

Clinical and managerial engagement in the GIRFT process has been good.

No major quality or safety issues have been identified by the reviewing teams.

Feedback on the 4 services inspected has been good with no major safety or quality issues identified.

Trust data is uploaded to the Model Hospital portal, which will be the gateway for accessing GIRFT information for all providers and commissioners.

The GIRFT visits/reports are being utilised by the services to reduce unwanted variation and improve care delivery

Name: Dr John Hunter
Job Title: Medical Director
Appendix 1 – The GIRFT Process

THE GIRFT PROCESS

Data, visits and reports
- Reinforce the dashboard
- Mandate collection of data
- Use data to change practice

Return visits
- Re-run GIRFT dataset
- Re-visit all units within speciality
- Meet SMT and clinicians to track deliver

Objective setting
- Agreeing actions for each trust
- Failure to act on data not an option

Providing support
- Supporting trusts to drive change
- Measuring implementation and productivity
<table>
<thead>
<tr>
<th>Report of:</th>
<th>Deputy Director of Corporate Affairs and Governance Director of Corporate Affairs and Governance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responsible Officer</td>
<td>Accountable Officer</td>
</tr>
<tr>
<td>Author of Report:</td>
<td>Head of Integrated Governance</td>
</tr>
<tr>
<td>Subject/Title</td>
<td>Review of Assurance Framework and Corporate Risk Register</td>
</tr>
<tr>
<td>Background papers (if relevant)</td>
<td>Assurance Framework and Corporate Risk Register</td>
</tr>
<tr>
<td>Purpose of Paper</td>
<td>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</td>
</tr>
<tr>
<td>Action/Decision required</td>
<td>The Board is asked to:</td>
</tr>
<tr>
<td></td>
<td>• Review and discuss the content of the Board Assurance Framework and Corporate Risk Register</td>
</tr>
<tr>
<td></td>
<td>• Note the key areas of focus for the next 3 months to reduce the level of risk</td>
</tr>
<tr>
<td></td>
<td>• Confirm that the risks identified are consistent with reported information about the organisation</td>
</tr>
<tr>
<td>Mitigates Risk Number: (identify) On Corporate Risk Register</td>
<td>This paper relates to the Assurance Framework and Corporate Risk Register and therefore is linked to all risks.</td>
</tr>
<tr>
<td>Mitigates Risk Number: (identify) On Assurance Framework</td>
<td></td>
</tr>
<tr>
<td>Link to Care Quality Commission domain</td>
<td>All domains</td>
</tr>
<tr>
<td>Link to:</td>
<td>All Objectives</td>
</tr>
<tr>
<td>Trust’s Strategic Direction</td>
<td>Corporate Objectives</td>
</tr>
<tr>
<td>Legal implications - (identify)</td>
<td>There are no legal implications</td>
</tr>
<tr>
<td>Impact on quality</td>
<td>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</td>
</tr>
<tr>
<td>Resource impact</td>
<td>There are no resource implications</td>
</tr>
<tr>
<td>Impact of equality/diversity</td>
<td>There is no impact on equality/diversity</td>
</tr>
<tr>
<td>Avoid acronyms or abbreviations - if necessary list:</td>
<td>CQC – Care Quality Commission RTT – Referral to Treatment QIPP – Quality, Innovation, Productivity and Prevention ED – Emergency Department STP – Sustainability and transformation plan</td>
</tr>
</tbody>
</table>
Review of Assurance Framework and Corporate Risk Register

This report is to provide the Board with an opportunity to review and discuss the risks contained in 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.

1 INTRODUCTION

1.1 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 2018 to 2019, which was approved by the Board at its January 2018 meeting.

1.2 The Board 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.

1.3 The Audit Committee and Clinical Management Board reviewed the Board Assurance Framework and Corporate Risk Register at their meetings in February 2018

2 STRATEGIC RISKS

The Board approves the Strategic Risks for Each Financial Year

2.1 At the April 2017 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.
The level of risk within the Board Assurance Framework remains unchanged

3.1 The level of risk recorded in the Board Assurance Framework remains unchanged from the previous report. This is in line with the partnership working to support a sustainable local solution. Following review of the framework one gap in control has been closed:

- Assurance Framework for Caring Together not fully embedded

3.1.1 There is one further gap in assurance added since the previous review:

- Annual Clinical Training update below targets and Core Clinical Learning below target – action taken: Additional training capacity and proactive management of bank assignments. Training commitments have been shared with the Deputy Director of Operations and operational leads to review.

The strategic risk scores may not be fully reduced to their optimum score for 2 to 3 years

3.2 Of the five agreed Strategic Risks, three are currently rated high risks and two are rated moderate risks. The table below sets out the expected change of risk scores over time when all strategic actions have been implemented. The focus for the next three months is listed along with the responsible committee/board which have been delegated to monitor each of the risks.

<table>
<thead>
<tr>
<th>Strategic Risk</th>
<th>Monitoring Committee / Board</th>
<th>Focus over next 3 months</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Risk Rating without controls</td>
<td>Current Risk Rating</td>
</tr>
<tr>
<td></td>
<td></td>
<td>25</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Leadership of Strategic Transformation</td>
<td>Clinical Management Board</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Quality &amp; Compliance: patient safety, patient experience and effectiveness</td>
<td>Safety, Quality &amp; Standards Committee</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Full Compliance was achieved following assessment of the Board Assurance Framework

The Board will continue to focus on improving controls linked to the following agreed priority areas:

- Ensuring patient safety
- Maintaining patient satisfaction
- Achieving the 4-hour operational standard by March 2018
- Producing a regulator approved plan for the future delivery of sustainable services
- Delivering the agreed financial control target
- Reducing the level of vacancies within the workforce and meet the regulators agency spend target
- Continuing to improve staff engagement especially in the area of our future strategy

At its meeting of February 2018, the Audit Committee received the outcome of “Full Compliance” following a review of the Board Assurance Framework by Mersey Internal Audit Agency.

Additionally, it was agreed to explore opportunities for further improvement and Mersey Internal Audit Agency have agreed to provide examples of good practice from other organisations for our consideration.

The CEO, as Chair of the Clinical Management Board (CMB), will provide assurance to the Audit Committee in May 2018 on the risks owned by CMB.

The Safety Quality and Standards Committee and Finance, Performance and Workforce Committee are scheduled to review their strategic risks at March 2018 meetings. Clinical Management Board has already undertaken their March 2018 review.
4 CORPORATE RISK REGISTER

Corporate Risk Profile – overall increase in the total number of red rated risks since the previous report

4.1 There are currently 29 red risks included on the risk register, which is a net reduction from the previous report of 1 risk, although the risks will not be identical to those in the previous report. A comparison of the current risk register and the previous reported risk register shows that 11 risks have been added or had their risk scores increased, whilst 12 risks have either been closed or had their risk scored reduced (Appendix 1 refers). This includes reported Serious Incidents Requiring Investigation.

4.1.1 The Corporate Risk Register is a living document in which risks are added and removed on an on-going basis. Therefore, the statement given above is at a specific point of time, rather than being reflective of all the changes which have happened during the period.

4.1.2 The table below shows the total number of risks contained on the risk register in each of the quarters reported in 2017/18 (which is specific to the time of the report being run from the risk management system).

<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>19 (includes 9 serious 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>

4.2 A considerable number of serious incidents once investigated are downgraded.
4.2.1 The Safety Quality and Standards Committee and Finance, Performance and Workforce Committee are scheduled to review the red rated risks delegated to them at their March 2018 meetings. Clinical Management Board last reviewed its delegated red risks in March 2018.

4.2.2 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 if appropriate.

4.3 As agreed by Audit Committee a planned audit took place of high rated risk target dates in March 2018 and the results are given below:

- 18 risks had yet to reach their initial target date
- 11 risks had a revision to the target date
  - Of the 11 risks with revised target dates:
    - All had been amended by appropriate individuals within the area in line with procedure
    - Seven had clearly documented explanations why the target date had changed and the agreement of the Executive
  - One had an explanation of “ongoing pressures”:
  - Three had no explanation as to why the target date had been changed recorded, although comments were made in the majority of risks to show work was continuing in addressing the risk:

<table>
<thead>
<tr>
<th>Risk No.</th>
<th>Risk Description</th>
<th>Responsible Manager</th>
</tr>
</thead>
<tbody>
<tr>
<td>2272</td>
<td>If inpatient flow is not maintained effectively then AAU may be used to accommodate inpatients, additional beds may be placed in ward bays and ED may become overcrowded with patients on corridors, which will impact the delivery of safe care leading to patient harm</td>
<td>Associate Director, Acute &amp; Integrated Care (Committee monitoring assurance is Safety, Quality &amp; Standards Committee)</td>
</tr>
<tr>
<td>2663</td>
<td>If the inpatient 18-week backlog continues to increase, there may be an impact on patient safety due to delays in treatment (potential 52 week breaches), the NHS constitutional standard will not be achieved with associated reputational risk and potential financial impact due to loss of income or penalties.</td>
<td>Associate Director – Planned Care (Committee monitoring assurance is Finance, Performance &amp; Workforce and Safety, Quality &amp; Standards Committee)</td>
</tr>
</tbody>
</table>
### 4.3.1

In summary, although the audit has identified no significant concerns with the process, the responsible managers for the four risks with no explanation have been contacted and asked to include details of why there is a revision in the target date.

<table>
<thead>
<tr>
<th>Risk No.</th>
<th>Risk Description</th>
<th>Responsible Manager</th>
</tr>
</thead>
<tbody>
<tr>
<td>2269</td>
<td>If there is no commissioned diabetes specialist nursing service for Eastern Cheshire then there is a significant clinical risk that pregnant women that require support with optimising their glyceamic control will not be managed appropriately.</td>
<td>Associate Director, Acute &amp; Integrated Care (Committee monitoring assurance is Safety, Quality &amp; Standards Committee)</td>
</tr>
<tr>
<td>2389</td>
<td>If the Trust does not have plans in place to upgrade the Intensive Care Unit, this will impact on the ability to comply with Health Building Note (HBN) 04-02</td>
<td>Associate Director, Acute &amp; Integrated Care (Committee monitoring assurance is Clinical Management Board) Capital Programme - Review to take place after operational pressures</td>
</tr>
</tbody>
</table>

### 5 RECOMMENDATION

5.1 The Board is asked to:

- Review the content of the Board Assurance Framework
- Note the key areas of focus for the next 3 months to reduce the level of risk
- Note that the Red Rated risks currently held on the corporate risk register are being reviewed by committees of the Board

**Sign off**

Julie Green - Director of Corporate Affairs and Governance

**Role title**

Julie Green - Director of Corporate Affairs and Governance
APPENDIX 1

The following 11 risks have been added to the Corporate Risk Register or had their risk score increased since the last report (this compares with 15 risks which were added in the previous report)

<table>
<thead>
<tr>
<th>Risk No.</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Risks Monitored by Clinical Management Board</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2674</td>
<td>If the Trust does not adequately manage winter pressures with system partners then this will impact on patient care and delivery of key national standards</td>
<td>Revised and approved risk – current score 20</td>
</tr>
<tr>
<td>2745</td>
<td>If clinicians are not fully engaged in delivery of the operational plan this could have an impact on cost reduction, maximising productivity; and plans for transformation.</td>
<td>Newly approved risk – current score 12</td>
</tr>
<tr>
<td><strong>Risks Monitored by Finance, Performance &amp; Workforce Committee</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2726</td>
<td>If we are unable to achieve our 2018/19 financial control total then there is a risk to the reputation and sustainability of the organisation</td>
<td>Newly approved risk – current score 15</td>
</tr>
<tr>
<td>2727</td>
<td>If we are unable to identify and deliver adequate QIPP schemes within the 2018-19 financial year then there is a possibility that the financial plan will not be achieved</td>
<td>Newly approved risk – current score 16</td>
</tr>
<tr>
<td><strong>Risks Monitored by Safety, Quality &amp; Standards Committee</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2691</td>
<td>A Serious Incident relating to a Slip, Trip, Fall on Ward 11 Intermediate Care has been reported on the Strategic Executive Information System (2017/31265 Web-45995).</td>
<td>Newly approved risk – current score 15</td>
</tr>
<tr>
<td>2684</td>
<td>A Serious Incident relating to a Slip, Trip, Fall on Ward 2 has been reported on the Strategic Executive Information System (2017/29893 Web-49343).</td>
<td>Newly approved risk – current score 15</td>
</tr>
<tr>
<td>2690</td>
<td>A Serious Incident relating to a Slip, Trip, Fall on Aston Unit has been reported on the Strategic Executive Information System (2017/31156 Web-49787).</td>
<td>Newly approved risk – current score 15</td>
</tr>
<tr>
<td>2671</td>
<td>A Serious Incident relating to a Slip, Trip, Fall on Ward 11 has been reported on the Strategic Executive Information System (2017/28962 Web-49167).</td>
<td>Newly approved risk – current score 15</td>
</tr>
<tr>
<td>2672</td>
<td>A Serious Incident relating to a Slip, Trip, Fall on Ward 8 / MAU has been reported on the Strategic Executive Information System (2017/29097 Web-49192).</td>
<td>Newly approved risk – current score 15</td>
</tr>
<tr>
<td>2728</td>
<td>A Serious Incident relating to a Slip, Trip, Fall on Ward 9 has been reported on the Strategic Executive Information System (2018/2344 Web-50693).</td>
<td>Newly approved risk – current score 15</td>
</tr>
<tr>
<td><strong>Risks Monitored by Finance, Performance &amp; Workforce Committee and Safety, Quality &amp; Standards Committee</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2552</td>
<td>If patients are bedded in ED/AAU due to lack of core bed availability in the Trust, with no increased resources; capacity, staffing and no reduction in ED/AAU emergency activity, then there is a potential risk that both in patient care / management and new emergency attendances will be compromised with regard to patient experience, completion of nursing documentation and risk assessments within 6 hours, timeliness of interventions, suitability of environment, staff morale and finance</td>
<td>Revised and approved risk – current score 15</td>
</tr>
</tbody>
</table>
The following 12 risks have been either closed or downgraded since the last report and are therefore no longer showing on the high level corporate risk register (this compares with ten risks which were closed or downgraded in the previous report):

<table>
<thead>
<tr>
<th>Risk No.</th>
<th>Description</th>
<th>Status</th>
<th>Additional detail</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Risks Monitored by Clinical Management Board</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2664</td>
<td>If the Trust is only able to invest internally generated resources into its capital programme, it will not be able to maintain its estate in a way that provides a safe and sustainable service.</td>
<td>Reduction in risk score – current score 12</td>
<td>Based on the metrics shown in the NHSI model hospital report, our critical infrastructure risk is much lower than our peers</td>
</tr>
<tr>
<td>2514</td>
<td>If the Estates function cannot appoint /retain suitable tradesmen and officers then the Estates Department would be unable to provide maintenance, technical services, minor works and statutory compliance which in turn could present a risk to patients, visitors, staff and service provision. There is also a risk of existing staff becoming less motivated, less committed and stressed due to overload with work demand</td>
<td>Reduction in risk score – current score 10</td>
<td>Risk score reduced due to the way in which the work is provided and arrangements already in place</td>
</tr>
<tr>
<td></td>
<td><strong>Risks Monitored by Clinical Management Board and Safety, Quality &amp; Standards Committee</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2455</td>
<td>If the street lighting at Congleton War Memorial Hospital is not improved, then there is a risk to patients and staff from trips and falls due to the street lighting not being in a serviceable condition.</td>
<td>Risk closed</td>
<td>Lighting solution installed December 2017</td>
</tr>
<tr>
<td>2665</td>
<td>If the general environment of operating theatres (1, 5, 6 and 7) is not meeting specification, then there is a risk of infection to patients undergoing surgery</td>
<td>Reduction in risk score – current score 12</td>
<td>Theatre refurbishment commenced, with some areas completed</td>
</tr>
<tr>
<td></td>
<td><strong>Risks Monitored by Clinical Management Board; Finance, Performance &amp; Workforce Committee; and Safety, Quality &amp; Standards Committee</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2486</td>
<td>If persistent gaps in the middle grade rota are not addressed then there is a risk the emergency department does not have safe staffing levels and safe standards may not be maintained.</td>
<td>Reduction in risk score – current score 12</td>
<td>New consultants in place covering most significant gaps</td>
</tr>
<tr>
<td></td>
<td><strong>Risks Monitored by Safety, Quality &amp; Standards Committee</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2647</td>
<td>If the Endoscopy and Treatment service are dependent on one room alone having a scope guide there is an inequality of care to patients undergoing (colon) procedures in the other rooms. Without the use of a scope guide there is the potential for the procedure time to be increased, meaning longer time on examination table for patients.</td>
<td>Reduction in risk score – current score 12</td>
<td>Likelihood reduced following discussion at last SQS Committee</td>
</tr>
<tr>
<td>2640</td>
<td>A Serious Incident relating to an Unsafe Clinical Environment on the Children's Ward has been reported on the Strategic Executive Information System (2017/26036 Web-48361).</td>
<td>Reduction in risk score – current score 5</td>
<td>RCA complete, approved at check and challenge and sent to CCG</td>
</tr>
<tr>
<td>Risk No.</td>
<td>Description</td>
<td>Status</td>
<td>Additional detail</td>
</tr>
<tr>
<td>--------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>2643</td>
<td>A Serious Incident relating to a Slip, Trip, Fall resulting in a #NOF on Ward 7 has been reported on the Strategic Executive Information System (2017/26583 Web-48520).</td>
<td>Reduction in risk score – current score 5</td>
<td>RCA complete, approved at check and challenge and sent to CCG</td>
</tr>
<tr>
<td>2552</td>
<td>If patients are bedded in ED/AU due to lack of core bed availability in the Trust, with no increased resources; capacity, staffing and no reduction in ED/AU emergency activity, then there is a potential risk that both in patient care / management and new emergency attendances will be compromised with regard to patient experience, completion of nursing documentation and risk assessments within 6 hours, timeliness of interventions, suitability of environment, staff morale and finance</td>
<td>Risk closed</td>
<td>Following discussion at CMB it was agreed that risks 2272 incorporates this risk</td>
</tr>
<tr>
<td></td>
<td>Risks Monitored by Finance, Performance &amp; Workforce Committee; and Safety, Quality &amp; Standards Committee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2179</td>
<td>If the Trust fails to meet the standard for 95% of patients to be assessed, admitted or discharged within 4 hours of arrival in ED, this may delay initiation of essential care and treatment leading to patient harm, and also adversely impact patient experience and trust reputation</td>
<td>Risk closed</td>
<td>Old year performance risk replaced by risk 2667 below (which has now been closed)</td>
</tr>
<tr>
<td>2667</td>
<td>If the Trust fails to meet the standard for 95% of patients admitted or discharged within 4 hours of arrival in ED, this may delay</td>
<td>Risk closed</td>
<td>Following discussion at CMB it was agreed that risks 2272 incorporates this risk</td>
</tr>
</tbody>
</table>
**Agenda Item Number 16: TB 18 (19)**

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

Date:  26th April 2018

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 26th April 2018 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 2018 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 and Quality</td>
<td>10 mins</td>
<td></td>
</tr>
<tr>
<td>2. Apologies:</td>
<td>Chairman</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## ASSURANCE ITEMS

<table>
<thead>
<tr>
<th>AGENDA TOPIC</th>
<th>PRESENTED BY</th>
<th>TIME ALLOCATION</th>
<th>REF. NO.</th>
<th>LINKED TO TRUST OBJECTIVE ON:</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Register of Interests:</td>
<td>The Chairman</td>
<td>5 mins</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>- Declared interest agenda</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Hospitality and Gifts Register Declaration</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Minutes of the March 2018 meeting</td>
<td>The Chairman</td>
<td>-</td>
<td>TB 18 (28)</td>
<td>-</td>
</tr>
<tr>
<td>5. Matters Arising</td>
<td>The Chairman</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>6. Action Log</td>
<td>The Chairman</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>7. Verbal update: SQS</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</td>
<td>Mr M Wildig</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## STRATEGIC/GOVERNANCE/ASSURANCE ITEMS

<table>
<thead>
<tr>
<th>AGENDA TOPIC</th>
<th>PRESENTED BY</th>
<th>TIME ALLOCATION</th>
<th>REF. NO.</th>
<th>LINKED TO TRUST OBJECTIVE ON:</th>
</tr>
</thead>
<tbody>
<tr>
<td>8. Chief Executive’s Commentary</td>
<td>Chief Executive</td>
<td>40 mins</td>
<td>TB 18 (29)</td>
<td>All corporate objectives</td>
</tr>
<tr>
<td>9. Annual Review – Equality, Diversity and Human Rights</td>
<td>Director of Corporate Affairs &amp; Governance</td>
<td>10 mins</td>
<td>TB 18 (30)</td>
<td>PEOPLE - Build, Value and develop a motivated and sustainable workforce</td>
</tr>
<tr>
<td>10. Bi-annual Report - Safer Staffing</td>
<td>Director of Nursing, Performance &amp; Quality</td>
<td>10 mins</td>
<td>TB 18 (31)</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></td>
<td></td>
</tr>
<tr>
<td>11. Standing Agenda Item: Does the Board wish to add anything to the Assurance Framework or Corporate Risk</td>
<td>Chief Executive</td>
<td>5 mins</td>
<td>Verbal</td>
<td>All corporate objectives</td>
</tr>
</tbody>
</table>
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>12. Public Trust Board Agenda – May 18</td>
<td>The Chairman</td>
<td>5 mins</td>
<td>TB 18 (32)</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>12. Chairman’s Commentary</td>
<td>TB 18 (33)</td>
<td>Information</td>
<td>All corporate objectives</td>
</tr>
</tbody>
</table>
| 13. Safer Staffing Exception Report  | TB 18 (34) | Assurance              | PATIENTS - Provide the best services to our population through improvements to safety, productivity and patient experience
|                                      |           |                        | STAFF - Empower, develop and value staff in providing innovative patient focused care |
| 14. Minutes of the committees of the Board: | TB 18 (35) | Information            |                              |
| SQS – February 18                    |          |                        |                              |
| FP&W – February 18                   | TB 18 (36) |                        |                              |
| Audit - February 18                  | TB 18 (37) |                        |                              |

Date and Time of Next Meeting:

Date: Thursday 31st May 2018
Time: 3.00pm - Venue: Board Room 1, New Alderley House, Macclesfield District Hospital
TRUST BOARD  
Thursday 29th March 2018  
Agenda Item Number 18: TB 18 (20)

<table>
<thead>
<tr>
<th>Report of: The Responsible &amp; Accountable Officer</th>
<th>The Chairman</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author of Report:</td>
<td>Lynn McGill, 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>To note</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>If we fail to contribute to sustainability and improvement of local communities, then we risk the loss of organisational reputation and loss of confidence by stakeholders.</td>
</tr>
<tr>
<td>Mitigates Risk Number: (identify) On Assurance Framework</td>
<td>If we fail to achieve effective communications with partners this will impact on the ability of the Trust to ensure we are financially sustainable and can deliver our clinical strategy.</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 |
<p>| Legal implications - (identify)                  | None |
| Impact on quality                                | Positive impact |</p>
<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 – National Health Service  
NHSI – National Health Service Improvement  
CEC - Cheshire East Council  
CCG - Clinical Commissioning Group  
ECT - East Cheshire NHS Trust  
SQS – Safety, Quality & Standards Board committee  
Cllr – Councillor  
ECHO – The Trust’s official charity. |
1 NATIONAL, REGIONAL AND LOCAL CONTEXT

1.1 NHS Improvement Northern Chairs forum

Attended this event in Leeds on Friday 2\textsuperscript{nd} February 2018. Topics of discussion included progress and performance against plan, linked to quality, finance and workforce and the growth in overall demand. Looking to the future, the workforce and how we both prepare for and shape this collectively as we seek to transform was also in sharp focus.

1.2 Health & Care Partnership Cheshire and Merseyside

Attended a meeting of partners, together with our Chief Executive, on the afternoon of Wednesday 14\textsuperscript{th} March 2018. Discussion topics included the development and progress of sustainability and transformation, together with areas linked to delivery within health economies, maximising use of all our resources and deploying assets for the benefit of our population. Outcomes from these discussions will feed through to working papers for the Trust Board and the local Central & East Cheshire joint partnership Board, ensuring local participation, ownership and engagement.

2 LOCAL CONTEXT

2.1 Cheshire Leaders Forum

Attended on the evening of Tuesday 20\textsuperscript{th} March 2018, where delegates were appraised of progress against the Cheshire East Council Vision, discussed innovation & Technology and its impact on economic growth, efficiency & productivity. Speakers from Cheshire organisations included Bentley, Cheshire Fire and Rescue, Cheshire East Council and their Skills and Growth company.

There is increasing ambition with regards to the current and future digital offer across Cheshire and the leadership group agreed to develop this further. There was also consensus that consistent messages about Cheshire as a great place to live and work and these too would be developed to ensure we all reinforce these and make every contact count.

. PARTNERSHIPS

2.2 Central and East Cheshire Joint Programme Board

In support of the health and care economy-wide transformation and with two programmes at a similar stage of development, the programme Boards of Caring Together and Connecting Care have agreed to work together for mutual patient benefit. The new Joint Programme Board met on the afternoons of February 7\textsuperscript{th} February and 8\textsuperscript{th} March 2018 and agreed several priority areas of focus. For regular updates, please continue to see http://www.caringtogether.info
In support of strong partnership relationships I continue to meet informally with the Eastern Cheshire CCG Chair; this took place on both 8th February and 8th March 2018.

2.3 Partner Support
Trust representatives have met with colleagues from a local housing association to discuss out of hospital care and explore any common ground. This approach is in keeping with our vision, ensuring patients receive the best care in the right place.

2.4 ECHO & the Pancake Race

Fun, success and good local participation despite the cold, wet and windy weather! This year’s pancake race organised by and for ECHO, the Trust’s official Charity, is an increasingly popular event for both participants and public supporters, in spite of the weather. Promoting the event beforehand and the race broadcasts were hosted by DJ Darren Antrobus of Silk 106.9 and there were winners for the race and the best fancy dress costume. Always a popular event, this is an important fundraiser for ECHO and every supporter makes a difference for our people and patients.

Thank you to all whom participated, helped with the preparations and with the event on the day to make it a success.

2.5 Health Matters

The first of Health Matters in 2018, in February focused on ‘Your Local GP; what you can expect from your GP and how this is changing’ within a changing NHS. With a focus on wellbeing this included ways you can find information and support to help yourself, as well as how GPs are working with partners in the community to improve wellbeing.

In March the focus was on ‘Exploring healthy eating and lifestyle’; key messages are keep moving and take a few moments now and again to reflect on what and how you eat. It may lead to different habits that suit at different times of life.

To see this and previous topics and video presentations, please use this link. http://www.eastcheshire.nhs.uk/News-Events/Health-matters.htm

3 TRUST BOARD

3.1 Trust Board membership

It is with sincere regret that I have accepted a resignation from one of our Board team. Dr Jane Cowan, Non Executive Director, tendered her resignation on 16th January 2018 and stood down as of 14th February 2018, for personal reasons. In her letter Dr Cowan noted her positive experience and having enjoyed working with the Trust, albeit at such a challenging time of transformation.
I and my Board colleagues would like to place our thanks on record for the broad and deep contribution Dr Cowan has made during her time with the Trust. We wish her and her family well.

We are currently recruiting into this non-executive role.

3.2 **The Trust Board Programme of Work** is largely as planned, with two changes; first to the Equality annual report and second, the Bi Annual Safer Staffing report, both of which will be on the April Agenda.

Please see the plan on a page confirming the full 2017-18 programme which is attached for information (Appendix 1). The plan for the year 2018-19 is also attached (Appendix 2); this is a ‘live’ document and may be subject to further developments in light of the changes affecting health regionally and nationally.

3.3 **Board Development**

As planned with a focus on leadership and sustainability across the local health economy. We have also been developing our programme for the forthcoming year.

3.4 **Board Walkabouts**

The programme for Board walkabouts is largely as planned. These are supplemented by walkabouts in areas of increased risk which aids triangulation of information for greater assurance. Visits have taken place across the full breadth of services across the Trust, have helped to inform questions and challenge around the board table and bring reports and papers to life.

Please find at Appendix 3 the 2017-18 Board Walkabout programme.

During January 2018 the planned session with Junior Doctors was postponed due to significant operational pressures and patient need; this was reinstated on 6th March 2018 and I was pleased to attend.

In addition, Board members continue to attend ad hoc SIRI meetings to be assured of the Trust’s handling of incidents, visible via our Safety, Quality and Standards board sub-committee (SQS).

3.5 **Conflicts of Interests**

This year the trust has introduced a new Conflict of Interest policy which offers consistent principles, rules and advice about what to do in common situations. The trust asks that all salaried employees, prospective employees, contractors and sub-contractors, volunteers, agency staff and decision making group members declare any conflict of interest that they may have.

There are eleven different categories where conflicts can arise, these include:

- Gifts
- Hospitality

Chairman: Lynn McGill
Chief Executive: John Wilbraham
Outside employment
Shareholdings
Patents
Loyalty Interests
Donations
Sponsored events
Sponsored research
Sponsored posts
Clinical private practice

The declarations are made public and can be viewed on the trusts website.

I can confirm that all Board members are up to date with their declarations.

3.6 **Fit and Proper Persons**

I have received assurance that all members of the Trust Board meet the Fit and Proper Persons definition as determined by Regulatory requirements for all NHS providers. The regulations require trusts to assure themselves that all executive and non-executive directors are fit and proper individuals to carry out their role; the trust concluded this year’s process in January 2018.

3.7 **Encouraging and Supporting Board level Diversity**

The Trust is participating in the Insight Programme, run by a third party in support of NHS Improvement ‘Diversity on Boards’ programme. This is aimed at developing aspirational directors to develop and hone their skills and experience in readiness for future leadership and board roles. I am pleased to share we have a new Insight Programme placement whom will be joining us from May until the end of August 2018.

Lynn McGill
Chairman
### 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

### Standing Board Agenda Items

- The Patient’s Voice (Patient Story)/The Staff Voice (Staff Story)
- Chairman’s Report (inc annual Fit & Proper person test, RoI 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

### Board Assurance Framework

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

### Appendix 1: The Board 2017/18 – Year at a Glance

<table>
<thead>
<tr>
<th>Month</th>
<th>April 17</th>
<th>May 17</th>
<th>June 17</th>
<th>July 17</th>
<th>August 17</th>
<th>Sept 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Board Objectives</td>
<td>Refresh of ECT’s Clinical Strategy</td>
<td>AGM (inc Annual Report &amp; Quality Account)</td>
<td>Board Assurance Framework &amp; Corporate Risk Register</td>
<td>No public meeting</td>
<td>No public meeting</td>
<td>Annual Report – Controlled Drugs</td>
</tr>
<tr>
<td></td>
<td>Annual review of Board members</td>
<td>Annual Report - Infection, Prevention &amp; CItl</td>
<td>Annual review - Complaints Policy</td>
<td>No public meeting</td>
<td>No public meeting</td>
<td>Bi-Annual Report – Safe Staffing Levels</td>
</tr>
<tr>
<td></td>
<td>Attendance at Committee’s</td>
<td>Annual Report Committees of the Board</td>
<td>Annual Report – Guardian of Safe Working</td>
<td></td>
<td></td>
<td>IT Strategy Update</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Capital Programme</td>
<td>Workforce &amp; OD Strategy Update</td>
<td></td>
<td></td>
<td>Winter Plan</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>BAF/CRR</td>
</tr>
<tr>
<td>Oct 17</td>
<td>Nov 17</td>
<td>Dec 17</td>
<td>Jan 18</td>
<td>Feb 18</td>
<td>March 18</td>
<td>Apr 18</td>
</tr>
<tr>
<td>No public meeting</td>
<td>Corporate Governance Manual</td>
<td>Board Assurance Framework &amp;</td>
<td>Risk Management Strategy</td>
<td>BAF/CRR</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Corporate Risk Register</td>
<td></td>
<td>Bi-Annual Report – Safe Staffing Levels</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(BAF)</td>
<td>Delegated Authority Update via Audit Cmte</td>
<td>Annual review - Action Plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Mortality - Learning from Deaths+</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Annual review - Carter Review</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Budgets</td>
</tr>
</tbody>
</table>

**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 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

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
<table>
<thead>
<tr>
<th>April 2017</th>
<th>May 2017</th>
<th>June 2017</th>
<th>July 2017</th>
<th>August 2017</th>
<th>September 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICU</td>
<td>Theatres</td>
<td>Radiology</td>
<td>Theatres</td>
<td>HR Department</td>
<td>Junior Doctor’s Forum</td>
</tr>
<tr>
<td>Theatres</td>
<td></td>
<td>A&amp;E Department</td>
<td>Ward 9</td>
<td>Safeguarding Team</td>
<td>ISS Supervisors</td>
</tr>
<tr>
<td>Discharge Liaison Team (IDT Meeting)</td>
<td></td>
<td>Volunteer Thank You Event</td>
<td>Ward 4</td>
<td>Knutsford District Nurses</td>
<td>Paediatrics</td>
</tr>
<tr>
<td>Congleton District Nurses</td>
<td></td>
<td>Knutsford Community Nurses</td>
<td>Waters Green Community Nurses</td>
<td>Knutsford Hospital Site Visit</td>
<td>Endoscopy Unit</td>
</tr>
<tr>
<td>Holmes Chapel District Nurses</td>
<td></td>
<td>Ward 1, Surgical Day Case Unit, Surgical Treatment Unit</td>
<td>Sexual Health East</td>
<td>Knutsford District Nurses</td>
<td>Maternity Department</td>
</tr>
<tr>
<td></td>
<td>Congleton Hospital Site Visit</td>
<td>Ward 3</td>
<td>Alderley Edge/Chelford District Nurses</td>
<td>Congleton District Nurses</td>
<td>Chaplaincy Thank You Event</td>
</tr>
<tr>
<td></td>
<td>Booking Centre Team</td>
<td>ED Staffing Meeting</td>
<td>Finance Department</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Urgent Care SQS Meeting</td>
<td>Maternity/Neonatal Departments</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ward 9 MAPLE Project</td>
<td>Paediatrics</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Main Reception - Volunteers</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>October 2017</th>
<th>November 2017</th>
<th>December 2017</th>
<th>January 2018</th>
<th>February 2018</th>
<th>March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatients</td>
<td>Estates – MDGH Site</td>
<td>Medical Secretaries Meeting</td>
<td>Paediatrics</td>
<td>Orthopaedic Department</td>
<td>Junior Doctor’s Forum</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>A&amp;E Department</td>
<td>Congleton/Holmes Chapel District Nurses</td>
<td>Ward 11</td>
<td>Infection Control Team</td>
<td>Outpatients Department</td>
</tr>
<tr>
<td>Porters</td>
<td>Alderley Edge District Nurses</td>
<td>GP Out of Hours District Nurse Visit</td>
<td>Ward 4</td>
<td>MAU/AAU</td>
<td>Theatres</td>
</tr>
<tr>
<td>Discharge Lounge</td>
<td>Hospital Walkabout</td>
<td>A&amp;E Department</td>
<td>Endoscopy Unit</td>
<td>Discharge Lounge</td>
<td>Safeguarding Team</td>
</tr>
<tr>
<td>Day Case Unit</td>
<td></td>
<td></td>
<td>Radiology/X-Ray Dept</td>
<td>Porters</td>
<td>Wards 1 and 2</td>
</tr>
<tr>
<td>Critical Care Unit</td>
<td></td>
<td></td>
<td>Maternity Unit</td>
<td>Porters</td>
<td>ICU/HDU</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Planned Care Directorate Meeting</td>
<td></td>
<td>Pre-Operative Assessment Team</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Ophthalmology</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Ward 10</td>
</tr>
<tr>
<td><strong>Report of:</strong></td>
<td>Director of Corporate Affairs &amp; Governance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------</td>
<td>-------------------------------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Responsible Officer</strong>&lt;br&gt;<strong>Accountable Officer</strong></td>
<td>Head of Integrated Governance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Subject/Title</strong></td>
<td>Review of Corporate Governance Manual</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Background papers (if relevant)</strong></td>
<td>Corporate Governance Manual 2018/19 incorporating:&lt;br&gt;Standing Orders&lt;br&gt;Standing Financial Instructions&lt;br&gt;Reservation of Powers to the Board and Delegation of Powers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Purpose of Paper</strong></td>
<td>To present the revised Corporate Governance manual</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Action/Decision required</strong></td>
<td>The Board is asked to:&lt;br&gt;• Approve the revised Corporate Governance Manual</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Mitigates Risk Number:</strong>&lt;br&gt;(identify)&lt;br&gt;<strong>On Corporate Risk Register</strong></td>
<td>• 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.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Mitigates Risk Number:</strong>&lt;br&gt;(identify)&lt;br&gt;<strong>On Assurance Framework</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Link to Care Quality Commission Domain (identify)</strong></td>
<td>All domains</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Link to:</strong></td>
<td>All objectives</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Trust’s Strategic Direction&lt;br&gt;• Corporate Objectives</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Legal implications - (identify)</strong></td>
<td>No legal implications</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Impact on quality</strong></td>
<td>No impact on quality</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Resource impact</strong></td>
<td>None</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Impact of equality/diversity</strong></td>
<td>No impact on equality / diversity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Avoid acronyms or abbreviations - if necessary list:</strong></td>
<td>CQC – Care Quality Commission&lt;br&gt;BMA – British Medical Association&lt;br&gt;OJEU - Official Journal of the European Union</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Corporate Governance Manual

Including:

Standing Orders;
Standing Financial Instructions; and
Scheme of Reservation and Delegation

March 2018
## CONTENTS

<table>
<thead>
<tr>
<th>Manual Contents</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PART A</strong> OVERARCHING GOVERNANCE ARRANGEMENTS</td>
<td></td>
</tr>
<tr>
<td>FOREWORD</td>
<td>5</td>
</tr>
<tr>
<td>1 Introduction</td>
<td>7</td>
</tr>
<tr>
<td>2 Assurance Process</td>
<td>8</td>
</tr>
<tr>
<td>3 Policy and Procedural documents</td>
<td>9</td>
</tr>
<tr>
<td>4 Training</td>
<td>9</td>
</tr>
<tr>
<td>5 Risk Management</td>
<td>9</td>
</tr>
<tr>
<td>6 Annual Governance Statement</td>
<td>11</td>
</tr>
<tr>
<td>7 Committee Structure</td>
<td>11</td>
</tr>
<tr>
<td><strong>PART B</strong> STANDING ORDERS</td>
<td></td>
</tr>
<tr>
<td>FOREWORD</td>
<td>14</td>
</tr>
<tr>
<td>1 Introduction</td>
<td>17</td>
</tr>
<tr>
<td>2 Interpretation</td>
<td>18</td>
</tr>
<tr>
<td>3 The Trust Board</td>
<td>20</td>
</tr>
<tr>
<td>4 Meetings of the Board</td>
<td>24</td>
</tr>
<tr>
<td>Arrangements for the Exercise of Functions by Delegation</td>
<td>33</td>
</tr>
<tr>
<td>5 Committees</td>
<td>34</td>
</tr>
<tr>
<td>6 Duties and Obligations of Board Members</td>
<td>38</td>
</tr>
<tr>
<td>7 Custody of Seal and Sealing of Documents</td>
<td>47</td>
</tr>
<tr>
<td>8 Overlap with Other Trust Policy Statements</td>
<td>48</td>
</tr>
<tr>
<td>9 Miscellaneous</td>
<td>49</td>
</tr>
<tr>
<td><strong>PART C</strong> SCHEME OF RESERVATION AND DELEGATION</td>
<td></td>
</tr>
<tr>
<td>Introduction</td>
<td>52</td>
</tr>
<tr>
<td>1 Reservation of Powers to the Board</td>
<td>53</td>
</tr>
<tr>
<td>2 Delegation of Powers</td>
<td>56</td>
</tr>
<tr>
<td>3 Scheme of Delegation to Officers</td>
<td>56</td>
</tr>
<tr>
<td>4 Detailed Scheme of Delegation</td>
<td>57</td>
</tr>
<tr>
<td>5 Delegated Financial Limits</td>
<td>83</td>
</tr>
<tr>
<td><strong>PART D</strong> STANDING FINANCIAL INSTRUCTIONS</td>
<td></td>
</tr>
<tr>
<td>FOREWORD</td>
<td>90</td>
</tr>
<tr>
<td>1 Introduction</td>
<td>92</td>
</tr>
<tr>
<td>2 Audit</td>
<td>95</td>
</tr>
<tr>
<td>3 Business Planning, Budgets, Budgetary Control and Monitoring</td>
<td>98</td>
</tr>
<tr>
<td>4 Annual Accounts and Reports</td>
<td>101</td>
</tr>
<tr>
<td>5 Bank Accounts</td>
<td>101</td>
</tr>
<tr>
<td>6 Income, Fees and Charges and Security of Cash, Cheques and other Negotiable Instruments</td>
<td>102</td>
</tr>
<tr>
<td>7 Contracting for Provision of Services</td>
<td>104</td>
</tr>
<tr>
<td>8 Competing for Contracts for Provision of Services</td>
<td>105</td>
</tr>
<tr>
<td>9 Terms of Service and Payment of Directors and Employees</td>
<td>106</td>
</tr>
<tr>
<td>10 Non-Pay Expenditure</td>
<td>109</td>
</tr>
<tr>
<td>11 Borrowing and Investment</td>
<td>113</td>
</tr>
<tr>
<td>12 Capital Investment, Private Investment, Private Financing, Fixed Asset Registers and Security of Assets</td>
<td>114</td>
</tr>
<tr>
<td>Manual Contents</td>
<td>Page</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>13 Stores and Receipt of Goods</td>
<td>117</td>
</tr>
<tr>
<td>14 Disposals and Condemnations, Losses and Special Payments</td>
<td>118</td>
</tr>
<tr>
<td><strong>PART D STANDING FINANCIAL INSTRUCTIONS</strong></td>
<td></td>
</tr>
<tr>
<td>15 Information Technology</td>
<td>120</td>
</tr>
<tr>
<td>16 Patients’ Property</td>
<td>122</td>
</tr>
<tr>
<td>17 Retention of Documents</td>
<td>123</td>
</tr>
<tr>
<td>18 Risk Management and Insurance</td>
<td>123</td>
</tr>
<tr>
<td>19 Tendering and Contract Procedure</td>
<td>124</td>
</tr>
<tr>
<td>20 Disposals</td>
<td>130</td>
</tr>
<tr>
<td>21 In House Services</td>
<td>130</td>
</tr>
<tr>
<td>22 Acceptance of Gifts by Staff</td>
<td>131</td>
</tr>
<tr>
<td><strong>PART E APPENDICES</strong></td>
<td></td>
</tr>
<tr>
<td>A1 Standards of Business Conduct for NHS Staff</td>
<td>132</td>
</tr>
<tr>
<td>A1b Updated NHS Standards of Business Conduct</td>
<td>137</td>
</tr>
<tr>
<td>A2 Code of Conduct for NHS Boards</td>
<td>141</td>
</tr>
<tr>
<td>A3 Code of Conduct for NHS Managers</td>
<td>147</td>
</tr>
<tr>
<td><strong>Terms of Reference for Board Committees</strong></td>
<td></td>
</tr>
<tr>
<td>B1 Safety Standards and Quality Committee</td>
<td>152</td>
</tr>
<tr>
<td>B2 Remuneration Committee</td>
<td>158</td>
</tr>
<tr>
<td>B3 Audit Committee</td>
<td>164</td>
</tr>
<tr>
<td>B4 Finance, Performance and Workforce Committee</td>
<td>173</td>
</tr>
<tr>
<td>B5 Clinical Management Board</td>
<td>179</td>
</tr>
<tr>
<td><strong>Supporting Policies and Procedures</strong></td>
<td></td>
</tr>
<tr>
<td>C1 Local Anti-Fraud, Bribery and Corruption Policy</td>
<td>184</td>
</tr>
<tr>
<td>C2 Raising Concerns – Speaking Up Policy</td>
<td>204</td>
</tr>
<tr>
<td>C3 Tendering Procedure</td>
<td>209</td>
</tr>
<tr>
<td>C4 Standard operating procedure for competing for contracts</td>
<td>221</td>
</tr>
<tr>
<td>C5 Procurement Waiver Process Diagram</td>
<td>222</td>
</tr>
<tr>
<td>C6 Fit and Proper Persons Process</td>
<td>223</td>
</tr>
<tr>
<td>C7 Guidance and Business Case Template for Consultancy over 50K (to be</td>
<td>236</td>
</tr>
<tr>
<td>submitted to the NHS Improvement)</td>
<td></td>
</tr>
<tr>
<td>C8 Conflict of Interest Policy</td>
<td>244</td>
</tr>
</tbody>
</table>
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
CONTENTS

FOREWORD

1. INTRODUCTION

2. ASSURANCE PROCESS
   COMMITTEE STRUCTURE

3. POLICY AND PROCEDURAL DOCUMENTS

4. TRAINING

5. RISK MANAGEMENT
   i. RISK MANAGEMENT PROCESS
   ii. BOARD ASSURANCE FRAMEWORK
   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**

- **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 (Overseeing 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**

- **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

---

The Board may also identify risks for inclusion in the Assurance Framework
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;
(c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

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

(e) audit arrangements including; internal audit, clinical audit, health and safety review;

(f) arrangements to review the risk management programme.

5.1.3 It is the responsibility of all service areas and departments to have a clearly defined process to review and update the risk register to ensure that there is a live system which accurately reflects the risk position of the Trust at any time.

5.1.4 The following diagram shows the structure and flow chart for the management of assurance and Risk.
5.2 BOARD ASSURANCE FRAMEWORK

5.2.1 The Board Assurance Framework identifies and quantifies all risks that may potentially compromise the organisation’s ability to meet its strategic objectives. These strategic risks to the organisation are identified by the East Cheshire NHS Trust Board and recorded on the Board Assurance Framework. Gaps identified in controls or assurances, and the associated treatments to address them, contribute to the Trust’s Corporate Risk Register.

5.2.2 These high level risks are monitored by the Executive Directors and reported to the Board and the relevant Board Committees for review and scrutiny.

5.3 CORPORATE RISK REGISTER

5.3.1 The Corporate Risk Register consists of two elements: all risks which cross cut the organisation, regardless of the level of risk; and any operational risks which have been scored at a level of 15 or more.

5.3.2 An up-to-date position on the significant risks i.e. those risks of a score of 15 and above, is provided 4 times a year to the Trust Board, Clinical Management Board and Committees of the Board. The Audit Committee reviews its effectiveness 3 times per year, with an additional review undertaken by Internal Audit. The Clinical Management Board is responsible for the co-ordination of both strategic and significant risks and therefore discusses risks as part of their agenda on a monthly basis. Additionally the Operational Management Team receives and discusses the Corporate Risk Register.

6 ANNUAL GOVERNANCE STATEMENT

6.1 The existence, integration and evaluation of the above risk management process will provide a basis (along with opinions received from Internal and External Audit) to make a statement on the effectiveness of internal control in the form of the Annual Governance Statement, within the Annual Report and Accounts. This is signed by the Chief Executive on behalf of the Board.

7 COMMITTEE STRUCTURE

7.1 The Trust Board is supported by the following Formal Committee Structure

(a) Audit Committee – this is one of the two committees that the Trust is required to have by statute. Its role is to review, on behalf of the Board, that the Trust has effective processes in place to manage and oversee the systems necessary for integrated governance, risk management, internal control (i.e., financial and clinical management). The committee is informed by reports on the Trust’s systems and processes prepared by both internal and external auditors;

(b) Finance, Performance & Workforce Committee – this committee provides the Trust Board with assurance that standards relating to finance and workforce are being met. It will discuss the integrated performance of the organisation and provide assurance that there is a robust performance management framework in place. Its quality focus will be on systems and processes which underpin sound performance and workforce modeling to deliver a redesigned clinical workforce;
(c) **Remuneration Committee** – this is one of the two committees that the Trust is required to have by statute. Its role is to:

(i) oversee and agree the remuneration and terms of service of the Chief Executive and Other Directors who are members of the Board, together with any member of staff employed by the trust whose terms of service are not covered by national agreements,

(ii) provide advice to the Board on a range of employment issues for all staff (i.e., pensions, car schemes, termination of employment);

(d) **Safety, Quality & Standards Committee** – this committee exists to provide the Trust Board with assurance that national and local safety, quality and other standards are being met for both clinical and non-clinical activities of the Trust. The committee provides the assurance that effective systems, process and training is in place to ensure all employees are aware of their responsibilities for promoting and maintaining the highest standards in everything the Trust does;

7.2 In addition the Trust Board is supported by two *Operational Reporting Forums*, which are accountable to the Chief Executive. Although these Forums are not formal Committees of the Trust Board, they provide a forum for the Chief Executive to ensure clear accountability and gain assurance from the relevant Directors / Clinical Directors, 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.
CONTENTS

FOREWORD

1. INTRODUCTION
1.1. STATUTORY FRAMEWORK
1.2. EQUALITY AND HUMAN RIGHTS
1.3. NHS FRAMEWORK
1.4. DELEGATION OF POWERS

2. INTERPRETATION

3. THE TRUST BOARD
  3.1. CORPORATE ROLE OF THE BOARD
  3.2. SCHEDULE OF MATTERS RESERVED TO THE BOARD AND SCHEME OF DELEGATION
  3.3. COMPOSITION OF THE BOARD
  3.4. APPOINTMENT OF THE CHAIRMAN AND DIRECTORS
  3.5. TERMS OF OFFICE OF THE CHAIRMAN AND DIRECTORS
  3.6. APPOINTMENT AND POWERS OF VICE-CHAIRMAN
  3.7. ROLE OF MEMBERS
  3.8. LEAD ROLES FOR BOARD MEMBERS

4. MEETINGS OF THE TRUST
  4.1 ADMISSION OF THE PUBLIC AND PRESS
  4.2 CALLING MEMBERS
  4.3 NOTICE OF MEETINGS
  4.4 SETTING THE AGENDA
  4.5 PETITIONS
  4.6 CHAIRMAN OF THE MEETING
  4.7 ANNUAL PUBLIC MEETING
  4.8 NOTICES OF MOTION
  4.9 EMERGENCY MOTION
  4.10 MOTIONS
  4.11 WITHDRAWAL OF MOTION OR AMENDMENTS
  4.12 MOTION TO RESCIND A RESOLUTION
  4.13 CHAIRMAN’S RULING
  4.14 VOTING
  4.15 MINUTES
  4.16 JOINT DIRECTORS
  4.17 SUSPENSION OF STANDING ORDERS
  4.18 VARIATION AND AMENDMENT OF STANDING ORDERS
  4.19 RECORD OF ATTENDANCE
  4.20 QUORUM
  4.21 DELEGATION OF FUNCTIONS
  4.22 EMERGENCY POWERS AND URGENT DECISIONS
  4.23 DELEGATION TO COMMITTEES
  4.24 DELEGATION TO OFFICERS
  4.25 SCHEDULE OF MATTERS RESERVED TO THE BOARD
  4.26 DUTY TO REPORT NON-COMPLIANCE WITH STANDING ORDERS AND STANDING FINANCIAL INSTRUCTIONS

5. COMMITTEES
  5.1 APPOINTMENT TO COMMITTEES
5.2 JOINT COMMITTEES
5.3 COMMITTEES ESTABLISHED BY THE BOARD
5.4 OPERATIONAL REPORTING FORUMS
5.5 CONFIDENTIALITY

6. DUTIES AND OBLIGATIONS OF BOARD MEMBERS
   6.1 DECLARATION OF INTEREST
   6.2 REGISTER OF INTERESTS
   6.3 EXCLUSION OF CHAIRMAN AND BOARD MEMBERS
   6.4 STANDARDS OF BUSINESS CONDUCT

7. CUSTODY OF SEAL AND SEALING OF DOCUMENTS
   7.1 CUSTODY OF SEAL
   7.2 SEALING OF DOCUMENTS
   7.3 WHEN THE SEAL SHOULD BE USED
   7.4 REGISTER OF SEALING
   7.5 SIGNATURE OF DOCUMENTS

8. OVERLAP WITH OTHER TRUST POLICY STATEMENTS/PROCEDURES AND REGULATIONS
   8.1 POLICY STATEMENTS: GENERAL PRACTICE
   8.2 SPECIFIC POLICY STATEMENTS
   8.3 SPECIFIC GUIDANCE

9. MISCELLANEOUS
   9.1 STANDING ORDER TO BE GIVEN TO DIRECTORS AND OFFICERS
   9.2 DOCUMENTS HAVING THE STANDING OF STANDING ORDERS
   9.3 INDEMNITY
   9.4 JOINT FINANCE ARRANGEMENTS
   9.5 REVIEW OF STANDING ORDERS
1 INTRODUCTION TO STANDING ORDERS

1.1 Statutory Framework

1.1.1 The East Cheshire NHS Trust (the Trust) is a body corporate which was established under the National Health Service Trust (Establishment) Order 1993 (the Establishment Order).

1.1.2 The principal places of business of the Trust are Macclesfield DGH, Knutsford Hospital and Congleton War Memorial Hospital.

1.1.3 NHS Trusts are governed by Act of Parliament, mainly the NHS Act 2006 (as amended by the Health and Social Care Act 2012) and the National Health Service and Community Care Act 1990 (as amended and the Health and Social Care Act 2008).

1.1.4 The functions of the Trust are conferred by this legislation.

1.1.5 As a statutory body, the Trust has specified powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable as well as to the Secretary of State for Health.

1.1.6 The Membership and Procedure Regulations require the Trust to adopt Standing Orders for the regulation of its proceedings and business. The Trust must also adopt Standing Financial Instructions as an integral part of Standing Orders setting out the responsibilities of individuals.

1.1.7 The Trust will also be bound by such other statutes and legal provisions which govern the conduct of its affairs.

1.2 Equality and Human Rights

1.2.1 The Trust recognises that some sections of society experience prejudice and discrimination. The Equality Act 2010 specifically recognises the protected characteristics of age, disability, gender, race, religion or belief, sexual orientation 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:

<table>
<thead>
<tr>
<th>Level of Authority</th>
<th>Authority Delegated to</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>Administrator</td>
</tr>
<tr>
<td>7</td>
<td>Budget Holder</td>
</tr>
<tr>
<td>6</td>
<td>Service Manager, including senior finance staff</td>
</tr>
<tr>
<td>5</td>
<td>Associate Director</td>
</tr>
<tr>
<td>4</td>
<td>Deputies (excluding Deputy Director of Finance)</td>
</tr>
<tr>
<td>3</td>
<td>Executive (excluding Director of Finance)</td>
</tr>
<tr>
<td>2</td>
<td>Director of Finance and Deputy Director of Finance</td>
</tr>
<tr>
<td>1</td>
<td>Chief Executive and Deputy Chief Executive</td>
</tr>
</tbody>
</table>

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**

(i) 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.

(ii) 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**

(i) The Director of Finance shall be responsible for the provision of financial advice to the Trust and to its members and for the supervision of financial control and accounting systems. They shall be responsible along with the Chief Executive for ensuring the discharge of obligations under relevant Financial Directions.

(ii) The Director of Finance 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**

(i) 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**

(i) The Medical Director is responsible for the provision of medical advice to the Board. They are the designated individual for Human Tissue Authority regulations. The Medical Director is responsible for Clinical Medical Risk 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**

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

(ii) The Director of Corporate Affairs & Governance is responsible for Clinical and Non-Clinical Risk Management; Health, Safety and Fire; 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.

(h) 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.

(i) 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
Public Bodies (Admission to Meetings) Act 1960 Section 1 (4) (a)).

4.3.5 Failure to serve such a notice on more than three directors will invalidate the meeting. A notice shall be presumed to have been served at the time at which the notice would be delivered in the ordinary course of the post.

4.4 Setting the Agenda and Supporting Papers

4.4.1 The Trust may determine that certain matters shall appear on every agenda for a meeting of the Trust and shall be addressed prior to any other business being conducted.

4.4.2 A member desiring a matter to be included on an agenda shall make their request in writing to the Chairman at least 10 clear days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 10 days before a meeting may be included on the agenda at the discretion of the Chairman.

4.5 Petitions

4.5.1 Where a petition has been received by the Trust, the Chairman shall include the petition as an item for the agenda of the next meeting.

4.5.2 At the discretion of the Chairman 10 minutes will be allocated at the beginning of each public meeting for members of the public to address the Board, providing that prior notification has been made to the Trust. Any address by members of the public will not form part of the “minute record” of the Trust Board. At the Chairman’s discretion any notes taken of the address may be shared to members of the Board meeting.

4.6 Chairman of meeting

4.6.1 At any meeting of the Board the Chairman, if present, shall preside. If the Chairman is absent from the meeting, the Vice-Chairman 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
accountability to the Trust Board.

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.
(b) 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.

(c) 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’)

44
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 following 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.
Reservation of Powers to the Board and Delegation of Powers
CONTENTS

INTRODUCTION
ROLE OF THE CHIEF EXECUTIVE
CAUTION OVER THE USE OF DELEGATED POWERS
DIRECTORS' ABILITY TO DELEGATE THEIR OWN DELEGATED POWERS
ABSENCE OF DIRECTORS OR OFFICER TO WHOM POWERS HAVE BEEN DELEGATED

1. RESERVATION OF POWERS TO THE BOARD
GENERAL ENABLING PROVISION
REGULATION AND CONTROL
APPOINTMENTS
POLICY DETERMINATION
STRATEGY AND BUSINESS PLANS AND BUDGETS
DIRECT OPERATIONAL DECISIONS
FINANCIAL AND PERFORMANCE REPORTING ARRANGEMENTS
AUDIT ARRANGEMENTS

2. DELEGATION OF POWERS
DELEGATION TO COMMITTEES

3. SCHEME OF DELEGATION TO OFFICERS

4. DETAILED SCHEME OF DELEGATION

5. DELEGATED FINANCIAL LIMITS
INTRODUCTION

Standing Orders paragraph 4.1 provides that “subject to such directions as may be given by the Secretary of State, the Trust may make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee or sub-committee or by the Chairman or a director or by an officer of the Trust, in each case subject to such restrictions and conditions as the Board thinks fit”. The Code of Accountability also requires that there should be a formal schedule of matters specifically reserved to the Trust.

The purpose of this document is to provide an example of how those powers may be reserved to the Board - generally matters for which it is held accountable to the Secretary of State, while at the same time delegating to the appropriate level the detailed application of Trust policies and procedures. However, the Board remains accountable for all of its functions, even those delegated to the Chairman, individual directors or officers and would therefore expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

A. Role of the Chief Executive

All powers of the Trust which have not been retained as reserved by the Board or delegated to an executive committee or sub-committee shall be exercised on behalf of the Board by the Chief Executive. The Chief Executive shall prepare a Scheme of Delegation identifying which functions he shall perform personally and which functions have been delegated to other directors and officers.

All powers delegated by the Chief Executive can be re-assumed by him should the need arise. As Accountable Officer the Chief Executive is accountable to the Accounting Officer of the NHS 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.

<table>
<thead>
<tr>
<th>Level of Authority</th>
<th>Authority Delegated to</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>Administrator</td>
</tr>
<tr>
<td>7</td>
<td>Budget Holder</td>
</tr>
<tr>
<td>6</td>
<td>Service Manager, including senior finance staff</td>
</tr>
<tr>
<td>5</td>
<td>Associate Director</td>
</tr>
<tr>
<td>4</td>
<td>Deputies (excluding Deputy Director of Finance)</td>
</tr>
<tr>
<td>3</td>
<td>Executive (excluding Director of Finance)</td>
</tr>
<tr>
<td>2</td>
<td>Director of Finance and Deputy Director of Finance</td>
</tr>
<tr>
<td>1</td>
<td>Chief Executive and Deputy Chief Executive</td>
</tr>
</tbody>
</table>

### REFERENCE DELEGATED TO DUTIES DELEGATED

1. STANDING ORDERS AND STANDING FINANCIAL INSTRUCTIONS

<table>
<thead>
<tr>
<th>Reference</th>
<th>Delegated To</th>
<th>Duties Delegated</th>
</tr>
</thead>
<tbody>
<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>
</tr>
</tbody>
</table>

2. MEETINGS

<table>
<thead>
<tr>
<th>Reference</th>
<th>Delegated To</th>
<th>Duties Delegated</th>
</tr>
</thead>
<tbody>
<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>
</tbody>
</table>

3. REGISTER OF INTERESTS

<table>
<thead>
<tr>
<th>Reference</th>
<th>Delegated To</th>
<th>Duties Delegated</th>
</tr>
</thead>
<tbody>
<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>REFERENCE</td>
<td>DELEGATED TO</td>
<td>DUTIES DELEGATED</td>
</tr>
<tr>
<td>-----------------</td>
<td>----------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------</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>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>4. SIGNATURE OF DOCUMENTS</td>
<td></td>
<td></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>
<tr>
<td>5. PROPERTY AGREEMENTS AND LICENCES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SO 7.2.1</td>
<td>Director of Finance / Director of Human Resources and Organisational Development</td>
<td>a) Preparation and signature of all tenancy agreements/licenses for all staff subject to Trust Policy on accommodation for staff</td>
</tr>
<tr>
<td></td>
<td>Director of Finance / Director of Human Resources and Organisational Development</td>
<td>b) Extensions to existing leases</td>
</tr>
<tr>
<td></td>
<td>Director of Human Resources and Organisational Development</td>
<td>c) Letting of premises to outside organizations</td>
</tr>
<tr>
<td></td>
<td>Director of Human Resources and Organisational Development</td>
<td>d) Approval of rent based on professional assessment</td>
</tr>
<tr>
<td>6. AUDIT ARRANGEMENTS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SFI 2.1.1</td>
<td>Audit Committee</td>
<td>Provide independent and objective view on internal control and probity.</td>
</tr>
<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>
</tr>
<tr>
<td>------------------</td>
<td>-----------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------</td>
</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 Counter Fraud Authority’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**

<table>
<thead>
<tr>
<th>REFERENCE</th>
<th>DELEGATED TO</th>
<th>DUTIES DELEGATED</th>
</tr>
</thead>
<tbody>
<tr>
<td>SFI 1.3.7</td>
<td>Director of Finance</td>
<td>Responsible for implementing the Trust’s financial policies and co-ordinating corrective action and ensuring detailed financial procedures and systems are prepared and documented.</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>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 |
<table>
<thead>
<tr>
<th>REFERENCE</th>
<th>DELEGATED TO</th>
<th>DUTIES DELEGATED</th>
</tr>
</thead>
<tbody>
<tr>
<td>SFI 3.3.2</td>
<td>Chief Executive</td>
<td>Responsibility of keeping expenditure within budgets</td>
</tr>
<tr>
<td>SFI 3.3.2</td>
<td>Level 1 - 8</td>
<td>a) For the Trust as a whole</td>
</tr>
<tr>
<td>SFI 3.3.2</td>
<td></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>
<thead>
<tr>
<th><strong>REFERENCE</strong></th>
<th><strong>DELEGATED TO</strong></th>
<th><strong>DUTIES DELEGATED</strong></th>
</tr>
</thead>
<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><strong>REFERENCE</strong></th>
<th><strong>DELEGATED TO</strong></th>
<th><strong>DUTIES DELEGATED</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>SFI 7.1</td>
<td>Chief Executive with Director of Finance</td>
<td>Negotiating contracts for provision of patient services in accordance with the Trust plan.</td>
</tr>
<tr>
<td>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>
</tr>
</tbody>
</table>

12. **BUSINESS CASES**

<table>
<thead>
<tr>
<th><strong>REFERENCE</strong></th>
<th><strong>DELEGATED TO</strong></th>
<th><strong>DUTIES DELEGATED</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Level 4</td>
<td>Development and submission of Business Cases in line with the agreed approval process</td>
</tr>
</tbody>
</table>
### REFERENCE | DELEGATED TO | DUTIES DELEGATED
---|---|---
| | Chief Executive | Delegate responsibility for approval of business cases subject to defined limits (refer to delegated financial limits)

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

| SFI 9.1.1 | Chairman | Establish a Remuneration & Terms of Service Committee
| 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 | Director of Human Resources and Organisational Development or Director of Finance | 18. **Personnel & Pay**
  | Level 1 -7 | a) Authority to fill funded post on the establishment with permanent staff.
  | Level 1 -7 | b) Authority for additional staff to the agreed establishment with specifically allocated 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
<table>
<thead>
<tr>
<th>REFERENCE</th>
<th>DELEGATED TO</th>
<th>DUTIES DELEGATED</th>
</tr>
</thead>
<tbody>
<tr>
<td>SFI 9.4.3</td>
<td>Level 1 -7</td>
<td>d) Pay</td>
</tr>
<tr>
<td></td>
<td></td>
<td>i) Authority to authorise standing data forms effecting pay, new starters, variations and leavers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ii) Authority to authorise positive reporting forms, or recognised alternative, where appropriate</td>
</tr>
<tr>
<td></td>
<td></td>
<td>iii) Authority to authorise overtime</td>
</tr>
<tr>
<td></td>
<td>Level 1 -7</td>
<td>e) Leave</td>
</tr>
<tr>
<td></td>
<td>(Line Manager in line with Trust Policy)</td>
<td>i) Approval of annual leave</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ii) Annual leave - approval of carry forward (up to maximum of 5 days or in the case of Ancillary &amp; Maintenance staff as defined in their initial conditions of service).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>iii) Annual leave – approval of carry over in excess of 5 days but less than 10 days.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>iv) Annual leave - approval to carry forward 10 days or more.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>v) Compassionate leave between 1 and 5 days</td>
</tr>
<tr>
<td></td>
<td></td>
<td>vi) Carers leave (up to a maximum of 3 days)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>vii) Leave without pay and career break</td>
</tr>
<tr>
<td></td>
<td></td>
<td>viii) Medical Staff Leave of Absence, paid and unpaid</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ix) Time off in lieu</td>
</tr>
<tr>
<td></td>
<td></td>
<td>x) Maternity Leave</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Paternity Leave</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Adoption Leave</td>
</tr>
<tr>
<td></td>
<td></td>
<td>– paid and unpaid (In line with trust policy)</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>Level 1 - 7</td>
<td>(Line Manager in line with Trust Policy)</td>
<td>f) Sick Leave</td>
</tr>
<tr>
<td>Director of Human Resources and Organisational Development</td>
<td></td>
<td>Extension of Sick Leave</td>
</tr>
<tr>
<td></td>
<td></td>
<td>i) Extension of sick leave on half pay up to three months</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ii) Extension of sick leave on full pay</td>
</tr>
<tr>
<td>Level 1 - 7</td>
<td>(Line Manager in line with Trust Policy)</td>
<td>g) Study Leave – In line with trust policy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>i) Study leave outside the UK</td>
</tr>
<tr>
<td></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>Director of Human Resources and Organisational Development</td>
<td></td>
<td>h) Removal Expenses, Excess Rent and House Purchases</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Authorisation of payment of removal expenses incurred by officers taking up new appointments (consultants &amp; hard to recruit to posts only - 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>
</tr>
<tr>
<td>-----------</td>
<td>--------------</td>
<td>------------------</td>
</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 | |
| Level 6 | 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 | |
| Level 1 - 7 | 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>Dismissing Officers with advice from Director of Human Resources and Organisational Development</td>
<td>o) Dismissal</td>
<td></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. |
<p>| 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 |
| 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

<p>| SFI 10.1.1 | Director of Finance                              | Determine, and set out, level of delegation of non-pay expenditure to budget managers.                                                                                                                                                                                                                                                                                           |
| SFI 10.1.3 | Director of Finance                              | Set out procedures on the seeking of professional advice regarding the supply of goods and services.                                                                                                                                                                                                                                                                        |
| SFI 10.2.2 | Director of Finance                              | Prompt payment of accounts.                                                                                                                                                                                                                                                                                                                                                   |</p>
<table>
<thead>
<tr>
<th>REFERENCE</th>
<th>DELEGATED TO</th>
<th>DUTIES DELEGATED</th>
</tr>
</thead>
<tbody>
<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>
</tr>
<tr>
<td>-----------</td>
<td>--------------</td>
<td>------------------</td>
</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>
</tbody>
</table>

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

<p>| SFI 12.1.1 | Director of Finance | Capital investment programme developed which ensures that there is adequate appraisal and approval process for determining capital expenditure priorities and the effect that each has on plans; cost; and that capital investment is not undertaken without availability of resources to finance all revenue consequences. |
| SFI 12.1.2 | Director of Finance | Business case is produced for each proposal |
| SFI 12.1.2 | Director of Finance or nominated deputy | Certify professionally the costs and revenue consequences detailed in the business case for capital investment |
| N/A       | Director of Finance | Selection of architects, quantity surveyors, consultant engineer and other professional advisors within EU regulations |
| SFI 12.1.3 | Director of Finance | Financial Monitoring and reporting on the capital programme. |
| SFI 12.1.4 | Chief Executive | Issue a scheme of delegation for capital investment management in accordance with &quot;Estatecode&quot; guidance and the Trust's Standing Orders |
| SFI 12.1.5 | Director of Finance | Issue procedures governing financial management, including variations to contract, of capital investment projects and valuation for accounting purposes. |
| SFI 12.2  | Director of Finance | Demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector. |
| SFI 12.3.1 | Director of Finance | Maintenance of asset registers. |</p>
<table>
<thead>
<tr>
<th>REFERENCE</th>
<th>DELEGATED TO</th>
<th>DUTIES DELEGATED</th>
</tr>
</thead>
<tbody>
<tr>
<td>SFI 12.3.5</td>
<td>Director of Finance</td>
<td>Approve procedures for reconciling balances on fixed assets accounts in ledgers 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 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 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>REFERENCE</th>
<th>DELEGATED TO</th>
<th>DUTIES DELEGATED</th>
</tr>
</thead>
<tbody>
<tr>
<td>SFI 13.1.2</td>
<td>Director of Finance</td>
<td>Responsible for systems of control over stores and receipt of goods.</td>
</tr>
<tr>
<td>SFI 13.1.2</td>
<td>Designated Pharmaceutical Officer</td>
<td>Responsible for controls of pharmaceutical stock</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/ Pharmaceutical Officer</td>
<td>Security arrangements and custody of keys</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 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, disposal and replacement of all unserviceable items.</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>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>REFERENCE</th>
<th>DELEGATED TO</th>
<th>DUTIES DELEGATED</th>
</tr>
</thead>
<tbody>
<tr>
<td>SFI 14.1.1</td>
<td>Director of Finance</td>
<td>Prepare detailed procedures for disposal of assets including condemnations and ensure that these are notified to managers.</td>
</tr>
<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 Counter Fraud Authority 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>
</tr>
<tr>
<td>-----------</td>
<td>--------------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
</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 Counter Fraud Authority’s Security Standards for Providers on security management</td>
</tr>
<tr>
<td>SFI 14.3.2</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>
</tr>
<tr>
<td>-----------</td>
<td>--------------</td>
<td>------------------</td>
</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>
<thead>
<tr>
<th>REFERENCE</th>
<th>DELEGATED TO</th>
<th>DUTIES DELEGATED</th>
</tr>
</thead>
<tbody>
<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>
</tbody>
</table>
| 25. COMPLAINTS | N/A                                              | Director of Corporate Affairs and Governance  
Deputy Director of Corporate Affairs and Governance  
Level 5  
  
 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 - Co ordination of their management.  |

| 26. SEAL     | SO 7.1.1/7.4.1                                  | Chief Executive  
SO 7.2.1  
  
Chairman/Chief Executive  
  
 a) Keep seal in safe place and maintain a register of sealing.  
 b) Attestation of sealings in accordance with Standing Orders |

| 27. SPONSORSHIP | N/A                                             | Chief Executive & Medical Director  
  
 a) Authorisation of Sponsorship deals |

| 28. RESEARCH & CLINICAL TRIALS | N/A                                              | Chief Executive & Medical Director  
  
 a) Authorisation of Research Projects  
 b) Authorisation of Clinical Trials |

| 29. RELATIONSHIPS WITH PRESS | N/A                                              | Director of Corporate Affairs & Governance  
  
 a) Non-Emergency General Enquiries  
 b) Within Hours |
<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></td>
<td>Outside Hours</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 |
### REFERENCE

<table>
<thead>
<tr>
<th>SERVICE AREA MANAGER OR CLINICAL DIRECTOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>DELEGATED TO</td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>Service area Manager or Clinical Director</td>
</tr>
<tr>
<td>Service area Manager or Clinical Director</td>
</tr>
<tr>
<td>Service area Manager or Clinical Director</td>
</tr>
<tr>
<td>Bed Manager / On Call Manager</td>
</tr>
<tr>
<td>Director of Nursing Performance and Quality</td>
</tr>
</tbody>
</table>

b) All proposed changes in bed allocation and use

#### FACILITIES FOR STAFF NOT EMPLOYED BY THE TRUST TO GAIN PRACTICAL EXPERIENCE

<table>
<thead>
<tr>
<th>FACILITIES</th>
<th>N/A</th>
<th>Clinical Director or Director of Human Resources and Organisational Development</th>
<th>Professional Recognition, Honorary Contracts, &amp; Insurance of Medical Staff. Work experience students</th>
</tr>
</thead>
</table>

#### FIRE

<table>
<thead>
<tr>
<th>FACILITIES</th>
<th>N/A</th>
<th>Director of Corporate Affairs and Governance</th>
<th>Review of fire precautions</th>
</tr>
</thead>
<tbody>
<tr>
<td>FACILITIES</td>
<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>
</tbody>
</table>

#### HEALTH & SAFETY

<table>
<thead>
<tr>
<th>FACILITIES</th>
<th>N/A</th>
<th>Director of Corporate Affairs</th>
<th>Review of all statutory compliance legislation and Health and Safety requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>FACILITIES</td>
<td>N/A</td>
<td>Ms A Harrison</td>
<td>Non Executive lead for Health &amp; Safety</td>
</tr>
<tr>
<td>REFERENCE</td>
<td>DELEAGTED TO</td>
<td>DUTIES DELEGATED</td>
<td></td>
</tr>
<tr>
<td>-----------</td>
<td>--------------</td>
<td>------------------</td>
<td></td>
</tr>
<tr>
<td>and Governance</td>
<td>including control of Substances Hazardous to Health Regulations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>36. MEDICINES INSPECTORATE</td>
<td>N/A</td>
<td>Medical Director</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Review of Medicines Inspectorate Regulations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>37. ENVIRONMENTAL REGULATIONS</td>
<td>N/A</td>
<td>Director of Finance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Review of compliance with environmental regulations, for example those relating to clean air and waste disposal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>38. CONTRACTUAL ARRANGEMENTS</td>
<td>N/A</td>
<td>Director of Finance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Monitor proposals for contractual arrangements between the Trust and outside bodies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>39. INFORMATION GOVERNANCE</td>
<td>N/A</td>
<td>Chief Executive</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Identified as Qualified Person for Freedom of Information Requests</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Director of Corporate Affairs and Governance</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Set up a system for monitoring compliance against the Information Governance Toolkit</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>All employees</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Undertake the information governance training module on an annual basis</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Director of Corporate Affairs and Governance</td>
<td></td>
<td></td>
</tr>
<tr>
<td></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>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Director of Corporate Affairs and Governance (SIRO)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Develop robust systems and policies to ensure patient confidentiality and confidentiality of person identifiable data</td>
<td></td>
<td></td>
</tr>
<tr>
<td>40. GMC</td>
<td>N/A</td>
<td>Reporting to Medical Director</td>
<td></td>
</tr>
<tr>
<td></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>
<td></td>
<td></td>
</tr>
<tr>
<td>41. NURSING &amp; MEDICAL ADVICE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>REFERENCE</td>
<td>DELEGATED TO</td>
<td>DUTIES DELEGATED</td>
<td></td>
</tr>
<tr>
<td>-----------</td>
<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>
<td></td>
</tr>
<tr>
<td>N/A</td>
<td>Medical Director</td>
<td>Provision of Medical Advice to the Board</td>
<td></td>
</tr>
<tr>
<td>N/A</td>
<td>Medical Director</td>
<td>Designated individual for Human Tissue Authority regulations</td>
<td></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**

<table>
<thead>
<tr>
<th>REFERENCE</th>
<th>DELEGATED TO</th>
<th>DUTIES DELEGATED</th>
</tr>
</thead>
<tbody>
<tr>
<td>SFI 15.5.1</td>
<td>Director of Corporate Affairs and Governance</td>
<td>Set up a system to monitor freedom of information requests received, responded to and where exemptions apply</td>
</tr>
<tr>
<td>SFI 15.5.2</td>
<td>Director of Corporate Affairs and Governance</td>
<td>Publish and maintain a Freedom of Information publication scheme</td>
</tr>
</tbody>
</table>

**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>
5. DELEGATED FINANCIAL LIMITS

<table>
<thead>
<tr>
<th>Level of Authority</th>
<th>Authority Delegated to</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>Administrator</td>
</tr>
<tr>
<td>7</td>
<td>Budget Holder</td>
</tr>
<tr>
<td>6</td>
<td>Service Manager, including senior finance staff</td>
</tr>
<tr>
<td>5</td>
<td>Associate Director</td>
</tr>
<tr>
<td>4</td>
<td>Deputies (excluding Deputy Director of Finance)</td>
</tr>
<tr>
<td>3</td>
<td>Executive (excluding Director of Finance)</td>
</tr>
<tr>
<td>2</td>
<td>Director of Finance and Deputy Director of Finance</td>
</tr>
<tr>
<td>1</td>
<td>Chief Executive and Deputy Chief Executive</td>
</tr>
</tbody>
</table>

<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>Level 8 - Administrator</td>
<td>SFIs Section 9</td>
</tr>
<tr>
<td>Non Purchase Order invoice, Stock / non stock requisitions up to £1,000</td>
<td>Level 7 – Budget Holder</td>
<td></td>
</tr>
<tr>
<td>Non Purchase Order invoice, Stock / non stock requisitions up to £5,000</td>
<td>Level 6 – Service manager, including senior finance staff</td>
<td></td>
</tr>
<tr>
<td>Non Purchase Order invoice, Stock / non stock requisitions up to £15,000</td>
<td>Associate Directors</td>
<td></td>
</tr>
<tr>
<td>Non Purchase Order invoice, Stock / non stock requisitions up to £30,000</td>
<td>Deputies (excluding Deputy Director of Finance)</td>
<td></td>
</tr>
<tr>
<td>Non Purchase Order invoice, Stock / non stock requisitions up to £74,999</td>
<td>Level 3 – Executive (excluding Director of Finance)</td>
<td></td>
</tr>
<tr>
<td>Non Purchase Order invoice, Stock / non stock requisitions up to £74,999</td>
<td>Level 3 – Executive (excluding 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>Non Purchase Order invoice, Stock / non stock requisitions up to £999,999</td>
<td>Director of Finance and Deputy Director of Finance</td>
<td></td>
</tr>
<tr>
<td>Non Purchase Order invoice, Stock / non stock requisitions over £1,000,000</td>
<td>Chief Executive and Deputy 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>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></th>
<th></th>
<th>SFI's Section 18 / Appendix C3</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Obtaining price information for goods and services up to £5,000</td>
<td>Head of Procurement</td>
<td></td>
</tr>
<tr>
<td>b) Inviting a minimum of 3 written quotations where appropriate for goods/services</td>
<td>Head of Procurement</td>
<td></td>
</tr>
<tr>
<td>c) Obtaining written competitive tenders for goods/services over £50,000 up to EU threshold</td>
<td>Chief Executive or Designated Officer</td>
<td></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>
<td></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>
<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>f) Opening tenders</td>
<td>Two Executive Directors</td>
<td></td>
</tr>
</tbody>
</table>

3. **Business Case Approval**

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Approval of business cases for individual schemes up to £250,000, within the overall capital budget</td>
<td>Chief Executive</td>
<td></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>
<td></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>
<td></td>
</tr>
</tbody>
</table>

4. **Engagement of Staff Not On the Establishment** To include Management consultants (including professional services) and agency staff

<table>
<thead>
<tr>
<th>Budget holders have a responsibility to manage resources</th>
<th>SFIs Section 8</th>
</tr>
</thead>
<tbody>
<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>
</tbody>
</table>
| d) Booking of Bank, Locums or Agency Staff  
  - Medical Locums  
  - Nursing  
  - Clerical | As per trust policy |
### FINANCIAL LIMITS

<table>
<thead>
<tr>
<th>FINANCIAL LIMITS</th>
<th>AUTHORITY DELEGATED TO</th>
<th>REFERENCE DOCUMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>5. Condemning &amp; Disposal</strong></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>Items obsolete, redundant or cannot be repaired cost effectively</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>a) Condemnation of equipment</strong></td>
<td>Director of Finance</td>
<td></td>
</tr>
<tr>
<td><strong>b) disposal of x-ray films (subject to estimated income of £1,000 per sale)</strong></td>
<td>Head of Integrated Governance</td>
<td></td>
</tr>
<tr>
<td><strong>c) disposal of mechanical and engineering plant (subject to estimated income of less than £1,000 per sale)</strong></td>
<td>Estates Manager</td>
<td></td>
</tr>
<tr>
<td><strong>d) disposal of mechanical and engineering plant (subject to estimated income exceeding £1,000 per sale)</strong></td>
<td>Estates Manager/Director of Finance</td>
<td></td>
</tr>
<tr>
<td><strong>6. Losses, Write-off &amp; Compensation</strong></td>
<td>SFIs Section 13</td>
<td></td>
</tr>
<tr>
<td><strong>a) Losses and Cash due to theft, fraud, overpayment &amp; others</strong></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><strong>b) Fruitless Payments (including abandoned Capital Schemes)</strong></td>
<td>Chief Executive or Director of Finance</td>
<td></td>
</tr>
<tr>
<td>Up to £250,000</td>
<td></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>Chief Executive or Director of Finance</td>
</tr>
<tr>
<td>a) Up to £25,000</td>
<td></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>Chief Executive or Director of Finance</td>
</tr>
<tr>
<td>a) up to £25,000</td>
<td></td>
<td>[Reported to Audit Committee for information]</td>
</tr>
<tr>
<td>b) over £25,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>h) Write off of Non NHS Debtors</td>
<td>Deputy Director of Finance</td>
<td>Chief Executive or Director of Finance</td>
</tr>
<tr>
<td>a) up to £25,000</td>
<td></td>
<td>[Reported to Audit Committee for information]</td>
</tr>
<tr>
<td>b) over £25,000</td>
<td></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) Ex-Gratia Payments</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>SFIs Section 13</td>
<td></td>
</tr>
<tr>
<td>a) For clinical negligence</td>
<td>i. Chief Executive or Director of Finance</td>
<td></td>
</tr>
<tr>
<td>i. up to £1,000,000 (negotiated settlements) 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>i. Chief Executive or Director of Finance</td>
<td></td>
</tr>
<tr>
<td>i. Up to £1,000,000 (including plaintiff's costs) 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>SFIs Section 9</td>
<td></td>
</tr>
<tr>
<td>a) Expenditure up to £25 per item</td>
<td>Senior Finance Staff</td>
<td></td>
</tr>
<tr>
<td>b) Reimbursement of patients monies up to £100</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) Reimbursement of patients monies in excess of £100</td>
<td></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>9. Authorisation of New Drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated total yearly cost up to £25,000</td>
<td>Clinical Director/Head of Pharmacy</td>
<td>SFI’s Section 9</td>
</tr>
<tr>
<td>Estimated total yearly cost above £25,000</td>
<td>Medicines Management Committee and Clinical Director and Director of Finance</td>
<td></td>
</tr>
<tr>
<td>10. Virement (in year transfer between budget lines)</td>
<td></td>
<td></td>
</tr>
<tr>
<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</td>
<td></td>
</tr>
<tr>
<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>
<td></td>
</tr>
<tr>
<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>
<td></td>
</tr>
</tbody>
</table>
Standing Financial Instructions
FOREWARD

The Board operates within a statutory framework within which it is required to adopt Standing Orders. The "Directions on Financial Management in England" issued under HSG(96)12 in 1996 states that the Board must adopt Standing Financial Instructions (SFIs) setting out the responsibilities of individuals. NHS trusts are asked to observe the Directions as far as they are relevant as a matter of good practice.

The Code of Accountability for NHS Boards (published by the Department of Health in April 1994, EL(94)40) requires Boards to draw up standing orders, a schedule of decisions reserved to the board and standing financial instructions. The code also requires Boards ensure that there are management arrangements in place to enable responsibility to be clearly delegated to senior executives. Additionally, Boards will have drawn up locally generated rules and instructions, including financial procedural notes, for use within their organisation. Collectively these must comprehensively cover all aspects of (financial) management and control. In effect, they set the business rules which directors and employees (including employees of third parties contracted to the Trust) must follow when taking action on behalf of the Board.

Once SFIs have been adopted by the Board they become mandatory on all directors and employees of the organisation
CONTENTS

FOREWORD

1 INTRODUCTION

2 AUDIT

3 BUSINESS PLANNING, BUDGETS, BUDGETARY CONTROL AND MONITORING

4 ANNUAL ACCOUNTS AND REPORTS

5 BANK ACCOUNTS

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

7 CONTRACTING FOR PROVISION OF SERVICES

8 COMPETING FOR CONTRACTS FOR PROVISION OF SERVICES

9 TERMS OF SERVICE AND PAYMENT OF DIRECTORS AND EMPLOYEES

10 NON-PAY EXPENDITURE

11 BORROWING AND INVESTMENTS

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

13 STORES AND RECEIPT OF GOODS

14 DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

15 INFORMATION TECHNOLOGY

16 PATIENTS' PROPERTY

17 RETENTION OF DOCUMENTS

18 INSURANCE

19 TENDERING AND CONTRACT PROCEDURE

20 DISPOSALS

21 IN HOUSE SERVICES

22 ACCEPTANCE OF GIFTS BY STAFF AND LINK TO STANDARDS OF BUSINESS CONDUCT
1 INTRODUCTION

1.1 GENERAL

1.1.1 These Standing Financial Instructions (SFIs) are issued in accordance with the Financial Directions issued by the Secretary of State - under the provisions of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) and the National Health Service and Community Care Act 1990 (as amended and the Health and Social Care Act 2008) - for the regulation of the conduct of the Trust in relation to all financial matters. They shall have effect as if incorporated in the Standing Orders (SOs) of the Trust.

1.1.2 These SFIs detail the financial responsibilities, policies and procedures to be adopted by the Trust. They are designed to ensure that its financial transactions are carried out in accordance with the law and Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Schedule of Decisions Reserved to the Board and the Scheme of Delegation adopted by the Trust.

1.1.3 These SFIs identify the financial responsibilities which apply to everyone working for the Trust and its constituent organisations including Trading Units. They do not provide detailed procedural advice. These statements should therefore be read in conjunction with the detailed departmental and financial procedure notes. All financial procedures must be approved by the Director of Finance.

1.1.4 Should any difficulties arise regarding the interpretation or application of any of the SFIs then the advice of the Director of Finance (Must be sought before acting). The user of these SFIs should also be familiar with and comply with the provisions of the Trust's SOs.

1.1.5 Failure to comply with SFIs and SOs is a disciplinary matter which could result in dismissal.

1.2 TERMINOLOGY

1.2.1 Any expression to which a meaning is given in Health Service Acts, or in the Financial Directions made under the Acts, shall have the same meaning in these instructions; and

(a) "Board" means the Board of the Trust;

(b) "Budget" means a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust;

(c) "Budget Holder" means the director or employee with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisation; and

(d) "Chief Executive" means the chief officer of the Trust;
(e) "Director of Finance" means the chief financial officer of the Trust;

(f) "Funds held on trust" shall mean those funds which the Trust holds at 1st April 1996 or date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under powers derived under paragraph 14(2) of Schedule 4 on the NHS Act 2006, as amended. Such funds may or may not be charitable

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

(h) "Trust" means the East Cheshire NHS Trust.

1.2.2 Wherever the title Chief Executive, Director of Finance, or other nominated officer is used in these instructions, it shall be deemed to include such other director or employees who have been duly authorised to represent them.

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

1.3 RESPONSIBILITIES AND DELEGATION

1.3.1 The Board exercises financial supervision and control by:

(a) formulating the financial strategy;

(b) requiring the submission and approval of budgets within approved allocations/overall income;

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

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

1.3.2 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the 'Reservation of Powers to the Board' document.

1.3.3 The Board will delegate responsibility for the performance of its functions in accordance with the Scheme of Delegation document adopted by the Trust.

1.3.4 Within the SFIs, it is acknowledged that the Chief Executive is ultimately accountable to the Board and as accountable officer to the Secretary of State, for 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 Counter Fraud Authority in relation to fraud, bribery and corruption.

2.2.2 The Trust shall nominate a suitable person to carry out the duties of the Local Anti-Fraud Specialist as specified by the NHS Counter Fraud Authority Fraud and Corruption manual and guidance.

2.2.3 The Local Anti-Fraud Specialist shall report to the Trust Director of Finance and work with staff of NHS Counter Fraud Authority and requirements of the
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 Counter Fraud Authority).

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:

(a) approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;

(b) ordering and securely controlling any such stationery;

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

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

6.4.2 Official money shall not under any circumstances be used for the encashment of private cheques.

6.4.3 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Director of Finance.

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

6.4.5 Any loss or shortfall of cash, cheques or other negotiable instruments, however occasioned, shall be reported immediately to the Director of Finance. Where there is prima facie evidence of fraud or corruption this should follow the form of the Trust’s Anti Fraud, Bribery and Corruption
Policy & Response Plan and the guidance provided by the Anti-Fraud Specialist.
Where there is no evidence of fraud or corruption the loss should be dealt with in line with the Trust’s Losses and Special Payments Procedures

6.4.6 The Money Laundering Regulations 2007\(^1\) 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
8.1.4 In deciding whether to bid for contracts, the Chief Executive shall prepare and regularly review a Standard Operating Procedure (S.O.P.) for ensuring that decisions follow a strategic and logical framework and that bids are made in an appropriate and timely manner (C4 contains the current S.O.P.).

8.2 INVOLVING PARTNERS AND JOINTLY MANAGING RISK

8.2.1 The Chief Executive should ensure that the Trust works, within the constraints of the tender process, with all partner agencies/bodies involved in both the delivery and the commissioning of the service required.

8.2.2 Where partner agencies/bodies are involved the contract should apportion responsibility for handling a particular risk to the party or parties in the best position to influence the event and financial arrangements should reflect this. In this way the Trust can jointly manage risk with all interested parties.

8.3 REPORTS TO THE BOARD AND ITS COMMITTEES ON CONTRACTS

8.3.1 The Chief Executive, as the Accountable Officer, will delegate to the Director of Finance, the responsibility to ensure that regular reports are provided to the Trust Board or its appropriate committee (currently Finance, Performance & Workforce Committee), detailing the nature of the contract, the forecast income, timescales. The report will also outline potential future tenders expected, as well as recently bid contract.

9 TERMS OF SERVICE AND PAYMENT OF DIRECTORS AND EMPLOYEES

9.1 REMUNERATION AND TERMS OF SERVICE

9.1.1 In accordance with Standing Orders the Board shall establish a Remuneration and Terms of Service Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting. (See NHS guidance contained in the Higgs report.)

9.1.2 The Committee will:

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

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

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

(iii) arrangements for termination of employment and other contractual terms;
(b) Make such recommendations to the Board on the remuneration and terms of service of executive directors (and other senior employees) to ensure they are fairly rewarded for their individual contribution to the Trust - having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such staff where appropriate. The Chief Executive will report on the performance of individual Executive Directors.

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

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

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

9.1.5 The Trust will remunerate the Chairman and Non-executive Directors in accordance with instructions issued by the Secretary of State.

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.
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

114
(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 Counter Fraud Authority in accordance with its contractual requirements under the NHS Standards Contract.

14.2.3 The Director of Finance must notify the NHS Counter Fraud Authority and the External Auditor of all frauds.

14.2.4 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Director of Finance must immediately notify:

(a) the Audit Committee, and

(b) the External Auditor.

14.2.5 Within limits delegated to it by the Department of Health, the Audit Committee shall approve the writing-off of losses.

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

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

14.2.8 The Director of Finance shall maintain a Losses and Special Payments Register in which write-off action is recorded.

14.2.9 No special payments exceeding delegated limits shall be made without the prior approval of the Department of Health.

14.2.10 All losses and special payments must be reported to the Audit Committee at every meeting.

14.3 SECURITY MANAGEMENT

14.3.1 In line with their responsibilities, the Trust Director of Finance will monitor and ensure compliance with the requirements of the NHS Counter Fraud Authority security standards for providers on NHS security management.

14.3.2 The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist, as specified by the requirements of the NHS Counter Fraud Authority security standards for providers on NHS Security Management.

14.3.3 The Chief Executive has overall responsibility for controlling and coordinating security. However, key tasks are delegated to the Director of Finance and the appointed Local Security Management Specialist.
15 INFORMATION TECHNOLOGY

15.1 The Chief Executive has overall responsibility for Information Technology. The Director of Finance, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:

(a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which he/she is responsible and from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998;

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

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

(d) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews are being carried out.

15.1.2 The Director of Finance shall satisfy himself that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy will be obtained from them prior to implementation.

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

15.1.4 Where another health organisation or any other agency provides a computer service for financial applications, the Director of Finance shall periodically seek assurances that adequate controls are in operation.

15.1.5 Where computer systems have an impact on corporate financial systems the Director of Finance shall satisfy themselves that:

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

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

(c) staff have access to such data; and such computer audit reviews as are considered necessary are being carried out.
15.2 RESPONSIBILITIES AND DUTIES OF OTHER DIRECTORS AND OFFICERS IN RELATION TO COMPUTER SYSTEMS OF A GENERAL APPLICATION

15.2.1 In the case of computer systems which are proposed General Applications (i.e. normally those applications which the majority of Trust’s in the region wish to sponsor jointly) all responsible directors and employees will send to the Director of Finance:

(a) details of the outline design of the system;

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

15.3 CONTRACTS FOR COMPUTER SERVICES WITH OTHER HEALTH BODIES OR OUTSIDE AGENCIES

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

15.3.2 Where another health organisation or any other agency provides a computer service for financial applications, the Director of Finance shall periodically seek assurances that adequate controls are in operation.

15.4 RISK ASSESSMENT

15.4.1 The Director of Corporate Affairs and Governance shall ensure that risks to the Trust arising from the use of IT are effectively identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans.

15.5 FREEDOM OF INFORMATION

15.5.1 The Director of Corporate Affairs and Governance shall ensure that processes for the receipt, assessment and response to Freedom of Information requests are in place, defined and monitored against the requirements of the Freedom of Information Act (2000).

15.5.2 The Director of Corporate Affairs and Governance shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about our Trust that we make publicly available.
16 PATIENTS PROPERTY

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

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

(a) notices and information booklets,
(b) hospital admission documentation and property records,
(c) the oral advice of administrative and nursing staff responsible for admissions,
(d) that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

16.3 The Director of Finance must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

16.4 Where Department of Health instructions require the opening of separate accounts for patients' moneys, these shall be opened and operated under arrangements agreed by the Director of Finance.

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

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

16.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.
17 RETENTION OF RECORDS

17.1 The Director of Corporate Affairs and Governance shall be responsible for maintaining archives for all records required to be retained in accordance with Department of Health guidelines.

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

17.3 Records held in accordance with the latest Department of Health guidance shall only be destroyed at the express instigation of the Director of Corporate Affairs and Governance, records shall be maintained of documents so destroyed.

18 INSURANCE

18.1 INSURANCE: RISK POOLING SCHEMES ADMINISTERED BY 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 advantage or further private business or other interests, in the course of their official duties.

IMPLEMENTING THE GUIDING PRINCIPLES

CASUAL GIFTS

7. Casual gifts offered by contractors or others, e.g. at Christmas time, may not be in any way connected with the performance of duties so as to constitute an offence under the Bribery Act 2010. Such gifts should nevertheless be politely but firmly declined.

Articles of low intrinsic value such as diaries or calendars, or small tokens of gratitude from patients or their relatives, need not necessarily be refused. In cases of doubt staff should either consult their line manager or politely decline acceptance.

HOSPITALITY

8. Modest hospitality provided it is normal and reasonable in the circumstances, e.g. lunches in the course of working visits, may be acceptable, though it should be similar to the scale of hospitality which the NHS as an employer would be likely to offer.

9. Staff should decline all other offers of gifts, hospitality or entertainment. If in doubt they should seek advice from their line manager.
DECLARATION OF INTERESTS

10. NHS employers need to be aware of all cases where an employee, or his or her close relative or associate, has a controlling and/or significant financial interest in a business (including a private company, public sector organisation, other NHS employer and/or voluntary organisation), or in any other activity or pursuit, which may compete for an NHS contract to supply either goods or services to the employing authority.

11. All NHS staff should therefore declare such interests to their employer, either on starting employment or on acquisition of the interest, in order that it may be known to and in no way promoted to the detriment of either the employing authority or the patients whom it serves.

12. One particular area of potential conflict of interest which may directly affect patients, is when NHS staff hold a self-beneficial interest in private care homes or hostels. While it is for staff to declare such interests to their employing authority, the employing authority has a responsibility to introduce whatever measures it considers necessary to ensure that its interests and those of patients are adequately safeguarded. This may for example take the form of a contractual obligation on staff to declare any such interests. Advice on professional conduct issued by the General Medical Council recommends that when a doctor refers a patient to a private care home or hostel in which he or she has an interest, the patient must be informed of that interest before referral is made.

13. In determining what needs to be declared, employers and employees will wish to be guided by the principles set out in paragraph 5 above; also the more detailed guidance to staff contained in Part D.

14. NHS employers should:
   - ensure that staff are aware of their responsibility to declare relevant interests (perhaps by including a clause to this effect in staff contracts)
   - consider keeping registers of all such interests and making them available for inspection by the public.
   - develop a local policy, in consultation with staff and local staff interests, for implementing this guidance. This may include the disciplinary action to be taken if an employee fails to declare a relevant interest, or is found to have abused his or her official position, or knowledge, for the purpose of self-benefit, or that of family or friends.

PREFERENTIAL TREATMENT IN PRIVATE TRANSACTIONS

15. Individual staff must not seek or accept preferential rates or benefits in kind for private transactions carried out with companies with which they have had, or may have, official dealings on behalf of their NHS employer. (This does not apply to concessionary agreements negotiated with companies by NHS management, or by recognised staff interests, on behalf of all staff - for example, NHS staff benefits schemes.)

CONTRACTS

16. All staff who are in contact with suppliers and contractors (including external consultants), and in particular those who are authorised to sign Purchase Orders, or place contracts for goods, materials or services, are expected to adhere to professional standards of the kind set out in the Ethical Code of the Chartered Institute of Purchasing and Supply (IPS), reproduced at PART E.
FAVORITISM IN AWARDING CONTRACTS

17. Fair and open competition between prospective contractors or suppliers for NHS contracts is a requirement of NHS Standing Orders and of EC Directives on Public Purchasing for Works and Supplies. This means that:

- no private, public or voluntary organisation or company which may bid for NHS business should be given any advantage over its competitors, such as advance notice of NHS requirements. This applies to all potential contractors, whether or not there is a relationship between them and the NHS employer, such as a long-running series of previous contracts.
- each new contract should be awarded solely on merit, taking into account the requirements of the NHS and the ability of the contractors to fulfill them.

18. NHS employers should ensure that no special favour is shown to current or former employees or their close relatives or associates in awarding contracts to private or other businesses run by them or employing them in a senior or relevant managerial capacity. Contracts may be awarded to such businesses where they are won in fair competition against other tenders, but scrupulous care must be taken to ensure that the selection process is conducted impartially, and that staff who are known to have a relevant interest play no part in the selection.

WARNINGS TO POTENTIAL CONTRACTORS

19. NHS employers will wish to ensure that all invitations to potential contractors to tender for NHS business include a notice warning tenderers of the consequences of engaging in any corrupt practices involving employees of public bodies.

OUTSIDE EMPLOYMENT

20. NHS employees are advised not to engage in outside employment which may conflict with their NHS work, or be detrimental to it. They are advised to tell their NHS employing authority if they think they may be risking a conflict of interest in this area: the NHS employer will be responsible for judging whether the interests of patients could be harmed, in line with the principles in paragraph 5 above. NHS employers may wish to consider the preparation of local guidelines on this subject.

PRIVATE PRACTICE

21. Consultants (and associate specialists) employed under the Terms and Conditions of Service of Hospital Medical and Dental Staff are permitted to carry out private practice in NHS hospitals subject to the conditions outlined in the consultant contract and BMA guidance. Consultants who have signed new contracts with Trusts will be subject to the terms applying to private practice in those contracts.

22. Other grades may undertake private practice or work for outside agencies, providing they do not do so within the time they are contracted to the NHS, and they observe the conditions in paragraph 20 above. All hospital doctors are entitled to fees for other work outside their NHS contractual duties under "Category 2" (paragraph 37 of the TCS of Hospital Medical and Dental staff), e.g. examinations and reports for life insurance purposes. Hospital doctors and dentists in training should not undertake locum work outside their contracts where such work would be in breach of their contracted hours. Career grade medical and dental staff employed by NHS Trusts may agree terms and conditions different from the National Terms and Conditions of Service.
REWARDS FOR INITIATIVE (PLEASE REFER TO HR56 INTELLECTUAL PROPERTY POLICY)

23. NHS employers should ensure that they are in a position to identify potential intellectual property rights (IPR), as and when they arise, so that they can protect and exploit them properly, and thereby ensure that they receive any rewards or benefits (such as royalties) in respect of work commissioned from third parties, or work carried out by their employees in the course of their NHS duties. Most IPR are protected by statute; e.g. patents are protected under the Patents Act 1977 and copyright (which includes software programmes) under the Copyright Designs and Patents Act 1988. To achieve this, NHS employers should build appropriate specifications and provisions into the contractual arrangements which they enter into before the work is commissioned, or begins. They should always seek legal advice if in any doubt in specific cases.

24. With regard to patents and inventions, in certain defined circumstances the Patents Act gives employees a right to obtain some reward for their efforts, and employers should see that this is effected. Other rewards may be given voluntarily to employees who within the course of their employment have produced innovative work of outstanding benefit to the NHS. Similar rewards should be voluntarily applied to other activities such as giving lectures and publishing books and articles.

25. In the case of collaborative research and evaluative exercises with manufacturers, NHS employers should see that they obtain a fair reward for the input they provide. If such an exercise involves additional work for an NHS employee outside that paid for by the NHS employer under his or her contract of employment, arrangements should be made for some share of any rewards or benefits to be passed on to the employee(s) concerned from the collaborating parties. Care should however be taken that involvement in this type of arrangement with a manufacturer does not influence the purchase of other supplies from that manufacturer.
Appendix 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 Counter Fraud Authority;
- judgements about colleagues (including appraisals and references) are consistent, fair and unbiased and are properly founded; and
- open and learning organisations are created in which concerns about people breaking the Code can be raised without fear.

4) I will accept responsibility for my own work and the proper performance of the people I manage. I will seek to ensure that those I manage accept that they are responsible for their actions to:
- the public and their representatives by providing a reasonable and reasoned explanation of the use of resources and performance;
- patients, relatives and carers by answering questions and complaints in an open, honest and well researched way and in a manner which provides a full explanation of what has happened, and of what will be done to deal with any poor performance and, where appropriate giving an apology; and
- NHS staff and partners in other agencies by explaining and justifying decisions on the use of resources and give due and proper consideration to suggestions for improving performance, the use of resources and service delivery. I will support and assist the Accountable Officer of my organisation in his or her responsibility to answer to Parliament, Ministers and the Department of Health in terms of fully and faithfully declaring and explaining the use of resources and the performance of the local NHS in putting national policy into practice and delivering targets.

For the avoidance of doubt, nothing in paragraphs two to four of this Code requires or authorises an NHS manager to whom this Code applies to:
- make, commit or knowingly allow to be made any unlawful disclosure;
- make, permit or knowingly allow to be made any disclosure in breach of his or her duties and obligations to his or her employer, save as permitted by law.

If there is any conflict between the above duties and obligations and this Code, the former shall prevail.

5) I will show my commitment to working as a team by working to create an environment in which:
- teams of frontline staff are able to work together in the best interests of patients;
- leadership is encouraged and developed at all levels and in all staff groups; and
- the NHS plays its full part in community development.

6) I will take responsibility for my own learning and development. I will seek to:
- take full advantage of the opportunities provided;
- keep up to date with best practice; and
- share my learning and development with others.
IMPLEMENTING THE CODE

1. The Code should be seen in a wider context that NHS managers must follow the ‘Nolan Principles on Conduct in Public Life’, the ‘Corporate Governance Codes of Conduct and Accountability’, the ‘Standards of Business Conduct’, the ‘Code of Practice on Openness in the NHS’ and standards of good employment practice.

2. In addition many NHS managers come from professional backgrounds and must follow the code of conduct of their own professions as well as this Code. In order to maintain consistent standards, NHS bodies need to consider suitable measures to ensure that managers who are not their employees but who:
   (i) manage their staff or services; or
   (ii) manage units which are primarily providing services to their patients also observe the Code.

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).
<table>
<thead>
<tr>
<th>Title: Safety, Quality and Standards (SQS) Committee</th>
<th>East Cheshire NHS Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Authors Name: Director of Nursing, Performance and Quality</td>
<td></td>
</tr>
<tr>
<td>Scope: Trust Wide</td>
<td>Classification: Trust Organisation Structure and Minutes</td>
</tr>
<tr>
<td>Replaces: Safety Quality and Standards Committee Terms of Reference February 17</td>
<td></td>
</tr>
<tr>
<td>To be read in conjunction with the following documents: The Trust’s Standing Orders and other Committee Terms of Reference</td>
<td></td>
</tr>
<tr>
<td>Review Date: February 2019</td>
<td></td>
</tr>
<tr>
<td>This document is no longer authorised for use after this date</td>
<td></td>
</tr>
<tr>
<td>Issue Status: 1</td>
<td>Issue No: 1 Issue Date: February 2018</td>
</tr>
<tr>
<td>Authorised by: The Trust Board</td>
<td>Authorisation Date: February 2018</td>
</tr>
<tr>
<td>Document for Public Display: Yes</td>
<td></td>
</tr>
<tr>
<td>After this document is withdrawn from use it must be kept in an archive for 6 years.</td>
<td></td>
</tr>
<tr>
<td>Archive:</td>
<td>Date added to Archive:</td>
</tr>
<tr>
<td>Officer responsible for archive: Committee Secretary</td>
<td></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.

- Declarations of interest will be collected at the start of each meeting – there is requirement that members of committee must make annual declarations of interests

- 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 2, in that the SQS Committee is responsible for providing assurance on clinical and non-clinical safety, quality and standards of practice throughout the Trust, the following Sub-Committees and Groups will provide a written report to the SQS Committee on at least an annual basis, in line with agreed Terms of Reference:
    1. Quality Forum Sub-Committee
    2. Clinical Audit and Research Effectiveness Sub-Committee
    3. Risk Management Sub-Committee
    4. Organ Donation Sub-Committee
    5. Medicines Management Sub-Committee (to include the report of the Controlled Drugs Accountable Officer)
    6. Human Tissue Authority Sub-Committee
    7. Integrated Safeguarding Sub-Committee
    8. Serious Incident Review Sub-Committee
    9. Mortality Review Sub Committee
    10. Infection, Prevention and Control Sub-Committee
    11. Safety Quality & Standards Sub-Committees of Clinical Directorates x3
    12. Radiation Protection Sub-Committee

- The committee will review and provide recommendations to the Board of any changes to the sub committees reporting to SQS. Reports by exception may take place, where necessary, to escalate significant issues / risks outside of the regular scheduled reporting.

- The committee will receive Annual Reports from Sub-Committees, which will include their self-assessments, as appendices to their reports. A schedule will be shared with the Sub-Committee Chairman
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 2019 (annually) or as required.
<table>
<thead>
<tr>
<th><strong>Title:</strong> Remuneration Committee - Terms of Reference</th>
<th><strong>East Cheshire NHS Trust</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Authors Name:</strong> Lynn McGill, Chairman</td>
<td></td>
</tr>
<tr>
<td><strong>Scope:</strong> Trust Wide</td>
<td><strong>Classification:</strong> Trust Organisation Structure and Minutes</td>
</tr>
<tr>
<td><strong>Replaces:</strong> Remuneration Committee - Terms of Reference March 2017</td>
<td></td>
</tr>
<tr>
<td><strong>To be read in conjunction with the following documents:</strong></td>
<td></td>
</tr>
</tbody>
</table>

- **Unique Identifier:** Review Date: March 2018
  - This document is no longer authorised for use after this date

- **Issue Status:** Issue No: 2 Issue Date: March 2018
  - Authorised by: Trust Board Authorisation Date: March 2018

- **Document for Public Display:** Yes

After this document is withdrawn from use it must be kept in an archive for 6 years.

- **Archive:** Date added to Archive:
- **Officer responsible for archive:**
1. **Constitution**

The Board hereby resolves to establish a Committee of the Board to be known as the 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 the NHS TDA and the Treasury, as appropriate;

- review and agree arrangements for termination of employment including proper calculation and scrutiny of termination payments and other contractual terms for staff where Executives see the circumstances as
novel or unusual; which could impact on the reputation of the organization, or where the cost of the contractual payments are over £50,000 and all non-contractual severance payments and where exceptional arrangements are made; and

- identify to the Board any unusual trends arising from termination of employment information presented to the Committee.

10.2 Delegated Authority

This committee has the delegated power to act on any decision within its remit, subject to the requirements of Standing Orders and Standing Financial Instructions.

10.3 Establishment of Groups reporting to the Committee

The Committee may establish standing and/or time limited sub-groups as it sees fit for the effective conduct of its business. Such sub-groups will not exercise powers delegated from the Trust Board unless they are established by the Trust Board as formal Sub-Committees of the Board. Terms of reference of sub-groups which are not established as Sub-Committees of the Board will be approved by the Committee. Terms of reference of formal Sub-Committees of the Board will be approved by the Trust Board.

10.4 Responsibilities

For the Chief Executive, officer members of the Board and other management staff directly accountable to the Chief Executive who are not covered by national agreements:

- Using very senior manager pay scale as guidance, to review and agree on all matters relating to the setting of, and any variations to, the terms and conditions of employment and remuneration relating to the post of Chief Executive;

- To receive, discuss and agree recommendations from the Chief Executive on all matters relating to the setting of, and any variation to, the terms and conditions of employment, and remuneration for all staff on senior manager contracts reporting directly to the Chief Executive who are not covered under Agenda for Change or any remaining staff who have not transferred to an Agenda for Change contract;

- Using very senior manager pay scale as guidance, to review and agree the remuneration of each of the above posts at least annually taking into account prevailing norms and national pay agreements and, in the case of officer members, individual performance and comparative information and any other matter the committee considers relevant;

- To determine the appropriate contractual arrangements for these staff including the proper calculation and scrutiny of termination payments, taking account of such national guidance as is appropriate;

- To ensure that the principles pertaining to remuneration packages are applied consistently and are sufficient to recruit, retain and motivate
people of high ability at the level of skills appropriate to the proper management of the Trust having regard to the affordability and value for money;

- To report annually to the Trust Board on the total impact of agreed changes;

- To ensure that the Board members emoluments and the composition of the committee is correctly disclosed in the annual report;

- To receive and consider recommendations from the Chief Executive or Executives on matters relating to the setting of remuneration local terms and conditions for other staff on local contracts; to agree recommendations to the Trust Board, e.g. senior managers on local contracts;

- To review termination arrangements for other staff members where Executives identify unusual or novel circumstances which could impact on the reputation of the organisation or where the contractual payments are over £50,000 and all non-contractual severance payments.

11. **Conduct of Meetings**

Agendas will normally be prepared and circulated 7 days in advance

Any member may request an item for the agenda through the Chair.

In order for the Committee to conduct its business, the Chief Executive will produce an annual report for consideration at the May meeting on the performance of the named executive staff reporting to him/her together with recommendations for any changes to pay or terms and conditions.

The committee will also receive:

- individual contracts/terms and conditions for staff within its remit prior to any offer of appointment and whenever any changes are proposed;
- termination conditions and calculations;
- routine analysis of total pay package of senior executives annually in May, or as required; and
- annual performance reports relating to Chief Executive annually in May, and relating to other senior managers when changes to pay or package are proposed – other than national pay awards.

Members will have the right to speak and if necessary vote at meetings of the Committee. Attendees may speak and their opinions may be sought but they will not participate in any formal vote.

Declarations of interest will be collected at the start of each meeting – there is requirement that members of committee must make annual declarations of interests

Any interest in the matter under discussion (as defined in Standing Orders) will be declared. The person declaring an interest will withdraw whilst the issue is being discussed.
In the event of a formal vote, a simple majority will prevail. In the event of a tied vote the Chair will have a deciding vote. Provided that nothing in the way business is conducted is prohibited in Standing Orders of the Trust.

Minutes of meetings will be prepared by the Director of Human Resources and Organisational Development and will be:

- Approved by the Chair before submission to the Trust Board or wider circulation;
- Approved by the Committee at the next meeting of the Committee.

Submission to the Trust Board or wider circulation should not be delayed until after approval by the Committee but should be clearly marked as not yet fully approved.

12. **Terms of Reference**

These Terms of Reference will be presented to the Trust Board at its March meeting for ratification. Any variation, including to the membership, will require the approval of the Trust Board.

The Trust Board may formally change the Terms of Reference at any time, either at its own initiation or following a request for variation submitted by the Committee.

The Committee will review the Terms of Reference annually for resubmission to the Trust Board.

The Trust Board will review the Terms of Reference submitted in the light of the wider requirements of the Trust and may amend them before approval.

These will be reviewed in March 2019.
<table>
<thead>
<tr>
<th><strong>Title:</strong></th>
<th>Audit Committee - Terms of Reference</th>
<th><strong>East Cheshire NHS Trust</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Authors Name:</strong></td>
<td>Ian Goalen - Non Executive Director</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Chair of Audit Committee</td>
<td></td>
</tr>
<tr>
<td><strong>Scope:</strong></td>
<td>Trust Wide</td>
<td></td>
</tr>
<tr>
<td><strong>Classification:</strong></td>
<td>Trust Organization Structure and Minutes</td>
<td></td>
</tr>
<tr>
<td><strong>Replaces:</strong></td>
<td>Previous Terms of Reference approved February 2017</td>
<td></td>
</tr>
<tr>
<td><strong>To be read in conjunction with the following documents:</strong></td>
<td>The Trusts Standing Orders and other Committees of the Board Terms of Reference</td>
<td></td>
</tr>
<tr>
<td><strong>Unique Identifier:</strong></td>
<td>ECT000668.AudTOR.20090318. Audit CtteeTOR</td>
<td></td>
</tr>
<tr>
<td><strong>Review Date:</strong></td>
<td>February 2019</td>
<td>This document is no longer authorised for use after this date</td>
</tr>
<tr>
<td><strong>Issue Status:</strong></td>
<td>Issue No:5</td>
<td>Issue Date: February 2018</td>
</tr>
<tr>
<td><strong>Authorised by:</strong></td>
<td>Trust Board</td>
<td>Authorisation Date: February 2018</td>
</tr>
<tr>
<td><strong>Document for Public Display:</strong></td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td><strong>After this document is withdrawn from use it must be kept in an archive for 6 years.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Archive:</strong></td>
<td>Date added to Archive:</td>
<td></td>
</tr>
<tr>
<td><strong>Officer responsible for archive:</strong></td>
<td>Head of Integrated Governance</td>
<td></td>
</tr>
</tbody>
</table>
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 above disclosure statements;

- the policies for ensuring compliance with relevant regulatory, legal, code of conduct and NHSLA requirements and related reporting and self certification; and

- the policies and procedures for all work related to fraud, bribery and corruption as set out within the NHS Standards Contract and as required by NHS Counter Fraud Authority’s Standards for Providers.

In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from Directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of effectiveness.

This will be evidenced through the Committee’s use of an effective Assurance Framework to guide its work and that of the audit and assurance function that report to it.

10.2 Internal Audit

The Committee shall ensure that there is an effective internal audit function established by management that meets mandatory NHS Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. This will be achieved by:

- consideration of the appointment of the internal audit service, the audit fee and any questions of resignation and dismissal;

- review and approval of the internal audit strategy, operational plan and programme of work in the context of the Assurance Framework;

- consideration of the major findings of internal audit investigations (and management’s response), and ensure co-ordination between the Internal and External Auditors; and

- ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation.

- Receipt of an annual review of the effectiveness of Internal Audit
10.3 **External Audit**

The Committee shall seek assurance on the work and findings of the External Auditor and consider the implications and management’s responses to their work. This will be achieved by:

- consideration of the appointment and performance of the External Auditor, as far as the rules governing the appointment permit;

- discussion and agreement with the External Auditor, before the audit commences, the nature and scope of the audit as set out in the Trust Plan (formally Annual Plan), and ensure co-ordination, as appropriate, with other External Auditors in the local health economy; and

- review of all External Audit reports, including the report to those charged with governance and agreement of the annual audit letters before submission to the Board and any work carried out which is outside the Trust Plan (formally Annual Plan), together with the appropriateness of management responses.

10.4 **Other Assurance Functions**

The Committee shall review the findings of the other assurance functions, both internal and external to the organisation and consider the implications to the governance of the organisation.

These will include, but will not be limited to, any reviews by the Department of Health arm’s length bodies or regulators/inspections for example the Care Quality Commission, NHS Resolution Authority and professional bodies with responsibilities for the performance of staff or functions.

The Committee will review the updated Assurance Framework on 3 occasions during the year, as well as a full annual review, provided by the trust’s Internal Auditors to gain assurance on the robustness of the process.

10.5 **Reporting Arrangements of other Committees and Groups**

In order to comply with the requirement that the Audit Committee is responsible for providing the Board with assurance that an effective system of integrated governance, risk management and internal control, across the whole of the organisation’s activities (both clinical and non-clinical), the following arrangements have been put in place:

Although the Safety, Quality and Standards Committee, and the Finance, Performance and Workforce Committee report directly to the Trust Board, the Audit Committee will receive formal feedback on the work of these committees particularly where their work can provide relevant assurance to the Audit Committees own scope of work

In receiving feedback on the work of the Safety, Quality and Standards Committee and issues around clinical risk management the Audit Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function.
In addition, the Committee will seek assurance on the work of other committees within the organisation, which fall within the Audit Committee’s own scope of work.

10.6 Anti Fraud

The Committee shall seek assurance that the organisation has adequate arrangements in place for countering fraud, bribery and corruption and shall review the outcomes of the anti-fraud work programme. This will include receipt of the Anti-Fraud Work Plan with progress reports provided on a recurring basis, plus the Anti-Fraud Annual Report, to ensure that the Committee is satisfied with action taken throughout the year and that significant losses have been properly investigated and reported to the internal and external auditors and relevant external bodies including NHS Counter Fraud Authority.

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.
- Declarations of interest will be collected at the start of each meeting – there is requirement that members of committee must make annual declarations of interests.
- Any interest in the matter under discussion (as defined in Standing Orders) will be declared. The person declaring an interest will withdraw whilst the issue is being discussed.
- In the event of a formal vote, a simple majority will prevail. In the event of a tied vote the Chair will have a deciding vote, provided that nothing in the way business is conducted is prohibited in Standing Orders of the Trust.

12. Reporting

Reports to the Board will be made as follows:

- The minutes of Audit Committee meetings shall be formally recorded and submitted to the Trust Board by the Chair and/or lead Executive of the Committee. In limited circumstances as covered in the Freedom of Information Act, e.g. where confidential personal information is involved, a summary or suitably edited minutes will be presented.
- Due to the timing of the Committee meetings, a verbal update, providing items for assurance and emerging risks and mitigating actions will be given to the trust board following meetings on matters that were discussed at Audit Committee meetings.
- An Annual Report of the Audit Committee
• The External Audit Annual Report.

13. **Annual Review of the Audit Committee**

The Committee will undertake an annual self assessment on their effectiveness and performance to:

- Review its own performance to ensure it is operating effectively;
- Determine whether its planned activities and responsibilities for the previous year have been sufficiently discharged; and
- Recommend any changes and/or actions it considers necessary, in respect of the above.

An annual written report will be provided to the Board which will provide details of the outcome of an annual self-assessment.

14. **Monitoring Compliance**

As part of the annual self assessment referred to in paragraph 13 which will be reported in the annual report, the Committee will review that the terms of reference have been complied with and whether they remain fit for purpose. As a minimum, the terms of reference must include:

a) Duties  
b) Reporting arrangements to the board  
c) Membership, including nominated deputy where appropriate  
d) Required frequency of attendance by members  
e) Reporting arrangements into the Audit Committee  
f) Requirements for a quorum  
g) Frequency of meetings  
h) Process for monitoring compliance with all of the above

15. **Terms of Reference**

These Terms of Reference were approved by the Trust Board at its meeting in February 2018. 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 2019 (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.
<table>
<thead>
<tr>
<th><strong>Title:</strong> Finance, Performance and Workforce Committee</th>
<th><strong>East Cheshire NHS Trust</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Authors Name:</strong> Julie Green, Director of Corporate Affairs &amp; Governance</td>
<td><strong>Classification:</strong> Trust Organisation Structure and Minutes</td>
</tr>
<tr>
<td><strong>Scope:</strong> Trust Wide</td>
<td><strong>Replaces:</strong> Not Applicable</td>
</tr>
<tr>
<td><strong>To be read in conjunction with the following documents:</strong> The Trusts Standing Orders and other Committee Terms of Reference</td>
<td></td>
</tr>
<tr>
<td><strong>Unique Identifier:</strong></td>
<td><strong>Review Date:</strong> February 2019</td>
</tr>
<tr>
<td></td>
<td>This document is no longer authorised for use after this date</td>
</tr>
<tr>
<td><strong>Issue Status:</strong> 1</td>
<td><strong>Issue No:</strong> 1</td>
</tr>
<tr>
<td><strong>Issue Date:</strong> February 2018</td>
<td><strong>Authorised by:</strong> The Trust Board</td>
</tr>
<tr>
<td><strong>Authorisation Date:</strong> March 2018</td>
<td><strong>Document for Public Display:</strong> Yes</td>
</tr>
<tr>
<td></td>
<td>After this document is withdrawn from use it must be kept in an archive for 6 years.</td>
</tr>
<tr>
<td><strong>Archive:</strong></td>
<td><strong>Date added to Archive:</strong></td>
</tr>
<tr>
<td><strong>Officer responsible for archive:</strong></td>
<td></td>
</tr>
</tbody>
</table>
1. **Constitution**

The Board hereby resolves to establish a Committee of the Board to be known as the Finance, Performance and Workforce Committee (the Committee), which is directly accountable to the Board.

2. **Definition**

This Committee is established as a Standing Committee of the Trust Board of East Cheshire NHS Trust in order to provide the Trust Board with assurance that national and local standards relating to finance, performance and workforce are being met.

3. **Membership**

Minimum 2 Non-Executive Directors (one of which will Chair) All Executive Directors

4. **Quorum**

The quorum shall be at least three members, one of which shall be a Non-Executive Director.

5. **Attendance**

Members of the Committee should make every effort to attend meetings in person. There may be circumstances where members join by telephone. If members are on annual or sick leave, deputies who have the appropriate level of authority, should attend. The Chair should be notified of members wishing to join by telephone, and the attendance of deputies, at least 24 hours in advance of the meeting.

Other specialists may be co-opted to discuss specific items on the agenda.

Members of the Finance, Performance and Workforce Committee must achieve a minimum of 75% meeting attendance. Nominated deputies attendance will not count towards the member’s attendance levels.

6. **Chairmanship**

The Chair of the Committee will be a Non-Executive Director.

The Chair will nominate a member of the Committee to Chair the meeting in their absence.
7. **Minutes**

The minutes of the meeting shall be drawn up and submitted for agreement at the next ensuing meeting.

8. **Frequency of Meetings**

The Committee shall meet a minimum of ten times per annum.

8.1 **Emergency Powers**

Where an urgent decision needs to be made in between scheduled meetings, the Chair of the committee can convene an Extra-ordinary meeting to discuss a particular issue, quorum rules as stated in paragraph 4 still apply. If it is not practicable to meet in person, matters can be dealt with through telephone or the exchange of emails. The exercise of such powers shall be reported and minuted at the next Committee meeting.

9. **Authority**

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

10. **General Responsibilities and Principles**

10.1 **Finance**

- To seek assurance that systems and controls are in place to enable the Trust to meet its 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.
- To seek assurance on the performance and associated risks of finance plans and reporting.
10.2 Workforce

- To seek assurance on the continued development and timely delivery of the workforce strategy and its supporting plans and to ensure the workforce plan is aligned with service and financial plans.

- To provide assurance that the Trust is working within legislation and a good employment framework.

- To seek assurance on the development of appropriate learning and development and receive assurance that the trust is meeting its statutory and mandatory requirements.

- To seek assurance on the performance and associated risks of workforce plans and reporting.

- To seek assurance on the production and implementation of long term workforce plans.

10.3 Performance

- To provide assurance that the organisation has quality systems and processes which underpin sound performance and workforce modelling to deliver redesigned clinical pathways.

- To seek assurance on the delivery of the key performance measures of the Trust, with a focus on sustained performance and future delivery.

- To seek assurance on the performance and associated risks of performance plans and reporting.

10.4 Other Matters

The Finance, Performance and Workforce Committee seeks assurance from each of the Sub-Committees and in conjunction with the scope of its own work, provides assurance directly to the Board.

This Committee will work closely with the Audit Committee in supporting their assurance function.

The Committee will look to see how finance, workforce and performance initiatives align with those of partner organisations.

11. Conduct of Meetings

- Agendas will normally be prepared and circulated 5 days in advance.

- Any member may request an item for the agenda through the Chair.

- Declarations of interest will be collected at the start of each meeting –
there is requirement that members of committee must make annual declarations of interests.

- Any interest in the matter under discussion (as defined in Standing Orders) will be declared. The person declaring an interest will withdraw whilst the issue is being discussed.

- All meetings will be minuted and:
  - approved by the Chair before submission to the Trust Board or wider circulation
  - approved by the Committee Members at the following meeting of the Committee
  - an Action Log will be updated following each meeting which will include open and closed actions

12. Reporting

12.1 Reports to the Board will be made as follows:

- 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 2018 and will be reviewed at the meeting in February 2019. Any variation, including to the membership, will require the approval of the Trust Board.

The Trust Board may formally change the Terms of Reference at any time, either at its own initiation or following a request for variation submitted by the Committee.

The Committee will review the Terms of Reference annually for resubmission to the Trust Board.

The Trust Board will review the Terms of Reference submitted in the light of the wider requirements of the Trust and may amend them before approval.

The terms of reference will next be reviewed in February 2019 (unless required to be reviewed earlier).
| Title: Terms of Reference Clinical Management Board | East Cheshire NHS Trust |
| Authors Name: Chief Executive | |
| Scope: Trust Wide | Classification: Trust Organisation Structure and Minutes |
| Replaces: Terms of Reference for Clinical Management Board February 2017 | |
| To be read in conjunction with the following documents: None | |

| Unique Identifier: | Review Date: April 2018 |
| Issue Status: V1 | Issue No: 1 Issue Date: April 2017 |
| Authorised by: Clinical Management Board | Authorisation Date: April 2017 |
| Document for Public Display: Yes | |

After this document is withdrawn from use it must be kept in an archive for 6 years.

| Archive: | Date added to Archive: |
| Officer responsible for archive: Director of Corporate Affairs and Governance | |
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

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.

Declarations of interest will be collected at the start of each meeting – there is requirement that members of committee must make annual declarations of interests.

Any interest in the matter under discussion (as defined in Standing Orders) will be declared. The Person declaring an interest will withdraw whilst the issue is being discussed.

In the event of a formal vote, a simple 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:** V7

**Description of Amendment(s):**
- Change of contact point
- Changes from NHS Protect to NHS Counter Fraud Authority along with changes to the links and national policy changes
- Amend reference to Statement of Internal Control to annual governance statement
- Correct role name to Anti-Fraud Specialist to link back to progress and annual reports to Audit Committee.

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

**Financial Implications:**

<table>
<thead>
<tr>
<th>Policy Area</th>
<th>Document Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Version Number</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>V8</td>
<td>April 2018</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Issued By</th>
<th>Review Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mark Ogden Director of Finance</td>
<td>31 March 2019</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Author</th>
<th>Impact Assessment Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Roger Causer Local Anti-Fraud Specialist</td>
<td>March 2018</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Committees / Group</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultation:</td>
<td></td>
</tr>
<tr>
<td>Deputy Director of Corporate Affairs and Governance Audit Committee</td>
<td>March 2018</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Approved by Director</th>
<th>Approved by</th>
<th>Received for information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mark Ogden, Director of Finance</td>
<td>Trust Board</td>
<td>Operational Management Team</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>APPROVAL RECORD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
</tr>
<tr>
<td>------</td>
</tr>
<tr>
<td>March 2018</td>
</tr>
<tr>
<td>Mark Ogden, Director of Finance</td>
</tr>
<tr>
<td>Trust Board</td>
</tr>
<tr>
<td>Operational Management Team</td>
</tr>
<tr>
<td>Contents</td>
</tr>
<tr>
<td>----------------------------------------------</td>
</tr>
<tr>
<td>1 Introduction</td>
</tr>
<tr>
<td>1.1 Objectives</td>
</tr>
<tr>
<td>1.2 Scope</td>
</tr>
<tr>
<td>2 Definitions</td>
</tr>
<tr>
<td>2.1 NHS Counter Fraud Authority</td>
</tr>
<tr>
<td>2.2 Fraud</td>
</tr>
<tr>
<td>2.3 Bribery and Corruption</td>
</tr>
<tr>
<td>3 Other Relevant Procedural Documents</td>
</tr>
<tr>
<td>4 Code of Conduct</td>
</tr>
<tr>
<td>5 Roles and Responsibilities</td>
</tr>
<tr>
<td>5.1 Role of the Board / Audit Committee</td>
</tr>
<tr>
<td>5.2 Chief Executive</td>
</tr>
<tr>
<td>5.3 Director of Finance (DoF)</td>
</tr>
<tr>
<td>5.4 Managers</td>
</tr>
<tr>
<td>5.5 Employees</td>
</tr>
<tr>
<td>5.6 Anti-Fraud Specialist (AFS)</td>
</tr>
<tr>
<td>5.7 NHS Counter Fraud Authority (NHSCFA)</td>
</tr>
<tr>
<td>5.8 Internal and External Audit</td>
</tr>
<tr>
<td>5.9 Human Resources</td>
</tr>
<tr>
<td>5.10 Information Management and Technology</td>
</tr>
<tr>
<td>6 The Response Plan</td>
</tr>
<tr>
<td>6.1 Reporting fraud, bribery and/or corruption</td>
</tr>
<tr>
<td>6.2 Sanctions and Redress</td>
</tr>
<tr>
<td>Appendices</td>
</tr>
<tr>
<td>Appendix A – Desktop Guide</td>
</tr>
<tr>
<td>Appendix B – Referral Form</td>
</tr>
<tr>
<td>7 Dissemination and Implementation</td>
</tr>
<tr>
<td>7.1 Dissemination</td>
</tr>
<tr>
<td>7.2 Implementation</td>
</tr>
<tr>
<td>8 References</td>
</tr>
</tbody>
</table>
1 Introduction

One of the basic principles of public sector organisations is the proper use of public funds. The majority of people who work in the NHS conduct themselves in an honest and professional manner and they believe that fraud, bribery and corruption, committed by a minority, is wholly unacceptable as it ultimately leads to a reduction in the resources available for patient care.

East Cheshire NHS Trust] (the ‘Trust) is committed to reducing the level of fraud, bribery and corruption within the NHS to an absolute minimum and keeping it at that level, freeing up public resources for better patient care. The Trust does not tolerate fraud, bribery or corruption and aims to eliminate all such activity as far as possible.

The Trust wishes to encourage anyone having reasonable suspicions of fraud, bribery or corruption to report them. For the purposes of this policy “reasonably held suspicions” shall mean any suspicions other than those which are totally groundless (and/or raised maliciously).

It is the Trust policy that no employee will suffer in any way as a result of reporting these suspicions. This protection is given under the provisions of the Public Interest Disclosure Act which the Trust is obliged to comply with.

The Trust will take all necessary steps to counter fraud, bribery and corruption in accordance with this policy, the NHS Anti-Fraud, Bribery and Corruption Manual, the policy statement ‘Applying Appropriate Sanctions Consistently’ published by NHS Counter Fraud Authority (NHS CFA), formerly known as NHS Protect and in line with the NHS CFA’s strategy ‘Tackling crime against the NHS: A strategic approach’ plus any other relevant guidance or advice issued by the NHS CFA. The Trust will seek the appropriate disciplinary, regulatory, civil and criminal sanctions [as well as referral to professional bodies, where appropriate] against fraudsters and where possible will attempt to recover losses.

Each Trust is required to appoint its own dedicated Anti-Fraud Specialist (AFS) who is accredited by the NHS CFA and accountable to them professionally for the completion of a range of preventative anti-fraud and corruption work, as well as for undertaking any necessary investigations. Locally, the AFS is accountable on a day-to-day basis to the Trust’s Director of Finance and reports, periodically, to the Trust Audit Committee.

All instances where fraud, bribery and/or corruption is suspected are thoroughly investigated by staff trained by NHS CFA. Any investigations will be undertake in accordance with the NHS Anti-Fraud and Corruption Manual.

[NB. For staff awareness, theft issues are usually dealt with by local security management (LSMS), not the AFS. However, the AFS will be mindful of any potential criminality identified in the course of any investigation and will, with the agreement of the Director of Finance, notify the appropriate investigating authority.
1.1 Objectives

The Trust is committed to taking all necessary steps to counter fraud, bribery and corruption.

Under the NHS Standards Contract all organisations providing NHS services are required to put in place appropriate anti-fraud management arrangements. The NHSCFA approach to tackling fraud and other economic crime against the NHS (‘Leading the fight against NHS fraud: Organisational strategy 2017-20’) is guided by four principles:

- **Inform and involve**: raise awareness of fraud against the NHS, and work with over 1.3 m NHS staff, with stakeholders and the public to highlight those risks and the consequences of fraud against the NHS;
- **Prevent and deter**: provide solutions to identified fraud risks, discourage individuals who may be tempted to commit fraud against the NHS and ensure that opportunities for fraud to occur are minimised;
- **Investigate, sanction and seek redress**: investigate allegations of fraud thoroughly and to the highest professional standards, where appropriate seek the full range of civil, criminal and disciplinary sanctions and seek redress where possible;
- **Continuously review and hold to account**: fraud is constantly evolving and continuous re-evaluation and improvement is needed to ensure that we keep ahead of the problem. Where this does not take place, or where there is a reluctance to do so, then organisations must be held to account for their inaction.

The overall requirement underpinning these principles is effective **strategic governance**, strong leadership and a demonstrable level of commitment to tackling fraud from senior management within organisations.

1.2 Scope

This policy has been produced by the Trust’s AFS, and is intended to provide a guide for all employees [regardless of position], contractors, consultants, vendors and other internal and external stakeholders who have a professional or business relationship with the Trust, on what fraud and corruption are in the NHS; what everyone’s responsibility are to prevent fraud, bribery and corruption; and also how to report concerns and/or suspicions with the intention of reducing fraud to a minimum within the Trust.

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

The definitions applicable to this policy are as follows:

2.1 NHS Counter Fraud Authority

The NHS CFA is a new special health authority dedicated to tackling fraud, bribery and corruption within the health service. The NHS CFA provides a clear focus for both the prevention and investigation of fraud across the health service and works with NHS England and NHS Improvement to properly uncover fraud and tackle it effectively.

2.2 Fraud

The Fraud Act 2006 introduced an entirely new way of investigating and prosecuting fraud. Previously, the word ‘fraud’ was an umbrella term used to cover a variety of criminal offences falling under various legislative acts. It is no longer necessary to prove that a person has been deceived, or for a fraud to be successful. The focus is now on the dishonest behaviour of the suspect and their intent to make a gain either for themselves or another; to cause a loss to another; or, expose another to a risk of a loss.

There are several specific offences under the Fraud Act 2006; however, there are three primary ways in which it can be committed that are likely to be investigated by the AFS;

The offence of fraud can be committed in three ways:

- **Fraud by false representation (s.2)** – lying about something using any means, e.g. falsifying a CV or NHS job application form

- **Fraud by failing to disclose (s.3)** – not saying something when you have a legal duty to do so, e.g. failing to declare a conviction, disqualification or commercial interest when such information may have an impact on your NHS role, duties or obligation and where you are required to declare such information as part of a legal commitment to do so.

- **Fraud by abuse of a position of Trust (s.4)** – abusing a position where there is an expectation to safeguard the financial interests of another person or organisation, e.g. a carer abusing their access to patients monies, or an employee using commercially confidential NHS information to make a personal gain.

It should be noted that all offences under the Fraud Act 2006 occur where the act or omission is committed dishonestly and with intent to cause gain or loss. The gain or loss does not have to succeed, so long as the intent is there. Successful prosecutions under the Fraud Act 2006 may result in an unlimited fine and/or a potential custodial sentence of up to 10 years.

2.3 Bribery and Corruption

Bribery and corruption prosecutions can be brought using specific pieces of legislation:
- Prevention of Corruption Acts 1906 and 1916, for offences committed prior to 1st July 2011
- Bribery Act 2010, for offences committed on or after 1st July 2011.

The Bribery Act 2010 reforms the criminal law of bribery, making it a criminal offence to:
- Give, promise or offer a bribe (s.1), and/or
- Request, agree to receive or accept a bribe (s.2).

Corruption is generally considered to be an “umbrella” term covering such various activities as bribery, corrupt preferential treatment, kickbacks, cronyism, theft or embezzlement. Under the 2010 Act, however, bribery is now a series of specific offences.

Generally, bribery is defined as: an inducement or reward offered, promised or provided to someone to perform their functions or activities improperly in order to gain a personal, commercial, regulatory and/or contractual advantage.

Examples of bribery in an NHS context could be a contractor attempting to influence a procurement decision-maker by giving them an extra benefit or gift as part of a tender exercise; or, a medical or pharmaceutical company providing holidays or other excessive hospitality to a clinician in order to influence them to persuade their Trust to purchase that company’s particular clinical supplies.

A bribe does not have to be in cash; it may be the awarding of a contract, the provision of gifts, hospitality, sponsorship, the promise of work or some other benefit. The persons making and receiving the bribe may be acting on behalf of others – under the Bribery Act 2010, all parties involved may be prosecuted for a bribery offence.

All staff are reminded to ensure that they are transparent in respect of recording any gifts, hospitality or sponsorship and they should refer to the separate Trust policy, the ‘Conflict of Interest Policy’ covering:
- Acceptance of Gifts and Hospitality
- Declaration of Interests
- Sponsorship.

The Bribery Act 2010 is also extra-territorial in nature. This means that anyone involved in bribery activity overseas may be liable to prosecution in the UK if the bribe is in respect of any UK activity, contract or organisation. To this end, the Bribery Act 2010 also includes an offence of bribing a foreign public official [s.6].

In addition, the Bribery Act 2010 introduces a new ‘corporate offence’ [s.7] of the failure of commercial organisations to prevent bribery. The Department of Health Legal Service has stated that NHS bodies are deemed to be ‘relevant commercial organisations’ to which the Act applies. As a result, an NHS body may be held liable (and punished with a potentially unlimited fine) when someone “associated” with it bribes another in order to get, keep or retain
business for the organisation. However, the organisation will have a defence, and avoid prosecution, if it can show it had ‘adequate procedures’ in place designed to prevent bribery.

Finally, under section 14 of the Bribery Act 2010, a senior officer of the organisation (e.g. a Senior Manager, an Executive or Non-Executive Director) would also be liable for prosecution if they consented to or connived in a bribery offence carried out by another. Under such circumstances, the senior officer may be prosecuted for a parallel offence to that brought against the primary perpetrator. Furthermore, the organisation could also be subject to an unlimited fine because of the senior officer’s consent or connivance.

To re-iterate, the Bribery Act 2010 is applicable to NHS organisations including East Cheshire NHS Trust and, consequently, it also applies to (and can be triggered by) everyone “associated” with this Trust who performs services for us, or on our behalf, or who provides us with goods. This includes those who work for and with us, such as employees, agents, subsidiaries, contractors and suppliers (regardless of whether they are incorporated or not). The term ‘associated persons’ has an intentionally wide interpretation under the Bribery Act 2010.

The Trust adopts a ‘zero tolerance’ attitude towards bribery and does not, and will not, pay or accept bribes or offers of inducement to or from anyone, for any purpose. The Trust is fully committed to the objective of preventing bribery and will ensure that adequate procedures, which are proportionate to our risks, are in place to prevent bribery and which will be regularly reviewed. We will, in conjunction with the NHS CFA seek to obtain the strongest penalties – including criminal prosecution, disciplinary and/or civil sanctions – against anyone associated with the Trust who is found to be involved in any bribery or corruption activities.

As with the Fraud Act 2006, a conviction under the Bribery Act 2010 may ultimately result in an unlimited fine and/or a custodial sentence of up to 10 years imprisonment.

3 Other Relevant Procedural Documents

This policy should be read in conjunction with the following documents:

- Disciplinary Policy and Procedure
- Speak Up Policy
- Conflicts of Interest Policy.

4 Codes of Conduct

The Codes of Conduct for NHS boards and NHS managers set out the key public service values. They state that high standards of corporate and personal conduct, based on the recognition that patients come first, have been a requirement throughout the NHS since its inception. These values are summarised as:
**Accountability** - Everything done by those who work in the authority must be able to stand the tests of parliamentary scrutiny, public judgements on propriety and professional codes of conduct.

**Probity** - Absolute honesty and integrity should be exercised in dealing with NHS patients, assets, staff, suppliers and customers.

**Openness** - The health body’s activities should be sufficiently public and transparent to promote confidence between the authority and its staff and the public.

All staff should be aware of and act in accordance with these values. In addition, staff are expected to:

- Act impartially in all their work
- Refuse gifts, benefits, hospitality or sponsorship of any kind that might reasonably be seen to compromise their judgement or integrity; and, to avoid seeking to exert influence to obtain preferential consideration. All such gifts should be returned and hospitality refused
- Declare and register gifts, benefits or sponsorship of any kind, in accordance with limits agreed locally, whether refused or accepted
- Declare and record financial, non-financial or personal interest (e.g. company shares, research grant) in any organisation with which they have to deal, and be prepared to withdraw from those dealings if required, thereby ensuring that their professional judgement is not influenced by such considerations
- Make it a matter of policy that offers of sponsorship that could possibly breach the Code be reported to the Board
- Not misuse their official position or information acquired in the course of their official duties, to further their private interests or those of others
- Ensure professional registration (if applicable) and/or status are not used in the promotion of commercial products or services
- Beware of bias generated through sponsorship, where this might impinge on professional judgement or impartiality
- Neither agree to practice under any conditions which compromise professional independence or judgement, nor impose such conditions on other professionals.

All staff are also reminded that every NHS employee, regardless of position or status, must comply with the Conflicts of Interest in the NHS – Guidance for staff and organisations which may be accessed at: [https://www.england.nhs.uk/wp-content/uploads/2017/02/guidance-managing-conflicts-of-interest-nhs.pdf](https://www.england.nhs.uk/wp-content/uploads/2017/02/guidance-managing-conflicts-of-interest-nhs.pdf)

Relevant personnel are also reminded that their professional bodies will also have codes of conduct or standards of behaviour which they will be expected to adhere to.
5 Roles and Responsibilities

Through our day-to-day work, we, i.e. all staff, are in the best position to recognise any specific risks within our own areas of responsibility. We also have a duty to ensure that those risks – however large or small – are identified and eliminated. Where you believe the opportunity for fraud, corruption or bribery exists, whether because of poor procedures or oversight, you should report it to the AFS or the NHS Fraud and Corruption Reporting Line and/or online Fraud Reporting Form.

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

5.1 Role of the Board / Audit Committee

The Trust has a duty to ensure that it provides a secure environment in which to work, and one where people are confident to raise concerns without worrying that it will reflect badly on them. This extends to ensuring that staff feel protected when carrying out their official duties and are not placed in a vulnerable position. If staff have concerns about any procedures or processes that they are asked to be involved in, the Trust has a duty to ensure that those concerns are listened to and addressed.

The Trust Board (via its Audit Committee) has a duty to provide adequate governance and oversight of the Trust to ensure that its funds, people and assets are adequately protected against criminal activity, including fraud, bribery and corruption.

5.2 Chief Executive

The Trust's Chief Executive, as the organisations accountable officer, has overall responsibility for securing funds, assets and resources entrusted to it, including instances of fraud, bribery and corruption.

The Chief Executive must ensure adequate policies and procedures are in place to protect the organisation and the public funds it receives. However, responsibility for the operation and maintenance of controls falls directly to line managers and requires the involvement of all of Trust employees. The Trust therefore has a duty to ensure employees who are involved in or who are managing internal control systems receive adequate training and support in order to carry out their responsibilities. Therefore, the Chief Executive and Director of Finance will monitor and ensure compliance with this policy.

5.3 Director of Finance

The Director of Finance [DoF], in conjunction with the Chief Executive, monitors and ensures compliance with the Trust’s contractual requirements regarding fraud, bribery and corruption.

The DoF has powers to approve financial transactions initiated by directorates across the organisation. The DoF prepares documents and maintains detailed financial procedures and systems; and applies the principles of separation of duties and internal checks to supplement those procedures and systems.
The DoF will report annually to the Board on the adequacy of internal financial controls and risk management as part of the Board’s overall responsibility to prepare the annual governance statement for inclusion in the organisation’s annual report.

The DoF will, depending on the outcome of investigations (whether on an interim/on-going or concluding basis) and/or the potential significance of suspicions that have been raised, inform appropriate senior management accordingly.

The AFS shall be responsible, in discussion with the DoF, for informing third parties such as external audit or the police at the earliest opportunity, as circumstances dictate.

The DoF will inform and consult the Chief Executive in cases where the loss or where the incident may lead to adverse publicity.

The DoF or the AFS will consult and take advice from the Director of Human Resources and Organisational Development if a member of staff is to be interviewed, suspended or disciplined. The DoF or AFS will not conduct a disciplinary investigation, but the employee may be the subject of a separate investigation by HR.

### 5.4 Managers

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

Managers must instil and encourage an anti-fraud, bribery and corruption culture within their team and ensure that information on procedures is made available to all employees. The desktop guide [Appendix A] provides a reminder of the key contacts and a checklist of the actions to follow if fraud, bribery and corruption, or other illegal acts, are discovered or suspected. Managers are encouraged to copy this to staff and to place it on staff notice boards in their department.

The AFS will proactively assist the encouragement of an anti-fraud, bribery and corruption culture by undertaking work that will raise fraud awareness.

All instances of actual or suspected fraud, bribery and corruption which come to the attention of a manager must be reported immediately. It is appreciated that some employees will initially raise concerns with their manager. However, in such cases, managers must not attempt to investigate the allegation themselves; they have the clear responsibility to refer the concerns to the AFS as soon as possible.

Line managers at all levels have a responsibility to ensure that an adequate system of internal control exists within their areas of responsibility and that controls operate effectively. The responsibility for the prevention and detection of fraud, bribery and corruption therefore primarily rests with managers but requires the co-operation of all employees.

As part of that responsibility, line managers need to:
Inform staff of the Trust’s code of business conduct and anti-fraud, bribery and corruption policy as part of their induction process, paying particular attention to the need for accurate completion of personal records and forms

Ensure that all employees for whom they are accountable are made aware of the requirements of the policy

Assess the types of risk involved in the operations for which they are responsible

Ensure that adequate control measures are put in place to minimise the risks. This must include clear roles and responsibilities, supervisory checks, staff rotation (particularly in key posts), separation of duties wherever possible so that control of a key function is not invested in one individual, and regular reviews, reconciliations and test checks to ensure that control measures continue to operate effectively

Ensure that any use of computers by employees is linked to the performance of their duties within the Trust

Be aware of the Trust’s anti-fraud, bribery and corruption policy and the rules and guidance covering the control of specific items of expenditure and receipts

Identify financially sensitive posts

Ensure that controls are being complied with

Contribute to their director’s assessment of the risks and controls within their business area, which feeds into the Trust’s and the Department of Health Accounting Officer’s overall statements of accountability and internal control.

5.5 Employees

the Trust’s Standing Orders, Standing Financial Instructions, policies and procedures place an obligation on all employees and non-executive directors to act in accordance with best practice.

Employees are expected to act in accordance with the standards laid down by their professional institutes, where applicable, and have a personal responsibility to ensure that they are familiar with them.

Employees also have a duty to protect the assets of the Trust, including information and property.

In addition, all employees have a responsibility to comply with all applicable laws, regulations and Trust policies relating to ethical business behaviour, procurement, personal expenses, conflicts of interest, confidentiality and the acceptance of gifts and hospitality. This means, in addition to maintaining the normal standards of personal honesty and integrity, all employees should always:
Avoid acting in any way that might cause others to allege or suspect them of dishonesty

Behave in a way that would not give cause for others to doubt that the Trust’s employees deal fairly and impartially with official matters

Be alert to the possibility that others might be attempting to deceive.

All employees have a duty to ensure that public funds are safeguarded, whether or not they are involved with cash or payment systems, managing budgets or dealing with contractors or suppliers.

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

Mersey Internal Audit Agency (MIAA), an NHS agency, provides the Trust’s AFS service under contract. The Trust’s nominated AFS is Roger Causer who can be contacted on 0151 285 4675 or 07768 131 806

5.6 Anti-Fraud Specialist (AFS)

The AFS is operationally accountable to the Trust’s Director of Finance and reports on the progress of all anti-fraud and corruption activity to the Trust Audit Committee. The AFS is responsible for taking forward all anti-fraud work locally in accordance with national standards and regularly reports to the Director of Finance on the progress of the investigation and when/if referral to the police is required.

The AFS liaises with several key stakeholders and key contacts across the Trust and undertakes their duties to the highest possible standards at all times.

The AFS will:

- Ensure that the Director of Finance is informed about all referrals/cases and approves any necessary investigation activity
- In particular, conduct investigations of all alleged fraud, bribery and corruption in accordance with the NHS Anti-Fraud and Corruption Manual, Investigations Toolkit, NHS Standards for Providers and relevant criminal law.
- Be responsible for the day-to-day implementation of the key principles of anti-fraud, bribery and corruption activity and, in particular, the investigation of all suspicions of fraud, bribery and corruption
- Investigate all cases of fraud
- In consultation with the Director of Finance, report any cases to the NHS CFA as agreed and in accordance with the NHS Anti-Fraud and Corruption Manual
- Report any case and the outcome of the investigation through the NHS CFA national case management system (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.

Ensure that the Trust incident and losses reporting system DATIX is followed.

Ensure that any system weaknesses identified as part of an investigation are followed up with management and reported to internal audit.

Adhere to the Counter Fraud Professional Accreditation Board (CFPAB)'s Principles of Professional Conduct as set out in the NHS Anti-Fraud and Corruption Manual.

Not have responsibility for or be in any way engaged in the management of security for any NHS body.

In addition, the AFS will be responsible for the day to day implementation of the generic areas of anti-fraud, bribery and corruption strategy, as agreed in the fraud risk assessed annual work plan.

5.7 NHS Counter Fraud Authority (NHS CFA)

NHS CFA deliver anti-crime work that cannot be carried out by NHS health bodies regionally or in isolation. They use intelligence to identify serious and complex economic crime, reduce the impact of crime and drive improvements in anti-crime work.

Local NHS organisations are primarily accountable for dealing with crime risks in the NHS. NHS CFA provides information and guidance to local AFSs to improve anti-fraud, bribery and corruption work across the NHS.

NHSCFA’s main objectives are:

- to deliver the Department of Health (DH) strategy, vision and strategic plan, and be the principal lead for counter fraud activity in the NHS in England;
- to be the single expert intelligence led organisation providing a centralised investigation capacity for complex economic crime matters;
- to lead, guide and influence the improvement of standards in counter fraud work, in line with HM Government Counter Fraud Professional Standards, across the NHS and wider health group, through review, assessment and benchmark reporting of counter fraud provision across the system;
- to take the lead and encourage fraud reporting across the NHS and wider health group, by raising the profile of fraud and its effect on the health care system.
5.8 **Internal and External Audit**

The role of internal and external audit includes reviewing controls and systems and ensuring compliance with financial instructions.

Any incident or suspicion of fraud, corruption or bribery that comes to internal or external audit’s attention will be passed immediately to the nominated AFS. The outcome of the investigation may necessitate further work by internal or external audit to review systems.

5.9 **Human Resources**

HR will liaise closely with managers and the AFS from the outset if an employee is suspected of being involved in fraud, corruption and/or bribery, in accordance with agreed liaison protocols. HR staff are responsible for ensuring the appropriate use of the Trust’s disciplinary procedure. The HR department will advise those involved in the investigation on matters of employment law and other procedural matters, such as disciplinary and grievance procedures, as requested.

Close liaison between the AFS and HR will be essential in respect of any decision as to whether to exclude an employee from the Trust whilst necessary enquiries are on-going, though any final decision to exclude is that of the Trust. Close liaison will also be necessary to ensure that any parallel sanctions (i.e. criminal, civil and disciplinary sanctions) are applied effectively and in a coordinated manner.

HR will take steps at the recruitment stage to establish, as far as possible, the previous record of potential employees, as well as the veracity of required qualifications and memberships of professional bodies, in terms of their propriety and integrity. In this regard, temporary and fixed-term contract employees are treated in the same manner as permanent employees.

5.10 **Information Management and Technology**

The Head of Information Security (or equivalent) will contact the AFS immediately in all cases where there is suspicion that Trust ICT is being used for fraudulent purposes in accordance with the Computer Misuse Act 1990. Similarly, the Head of Information Security will liaise closely with the AFS to ensure that a subject’s access (both physical and electronic) to Trust ICT resources is suspended or removed where an investigation identifies that it is appropriate to do so.

6 **The Response Plan**

6.1 **Reporting fraud, bribery and/or corruption**

This section outlines the action to be taken if fraud, corruption or bribery is discovered or suspected.

All genuine suspicions of fraud, bribery and corruption must be reported directly to the AFS – contact details can be found using the following link:
Anti-Fraud Specialist Roger Causer on 0151 285 4675 or 07768131806

If the referrer believes that the Director of Finance or AFS is implicated, they should notify whichever party is not believed to be involved who will then inform the Chief Executive and Audit Committee Chairperson.

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

If an employee feels unable, for any reason, to report the matter internally, employees can also call the NHS Fraud and Corruption Reporting Line on Freephone 08000 28 40 60 or report their concerns via the NHS Online Fraud Reporting Form www.cfa.nhs.uk/reportfraud

This provides an easily accessible route for the reporting of genuine suspicions of fraud, bribery and corruption within or affecting the NHS. It allows NHS staff who are unsure of internal reporting procedures to report their concerns in the strictest confidence. All calls are dealt with by experienced trained staff and any caller who wishes to remain anonymous may do so.

Anonymous letters, telephone calls, etc. are occasionally received from individuals who wish to raise matters of concern, but not through official channels. While the suspicions may be erroneous or unsubstantiated, they may also reflect a genuine cause for concern and will always be taken seriously.

The AFS will make sufficient enquiries to establish whether or not there is any foundation to the suspicion that has been raised. If the allegations are found to be malicious, they will also be considered for further investigation to establish their source.

Staff are encouraged to report reasonably held suspicions directly to the AFS. You can do this by completing the Referral Form [Appendix B] or by contacting the AFS by telephone or email using the contact details supplied on the desktop guide.

The Trust wants all employees to feel confident that they can expose any wrongdoing without any risk to themselves. In accordance with the provisions of the Public Interest Disclosure Act 1998, the Trust has produced a Speak Up Policy. This procedure is intended to complement the Trust's Anti-Fraud, Bribery and Corruption Policy as well as other relevant Trust policies and ensures there is full provision for staff to raise any concerns with others if they do not feel able to raise them with their line manager/management chain. Corporate policies can be found on the Trust’s infonet site.

6.2 Sanctions and Redress

The Trust’s approach to pursuing sanctions in cases of fraud, bribery and corruption is that the full range of possible sanctions – including criminal, civil, disciplinary and regulatory – should be considered at the earliest opportunity and any or all of these may be pursued where and when appropriate. The consistent use of an appropriate combination of investigative processes in each case demonstrates this organisation’s commitment to take fraud, bribery and corruption seriously and ultimately contributes to the deterrence and prevention of such actions.
This organisation endorses the NHS CFA’s approach and adopts the principles contained within their policy entitled, ‘Parallel Criminal and Disciplinary Investigations’; as well as complying with the provisions of the NHS Anti-Fraud Manual with regard to applying sanctions where fraud, bribery or corruption is proven. The organisation maintains an internal joint-working and data sharing protocol between the AFS and the HR department which also covers their respective investigative duties.

The types of sanction which this organisation may apply when a financial offence has occurred include:

- **Civil Redress** – We will seek financial redress, whenever possible, to recover losses (of money or assets), including interest and costs, to fraud, bribery and corruption. Redress can be sought in various ways. These include confiscation or compensation orders or use of the Proceeds of Crime legislation in the criminal courts, as well as civil legal sanctions such as an order for repayment or an attachment to earnings where appropriate, in addition to any locally agreed voluntary negotiations or repayments. As an organisation, we actively publicise the fact that redress will be sought where applicable to recover monies lost to fraud and corruption, thus creating a further deterrent effect.

- **Criminal Prosecution** – The AFS will work in partnership with NHS CFA, the police and/or the Crown Prosecution Service, where appropriate, to bring a case to court against an alleged offender. Outcomes can range from a criminal conviction to fines and imprisonment.

- **Disciplinary Sanctions** – Disciplinary procedures will also be initiated where an employee is suspected of being involved in a fraudulent or illegal act. The health body’s disciplinary policy can be located on the Trusts infonet.

- **Professional Body Disciplinary Sanctions** – Where appropriate and if warranted, the organisation reserves the right to also report staff to their professional body as a result of a successful investigation and/or prosecution.

### 7 Dissemination and Implementation

#### 7.1 Dissemination

This policy will be brought to the attention of all employees and will form part of the induction process for new staff.

This policy will be disseminated Trust wide for all employees to understand and be made aware of via awareness presentations, the Trust’s Bulletin’s and on the Trust’s Anti-Fraud intranet page.

#### 7.2 Implementation

The Trust’s AFS will be responsible for implementing this policy and all Trust managers have a responsibility to ensure all staff are made aware of the policy and understand it. The AFS will provide any training where required.
8 References

NHS Anti-Fraud Manual

NHS Investigations Toolkit

Speak up Policy

Disciplinary Policy

Conflicts of Interest Policy

Standing Financial Instructions, Standing Orders and the Scheme of Delegation


NHS Protect ‘Parallel Criminal and Disciplinary Investigations’


| Applicable Statutory, Legal or National Best Practice Requirements | Anti-Fraud and Corruption Manual  
|  | Public Interest Disclosure Act 1998  
|  | NHS Standards Contract  
|  | Fraud Act 2006  
|  | Bribery Act 2010  
|  | NHS Conflicts of Interest Guidance |
Appendix A

6 Policy appendices

A Desktop Guide to Reporting NHS Fraud, Bribery and Corruption

**FRAUD** is the dishonest intent to obtain a financial gain from, or cause a financial loss to, a person or party through false representation, failing to disclose information or abuse of position.

**CORRUPTION/ BRIBERY** is the deliberate use of bribery or payment of benefit-in-kind to influence an individual to use their position in an unreasonable way to help gain advantage for another.

**DO**
- Note your concerns
  Record details such as your concerns, names, dates, times, details of conversations and possible witnesses. Time, date and sign your notes.
- Retain or secure evidence
  Retain any evidence that may be destroyed, but do not alter or write on it an in any way.
- Report your suspicion promptly
  Confidentiality will be respected – delays may lead to further financial loss.
- Be discreet
  Don’t discuss your concerns with anyone who doesn’t need to know

**DO NOT**
- Confront the suspect or convey concerns to anyone other than those authorised
  Never attempt to question a suspect yourself; this could alert a fraudster and place you at harm.
- Try to investigate the concern yourself
  Never attempt to gather evidence yourself unless it is about to be destroyed; gathering evidence must take into account legal procedures in order for it to be useful. Your AFS will conduct an investigation in accordance with legislation.
- Be afraid of raising your concerns
  The Public Interest Disclosure Act 1998 protects employees who have reasonable concerns. You will not suffer discrimination or victimisation by following the correct procedures.
- Do nothing!

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

**Report NHS Fraud, Bribery & Corruption – contact details:**

Your Trust AFS: 0151 285 4675 or 0151 285 4500 (MIAA)
NHS Fraud and Corruption Reporting Line: 0800 028 40 60
NHS Online Reporting Form: [www.cfa.nhs.uk/reportfraud](http://www.cfa.nhs.uk/reportfraud)

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

Your nominated Anti-Fraud Specialist is Roger Causer, who can be contacted by telephoning 0151 285 4675, or emailing roger.causer@miaa.nhs.uk or r.causer@nhs.net

If you would like further information about NHS Counter Fraud Authority or the work of the AFS, please visit [https://cfa.nhs.uk](https://cfa.nhs.uk)
NHS Fraud, Bribery and Corruption Referral Form

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

Note: Referrals should only be made when you can substantiate your suspicions with one or more reliable pieces of information. Anonymous applications are accepted but may delay any investigation.

1. Date

2. Anonymous application <Delete as appropriate>
   Yes (If ‘Yes’ go to section 6) or No (If ‘No’ complete sections 3–5)

3. Your name

4. Your organisation/profession

5. Your contact details

6. Suspicion

7. Please provide details including the name, address and date of birth (if known) of the person to whom the allegation relates.

8. Possible useful contacts

9. Please attach any available additional information.

Submit the completed form (in a sealed envelope marked ‘Restricted – Management’ and ‘Confidential’) for the personal attention of Roger Causer, the nominated AFS for East Cheshire NHS Trust c/o Mersey Internal Audit Agency, 1829 Building, Liverpool Road, Chester CH2 1UL
Freedom to speak up: raising concerns (whistleblowing) policy for the NHS

April 2016
Contents

Speak up – we will listen ........................................................................................................ 3
This policy ............................................................................................................................ 3
What concerns can I raise? ................................................................................................. 4
Feel safe to raise your concern ......................................................................................... 4
Confidentiality ..................................................................................................................... 4
Who can raise concerns? ................................................................................................... 5
Who should I raise my concern with? ................................................................................ 5
Advice and support ............................................................................................................. 6
How should I raise my concern? ........................................................................................ 6
What will we do? .................................................................................................................. 6
Raising your concern with an outside body ......................................................................... 7
Annex A: Trust process for raising and escalating a concern ........................................... 9
Annex B: A vision for raising concerns in the NHS ......................................................... 10
Speak up – we will listen

Speaking up about any concern you have at work is really important. In fact, it’s vital because it will help us to keep improving our services for all patients and the working environment for our staff.

You may feel worried about raising a concern, and we understand this. But please don’t be put off. In accordance with our duty of candour, our senior leaders and entire board are committed to an open and honest culture. We will look into what you say and you will always have access to the support you need.

This policy

This ‘standard integrated policy’ was one of a number of recommendations of the review by Sir Robert Francis into whistleblowing in the NHS, aimed at improving the experience of whistleblowing in the NHS. This policy (produced by NHS Improvement and NHS England) has been adopted by East Cheshire NHS Trust and all NHS organisations in England as a minimum standard to help to normalise the raising of concerns for the benefit of all patients.

Our local process has been integrated into this policy.

What concerns can I raise?

You can raise a concern about risk, malpractice or wrongdoing you think is harming the service we deliver. Just a few examples of this might include (but are by no means restricted to):

(a) unsafe patient care

(b) unsafe working conditions

(c) inadequate induction or training for staff

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

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

   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

(f) a bullying culture (across a team or organisation rather than individual instances of bullying).

For further examples, please see the Health Education England video.

Remember that if you are a healthcare professional you may have a professional duty to report a concern. If in doubt, please raise it.
Don’t wait for proof. We would like you to raise the matter while it is still a concern. It doesn’t matter if you turn out to be mistaken as long as you are genuinely troubled.

This policy is not for people with concerns about their employment that affect only them – that type of concern is better suited to our Grievance and Disputes Policy available via HR Direct or the HR team.

**Feel safe to raise your concern**

If you raise a genuine concern under this policy, you will not be at risk of losing your job or suffering any form of reprisal as a result. We will not tolerate the harassment or victimisation of anyone raising a concern. Nor will we tolerate any attempt to bully you into not raising any such concern. Any such behaviour is a breach of our values as an organisation and, if upheld following investigation, could result in disciplinary action.

Provided you are acting honestly, it does not matter if you are mistaken or if there is an innocent explanation for your concerns.

**Confidentiality**

We hope you will feel comfortable raising your concern openly, but we also appreciate that you may want to raise it confidentially. This means that while you are willing for your identity to be known to the person you report your concern to, you do not want anyone else to know your identity. Therefore, we will keep your identity confidential, if that is what you want, unless required to disclose it by law (for example, by the police). You can choose to raise your concern anonymously, without giving anyone your name, but that may make it more difficult for us to investigate thoroughly and give you feedback on the outcome.

**Who can raise concerns?**

Anyone who works (or has worked) in the NHS, or for an independent organisation that provides NHS services can raise concerns. This includes agency workers, temporary workers, students, volunteers and governors.

**Who should I raise my concern with?**

In many circumstances the easiest way to get your concern resolved will be to raise it formally or informally with your line manager (or lead clinician or tutor). But where you don’t think it is appropriate to do this, you can use any of the options set out below in the first instance.

If raising it with your line manager (or lead clinician or tutor) does not resolve matters, or you do not feel able to raise it with them, you can contact one of the following people:

(a) our Freedom to Speak Up Guardian: Mrs Lorraine Jackman Deputy Director of Corporate Affairs and Governance  01625 663175 or
email ecn-tr.SpeakingUpForSafety@nhs.net

This is an important role identified in the Freedom to Speak Up review to act as an independent and impartial source of advice to staff at any stage of raising a concern, with access to anyone in the organisation, including the chief executive, or if necessary, outside the organisation

You can also contact:

(b) our Executive Director with responsibility for whistleblowing:

Mrs Julie Green, Director of Corporate Affairs and Governance
Independent Board Member Tel 01625 661501

John Wilbraham, Chief Executive Tel 01625 661501

Mrs Lynn McGill, Chairman of the Trust - Tel 01625 661501

Or email ecn-tr.SpeakingUpForSafety@nhs.net

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

(c) You can also report your concern via the module on the DATIX system, using the following link:


If for any reason you do not feel comfortable raising your concern internally, you can raise concerns with external bodies, listed on page 7.
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 Counter Fraud Authority** for concerns about fraud and corruption.
Making a ‘protected disclosure’

There are very specific criteria that need to be met for an individual to be covered by whistleblowing law when they raise a concern (to be able to claim the protection that accompanies it). There is also a defined list of ‘prescribed persons’, similar to the list of outside bodies on page 7, who you can make a protected disclosure to. To help you consider whether you might meet these criteria, please seek independent advice from the Whistleblowing Helpline for the NHS and social care, Public Concern at Work or a legal representative.

National Guardian Freedom to Speak Up

The 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:  
(d) our Executive Director with responsibility for whistleblowing:  
Mrs Julie Green, Director of Corporate Affairs and Governance  
Independent Board Member Tel 01625 661501

John Wilbraham, Chief Executive Tel 01625 661501

Mrs Lynn McGill, Chairman of the Trust - Tel 01625 661501

Or email ecn-tr.SpeakingUpForSafety@nhs.net
Step three

You can raise concerns formally with external bodies:

xi. **NHS Improvement** for concerns about:
   - how NHS trusts and foundation trusts are being run
   - other providers with an NHS provider licence
   - NHS procurement, choice and competition
   - the national tariff

xii. **Care Quality Commission** for quality and safety concerns

xiii. **NHS England** for concerns about:
   - primary medical services (general practice)
   - primary dental services
   - primary ophthalmic services
   - local pharmaceutical services

xiv. **Health Education England** for education and training in the NHS

xv. **NHS Counter Fraud Agency** 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.*
## C3 - TENDERING PROCEDURE (PROCUREMENT OF GOODS AND SERVICES)

### CONTENTS

<table>
<thead>
<tr>
<th></th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>SUMMARY</td>
</tr>
<tr>
<td>2</td>
<td>QUOTATIONS AND TENDERS</td>
</tr>
<tr>
<td>3</td>
<td>WAIVING OF ALL OR PART OF THE COMPETITION REQUIREMENTS</td>
</tr>
<tr>
<td>4</td>
<td>IDENTIFYING POTENTIAL BIDDERS</td>
</tr>
<tr>
<td>5</td>
<td>TENDER PROCEDURE</td>
</tr>
<tr>
<td>6</td>
<td>RECEIPT OF TENDERS</td>
</tr>
<tr>
<td>7</td>
<td>OPENING OF TENDERS</td>
</tr>
<tr>
<td>8</td>
<td>REGISTER OF TENDERS</td>
</tr>
<tr>
<td>9</td>
<td>ADMISSIBILITY OF TENDERS</td>
</tr>
<tr>
<td>10</td>
<td>CRITERIA FOR AWARD OF BUSINESS</td>
</tr>
<tr>
<td>11</td>
<td>PRE TENDER AND POST TENDER BIDDER ENGAGEMENT</td>
</tr>
<tr>
<td>12</td>
<td>CAPITAL AND PROPERTY DEVELOPMENT</td>
</tr>
<tr>
<td>13</td>
<td>FORMAL AWARD OF BUSINESS</td>
</tr>
<tr>
<td>14</td>
<td>DISPOSALS</td>
</tr>
<tr>
<td>15</td>
<td>PLANNING AND IMPLEMENTATION</td>
</tr>
<tr>
<td>16</td>
<td>REVIEW</td>
</tr>
</tbody>
</table>

**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>Quotation/Tender 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>Minimum of 3 Formal Tenders issued and received in accordance with Trust Policy as detailed in 5 and 6 below.</td>
</tr>
</tbody>
</table>

It should be noted that;

Both quotations and tenders are formal requests from the Trust to potential suppliers to provide prices /costs against a defined procurement.

Quotations will usually comprise a single document. The use of quotations provided by potential suppliers to satisfy the requirement for 3 Quotations will be at the discretion of the Procurement Department.

This discretion will be exercised based upon the knowledge of the potential supplier and proposed procurement.

Tenders representing a greater value and potentially more complicated procurements will comprise a range of standard documentation as advised by the Department of Health and Office of Government Commerce.
In cases where the Trust, by prior agreement, uses another Public Body to undertake procurement then the Statutory Framework of that Body will apply to the procurement – the Trust having agreed and documented this in advance.

In cases where the Trust, by prior agreement, undertakes procurement on behalf of another Public Body the Trust’s Statutory Framework will apply – all parties having agreed and documented this in advance.

3. WAIVING ALL OR PART OF THE COMPETITION REQUIREMENTS.

All Trust Officers should seek, wherever possible, to satisfy the requirements for competition as detailed in 2 above.

In exceptional cases where this is not deemed possible, Trust Officers may seek the approval of the Trust to waive these requirements. All proposed Waivers will be requested by means of the attached Form – Appendix A.

The following Approval process for the waiving of competition requirements applies:

- The Trust Procurement Department will consider all requests and review based upon both the information presented and appropriate research.
- The Trust Procurement Department will either approve or decline the request or, if the value is above £50000 either submit to the Director of Finance or decline. In cases of the latter, full reasons will be given to the Trust Officer and advice given as to how the procurement can be progressed.

Waiving of tender requirements may be considered in the following circumstances:

i. Where goods or services are only available from one or two sources
ii. Where genuine and unforeseen urgency exists that precludes compliance to the process as identified in 2 above
iii. Where it is in the commercial and/or operational interest of the Trust
iv. Where there is clear benefit to be gained from maintaining continuity with an earlier procurement and with the benefits of that continuity outweighing any potential financial advantage which could gained by competitive tendering;

A Waiver Request form (Appendix 1) should be completed and the reasons should be documented and recorded within this form.

Waiver forms still require authorisation in line with the Trust’s Scheme of Delegation. This is set out in the table below:

<table>
<thead>
<tr>
<th>Financial Limit (including VAT)</th>
<th>Waiver Authorised by</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Exec/ Director of Finance</td>
<td>Board of Directors</td>
</tr>
<tr>
<td>Over £106,047</td>
<td></td>
</tr>
</tbody>
</table>

It should be noted that European Procurement Law applies at all times and in particular to proposed procurements in excess of the financial threshold appertaining at the time (£106,047 in total value excl VAT as from 1st January, 2016). The prevailing rate can be found - [http://www.ojec.com/thresholds.aspx](http://www.ojec.com/thresholds.aspx). European Procurement Law cannot be 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 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 1\textsuperscript{st} January, 2016)

The Trust will comply with Department of Health and other Public Body Guidance.

13. FORMAL AWARD OF BUSINESS

Provided all of the above conditions and circumstances set out above have been fully complied with, formal authorisation and award of a contract may be agreed under the authorisation limits defined in Section 3 of the Trust’s Scheme of Delegation. In the case of authorisation by the Board of Directors, this shall be recorded in their minutes.

14. DISPOSALS

Competitive tendering or quotation procedures shall not apply to the disposal of:

(a) Any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Director of Finance or his nominated officer;
(b) Obsolete or condemned articles and stores, which may be disposed of in accordance with appropriate Trust Policy;
(c) Items to be disposed of with an estimated sale value of less than £1000, this figure to be reviewed annually;
(d) Items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;
(e) Land or buildings concerning which Department of Health guidance has been issued but subject to compliance with such guidance.
Appendix 1

WAIVER TO STANDING FINANCIAL INSTRUCTIONS

PROCEDURE INSTRUCTIONS FOR THE COMPLETION OF WAIVER FORMS

Please refer to the Waiver Form below (WAIV4) Revised March 2016.
Please be aware that multi-year contracts may result in the requirement of a Waiver

1. The Waiver form is to be used when:
   - The requester wishes the requirement for tender/competitive quotes in the Standing Financial Instructions to be waived.
   **Note:** where the reason is urgency resulting from a lack of forward planning, a waiver will not be authorised.
   **Note:** where the reason is the purchase is from a sole supplier of products/services – written evidence must be provided by the Procurement Manager that alternative sources are impractical.

2. All waiver forms should be completed by providing information as required on the form. The form may be completed electronically or in ink and should be legible (authorisation signature should be done in ink).

3. All waiver forms should be completed in full as requested on the form and signed (in ink) by the appropriate budget holder before being sent to the Procurement Manager. Where necessary please provide additional/supporting information on a separate sheet.
   **Note:** waiver forms not completed correctly and with insufficient details will be returned to the originator for completion.

4. Each waiver form will be registered using the Requisition No on the form and will be assessed by the Procurement Manager prior to sign off by departmental Director & approval.

5. All waivers will be recorded on the Trust’s waiver log.

6. All waivers will be returned to the Procurement Department, approved waivers will be processed and a Purchase Order will be issued for the purchase of the goods/services. Rejected waivers will be returned to the originator.

7. Waivers are presented each quarter to the Audit Committee meeting. If the Committee feel that insufficient information has been provided, the person responsible for completing the waiver will be required to attend to explain their actions.
PROCEDURE TO COMPLETING WAIVER DOCUMENT (Waiv4)

Completing the Waiver Form

Reason for Waiver – is the Product/Service;

i. Where the goods/services are available from a fewer number of suppliers required by Trust Standing Financial Instructions.

ii. Where genuine and unforeseen urgency exists that precluded compliance to the process as identified in Trust Policy. Note: where the urgency results from a lack of forward planning, a waiver will not be authorised.

iii. Where it is in the commercial or operational interest of the Trust as clearly evidenced.

iv. Where there is a clear benefit to gained from maintaining continuity with an earlier procurement

For Interim Agency Staff:
Where a Waiver concerns an interim member of staff please liaise with your Business Accountant as a full cost analysis will need to accompany the waiver document before being passed for authorisation. (Business Accountant will complete the cost analysis)

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

Yes

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.
APPLICATION TO ACCEPT A NON COMPETITIVE QUOTATION
(Value £10,000.00 TO £25,000.00) OR TENDER (Value exceeding £50,000.00)
Ref: /

Please ensure all sections are fully completed, failure to do so will result in the form being returned

**STAGE ONE**

SBS Requisition No........................................ Purchase Order No..................................................
(Procurement use only)

For the purchase of:

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

Ward/Department.............................................................Division..........................................

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

Price (inc VAT irrespective of application).£ .........................-…..p.

Funding Source (please delete as appropriate) Capital / Revenue / Charitable

 Proposed supplier........................................................................................................................................

**STAGE TWO**

<table>
<thead>
<tr>
<th>Reasons for non-competitive quotation application (please tick as appropriate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>i. Where the goods or services are only available from a fewer number of suppliers than required by Trust Standing Financial Instructions</td>
</tr>
<tr>
<td>ii. Where genuine and unforeseen urgency exists that precludes compliance to the process as identified in the Trust Policy.</td>
</tr>
<tr>
<td>iii. Where it is in the commercial or operational interest of the Trust as clearly evidenced.</td>
</tr>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>

**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**

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

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

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

218
STAGE THREE

Waiver Requested by

Name ....................................................................................................................

Position........................................Signature………………………Date.....................Ext No………..

“In Signing this Application, I declare I have (1) read the appropriate sections of the Standing Financial Instructions/ Scheme of Reservation & Delegation (2) hold no pecuniary interest in the company/ individual supplying the goods/services described in this Application. I understand that if I breach any of the above I could face disciplinary action.”

Supported by Budget Holder

Name…………………….…….………Signature…………..………….………Date.............................Ext No…………..…..

I CONFIRM THAT I AM THE BUDGET HOLDER AND THAT I HAVE DOCUMENTARY EVIDENCE TO SUPPORT THIS APPLICATION TO WAIVER TRUST STANDING FINANCIAL INSTRUCTIONS

“In Signing this Application, I declare I have (1) read the appropriate sections of the Standing Financial Instructions/ Scheme of Reservation & Delegation (2) hold no pecuniary interest in the company/ individual supplying the goods/services described in this Application. I understand that if I breach any of the above I could face disciplinary action.”

THIS COMPLETED FORM IS TO BE HANDED TO THE TRUST PROCUREMENT TEAM – located on the 2nd Floor of New Alderley House

STAGE FOUR

RECEIVED in Trust Procurement and acknowledged to originator………………………………………………………………

Procurement
Comments ..........................................................................................................

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

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

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

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

PROCUREMENT TEAM TO PROGRESS TO TRUST HQ
**STAGE FIVE**

Supported by Director

Name ........................................Signature……
........................................Date....................Ext No............

**STAGE SIX  Final Authorisation / Rejection**

Director of Finance / Chief Executive / Deputy Chief Executive

Name: .................................................................

Signed: .................................................................

Date.................................

**APPROVED WAIVERS WILL RESULT IN A PURCHASE ORDER BEING ISSUED TO THE SUPPLIER – VISIBLE IN SBS**

Reason for Rejection:

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

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

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

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

**REJECTED WAIVERS WILL BE RETURNED TO THE REQUESTOR**
DECISION TO BID

The decision to bid shall be made by the Trust Board, where:

1. The Chief Executive (in conjunction with the Executive Management Team) recommends bidding, and
2. The value of the contract exceeds 1% of Trust Turnover

Where the value of the contract is below 1% of Trust Turnover then the Chief Executive (in conjunction with the Executive Management Team), will be delegated to make the decision to bid.

Where the Trust Board, or the Chief Executive (in conjunction with the Executive Management Team) decide against bidding then their rationale will be captured in the regular report to the Trust Board or its appropriate committee (currently Finance, Performance & Workforce Committee).

CRITERIA FOR BIDDING

In order to decide whether to bid for contracts the Chief Executive (in conjunction with the Executive Management Team) will utilise:

1. The potential services fit with the Trust’s strategic plan
2. The view of the Service Line, or Corporate Directorate utilising the Trust’s Bid/No Bid tool
3. The view of the potential services geographic and strategic fit with existing services
4. The economic case for bidding or not bidding, based on the cost of the bid and the indicative bid value, especially where this is a pass/fail criterion

CONSTRUCTION AND SUBMISSION OF THE BID

The format and construction of the bid will be determined by the Executive Director of Finance and will be prepared by Service Line, Planning and Business Development, Human Resources, Estates & Finance staff in partnership, where appropriate.

The Chief Executive will nominate an Executive Director to sign off and oversee the submission of the bid, by the deadline. The nominated Executive Director will ensure that all advisory functions have supported the service in signing off the bid.
Fit 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 (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 been</td>
<td></td>
</tr>
<tr>
<td>convicted elsewhere of any offence which, if committed in any part of</td>
<td></td>
</tr>
<tr>
<td>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</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>
</tr>
<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>
</tr>
<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 references; | 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. |
### Standard

<table>
<thead>
<tr>
<th>3.</th>
<th>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.</th>
</tr>
</thead>
</table>

### Assurance process

- Requirements included within the job description for all relevant posts.
- Checked as part of the pre-employment checks and references on qualifications.

### Evidence

- Person specification
- Recruitment policy and procedure

---

<table>
<thead>
<tr>
<th>4.</th>
<th>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 leadership skills and a caring and compassionate nature), to undertake the role; these should be followed in all cases and relevant records kept.</th>
</tr>
</thead>
</table>

**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.**

### Assurance process

- 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)

### Evidence

- Recruitment policy and procedure
- Values-based questions
- Minutes of board of directors.

---

<table>
<thead>
<tr>
<th>5.</th>
<th>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.</th>
</tr>
</thead>
</table>

### Assurance process

- 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.

### Evidence

- Minutes of committee,
- NED appraisal framework
- NED competence framework
- Notes of ED appraisals

---

<table>
<thead>
<tr>
<th>6.</th>
<th>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.</th>
</tr>
</thead>
</table>

### Assurance process

- Self-declaration subject to clearance by occupational health as part of the pre-employment process.

### Evidence

- Occupational health clearance
<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>
<tr>
<td>Standard</td>
<td>Assurance process</td>
<td>Evidence</td>
</tr>
<tr>
<td>----------</td>
<td>-------------------</td>
<td>----------</td>
</tr>
<tr>
<td>8.</td>
<td>Consequences of false or inaccurate or incomplete information included in recruitment packs.</td>
<td>NED Recruitment Information pack Reference Request for ED/NED</td>
</tr>
<tr>
<td></td>
<td>Checks set out in 1. Above i.e. Employment checks in accordance with NHS Employers pre-employment check standards including:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- self-declarations of fitness including explanation of past conduct/character issues where appropriate by candidates;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- two references, one of which must be most recent employer;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- qualification and professional registration checks;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- right to work checks;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- proof of identity checks;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- occupational health clearance;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- DBS checks (where appropriate);</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- search of insolvency and bankruptcy register;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- search of disqualified directors register</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Included in reference requests.</td>
<td></td>
</tr>
</tbody>
</table>

N.B. This provision applies equally to executives and NEDs.

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.
<table>
<thead>
<tr>
<th><strong>Standard</strong></th>
<th><strong>Assurance process</strong></th>
<th><strong>Evidence</strong></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 &quot;regulated activity&quot; 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><strong>Standard</strong></th>
<th><strong>Assurance process</strong></th>
<th><strong>Evidence</strong></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>
<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>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<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? |
<table>
<thead>
<tr>
<th>Wider use of findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Whether or not there are any contractual restrictions to sharing the outcomes of this work with the wider sector. Where the outcomes are not commercially sensitive, we will expect all future work to be made available for the wider benefit of the NHS, particularly where the advice is technical and likely to be generic to similar situations</td>
</tr>
<tr>
<td>• We expect this right of access to be written into contracts. You should check that a contract clause is in place allowing for the wider use of any generic technical findings, and also that the deliverables have been scoped so that such technical work is as far as possible separated from any commercially sensitive elements of the scope</td>
</tr>
</tbody>
</table>
Consultancy expenditure business case approval form

<table>
<thead>
<tr>
<th>For provider completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider name</td>
</tr>
<tr>
<td>Date submitted</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Project description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please give a high level summary of what this project entails (~250 words)</td>
</tr>
</tbody>
</table>

NHS Improvement’s Consultancy Approval Panel will give final approval for all expenditure requested in this business case approval form. This panel exercises the authority of the Executive Director of Resources/Deputy CEO, Executive Director of Regulation/Deputy CEO, Director of Finance and Programme Director – Improvement.

<table>
<thead>
<tr>
<th>For NHS Improvement completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reference number</td>
</tr>
<tr>
<td>Date received</td>
</tr>
</tbody>
</table>
### Reference information

<table>
<thead>
<tr>
<th>Title of the project:</th>
<th>Job role of requestor:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of requestor:</th>
<th>Email address of requestor:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Job role of requestor:</th>
<th>Date submitted for approval:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total contract value (£) (including expenses and irrecoverable VAT)¹:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Contract duration (days):</th>
<th>Vanguard project (Y/N):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Start date:</th>
<th>End date:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</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; human resources, training and education; programme and project management; technical, other (specify))</th>
</tr>
</thead>
<tbody>
<tr>
<td>Management consultancy</td>
<td>✓ [e.g. Strategy]</td>
</tr>
<tr>
<td>Specialist day rate contractors</td>
<td>Interim managers and day rate contractors do not currently require approval</td>
</tr>
<tr>
<td>Interim managers</td>
<td>Interim managers and day rate contractors do not currently require approval</td>
</tr>
</tbody>
</table>

### Authorisation (two internal authorisations required as a minimum)

<table>
<thead>
<tr>
<th>Authorisers²</th>
<th>Please tick (✓)</th>
<th>Name and date</th>
</tr>
</thead>
<tbody>
<tr>
<td>[Specify job role]</td>
<td>By: [Specify name]; Date: [Specify date]</td>
<td></td>
</tr>
<tr>
<td>[Specify job role]</td>
<td>By: [Specify name]; Date: [Specify date]</td>
<td></td>
</tr>
<tr>
<td>[Specify job role]</td>
<td>By: [Specify name]; Date: [Specify date]</td>
<td></td>
</tr>
<tr>
<td>[Specify job role]</td>
<td>By: [Specify name]; Date: [Specify date]</td>
<td></td>
</tr>
</tbody>
</table>

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

² Business case approval forms should be signed off in accordance with your own governance arrangements. Please note that NHS Improvement also expects this form to be authorised by at least two board level executives. For projects with direct impact on clinical services, authorisation by the Nursing Director or the Medical Director is required.

Note: It is the responsibility of the requestor to ensure that approval information is retained for audit purposes.

Please submit this form via nhsi.businesscases@nhs.net
### Assessment criteria
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.

<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></td>
<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>
</tr>
<tr>
<td></td>
<td>Please provide details of the clinical case where the proposed work directly affects the provision of services for patients or quality improvement.</td>
</tr>
<tr>
<td></td>
<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>
</tr>
<tr>
<td></td>
<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>
</tr>
<tr>
<td></td>
<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>
</tr>
<tr>
<td>Clear scope</td>
<td>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?</td>
</tr>
<tr>
<td>Robust contract management</td>
<td>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.</td>
</tr>
</tbody>
</table>
**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.

<table>
<thead>
<tr>
<th>Timeframe of work</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please include when expected outcome will be delivered. Why does the project need to start now and not in say 6 months' time?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Robust post-implementation review proposal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please outline how you will review the effectiveness of the consultancy support procured.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Wider use of findings</th>
</tr>
</thead>
<tbody>
<tr>
<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</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>
<th></th>
<th></th>
<th></th>
<th>Financial Year Expenditure Due</th>
<th>Sub Total (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Product, service, role(s) and grade(s) (or equivalent)</td>
<td>Unit cost or daily rate</td>
<td>Discount agreed (%)</td>
<td>Units required</td>
<td>16/17</td>
<td>17/18</td>
</tr>
<tr>
<td>Contingency Expenses VAT (irrecoverable only)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total cost</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Conflicts of Interest Policy
June 2017 – June 2020
# Conflict of Interest Policy

## Executive Summary:
This policy outlines the processes followed by East Cheshire NHS Trust in meeting the requirements for any trust ‘Decision Maker’ to declare any actual or potential conflicts of interest that arise in the course of conducting NHS business.

These should be declared on appointment and updated as necessary (at least annually, including a nil return) any potential or actual conflict.

## Supersedes:
Conflict of Interest v2 issued in November 2017

## Description of Amendment(s):
Section 7 – Revision to the trusts Decision Making Staff  
Section 12 – Revision to the trusts Decision Making Groups

## This policy will impact on:
All staff and volunteers of ECT

## Financial Implications:
None

## Policy Area:
Corporate Affairs and Governance

## Document Reference:

## Version Number:
3

## Effective Date:
1<sup>st</sup> April 2018

## Issued By:
Director of Corporate Affairs and Governance

## Review Date:
1<sup>st</sup> June 2020

## Author:
Corporate Affairs & EPRR Manager

## Impact Assessment Date:
June 2017

## APPROVAL RECORD

| Consultation | Deputy Director of CAG  
Director of CAG | March 2018 |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Approved by:</td>
<td>Director of Corporate Affairs &amp; Governance</td>
<td>March 2018</td>
</tr>
</tbody>
</table>
# Contents

1. Policy Summary ................................................................. 7
2. Introduction ........................................................................... 8
3. Purpose .................................................................................. 8
4. Key terms ............................................................................. 8
5. Interests ................................................................................ 9
6. Staff ...................................................................................... 9
7. Decision Making Staff .......................................................... 10
8. Identification, declaration and review of interests ....................... 10
   8.1 Identification & declaration of interests (including gifts and hospitality) 10
   8.2 Proactive review of interests ............................................. 10
9. Records and publication .......................................................... 11
   9.1 Maintenance ..................................................................... 11
   9.2 Publication ....................................................................... 11
   9.3 Wider transparency initiatives .......................................... 11
10. Management of interests – general ......................................... 12
11. Management of interests – common situations .......................... 12
   11.1 Gifts ............................................................................... 12
   11.2 Hospitality ...................................................................... 13
   11.3 Outside Employment ....................................................... 14
   11.4 Shareholdings and other ownership issues .......................... 14
   11.5 Patents .......................................................................... 15
   11.6 Loyalty interests ............................................................ 15
   11.7 Donations ...................................................................... 15
   11.8 Sponsored events .......................................................... 16
   11.9 Sponsored research ....................................................... 16
   11.10 Sponsored posts .......................................................... 17
   11.11 Clinical private practice ................................................ 17
12. Management of interests – advice in specific contexts ............... 18
   12.1 Strategic decision making groups ..................................... 18
   12.2 Procurement .................................................................. 19
13. Dealing with breaches ........................................................... 20
   13.1 Identifying and reporting breaches .................................... 20
   13.2 Taking action in response to breaches ............................... 20
14. Review ................................................................................. 21
15. Associated documentation ...................................................... 21
16. Appendix 1 – trust declaration template for conflict of interests ...... 22
Adhering to this policy will help to ensure that we use NHS money wisely, providing best value for taxpayers and accountability to our patients for the decisions we take.

<table>
<thead>
<tr>
<th>As a member of staff you should…</th>
<th>As an organisation we will…</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Use your common sense and judgement to consider whether the interests you have could affect the way taxpayers’ money is spent.</td>
<td>• Identify a team or individual with responsibility for:</td>
</tr>
<tr>
<td>• Regularly consider what interests you have and declare these as they arise. If in doubt, declare.</td>
<td>o Keeping this policy under review to ensure we are in line with the guidance.</td>
</tr>
<tr>
<td>• <strong>NOT</strong> misuse your position to further your own interests or those close to you.</td>
<td>o Provide advice, training and support for staff on how interests should be managed.</td>
</tr>
<tr>
<td>• <strong>NOT</strong> be influenced, or give the impression that you have been influenced by outside interests.</td>
<td>o Maintain register(s) of interests.</td>
</tr>
<tr>
<td>• <strong>NOT</strong> allow outside interests you have to inappropriately affect the decisions you make when using taxpayers’ money.</td>
<td>o Audit this policy and its associated processes and procedures at least once every three years.</td>
</tr>
<tr>
<td>• <strong>NOT</strong> avoid managing conflicts of interest.</td>
<td>• <strong>NOT</strong> interpret this policy in a way which stifles collaboration and innovation with our partners.</td>
</tr>
</tbody>
</table>
2. INTRODUCTION

East Cheshire NHS Trust (the ‘organisation’), and the people who work with and for us, collaborate closely with other organisations delivering high quality care for our patients.

These partnerships have many benefits and should help ensure that public money is spent efficiently and wisely; but there is a risk that conflicts of interest may arise.

Providing best value for taxpayers and ensuring that decisions are taken transparently and clearly, are both key principles in the NHS Constitution. We are committed to maximising our resources for the benefit of the whole community. As an organisation and as individuals, we have a duty to ensure that all our dealings are conducted to the highest standards of integrity and that NHS monies are used wisely so that we are using our finite resources in the best interests of patients.

3. PURPOSE

This policy should be considered alongside the following East Cheshire NHS Trust policies and procedures:

- Corporate Governance Manual (Part D – Standing Financial Instructions, section 22 – Acceptance of gifts by staff)
- Local Anti-Fraud, Bribery and Corruption Policy
- Freedom to Speak-Up – Raising Concerns Policy

This policy will help our staff manage conflicts of interest risks effectively; it:

- Introduces consistent principles and rules
- Provides simple advice about what to do in common situations
- Supports good judgement about how to approach and manage interests

4. KEY TERMS

A ‘conflict of interest’ is defined as:

“A set of circumstances by which a reasonable person would consider that an individual’s ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold.”

A conflict of interest may be:

- Actual - there is a material conflict between one or more interests
- Potential – there is the possibility of a material conflict between one or more interests in the future

Staff may hold interests for which they cannot see potential conflict. However, caution is always advisable because others may see it differently and perceived conflicts of interest can
be damaging. All interests should be declared where there is a risk of perceived improper conduct.

5. INTERESTS

Interests fall into the following categories:

- **Financial interests:**
  Where an individual may get direct financial benefit* from the consequences of a decision they are involved in making.

- **Non-financial professional interests:**
  Where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making, such as increasing their professional reputation or promoting their professional career.

- **Non-financial personal interests:**
  Where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career.

- **Indirect interests:**
  Where an individual has a close association† with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest and could stand to benefit from a decision they are involved in making.

6. STAFF

At East Cheshire NHS Trust we use the skills of many different people, all of whom are vital to our work. This includes people on differing employment terms, who for the purposes of this policy we refer to as ‘staff’ and are listed below:

- All salaried employees
- All prospective employees – who are part-way through recruitment
- Contractors and sub-contractors
- Volunteers
- Agency staff; and
- Committee, sub-committee and advisory group members (who may not be directly employed or engaged by the organisation)

NHS England have produced some frequently asked questions for specific staff groups on the issues posed and how the guidance applies to you; for further information this can be found at [www.england.nhs.uk/ourwork/coi](http://www.england.nhs.uk/ourwork/coi).

---

* This may be a financial gain, or avoidance of a loss.
† A common sense approach should be applied to the term ‘close association’. Such an association might arise, depending on the circumstances, through relationships with close family members and relatives, close friends and associates, and business partners.
7. DECISION MAKING STAFF

Some staff are more likely than others to have a decision making influence on the use of taxpayers' money, because of the requirements of their role. For the purposes of this guidance these people are referred to as ‘decision making staff.’

Decision making staff in this organisation are:

- Those on Agenda for Change 8C (or salary equivalent) and above and the trusts Procurement team
- Those on Agenda for Change whose salary is on or above spine point 41
- Those staff who are not on Agenda for Change and who receive income exceeding spine point 41
- Medical staff who receive a whole time equivalent salary (or pro rata) of £56,665 (April 2017) or above
- Executive and Non-Executive Directors

Please remember if you are in one of the above categories and have nothing to declare you still have to go onto the system and input a 'nil' declaration.

8. IDENTIFICATION, DECLARATION AND REVIEW OF INTERESTS

8.1 Identification & declaration of interests (including gifts and hospitality)

All staff should identify and declare material interests at the earliest opportunity (and in any event within 28 days). If staff are in any doubt as to whether an interest is material then they should declare it, so that it can be considered. Declarations should be made:

- On appointment with the organisation;
- When staff move to a new role or their responsibilities change significantly;
- At the beginning of a new project/piece of work and
- As soon as circumstances change and new interests arise (for instance, in a meeting when interests staff hold are relevant to the matters in discussion).

The trust has an electronic system which is linked to ESR in full.

The responsibility for the management of the trust’s conflict of interest’s process including the review of this policy lies with the Director of Corporate Affairs & Governance. A declaration of staff conflicts of interest will be made annually at the Trust Board meeting in March.

Should staff members require any further advice or guidance please email the following address:

Ecn-tr.conflictofinterest@nhs.net

After expiry, an interest will remain on register(s) for a minimum of 6 months and a private record of historic interests will be retained for a minimum of 6 years.
8.2 Proactive review of interests

A prompt will be emailed to all decision making staff on an annual basis to ensure that interests are kept up to date and remain current.

9. RECORDS AND PUBLICATION

9.1 Maintenance

The organisation will maintain the following register:

- Conflict of Interest Register

9.2 Publication

We will:

- Publish the declarations made by staff in the conflict of interest register on an ongoing basis and note this annually at Trust Board in March
- Make this information available on the Trust’s website

If decision making staff have substantial grounds for believing that publication of their interests should not take place then they should contact either the Director of Corporate Affairs & Governance (Julie.green4@nhs.net) or the Corporate Affairs Manager (fionabaker@nhs.net) to explain why. In exceptional circumstances, for instance where publication of information might put a member of staff at risk of harm, information may be withheld or redacted on public registers. However, this would be the exception and information will not be withheld or redacted merely because of a personal preference.

9.3 Wider transparency initiatives

East Cheshire NHS Trust fully supports wider transparency initiatives in healthcare, and we encourage staff to engage actively with these.

Relevant staff are strongly encouraged to give their consent for payments they receive from the pharmaceutical industry to be disclosed as part of the Association of British Pharmaceutical Industry (ABPI) Disclosure UK initiative. These “transfers of value” include payments relating to:

- Speaking at and chairing meetings
- Training services
- Advisory board meetings
- Fees and expenses paid to healthcare professionals
- Sponsorship of attendance at meetings, which includes registration fees and the costs of accommodation and travel, both inside and outside the UK
- Donations, grants and benefits in kind provided to healthcare organisations

Further information about the scheme can be found on the ABPI website:

http://www.abpi.org.uk/our-work/disclosure/about/Pages/default.aspx
10. MANAGEMENT OF INTERESTS – GENERAL

If an interest is declared but there is no risk of a conflict arising then no action is warranted. However, if a material interest is declared then the general management actions that could be applied include:

- restricting staff involvement in associated discussions and excluding them from decision making
- removing staff from the whole decision making process
- removing staff responsibility for an entire area of work
- removing staff from their role altogether if they are unable to operate effectively in it because the conflict is so significant

Each case will be different and context-specific, and East Cheshire NHS Trust will always clarify the circumstances and issues with the individuals involved. Staff should maintain a written audit trail of information considered and actions taken.

Staff who declare material interests should make their line manager or the person(s) they are working to aware of their existence.

11. MANAGEMENT OF INTERESTS – COMMON SITUATIONS

This section sets out the principles and rules to be adopted by staff in common situations, and what information should be declared.

11.1 Gifts

- Staff should not accept gifts that may affect, or be seen to affect, their professional judgement

Gifts from suppliers or contractors:

- Gifts from suppliers or contractors doing business (or likely to do business) with the organisation should be declined, whatever their value
- Low cost branded promotional aids such as pens or post-it notes may, however, be accepted where they are under the value of £6* in total, and need not be declared

Gifts from other sources (e.g. patients, families, service users):

- Gifts of cash and vouchers to individuals should always be declined
- Staff should not ask for any gifts
- Gifts valued at over £50 should be treated with caution and only be accepted on behalf of East Cheshire NHS Trust and then given to the trust’s charity ECHO for fund raising purposes and not by an individual member of staff; any incidents of this should also be declared
- Modest gifts accepted under a value of £50 do not need to be declared

* The £6 value has been selected with reference to existing industry guidance issued by the ABPI: http://www.pmcpa.org.uk/thecode/Pages/default.aspx
• A common sense approach should be applied to the valuing of gifts (using an actual amount, if known, or an estimate that a reasonable person would make as to its value)
• Multiple gifts from the same source over a 12 month period should be treated in the same way as single gifts over £50 where the cumulative value exceeds £50

11.1.2 What should be declared

• Staff name and their role with the organisation
• A description of the nature and value of the gift, including its source
• Date of receipt
• Any other relevant information (e.g. circumstances surrounding the gift, action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

11.2 Hospitality

• Staff should not ask for or accept hospitality that may affect, or be seen to affect, their professional judgement
• Hospitality must only be accepted when there is a legitimate business reason and it is proportionate to the nature and purpose of the event
• Particular caution should be exercised when hospitality is offered by actual or potential suppliers or contractors. This can be accepted, and must be declared, if modest and reasonable. Senior approval must be obtained.

Meals and refreshments:

• Under a value of £25 - may be accepted and need not be declared
• Of a value between £25 and £75* - may be accepted and must be declared
• Over a value of £75 - should be refused unless (in exceptional circumstances) senior approval is given. A clear reason should be recorded on the organisation’s register(s) of interest as to why it was permissible to accept
• A common sense approach should be applied to the valuing of meals and refreshments (using an actual amount, if known, or a reasonable estimate)

Travel and accommodation:

• Modest offers to pay some or all of the travel and accommodation costs related to attendance at events may be accepted and must be declared
• Offers which go beyond modest, or are of a type that the trust might not usually offer, need approval by senior staff, should only be accepted in exceptional circumstances, and must be declared. A clear reason would need to be recorded on the organisation’s register(s) of interest as to why it was permissible to accept travel and accommodation of this type. A non-exhaustive list of examples includes:
  • offers of business class or first class travel and accommodation (including domestic travel)
  • offers of foreign travel and accommodation.

* The £75 value has been selected with reference to existing industry guidance issued by the ABPI
http://www.pmcpa.org.uk/thecode/Pages/default.aspx
11.2.1 What should be declared

- Staff name and their role with the organisation
- The nature and value of the hospitality including the circumstances
- Date of receipt
- Any other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy)

11.3 Outside Employment

- Existing staff should declare any current outside employment and for new staff this will be required on appointment
- Where a risk of conflict of interest arises, the general management actions outlined in this policy should be considered and applied to mitigate risks
- Where contracts of employment or terms and conditions of engagement permit, staff may be required to seek prior approval from the organisation to engage in outside employment

The organisation may also have legitimate reasons within employment law for knowing about outside employment of staff, even when this does not give rise to risk of a conflict.

11.3.1 What should be declared

- Staff name and their role with the organisation
- The nature of the outside employment (e.g. who it is with, a description of duties, time commitment)
- Relevant dates
- Other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy)

11.4 Shareholdings and other ownership issues

- Staff should declare, as a minimum, any shareholdings that are material to them (ie equivalent of 5% or more of their overall wealth) or material to the organisation and other ownership interests in any publicly listed, private or not-for-profit company, business, partnership or consultancy which is doing, or might be reasonably expected to do, business with the trust
- Where shareholdings or other ownership interests are declared and give rise to risk of conflicts of interest then the general management actions outlined in this policy should be considered and applied to mitigate risks
- There is no need to declare shares or securities held in collective investment or pension funds or units of authorised unit trusts

11.4.1 What should be declared

- Staff name and their role with the organisation
- Nature of the shareholdings/other ownership interest
- Relevant dates
- Other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy)

11.5 Patents

- Staff should declare patents and other intellectual property rights they hold (either individually, or by virtue of their association with a commercial or other organisation), including where applications to protect have started or are ongoing, which are, or might be reasonably expected to be, related to items to be procured or used by the organisation
• Staff should seek prior permission from the organisation before entering into any agreement with bodies regarding product development, research, work on pathways etc, where this impacts on the organisation’s own time, or uses its equipment, resources or intellectual property
• Where holding of patents and other intellectual property rights give rise to a conflict of interest then the general management actions outlined in this policy should be considered and applied to mitigate risks

11.5.1 What should be declared
• Staff name and their role with the organisation
• A description of the patent
• Relevant dates
• Other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy)

11.6 Loyalty interests

Loyalty interests should be declared by staff where they:

• Hold a position of authority in another NHS organisation or commercial, charity, voluntary, professional, statutory or other body which could be seen to influence decisions they take in their NHS role
• Sit on advisory groups or other paid or unpaid decision making forums that can influence how an organisation spends taxpayers’ money
• Are, or could be, involved in the recruitment or management of close family members and relatives, close friends and associates, and business partners
• Are aware that their organisation does business with an organisation in which close family members and relatives, close friends and associates, and business partners have decision making responsibilities

11.6.1 What should be declared
• Staff name and their role with the organisation
• Nature of the loyalty interest
• Relevant dates
• Other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy)

11.7 Donations

• Donations made by suppliers or bodies seeking to do business with the trust should be treated with caution and not routinely accepted. In exceptional circumstances they may be accepted but should always be declared. A clear reason should be recorded as to why it was deemed acceptable, alongside the actual or estimated value
• Staff should not actively solicit charitable donations unless this is a prescribed or expected part of their duties for the organisation, or is being pursued on behalf of the organisation’s own registered charity or other charitable body and is not for their own personal gain.
• Staff must obtain permission from the organisation if in their professional role they intend to undertake fundraising activities on behalf of a pre-approved charitable campaign for a charity other than the organisation’s own
• Donations, when received, should be made to a specific charitable fund (never to an individual) and a receipt should be issued
• Staff wishing to make a donation to a charitable fund in lieu of receiving a professional fee may do so, subject to ensuring that they take personal responsibility for ensuring that any tax liabilities related to such donations are properly discharged and accounted for.

11.7.1 What should be declared
• The organisation will maintain records in line with the above principles and rules and relevant obligations under charity law.

11.8 Sponsored events

• Sponsorship of events by appropriate external bodies will only be approved if a reasonable person would conclude that the event will result in clear benefit to the organisation and the NHS
• During dealings with sponsors there must be no breach of patient or individual confidentiality or data protection rules and legislation
• No information should be supplied to the sponsor from whom they could gain a commercial advantage, and information which is not in the public domain should not normally be supplied
• At the organisation’s discretion, sponsors or their representatives may attend or take part in the event but they should not have a dominant influence over the content or the main purpose of the event
• The involvement of a sponsor in an event should always be clearly identified
• Staff within the organisation involved in securing sponsorship of events should make it clear that sponsorship does not equate to endorsement of a company or its products and this should be made visibly clear on any promotional or other materials relating to the event
• Staff arranging sponsored events must declare this to the organisation

11.8.1 What should be declared
• The organisation will maintain records regarding sponsored events in line with the above principles and rules.

11.9 Sponsored research

• Funding sources for research purposes must be transparent
• Any proposed research must go through the relevant health research authority or other approvals process
• There must be a written protocol and written contract between staff, the trust, and/or institutes at which the study will take place and the sponsoring organisation, which specifies the nature of the services to be provided and the payment for those services
• The study must not constitute an inducement to prescribe, supply, administer, recommend, buy or sell any medicine, medical device, equipment or service
• Staff should declare involvement with sponsored research to the trust

11.9.1 What should be declared
• The trust will retain written records of sponsorship of research, in line with the above principles and rules
• Staff should declare:
  • Their name and their role with the organisation
  • Nature of their involvement in the sponsored research
  • Relevant dates.
• Other relevant information (e.g. what, if any, benefit the sponsor derives from
the sponsorship, action taken to mitigate against a conflict, details of any
approvals given to depart from the terms of this policy)

11.10 Sponsored posts

• External sponsorship of a post requires prior approval from the trust
• Rolling sponsorship of posts should be avoided unless appropriate checkpoints are
put in place to review and withdraw if appropriate
• Sponsorship of a post should only happen where there is written confirmation that the
arrangements will have no effect on purchasing decisions or prescribing and
dispensing habits. This should be audited for the duration of the sponsorship. Written
agreements should detail the circumstances under which organisations have the
ability to exit sponsorship arrangements if conflicts of interest which cannot be
managed arise
• Sponsored post holders must not promote or favour the sponsor’s products, and
information about alternative products and suppliers should be provided
• Sponsors should not have any undue influence over the duties of the post or have
any preferential access to services, materials or intellectual property relating to or
developed in connection with the sponsored posts

11.10.1 What should be declared

• The trust will retain written records of sponsorship of posts, in line with the above
principles and rules
• Staff should declare any other interests arising as a result of their association with the
sponsor, in line with the content in the rest of this policy

11.11 Clinical private practice

Clinical staff should declare all private practice on appointment, and/or any new private
practice when it arises including:

• Where they practise (name of private facility)
• What they practise (specialty, major procedures)
• When they practise (identified sessions/time commitment)

Clinical staff should (unless existing contractual provisions require otherwise or unless
emergency treatment for private patients is needed):

• Seek prior approval of their organisation before taking up private practice
• Ensure that, where there would otherwise be a conflict or potential conflict of interest, NHS commitments take precedence over private work†
• Not accept direct or indirect financial incentives from private providers other than those allowed by Competition and Markets Authority
guidelines: https://assets.publishing.service.gov.uk/media/542c1543e5274a1314000c56/Non-Divestment_Order_amended.pdf

† Hospital Consultants are already required to provide their employer with this information by virtue of Para.3 Sch. 9 of the Terms and Conditions – Consultants (England) 2003: https://www.bma.org.uk/-/media/files/pdfs/practical advice at work/contracts/consultanttermsandconditions.pdf

‡ These provisions already apply to Hospital Consultants by virtue of Paras.5 and 20, Sch. 9 of the
Hospital Consultants should not initiate discussions about providing their Private Professional Services for NHS patients, nor should they ask other staff to initiate such discussions on their behalf.

**11.11.1 What should be declared**

- Staff name and their role with the organisation
- A description of the nature of the private practice (e.g. what, where and when staff practise, sessional activity, etc)
- Relevant dates
- Any other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy)

### 12 MANAGEMENT OF INTERESTS—ADVICE IN SPECIFIC CONTEXTS

#### 12.1 Strategic decision making groups

In common with other NHS bodies East Cheshire NHS Trust uses a variety of different groups to make key strategic decisions about things such as:

- Entering into (or renewing) large scale contracts
- Awarding grants
- Making procurement decisions
- Selection of medicines, equipment, and devices

The interests of those who are involved in these groups should be well known so that they can be managed effectively. For this organisation these groups are:

- Trust Board
- Audit Committee
- Safety, Quality and Standards Committee
- Directorate Safety, Quality and Standards sub-committees and Operational Boards
- Finance, Performance and Workforce Committee
- Remuneration Committee
- Clinical Management Board
- Operational Management Team
- Digital Transformation Group
- Capital and Space Planning Group
- Medicines Management Group
- Pathology Executive Board
- A&E Delivery Board
- Operational Resilience Group

These groups should adopt the following principles:

- Chairs should consider any known interests of members in advance, and begin each meeting by asking for declaration of relevant material interests
- Members should take personal responsibility for declaring material interests at the beginning of each meeting and as they arise
- Any new interests identified should be added to the trusts register(s)
• The vice chair (or other non-conflicted member) should chair all or part of the meeting if the chair has an interest that may prejudice their judgement.

If a member has an actual or potential interest the chair should consider the following approaches and ensure that the reason for the chosen action is documented in minutes or records:

• Requiring the member to not attend the meeting
• Excluding the member from receiving meeting papers relating to their interest
• Excluding the member from all or part of the relevant discussion and decision
• Noting the nature and extent of the interest, but judging it appropriate to allow the member to remain and participate
• Removing the member from the group or process altogether

The default response should not always be to exclude members with interests, as this may have a detrimental effect on the quality of the decision being made. Good judgement is required to ensure proportionate management of risk.

12.2 Procurement

Procurement should be managed in an open and transparent manner, compliant with procurement and other relevant law, to ensure there is no discrimination against or in favour of any provider. Procurement processes should be conducted in a manner that does not constitute anti-competitive behaviour - which is against the interest of patients and the public.

Those involved in procurement exercises for and on behalf of the organisation should keep records that show a clear audit trail of how conflicts of interest have been identified and managed as part of procurement processes. At every stage of procurement steps should be taken to identify and manage conflicts of interest to ensure and to protect the integrity of the process.

13 DEALING WITH BREACHES

There will be situations when interests will not be identified, declared or managed appropriately and effectively. This may happen innocently, accidentally, or because of the deliberate actions of staff or other organisations. For the purposes of this policy these situations are referred to as ‘breaches’.

13.1 Identifying and reporting breaches

Staff who are aware about actual breaches of this policy, or who are concerned that there has been, or may be a breach, should report these concerns to the Corporate Affairs Manager at fionabaker@nhs.net

To ensure that interests are effectively managed staff are encouraged to speak up about actual or suspected breaches. Every individual has a responsibility to do this. For further information about how concerns should be raised please refer to the trust’s Freedom to Speak-Up – Raising Concerns Policy or the trust’s Local Anti-Fraud, Bribery and Corruption Policy.
The organisation will investigate each reported breach according to its own specific facts and merits, and give relevant parties the opportunity to explain and clarify any relevant circumstances.

**13.1 Following investigation the organisation will**

- Decide if there has been or is potential for a breach and if so what severity the breach is
- Assess whether further action is required in response – this is likely to involve any staff member involved and their line manager, as a minimum
- Consider who else inside and outside the organisation should be made aware
- Take appropriate action as set out in the next section

**13.2 Taking action in response to breaches**

Action taken in response to breaches of this policy will be in accordance with the disciplinary procedures of the trust and could involve organisational leads for staff support (e.g. Human Resources), fraud (e.g. Local Counter Fraud Specialists), members of the management or executive teams and organisational auditors.

Breaches could require action in one or more of the following ways:

- Clarification or strengthening of existing policy, process and procedures
- Consideration as to whether HR/employment law/contractual action should be taken against staff or others
- Consideration being given to escalation to external parties. This might include referral of matters to external auditors, NHS Protect, the Police, statutory health bodies (such as NHS England, NHS Improvement or the CQC), and/or health professional regulatory bodies

Inappropriate or ineffective management of interests can have serious implications for the organisation and staff. There will be occasions where it is necessary to consider the imposition of sanctions for breaches.

Sanctions should not be considered until the circumstances surrounding breaches have been properly investigated. However, if such investigations establish wrong-doing or fault then the organisation can and will consider the range of possible sanctions that are available, in a manner which is proportionate to the breach. This includes:

- Employment law action against staff, which might include:
  - Informal action (such as reprimand, or signposting to training and/or guidance)
  - Formal disciplinary action (such as formal warning, the requirement for additional training, re-arrangement of duties, re-deployment, demotion, or dismissal)
- Reporting incidents to the external parties described above for them to consider what further investigations or sanctions might be
- Contractual action, such as exercise of remedies or sanctions against the body or staff which caused the breach
- Legal action, such as investigation and prosecution under fraud, bribery and corruption legislation
13.3 Learning and transparency concerning breaches

Reports on breaches, the impact of these, and action taken will be considered by the Audit Committee on a six monthly basis.

To ensure that lessons are learnt and management of interests can continually improve, anonymised information on breaches, the impact of these, and action taken will be prepared and published as appropriate, or made available for inspection by the public upon request.

14 REVIEW

This policy will be reviewed in June 2020 unless an earlier review is required. This will be led by the Director of Corporate Affairs & Governance.

15 ASSOCIATED DOCUMENTATION

- Freedom of Information Act 2000
- ABHI Code of Business Practice
- NHS Code of Conduct and Accountability (July 2004)
- Corporate Governance Manual (Part D – Standing Financial Instructions, section 22 – Acceptance of gifts by staff)
- Local Anti-Fraud, Bribery and Corruption Policy
- Freedom to Speak-Up – Raising Concerns Policy
**Public Trust Board**  
**Thursday 29th March 2018**

**Agenda Item Number 20: TB 18 (22)**

| Report of: | Kath Senior  
| Responsible Officer: | Director of Nursing, Performance & Quality |
| Accountable Officer: |  |

| Author of Report: | Jeanette Sarkar  
| Subject/Title | Head of Nursing, Quality  
|  | 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 |  

| Legal implications - (identify) | No legal implications |

| Impact on quality | May potentially impact upon the quality of care, patient experience, patient outcomes and staff well being |

<p>| Resource impact | Identified gaps in funded establishments due to wte |</p>
<table>
<thead>
<tr>
<th>Impact of equality/diversity</th>
<th>No impact on equality and diversity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Avoid acronyms or abbreviations</strong></td>
<td><strong>DoH</strong></td>
</tr>
<tr>
<td>- if necessary list:</td>
<td><strong>YTD</strong></td>
</tr>
<tr>
<td></td>
<td><strong>WTE</strong></td>
</tr>
<tr>
<td></td>
<td><strong>RAG</strong></td>
</tr>
<tr>
<td></td>
<td><strong>NMC</strong></td>
</tr>
<tr>
<td></td>
<td><strong>HRBP</strong></td>
</tr>
</tbody>
</table>

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.
Safe Staffing Levels – Exception Report

This report provides a high level summary of Safe Staffing levels on all inpatient wards across the Trust and an overview of community nurse vacancy positions. It provides a high level exception report in relation to the actual fill rate for ward in patient registered and unregistered staff during the day and night, highlighting where this falls below a 95% threshold using a RAG system.

1 INTRODUCTION

1.2 Actual staff numbers compared to planned staffing numbers is 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 WARD STAFFING

Registered midwife fill rate of 94.3% during daytime hours. Safe staffing levels maintained

Post-natal and labour ward shows a registered midwife fill rate of 94.3% during the day, with in-month sickness and absence rates responsible for this variance.

Mitigating actions included daily monitoring of staffing levels, clinical caseload and risk assessment. Safe staffing levels were maintained.

Safe staffing levels were maintained overnight through changing shift patterns and use of bank staff

Post-natal and labour ward shows an improved healthcare assistant fill rate of 89% during the day compared to the previous month (88.2%).

The average actual healthcare assistant fill rate of 78.5% overnight shows a worsening position compared to the previous month (83.7%).

An increase in short term sickness and 2.0wte vacancies is responsible for this variance.

Improved healthcare assistant daytime fill rate of 91.1% on Aston Ward.

Aston ward healthcare assistant fill rate in month was 91.1% during the day, demonstrating an improved position compared to the previous month (88.2%), with sickness absence and vacancies responsible for this variance.
Ward 10 were impacted by vacancy and short term sickness; mitigations included bank and agency and cohort nursing to support 1:1 enhanced care.

Vacancy levels and short term sickness absence rates are responsible for this variance. Mitigating actions included staff deployment, bank and agency utilisation and senior sister stepping down into core numbers to support and maintain patient safety.

Increased patient complexities and enhanced 1:1 care is reflected in some overall fill rates exceeding 116% during the day and 130% during the night.

Additional bed capacity has an impact on the fill rate returns.

Professional judgement based on clinical need ensures safety is maintained.

Some core and enhanced 1:1 care shifts remained unfilled despite going out to agency and bank but staff worked additional hours or stepped down to maintain patient safety.

On a number of occasions throughout February, outstanding core shifts and 1:1 enhanced care remained unfilled via nurse bank, agency shifts and requests to respective agency tiers. Mitigating actions included staff working additional hours, senior sisters, matrons and corporate nursing teams ‘stepping down’ to support patient safety and maintain an overview of the completion of risk assessments. All non-urgent clinical meetings were cancelled to support.

3 RECRUITMENT

Excluding maternity leave and long term sickness registered nurse vacancies within acute inpatient areas has improved and is currently 40.77 wte.

In month registered nurse fill rate of 92.2% during the day which compared to the previous month (99.6%).

Inclusion of Maternity Leave (4.07 wte) and Long Term Sickness (6.61 wte) increases the overall registered nurse gap as to 51.45 wte compared to 52.12 wte the previous month.
9 registered nurses commenced in post and 2 substantive posts were offered in February 2018.

3.2 Following registered nurse interviews held in February 2018, 2 registered nurses were offered substantive posts. A total of 8 acute and 4 community previously offered posts remain subject to satisfactory pre-employment checks. Nine registered nurses commenced in post during February of which 3 were aligned to nurse bank.

The 3 overseas nurses who arrived in the autumn who partially failed their final OSCE are preparing to re-take their OSCE 9th April 2018. A further cohort of 3 international nurses are due to arrive in April.

22 Healthcare Assistant posts offered following interviews held in February.

Following interviews held on the 21st and 22nd February 2018, 22 Healthcare Assistant posts were offered; 10 substantive ward posts, 2 pool and 10 aligned to nurse bank pending satisfactory pre-employment checks. 7 healthcare assistants commenced in post during February; 1 ward based substantive role and 6 candidates were aligned to nurse bank.

In month registered nurse vacancies within the community setting is 2 wte Band 6 which illustrates an similar position compared to the previous month. As part the community work stream re-design programme, alternative training and development opportunities are being explored in an attempt to attract and recruit to existing Band 6 vacancies. Temporary fixed term contracts remain in place to cover 2.7 wte maternity leave and 1.0wte remains on long term sickness.

Mitigating actions to support depleted community teams is managed by deployment between teams based on daily RAG status risk assessment. In addition, part time staff have undertaken ad hoc additional hours to support staffing levels and utilisation of bank and agency as required.

The Trust Nursing Associate Pilot training programme continues

Ten staff members have completed the first year of the two-year Trust’s Nursing Associate Pilot training programme.

4 RETENTION

4.1 A clear focus is required on staff retention and succession planning in view of the demographic profile of the Trust’s nursing workforce, risks to business continuity and local and national shortfall forecasts.

4.2 A retention strategic steering group has been established to drive and focus local profiling and to consider initiatives and workforce development, with a particular emphasis on nurse retention.
The Clinical Workforce Deployment Group will review ward staffing models in order to ensure accurately funded whole time equivalent establishments and inform recruitment and retention strategies.

4.3 The clinical workforce deployment group has been established to facilitate and review ward staffing models inclusive of nursing and medical roles. This will further inform actions around recruitment and retention strategies that take into account safe staffing levels, skill mix and appropriately funded whole time equivalent ward establishments based upon acuity, dependency, patient safety, nurse sensitive quality indicators and patient outcomes.

Review of clinical areas has been prioritised, with initial focus on in patient ward nurse staffing establishments. The proposed workforce model and skill mix required for Ward 10 has been completed and costed. Three costed options are currently in discussion whilst preliminary work on wards 3, 4, and 11 progress. Baseline data has been collated for the remaining inpatient wards.

Continued trust wide operational and capacity pressures throughout February has impacted timescales for completion of the ward review programme.

4.5 Other potential solutions to support workforce retention include consideration of apprenticeship roles, identify and agree funding streams for further cohorts of trainee nursing associates, offer newly qualified staff a rotational post with bespoke placements to support development, access to return to practice courses and support flexible retirement applications.

4.6 A further registered nurse recruitment open event is scheduled to take place in April and a Facebook campaign supported by ‘Just R’ media experts is in developmental stages. These are medium to long term solutions and do not address immediate operational challenges.

4.7 Although the actual fill rate % for ward areas in most cases remains above 95%, signs of skill mix dilution are evident and are being closely monitored against patient safety incidents and nurse sensitive indicators.

4.8 In order to meet practice, training and student placement standards careful consideration is required as part of workforce analysis to ensure that the correct infrastructure enables adequate and safe supervision in practice to support new and existing roles. The current level of vacancy within the acute setting challenges this mentorship requirement. Mitigating actions include liaison between senior sisters, practice educator facilitators and the universities. Collective agreement and co-ordination with regards to the maximum number of student nurse or return to practice placements per clinical area is proactively managed to ensure mentorship requirements can be met. Student nurse focus groups are held monthly to support learners in practice and escalation of concerns raised are dealt with in as real time as possible by the learning and development team in liaison with senior sisters, matrons and Heads of Nursing.
5 STAFF TURNOVER

5.1 In month staff turnover is 0.37% compared to 0.5% the previous month. YTD 12.40%.

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.

6 RECOMMENDATION

6.1 The Board is asked to note the content of the report.
### COMMITTEE CHAIR: Ms Ali Harrison, Non-Executive Director

**MEETING SECRETARY:** Gareth Rydings

**PRESENT:**
- Ali Harrison: Non-Executive Director
- Dr Jane Cowan: Non-Executive Director
- John Wilbraham: Chief Executive
- Kath Senior: Director of Nursing, Performance and Quality
- Julie Green: Director of Corporate Affairs and Governance
- John Hunter: Medical Director
- Lorraine Jackman: Deputy Director of Corporate Affairs and Governance
- Brian Green: Deputy Director Nursing and Quality
- Kath Senior: Director of Nursing, Performance and Quality
- Julie Green: Director of Corporate Affairs and Governance
- John Hunter: Medical Director
- Lorraine Jackman: Deputy Director of Corporate Affairs and Governance
- Brian Green: Deputy Director Nursing and Quality
- Kath Senior: Director of Nursing, Performance and Quality
- Julie Green: Director of Corporate Affairs and Governance

**IN ATTENDANCE:**
- Dr Matt Davies: Clinician Emergency Medicine
- Arabella Ahmed: Trainee Non-Executive Director

### AGENDA NO | SUBJECT | ACTION
---|---|---
17/139 | Patient Story (included in Spotlight) | The patient story was incorporated into agenda item 17/145 Spotlight on Overcrowding in ED
17/140 | Apologies | 1. Dr Susan Knight 2. Kashif Haque 3. Rachael Charlton 4. Dr Mary Higgins 5. Mark Ogden
17/141 | Matters Arising | a) Year at a Glance Confirmed as accurate  
b) SQS Committee Minutes – November 2017 The minutes were confirmed as an accurate representation of the November SQS meeting.  
9438 – Meeting agenda item. Action closed.  
d) Collection of Any Other Business None
**e) Formal Request for Removal of Items from Consent Agenda**

None

<table>
<thead>
<tr>
<th>ASSURANCE ITEMS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>17/142</strong> Integrated Quality &amp; Governance Report</td>
</tr>
<tr>
<td>• Complaints (November 2017)</td>
</tr>
<tr>
<td>• Quarter 2 Complaints/PALS, Incidents, Claims and Patient Experience Report</td>
</tr>
<tr>
<td>• Duty of Candour Policy</td>
</tr>
<tr>
<td>• Care Quality Commission Children’s and Young People Survey</td>
</tr>
<tr>
<td>• Antenatal and New born Screening Action Plan update</td>
</tr>
<tr>
<td>• CQC Radiology Backlog Query</td>
</tr>
<tr>
<td>• National Guardian’s Office Case Review – trust learning</td>
</tr>
<tr>
<td>• Duty of Candour</td>
</tr>
</tbody>
</table>

The DDCAG presented the report and highlighted the following key areas:

- Amendment to section 5.2 CQC Radiology queries. This was in light of the recent findings at the Queen Alexandra Hospital, Portsmouth. **Action** – LJ/GR to amend.

- Quarterly Report on Complaints, Incidents, Claims and Patient Experience addresses the learning and trends identified in the previous quarter and includes the improvement actions for Q3.

- The National Guardians Office case review undertaken at Southport and Ormskirk Hospital NHS Trust has been reviewed and an action plan has been devised for ECT.

The report was taken as read and the committee noted:

- The revised changes to the Duty of Candour policy. It was agreed that examples of what a ‘high risk serious incident’ is will be included in the policy under section 5, Reporting incidents and Duty of Candour.

- Section 5.2 of the Integrated report CQC Radiology Query, the CEO clarified that appendix 4 is the trusts response to the questions asked by the CQC nationally. The CEO informed that there is nothing of concern for the trust and that processes are in place to escalate any concerns. It was noted that nobody internal or in primary care have raised this as an issue.

- Complaints are on track to improve on the annual target in relation to clinical complaints regarding clinical treatment.

- The committee approved of the revised format of the Quarterly Report on Complaints, Incidents, Claims and Patient Experience.

- The SQS committee will overview the delivery of the actions identified from the Southport and Ormskirk review and updates will form part of the Quarterly Governance report.

<table>
<thead>
<tr>
<th>17/143 Bi-Annual SIRI Report Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>The report was taken as read and the committee noted the following:</td>
</tr>
<tr>
<td>The number of incidents being undeclared is very positive and indicates that teams are focussed on documenting the care that’s being provided.</td>
</tr>
<tr>
<td>The DDCAG clarified that the new fetal movement guideline is in line with national guidelines and that records that staff are adhering to the guidelines are available.</td>
</tr>
<tr>
<td>The DNPQ confirmed that the MRSA bacteraemia case noted has no clear documentation as to when the cannula was inserted. An action plan has been</td>
</tr>
</tbody>
</table>
developed to strengthen documentation around NWAS.

The Committee noted the contents and the summary of the SIRI investigation report.

### STRATEGIC ITEMS

<table>
<thead>
<tr>
<th>17/144</th>
<th>Quarterly Quality Strategy – Harm Free Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Quality strategy report was taken as read and the committee noted the following:</td>
<td></td>
</tr>
<tr>
<td>• The delivery of frailty training has been challenging due to staffing levels. There is a plan in place to get staff through the training and this will resume once operational winter pressures have receded.</td>
<td></td>
</tr>
<tr>
<td>• Falls target has been achieved in relation to number of falls resulting in patient harm per 1000 bed days. The trust is achieving 2.1 against a target of 2.5</td>
<td></td>
</tr>
<tr>
<td>• The appointment of the Falls Coordinator will help support the wards to manage and coordinate early intervention and prevention support.</td>
<td></td>
</tr>
<tr>
<td>• The bed rail policy SOP highlighted equipment and training issues. There are challenges around equipment variance, maintenance, bed compliance with bed rails and lack of staff training. It was noted that the Head of Facilities is currently reviewing all equipment due to risks identified.</td>
<td></td>
</tr>
<tr>
<td>• New falls equipment will be piloted on wards 4 and 10 in January 18 and training for staff will be provided in December 17.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>17/145</th>
<th>Spotlight on Overcrowding in ED</th>
</tr>
</thead>
<tbody>
<tr>
<td>The DDNQ presented the patient story which focussed on the patient voice and perception when attending ED. The following patient concerns have been received by the PALS service between the period of 01/09/17 – 17/12/17.</td>
<td></td>
</tr>
<tr>
<td>• Disappointment with the ED experience and long waits before being seen.</td>
<td></td>
</tr>
<tr>
<td>• Patient asked to attend ED by the charge nurse to see a patient with chronic pain in distress.</td>
<td></td>
</tr>
<tr>
<td>• Dissatisfied with level of care received and staff attitude in ED.</td>
<td></td>
</tr>
<tr>
<td>• Concerns with the shortage of Doctors in ED and the long waiting times as a result.</td>
<td></td>
</tr>
</tbody>
</table>

During this period 29 compliments were received for the ED department and the family and friends test survey highlights a high positive patient experience within the Emergency Department.

The spotlight documentation was taken as read and the Committee noted the following:

• ED is challenged and there is risk of overcrowding.
• The current risk on the Corporate Risk Register is 16.
• The impact of reduced patient flow is increased clinical risk, negative patient experience and failure to achieve the 4 hour emergency access standard.
• ED overcrowding is an escalating risk to safety
• The impact of ED Overcrowding are:
  - Patients – Delays in assessments, care, and treatment. Increased morbidity and mortality rates
  - Workforce – Low staff resilience and difficulties in recruitment and retention.
  - Organisation - reputation and regulators.
  - Other services – delays in ambulance handovers, and increased length of stay, outliers and electives.
  - System – ED Overcrowding is a symptom of an ineffective urgent care
• There are both internal and system wide escalation protocols in place to help avoid ED overcrowding these include implementation of the Full Capacity Protocol, escalation polices and system wide OPEL reporting.
• When the trust is recording OPEL level 3 this indicates the system is experiencing major pressures compromising patient flow. Senior daily telecoms with system leaders take place and real time actions and updates are fed into the afternoon capacity meeting.
• The Full Capacity protocol (FCP) has been developed and implemented this year and is aligned with the RCEM recommendations for managing ED overcrowding. These include maintaining safety through risk sharing, accelerated transfers from ED and MAU to wards to set criteria, senior review to expedite timely discharges and leadership though the Gold Command function.
• The trust is anticipating and preparing to be at OPEL level 4 for the first 2 weeks of January 2018.

The DNPQ shared incidents reported with the Committee and noted that there is only a slight increase in the reporting since October which is likely to be due to the additional pressure in the system. There was one severe incident reported within this period and the DDCAG informed that this was not due to the additional pressures and overcrowding in ED.

The trust will continue to focus on the following areas:

• Escalation policy check and challenge
• Embedding of the SAFER bundle
• OOH clinical engagement and risk escalation
• Strengthening the OPEL flash cards
• Patient safety and quality walkabouts with real time action.
• Optimising hospital capacity
• Deploying additional winter schemes
• Continued support from the NHSI team.

The CEO informed that £250k has been received from the 1st batch of winter pressure money and the trust has secured extra care at home and domiciliary care which should help improve patient flow and reduce overcrowding. The trust will receive an additional £600k from the 2nd batch of winter pressure money and this will be used to buy additional beds out of hospital.

<table>
<thead>
<tr>
<th>17/146</th>
<th>Key Items for the Chair to be reported to the Board</th>
</tr>
</thead>
</table>

**Points for Assurance**

• The Trust is on track to achieve end of year target of 200 or less formal complaints. PALS outreach is undertaken daily with real time local action taken to resolve any identified concerns
• The Committee ratified the updated Duty of Candour and Being Open policy
• The trust responded in a timely manner with all requisite data to the CQC Chief Inspector of Hospitals national request regarding reporting of radiological examinations
• Freedom to Speak Up - The trusts guardian provided the committee with the trusts position and commentary following the recent findings at the Southport & Ormskirk NHS Trust where good practice was not followed in relation to concerns regarding bullying and discrimination
• Learning from 'near misses' - using the principles of 'appreciative enquiry', all near misses with by analysed in order to identify positive measures implemented which
will contribute to improvement in patient and carer experience and links with NHS
Resolution aims to reduce clinical claims
• The committee received assurances from the biannual SIRI report in terms of the
trusts responsiveness and governance arrangements for serious incidents,
including use of check & challenge process; executive sign off of investigation
reports & action plans and involvement of non-executive directors at SIRI sub
committees. The Committee approved the updated Terms of Reference
• The Committee received Q3 update on Harm Free Care component of our quality
strategy. Improvements in achievement of safety thermometer in Community were
noted compared with last year. Ongoing improvement work relating to pressure
ulcer identification and documentation also noted both in community and hospital
together with ongoing work to roll out frailty training package across health &
social care economy including private sector.

Emerging Risks & Mitigating actions

• A spotlight on Risk 2272 relating to ED overcrowding was presented and clinical
risks arising from Patient Flow & Overcrowding discussed. Appropriate Control and Escalation measures were seen to be in place (including system wide OPEL and Full Capacity protocol measures). Governance structures including ORG & A&E Delivery Board and SQS/Trust Board were noted. Continued focus on developing out of hospital capacity; deployment of additional winter funding schemes; new patient screening on arrival processes and ongoing intensive leadership proactive engagement resulting in real time action to assure ongoing safety. Risk 2272 wording has subsequently been reviewed and list of controls updated, with current risk score adjusted to likelihood 3, impact 5, total =15 (reduced from 16).
• Following the issuance of 2016 Children & Young people’s inpatient and day case
surgery, the trust has developed an action plan to address the four areas where
we performed 'worse than expected' compared with other trusts. The action plan
will be seen by the Committee in January
• Mortality reviews have identified that end of life care plan documentation is not
being consistently completed. An End of Life Facilitator is now in post to work
alongside nursing and medical staff to improve compliance

<table>
<thead>
<tr>
<th>17/147</th>
<th>Any Other Business</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td></td>
</tr>
</tbody>
</table>

**CONSENT ITEMS**

<table>
<thead>
<tr>
<th>17/148</th>
<th>SIRI Annual Report and Self-Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The Committee noted and accepted the assurance provided within the revised terms of reference and its effectiveness in terms of providing assurance that the trust is complying with its statutory and mandatory responsibilities for responding to and managing serious incidents.</td>
</tr>
</tbody>
</table>

**FOR INFORMATION**

Chairman’s Confirmation of Agenda items for January meeting (not standing items):

• Infection, Prevention and Control Sub-Committee Annual Report and Self-Assessment
• Duty of Candour – Being Open Update (via Governance Report)
• SQS Terms of Reference and Self-Assessment
• Quarterly Mortality Report and Self-Assessment
<table>
<thead>
<tr>
<th>Freedom to Speak Up (via Governance Report)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date and time of next meeting:</td>
</tr>
<tr>
<td>Tuesday 30\textsuperscript{th} January</td>
</tr>
<tr>
<td>12:00 – 14:00</td>
</tr>
<tr>
<td>Boardroom 1</td>
</tr>
</tbody>
</table>
The DNPQ informed that the story being presented related to a patient on ward 9. It was noted that this patient record was routinely reviewed by CQC as part of their inspection, on the day following admission.

This is a complex admission of a gentleman who attended the Emergency Department in January from a Nursing Home. The patient was nursed on MAU and Ward 9 and required a high level of nursing support due to his confusion and associated challenging behaviours. The patient had previously been an inpatient on the Millbrook unit with a diagnosis of Alzheimer’s dementia.

The following areas of good practice were highlighted:

- The patient was triaged and seen by an ED doctor within a timely manner
- DOLs and mental capacity assessments were completed
- Early reviews of medications were undertaken
- A ‘this is me’ passport was completed on ward 9 with the support of relatives.
- Correct escalation processes were followed
- Early psychiatric review was undertaken on MAU as the patient was known to mental health services.

The following areas were highlighted as opportunities for improvement:

- Better communication between care homes, hospital wards and relatives.
- Documentation of care provided to the patient did not meet expected standards.
A patient passport was not available to staff as this had not been put in place at the care home.

Process of prescribing medications for patients requiring enhanced care in this context

The following actions have been implemented:

- Enhanced care risk assessments will be audited as part of the senior sister and matron audits.
- Professional reflections and learning reviews for shift co-ordinator, doctors and two staff nurses involved in care delivery.
- ED patient safety check list will be rolled out and embedded in practice and form part of the new ED patient record.
- Feedback will be provided to the care home to ensure patient passports completed.

These actions will be monitored in the acute directorate and reported through the appropriate governance process.

The DNPQ concluded there was no identifiable harm caused to the patient although patient experience was not to the standard expected.

It was noted that all nurses and medical staff have undertaken a reflective review of practise in relation to this case and the importance of good documentation and patient awareness has been reiterated.

18/02 Apologies

1. Rachael Charlton – Annual Leave
2. Lorraine Jackman – Off site Nye Bevan Course
3. Jane Cowan – Notice period following resignation
4. Julie Green – CQC Interviews

18/03 Matters Arising

a) Year at a Glance

The Year at a Glance was approved.

It was noted that 2018/19 Year at a Glance is in development and that the Chair and DNPQ will be reviewing potential Spotlights for the year.

b) SQS Committee Minutes – December 2017

The DoF apologies to be added to December minutes.

Minutes were agreed as accurate after the above amendment has been made.

c) Action Log

9437 – Agenda item. Action closed.
9442 – Action completed and closed.
9443 – Action completed and closed.

**Action** - The Committee sought further assurances in relation to completion /on track actions relating to the action plan for the CQC Children and young people’s inpatient and day case survey 2016.
d) Collection of Any Other Business

Addressed under agenda item 18/09

e) Formal Request for Removal of Items from Consent Agenda

None received.

ASSURANCE ITEMS

<table>
<thead>
<tr>
<th>18/04</th>
<th>Integrated Quality &amp; Governance Report including</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The paper was taken as read and the DNPQ highlighted the following key areas to the Committee:</td>
</tr>
<tr>
<td></td>
<td>• The revised version of the Never Events policy and framework and updated Never Events list.</td>
</tr>
<tr>
<td></td>
<td>• A wrong site surgery never event occurred within the trust in December 2017. A root cause analysis investigation is underway and in line with due process. The draft findings will be subject to executive check and challenge and approval via the Serious Incident Review Sub-committee. Duty of candour stage 1 has been completed in line with trust policy.</td>
</tr>
<tr>
<td></td>
<td>• In month, two patients have been detained under sections 3 and 5.2 of the mental health act to enable psychiatric assessment to take place.</td>
</tr>
<tr>
<td></td>
<td>• One case of hospital acquired MRSA bacteraemia was reported in November 2017 which brings the 2017/18 total to two against a zero tolerance target. A root cause analysis is underway and will go through the Check and Challenge process.</td>
</tr>
<tr>
<td></td>
<td>• There was an increase in falls resulting in harm. RCAs are underway and duty of candour has been applied. Check and challenge will be provided via the SIRI subcommittee.</td>
</tr>
<tr>
<td></td>
<td>• There were 2 mixed sex accommodation breaches in November 2017 with a further 31 in December 2017. This was due to operational and capacity pressures. The DNPQ informed that every effort has been made to maintain patient privacy and dignity and patients received apologies. Clinical safety has been the absolute priority.</td>
</tr>
<tr>
<td></td>
<td>• Emergency access continues to be very challenging. The trust’s full capacity protocol has been implemented and escalation processes have been followed.</td>
</tr>
<tr>
<td></td>
<td>• CCG managers undertook a Quality Assurance Visit to Aston Ward within Congleton War Memorial Hospital. This provided positive assurance across a number of quality areas. The report is attached to papers.</td>
</tr>
<tr>
<td></td>
<td>• Despite operational pressures, the friends and family test results for both November and December are positive.</td>
</tr>
<tr>
<td></td>
<td>• Congleton, Holmes Chapel &amp; Knutsford Community teams continue to flag on RADA. Face to face visits and support have been provided from the DNPQ &amp; Deputy Director of Nursing &amp; Quality. It was noted that gaps in vacancies have improved, however sickness and maternity leave are still causing staffing challenges. Sickness is expected to improve this month and team level action plans are being monitored by service manager and team leaders.</td>
</tr>
<tr>
<td></td>
<td>• The impact of emergency pressures has been very challenging and significantly reduced capacity for routine elective patients. All patients that have had cancelled appointments are scheduled in accordance with clinical priority and are normally rebooked in within the 28 day guidelines. It was noted that patient waiting times regarding the number of potential 52 week breaches are being monitored though the Finance, Performance and Workforce Committee.</td>
</tr>
</tbody>
</table>
• Delayed eDNF communication between AAU and GP may result in delayed treatment for patients. There has been no reported patient harm as a result of clinical correspondence delays (AAU to GP) in this reporting period. The DDNP advised that the trust and CCG meet monthly to review the quality contract and no reported incidents have been highlighted as a result of delayed correspondence.

The CEO noted that the national decision to postpone routine elective surgery to the end of January 18, and added that this is currently under review. Currently ECT is not in a position to reinstate routine elective surgery as the Surgical Treatment Unit is currently bedding medical patients. This is being reviewed on a daily basis.

18/05 Quarterly Mortality Report inc Self Assessments

The MD presented the report for October to December 2017 highlighting the following key areas:

• RAMI remains stable for the trust, however the crude mortality rate has increased due to an increase in overall deaths recorded in December 2017.

The MD informed that this increase is seasonal and no themes have been identified from the stage 1 mortality reviews.

• The depth of coding indicator continues to improve and there has been an increase in deaths coded with the palliative care code.
• The crude mortality rate continues to be consistently above the peer rate.
• Pneumonia remains the most common reason for admission followed by sepsis.
• The Annual Quality Report for Adult General Intensive Care has demonstrated that the trust’s mortality rate for the intensive care unit is well within the expected range.
• Documentation standards for end of life care are not being consistently met and this impacts the ability to determine if the patient is being managed in full compliance with the appropriate care bundle.
• Good communication is being provided to patients and relatives who are at end of life but this is not being reflected in the universal use of the end of life care plan.
• Stage 1 mortality reviews are being completed as soon as practical after a patient’s death allowing clinical colleagues the ability to complete stage 2 reviews expeditiously.
• Concerns have been raised by the clinical coding department regarding the quality of the patients’ case notes and clinical documentation.

The MD informed that a case note audit was performed in December 2017 to address these concerns and focused on the following 7 areas:

• Are notes filed in correct chronological order
• The physical state of the notes
• Presence /absence of EDNF
• Correct filing of diagnostic interventions e.g. endoscopy, bronchoscopy
• Accuracy of finished consultant episodes (FCE) within the hospital spell recorded on a hospital patient administration system (PAS)
• Compliance with PAS discharge
• Presence of documentation explaining the reason(s) for the cancellation of planned procedures
As a result of the audit, 8.48% of the 1285 case notes audited were found to have some issue related to the above which could impact on accurate coding. The MD noted that the Head of Clinical Coding is due to meet the Clinical Administration Manager and the Head of Integrated Governance to address the audit findings.

**Action** – The MD to speak with the Head of Clinical Coding regarding finding out how the 8.48% of records identified to having documentation related issues compares to peer trusts.

- The MD noted there is always an increase in clinical coding issues around the junior doctor intake. The coding department are offering additional training sessions to help address this.
- The trust has received no mortality alerts this quarter.
- A new cellulitis pathway was introduced at the trust in December 2017 as recommended by the investigation into the excess mortality associated with skin and soft tissue infections highlighted by the Dr Foster Unit.
- The trust has appointed a new nurse end of life coordinator to facilitate end of life care and improve utilisation of the end of life care pathway.

The MD confirmed to the DoF that monitoring is in place for patients being admitted from nursing homes for end of life care and no themes have been identified to suggest patients are being admitted inappropriately.

- Rebasing of the RAMI occurred at the end of November 2017 and the new trust now uses the new model. This has resulted in a reduction in RAMI from 95 to 84 because of an increase in the number of ‘expected deaths’.
- Guidelines and paperwork supporting anticipatory prescribing for patients at the end of life in the community have been revised and updated and training will be rolled out throughout the hospital and the community this month.

The Committee agreed and approved the recommendations to the Terms of Reference.

### STRATEGIC ITEMS

<table>
<thead>
<tr>
<th>Date</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>18/06</td>
<td>SQS Terms of Reference and Self Assessments review</td>
</tr>
</tbody>
</table>

Discussions took place and the Committee agreed that there will be no changes to the Terms of Reference (except for administrative correction relating to ‘as referenced in paragraph 8’). It was agreed that further consideration could be given to increasing clinical director attendance in due course.

There was discussion around the wording ‘formally’ in the self assessment form in relation to review of risks (and any associated potential gaps) across the board committees

**Action** - ToR to be amended to reflect the current term.

**Action** – It was agreed that for the board agenda going forward, a view to confirm that current committee structures and remits remain optimal would be helpful.

<table>
<thead>
<tr>
<th>Date</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>18/07</td>
<td>Spotlight – Medical Staffing</td>
</tr>
</tbody>
</table>

The MD presented the spotlight on Medical Staffing and informed the Committee that if the trust is unable to cover gaps in junior doctor rotas there is a risk to patient safety, quality of care and patient experience.
The following key areas were highlighted

- The current risk score is 16
- There are 8 specific risks reported on the risk register relating to medical staffing. These are:
  - Single handed consultant (x 2)
  - Inability to recruit to junior doctor gaps in T&O and general surgery
  - Excessive workload of general medical consultants (x 2)
  - Gaps in middle grade A&E rota
  - Gaps in weekend rotas due to new trainee doctor contract
  - Gaps in junior doctors rotas.

- The staffing challenge is national and relates to a number of factors. These being the UK medical workforce not keeping pace with changes in demand, an increase in demand for non-UK qualified doctors in specific specialities, severe shortages in specialists in some occupations, a strain on doctors being able to train and an ever increasing reliance to use locum and agency staff to fill gaps in rotas.

- The trust currently has 7 consultant vacancies across the directorates, which is roughly a 10% shortage in consultants. The MD noted that the trust has advertised these positions and there has been little interest in substantive posts.

- Some of the current factors believed to be influencing the local shortages in medical workforce are the uncertainty of future provision, there is a heavy reliance on scarce staff and trust grade specialty (SAS) doctors compared to larger hospitals and therefore the trust operates a more onerous rota system. The lack of opportunity for specialist training and neighbouring trusts being able to offer a more significant recruitment and retention premia.

Controls in place to manage the risk are as follows:

- Daily oversight of staffing requirements by Clinical Leads and medical staffing.
- Daily oversight of deployment of doctors by silver command to maintain patient safety.
- Increased employment of specialist nurse practitioners to cover gaps.
- Development of a medical bank to fill gaps.
- Substantial use of bank/agency docs to ensure safe staffing levels.
- Consultants have been ‘acting down’ to cover critical gaps in rotas.
- The trust has appointed a Guardian of Safe Working to ensure that trainee doctors don’t work excess hours.

The trust has introduced the following actions to reduce the risk

- Medical staffing department has been strengthened
- The introduction of medical e-rostering for medical staff to ensure efficient deployment of doctors.
- The trust is currently working with agencies to help with overseas recruitment.
- The medical staff bank has been developed substantially.
- Joint working with peer trusts to aid recruitment in specialist areas.
- It was noted that the Government are increasing the number of medical student places by 1500 from September 2018.

The MD confirmed that the trust is doing all it can to address the risk and that the
Directorates are working hard to improve the position of the medical workforce. The Directorates are working closely with the medical staffing teams to ensure that they're well sighted on any potential gaps and are therefore able to deploy doctors more efficiently.

The DNPQ highlighted the link between gaps in rotas and the use of agency and informed that high cost agencies are being used to fill these gaps to ensure safe staffing rotas. The MD confirmed that the quality of locums provided by agencies is variable but the development of the medical bank has seen a big improvement in quality of staff.

The Committee accepted the current risk rating and all current risk mitigations. This topic will be kept under review to return to SQS as part of next year annual workplan.

### ANY OTHER BUSINESS

**18/08**

**Key Items for the Chair to be reported to the Board**

#### Points for Assurance

- Committee Terms of Reference and Self-Assessment: the committee agreed that the current terms of reference should remain (minor administrative changes) but that further consideration could be given to increasing clinical director attendance in due course (full agenda or item specific).
- The committee received assurances in relation to mortality outcomes and associated procedures (including revised RAMI methodology) and all indicators remain within expected ranges. Further work is ongoing in relation to improved case note recording resulting in increased accuracy of clinical coding.
- The Committee noted and accepted the Infection Prevention & Control Sub Committee annual report & self-assessment.
- The Committee noted the progress recorded in the quarterly CARE report in relation to timely responses to NICE guidance; compliance with NICE guidance; approved audit plan; research studies & recruitment. Outcomes and learning from 2017-18 Medical Specialties and Urgent Care Local audits has been collated, disseminated & actions are progressing as has the learning from the Trusts participation in the recent national diabetes and COPD audits.
- The Trust Never Event Policy will be updated with national changes effective 1st February 2018 (post meeting note: undetected oesophageal intubation reporting is on hold until further notice according to NHSI newsletter 31 Jan 18).
- Cases of Clostridium Difficile remain well below trajectory (7 vs 14) for 17-18.
- The Trust was notified by NHSE that we have maintained accreditation on patient information literature providing external assurance for this service provision.
- ED access: 72.4% patients were seen within 4 hours in December with one 12 hour wait to be admitted to a ward. No patient harm was identified as a result of this wait. No serious incidents associated with ED overcrowding have been reported during this period and no formal complaints were raised in relation to the access standard in this period.
- ECCHCC undertook a quality assurance visit to Aston Ward in October 17. Their report concluded that the unit provided a good workplace culture, with everyone working together as a team to provide excellent safe and effective personal care.
- Freedom to Speak Up - the trust submitted its 2Q report to the National Guardian Office. The January Learning into Action focussed on actions taken...
arising from staff concerns. Only 1 of the 4 cases raised this quarter was raised anonymously indicating confidence in the role of the Freedom to Speak Up Guardian.

**Emerging Risks & Mitigating Actions**

- Medical Staffing - Spotlight discussion covering 8 specific risks relating to medical staffing. Assurance was provided in relation to current controls in place, action planning and risk mitigations however this risk is unlikely to reduce further within short term and will continue to be monitored by SQS.
- The Committee sought further assurances in relation to completion / on track actions relating to the action plan for the CQC Children and young people’s inpatient and day case survey (2016).
- A wrong site surgery never event occurred in the Trust in December 2017 with route cause analysis underway and approval by SIRI Committee due February 2018.
- A second MRSA case has occurred and investigation is underway to confirm avoidability or otherwise.
- Whilst overall level of falls per 1000 bed days reduced below target in December, 3 falls (total) resulted in serious harm in November and December. Duty of Candour has been applied and investigations are underway which will be reported back via SIRI Committee.
- Mixed sex accommodation breaches increased from 2 in November to 31 in December due to operational pressures. Maintaining patient safety was prioritised and patient dignity maintained as far as possible.
- Congleton, Holmes Chapel & Knutsford Community teams continue to flag and visit and support have been provided from Director & Deputy Director Nursing. Sick leave absence is anticipated to reduce this month and action plans will continue to be monitored by the Directorate.

<table>
<thead>
<tr>
<th>18/09</th>
<th>Any Other Business</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>National Maternity survey results – The result have recently been published by the CQC and have highlighted ECT as performing better than expected.</td>
</tr>
</tbody>
</table>

**CONSENT ITEMS**

<table>
<thead>
<tr>
<th>18/10</th>
<th>Infection, Prevention and Control Sub – Committee Annual Report and Self - Assessments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The Committee noted and accepted assurances and the recommendations provided within the report.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>18/11</th>
<th>Quarterly CARE Report</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The Committee noted the work of the CARE sub-committee and the actions taken to ensure:</td>
</tr>
<tr>
<td></td>
<td>• Timely responses are provided to NICE guidance.</td>
</tr>
<tr>
<td></td>
<td>• Areas of partially compliant NICE guidelines, where appropriate, are progressing.</td>
</tr>
<tr>
<td></td>
<td>• Progress against the approved clinical audit plan.</td>
</tr>
<tr>
<td></td>
<td>• Research targets and recruitment figures are achieved.</td>
</tr>
<tr>
<td></td>
<td>• Outcomes and learning from 2017-18 Medical Specialties and Urgent Care Local audits has been collated, disseminated &amp; actions are progressing as has the learning from the Trusts participation in the recent national diabetes and COPD audits.</td>
</tr>
</tbody>
</table>

**FOR INFORMATION**

| Chairman’s Confirmation of Agenda items for February meeting (not standing items): |
| Quality Strategy – Annual Refresh  |
| Equality Report – Interpretation (via Governance Report) |
| SQS Committee Annual Report and Self-Assessment |

**Date and time of next meeting:**
Tuesday 27th February 2018
12:00 – 14:00
Boardroom 1
## Agenda item 21: TB 18 (25)

**FINANCE, PERFORMANCE & WORKFORCE COMMITTEE**

### MINUTES OF MEETING HELD:

- **Meeting Chair:** Mike Wildig
- **Meeting Secretary:** Janine Homer

- **Venue:** Boardroom 1, First Floor, New Alderley House
- **Date:** Thursday 30th November 2017

### PRESENT:

- Mike Wildig: Non-Executive Director
- Dr Tony Coombs: Non-Executive Director
- Ian Goalen: Non-Executive Director
- Rachael Charlton: Director of HR and Organisational Development
- Dr John Hunter: Medical Director
- Mark Ogden: Director of Finance
- Kath Senior: Director of Nursing, Performance and Quality
- John Wilbraham: Chief Executive
- Julie Green: Director of Corporate Affairs and Governance

### IN ATTENDANCE:

- Janine Homer: Meeting Secretary
- Ruth Knighton: Workforce Lead for Engagement, Wellbeing and Inclusion

### AGENDA

<table>
<thead>
<tr>
<th>ITEM</th>
<th>SUBJECT</th>
<th>ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>17/95</td>
<td>Apologies</td>
<td>None received.</td>
</tr>
<tr>
<td>17/96</td>
<td>Minutes of meeting held 26th October 2017</td>
<td>The minutes of the previous meeting were agreed as an accurate record, however, under item no. 17/91 Performance Report page 3 paragraph 1 it was clarified that within Primary Care Streaming, an estimated 98% of patients streamed were seen within 4 hours.</td>
</tr>
<tr>
<td>17/97</td>
<td>Matters arising</td>
<td>None.</td>
</tr>
<tr>
<td>17/98</td>
<td>Action points from previous meeting</td>
<td>9368 – The focus is on appointing the five managers for the hubs as CWP and social services have yet to identify anybody from within their teams. The DoN is to circulate the community outcome framework. Completed, action closed.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>9337 – Completed, action closed.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>9338 – Completed, action closed.</td>
</tr>
</tbody>
</table>
9339 – Completed, action closed.

9340 – Completed, action closed.

17/99 Annual work plan

Agreed as up to date.

Workforce Report Inclusive of the below appendices

17/100

- Workforce Risk and Mitigation Report – with monthly KPI dashboard and update on agency spend
- Engagement – sickness absence

The DHR presented the Workforce report, highlighting:
- An improved position within training metrics;
- An improved position within medical recruitment;
- There is a concern within acute nursing services due to the high level of vacancies and the impact of sickness and maternity leave rates;
- A further concern exists around the long term impact of reported national shortages, which needs exploring further.

Ruth Knighton, Workforce Lead for Engagement, Wellbeing and Inclusion (RK) was welcomed to the meeting to present a deep dive on sickness and absence highlighting:
- An integrated plan is in place to support improvements in rates and the Wellbeing CQUIN has been delivered;
- Absence due to stress has reduced by 4 days per episode over the last 12 months;
- The provision of the fast track Physiotherapy service has reduced episodes of absence from musculoskeletal and back problems by 4 days;
- 60% of absence is long term;
- Benchmarking has shown that performance is varied at other trusts – The North West and North East typically have higher sickness rates both inside and outside the NHS.

In response to questions from the Committee, RK commented
- Episodes of stress-related absence were a complex mix, not all work-related;
- There is one counsellor on-site, who is operating at capacity, and a telephone-based Employee Assistance Programme, however, take up on this is low;
- Typically, the public sector reports higher sickness and absence rates than the private sector;
- The aim is for performance to move towards the bottom of the benchmark group;
- The average number of days lost for ECT is 13.4 compared with a public sector average of 9-10 days;
- Acute and Integrated Community Care Services report the highest rates;
- Wellbeing communications have been improved but more
work needs to be done to reach staff who may need more support eg HCAs.

- The recent sickness and absence management audit provided assurance that the correct systems are in place.

The Chair thanked RK for attending the meeting.

In response to questions from the Committee about the Workforce report, the DHR clarified:

- The proportion of EU nurses employed at ECT is relatively low;
- A significant improvement in Safeguarding Level 2 Adults and Children training is expected for next month following discussions at Directorate Performance Meetings;
- The decision not to invest further in Nursing Associates is an example of financial pressures impacting on workforce sustainability (the cost of the programme is £13k). Vacancies over the last 12-18 months have been between 30-40 and there is potential for this position to worsen for the same reasons;
- Agency utilisation is within NHSI trajectory overall; it is expected that medical expenditure will reduce, but there is a concern around nursing.

The DoN added that the NMC have reported a drop in applications from across Europe. Neighbouring trusts are offering incentives that ECT cannot afford to compete with. When visiting wards, the first issue mentioned by staff is vacancy rates even though rotas are being covered by agency work.

The DCAG noted a lack of confidence from staff despite there being no issue with adhering to safer staffing and that this will add to pressures when compiling rotas.

**Finance Report Inclusive of the below appendices**

| 17/101 | • Finance Risk Report  
|        | • QIPP Report (including milestone delivery plan and risk register)  
|        | • Repeating presentations – Revolving Working Capital facility  
|        | • Quarterly capital update  
|        | • SLR update |

The DoF presented the Finance, highlighting:

- The Trust reported £182k better than plan YTD, however, the trend of being ahead of plan each month is slowing;
- The capital programme is £400k behind plan. Some of this slippage is due to works within ETU being delayed but expected to come back in line with plan, however work scheduled in other areas has been cancelled until spring to avoid impacting on winter pressures;
- SLR – changes in income are a key driver of quarterly performance. Work is underway on improving productivity in Outpatients and Endoscopy;
- CTP – ECT is performing well against other trusts, being the
only trust to receive a green overall NHSI RAG assessment for the quality of the assessment.

In response to questions from the Committee about the report, the DoF clarified:

- Performance in previous months has been better than plan but this slowed during October as an improvement in the trajectory was required. There was also an assumption made that A&E target funding for October would not be received;
- Non-pay variance reports a £453k credit in month;

Action: The DoF to provide an explanation on the non-pay variance.

- There is confidence that the QIPP total will be achieved - Corporate and Allied Health and Clinical Support services have already achieved. Medicine and Surgery can achieve if their productivity improves. There is some concern regarding the income QIPP in Surgery due to the number of red schemes. Conversion of red schemes within Planned Care has been discussed at the Directorate Performance meeting and Recovery Programme Board as one scheme for £230k will be removed. Planning for next year has started with productivity discussions as there will be limited opportunity for additional income from the Commissioners;
- To achieve the financial control total of £20.2m by March 2018 requires control of agency spend over winter and increased productivity in areas not reliant on beds. Financial performance is measured on the position excluding A&E-related performance. In other words, if we lost £1m A&E STP funding but achieved the financial control target of £20.2m, the Trust would be assessed as being £1m better than plan. The report is based on the bottom line required to hit £20.2m as cash and loan funding are based on this;
- Premises – health visiting at Winsford has now transferred to CWP;
- Planned Care & Acute and Integrated Community Care – income is not improving as expected within Surgery. Key drivers are productivity eg the number of cases on lists within Ophthalmology and T&O.

The DoN added that there are challenges in aligning job plans to service needs, for example, Endoscopy post-take ward rounds are scheduled for the same time as lists start, which is inefficient.

- Elective and day case activity – 9968 cases have been carried out this year, 350 more than last year, but still behind plan of 10,200. The Surgery CIP last year was to deliver more activity in the latter part of the year but it is a full year effect.

Action: The DoF to report back to the Committee in what areas the accountability for the additional work of 600 cases lies.

- Capital update – fire precautions work has been delayed until next year, but this is in agreement with Cheshire Fire Authority. Expenditure is £400k behind plan but this will be back on track before the end of the year;
- It was noted that further clarity is required to understand the fluctuations month-on-month within the EBITDA data.
Radiology is a significant example, however, there have been discussions within this area concerning where the allocation credit for some Outpatient procedures should be; **Action:** The DoF is to examine the detail further to confirm activity in Radiology.

- SLR – under PBR, only 50% of services make a favourable contribution before overheads. Some are known issues e.g. A&E and Maternity, but General Surgery and Trauma and Orthopaedics should be higher. Indirect costs relate to direct recharges in areas such as Pathology. Allocation here is based on the number of patients rather than consumables.

**Performance Report Inclusive of the below appendices**

| 17/102 | ED 4-hour standard  
| 18 weeks RTT standard  
| 62 day cancer standard  
| 6 week access to diagnostics  
| Community activity and outcomes including Hubs  
| Operational efficiency indicators (theatres, outpatients, bed utilisation) |

The DoN presented the Performance Report, highlighting:

- A&E performance during October was 89.9% against the trajectory of 90% (86% QTD) but this is increasingly challenging as the position is worsening weekly, largely due to case mix and a more complex patient cohort. The DTOC position has improved. There are six persistent DTOC out of area patients from Staffordshire. Enabling work has some impact on performance as there is less flexibility whilst AAU is temporarily relocated.

- ECIP are withdrawing their support as their focus moves to level 3 trusts but additional support will be provided by NHSI (ECT is a level 4 trust).

- RTT performance is just below trajectory at 91.45%. The outsourcing of some patients to Mid Cheshire which had previously been opposed by the commissioners is being revisited;

- Diagnostics achieved 89.6% against 99% standard. Productivity discussions are underway including start times for lists and WLIs. Middle grades and consultants are resisting against £400 per session offered in favour of £500, however, following meetings with Clinical Leads and Directorates, the Trust is currently holding its position on this. There is the possibility to outsource activity and a quote is being worked through. The associated risk to this is waiting lists time, however, the Trust is well within the JAG guidelines of a six month tolerance as the current longest wait is 17 weeks.

In response to questions from the Committee about the report, the DoN clarified:

- In reference to the report 2.1.3 Emergency Admissions, the narrative should read that there were no breaches of the 12 hour emergency care standard during October;
Bed occupancy was lower in the month, and patient flow has improved. However, the system remains fragile without additional acute capacity; the service is six beds down whilst enabling work continues although six would be available in Maternity if escalation required. The only release valve is outside in Community, which is under discussion with the Commissioners;

- The trajectory for DTOCs is 20, and conversations are taking place with Staffordshire about the out of area patients, which appears to be due to bed closures in Leek;
- Additional support is being provided to patients discharged at home in the evenings and the medical intervention operating suite hours are increasing;
- Winter plans are currently being tested including reviewing schedules for training and the effectiveness of OPEL 3 and 4 action cards based on the assumption that the Trust will be operating at either of those levels;
- There is opportunity to review bed reconfiguration to address concerns around medical outliers in surgical wards and this will be considered later in the year;
- RTT - there has been opportunity to outsource work to Mid-Cheshire but after discussions with NHSI, the CEO accepted the request from the commissioners not to proceed.

The committee are asked to recognise that there may be a risk to achieving internal standards such as statutory and mandatory training and appraisals given the assumptions about the OPEL status.

<table>
<thead>
<tr>
<th>Risk and Assurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>17/103 All Finance, CIP, Performance and Workforce Risks rated 15 and above to be reported</td>
</tr>
</tbody>
</table>

The DCAG presented the Corporate Risk Register highlighting:

- Corporate Risk Register – an emerging risk not yet recorded is high level vacancies compounded with maternity leave;
- Robust plans for actions outstanding longer than this financial year are in place;
- A low risk appetite for further funding to support additional ANP’s at this point. The Committee noted that ten people were currently on the programme.

In response to questions from the Committee about the register, the DCAG clarified:

- QIPP and the 2018/19 financial control target will be added to the Register;
- Agency spend remains on the register to maintain a focus;

**Action:** QIPP and 2018/19 financial control target to be added to the Corporate Risk Register.

**Next Meeting:**

Thursday 21st December 2017
08:30-10:30
**FINANCE, PERFORMANCE & WORKFORCE**

**COMMITTEE**

**MINUTES OF MEETING HELD:**

Thursday 25th January 2018

**Meeting Chair:** Mike Wildig

**Meeting Secretary:** Janine Homer

**Venue:** Boardroom 1, First Floor, New Alderley House

---

**PRESENT:**

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Attendee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mike Wildig</td>
<td>Non-Executive Director</td>
<td>Mr Wildig</td>
</tr>
<tr>
<td>Dr Tony Coombs</td>
<td>Non-Executive Director</td>
<td>Dr Coombs</td>
</tr>
<tr>
<td>Ian Goalen</td>
<td>Non-Executive Director</td>
<td>Mr Goalen</td>
</tr>
<tr>
<td>Rachael Charlton</td>
<td>Director of HR and Organisational Development</td>
<td>DHR</td>
</tr>
<tr>
<td>Dr John Hunter</td>
<td>Medical Director</td>
<td>MD</td>
</tr>
<tr>
<td>Mark Ogden</td>
<td>Director of Finance</td>
<td>DoF</td>
</tr>
<tr>
<td>Kath Senior</td>
<td>Director of Nursing, Performance and Quality</td>
<td>DNPQ</td>
</tr>
<tr>
<td>Julie Green</td>
<td>Director of Corporate Affairs and Governance</td>
<td>DCAG</td>
</tr>
</tbody>
</table>

**IN ATTENDANCE:**

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Janine Homer</td>
<td>Meeting Secretary</td>
</tr>
<tr>
<td>Steve Redfern</td>
<td>Deputy Director of Operations</td>
</tr>
</tbody>
</table>

---

**AGENDA ITEM**

<table>
<thead>
<tr>
<th>SUBJECT</th>
<th>ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>18/01 Apologies</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• John Wilbraham</td>
</tr>
<tr>
<td>18/02 Minutes of meeting held 30th November 2017</td>
<td></td>
</tr>
</tbody>
</table>

With reference to agenda item no. 17/100 page 3 ‘In response to questions from the committee’, Mr Goalen noted an omission that the Trust’s aim is to reduce the average number of sick days lost from 13.4 days to the public sector average of 9-10 days.

**Action:** The DNPQ and the DHR to discuss the reduction of sickness and absence reducing to an average of 10 per year and what improvements will be required to achieve this.

Following this amendment, the minutes of the November meeting were agreed as an accurate record.

The Chair noted that no meeting was held in December. A set of papers were circulated and no questions arising from these were received by the CEO.

---

<table>
<thead>
<tr>
<th>18/03 Matters arising</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>None.</td>
</tr>
</tbody>
</table>

| 18/04 Action points from previous meeting |        |
|                                          |        |
9379 – Completed, action closed.
9428 – Completed, action closed.
9440 – Completed, action closed.
9454 – Completed, action closed.

**18/05 Annual work plan**

No changes noted.

**Performance Report Inclusive of the below appendices**

**18/06**

- ED 4-hour standard
- 18 weeks RTT standard
- 62 day cancer standard
- 6 week access to diagnostics
- Community activity and outcomes including Hubs
- Operational efficiency indicators (theatres, outpatients, bed utilisation)
- GP referrals profile

The DNPQ presented the report, noting that GP referrals had been omitted (and would be included next month), and highlighted:

- ED 4 hour standard - compliance during December was 72.73% and 81.5% for Q3 against trajectory of 90%. This is due to an increase in complexity of cases and work is ongoing within the CCG to reduce attendance through communication with the public. DTOC numbers have improved against year-end trajectory of 15;
- RTT – 89.35% against 92% standard;
- Diagnostics – largely unaltered from last month at 87.46%;
- Cancer 62 day - below standard of 85% at 82.35%;

Mr Goalen queried the likelihood of meeting the ED 4 hour standard. The DNPQ responded that there are still process issues that can be improved upon, despite improvement in DTOC. The Trust has had some days where there has been improved ED flow but overall performance is very fragile and with the current case mix she is not confident that the standard is achievable in the foreseeable future.

The following points were noted which are having an impact at the current time:

- The challenge is greater for small DGHs as there is less flexibility in the system when the organisation is under extreme pressure;
- Although the Discharge Lounge has had some improvements is not ideally located and is constrained by its size as it can only receive two patients who require beds;
- The expected date of discharge process requires further work to ensure it is fully embedded and agreeing more meaningful
actions;
- The medical consultants’ rota has improved from 4 in 9 to 6 in 9;
- Bed occupancy remains 100% consistently;
- There is a known shortfall in medical beds. An SBAR was presented at the last meeting of the Clinical Management Board concerning the possibility of converting the Day Case Unit into a surgical inpatients ward. Due to the concerns relating to the ability to staff the ward overnight and the potential compromise to Category A patients this would be make this a 'last resort' option. The CEO, DNPQ and MD will continue to monitor the situation.
- One 12 hour trolley wait was reported in December, however, 38 have been reported in January to date;
- GP streaming, AVS and Alcohol Service are all working well;
- The improvement trajectory has been amended to 90% for the whole of Quarter 4.

The DNPQ added that despite performance figures, feedback from staff and the PALS service provide assurance that patient safety is still being maintained.

Mr Goalen queried the data for 12 hour trolley waits and the DNPQ responded that breaches are only recorded where a patient is admitted, therefore others may have waited longer but have subsequently been discharged.

**Action:** The DNPQ agreed to provide a data snapshot to show the number of patients waiting at the 12th hour during December and January.

In response to a question from Dr Coombs, the DNPQ confirmed that the reduced trajectory for Cancer 62 Day during December reflected an expected dip in performance pertaining to the availability of patients during that month.

The DNPQ went on to explain that in relation to RTT, a national request to postpone all routine elective inpatient surgery until 15th January had been sent to providers. This was followed by a further request to cancel all elective, day case and outpatient activity until the end of the month where this would have an impact on non-elective performance. ECT is currently still able to carry out some day case and outpatient work but inpatient work has been affected and is reflected in the RTT performance.

The 52 week standard is now a higher risk and if the postponement continues beyond January, an increase in breaches is anticipated during April.

The Trust has been asked to submit plans for February and March and has advised that scheduled activity will continue to be suspended during February.
Action: In response to a question from the Chair regarding RTT totals, the DNPQ is to clarify whether 13 patients had their operations cancelled during December due to the failure of ophthalmology equipment.

With reference to diagnostic standard the following points were noted:
- 364 patients were waiting in excess of six weeks, of those without dates the longest wait time was 14 weeks;
- This position is largely driven by Endoscopy and Gastro;
- Medinet are now in place and have had a positive impact on volumes at weekends and are likely to be used until the end of March;
- Negotiations with ECT clinicians regarding WLIs are ongoing.

There is confidence that the Cancer 62 day standard will be delivered for Quarter 4.

Action: The DNPQ is to strengthen the report analysis of theatre performance and bed utilisation performance.

Action: The overall presentation of the report is to be strengthened by moving to a new template.

The Committee thanked A&E staff for their hard work and commitment during the winter pressures.

The DNPQ updated the Committee on Community hubs:
- Meetings with other stakeholders have taken place;
- CEC and CWP initially intend to align rather than integrate;
- The Operational Managers will now likely comprise of two CEC locality managers, two from ECT and the potential resource for a further manager from CWP. The skill mix of these five will be sufficient to matrix manage the five teams and job descriptions and adverts are being finalised;
- Data on financial spend, workforce and activity remains unavailable at hub level but will be in place by the end of March;
- Community outcomes is still at draft stage.

Action: Spotlight on Community Hubs to be brought to the March meeting.

Workforce Report Inclusive of the below appendices

<table>
<thead>
<tr>
<th>18/07</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Workforce Risk and Mitigation Report – with monthly KPI dashboard</td>
</tr>
<tr>
<td>• Outcome of Quarterly Audit around Temporary Workforce Processes</td>
</tr>
<tr>
<td>• Guardian of Safe Working Quarterly update</td>
</tr>
</tbody>
</table>

Workforce Report
The DHR presented the report highlighting:
- Metrics improved overall during December, however, areas such as booked training and appraisals have been cancelled
which will have a negative impact during January;

- Agency and bank spend decreased during December but is expected to rise again during January;
- Acute nursing vacancy gaps remain a concern at 14% and are under regular review; this position is compounded by maternity and sick leave. Work is underway with Cavendish Hospital in Buxton to promote ECT vacancies to staff at risk there;
- ECT has achieved accreditation for simulation training, one of only five centres across the North West;

In relation to nursing gaps, the DNPQ commented that although there has been an increase in requests for agency staff, this is not always covering gaps and redeployment within ECT is taking place. The Safer Staffing report due at Trust Board demonstrates that cover is currently being maintained but will become more challenging during January.

The DHR noted that neighbouring Trusts’ rates are similar, but nationally the figure is slightly higher. The DoF stated the financial expectation would be to achieve between 4-5%.

The DCAG asked about staff resilience and the DHR reported that staff are regularly contributing over and above requirements and it was agreed that more recognition would be appropriate. The DHR confirmed an upcoming engagement event for HCAs to celebrate their achievements.

In response to a question from the Chair and the Committee, the DNPQ reported:

- There is a risk to delivery of metrics by March as a result of winter pressures;
- ‘E-roster trust hours owed’ increased due to limitations on annual leave allowed to be taken during December by ward staff;
- With reference to Trust digital apprenticeship account payments, the levy is not being fully utilised and will be forfeited if not spent within 18 months of the first year and 12 months of subsequent years;
- The negative vacancy rates reported under Corporate Directorates relate to central HCA bank within HR and Nursing Associates within Nursing and Quality.

The Committee wished to record their thanks to all East Cheshire NHS Trust staff for their hard work and ongoing commitment; their dedication to patients is highly valued.

**Guardian of Safe Working Hours Report**

The MD presented the report on behalf of Dr Chris Smart:

- The Junior Doctors’ Forum is a success with representation at senior and executive levels;
- Several exemplars at ECT are now used at other trusts;
- Staffing levels remain sub-optimal;
In response to questions from Mr Goalen, the MD noted:
- Completion of exception reports remain low at 50%, however it is not clear how this figure is obtained;
- E-rostering issues have now been resolved;
- A junior doctor has now been identified to take the lead with IT issues raised.

<table>
<thead>
<tr>
<th>Finance Report Inclusive of the below appendices</th>
</tr>
</thead>
<tbody>
<tr>
<td>18/08</td>
</tr>
<tr>
<td>• Finance Risk Report</td>
</tr>
<tr>
<td>• QIPP Report (including milestone delivery plan and risk register)</td>
</tr>
<tr>
<td>• Repeating presentations – Revolving Working Capital facility</td>
</tr>
<tr>
<td>• Directorate Presentation – Planned Care</td>
</tr>
</tbody>
</table>

The DoF presented the report highlighting:
- £368k better than plan at Month 9;
- A £665k non-recurrent reserve was released for drugs and data challenges;
- The revised forecast deficit including STF is £19.5m;

In response to questions from the Committee, the DoF clarified:
- Page 10 of the report refers to the Trust-wide variances released into the position with a further £300-400k expected before the year end;
- The DoF has written to NHSI seeking clarity on the financial evaluation behind the requests to cancel elective activity during January;
- Receipt of the additional £430k STF funding is now unlikely therefore the forecast will be amended;
- Capital expenditure is behind plan. £380k of this relates to the Endoscopy scheme which is delayed but due to finish during February and the full expenditure will be achieved by year end;
- Blue QIPP schemes are on target; however, Acute and Integrated Community Care (AICC) and Planned Care (PC) have a large number of high risk red schemes.
- The QIPP targets set are not unrealistic but identifying costs out is a challenge for AICC and no new schemes have been added since September. An operational manager has been put in place to assist with this;
- The QIPP for 2018/19 is £5m and is to be discussed at a future Executive Management Team meeting as few schemes have been identified for next year;
- Loans due for repayment during February 2019 are likely to be rolled over to the following year, however the associated planning guidance has yet to be issued;
- Cash drawdown is less than plan but will be completed in full by the end of the year;

Planned Care Directorate
The DoF presented the Planned Care briefing on behalf of the Directorate’s Associate Director including:
- Theatre services spend total is £10m, and a recovery programme is planned as the only QIPP scheme associated with this area is red and likely to be removed;
• The other red schemes for the area are challenging (Sexual Health) but will be kept under review;
• Work is ongoing to improve productivity in areas such as Theatres, Endoscopy and consultant job plans within Sexual Health;

Next Meeting:
Thursday 22nd February 2018
08:30-10:30,
Boardroom 1 NAH
Agenda item 21: TB 18 (27)

AUDIT COMMITTEE

MEETING CHAIR: Ian Goalen
Boardroom 1, First Floor, New Alderley House
MEETING SECRETARY: Bethan Rimmer
Tuesday 28th November 2017, 15:00 - 17:00

PRESENT:
Ian Goalen Non-Executive Director Chair
Michael Wildig Non-Executive Director Mr Wildig
Jane Cowan Non-Executive Director Dr Cowan

IN ATTENDANCE:
Julie Green Director of Corporate Affairs and Governance DCAG
Mark Ogden Director of Finance DoF
Lorraine Jackman Deputy Director of Corporate Affairs and Governance DDCAG
Lynn McGill Chairman Chairman
John Farrar Engagement Lead – Grant Thornton Mr Farrar
Andrew Rothwell Auditor – Mersey Internal Audit Agency Mr Rothwell
Roger Causer Anti-Fraud Specialist – Mersey Internal Audit Agency Mr Causer
Ian Curr Interim Head of Informatics (agenda item 17/66 only) IHol
Ian Hart Assistant CIO, MLCSU (agenda item 17/66 only) Mr Hart
Stephen Lord Head of IT North, MLCSU (agenda item 17/66 only) Mr Lord

AGENDA NO | ITEM | ACTION
--- | --- | ---
17/55 | Apologies | • John Wilbraham
17/56 | Minutes of Meeting held on 10th August 2017 | The minutes were approved as an accurate record.
17/57 | Matters Arising | There were no matters arising.
17/58 | Review of Action Log | 9256 – The individual concerned undertook a reflective piece of work as part of the HR processes. The DCAG confirmed assurance that the appropriate levels of the HR policy are applied. **Action Closed.**
9257 – On agenda. **Action Closed.**
9258 – Information included in report. **Action Closed.**
9259 – Complete. **Action Closed.**
9260 – It was confirmed the correct wording is anti-fraud and is consistent through all policy documents. **Action Closed.**
17/59 | Chair’s Introductory Comments |
The Chair noted this is an update meeting, including an update on Cyber Security.

**17/60** Corporate Governance Manual including:

- Review of Standing Orders and Changes to Financial Instructions / Scheme of Delegation

The DoF advised the changes made to the corporate governance manual are following the recommendation to align the hierarchy of the ledger with managerial hierarchy as is consistent with how other trusts are managing delegation.

Internal and External Auditors have confirmed agreement with the revised arrangements and the additional clarity provided.

The Committee approved the recommended changes to the Corporate Governance Manual.

**17/61** Board Assurance Framework and Corporate Risk Register

The DCAG presented the Board Assurance Framework and Corporate Risk Register, highlighting the following:

- Additional information has been added to the report to provide oversight of removed or downgraded risks and highlight risks that have been present for a significant period of time.
- The DCAG confirmed a piece of work will be undertaken to support teams to improve risk descriptions.
- The risk score for risk 2535 has been increased to 16 in relation to an increased risk of falling. The DoF has requested further evidence to support electric beds contributing to a reduction in falls.

The following comments were noted:

- Mr Wildig requested an update on the actions to resolve risk 2455 regarding Congleton Hospital street lighting. The DoF advised this has not yet been progressed through capital. The DCAG advised alternative options are being considered.
- Dr Cowan requested that additional information be provided on the outcome of risks that have been closed. The closed/removed summary should also detail the related committee.
- The Chair highlighted the increase of red rated risks from quarter 2. The DCAG advised there has been an increase of 8, 5 of which are STEIS risks. Risks are consistently monitored and reviewed to ensure mitigating actions are in place. All high and moderate risks have an action plan, risk assessment and end date in place. If the target end date is extended a rationale should be included. Sign off for extensions is by the Associate Directors through the SQS directorate meetings.
- The DCAG agreed to review the risks in Appendix 1 that have been on the register for longer than a year to determine those that have been extended and the rationale for extension.
- The Chair requested an update from Committee Chairs on how they seek assurance for these risks.
- The Chairman recommended including a flowchart with this report outlining the risk process on the Datix system to provide further understanding.
Mr Rothwell highlighted the three audits undertaken.

**Equality Spot Check**
- Three objectives were selected for review; pain assessment recording in ED, resuscitation trolleys and infection control for equipment and toys (paediatrics and maternity).
- The analysis on the resuscitation trolleys found of the 10 wards visited, 5 trolleys were adequately stocked with in date contents. On the remaining 5 wards issues noted included expired or additional contents, and the resuscitation trolley not being plugged in on ICU. Mr Rothwell confirmed the ICU trolley was resolved as soon as the issue was identified. An immediate review of all trolleys was instigated. Out of date contents and equipment was identified. Concerns were raised around regular checks.
- The DCAG highlighted the positive use of these spot checks and Internal Audit escalating concerns immediately. The DCAG advised daily spot checks and weekly and monthly reviews are now in place for the resuscitation trolleys.
- The infection control spot check on the toys in paediatrics identified that these have now been removed from the unit as they are not being utilised.
- Mr Rothwell raised concerns regarding recording of pain assessments and advised this will be reviewed again with the next spot checks.

**Absence Management**
- Policies are in place. Overall there were no significant issues highlighted, however it was noted that recording of dates on ESR for return to work interviews could be improved. The Chair praised the positive result of this review.

**Duty of Candour/Being Open Policy**
- High assurance and positive feedback was provided for this area. The DCAG agreed noting the positive work to resolve Stage 2 discrepancies.

**Work in Progress**
- IT Service Continuity Review – delayed due to obtaining access to MLCSU. Protocols have now been agreed to commence work.
- For the remaining 5 audits, the terms of reference is to be provided to the Board later this week.

---

**Anti-Fraud Progress Update**

Mr Causer presented the Anti-Fraud Progress Report, covering the period of April – October 2017, and highlighted the following:
- On the overview dashboard the majority of actions are planned or on track.
- Items for consideration include increasing fraud awareness and ensuring there is a strong anti-fraud process in place.
- Keys areas include identifying specific delivery on key stakeholders and completing additional bespoke presentations. Bespoke half day sessions
are scheduled on 'right to work employment checks'. Mr Causer noted the importance ensuring routine processes are embedded and additional awareness is raised.

- A new NHS Counter Fraud Authority has been established and relevant information will be shared with the Audit Committee.
- Mr Causer highlighted items of interests including news alerts, fraud alerts and the need to make staff aware of ongoing fraud issues.
- There have been two fraud investigations undertaken during the period. There was no fraud identified and one recommendation was highlighted.

The following was discussed:

- Mr Causer and the DCAG agreed to review the possibility of determining how many 'hits' the fraud newsletters and fraud section of the website have received.
- Mr Causer noted there are good processes in place for financial controls which will help to minimise risks. The DoF reiterated the need to remain vigilant on fraud.
- The Chair noted the fraud case examples included in the report querying the potential risk for this trust. The DCAG highlighted a recent case of a fraudulent HCA who was taken to court and prosecuted. The DoF advised that a review of waiting lists is currently underway which has highlighted one potential area for further investigation.

17/64 External Audit Progress Report & Emerging Issues & Developments

Mr Farrar presented on the External Audit progress report.

- Ian Pinches has taken over Stephen Nixon’s role for the trust and a handover has been completed. Introductions have taken place with the DoF and Finance department.
- The report sets out the key work-strands with no change to the work programme from 2016/17. This work is to enable the value for money conclusion by May 2018 and provide assurance on the Quality Account.
- The financial statements audit has commenced and auditors are onsite. Meetings have taken place to review continuous improvement and embed lessons learnt.
- Mr Farrar advised that Chief Accountant workshops will be provided in the New Year which will be available to the trust.
- Dialogue has commenced between MIAA and the trust regarding the going concern audit for 2017/18. An emphasis letter was included in the previous year’s report. The trust is in receipt of various loans from the department many of which are due to mature imminently.
- A risk assessment is being completed on the value for money work which will be brought through the Audit plan to the next meeting.
- Mr Farrar highlighted the Audit Deliverables for 2017/18. This will be taken to the Trust Board to request it be delegated to this committee.
- Mr Farrar highlighted a number of Grant Thornton and sector publications, noting key areas, including cyber security, as areas of focus. Mr Farrar agreed to circulate the link to these publications.
- The DCAG noted there is a plan for general data protection regulations with a data protection officer identified and this is on track to deliver.
The DoF noted the following:

- The report identifies that violence and abuse incidents have decreased however physical assaults have remained the same. There has been an increase in incidents for 1:1 care. Training and competencies are being reviewed.
- An objective has been set to reduce physical assaults by 25%. This is a strength goal to support improvement and reduction.
- ‘Prevent and deter’ is taking place to deliver a zero tolerance approach on violence towards staff. For any incidents marked moderate and above, rationale will need to be provided if a formal investigation wasn’t pursued e.g. reduced capacity.
- The DCAG advised there is an ‘Enhanced Nursing’ training programme provided to staff and a risk assessment on actions required to support nurses providing 1:1 care.

17/66 IT Cyber Security Report - Update

The DoF advised the Board have undertaken a briefing session on Cyber Security. The DoF welcomed the IHoI to the meeting to provide an update.

The IHoI welcomed Mr Lord and Mr Hart from NHS Midlands and Lancashire Commissioning Support Unit (MLCSU) who have been tasked with managing the infrastructure. Mr Lord provided the following update:

- The report updates on the ‘WannaCry’ cyber outbreak in May 2017 along with an update on progress to the Trust’s Cyber Security Audit.
- The impact of the ‘WannaCry’ attack varied across areas with those linked into the COIN network more severely affected. This was escalated to Gold Command and NHS England. The impact at East Cheshire was minimal.
- A detailed response has been issued following this incident outlining measures to prevent this type of incident reoccurring.
- A programme of work has commenced to review the core issues following the attack. One of the recommendations from NHS England is to ensure that all networks and PCs are up to date with patching. The MLCSU are proposing to run a network operating centre to focus solely on patching.
- Mr Lord noted the guidance also covers electronic devices, such as iPhones, that connect with the network. If there is a device that can’t be patched, the guidance states this should be removed from the system.
- The anti-virus that was in place was ineffective against the ‘WannaCry’ virus and as such this has been brought up to date with the latest product. Additional products are being reviewed to enhance further, including a zero day software programme which will identify unfamiliar programmes on the system.
- The MLCSU will be meeting monthly with NHS England to update on actions following the cyber-attack.

The following was highlighted.

- The wireless systems set up for public access need to have the appropriate security measures in place.
- The IHoI advised the trust’s position has improved since the cyber-attack. There are a small number of actions to complete to make the trust compliant with the report. Mr Lord advised that the MLCSU are also looking into funding streams that could support this work.
- The Chair challenged why an automatic update process is not in place. Mr
Lord advised one of the recommendations is for all PCs to be updated to Windows 10 as this has an automatic update function. There are a number of packages that the trust uses that are not Windows 10 compatible and there is an exercise underway to review these programmes and work to resolve this issue.

- The IHoI advised the MLCSU have offered to replace a number of systems including a new generator, at a cost of approx. £135k. The team are looking into potential funding to support this work.
- Mr Lord advised the MLCSU are reviewing cloud based systems where possible, noting this would reduce the reliance on local infrastructure as software could be accessed anywhere.
- The DoF reiterated that lessons learnt from the cyber-attack are being implemented appropriately.
- The IHoI recommended producing a KPI dashboard to outline the areas to be patched. The DCAG advised that CMB would be the responsible committee and they receive an update twice a year. This area should come via the risk register to Board level.
- Mr Hart noted that regular external testing of the network will be implemented to identify vulnerabilities. A test of the trust’s website has been completed with a report to follow. The MLCSU are reviewing additional training and improved communications.
- Mr Lord advised World Hospital are undertaking an STP wide review of levels of security.

<table>
<thead>
<tr>
<th>17/67</th>
<th>Review of Losses and Compensations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The DoF presented the Losses and Compensations paper noting the following;</td>
</tr>
<tr>
<td></td>
<td>- The incident date has been added to the report.</td>
</tr>
<tr>
<td></td>
<td>- There are no major trends to the report.</td>
</tr>
<tr>
<td></td>
<td>- Dr Cowan queried whether 0418 has been resolved. The DoF agreed to confirm.</td>
</tr>
<tr>
<td></td>
<td>- The Chairman noted the improved position on previous years.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>17/68</th>
<th>Any Other Business</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>There were no items of any other business.</td>
</tr>
</tbody>
</table>

**Next Meeting:**

**Tuesday 27th February 2018, 14:00 – 16:00**

Boardroom 2, Top Floor, New Alderley House