Southport and Ormskirk Hospital NHS Trust

BOARD OF DIRECTORS

SCHEDULE OF THE DAY

Wednesday 11th April, 2018

Seminar Room, Clinical Education Centre, Southport District General Hospital, Town Lane Kew, Southport, PR8 6PN

09.00-12.00 Audit Committee

12.00-12.30 ***BREAK/LUNCH***

12.30 – 13.30 Board of Directors: **Private Section**

13.30 – 16.30 Board of Directors: **Public Board**

Contacts:

Interim PA to the Company Secretary, Samantha (Sam) Scholes
Tel: 01704 704783 (Ext. 4783)
Email:s.scholes1@nhs.net

Company Secretary, Audley Charles
Tel: 01704 704769 (Ext. 4769)
Email: a.charles1@nhs.net

Mail: Southport Hospital Town Lane Kew Southport PR8 6PN
Web: www.southportandormskirk.nhs.uk
Twitter @SONHSTrust

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AGENDA OF THE BOARD OF DIRECTORS
PUBLIC BOARD

To be held at 13:30 – 16:30 on Wednesday 11th April 2018
Seminar Room, Clinical Education Centre, Southport District General Hospital

V = Verbal D = Document P = Presentation

Ref No.	Agenda Item	Lead	Time
PRELIMINARY BUSINESS			
TB077/18 (V)	**Chair's welcome & noting of apologies** To **note** the apologies for absence	**Chair**	**13.30**
TB078/18 (V)	**Declaration of Directors' Interests** To **review and update** declarations of interest relating to items on the agenda and/or any changes to the register of directors' declared interests	**Chair**	
TB079/18 (D)	**Minutes of the Meeting held on 7th March 2018** To **approve** the minutes of the Board of Directors	**Chair**	
TB080/18 (D)	**Matters arising action Log** To **review** the Action Log and receive relevant updates	**Chair**	
STRATEGIC CONTEXT			
TB081/18 (D)	**Chief Executive's Report** To **note** key issues and update from the CEO	**CEO**	**13.40**
QUALITY & SAFETY			
TB082/18 (P)	**Patient Story:** **Commissioning for Quality and Innovation (CQUIN)-Health and Wellbeing-Healthy Foods** To **receive** the mandatory awareness presentation as set out in guidance and to **discuss** learning from the above	**Simon Williams, Head of Facilities**	**13.50**
TB083/18 (D)	**Quality & Safety (Q&S) Committee: Alert Advise & Assure Report** To **receive** a summary report from the Committee	**Chair of QSC**	**14.00**
TB084/18 (D)	**Care Quality Commission Improvement Action Plan** To **receive** the monthly report	**DoN**	**14.05**
TB085/18 (D)	**Monthly Mortality Report** To **receive** the monthly report	**MD**	**14.15**
TB086/18 (D)	**Workforce Committee (WFC): Alert Advise & Assure Report**	**Chair of WFC**	**14.25**

Ref No.	Agenda Item	Lead	Time
	To **receive** a highlight report including any escalated risks from the Committee		
TB087/18 (D)	**Monthly Safer Staffing Report** To **receive** assurance of actions taken to maintain safe nurse staffing	**DoN**	**14.30**
PERFORMANCE			
TB088/18 (D)	**Finance, Performance & Investment (FP&I) Committee: Alert Advise & Assure Report** To **receive** a highlight report including any escalated risks from the Committee	**Chair of FP&I**	**14.40**
TB089/18	**Charitable Funds Committee: Alert Advise & Assure Report** To **receive** the highlight report	**DoF**	**14.45**
TB090/18 (D/P)	**Emergency Care Performance Report** **a**)To **receive** a monthly update report **b**) To **receive** the Trust-Wide Patient Flow Improvement Plan Update	**COO/EY**	**14.50**
TB091/18 (P)	**Integrated Performance Report (IPR)** To **receive assurance** from the current position in relation to national performance targets and integrated governance	**DoF**	**15.10**
TB092/18 (D)	**Director of Finance Report** a)To **receive** the **current financial position at Month 11** and progress on the Cost Improvement Programme / Internal Sustainability b) To **approve** the **5 Year Capital Plan**	**DoF**	**15.20**
GOVERNANCE / WELL LED			
TB093/18 (D)	**Risk Management: Risk Register** To **receive** the monthly report	**Executives**	**15.35**
TB094/18	**Trust Compliance with Provider Licence** To **receive** evidence for compliance and to **approve** the self-certification declaration to NHS Improvement	**ICoSec**	**15.40**
TB095/18 (D)	**Board Development Programme 2018/19** To **approve** the Board Development Programme	**Chair**	**15.45**
TB096/18 (D)	**Draft Annual Governance Statement 2017/18** To **receive** the draft reports and make recommendations for improvement	**ICoSec**	**15.55**
TB097/18	**Terms of Reference of the Board of Directors and Board's Annual Assessment of its Performance and Effectiveness Tool** To **approve:** • **The Terms of Reference of the Board** • **The Board's Assessment of Performance and Effectiveness Tool**	**ICoSec**	**16.05**

Ref No.	Agenda Item	Lead	Time
TB098/18 (D)	**Items for Approval / Ratification:** **A. Trust's Statutory Instruments:** ***-Standing Orders*** ***-Standing Financial Instructions*** ***-Scheme of Reservation and Delegation*** **B. Anti-Fraud, Bribery and Corruption Policy** **C. Risk Management Strategy**	**ICoSec** **DoN**	**16.15**
TB099/18 (V)	**Questions from Members of the Public**	**Public**	**16.20**
CONCLUDING BUSINESS			
TB100/18 (V)	**Any Other Business** To **consider** any other matters of business	**Chair**	**16.25**
TB101/18 (V)	**Items for the Risk Register/changes to the BAF** To **identify** any additional items for the Risk Register or changes to the BAF arising from discussions at this meeting	**Chair**	
TB102/18 (V)	**Message from the Board** To **agree** the key messages to be cascaded from the Board throughout the organisation	**Chair**	
TB103/18 (V)	**Date and time of next meetings** Wednesday ***2nd May 2018, 10.00am*** **AND** ***Extra-ordinary Board 23rd May 2018, 1.00pm*** Seminar Room, Clinical Education Centre, Southport District General Hospital	**Chair**	**16.30** **CLOSE**

ACTIONS REQUIRED:

Approve: To formally agree the receipt of a report and its recommendations OR a particular course of action

Receive: To discuss in depth a report, noting its implications for the Board or Trust without needing to formally approve it

Note: For the intelligence of the Board without the in-depth discussion as above

Assure: To apprise the Board that controls and assurances are in place

For Information: Literally, to inform the Board

Chair: Richard Fraser

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Register of Interests Declared by the Board of Directors 2018/19 AS AT 9 April 2018

NAME	POSITION/ROLE	Directorship, including non-executive directorship held in private companies or PLCs (with the exception of those dormant companies)	Ownership, or part ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS	A position of authority in a charity or voluntary body in the field of health and social care	Any connection with a voluntary or other body contracting for NHS services	Related to anybody that works in the Trust	Other	Date of entry on register or amendment
BIRRELL, Mr Jim	Non-Executive Director	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**4 July 2017** **Updated 25 September 2017**
BRICKNELL, Mr David	Non-Executive Director	**TBC**	**TBC**	**TBC**	**TBC**	**TBC**	**TBC**	**TBC**	**9 April 2018**
CLARKE, Mr Ged	Non-Executive Director	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Kinsella Clarke Chartered Accountants. A number of Trust's Medical Consultants are clients.**	**1 May 2016**
FRASER, Mr Richard	Chairman	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Trust Chairman of St Helens & Knowsley Hospital NHS Trust**	**1 December 2016** **Updated 2 April 2018**
GIBSON, Mrs Pauline	Non-Executive Director Designate		**Director, Excel Coaching & Consultancy. Provision of coaching services to Directorate and senior NHS**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**25 July 2017**

NAME	POSITION/ROLE	Directorship, including non-executive directorship held in private companies or PLCs (with the exception of those dormant companies)	Ownership, or part ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS	A position of authority in a charity or voluntary body in the field of health and social care	Any connection with a voluntary or other body contracting for NHS services	Related to anybody that works in the Trust	Other	Date of entry on register or amendment
			Management personnel						
GILLIES, Mr Rob	Executive Medical Director	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**June 2013**
GORRY, Mrs Julie	Non-Executive Director	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**NED Representative on the North West Coast Strategic Clinical Network for Palliative and End of Life Care**	**2 August 2017** **Updated 14 March 2018**
MAHAJAN Dr Jugnu	Interim Medical Director	**Nil**	**Director of M&M Professional Consultancy Services**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**22 January 2018**
MURPHY Mrs Gillian	Acting Director of Nursing	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**1 April 2018**
NICHOLLS Mr Silas	Chief Executive	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**1 April 2018**
PATTEN, Mrs Therese	Chief Operating Officer	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Trustee - Blackburn House Group**	**3 October 2015**
ROYDS, Mrs Jane	Associate HR Director	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Vice Chair of Governors, Farnborough Road Junior School, Southport**	**30 May 2017** **Updated 25 September 2017**
SINGH, Dr Gurpreet	Non-Executive Director	**TBC**	**TBC**	**TBC**	**TBC**	**TBC**	**TBC**	**TBC**	**9 April 2018**

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SHANAHAN, Mr Steve	Director of Finance	**Nil**	**Nil**	**Nil**	**Nil**	**Mr Shanahan's brother Mr Peter Shanahan is an Executive Director, Advisory on the Ernst & Young A&E Performance Improvement Project at Southport & Ormskirk Hospital Trust**.	**Nil**	**Nil**	**25th January 2018**

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Minutes of the Public Section of the Board of Directors' Meeting Wednesday, 7th March 2017

Seminar Room, Clinical Education Centre, Southport District General Hospital
(Subject to the approval of the Board on 11th April 2018)

Present

Richard Fraser, Chair
Jim Birrell, Non-Executive Director
Pauline Gibson, Non-Executive Director Designate*
Julie Gorry, Non-Executive Director
Dr Jugnu Mahajan, Interim Medical Director
Therese Patten, Chief Operating Officer
Jane Royds, Associate Director of HR*
Steve Shanahan, Director of Finance

In Attendance

Audley Charles, Interim Company Secretary
Tony Ellis, Marketing & Communications Manager
Caroline Griffiths, Improvement Director (NHSI)
Jan Ross, Interim Assistant Director of Nursing
Samantha Scholes, Interim PA to the Company Secretary

Apologies:

Ann Farrar, Interim Chief Executive
Shelia Lloyd, Director of Nursing
Gill Murphy, Deputy Director of Nursing

***Indicates Non-Voting Members**

AGENDA ITEM		ACTION LEAD
TB047/18	**CHAIRMAN'S WELCOME AND NOTE OF APOLOGIES**	
	The Chair opened the meeting by welcoming members and noted apologies from Ann Farrar, Interim Chief Executive, Shelia Lloyd, Director of Nursing and Gill Murphy, Deputy Director of Nursing. He welcomed Jan Ross, Interim Assistant Director of Nursing who represented the Nursing Team and Samantha Scholes, Interim PA to the Company Secretary, minute taker.	
TB048/18	**DECLARATION OF DIRECTORS' INTERESTS CONCERNING AGENDA ITEMS**	

	The Chair asked if any member had any conflict of interest relating to agenda items and that any changes or additions to the Register of Interests should be submitted to the Interim Company Secretary. There were no interests declared or changes noted.	
TB049/18	**MINUTES OF THE MEETING HELD ON 7h February 2018**	
	The Chair asked the Board to approve the Minutes of the Meeting of 7th February subject to the following changes: which were noted for amendments: Page 4: Add Ann Farrar, Interim Chief Executive and remove Carol Baxter, Non-Executive Director as being present. Page 6, TB259/17: should read '*1,200 staff had accessed E-learning'.* Page 9, TB023/18: Paragraph 3 to read 'Mrs Royds commented that the volunteering strategy would need to be part of a larger piece of work including how we engage more with our Community. Both Mrs Royds and Mrs Gorry highlighted the importance of volunteering roles as used widely in hospices. Mrs Royds advised that we need to widely publicise volunteering opportunities at the Trust e.g. attract Duke of Edinburgh Award participants who require volunteering experience.' Page 14, TB026/18: paragraph 1 to read, *'She questioned what formal roles, duties and responsibilities the Non-Executive Directors would undertake.'* Page 15: TB029/18: paragraph 1 amend to *Mrs Royds to Mr Birrell* and paragraph 4, *amend 'she' to 'he'.* Page 22: TB037/18: A&E Performance in January was 80.9%. Remove *checking data note.* Page 23: TB037/18: mirror the words of the Actions to Improve Performance. Page 24: TB039/18: add *'…in relation to agency staff'* to the first sentence. Page 25: TB039/18: paragraph 3 to read *'NHSE had been disappointed by the position of the CCGs…'* **RESOLVED:** The Board **approved** the minutes as an accurate record subject to the noted amendments.	
TB050/18	**MATTERS ARISING ACTION LOG**	**TB050/18**
	The Board considered the following matters arising in turn: **TB116/17 Staff Engagement Plan:** This continues to be an ongoing piece of work: item to remain on the log. **TB185/17 Items for Approval, Standard Operating Procedure for the Administration of Meetings:** To be brought to the April Board.	**ICOSEC**

	TB214/17 Items for Approval – Risk Management Strategy: This was deferred as it had not been reviewed by the Executive Management Team and will be brought to the April Board. **TB232/17 Quarterly Integrated Governance Report – MRSA Case:** Mrs Lloyd to circulate before the February Board. Deferred to March Board **TB254/17 Patient Story**: The need to improve contact with Social Services and Community Occupational Therapy for the patient in question had not been escalated to the Transition Board. Update to be provided at April Board. **Quality & Safety AAA Highlight Report:** unexpected TUPE issues had impacted on the Diabetic Eye Screening service and consideration for the future was required. Patient care was unaffected. Update requested. **TB037/18 Exec Ward Visits:** escalation requirements had improved.	**DoN** **DoN** **DoN** **COO**
TB051/18	**INTERIM CHIEF EXECUTIVE'S REPORT**	
	Mr Shanahan, acting as Accountable Officer in Mrs Farrar's absence, reported that the key areas on which Mrs Farrar had been working had been shared with Mr Silas Nicholls, the incoming Chief Executive. He added that Dr Mahajan, the Interim Medical Director's contract had been extended to June 2018. The report gave details of the areas summarised below: **Safety & Quality** The Quality Improvement Group had amended its format to ensure that there was a clear focus on the practical solutions by the teams and they are supported and empowered to deliver. **Performance on A&E & Patient Flow** EY had completed Phase 1 of their support and were commencing Phase 2 within the approved funding envelope. **Strategic Business: Care for You** The Sefton Transformation Board had agreed the definition of its aims and plans. **Financial Position** Mr Shanahan stated that the Trust had achieved a reduction in the deficit due to slight balance sheet adjustments to £29.2m. Sanctions, discussed with NHSI and NHS England (NHSE), might result in a £3m penalty and there was ongoing discussion to mitigate that. **Performance on A&E & Patient Flow** EY would present their findings in the Board and had commenced Phase 2 with the approval of NHSI and NHSE.	

	Strategic Business: Care for You The Sefton Transformation Board had brought together Councils, Commissioners, the Sustainability Transformation Plan (STP), the Trust and Aintree Hospitals were to determine together what the future would be. **Operational Plan 2018/19** Mr Shanahan informed the Board that he and Dr Mahajan would lead a process of discussion with Board members about the proposal by Cheshire & Merseyside STP's Radiology Clinical Group to agree a memorandum of understanding for a joint approach to the development of share strategic goals and investment in network working. The Chair added that financial improvements were to be celebrated and that there was clear evidence that the Trust was moving in the right direction. **RESOLVED:** The Board **received** the Interim Chief Executive's Report.	
TB052/18	**QUALITY & SAFETY** **A staff member's story: Safeguarding Team**	
	Michelle Kitson, Patient Safety Manager, Gemma Kehoe, Adult Safeguarding Specialist Nurse and Susan Norbury, Assistant Director of Safeguarding Ms Kehoe, a Safeguarding Specialist Nurse, related the story of Mrs A who had presented at A&E in September 2017 with complex medical needs. Mrs A's situation had been discussed at the Multi-Agency Risk Assessment Conference (MARAC) on occasions, over the past 10 years. MARAC is a forum where patients who were considered at high risk of harm were flagged up on the hospital system and with other agencies. A&E had advised the Safeguarding Team of Mrs A's attendance. Mrs A had a long history of being a victim of domestic violence and had been offered refuge and support on a number of occasions but had not accessed the refuge offered. Mrs A was admitted to a ward for a week and in that time, Ms Kehoe spoke with her on a daily basis, offering support, including the offer of a place in a refuge which an Independent Domestic Violence Advocate (IDVA) at Sefton had arranged, out of the area. As leaving the current area meant leaving friends and her job that was a significant challenge. Mrs A had a child less than 18 years of age and whilst that child did not reside with her, she did have access to that child, so the child was referred to the Children's Safeguarding Team.	

Ms Kehoe reinforced the support available on a daily basis and on the day of her discharge, the IDVA requested support to ensure medication to take out would be available to achieve a 2pm deadline for Mrs A to arrive at the Refuge. Ms Kehoe escorted Mrs A to the car park where the IDVA drove Mrs A to the Refuge.

Mrs A remained settled at the refuge and had found no need to return to the Southport area, so that case was considered successful.

At the next MARAC, consent was sought and obtained relating to sharing Mrs A's story.

Mrs Norbury, referring to training in this area, stated that Southport had seen significant improvement recently with previously poor training compliance now at 90%. In addition, bespoke training with Sefton Partnership had been worth £19k.

The Trust's Domestic Abuse policies had been updated recently, making them shorter and easier to understand. Acronyms, such as MARAC had been simplified as staff did not necessarily understand what it stood for and what benefit it would provide. Processes were in place to monitor what was going on and if anything was unclear it could be followed up.

Mrs Norbury commented that another lady, who had been supported in hospital, took the time, despite her chaotic lifestyle, to send a thank you card to Ms Kehoe for the support she received, highlighting the significant work of the team in engaging with very vulnerable people to support them and the significance that someone with many problems takes the trouble to recognise the support given

Mrs Gorry asked if an early review had taken place in respect of Item 1624: Lack of evidence of professional curiosity on the Extreme Risk Register to which Mrs Norbury responded that the professional curiosity audit was undertaken by the Safeguarding Team in A&E and continues to be monitored with the introduction of CRIB sheets.

Mr Clarke asked what process was in place to ensure Safeguarding for a child under 18 years of age, to which Ms Kehoe replied that the Children's Safeguarding Team would be advised of the potential risk along with the Paediatric Liaison Team which would notify Health Visitors and School Nurses and also referred to Children's Social Care Team and any Social Worker associated with the family. In this instance the child was 17 years old and lived away from his mother, with some contact and all agencies were notified.

Mrs Griffiths stated that the changes within Safeguarding were a

	masterclass in improvement with simplification and tools for use in busy environments (i.e. Grab Pack in A&E). She encouraged the Safeguarding Team to step back to review the developments and produce lessons learned. The Chair asked Ms Kehoe and Mrs Norbury to pass on the thanks of the Board to the whole Safeguarding Team. **RESOLVED:** The Board **received** the presentation.	
TB053/18	**QUALITY & SAFETY COMMITTEE AAAs HIGHLIGHT REPORT**	
	Mrs Gorry presented the highlight report commencing with rate of blood culture contamination which was approximately twice the national average. Dr Mahajan commented that all staff should be educated in best practice as some may have lapsed into habits which might involve inadvertent contact and subsequent contamination. The Infection Control Committee had recommended a non-touch technique. The Sepsis Pathway took place within the first ('Golden') hour, and blood cultures might be delayed due to monitoring, therefore it might be prudent to consider support. Mrs Gorry added that progress had been made with information about Learning from Deaths reviews which were now accessible on the Trust's website, including Mortality. The CQC report would be published imminently. A report on Stroke would be provided to the Quality & Safety Committee post the 29th March meeting. The Quality Improvement Strategy needed further refinement and the metrics needed development before it should be considered for adoption by the new Chief Executive and it should be returned to the Board for ratification. The Chair observed that the 'Golden Hour' was cited frequently in the media, which did not necessarily show an appreciation of the time sensitivity which added to attendance pressure. **RESOLVED:** The Board **received** the report.	**DoN**
TB054/18	**CQC IMPROVEMENT ACTION PLAN**	
	Mrs Ross informed the Board that the Quality and Safety Committee was recommending that the CQC action plan for 2016 be closed but any outstanding *must dos and should dos actions* be migrated into the 2018 *must dos/should dos* action plan when the new report was received from CQC on Tuesday 13th March. Outstanding actions	**DoN**

	relating primarily to those with a later date for completion or where assurance had not yet been given would be prioritised in the new plan. Mr Birrell stated that the Trust and the Board should raise their ambitions from a rating of 'Requires Improvement' to 'Good' with inclusion in a comprehensive plan within the next month or two, on how to achieve it. The Chair confirmed that that was an objective, to which Ms Ross concurred, adding that a significant amount of work was already taking place to achieve that. Mr Birrell commented that that was not yet in place and that a long-term vision needed adding to the plan, so that good care delivered every day for every patient was realised. Mrs Gorry echoed Mr Birrell's comments. The Chair added that the information regarding the long-term action should be captured so that Mr Nicholls has full line of sight when he joins the Board and identifies how the Trust aims to get to where it wanted to be and requested that it be brought to the May Board. **RESOLVED:** The Board **approved** the report.	
TB055/18	**INTEGRATED GOVERNANCE QUARTERLY REPORT**	
	Mrs Katharine Martin, Senior Information Analyst & Datix Project Lead presented the Quarter 3 Integrated Governance Report to the Board. Mrs Martin ran though the highlights of the very comprehensive report: • A further increase in incident reporting in Q3, including Safeguarding incidents raised and Deprivation of Liberty (DoLs) applications, demonstrating a positive reporting culture which is being encouraged. • A reduction in incidents reported relating to bed management issues in Q3, directly related to lower numbers of delayed transfers from Critical Care demonstrating the positive effect of the actions taken to improve patient flow throughout Q3. • An increase in the number of moderate harm incidents, from 21 in Q2, to 29 in Q3 as a result of grade 3 hospital acquired pressure ulcers, potentially impacted by increased demand in A&E and the number of frail, poorly patients presenting. Full action plans are in place for improvement, identification and trends. • Issues with delayed Outpatient follow-ups resulted in an increase	

	in incidents being reported as 'Delayed Access to Medical Care'. No patients had suffered harm to date. • As at 8th February, there were 190 overdue incident actions, of which 119 related to SUI or StEIS investigations. The Integrated Governance Team sends weekly reminders to all action leads and the CBU Triumvirates highlighting all overdue actions. • One Never Event had occurred in Q2 and reported in Q3 with lessons learnt disseminated and changes in practice in place. Mr Birrell stated that he was pleased that the current data was generally encouraging and asked how significant the 190 overdue incident actions were as that was concerning. Mrs Martin replied that the action plan was improving and communications issues had been discussed. Mr Birrell asked if there was concern about the extreme level of risks (above 15) to which Mrs Martin responded that those were actively chased on a weekly basis by the team and are included in the CBU's report. Mrs Ross commented that some actions were difficult to close as they were inaccurately defined at the outset. All actions should be Specific, Measurable, Agreed Upon, Realistic and Time-based (SMART). Mr Birrell commented that the increase in grade 3 pressure ulcers was a worrying risk and assurance of improvement was required which Mrs Martin agreed was occurring with all pressure ulcers reviewed by the lead specialist and clinical teams. Mrs Gorry observed from the report that Duty of Candour practice was inconsistent across the CBUs and actions were needed to ensure conformity. Mrs Martin stated that there were delays in verifying the level of harm due to issues with the harm review processes, particularly for hospital acquired infections and pressure ulcers, with a resulting delay in the Duty of Candour letters being sent. Processes were being changed to address these issues. Mrs Gorry asked if training had been delivered around Deprivation of Liberty (DOL), adding that there needed to be a constant reminder sent to all relevant staff. Mrs Ross agreed that that practice would be adopted.	**DoN**

	Mrs Martin added that the '*Saying Sorry'* leaflet would help with keeping that to the forefront and Mrs Gorry recommended that the leaflet should be available on the Trust's website. Mr Clarke queried if the increase in the number of needlestick injuries was of concern, to which Mrs Martin replied that no theme was immediately visible, however, the Occupational Health Audit might identify them and would be reported in Quarter 4. Mrs Griffiths concurred with Mr Birrell's earlier point about grades and prioritisation in all areas and stated that process was needed in the Corporate Clinical Governance Team relating to; 1. Capacity – re-design process, more responsive 2. Report developed really well with triangulation to enable critical analysis. Dr Mahajan asked if there really were 190 overdue incidents or were they day to day training needs and suggested some could be grouped together to make them SMART. The Chair observed that reporting had improved and was now clearer and quantifiable. **RESOLVED** The Board **received** the report.	**DoN**
TB056/18	**MONTHLY MORTALITY REPORT**	
	Dr Mahajan brought the attention of the Board to the draft diagram on page 123 of the Report: Reducing Avoidable Mortality, which detailed *Aim, Primary Drivers and Secondary Drivers*. In the 12 month rolling period, slight reductions had been seen in Hospital Standardised Mortality Ratio (HSMR) and Summary Mortality Hospital-level Mortality Indicator (SHMI) data. HSMR data for Pneumonia was stable, Bronchitis had a slight increase, Stroke was increased, Septicaemia had reduced and Urinary Tract Infection also demonstrated a reduction. Dr Mahajan stated that there would be a 'Look Back' exercise led by Dr McCloud who was very experienced in this area. All lines of enquiry would be considered including the involvement of Commissioners learning. Due to Clinicians' availability the meeting with them would be at the end of May, however the process would be in place beforehand. Going forward, training was on track, orthopaedic training would take place in March for anaesthetists and some surgeons. Datix was ready	

	for the link and robustness would be checked and monitored during the process. Mr Clarke asked when Dr Mahajan would know how many patients had died in February as that was not included in the Board report. Dr Mahajan responded by saying that there were approximately 80, with January and February being exceptional months. It was noted that nationally there had been a 10% increase in mortality. The Chair observed that that was potentially impacted by recent bad weather throughout the UK. **RESOLVED:** The Board **received** the report.	
TB057/18	**WORKFORCE COMMITTEE - AAAs HIGHLIGHT REPORT**	
	Mrs Gibson delivered the AAAs highlight report from the Workforce Committee (WFC) and alerted the Board to the following areas of non-compliance or matters that needed addressing urgently. **International Medical Recruitment** A national shortage of available certificates for sponsorship was likely to impact on the Trust's international recruitment and is being monitored closely. **Medical Appointments** Good progress was being made. **Personal Development Review (PDR)** Low numbers were partly impacted by the high levels of sickness absence over the recent short term. **Medical Education** Consideration had been given on how to best use the strengths of existing resources. **Mandatory Training** The target continued to be exceeded and thanks to the Teams for their efforts was recorded. **National Guardian Office (NGO) Action Plan** Excellent progress had been made. **RESOLVED:** The Board **received** the report.	**ADHR**
TB058/18	**MONTHLY SAFE STAFFING REPORT**	
	Mrs Ross delivered the Monthly Safe Staffing Report highlighting the	

	following information: there was an increase in staff sickness and escalation beds which had resulted in staff being spread thinly. The Trust's mandated monthly submission of staffing (headcount) levels to NHS Choices presented the following overall % fill rates of planned inpatient staffing levels against actual staffing levels for the month of January 2018 against the accepted level of 90%: **Trust overall 89.52%** • 84.26% Registered Nurses (RN) on days • 96.98% Registered Nurses on nights • 94.77% Care staff on days • 100.85% Care staff on nights **Trust vacancy:** • 11.81% (103.16 wte) Registered Nurse vacancies at band 5 and above • 10.46% (39.77 wte) Healthcare assistant vacancies band 2 and above. **Trust whole time equivalent (wte) funded establishment versus contracted:** • 874.3 wte funded establishment Registered Nurse • 770.3 wte contracted Registered Nurse • 380.08 wte funded non-registered Nurse • 340.31 wte contracted non-registered Nurse Mrs Ross added that recruitment via the Universities and keeping them engaged was ongoing. Mrs Gorry stated that facts had to be faced; the Trust's participation in engagement was crucial and that the Workforce Committee complied with the key principles in the Workforce Strategy. **RESOLVED:** The Board **received** the report.	
TB059/18	**MONTHLY MEDICAL EDUCATION TRAINING REPORT**	
	Mr Sanjeev Sharma, Director of Medical Education, presented the report, stating that following the visit by Health Education North West (HENW) on 5th December 2017, the Education Department had reviewed processes and protocols including the Governance Structure and was engaging with Senior Managers. Significant progress had been made and weekly meetings were taking place between Dr Mahajan and the Medical Education Team. Mr Birrell asked if the Education Department Team was happy and	

	comfortable with the changes, to which Mr Sharma responded that investment approval was a key factor to their satisfaction. Dr Mahajan commented that Ms Aspinall from St. Helen's & Knowsley Hospital NHS Trust had met with them and one-to-ones had taken place with others. The Team needed support in order to be built up. Specific objective setting along with an Away Day where roles, responsibilities, objectives and actions would be explored were planned. Mr Shanahan commented that the Away Day referred to above was planned for 5th May for half a day and as Tutors were currently conducting one-to-one's, work on roles and responsibilities would already be crystallised. Mr Clarke stated that allocated Medical School financial resources were to be used solely for the purposes of the school and assurance was required to ensure those were not being subsumed into Trust's Finances. **RESOLVED** The Board **received** the report.	
TB060/18	**FINANCE PERFORMANCE & INVESTMENT COMMITTEE, AAAs HIGHLIGHT REPORT**	
	Mr Birrell highlighted the following in his report as Chair of the Committee: **Alerts to the Board** • Contractual discussions with the local CCGs continue. There was significant underperformance on stroke targets for patients spending 90% of their time in a stroke bed and the treatment of Transient Ischaemic Attack (TIA) patients within 24 hours. **Advice to the Board** • The Committee asked that a report on the clinical management of medical outliers be presented to the March meeting of the Board **Assurance to the Board** All cancer waiting targets have been achieved for each of the last four months. **RESOLVED** The Board **received** the report.	**DoN**
TB061/18	**AUDIT COMMITTEE, AAAs HIGHLIGHT REPORT**	
	Mr Clarke highlighted the following in his report as Chair of the Committee:	

	Alerts to the Board • The Trust continued to have the highest level of sickness absence in the country. This needed to be addresses urgently **Advice to the Board** • Security in Pharmacy needed to be looked at urgently by the Security Management Specialist. • Security in Spinal Unit needed be looked at by the Security Management Specialist especially in relation to an abusive patient. • The siting of CCTV cameras should be reviewed to ensure they remain effective. • The Committee recommended that a Deep Dive of Quality Risks, especially Stroke and Mortality be undertaken in a Workshop setting by the Board. **Assurance to the Board** • All cancer waiting targets had been achieved for each of the last four months. The Chair requested to know the mechanics of how the Deep Dive would be undertaken. Mr Charles responded that a draft Board Development Programme was being written and would be brought to the Board in April after it was discussed with Mr Nicholls, the incoming CEO. The Quality Risks Deep Dive would be part of it. **RESOLVED** The Board **received** the report.	**DoF**
TB062/18	**EMERGENCY CARE PERFORMANCE REPORT**	
	Ms Patten presented this report which was in three parts: • Patient Flow • Emergency Care Performance • Patient Flow Safer **Patient Flow** Mrs Salden and Mr Mudgal, on behalf of EY presented the headlines and summary report resulting from Phase 1 of their project work on Patient Flow. During the six weeks of Phase 1, EY had observed the end to end activity of the Emergency Care Pathway to provide qualitative analysis, triangulate data and provide evidence that specific actions would impact positively for patients and comply with 4-hour performance.	

Information regarding the average time the first doctor was seen was difficult to obtain. There were time stamps in the Emergency Department (ED) and the average time to respond is 2h 47min. At Ormskirk admissions were consistent however this was not the case for the Southport site. In December 12% of patients had been in corridors.

The key elements of the report were in the following areas, details of which are in the Presentation:

- **Avoidable Breaches**
- **Emergency Department (ED)**
- **Flow**
- **Patient Flow**

Seven high impact changes in three areas were recommended:

1. Variation of triage/layout/use of space
2. Co-ordination in ED
3. Specials responses, 2 h 57m, 2h 47m average
4. Establish Clinical pathways, modular nursing estates
5. Ambulatory Care pathways – are these the right processes? Opinion sought
6. SAFER 15B and 11A (Stroke and Surgical)
7. Effective meetings with resulting actions

Positive news: During February 2018, despite winter challenges, in comparison to February 2017, the Trust had stabilised against a national downward trend.

Next Steps
The next steps listed were:

1. **Implement recommendations & ensure sustainability** of performance from two RIE's within established clinically led work streams governed through Patient Flow Improvement programme (PFIP) and highlight any emerging risks for prompt mitigation.
2. Prepare a robust plan and implement actions to **improve data completeness and accuracy** of key timestamps to reduce reliance of manually fed information for operational decision making
3. **Plan and deliver SAFER** (High Impact Change 6) as per agreed '2 wards at a time' launch plan starting from 5th March 2018
4. Plan for **Internal professional Standards Launch** (High Impact Change 3) in March'18 through agreement with all clinical directors, launch event, agreed operational processes and prompt

escalation and review.

5. Continue supporting **planning and launch of the 'Modular Unit'** (High Impact change 4) through working closely with lead clinicians for robust clinical pathways, agreed processes, staffing and performance impact.
6. **Support executive team in planning operational changes** that affect emergency care pathways and highlight any potential risks to delivery.
   - Introduce Data stamps
   - Embed Process and escalation
   - Introduce l Modular Unit by 24 April 2018

Members discussed the report's findings to date and EY agreed to provide the following in their next report:

- Data on length of stay and the numbers of stranded patients
- Ensure the focus remained on what was happening to individual patients.

Emergency Care Programme

This part of the report was presented by Ms Patten who informed the Board that A&E experience peak flow was between 6pm to 8pm, Monday to Friday, with a reduction flow from Friday 9pm to Monday 6pm. It was standard practice in the morning to be dealing with patients who were admitted pre-midnight. In February there had been one 12-hour breach and on 7th March there had been five breaches. It was noted that the clinicians and staff make difficult decisions in a non-arbitrary manner based on patient needs.

Support was needed to sustain discharge processes, including a permanent Integrated Discharge Team which had been advised by CQC.

The Chair asked why the recent Integrated Discharge Team had not continued when its benefits and results were so significant, to which Mr Birrell replied that staff members had been taken from their normal duties to achieve that, which was not sustainable. Ms Patten concurred that a seven-day team was required and added that the A&E Delivery Sub-group would present a paper outlining solutions.
It was hoped that the CCGs would find a way to fund them.

SAFER

Mrs Ross presented this part of the report on Patient Flow Safer. There is synergy between the work done by EY on Patient Flow and SAFER, for example the high impact changes especially Impact 1: *Variation of triage/layout/use of space* and the next steps outlined by EY.

She outlined that it had been recognised through the recent Multi Agency Discharge Event (MADE) event as well as extensive external reviews including CQC feedback, that there was opportunity for improvement and several key pieces of work could have a significant impact on flow and patient safety, as well as giving real time assurance.

There were planned pieces of work which included the roll out of SAFER, red to Green and standardised ward rounds. At the same time each ward would also work on standardisation of metrics and a refresh of matrons' check lists, as well as a leadership program for ward leaders.

Success would be measured by using a variety of metrics and the baseline was currently being established.

The following initiatives were set out:

- Knowing How We are Doing Boards
- Matrons' Check list
- Ward Level Leadership Development

Mrs Murphy and Mrs Ross had worked closely with University of Central Lancashire (UCLAN) to develop a bespoke program that would provide the leadership development programme. The program consisted of five modules and would be launched on Nurses' Day 2018 and would be fully delivered before the end of the year.

The Chair commented that that would be influential as an empowered leader was an effective leader.

Mrs Gorry asked if it was realistic that Nurses would be permitted time to attend, given the pressures on staffing, to which Mrs Ross replied that the programme would take place on full days, stretched over a number of months. Matrons and Lead Nurses would be supportive and with five nurses per programme that was achievable.

The Board was asked to note the planned work and regular updates would be given on progress

Mrs Gibson and Mrs Royds added that that the above item was a standing item on the Workforce Committee so it remained a focus.

RESOLVED:
The Board **received** the report.

TB063/18	**INTEGRATED PERFORMANCE REPORT**	
	Mr Shanahan presented the 36 indicators highlighting that 17 were currently red. Staffing was a particular issue. Dr Mahajan commented that the Trust needed to focus on reducing the 7% sickness level. Mrs Royds added that chest infections and 'flu over the winter period had resulted in that figure and that the data for February, which would be released on 17 March, should show a reduction in staff sickness. The Sickness Policy was being reviewed along with ensuring robust systems were in place. Ms Patten commented that during her tenure, sickness had never been so high and Mr Shanahan further added that the national trend was currently at 5%. Mr Birrell observed that Stroke data was significant and Falls data had identified that 46% of at risk patients did not have the correct care plan. Mrs Gorry questioned whether increased sickness was a direct result of staff being asked to undertake extra hours. Ms Patten commented that sickness had increased in A&E. Mrs Griffiths stated that it would be beneficial to examine causes, distribution and preventative measures put in place. Mrs Royds added that a suite of referrals and support including Occupational Health was provided. **RESOLVED** The Board **received** the report.	
TB064/18	**REVISED 2017/18 CAPITAL PLAN**	
	Mr Shanahan outlined that extra capital funds had been received for Accident and Emergency (A&E). Mark Wilson, Assistant Director of Finance and his assistant Suzanne McGrath, had undertaken significant work to secure that. Given that the Trust was not able to carry any unspent capital monies forward, it had been necessary to bring in some of the 2018/19 planned expenditure to absorb any potential underspend that had included medical equipment for A&E which the Trust had been assured would meet the requirement of being delivered before Financial Year end. Mr Shanahan asked the Board to **approve** the Plan. **RESOLVED** The Board **approved** the 2017/18 Capital Plan.	

TB065/18	OPERATIONAL PLAN 2018/19	
	Ms Patten and Mr Shanahan presented the report. Ms Patten advised the Board that the 2018/19 Planning Guidance provided advice and guidance for Trusts to update year 2 of their 2 year plans agreed prior to the start of 2017/18. Ms Patten highlighted that there were national growth assumptions for activity including Emergency Care. The Trust was required to make improvements in patient flow to be treating at least 90% of patients within 4 hours by September 2018. The Trust through the work with EY expects to achieve this by June 2018. In addition fortnightly Cancer meetings were taking place to ensure we meet all the cancer waiting time targets and added that Maternity had seven key standards which all providers needed to demonstrate compliance against. Robust Quality Improvement Plan was to be incorporated including 'plan on a page' with the objective of improving CQC rating from 'Requires Improvement' to 'Good'. Mrs Royds added that the Workforce Plan would also need to be submitted. She added that the plan incorporates the clinical strategy and the staff engagement strategy. Mr Shanahan explained that the financial plan also required a refresh and was based on the current 2017/18 forecast outturn. The plan before CIP was a deficit of £33.3m. The Trust had a target CIP of £7.0m which was being developed by the Deputy Turnaround Director. This gave a net deficit of £26.3m. The Chair asked about the Turnaround Director's involvement in the planning process. Mr Shanahan responded that the Deputy Financial Turnaround Director had scheduled to a planning workshop the week of the Board but it had to be postponed because of operational pressures. A new date had been arranged. The final plan submission is 30th April 2018. As there would not be a Board in time to submit the Plan for approval before it was submitted to NHSI, Mr Charles advised the Board that the Plan be discussed by the Finance, Performance and Investment Committee at its April meeting which would then make recommendations to the Board. A virtual Board would be convened to approve the Plan. The decision of the Virtual Board would be taken to the next Public Board at its meeting on 2nd May for ratification. **RESOLVED** The Board **received** the report and **approved** a deficit plan of £26.3m	

	to be submitted to NHSI on 8 March 2018.	
TB066/18	**DIRECTOR OF FINANCE REPORT**	
	Mr Shanahan presented the report, outlining that the Forecast Outturn for 2017/18 had been revised down by technical adjustments of £2.5m to £29.2m deficit, with which NHSI was satisfied. He added that Commissioners, as per regulation, were required to impose sanctions on the Trust as it did not sign up to its control total in line with the national contract; it was estimated that that would increase the Trust's forecast outturn deficit by a further £3.0m. Mr Shanahan further commented that the Trust's dispute with Southport & Formby CCG and West Lancashire CCG relating to CQUIN and coding and counting issues from 2015/16 and 2016/17 continued with CCGs having turned down an offer to settle and the issues would now be resolved by Expert Determination. A 2017/18 dispute would also be considered as part of that process. NHSE and NHSI had appointed the Expert and it was anticipated that the process would be concluded by 31 March 2018. The value of the dispute for the Expert Determination process was £6.4m. **RESOLVED** The Board **received** the report.	
TB067/18	**INFORMATION MANAGEMENT & TECHNOLOGY (IM&T) STRATEGY**	
	Mr Shanahan informed the Board that the Finance, Performance & Investment (FP&I) Committee had received the IM&T Strategy initially at its meeting on 23rd October 2017 and in light of the clinical benefit of e-Prescribing, the Committee asked for the implementation schedule to be reviewed. After careful consideration of the resource implications, the Trust's Chief Clinical Information Officers (CCIO) met with senior clinicians to discuss the order of the modules in the road map and support for the original implementation plan was agreed. The IM&T Strategy was brought back to the Finance, Performance & Investment Committee on 29th January 2018 when it is approval by the Board was recommended. Dr Mahajan commented that this work would support the Secretary of State's recent initiative to crackdown on errors in dispensing drugs to patients, which research showed, could be contributing to as many as 22,000 people dying every year. Mr Birrell added that the FP&I Committee was keen to support the IM&T Strategy to improve the quality of care with an electronic system as soon as possible. Mr Shanahan concluded that a final discussion with System C, the	**DoF**

	contractor, would take place and the contract brought to the April Board. **RESOLVED** The Board **approved** the strategy and requested that the Contract be brought to the April Board.	**DoF**
TB068/18	**OPERATIONAL SEGMENTAL REPORTING AND CHARITABLE FUNDS CONSOLIDATION**	
	Mr Shanahan presented the report which included plans not to consolidate the charitable funds into the Trust's 2017/18 accounts. **RESOLVED** The Board **approved** the report.	
TB069/18	**RISK MANAGEMENT BOARD ASSURANCE FRAMEWORK (BAF) AND RISK REGISTER**	
	Mr Charles introduced the Board Assurance Framework and Risk Register report and outlined that he had met with executive directors and that there was now greater focus on the risks, controls, assurances and gaps and action plans to close the gaps. Risks 3 and 4 were reviewed at the FP&I Committee and the Chair stated that there was an improvement. Dr Mahajan commented that the Trust would work together with the new CEO, Mr Nicholls on the overall Risk Management Strategy. Ms Patten added that the Clinical Strategy was in place and work was now required on the Financial Strategy. Dr Mahajan concurred, adding that integration was part of the strategy. Mr Birrell stated that detailed discussion on each risk should probably take place outside the Board at Assurance Commitees. The Chair responded that discussion would take place by exception and that the document had unquestionably improved and asked if anyone had additions or omissions to note. Mrs Gorry queried whether the dates given were realistic, given the work to be undertaken. The Chair asked further how the dates were arrived at to which Mr Charles and Dr Mahajan stated that the dates were aspirational and would benefit from being re-visited. The Chair added that the dates should be changed or be committed to.	

	He requested that the headers of the document be amended to show a neutral colour. **RESOLVED** The Board **received** the report.	**ICOSEC**
TB070/18	**ANNUAL REPORT STRUCTURE AND TIMELINES 2017/18**	
	Mr Charles advised that the first draft of the Annual Report would be brought to 4th April Board. Drafts will also go to QSC and Audit committees, a later version on 2nd May and with the final version being brought to the 23rd May Board for submission to NHSI on 29th May. **RESOLVED** The Board **received** the report.	**ICOSEC**
TB071/18	**ITEMS FOR APPROVAL/RATIFICATION**	
	Ratification of Emergency Powers taken by the Chair and CEO Emergency Powers were evoked under Section 4.3 of the Standing Orders to approve the submission of an application to the Secretary of State for an Uncommitted Revenue Support Loan. That was done as the application needed to be submitted before the Board convened. Mr Charles asked the Board to ratify that decision. **RESOLVED:** The Board **ratified** the action taken under Emergency Powers.	
TB072/18	**QUESTIONS FROM MEMBERS OF THE PUBLIC** Mr Ryan asked if he should contact Mr Charles, Interim Company Secretary to arrange the previously discussed meeting relating to external forums, potentially of interest to the Board, to which the Chair agreed.	**Public Member/ ICOSEC**
	CONCLUDING BUSINESS	
TB073/18	**ANY OTHER BUSINESS**	
	The Chair requested that the Board thank Mrs Farrar for her work as Interim CEO. It had been a pleasure to work with her and the Trust had benefited. The Chair reported that a Director from the CCG had recently brought their child to A&E following an incident and had subsequently contacted the Chair to express their gratitude for the professional work of the staff along with their composure and care of both the child and parent. Thanks to all staff in the departments who encountered them was recorded. The Chair advised the Board of the implications of Purdah, namely no activity that could be considered politically controversial or sensitive, or could give rise to criticism that public resources were being used	

	for party political/campaigning purposes should occur within or by the Trust during the period.	
TB074/18	**ITEMS FOR THE RISK REGISTER/CHANGES TO THE BAF**	
	There were no items for the Risk Register or changes to the BAF.	
TB075/18	**MESSAGE FROM THE BOARD**	
	There was no message from the Board.	
TB076/18	**DATE, TIME AND VENUE OF THE NEXT MEETING**	
	Wednesday 11th April 2018 **13.30 Seminar Room, Clinical Education Centre, Southport District General Hospital**	

There being no other business, the meeting was adjourned

NHS
Southport and Ormskirk Hospital
NHS Trust

Public Board Matters Arising Action List as at 11th April 2018

BRAG Status Key

Red	**Significantly delayed and/or of high risk**
Amber	**Slightly delayed and/or of low risk**
Green	**Progressing on schedule**
Blue	**Completed**

OUTSTANDING ACTIONS

DATE	AGENDA ITEM	LEAD AND TARGET DATE	ACTION	COMMENTS/UPDATE	BRAG STATUS
JUNE 2017	**TB116/17** **Staff Engagement Plan**	ADHR July 2017	Staff Engagement Plan to be brought to the Board on the back of the final version of the Cultural Review.	To ensure that the findings of the cultural review are fed into the WRES action plan. Final Version of Review received in late August. CEO to bring details of action to October Board. **Deferred until the Cultural review process has been completed and the Cultural Review is brought to the Board**	**AMBER**
SEPT 2017	**TB185/17** **Items for Approval - Standard Operating Procedure for the Administration of Meetings**	ICoSec April 2018	A further version including the dates for the Board Development Workshops to come to the March Board.	This has been further deferred pending consultation with the new substantive CEO and Executive Team. **To be brought to the May Board.**	**AMBER**

OUTSTANDING ACTIONS

DATE	AGENDA ITEM	LEAD AND TARGET DATE	ACTION	COMMENTS/UPDATE	BRAG STATUS
FEB 2018	**TB037/18 Exec Ward Visits – Stroke Rehabilitation Ward**	COO April 2018	Stroke rehabilitation area/bed was being used as an escalation for emergency admission preventing right care at the right time for stroke patients. This should be reviewed and The COO to update via the Emergency Care Performance Report.	**2 beds ring fenced for Stroke patients but due bed pressure they had to be used for escalation, starting again on 26th March.**	**GREEN**
DEC 2017	**Quality & Safety AAAs Highlight Report-Follow Up Appointments**	COO Jan 2018	**Overdue Follow Up Appointments.** Diabetic eye screening appointments have been impacted by the failure of a service provider arrangement with Aintree Hospital. High risks patients were to be consulted by the end of January and all patients by the end of March	Discussions with NHS England (NHSE) and the network lead (to clear the backlog of 2,020 diabetic eye screening appointments) have resulted in talks with Aintree Hospital about the future of the service. Update: unexpected TUPE issues have impacted on the Diabetic Eye Screening service and consideration for the future is required. Patient care is unaffected. **Update: Staffing issues will be resolved from April 18. Aintree provided bank staff to support screening service.**	**AMBER**
MAR 2018	**TB061/18 Audit Committee AAAs Report-Security in Pharmacy**	DoF April 2018	**Security in Pharmacy and Spinal Unit alongside CCTV camera review to be assessed by Local Security Management Specialist, Information Governance with Assistance from the Anti-Fraud Specialist if required.**	**Update: To be included in the Internal Audit Workplan 2018/19. Update to May Board.**	**AMBER**
MAR 2018	**TB067/18 Information Management & Technology (IM&T) Strategy**	DOF April 2018	The IM&T Contract to be brought to April Board.	**Contract discussions not concluded and should be ready for May Board.**	**AMBER**

NHS
Southport and Ormskirk Hospital
NHS Trust

Public Board Matters Arising Action List as at 4th April 2018

BRAG Status Key

Red	**Significantly delayed and/or of high risk**
Amber	**Slightly delayed and/or of low risk**
Green	**Progressing on schedule**
Blue	**Completed**

COMPLETED ACTIONS

DATE	AGENDA ITEM	LEAD AND TARGET DATE	ACTION	COMMENTS/UPDATE	BRAG STATUS
DEC 2017	**TB254/17 Patient Story**	ICEO/DoN Jan 2018	The case of the Patient from the December Board Patient Story was to be taken to the Southport and Ormskirk Senior Leaders' Forum as an illustration of patient experience but also to escalate required contact from Social Services and Community Occupational Therapy for the patient in question.	**COMPLETED. Update from Directorate Manager: Patient concerns are being managed and as some are around his self-management, further support is being given by system wide services**.	
DEC 2017	**TB259/17 Workforce Committee AAAs Highlight Report –measuring E-Learning**	ADHR April 2018	To inform the Board on percentage of mandatory training moved to E-learning from face-to-face.	**COMPLETED. 1,200 staff had accessed the E-Learning Tool.**	**BLUE**
DEC 2017	**TB259/17 Workforce Committee AAAs Highlight Report –measuring E-Learning**	ADHR April 2018	A method of measuring how effective the new E-Learning tool is to be agreed and incorporated into the workforce quarterly reports to the Workforce Committee.	**COMPLETED. Incorporated into Workforce Committee.**	**BLUE**

DATE	AGENDA ITEM	LEAD AND TARGET DATE	ACTION	COMMENTS/UPDATE	BRAG STATUS
MAR 2018	**TB054/18 CQC Improvement Action Plan**	DoN May 2018	CQC Action Plans 2016 and 2018 to be merged and brought to May Board.	**COMPLETED. Actions merged into 2017 Improvement Plan.**	**BLUE**
MAR 2018	**TB055/18 Integrated Governance Quarterly Report 'Saying Sorry' Leaflets**	DoN April 2018	'Saying Sorry' Leaflets should be available and information placed on the Trust's website. To be loaded to Trust's website.	**COMPLETED. On Trust's Website**	**BLUE**
MAR 2018	**TB055/18 Integrated Governance Quarterly Report - Deprivation of Liberty Training**	DoN March 2018	Training on Deprivation of Liberty to be delivered and constant reminders to be given to staff.	**COMPLETED: Training compliance is currently 90% with continuous training plan in place.**	**BLUE**
MAR 2018	**TB058/18 Monthly Safe Staffing Report- recruitment of stroke nurses**	ADHR April 2018	Mrs Royds to look at recruitment figures and report back to the Board.	**COMPLETED. Recruitment of two additional stroke nurses.**	**BLUE**
MAR 2018	**TB061/18 Audit Committee AAAs Report-Quality Risks Deep Dive**	ICoSec April 2018	The Audit Committee recommended that a Deep Dive of Quality Risks, especially Stroke and Mortality be undertaken by the Board. Mr Charles, as part of the Board Development Programme to bring a proposal as to the logistics around how this would be done.	**COMPLETED .This is incorporated in the Board Development Programme Schedule.**	**BLUE**
MAR 2018	**TB062/18 Emergency Care Performance Report**	COO/EY Ongoing	Patient Flow Improvement and System Plan to be brought to the Board on a monthly basis until project is completed then reports quarterly to the Board	**COMPLETED. In April's Report to the Board.**	**BLUE**
MAR 2018	**TB072/18 Questions from Members of the Public**	ICoSec April 2018	Assist in scheduling a meeting between Mr Ryan and Executive Representative regarding external forums which may be of interest to the Board	**COMPLETED. Mr Ryan contacted by email 21st March 2018 to establish availability.**	**BLUE**

NHS
Southport and Ormskirk Hospital
NHS Trust

PUBLIC TRUST BOARD

11th April 2018

Agenda Item	**TB081/18**	**Report Title**	**Chief Executive Report**
Executive Lead	Silas Nicholls, Chief Executive		
Produced By	Ann Farrar, Interim Chief Executive		
Action Required *(Definitions below)*	✓ To Receive ☐ To Approve ☐ To Assure	☐ To Note ☐ For Information	

Key Messages and Recommendations

Interim Leadership & Improvement Plan
Safety & Quality
Financial Position
Performance on A&E & Patient Flow
Strategic Business – Care for You
Operational Planning Process 18/19

Strategic Objective(s)
(*The content provides evidence for the following Trust strategic objectives for 2017/18)*

✓ **SO1** Agree with partners a long term acute services strategy
✓ **SO2** Improve clinical outcomes and patient safety
✓ **SO3** Provide care within agreed financial limit
✓ **SO4** Deliver high quality, well-performing services
✓ **SO5** Ensure staff feel valued in a culture of open and honest communication
✓ **SO6** Establish a stable, compassionate leadership team

Governance *(the report supports a…..)*

☐ Statutory requirement
☐ Annual Business Plan Priority
☐ Linked to a Key Risk on BAF / HLRR Ref: ALL
☐ Service Change
✓ Best Practice
☐ Other List (Rationale) _____

Impact *(is there an impact arising from the report on the following?)*

✓ Quality ✓ Finance ✓ Workforce ✓ Equality	✓ Risk ✓ Compliance ✓ Legal
Equality Impact Assessment *(If there* is *an impact on E&D, an Equality Impact* Assessment *must accompany the report)*	☐ Strategy ☐ Policy ☐ Service Change
Next Steps *(List the required actions following agreement by Board/Committee/Group)*	
To lead and deliver through the Executive Team and report progress to the Southport & Ormskirk Improvement Board led by NHS Improvement.	
Previously Presented at:	
☐ Audit Committee ☐ Finance Performance & Investment Committee ☐ Quality & Safety Committee	☐ Workforce & OD Committee ☐ Mortality Assurance & Clinical Improvement Committee

GUIDE TO ACTIONS REQUIRED *(TO BE REMOVED BEFORE ISSUE)*:

Approve: To formally agree the receipt of a report and its recommendations OR a particular course of action

Receive: To discuss in depth a report, noting its implications for the Board or Trust without needing to formally approve

Note: For the intelligence of the Board without the in-depth discussion as above

Assure: To apprise the Board that controls and assurances are in place

For Information: Literally, to inform the Board

1 Executive Leadership

I am delighted to confirm that Juliette Cosgrove, will commence as Executive Director of Nursing from May.

To provide focus, stability and maintain a positive momentum during January to April, the Executive Team produced a single executive improvement plan; the focus was to enhance substantive progress in our key priorities which was approved by the Southport & Ormskirk NHS Trust Improvement Board. External support continues to be provided by NHSI and this is welcomed by the Trust. A request for non-recurring funding to support the development of appropriate skills and capacity has been submitted and the Trust awaits confirmation of the final contribution. In the meantime, to progress key quality and strategic objectives appropriate steps have been put in place.

2. Safety & Quality

The Trust has developed a quality improvement strategy over-time and the Board continues to refine prior to approval. This strategy will ultimately drive the organisation to deliver high performing quality of care and experience through a journey of continual quality improvement.

The most urgent priorities are (a) to reduce harm and mortality by improved clinical processes and behaviours and Dr.Mahajan will describe the improvement programme, progress and next steps; (b) substantially improve the urgent and emergency patient flow and Therese Patton will describe the patient flow improvement plan, early wins and the significant improvement required to deliver 90% by June 2018; (c) address the safety short-comings in our quality of care, at Trust and specialty level and ensure this is sustainable and Gill Murphy, Interim Executive Director will describe the progress to produce the action plan in response to the latest CQC report published in March; the action plan is required by the CQC by 10th April.

3. Financial Position

The Trust continues to be off target to deliver its year-end financial position however, the mitigation since January with the support of the Improvement Director has resulted in a slightly better position. There is no change in the expenditure run rate; however, there is an emerging risk in the fill rate of junior medical staff posts and the potential consequence on operational and financial targets. This requires better grip on forecasting ahead of turnover and faster processes to recruit to create the right stability.

The Trust has formally raised the issue of changes to activity and income levels with its primary commissioners to determine whether the issues would lead to recovery of additional income to mitigate their impact. A formal response has been received by the Commissioners and this confirms no change to their position. It has been agreed by all parties to continue discussions and include representatives from both NHSI and NHS England to support a better system wide control total position for 18/19 and resolve the application of penalties issue during 17/18.

The first draft of the operational and financial plan was approved by the Board on 7th March. Final adjustments are required to firm up the efficiency measures and the quality impact assessments by the required due date, that is, 30th April. This may require an extra-ordinary meeting of the Board.

4. Performance on A&E & Patient Flow

A Trust-wide patient flow improvement plan has been produced to explain the primary drivers, the operational transformation required with urgency to address the challenges and a quality improvement methodology to embed these improvements across all teams. This is led by the Chief Operating Officer with the support of E&Y's improvement approach which has led to significant improvements in some local hospitals. This is a very high risk to the Trust and so a target has been set to improve our Southport A&E performance by 10% no later than the end of March and achieve 90% by June 2018. This requires transformation of our processes of care, enhanced standard operating procedures, appropriate resources for 7 day services and transformation of discharge processes led by system wide partners. Examples to date of improvement are:

- Rapid improvement event for enhanced emergency department processes took place week beginning 19th February. This resulted in a 10% improvement during this week but has not been sustained. A different level of support for the A&E co-ordination team was put in place week beginning 19th March and this will remain in place until a sustainable improvement is evident.
- A single list of patients (other than simple discharges) ready for discharge has been produced in partnership with our partners and the daily review and escalation process enhanced. This now requires the funding of the integrated discharge service business case by the Commissioners and the commissioning of the right capacity in the community to affect faster more timely discharge. The former is to be confirmed at the

next A&E Delivery Board (28th March) and first scope of the latter is to be presented at the same meeting. The outcome is to reduce the number of appropriate discharges by a third. This is required to deliver the 90% target.

- Better assessment services at the front of house are well advanced and require estate enabling works. All of the individual schedule of works will be completed by May and this is when the Trust moves into a principle of "red lines" for assessment services. In essence, patients will receive right care, right time.

I am very grateful to all the staff for their continued hard work and professionalism in caring for patients and continually striving to provide right care, right time, and right pace.

5. Strategic Business: Care for You

The aim is for a strategic direction of travel to be produced by the summer and this will describe the vision for the care to be provided closer to home, clinically and financially sustainable hospital acute services into the future, and how innovations in digital care and the workforce can enable these ambitions to be achieved. In the meantime, the clinical leaders are committed to a transformation of their services; the drivers for improvement and a comprehensive overview of their improvement plan, and by when, is attached is appendix one. This describes a very exciting transformational journey.

6. Operational Plan 18/19

The Chief Operating Officer has responded to the national guidance to revise the two-year operational plan agreed last year with the most recent latest performance and the highest priorities as described in the single executive improvement plan.

Ann Farrar
Interim Chief Executive
21st March 2018

HIGHLIGHT REPORT

Committee/Group Meeting date:	**Quality & Safety Committee 26th March 2018**
Lead:	**Mrs Julie Gorry, Chair**

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

(Alert the Committee to areas of non-compliance or matters that need addressing urgently)

- New Trust website has been delayed but it should be completed by end of April 2018.
- Some of the recorded hospital pressure sores may be due to not undertaking skin bundle assessment in A&E. Audits are being done with a view to improving working practices.
- The Trust is only generating a 3.7% response rate to the Friends & Family Test. Consideration is being given to ways in which this can be improved.

ADVISE

(Detail here any areas of on-going monitoring where an update has been provided to the sub-committee AND any new developments that will need to be communicated or included in operational delivery)

- Agreement reached on the links from NED supported Committees to the relevant assurance committee. This will clarify communication channels between the Board and the specialist area/subject.
- Patient survey will be reported to the Board in May, including action plans to address areas of concern.
- The Committee would like guidance to be implemented on the content and format of the AAA reports because of the lack of consistency in reports submitted to the Quality & Safety Committee.
- The Executive Team will discuss the appropriateness of the high end extreme risks, including issues that are not currently recognised.

ASSURE

(Detail here any areas of assurance that the committee has received)

- The CQC Action Plan, in full, will be considered at the Quality & Safety Committee in April.
- The format of the 2017/18 Quality Accounts has been agreed; the context will be considered at the Quality & Safety Committee in May, prior to submission to the Audit Committee.
- The National Maternity Survey ranked the Trust 11th out of the 68 Trusts involved in the exercise. The Trust was also ranked as 2nd most improved organisation.

New Risk identified at the meeting	

Review of the Risk Register

(Detail the risks on the committees risk register that were reviewed in the meeting, including scores C&L and current actions)

NHS
Southport and Ormskirk Hospital
NHS Trust

BOARD OF DIRECTORS MEETING

11th April 2018

Agenda Item	TB084/18	Report Title	Care Quality Commission Improvement Plan Update
Executive Lead	Gill Murphy, Acting Director of Nursing, Midwifery, Therapies & Governance		
Lead Officer	Jo Simpson, Assistant Director of Quality		
Action Required *(Definitions below)*	☐ To Receive ✓To Approve ✓To Assure		☐ For Note ☐ For Information

Key Messages and Recommendations

This report provides the Board of Directors with an update on the development of the CQC Improvement Plan in response to the Trust inspection report published on 13th March 2018. The report also provides an overview regarding how the Trust will monitor, embed and sustain recommendations from all Inspection reports.

Strategic Objective(s)
(*The content provides evidence for the following Trust strategic objectives for 2017/18)*

☐ **SO1** Agree with partners a long term acute services strategy
✓**SO2** Improve clinical outcomes and patient safety
☐ **SO3** Provide care within agreed financial limit
✓**SO4** Deliver high quality, well-performing services
✓**SO5** Ensure staff feel valued in a culture of open and honest communication
✓**SO6** Establish a stable, compassionate leadership team

Governance *(the report supports a…..)*

✓Statutory requirement
☐ Annual Business Plan Priority
☐ Linked to a Key Risk on BAF / HLRR Ref: _____
☐ Service Change
☐ Best Practice
☐ Other List (Rationale) _____

Impact *(is there an impact arising from the report on the following?)*

✓Quality	☐ Risk
☐ Finance	✓Compliance
☐ Workforce	

☐ Equality	☐ Legal
Equality Impact Assessment *(If there* is *an impact on E&D, an Equality Impact* Assessment *must accompany the report)*	☐ Strategy ☐ Policy ☐ Service Change
Next Steps *(List the required actions following agreement by Board/Committee/Group)*	
Monitoring of Improvement Plan by Board.	
Previously Presented at:	
☐ Audit Committee ☐ Finance Performance & Investment Committee ✓Quality & Safety Committee	☐ Workforce & OD Committee

GUIDE TO ACTIONS REQUIRED:

Approve: To formally agree the receipt of a report and its recommendations OR a particular course of action

Receive: To discuss in depth a report, noting its implications for the Board or Trust without needing to formally approve

Note: For the intelligence of the Board without the in-depth discussion as above

Assure: To apprise the Board that controls and assurances are in place

For Information: Literally, to inform the Board

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NHS Trust

CQC Improvement Plan Update

April 2018

1. Introduction

This report provides the Board of Directors with an update on the development of the CQC Improvement Plan in response to the Trust inspection report published on 13th March 2018 (http://www.cqc.org.uk/provider/RVY)

The report also provides an overview regarding how the Trust will monitor, embed and sustain recommendations from all Inspection reports.

2. November – December 2017 CQC Inspections

The CQC visited the Trust for an unannounced Core Services inspection between 20th – 23rd November, the North West Spinal Injuries Unit was also inspected 27th and 28th November 2017, and an announced Well-Led inspection was undertaken between 5th -7th December 2017.

During the inspection the CQC rated six of the Trust's seven services as 'Requires Improvement' and one as 'Good'. Overall the CQC rated the Trust as follows

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement Feb 2018	Requires improvement Feb 2018	Good Feb 2018	Requires improvement Feb 2018	Inadequate ↓ Feb 2018	Requires improvement Feb 2018

The CQC found that the Trust must take action to improve quality and safety of the services delivered and this resulted in three regulatory actions:

Regulation 5: Fit and proper persons: Directors

- The provider must ensure that the trust has an effective system in place to meet their legal obligations in relation to fit and proper persons employed at director level.

Regulation 17 Good Governance:

- The provider must ensure there are trust-wide effective governance systems in place.

Regulation 20: Duty of Candour

- The provider must ensure that the spirit of Duty of Candour is embraced in the service particularly in relation to notifiable safety incident investigations. Consideration should be given to wider involvement with relevant persons in the investigation and sharing of outcomes.

Together with 55 'Must Do' and 40 'Should Do' recommendations.

3. Unannounced A&E Responsive Visit

On 7th March 2018 the CQC visited the Trust in response to a query regarding patients being cared for in the back of ambulances, the CQC found no evidence of this during their visit. However, the CQC raised two concerns which required immediate response. The Trust is awaiting the draft report following the visit.

1. Professor Ted Baker's letter to all Trust Chief Executives dated 30th September 2017. On inspection the CQC found that staff were of the view that ambulance patients were the responsibility of the ambulance crew after they had been booked into the emergency department. In Professor Baker's letter, he clearly outlines that 'any patient physically on the hospital site should be regarded as under the care of the emergency department.' The CQC requested that this was changed with immediate effect and asked for assurances regarding this within 24 hours.

Outcome: The Trust has responded to the CQC in relation to the recommendations outlined into Professor Baker's letter, in addition all Emergency Department Staff have Letter circulated to Urgent Care CBU for every member of staff within A&E to read & Sign.

2. Triage times -Staff told the CQC, that the computer system within the emergency department does not allow staff to record the actual time that patients are triaged. The CQC requested that the Trust alerts NHS England and NHS Improvement immediately about the issue and a new system for recording triage times is implemented within 24 hours to accurately record triage times.

Outcome: IT resolved issue 8th March 2018 Director of Nursing escalated to NHSE and NHSI. Audit of Patient Records completed and on-going demonstrating the resolution of the issue.

3. Action and Improvement Planning

The recommendations and specific actions from the CQC visits are embedded in the Trust's overarching Quality Improvement Strategy (coming to Board for approval in May 2018) to ensure detailed coordination, governance and delivery to agreed timelines.

An Improvement Plan has been developed based on the need to address the Regulatory Actions and Must Do and Should Do actions highlighted in all the Trust's CQC reports. This serves as a document of record to capture the actions that the

Trust has taken and sets out clearly the plan for delivery. It provides assurance to the Board, partners, stakeholders and people in the community of Southport and Ormskirk, that the Trust is committed to deliver all the recommendations that the CQC have identified and have clear systems and processes in place (see Appendix A) to embed and sustain quality improvement.

As previously agreed by the board in March 2018, any outstanding actions from the 2016 CQC inspection have now been migrated into the new CQC Improvement Plan. The Trust will be required to submit this to the CQC by 10th April 2018.

4. Recommendations

The Board is asked to:

a) Note the outcome of the 2017 CQC Inspections and expected report from the March 2018 A&E visit.
b) Be assured that systems and processes are in place to address the recommendations identified in all CQC Inspection reports.

Jo Simpson

March 2018

NHS
Southport and Ormskirk Hospital
NHS Trust

CQC 2017 improvement plan process

The recommendations and specific actions from the CQC improvement plan are embedded in the Trust's overarching Quality Improvement Strategy and Plan (QIP) to ensure their detailed coordination, governance and delivery to agreed timelines.

The improvement plan has been developed based on the need to address the Regulatory actions, Must Do and Should Do actions highlighted in **all** the Trust's CQC reports. This serves as a document of record to capture the actions that we have taken and sets out clearly our plans for tackling any outstanding issues. It also provides assurance to our board, our colleagues and people in the community of Southport and Ormskirk, that we are committed to addressing all the issues that the CQC identified. It provides assurance to the Board, partners, stakeholders and people in the community of Southport and Ormskirk, that the Trust is committed to deliver all the recommendations that the CQC have identified and have clear systems and processes in place (Appendix A) to embed and sustain quality improvement.

We will ensure that we have delivered the Regulatory actions immediately, Must Do actions within 6 months unless there is substantial enabling factors, such as, estate works or recruitment of staff and Should Do actions within 12 months of receipt of the final inspection report relating to the November 2017 inspection. The Board has set the ambition to be rated from the present rating of 'Requires Improvement' to 'Good' by 2020. This will be delivered through the Draft Quality Improvement Strategy (going to Board in May 2018), this and the service improvement function within the proposed Programme Management Office (PMO) will support the implementation and delivery of a culture of continuous improvement and support frontline staff to improve services through innovation.

<u>Action Planning</u>
Action planning will commence immediately on receipt of the FINAL publication of the inspection report and will be led by the clinical and senior operational leaders in conjunction with the ward and service leaders.

A sense check of the FINAL published inspection report has taken place and any changes factored into the final list of Must Do / Should Do actions.

There will be a single Trust action plan underpinned by clinical business unit "service" action plans. In addition Must Do and Should Do actions which already form part of previous CQC reports will be incorporated into this plan.

1) Overarching high level action plan. This will be:

- A single document which provides a high-level summary of progress against must and should do actions. It will capture the key actions from the services action plans.
- Used for the purpose of reporting to and updating of stakeholders (Leadership Executive, CQC, CCG etc), Trust Board, committees etc.
- Underpinned by a service action plan for each must and should do.

2) CBU Services action plan

- A service action plan will be developed and incorporate the relevant must and should do action identified by the CQC. These will:
    - Identify the key high impact actions and timescales to be taken to deliver the required improvement.
    - Be used for the reporting and monitoring of progress against planned actions and outcomes for internal compliance and CBU purposes and to underpin the overarching high level action plan
    - Include an outcome metric for each action identified in order to determine “delivery” and parameters for closure

3) Existing action plans for improvement

- These will include existing plans for delivery of key strategic objectives such as 4 Hour compliance, Ambulance Handovers, Delayed Discharges etc. The Executive Lead will ensure that these existing action plans include the ‘Must Do / ‘Should Do’ action within them and are monitoring the delivery of these actions as appropriate. Updates will be required for the Improvement Plan.

Executive Directors are assigned for Board accountability and Action owners have been assigned to each of the must do and should do actions at the Executive Group meeting held on 6 March 2018.

<u>Monitoring and oversight</u>

Monitoring and oversight of the 2017 actions will be co-ordinated by the Assistant Director of Quality and facilitated by the submission of updates against dedicated action plans by the Action Owner.

<u>Action Plan</u>

A SMART approach to action planning is essential. That is, the actions should be: Specific, Measurable, Attainable, Relevant and Time-bound. The minimum requirements for an action plan include the following:

- Action plans must be formulated by those who have responsibility for implementation, delivery and financial aspects of any actions
- A responsible person (Action Owner) must be identified for implementation of each action
- Set ‘actions / improvement ’ - what it is you want to achieve, top three actions
- Target dates for achievement - By when will you have completed the action/s?
- Define your success criteria (metric)– ie How will you know whether you’ve achieved a given action

Naming Folders, Files and Documents

Naming conventions are standard rules to be used for naming both documents and electronic folders and are used to make it easier to find documents. Corporate standards must be followed in the naming of record files and folders.

The naming convention for the folders, files and documents is as follows:

Action Plan number, eg 94-2017
Core Service Name, eg Urgent Care
Month, eg April
Number of document, start with 01 and then 02 and upwards depending on the number of documents added

Example – 94-2017 Urgent Care April 01

Storage of evidence

A central folder on the Shared Drive will be used as a central location for documents relating to delivery of the Improvement Plans.

This will ensure that it is easily accessible to those with access to the shared drive assuming conformity to corporate requirements for the management of documents on the shared drive.

The central folder maintenance and safe storage is the responsibility of the principle author or nominated 'owner' which is the Assistant Director of Quality.

Action Owners are advised to liaise with the Triangles within CBUs to ensure that evidence is in line with the outcome metrics identified in improvement plan.

Lockdown of action plan

On the first Monday of the month the CQC improvement plan will be locked down and shared with BI for the purposes of generating a position statement for the Board. The Assistant Director of Quality will ensure this occurs in conjunction with BI.

Risk rating

Risk rating reporting is being used to ensure the Trust has a consistent approach to managing all risks. Each action identified to deliver a must and should do will be risk assessed using the Trust Policy Risk Assessment and Risk Register Process Policy RM26, appendix A which sets out the 5x5 matrix. This risk rating will be used in conjunction with the RATING status to assess the level of risk to delivery and the impact this will have on the organisation.

Rating status

Rating reporting is being used to indicate how well an action is doing using the series traffic lights. Rating status reporting is extremely effective in monitoring the improvement actions as it enables the Trust to create a summary report that consolidates all the status reports from a number of actions into one simple spreadsheet which will be used to give assurance on progress to appropriate groups.

Rating Status Indicators and definitions being used for the CQC improvement plan are as follows:

BLUE – action complete
GREEN – in progress – on track to achieve target date
AMBER – in progress – risk to delivery of outcomes identified
RED – in progress – significant risk to delivery or outcomes identified

The RATING ratings are assessed and determined by the Action Owner working with the Assistant Director of Quality. Ensuring an impartial evaluation of the evidence which provides a level of assurance and confidence in the findings.

Where an indicator is rated '**Red**', it will be standard practice for a more detailed report on that area of performance to be scheduled for a future meeting of the Quality & Safety Committee.

Where an indicator is rated '**Blue**', the Quality & Safety Committee will be asked to close down the action as complete.

If suggesting an action is blue complete this needs to be agreed by the action owner and the executive owner before recommending close to the Quality and Safety Committee.

Reporting Format
Appendix A includes a format of the summary report. It is proposed that not all groups, sub committees and the Board will require the full detail but will need at times full oversight. The report format will allow different reports to be provided to different groups and individuals tasked with delivery of the actions.

The following table set out the frequency and type of report that the Board and other groups expect to receive.

Name of Group	Frequency	Type of Report
Board of Directors	Quarterly	Full action plan initially, then by exception as escalated by the Quality & Safety Committee
Quality & Safety Committee	Monthly	Full action plan initially, then by exception based on a risk /rag approach to delivery, actions recommended for closure
Quality Improvement Delivery Group	Monthly	Themed report by attendance of CBU
Executive Group	Monthly	Themed report by Executive Sponsor, actions recommended for sign off
CBU	Monthly	Themed report by CBU
Board Sub Committees	Quarterly	Themed report by Committee

Process for sustainability

An assurance process has been developed to assess the level of confidence of embeddedness and sustainability of an improvement action, following an agreement by the Quality & Safety Committee to close an action which has been assessed as Green.

The assurance process is led by the Assistant Director of Quality and carried out in partnership with the Executive Sponsor and Action Owners. The overall purpose of the assurance process is to check what has been the impact and improvement and how do we know it has been sustained and embedded into normal business practice and delivered the outcome identified. For example this could include a go and see, peer review, audit, ward accreditation and governance processes or 3rd party assurance from Healthwatch or another partner or stakeholder.

This will assessed on a risk basis following sign off by the Executive Lead and assurance given to the Quality & Safety Committee and will ensure that quality and safety of services has been embedded.

Roles and Responsibilities

Roles and responsibilities for CQC Improvement Plan are as follows:

CBUs: CBUs will be responsible for monitoring and updating the 'Must Do' / 'Should Dos' relevant to their CBU. They should escalate risks as appropriate through the Quality Improvement Delivery Group and Executive Lead Sponsor. Monthly reports of all 'Must Do' / 'Should Dos' relevant to the CBU will be considered at the CBU Quality & Safety meeting.

Quality Improvement Delivery Group: The Quality Improvement Delivery Group will meet two times a month. The Group will have the responsibility of providing leadership and delivery of all planned works and events that will impact upon the Trusts CQC Improvement Plan and provide assurance to the Quality & Safety Committee.

It will be responsible for ensuring that action plans have been developed monitored appropriately and risks escalated.

Quality & Safety Committee: the Quality & Safety Committee is responsible for monitoring the delivery of the CQC Improvement Plan and providing assurance to the Trust Board. Reports to the Quality & Safety Committee will be provided monthly on an exception basis.

Board: the CQC Improvement plan is the responsibility of the Trust Board and as such it must approve the plan. It is proposed that the Board receive a full report setting out all of the actions and metrics once developed and signed off by the action owner and Executive lead for approval. Following this it is proposed that the Board receive quarterly updates on progress on an exception basis, eg risks to delivery.

CBU Leads: the CBU Leads are jointly accountable and responsible for their Clinical Business Unit to review and sign off actions for or evidence of achievement against the CQC 'Must Do / Should Dos' for their Clinical Business Unit. They will be

responsible for attending the Quality Improvement Delivery Group to report on actions in relation to gaps in assurance, any risk to delivery.

Executive Director: each Executive Director has been identified as a Sponsor for a number of the CQC Improvement Plan depending on their portfolio. Each Executive Director has a responsibility to oversee the development of a robust action plan and metrics and for appropriate completion of the evidence in relation to those actions within their portfolio. Final sign off of when an action is complete will be the responsibility of the Executive Director who will provide assurance to the Quality & Safety Committee.

Action Owners: are the individuals who have overall responsibility for delivering the action and metrics. This may require liaison with CBUs and other members of staff who have a special interest in or Trust wide remit for an outcome area such as Infection Prevention & Control, Nutrition & Hydration, Facilities management etc. The Action Owner is responsible for escalating to the Executive Lead Sponsor when there is a risk to delivery.

Assistant Director of Quality: the Assistant Director of Quality will have responsibility for monitoring and oversight of the CQC improvement plan, alerting the appropriate person or the appropriate Committee of risks to delivery. The post holder will support Action Owners to ensure the central folder for storage of evidence is maintained and safe and in identifying the rating status and the Risk Status of the action. On the first Monday of the month the Assistant Director of Quality will lock down the CQC improvement plan and share a copy with BI for the purposes of generating a position statement for the Board and relevant sub committees.

The Assistant Director of Quality will escalate risk to delivery of the Improvement Plan to the Deputy Director of Nursing and will escalate risk to delivery of individual actions to the Executive Lead Sponsor.

The Assistant Director of Quality has operational responsibility to link with the CQC Relationship Manager providing monthly updates on the CQC Improvement Plan.

APPENDIX A – SUGGESTED TEMPLATE FOR REPORTING

CQC IMPROVEMENT PLAN UPDATE

EXECUTIVE SUMMARY

This paper provides the [insert meeting name] with an update on progress against actions identified in the Trust's formal response to CQC inspections in 2017 and 2018 and translated in to the CQC Improvement Plan. It provides an update as of w/c [insert date].

Of the [insert total number of actions] actions in the improvement plan, [insert how many are red and amber] are identified as at risk of not delivering the required outcomes based on current results and progress, including [insert of these actions how many are red] actions assigned a red RATING status.

Completed	X
In progress - on track to achieve target date and outcomes	X
In progress – some risks to delivery or outcomes identified	X
In progress – significant risks to delivery or outcomes identified	x

Actions identified at significant risk of non-delivery of the target date or required outcomes relate to the [insert a list of those which are amber and red].

Name of author
Job Title
Date

CQC IMPROVEMENT PLAN UPDATE

1. PURPOSE OF REPORT

This paper provides the [insert name of meeting] with an update on progress against actions identified in the Trust's formal response to the CQC inspections in 2017 and 2018 and translated in to the CQC Improvement Plan. It provides an update as of w/c [insert date].

2. BACKGROUND

The CQC visited the Trust for an unannounced Core Services inspection between 20th – 23rd November, the North West Spinal Injuries Unit was also inspected 27th and 28th November 2017, and an announced Well-Led inspection was undertaken between 5th -7th December 2017.

In addition, on 7th March 2018 the CQC visited the Trust in response to a query regarding patients being cared for in the back of ambulances.

In line with the requirements of the CQC the Trust submitted a formal response to the CQC on 10 April 2018 which set out the actions being taken to deliver the improvement required.

3. DETAILS/PROGRESS

Of [insert total number of actions] actions in the improvement plan, [insert the number of amber and red] are identified as at risk of not delivering the required outcomes based on current results and progress, including [insert the number of red actions] actions assigned a red RATING status. A breakdown is provided below:

Completed	X
In progress - on track to achieve target date and outcomes	X
In progress – some risks to delivery or outcomes identified	X
In progress – significant risks to delivery or outcomes identified	x

Actions identified at significant risk of non-delivery

Actions identified at significant risk of non-delivery of the target date or required outcomes relate [insert the details of the amber and red actions] and are as follows:

[insert here the must do / should do action and what action is being taken to address it]

Completed actions – only use this para when recommending sign off to the Quality Committee

[insert the number of actions which are blue] actions are being recommended to the Quality Committee for sign off.

4. CONCLUSION

The Trust are identifying that [insert the number of actions which are green] are on track, risks to delivery are currently identified [insert the number of red and amber].

5. RECOMMENDATIONS

It is recommended that the [insert name of meeting]:

a. Notes the progress and risks identified in this report

Name
Job Title

APPENDICES

1. **Relevant report from the CQC improvement plan**

Southport and Ormskirk Hospital NHS Trust

PUBLIC BOARD
11th April 2018

Agenda Item	**TB085 /18**	**Report Title**	**Monthly Mortality Report**
Executive Lead	Jugnu Mahajan, Interim Medical Director		
Lead Officer	Rachel Flood-Jones, Project Delivery Manager Mike Lightfoot, Head of Information		
Action Required *(Definitions below)*	✓ To Receive ☐ To Approve ✓ To Assure		☐ For Note ✓ For Information

Key Messages and Recommendations

The Mortality Report to the April Trust Board consists of:

- **Measuring Mortality**:
  - Mortality Ratios
  - The Structured Judgement Review Method
- **Reducing Avoidable Mortality Project:**
  - Communicating with Patients, Families and Carers
  - Next Steps for the Reducing Avoidable Mortality Project
  - The Project Initiation Document
  - The RAM Project Baseline Report

The Board is asked to receive the report.

Strategic Objective(s)
(*The content provides evidence for the following Trust strategic objectives for 2017/18)*

- ☐ **SO1** Agree with partners a long term acute services strategy
- ✓ **SO2** Improve clinical outcomes and patient safety
- ☐ **SO3** Provide care within agreed financial limit
- ✓ **SO4** Deliver high quality, well-performing services
- ☐ **SO5** Ensure staff feel valued in a culture of open and honest communication
- ☐ **SO6** Establish a stable, compassionate leadership team

Governance *(the report supports a…..)*

- ☐ Statutory requirement
- ☐ Annual Business Plan Priority
- ☐ Linked to a Key Risk on BAF / HLRR Ref: _____
- ☐ Service Change
- ✓ Best Practice
- ☐ Other List (Rationale) _____

Impact *(is there an impact arising from the report on the following?)*

✓ Quality ☐ Finance ☐ Workforce ☐ Equality	☐ Risk ☐ Compliance ☐ Legal
Equality Impact Assessment *(If there* is *an impact on E&D, an Equality Impact* Assessment *must accompany the report)*	☐ Strategy ☐ Policy ☐ Service Change
Next Steps *(List the required actions following agreement by Board/Committee/Group)*	
Previously Presented at:	
☐ Audit Committee ☐ Finance Performance & Investment Committee ☐ Quality & Safety Committee	☐ Workforce & OD Committee ☐ Mortality Assurance & Clinical Improvement Committee

Monthly Mortality Report
April 2018

1.0 Strategic Context

Mortality is a core priority for the Trust which is now focused through the Reducing Avoidable Mortality Project (RAM). The project incorporates a number of work streams and subsumes the work previously undertaken by the Deteriorating Patient Project. There is now a comprehensive plan and resourced project group in place which will support improvements in safety and quality with the overriding aim of reducing avoidable mortality over the next 24 months.

2.0 Executive Summary

Section		Summary
3.0	**Measuring Mortality**	**3.1 Mortality Ratios** While the Summary Hospital-level Mortality Indicator SHMI and Hospital Standardised Mortality Ratio HSMR remain as outliers and are above expected level, the data for November 2017 shows a month on month improvement in all five diagnostics with the exception of stroke. An external review into deaths from Pneumonia and Stroke since May 2017 (covering a spike in related deaths at this point in time) will take place in May and June 2018. **3.2 Structured Judgement Review** Departments are being trained across the Trust in the SJR (Structured Judgement Review) method with the end date of 31st May 2018. The 'Go Live' date for full Trust implementation of the method in conjunction with DATIX is 31st August 2018.
4.0	**Reducing Avoidable Mortality (RAM) Project**	**4.1 Communicating with Patients, Families and Carers** The Trust has updated its website to provide clear information on mortality and bereavement in line with 2017 National Quality Board's 'National Guidance on Learning from Deaths.' **4.2 Next Steps for the Reducing Avoidable Mortality Project** The current focus of the project is the mobilisation of the work stream groups, alongside the activity which is already in progress (as identified on the Project Baseline Report, Appendix 2). Work is ongoing to develop mortality reporting to further drive the improvement delivered by the project.
Appendices		
1	**RAM Project Initiation Document**	The Project Initiation Document for the RAM Project reports the outputs and initial project plan as defined by the Mortality Project Scoping Group in March 2018.
2	**RAM Project Baseline Highlight Report**	The RAM Project Baseline Report gives a progress status update for all identified activity which is required to drive the project objectives. (This includes activity undertaken for the Deteriorating Patient Project).

3.0 Measuring Mortality

3.1 Mortality Ratio

Mortality reporting is now taken to the Mortality Operational Group, the Quality and Safety Committee and the Trust Board as well as the Southport Improvement Board. A new Mortality Dashboard is currently being developed which will be summarised in the May report.

3.1.1 Summary Hospital-level Mortality Indicator (SHMI):

The latest available reportable period for SHMI is for July 2016 to June 2017 for which the Trust was reported to be at a ratio of 117.39. The next available figure will be published this month and will be reported to the Board in May.

3.1.2 Hospital Standardised Mortality Ratio (HSMR):

HSMR applies to in-hospital mortality (excluding palliative care). It includes around 55-60% of deaths.

The latest available data from Dr Foster for November 2017 shows the Trust's rolling 12 month position at 113.2 and in-month position at 90.1; significantly below the mean. This has improved month on month, with the Trust's rolling 12 month position in October at 114.87 and in-month position at 90.57 which was further improvement on September 2017 with the Trust's rolling 12 month position at 120.17 and the in-month position was 105.92.

3.1.3 Disease-Specific Mortality:

Pneumonia rolling 12 month SMR to November 2017 which fell for a third consecutive month to 125.2, down from August when it was 134.82. Dr Chris McManus, Consultant in Respiratory Medicine reviewed all cases of pneumonia for diagnostic accuracy for six months from September 2017 to March 2018. This activity is to be recommenced in the near future.

Acute Bronchitis rolling 12 month SMR to November 2017 was 114.6 a great improvement on October 2017 which was 139.67, up from 137.55 in the previous period.

Stroke rolling 12 month SMR to November 2017 was 133.7 which continued the trend of marginal increases since a low of 120.21 in May 2017. The general trend of the last 18 months however shows an overall increase.

The Sentinel Stroke National Audit Programme (SSNAP) is currently reporting a ratio of 100 for the Trust; their calculations take into account specific indicators of poor stroke outcome (for example stroke severity).

Septicemia (Except in Labour) rolling 12 month SMR to November 2017 was down to 89.4 from 91.56 in September, holding the ratio below the target of 100. This has been the result of a downward trajectory since a high of 120 in December 2016. Raised awareness of septicaemia in A&E, ensuring the appropriate treatment is to have contributed to this improvement. The Sepsis Pathway Standard Operating Procedure has been signed off at the Clinical Effectiveness Committee.

Urinary Tract Infection rolling 12 month SMR to November 2017 was 118.5 from 121.73 in September 2017. This is currently on a downward trajectory following a high of 156.14 in the year to July 2017. This indicator was last below 100 in May 2016.

3.1.4 Crude Mortality:

The latest position is for February 2018 was 39.3, an improvement on January when it had risen to 48.9. In November the rate had been 21, at which time a significant increase had been predicted over the winter months, as crude mortality is particularly demonstrative of seasonal variation.

3.2 Structured Judgement Review:

The Trust is currently training clinicians in the Royal College of Physicians Structured Judgement Review (SJR) method for recording deaths, mortality reviews and their outcomes. To date the method has been rolled out to Orthopaedics and Critical Care, whilst clinicians in General Surgery, Urology and Spinal Unit are to be trained by the end of April followed by General Medicine and A&E in May.

The Trust has invested in the DATIX ICloud system with additional functionality to log Structured Judgement Reviews. There has been a delay in setting up individual access to the system for the purposes of SJR activity; this has been due to IT resourcing issues. It is expected however, that this will be resolved by the end of the month. 'The 'Go Live' date for Trust-wide implementation of the method is 31st August 2018.

4.0 Reducing Avoidable Mortality Project

A workshop took place in March 2018 to scope the aim and requirements of a mortality improvement project, the outputs from which are detailed in the attached Project Initiation Document (Appendix 1).

A Baseline Highlight Report (Appendix 2) was subsequently developed to detail the progress made to date against the required activities under each objective.

4.1 Communicating with Patients, Families and Carers

We would like to draw particular attention this month to the work undertaken to improve communication on mortality with patients, families and carers.

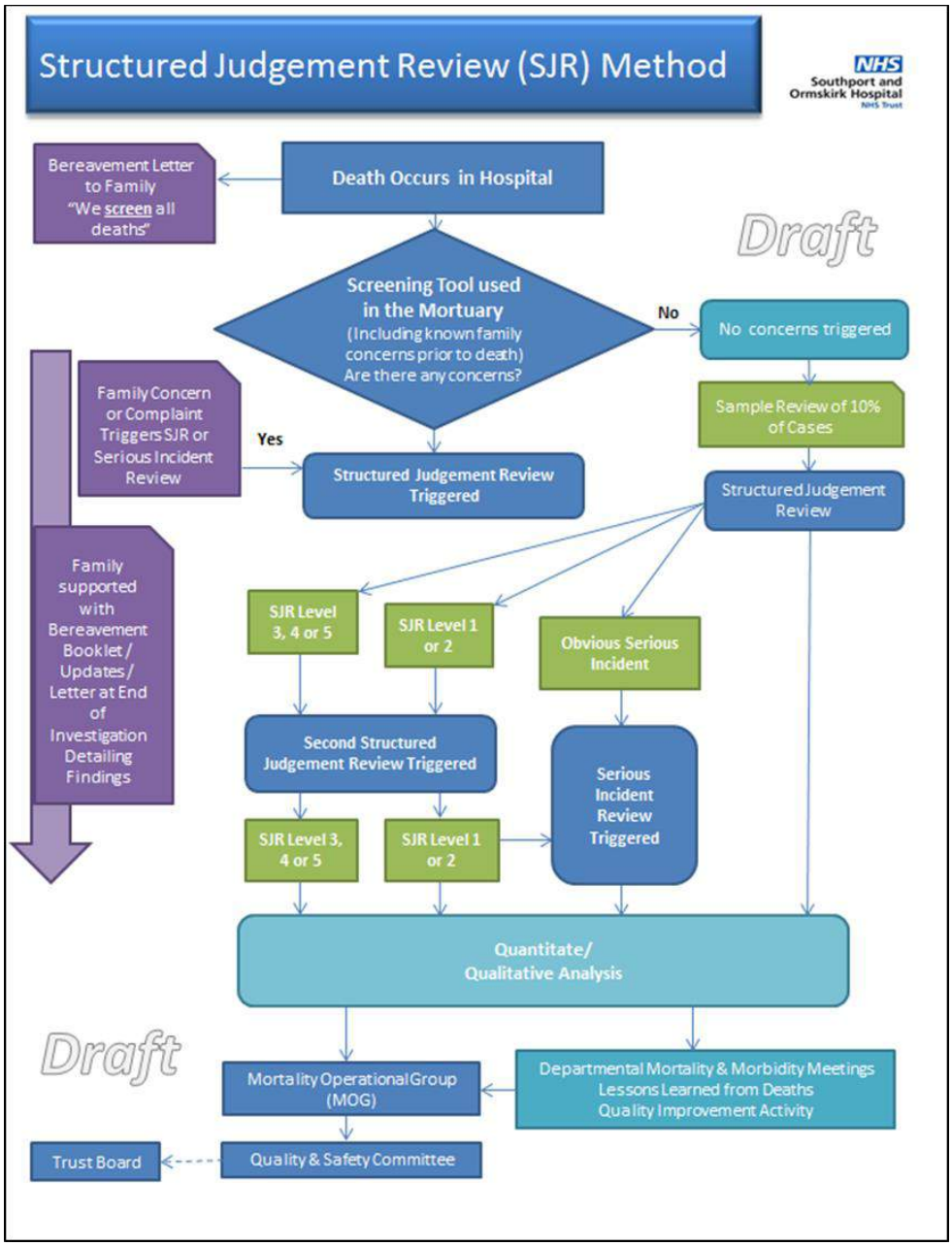
The Trust website now provides information on mortality and bereavement to the general public, in line with guidance from the 2017 National Quality Board's 'National Guidance on Learning from Deaths (the Framework for NHS Trusts and Foundation Trusts on identifying, reporting, investigating and learning from Deaths in Care).'

The Mortality webpage gives an overview of Trust's current mortality position with links to the latest Public Board reports containing mortality data along with an explanation of the way that mortality rates are measured.

The page also provides a link to the Trust's 'Learning from Deaths Policy' and a dedicated Bereavement webpage, all of which can be viewed at:

http://www.southportandormskirk.nhs.uk/learning-from-deaths.asp
http://www.southportandormskirk.nhs.uk/bereavement-information.asp

Further work is underway to ensure that there are robust processes in place to keep families and carers informed (in line with Duty of Candour requirements) throughout: the screening of a death, the SJR process and / or a serious incident review. Advice will be given to families and carers by means of a letter and a booklet, that they can raise concerns and that these will be considered when deciding whether or not to further investigate a death.



DRAFT Process Diagram for the Structured Judgement Review, Detailing Communication with Families & Carers.

4.2 Next Steps for the Reducing Avoidable Mortality Project

The current focus of the project is the mobilisation of the work stream groups, to further advance the activity which is already in progress (as identifiable in the Baseline Highlight Report; Appendix 2). Work is also ongoing to develop Key Performance Indicators to monitor progress of these work streams. This data will be triangulated with the learnings of the Structured Judgment Reviews and the milestones of the Reducing Avoidable Mortality Project to drive continuous improvement.

Appendix 1

Project Management Office

NHS Southport and Ormskirk Hospital NHS Trust

Southport and Ormskirk Hospital NHS Trust
Project Initiation Document

Project	**REDUCING AVOIDABLE MORTALITY**	**Reference**	**QSI001**

3.1 Contact information

Programme	**Quality, Service Improvement Programme**	**Project start date**	**12th February 2018**
Programme sponsor	Dr Jugnu Mahajan	**Project end date**	**1st April 2019**
CBU	Planned & Urgent Care		
Clinical lead	Chris Goddard		
Programme Manager	Diane Bradbury		
Project Manager	Rachel Flood-Jones		
Project Support Officer	Liz Woolley		

Other resources	**Project Leads** Chris Goddard, Clincal Project Lead & 'Communication' & 'Learning Culture' Lead Jugnu Mahajan, Board Lead Rachel Flood-Jones, Project Delivery Manager Karen Groves, 'Future Care Planning' Lead Kevin Thomas, 'Workforce' Lead Mike Lightfoot, 'Information' Lead Sue Elderton 'Care Pathways' Lead

3.2. Project Scope

3.2.1 Aim

The aim of the project is to reduce avoidable mortality, as evidenced by a reduction in standardised mortality ratios to within statistical norms by April 2019."

The project aim was discussed at the Project Scoping Workshop, as to whether the proposed target for the SHMI ratio of 100 is realistic for the Trust at any point in the future. (The proposed aim being 'SHMI to Sit Within Confidence Intervals by 2019 & to be Below 100 by 2020').

SHMI uses statistical mortality rate targets based on co-efficients for different conditions to make mortality indicators. It gives the ratio between the actual number of patients who die following hospitalisation at the trust and the number which would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.

The relative, national method of calculation of Standard Hospital Mortailty Indicator (SHMI) means that improvements made at Trust level will always appear modest in the context of a national trajectory of improvement. Neither do the co-efficients used to calculate SHMI appear to be proportionately weighted to fully appreciate the exceptionally high numbers of the aged patients or levels of acuity within the local population.

These factors however remain outside of the control of the Trust and the SHMI and the Hospital Standardised Mortality Ratio (HMSR) will continue to be the indicators that the regulators such as the CQC, NHSE and NHSI will look to in order judge the Trust's perfomance in the area of mortality.

There was concensus that evidenced improvement of quality of care would be the true internal indicator of progress, with Statistical Process Control (SPC), SHMI and HMSR as key performance indicators for the project. It was agreed that a more realistic aim for the Trust would be to reduce standardised mortality ratios to within statistical norms. It was felt that this was a more realistic

target which would be more readily embraced by staff.

3.2.2 Project Scoping Group / Project Scope Sign Off

The Workshop to sign off the Project Plan for 'Reducing Avoidable Mortality' (RAM) took place on 8th March 2018, attended by members of the Trust, Southport and Formby CCG and the NHS Improvement sponsored Academic Health Science Network for the North West Coast (AHSNNW), Patient Safety Collaborative:

Dr Chris Goddard	Associate Medical Director for Patient Safety
Dr Jugnu Mahajan	Interim Medical Director
Rachel Flood-Jones	Project Delivery Manager
Julie Gorry	Non-Executive Director End of Life Lead & Chair of the Quality & Safety Committee
Mike Lightfoot	Business Intelligence & Performance Lead
Rob Kinney	Coding Manager
Janette Mills	Head of Audit and Effectiveness
Katharine Martin	Senior Information Analyst & Datix Project Lead
Mandy Power	Assistant Director of Integrated Governance
Paddy McDonald	Associate Medical Director of Urgent Care
Rob Caudwell	Chair of Southport & Formby CCG
Andrew Cooper	Associate Director, Patient Safety Collaborative, Innovation Agency, Academic Health Science Network for the North West Coast (AHSNNW)

3.2.3 Project Duration

The project is to run from February 2017 to the end of the last objective which is to be achieved by April 2019. The final measure of SHMI for the project will be published in October 2019 (for the month of April 2019).

3.2.4 Project Scope

The project scope incorporates the work undertaken to date for 'Mortality' Project and 'The Deteriorating Patient' Project.

It was agreed that with the exception of specific coding activity, Paediatrics and Obstetrics would sit outside of the project scope. Both services have well developed, specific processes for the investigation and minimisation of mortality. This project will dovetail with the work done in these areas but will not come into the scope of RAM for redesign.

Contribution from Rob Caudwell, GP and Chair of Southport and Formby CCG at the Workshop ensured that consideration for community requirements were incorporated into the Project Objectives. (John Cain, Chair of West Lancashire CCG was unable to attend the Workshop but is being kept up to date on the project progress).

The project is to run from February 2017 to the end of the last objective which is to be achieved by April 2019. The final measure of SHMI for the project will be published in October 2019 (for the month of April 2019).

3.2.5 Project Group & Project Leads

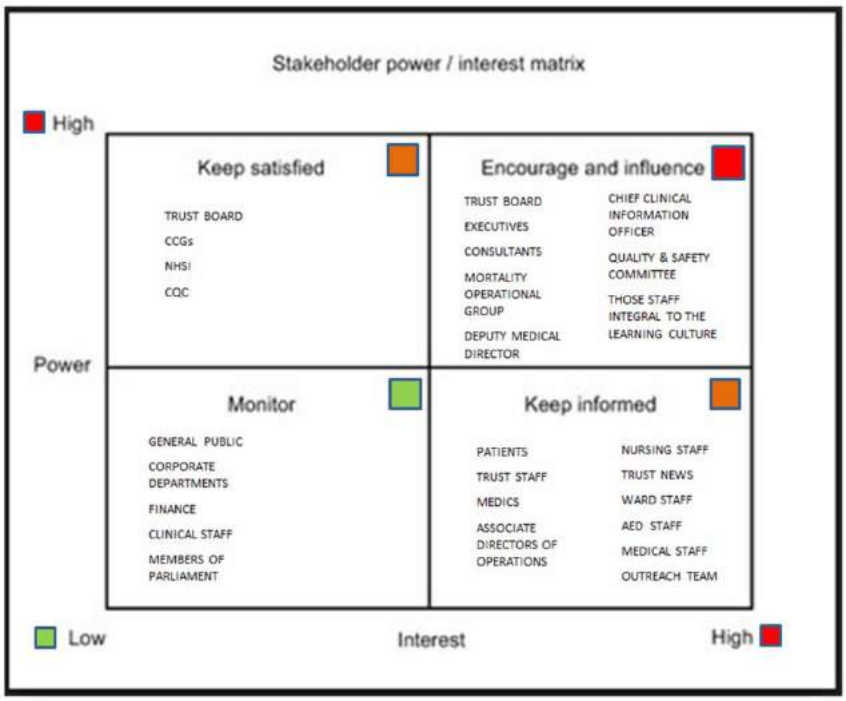
The project is to be driven by a single series of Project Group Meetings (as opposed to workstream meetings). The agenda for each meeting will be dictated by the milestones of the project, with the required attendees invited accordingly.

The Project Group is made up of the Project Leads as listed below, with a link into Julie Gorry, Non-Executive Director Lead for End of Life Care and Chair for the Quality and Safety Committee. Initial contact has been made regarding the project with Non-Executive Director, Jim Birrell.

Chris Goddard	Clincal Project Lead & Lead on 'Communication' & 'Learning Culture'
Jugnu Mahajan	Board and Executive Sponsor
Rachel Flood-Jones	Project Delivery Manager
Karen Groves	'Future Care Planning' Workstream Lead
Kevin Thomas	'Workforce' Workstream Lead
Mike Lightfoot	'Information' Workstream Lead
Sue Elderton	'Care Pathways' Lead (Tbc)

3.2.6 Stakeholder Matrix & Communications Plan

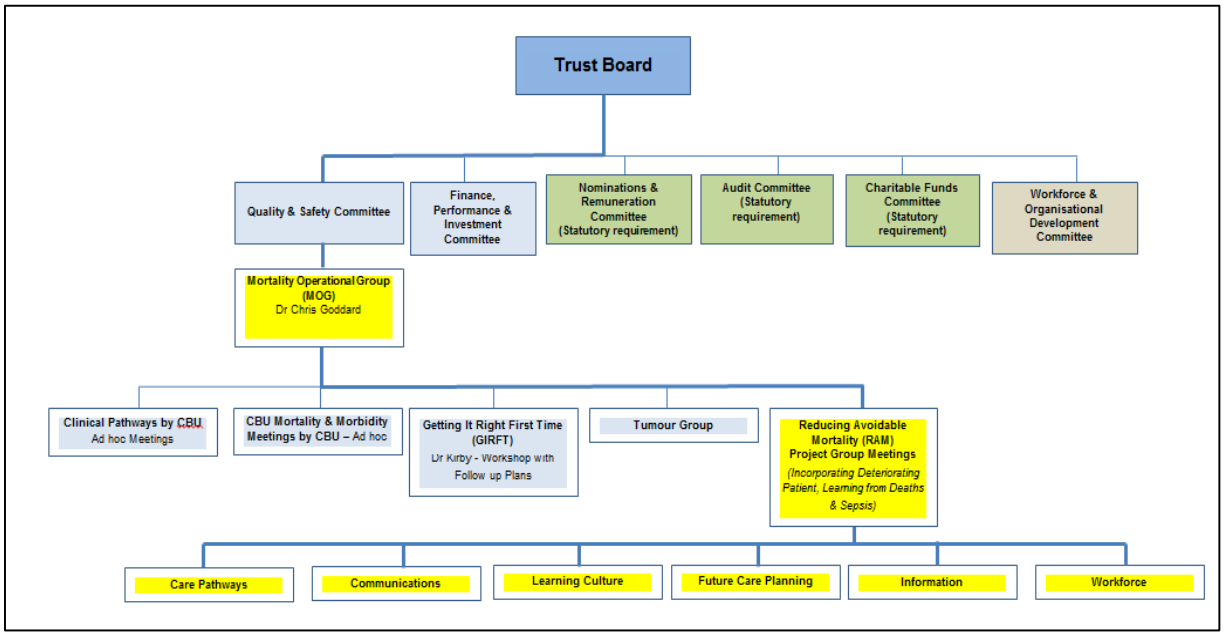
The Stakeholder matrix will inform the Project Communications Plan which will be created and signed off by the Project Group and reported back to both the Quality and Safety Committee and the Mortality Operational Group in April.



3.2.7 Project Governance Arrangements

The Project Group is accountable to the Mortality Operational Group which will report into the Trust Quality and Safety Committee. A monthly report on the project will be presented at the Mortality Operational Group which in turn will provide a monthly highlight report to the Quality and Safety Committee. A project update will also be included in the monthly Mortality Report to the Trust Board.

Governance Arrangements for the 'Reducing Avoidable Mortality' (RAM) Project



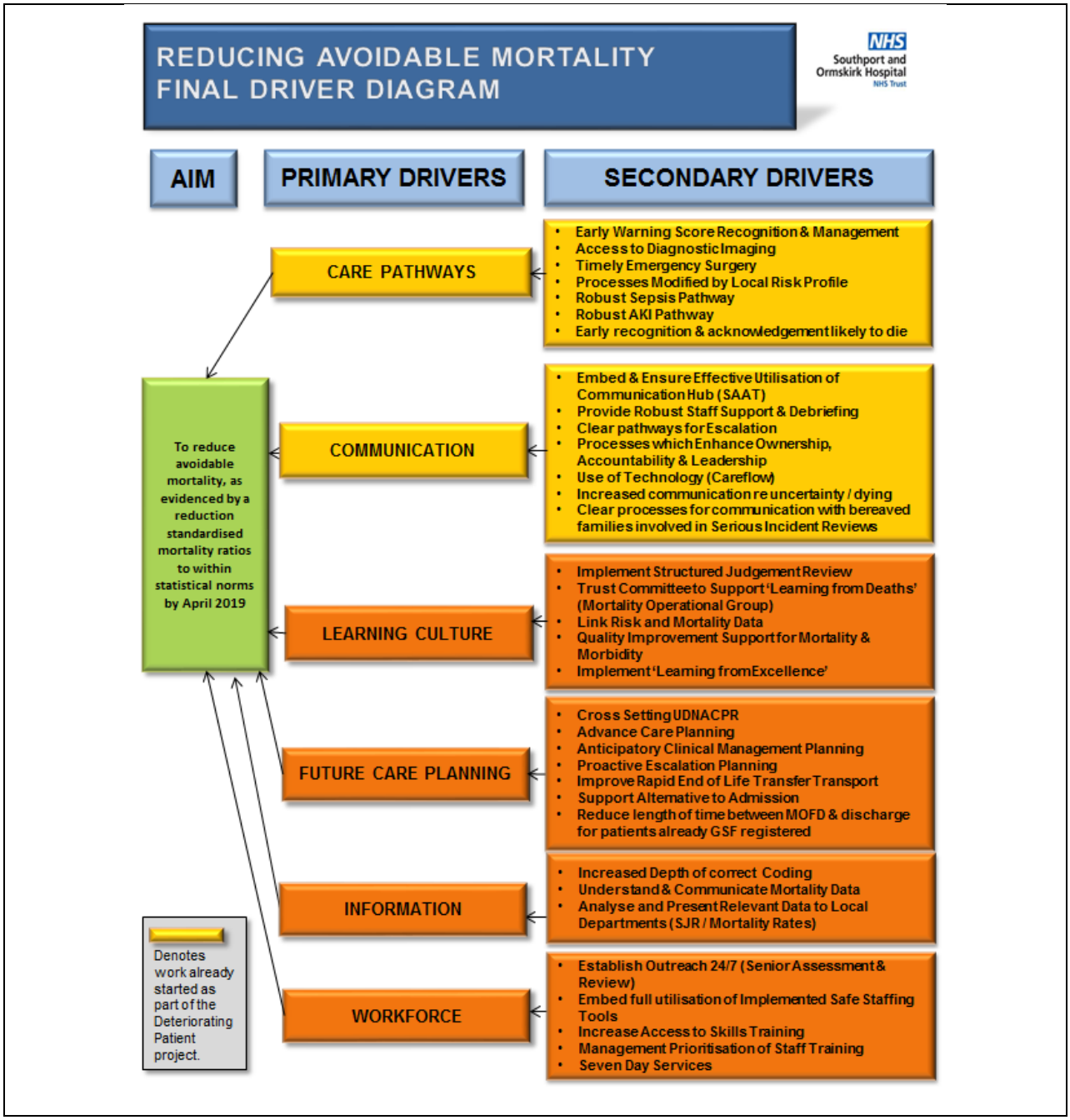
3.2.9 Regional Patient Safety Collaborative

Andrew Cooper, Associate Director, Patient Safety Collaborative, Innovation Agency, Academic Health Science Network for the North West Coast (AHSNNW) attended the Workshop*. Andrew will be returning to the Trust in March to give training and access to the Quality and Audit Teams to the ANSN 'Life QI'; a quality improvement resource web based platform which will support the 'Learning Culture' workstream. He will also attend the first Project Group, to define the requirements for further support. The Trust's alignment with the Academic Health Science Network as part of a regional collaboration will be a mutually beneficial arrangment allowing us to be linked to the regional work on patient safety improvement.

**The Innovation Agency, (Academic Health Science Network for the North West Coast) had been recommended by the Advanced Quality Alliance (AQuA) for the Trust's Reducing Avoidable Mortality Project as it links into the NHS Improvement sponsored Patient Safety Collaborative work that they are underaking. Andrew has already worked with Chris Goddard to support the Deteriorating Patient Project.*

3.2.10 Driver Diagram

The original Draft Driver Diagram had been created by Chris Goddard, in conjunction with Jugnu Mahajan, Interim Medical Director and with input from Caroline Griffiths, Improvement Director, NHSI. Additional input had been submitted by Karen Groves, Consultant in Palliative Care and was signed off at the Project Scoping Meeting.



3.3 Key Project Stages

	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Apr-19
Initiation & planning															
Development															
Implementation															
Control															
Closure															

Detailed activity to support the delivery of each objective will be confirmed with the relevant Project Lead as part of the Development Phase. Once established, all tasks will be assigned on a detailed Gantt Chart which will drive accountability and momentum. This will be available to influencing stakeholders and will be used in the reporting to the Quality and Safety Committee.

3.4 Next Steps (after the Project Scoping Meeting)

The Project Group will meet on 17th April 2018 to confirm in detail the activity required to deliver the agreed objectives, risks, risk mitigation, key performance indicators and Communications Plan. An updated plan will be summarised for the April Quality and Safety Committee and the May Mortality Operational Group, Trust May Board and Improvement Board.

3.5 Current Baseline Position

The Project Initiation Document was shared at the Southport and Ormskirk Hospital Improvement Board on 19th March. NHS Improvement requested further detail to clarify: the significant work that has already been undertaken within the Trust to improve mortality, the work that is in its infancy and that which is yet to commence. In response, the following 'Baseline Highlight Report' was produced.

Please note the following key, relevant only to the Baseline Highlight Report.

Key	
Red	Activity has not yet commenced
Amber	Activity has commenced / significant activity still required
Green	Project is on track / required activity has been undertaken

Appendix 2

Baseline Highlight Report for the 'Reducing Avoidable Mortality' Project – March 2018

PROJECT OBJECTIVE		STATUS UPDATE	Current Level of Completion
CARE PATHWAYS: To develop robust clinical processes for high risk conditions by June 2018		**SEPSIS PATHWAY:** Sepsis and AKI pathways were scheduled to start in February. The Sepsis Pathway and SOP are being submitted for agreement to CEC on 21/03/18. A revision to the process (requiring two blood samples to now be taken) has necessitated a change in paperwork which will have been implemented by the end of April. Sepsis Pathway has been shared with West Lancs Urgent Care Centre resulting in a unified process. There are ongoing discussions regarding community identification and the treatment of Sepsis.	Green
		AKI PATHWAY: Version 2 of the AKI Pathway amendments are to be implemented. To be completed by the end of April.	Amber
		IV FLUID THERAPY POLICY: The policy has been signed off by the Clinical Effectiveness Committee. An Implementation Meeting is set for 10/04/18 at which the roll out plan, including confirmation of training and education for doctors and nurses is to be decided. New drug charts require reprinting.	Green
		PNEUMONIA: Patients coded as having pneumonia have been reviewed since September 2017 by Chris McManus for diagnostic accuracy. This has resulted in HSMR for pneumonia reducing to within confidence intervals. This work is to continue until the External Review for pneumonia and stroke (funded by NHSI) is undertaken in May/June 2018.	Amber
		UPPER GI BLEED: A working group has been organised 22/03/18 by Mr Kevin Thomas, Deputy Medical Director to investigate options for 24 hour emergency endoscopy cover.	Amber
		NATIONAL EARLY WARNING SCORE (NEWS): Transition to NEWS 2 requires upgrade to VITALPAC Version 3.6. We are in the process of upgrading to Version 3.5. Timescales for further upgrade require clarification from the IM&T Project Board. At meeting with 'System C' (provider of VITALPAC) on 19/03/18, System C claimed that the reporting function has been fixed. This requires internal validation from VITALPAC Delivery Manager before it can be reinstituted.	Red
		ACCESS TO DIAGNOSTIC IMAGING: Weekend on-site radiology (CT Reporting and Ultrasound) provision is available for emergency procedures but is only available by negotiation for planned elective care. A strategy will be formulated to ensure this service continues and is robust."	Amber
		PROCESSES MODIFIED BY LOCAL RISK PROFILE: The priority for clinical pathway evaluation is based upon an assessment of the local risk profile. This is an ongoing activity.	Green
		TIMELY EMERGENCY SURGERY: Timely surgery will be improved by the implementation of the Surgical Assessment Unit (SAU) which comes under the scope of the Safe At All Times Project. Further work is required to ensure all acute admissions areas can provide post-operative care for minor non-elective procedures.	Red
		EARLY RECOGNITION OF ACKNOWLEDGEMENT LIKELY TO DIE: A meeting has been organised with Dr Karen Groves 17/04/18 regarding the design and roll out of enhanced training to acute specialities for specialist palliative care reviews.	Amber

Baseline Highlight Report for the 'Reducing Avoidable Mortality' Project – March 2018

PROJECT OBJECTIVE		STATUS UPDATE	Current Level of Completion
2. COMMUNICATION: Drive the implementation of a robust Communications Hub and ICT Infrastructure through the SAAT Project in place for both sites by May 2018		**COMMUNICATIONS HUB:** The Communications Hub and first draft of electronic reporting tools are to be implemented by the end of May 2018 as part of the Safe At All Times Project. There is a staged roll out plan including 'Open Door Policy' and Comms Strategy to maximise engagement: Week 1 Install Outreach Staff Week 2 Begin Nursing Operational Meetings Week 3 Begin Medical Operational Meetings (handover) Week 4 Fully Operational	Green
		PROVIDE ROBUST STAFF SUPPORT AND DEBRIEFING: Clear pathways for escalation are to be developed once the 'Comms Hub' is operational, which is to be reinforced by NEWS 2 implementation. This is to be developed as part of the next stage of this project.	Red
		PROCESSES WHICH ENHANCE OWNERSHIP, ACCOUNTABILITY & LEADERSHIP: Following the 'Comms Hub' go live, this will be developed as part of the next stage of project.	Red
		USE OF CAREFLOW TECHNOLOGY: Implementation of Careflow technology is dependent upon the outcome of the issues with 'SYSTEM C' (the provider of VITALPAC) There is an agreement in principal from Southport and Formby CCG to allow the Trust access to GP clinical summaries to ascertain correct clinical diagnoses allowing appropriate treatment to be delivered. Information sharing agreement requires revision as this was based on community services and requires AED clerical support. Discussions with West Lancashire are currently at the preliminary stage.	Amber
		INCREASED COMMUNICATION FOR UNCERTAINTY / DYING: Implementation of joint working with Palliative Care Transform Team and Critical Care Outreach Team post Hub 'Go Live' is to be developed as part of the next stage of the project.	Red

Baseline Highlight Report for the 'Reducing Avoidable Mortality' Project – March 2018

PROJECT OBJECTIVE		STATUS UPDATE	Current Level of Completion
3. LEARNING CULTURE: Implement and embed a learning culture with regard to learning from deaths across the organisation by September 2018.		**IMPLEMENT STRUCTURED JUDGEMENT REVIEW:** Training has commenced; so far 8 clinicians trained in the method by 23/03/18 this will be 11. Departments ready to start: Orthopaedics and Critical Care. Datix Screening Tool ready to use, training for Junior Doctors being organised, plan to go live with screening tool as soon as training is delivered. Implement SJR – SJR Datix package ready to start, requires resolution of access issues with the IT department regarding the 'active desktop' unified password controller. Resolution expected within the next fortnight.	Amber
		MORTALITY OPERATIONAL GROUP (MOG): The first meeting 19/02/18, was cancelled due to administrative issues, the first meeting will therefore now take place on 09/04/18. To allow the April meeting to run operationally as originally planned reports will be discussed in advance.	Amber
		LINK RISK AND MORTALITY DATA: Mortality data and information from Risk including STEIS, SUI and selected DATIX reports will be discussed at MOG. The output will be in the form of the Lessons Learned Newsletter and the cascade of discussions and decisions to the departmental Mortality and Morbidity Meetings. Meetings between the Project Clinical Lead, Chris Goddard and Mandy Power have been agreed to discuss how this can be taken forward.	Amber
		QUALITY IMPROVEMENT & SUPPORT FOR MORTALITY & MORBIDITY: Discussion with lead for Audit and Clinical Effectiveness demonstrates that Clinical Audit Team already has significant Quality Improvement Training. Ongoing support for this can be accessed through the Innovation Agency, departmental M&M will be supported to engage in QI Projects, results of which will be reported to MOG.	Amber
		IMPLEMENTING LEARNING FROM EXCELLENCE: This is to be developed as part of the next stage of project.	Red
4. FUTURE CARE PLANNING: Implement care planning for those patients identified as approaching end of life (GSF) that encourages appropriate levels or intervention and enables communication with the patient and their families by April 2019		**UNIFIED DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (UDNACPR):** Implemented	Green
		ADVANCED CARE PLANNING: Model in place on the Frail and Elderly Short Stay Unit (FESSU), implemented by Dr Fraser Gordon. Next stage of project to review and implement across the health economy.	Amber
		ANTICIPATORY CLINICAL MANAGEMENT PLANNING: Improving with greater clinical awareness. To be developed as part of the next stage of project.	Red
		RAPID END OF LIFE TRANSFER: Already implemented, review and improvement is the next stage of the project.	Green
		ALTERNATIVE TO ADMISSION: To be developed as part of the next stage of project: involving Clinical Commissioning Group partners.	Red
		REDUCE LENGTH OF TIME BETWEEN MEDICALLY FIT FOR DISCHARGE (MOFD) & DISCHARGE FOR PATIENTS ALREADY GOLD STANDARD FRAMEWORK (GSF) REGISTERED: To be developed as part of the next stage of project.	Red

Baseline Highlight Report for the 'Reducing Avoidable Mortality' Project – March 2018

PROJECT OBJECTIVE		STATUS UPDATE	Current Level of Completion
5. INFORMATION: Produce one version of reporting on mortality by October 2018 that provides clear and consistent information to inform different groups of leaders and clinicians		**INCREASE DEPTH OF CORRECT CODING:** Trust commissioned coding reviews have significantly increased co-morbidity scores and tariff. As noted above HSMR for pnuemonia has dropped as a result of this work. It is expected that trust HSMR has reduced In line with this.	Amber
		UNDERSTAND & COMMUNICATE MORTALITY DATA: Mortality page on website is live with links to Bereavement Services and Board reports containing Mortality data. Guidance and support for Serious Incident Reviews to follow.	Amber
		ANALYSE & PRESENT RELEVANT DATA TO LOCAL DEPARTMENTS (SJR/MORTALITY RATES): MOG will review standardised mortality data together with local risk data and specialities specific mortality reports to evaluate these figures in the context of clinical pathways, this will be communicated to specialty mortality and morbidity meetings.	Amber
6. WORKFORCE: Establish the proposed workforce model to deliver agreed clinical outcomes which will include a tangible 24/7 Outreach Team by September 2018		**ESTABLISH A 24/7 OUTREACH TEAM (SENIOR ASSESSMENT & REVIEW):** Business case submitted, further information has been requested to establish clinical relevance. Matron for Critical Care, Joyce Jordan is currently developing this case further for resubmission including how this team will link with resusc officers and advanced nurse practitioners.	Amber
		EMBED FULL UTILISATION OF IMPLEMENTED SAFE STAFFING TOOLS: Awaiting project meeting to confirm required activity.	Amber
		INCREASE ACCESS TO SKILLS TRAINING: Education and Training have plans to increase the number of skills facilitators from one to three. Awaiting project meeting for confirmation of required activity.	Amber
		MANAGEMENT PRIORISITISATION OF STAFF TRAINING: Work place based mandatory training funded within within Intensive care for ITU skills, such as tracheostomy management and prone ventilation; this process could be modelled elsewhere.	Amber
		SEVEN DAY SERVICES: Trust's Seven Day Services project is to be fully scoped in April with the aim of "Implementing Seven Day Services by April 2020 in line with the four mandatory clinical standards."	Red

HIGHLIGHT REPORT

Committee/Group Meeting date:	Workforce Committee Meeting 22.03.2018
Lead:	Pauline Gibson

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

(Alert the Committee to areas of non-compliance or matters that need addressing urgently)

Medical Education

This remains an alert. Feedback via pulse checks will continue to be undertaken and results will be reported back to the Committee in April.

Doctors to be actively encouraged to increase attendance at planned education activities.

Workforce reporting

An additional unplanned visit by CQC on 7th March has highlighted an issue with the reporting of safe staffing levels. Whilst we are confident we were safely staffed, and can provide assurance that staffing levels are reviewed 3 times a day there are issues with how this is being recorded on the system. Report back to next Committee in April.

Staff Survey results

Latest results show that the Trust is rated below average on 25 out of 32 scales. Whilst there are some slight improvements, overall the results are at an unacceptable level. This requires concerted resource and effort to improve the engagement of our people. Agenda item for Board and full survey results to be circulated.

Sickness Absence

Sickness levels remain a concern and will undoubtedly be linked with the survey results. An Action plan has been developed by the Associate HR Director. Board have mandated that the Policy must be reviewed to bring in line with other local NHS organisations. Discussions are on-going. A date of the end of April has been issued for agreement in principle at this Committee and will be on Agenda for JNC in May.

ADVISE

(Detail here any areas of on-going monitoring where an update has been provided to the sub-committee AND any new developments that will need to be communicated or included in operational delivery)

Apprenticeships

Excellent progress has been made in securing a pipeline for the Apprenticeship schemes and the trust is not at risk of the apprenticeship levy expiring until July 2019. An Apprenticeship Steering Group, which has its first meeting in April, has been set up to ensure we proactively plan for future workforce requirements. This group will be chaired by the Associate Director of HR.

International Recruitment

This remains a national issue regarding shortage of certificates of sponsorship. Close monitoring is ongoing.

ASSURE	
(Detail here any areas of assurance that the committee has received)	
NAVAJO Excellent news to report that we have been successful in retaining our accreditation. Well done to all involved in providing evidence for the reassessment.	
New Risk identified at the meeting	None
Review of the Risk Register (Detail the risks on the committees risk register that were reviewed in the meeting, including scores C&L and current actions)	

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD
11th April 2018

Agenda Item	**TB087/18**	**Report Title**	**Monthly Safer Staffing Report**
Executive Lead	Gill Murphy Acting Director of Nursing Midwifery Therapies and Governance		
Lead Officer	Carol Fowler, Assistant Director of Nursing – Workforce		
Action Required *(Definitions below)*	X To Receive ☐ To Approve ☐ To Assure		For Note ☐ For Information

Key Messages and Recommendations

This monthly safe staffing report has reflected the guidance within the following:
National Quality Board (NQB) guidance November 2013/updated July 2016
Care Quality Commission
NHSI Safe staffing for adult inpatients in acute care December 2016
NICE 2014 – safe staffing for nursing in adult inpatient wards in acute hospitals

This report presents the safer staffing position for the month February 2018 and confirms compliance with the requirement to publish monthly planned and actual staffing levels for nursing, midwifery and care assistant staff.

The Trust Board is advised that the Trust continues to comply with the requirements to upload and publish the aggregated monthly average registered nursing and non-registered nursing staff data for inpatient ward areas. These can be viewed via the following hyperlink address on the Trust's web-page

http://www.southportandormskirk.nhs.uk/safe-staffing.asp

The data reported is summarised as follows:

The Trust's mandated monthly submission of staffing (headcount) levels to NHS Choices presented the following overall % fill rates of planned inpatient staffing levels against actual staffing levels for the month of February 2018 against the accepted national level of 90%:

- Trust overall 85.09%
- 79.87% Registered Nurses (RN) on days
- 81.03% Registered Nurses on nights
- 90.60% Care staff on days
- 97.56% Care staff on nights

- **Trust vacancy:**
- 11.81% (103.16wte) Registered Nurse vacancies at band 5 and above
- 10.46% (39.77 wte) Healthcare assistant vacancies band 2 and above.

Trust whole time equivalent (wte) funded establishment versus contracted:

	Funded WTE	Contracted WTE
Registered	852.82	761.13
Non-registered	377.04	342.33
Total	1229.86	1103.46

Whilst completing a 'deep dive' into safe staffing in A&E, it emerged that not all hours worked by registered and non-registered staff are captured on the electronic roster system. This would suggest that we are potentially under reporting the percentage fill rate, as this monthly data is pulled from the electronic roster. A full review has commenced and all wards and departments are being supported to ensure ALL hours worked are recorded on the electronic roster system, HealthRoster. The outcome of this review will be reported to the workforce committee in April and in turn to the Board in May 2018. This issue is seen as a potential risk and has been added to the risk register.

Strategic Objective(s)
(*The content provides evidence for the following Trust strategic objectives for 2017/18)*

☐ **SO1** Agree with partners a long term acute services strategy
X **SO2** Improve clinical outcomes and patient safety
☐ **SO3** Provide care within agreed financial limit
☐ **SO4** Deliver high quality, well-performing services
X **SO5** Ensure staff feel valued in a culture of open and honest communication
☐ **SO6** Establish a stable, compassionate leadership team

Governance *(the report supports a…..)*

X Statutory requirement
☐ Annual Business Plan Priority
☐ Linked to a Key Risk on BAF / HLRR Ref:
_____
☐ Service Change
☐ Best Practice
☐ Other List (Rationale)
_____

Impact *(is there an impact arising from the report on the following?)*

X Quality	X Risk
☐ Finance	☐ Compliance
X Workforce	☐ Legal
☐ Equality	
Equality Impact Assessment *(If there* is *an impact on E&D, an Equality Impact* Assessment *must*	☐ Strategy ☐ Policy ☐ Service Change

accompany the report)	
Next Steps *(List the required actions following agreement by Board/Committee/Group)*	
To note this report	
Previously Presented at:	
☐ Audit Committee ☐ Finance Performance & Investment Committee ☐ Quality & Safety Committee	☐ Workforce & OD Committee ☐ Mortality Assurance & Clinical Improvement Committee

1. Aim of the Report

1.1 To inform the Board of the latest position in relation to Nursing and Midwifery staffing in line with the expectations of NHS England NQB and Care Quality Commission.

2. Background

The National Quality Board updated its guidance for provider Trusts in 2016, which set out revised responsibilities and accountabilities for Trust Boards for ensuring safe, sustainable and productive nursing and midwifery staffing levels. Trust Boards are also responsible for ensuring proactive, robust and consistent approaches to measurement and continuous improvement, including the use of a local quality framework for staffing that will support safe, effective, caring, responsive and well-led care.

This report presents the safer staffing position for the month February 2018 and confirms compliance with the requirement to publish monthly planned and actual staffing levels for nursing, midwifery and care assistant staff.

2.1 Overall Fill Rates

The February 2018 submission indicates a trust fill rate for registered nurses on days 79.87 %, non –registered nurses days 90.60%. Fill rate of registered nurses nights 81.03% and 97.56% for Non-registered nurses nights. Where the overall fill rates for care staff is higher than 100% the figures are raised by both the employment of additional 'specials' (i.e. 1 patient to 1 care staff member) to protect vulnerable patients and the wards compensating for a shortfall in the registered nurse headcount on a shift by employing a non –registered nurse when efforts to backfill with a bank and/or agency registered nurse or the permanent registered nurses being offered extra time or overtime have proved unsuccessful.

Whilst completing a 'deep dive' into safe staffing in A&E, it emerged that not all hours worked by registered and non-registered staff are captured on the electronic roster system. This would suggest that we are potentially under reporting the percentage fill rate, as this monthly data is pulled from the electronic roster. A full review has commenced and all wards and departments are being supported to ensure ALL hours worked are recorded on the electronic roster system, HealthRoster. The outcome of this review will be reported to the workforce committee in April and in turn to the Board in May 2018. This issue is seen as a potential risk and has been added to the risk register.

3. Recruitment and Retention

- The recruitment and retention of nursing and midwifery staff remains a priority for the Trust and is an on-going challenge. Trust workforce data shows there were 11.81% Registered nurse Vacancies (103.16WTE) and 10.46% non-registered nurse vacancies (39.77WTE) at the end of February 2018 across the Clinical Business Units.

Nurse staffing reports as a high risk on the Trust Risk Register and is reviewed monthly.
In terms of midwifery staff and children's services all Registered posts are filled.

Recruiting and retaining the nursing and midwifery workforce continues to be an area of increased focus.

In terms of strategic context with nursing staffing, the future supply of registered adult nurses remains the primary concern for the Trust's Chief Nurse and many other Chief Nurses across the Cheshire and Mersey region.

Nationally uptake is below 50% for the uptake of degree nurse training Jan –March 2018 – figures reflective for the local region are awaited.

Age profiling is supporting knowledge of an ageing registered and non- registered workforce, with many still having the option to retire at 55yrs of age. This is a risk to the local health economy. Trust workforce age profiling for nursing is currently being completed as part of the profiling for the North of England within the North of England Workforce Group.

Apprenticeship Levy:

Trust Apprenticeship Policy ratified and supports delivery against the Apprenticeship Delivery Action plan. Development of a recruitment strategy and process to make apprenticeships accessible to all relevant staff and to consider apprenticeships for vacant/upcoming vacancies is a trust focus. Supportive of this agenda is the commencement of the Trusts Apprenticeship steering group.

The trusts impending Bi-annual staffing review in April 2018 will further review and identify current establishments and new role opportunities going forward that can be supported through the apprenticeship levy. Open events have been facilitated at the trusts education centres on 30th January 2018 and further on 1st March 2018 where staff can meet colleges, universities and independent providers to find out how apprenticeships can develop individuals and teams.

3.1 The Recruitment of Bank staff via NHSP

Recruitment of bank Health Care Assistants (HCA) is on-going, advertising every two months to recruit to the nurse bank and is delivering continued improvements.

Monthly operational meetings with NHSP continue with key leads from clinical business units attending to assure business unit staffing requirements are actioned.

15 new Registered Nurses started on NHSP in February, 40% have picked up a shift.

4. Student Nurse Recruitment Update

The Trust attended the following careers fairs during February 2018:

RCN recruitment event Manchester Feb 2018 – inviting 7 conditional offers of employment

LJMU careers fair 20th Feb 2018

March 19th was the last Trust local recruitment event for adult nursing, with 12 nurses recruited.

On-going Recruitment of Registered Nursing Staff

The Trust has representation on the Cheshire and Merseyside Director of Nursing workforce recruitment and retention collaborative program. The program awaits appointment of a Director of Nursing to deliver this program going forward – advert remains out to recruitment currently.

The Trusts Assistant Director of Nursing (Workforce) represented the Trust on 13th December 2017 at the North Region Workforce Think Tank/Summit - "Care in the North: Our Future Our Workforce" – Chaired by Margaret Kitching, Chief Nurse North, NHS England/NHS Improvement. This meeting has formulated local, regional and national actions to support the next steps. Following this event Trust representation continues to deliver on the work regionally via the North of England Nursing and Midwifery workforce group.

The Trusts Chief Nursing Officer conference supported an additional conference: Perceptions of Nursing; Nurse Promoters Conference

5. Staffing Related Reported Incidents

38 staffing incidents were reported in February 2018, of which 23 highlighted insufficient nurses/midwives and a further 7 were shortage of doctors. The highest number of insufficient nurse/midwife incidents were reported within the Sexual Health service, at the May Logan Centre, with incidents highlighting patients being turned away from the service due to capacity being exceeded.

Ward 14B reported the second highest number of nurse shortages, with concerns raised that nursing numbers did not meet the acuity of patients on the ward. The same ward also reported 2 incidents of doctor shortages.

The Gynaecology ward, Spinal Injuries Unit and Ward 10B all reported two incidents of insufficient nurses in February, with the Gynaecology ward highlighting insufficient nurses to meet the number of patients in escalation beds.

Incidents were attributable to short term nurse sickness leaving areas challenged against being able to accommodate the acuity and volume of patients.
Senior Nurses continue to contribute to additional temporary cover across the Trust to assure safe staffing is reviewed and supported against patient flow challenges.

Ward matrons and Ward leaders clinical input remains considerable and necessary in supporting the safe staffing of each ward across the Trust sites. These clinical hours are not routinely captured on either HealthRoster or the Unify data and will form part of the review described above.

6. Inpatients experiencing moderate harm or above in January 2018

There was one Hospital Acquired Pressure Ulcer grade 3 reported in February, on ward 14B, and also one hospital acquired infection on 14B. In addition, there was an incident highlighting poor quality of care and deterioration for a patient on EAU, this incident has been reported to StEIS. These incidents are being investigated as part of the investigation process across the trust.

7. NHS Improvement (NHSI) Safer Staffing Guidance

NHSI visited Southport site as agreed on 12th/13th March 2018 to commence their workforce review. Further visits are planned over the next few months.

Summary

The report has presented information on staffing headcount fill rates on inpatient wards for the month of February 2018 and provided an update regarding on-going nursing and midwifery workforce recruitment activities to address vacancies.

The Draft health and care workforce strategy for England to 2027 is out for consultation. The consultation will lead to a workforce strategy for the health service to be published in July 2018 – the trust is participating in this consultation.

The Board is asked to note the Trust monthly safe staffing report. The format and content is being updated in order to strengthen the report and clearly meet the recommendations within the NQB, NICE. A revised reporting format is expected to be delivered to Board in May 2018.

Carol Fowler
Assistant Director of Nursing - Workforce

HIGHLIGHT REPORT

Committee/Group Meeting date:	Finance, Performance & Investment Committee 26 March 2018
Lead:	Jim Birrell, Committee Chair

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

(Alert the Committee to areas of non-compliance or matters that need addressing urgently)

- Discussions are continuing with the Staff Side regarding changes to the Trust's sickness absence policy.
- The identified 2018/19 CIP is approximately £4m, (2.5%); work is ongoing to identify further schemes to achieve £7m target.
- As anticipated, the Trust missed its January 62 day cancer target, partly down to diagnostic-related issues.
- There have been six recent instances of information governance breaches that require reporting to the Information Commissioner's Office. Training is taking place to minimise the possibility of further breaches.
- The Trust is experiencing difficulties with the level of support provided for its patient management system software, delaying implementation of some packages, including Order-Comms. Discussions on ways of improving the situation are taking place with the main supplier.

ADVISE

(Detail here any areas of on-going monitoring where an update has been provided to the sub-committee AND any new developments that will need to be communicated or included in operational delivery)

- Lancashire Care NHS Foundation Trust has been unable to obtain funding for out of hours CAMHS cover so alternative arrangements will be considered
- The Expert Determination process relating to the Trust's contractual disputes has commenced
- Financial performance in February is consistent with trends recorded in recent months. There is growing confidence that the Trust will deliver its revised year-end forecast of a £29.2m deficit, although this figure does exclude the outcome of the Expert Determination process or the application of sanctions.
- Based on the findings from an initial review, a more detailed assessment is be undertaken of the Trust's average length of stay
- Despite significant pressure, performance within A&E has been relatively consistent in March to date. The Trust remains on trajectory to hit 90% by June.
- The Executive Team will review the process for identifying and reporting high and extreme risks

ASSURE

(Detail here any areas of assurance that the committee has received)

- The reallocation of capital monies will enable the Trust to fully utilise its 2016/17 capital allocation; the 2018/19 programme will be adjusted to reflect the agreed 2017/18 changes
- The Trust has agreed to work with the NHSI Model Hospital Team on identifying potential productivity improvements.

New Risks identified at the meeting

No new risks were identified.

Review of the Risk Register

HIGHLIGHT REPORT

Committee/Group Meeting date:	Charitable Fund Committee 22.03.2018
Lead:	Richard Fraser, Chairman

KEY ITEMS DISCUSSED AT THE MEETING

- Potential joint Fundraising/Volunteers Manager.
- Investment policy.
- Utilisation of cash balances.
- Expenditure requests
- Transfer of funds to Lancashire Care charitable fund.
- Progress on fund rationalisation.
- Revised authorisation limits and terms of reference.

ALERT

(Alert the Committee to areas of non-compliance or matters that need addressing urgently)

Issue	Action
Lack of a fundraising post	Chief Executive to decide on whether a joint role of Fundraiser/Volunteer Manager should be advertised.

ADVISE

(Detail here any areas of on-going monitoring where an update has been provided to the sub-committee AND any new developments that will need to be communicated or included in operational delivery)

Issue	Action
Fund rationalisation	Continued progress with the number of funds reducing to 65 (down from 88 at the beginning of the year). Agreed to transfer 2 funds to Lancashire Care charitable fund.

ASSURE

(Detail here any areas of assurance that the committee has received)

Issue	Action
Revised terms of reference	Committee agreed to the change of frequency – minimum of 3 meetings per annum. Requires ratification by the Trust Board.
Utilisation of funds	The value of committed expenditure at £239k demonstrates that the Committee is ensuring that monies are spent for the benefits of patients and staff.
Investment policy	No changes made to Investment policy. However, a check was required to ensure that in the ethical constraints section that none of the portfolio was invested in no win, no fee medical claims companies.

Authorisation levels	Subject to Board approval it was agreed to increase the limits for the Director of Finance to £5,000 and for the Chair/Committee to £20,000. This has been built into the scheme of reservation and delegation.
New Risk identified at the meeting	Not applicable as the Charity is a separate entity to the Trust.
Review of the Risk Register (Detail the risks on the committees risk register that were reviewed in the meeting, including scores C&L and current actions)	
Not applicable	

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

11th April 2018

Agenda Item	**TB089/18**	**Report Title**	**Charitable Fund Committee Terms of Reference**
Executive Lead	Steve Shanahan, Director of Finance		
Lead Officer	Mark Wilson, Assistant Director of Finance		
Action Required *(Definitions below)*	☐ To Receive ✓ To Approve ☐ To Assure		☐ To Note ☐ For Information

Key Messages and Recommendations

Key messages:

- Minor change to bring into line with other NHS organisations that the frequency of meetings per annum is no less than three.
- The change was agreed at Charitable Fund Committee on 22nd March. However, the Committee cannot approve its own terms of reference, therefore this change requires Board approval.

Recommendations:

- The Board is recommended to approve the amended terms of reference for the Charitable Fund Committee.

Strategic Objective(s)
(*The content provides evidence for the following Trust strategic objectives for 2017/18)*

- ☐ **SO1** Agree with partners a long term acute services strategy
- ☐ **SO2** Improve clinical outcomes and patient safety
- ✓ **SO3** Provide care within agreed financial limit
- ✓ **SO4** Deliver high quality, well-performing services
- ☐ **SO5** Ensure staff feel valued in a culture of open and honest communication
- ☐ **SO6** Establish a stable, compassionate leadership team

Governance *(the report supports a…..)*

- ✓ Statutory requirement
- ☐ Annual Business Plan Priority
- ☐ Linked to a Key Risk on BAF / HLRR Ref: _____
- ☐ Service Change
- ☐ Best Practice

☐ Other List (Rationale) _____	
Impact *(is there an impact arising from the report on the following?)*	
✓ Quality ✓ Finance ☐ Workforce ☐ Equality	☐ Risk ☐ Compliance ☐ Legal
Equality Impact Assessment *(If there* is *an impact on E&D, an Equality Impact* Assessment *must accompany the report)*	☐ Strategy ☐ Policy ☐ Service Change
Next Steps *(List the required actions following agreement by Board/Committee/Group)*	
Previously Presented at:	
☐ Audit Committee ☐ Finance Performance & Investment Committee ☐ Quality & Safety Committee	☐ Workforce & OD Committee ☐ Mortality Assurance & Clinical Improvement Committee

GUIDE TO ACTIONS REQUIRED *(TO BE REMOVED BEFORE ISSUE)*:

Approve: To formally agree the receipt of a report and its recommendations OR a particular course of action

Receive: To discuss in depth a report, noting its implications for the Board or Trust without needing to formally approve

Note: For the intelligence of the Board without the in-depth discussion as above

Assure: To apprise the Board that controls and assurances are in place

For Information: Literally, to inform the Board

Southport and Ormskirk Hospital NHS Trust
CHARITABLE FUND
Charity registration number: 1049227

TERMS OF REFERENCE FOR THE CHARITABLE FUNDS COMMITTEE

1 Authority

1.1 Southport & Ormskirk Hospital NHS Trust are appointed as the sole Corporate Trustee of The Southport & Ormskirk NHS Trust Charitable Fund (Charity No 1049227). The Board of Directors have responsibility for ensuring that the Trust discharges its responsibilities as Corporate Trustee.

1.2 The Board hereby resolves to establish a Committee of the Trust to be known as the Charitable Funds Committee. The Board have the power to appoint and delegate functions in respect of charitable funds pursuant to section 11 of the Trustee Act 2000.

1.3 The Charitable Funds Committee has the delegated authority to:

a) seek any information it requires from any employee of the Trust in order to perform its duties as set out below
b) obtain, within the limits set out in the Trust Scheme of Delegation, outside professional advice on any matter within its terms of reference
c) call any employee to be questioned at a meeting of the committee as and when required.

1.4 Approved minutes of the committee are circulated to the Board for information at the first formal Board meeting following approval. The Chair of the Committee escalates items to the Board as appropriate

1.5 The committee operates within the Trust Standing Orders and Standing Financial Instructions.

2 Purpose

The committee is established to manage the charitable fund on behalf of the Trustees in line with appropriate legislation, Charity Commission requirements and the Trust Charitable Funds Governance Procedures.

3 Principal Duties

In order to achieve its purpose the committee will:

a) Ensure that the charity is managed and administered in accordance with the requirements of the Charities Act 2006 and Charities Act 2011 (or any modification of that Act).
b) To agree appropriate limits, policies and procedures to ensure the effective distribution and management of the charitable funds.
c) To make decisions involving the sound investment of charitable funds in a way which both preserves their capital value and produces a proper return consistent with prudent investment and ensuring compliance with:
    - Trustee Act 2000
    - The Charities Act 2006 & 2011
    - Charitable Fund Governance Procedures

d) To receive reports for the ratification of investment decisions and action taken through delegated powers.
e) To recommend a scheme of delegation and authorisation limits to the Board of Directors as Corporate Trustee.
f) To monitor expenditure in line with the delegated authority.
g) To approve all individual charitable fund expenditure within appropriate limits defined by the Scheme of Delegation.
h) To ensure funding decisions are appropriate and consistent with the purpose of the fund, the donor's wishes and the Trust's objectives and values.
i) To approve the Annual Report and Annual Accounts of the Charity.

3 Constitution

3.1 Chair

The Chair of the Finance, Performance & Investment Committee will also act as Chair of the Charitable Fund Committee. In the absence of the Chair a decision will be taken in advance of the meeting as to who will chair that particular meeting.

3.2 Membership

The following will be members of the committee:

- Non Executive Directors who are members of the Finance, Performance & Investment Committee.
- Director of Finance.

In attendance:

- Assistant Director of Finance.
- Deputy Financial Accountant.

Only members of the committee have the right to attend committee meetings and have a single vote for any decisions to be taken by the committee. However, other officers of the Trust may be invited to attend all or part of any meeting as and when appropriate and necessary.

Each member is required to nominate a deputy to attend in their absence.

All members are required to attend 75% of meetings held.

3.3 Quorum

A quorum will be no less than three members. In order for the decisions of the committee to be valid the meeting must be quorate.

3.4 Frequency of meetings

The Committee will meet no less than three times a year.

3.5 Organisation

The minutes of Charitable Funds Committee meetings shall be formally submitted to the Board. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board, or require executive action.

The Director of Finance will prepare the annual report and accounts in line with the Charity Commission requirements, which shall be received by the Charitable Funds Committee for consideration before submission to the Board of Directors as Corporate Trustee for approval.

The PA to the Director of Finance shall provide secretarial support to the committee. The agenda for the meeting shall be drawn up with the Chair of the committee. The agenda and papers for the meeting shall be distributed 7 days in advance of the meeting.

3.6 Review

The Terms of Reference shall be reviewed annually or in light of changes in practice or legislation. This shall include a review by the committee of its own performance.

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

11 April 2018

Agenda Item	**TB090/18**	**Report Title**	**Emergency Department Performance Report**
Executive Lead	Therese Patten Chief Operating Officer		
Lead Officer	Therese Patten Chief Operating Officer		
Action Required *(Definitions below)*	X To Receive ☐ To Approve ☐ To Assure	☐ For Note ☐ For Information	

Key Messages and Recommendations

There are several factors affecting the delivery of the 4 hour access target

The Committee to note

- There is multi agency support in addressing flow
- Additional funding has been granted to address some of the estate issues including the delivery of a portacabin to facilitate a Clinical Decision Unit and funding to expand the ED
- As part of our work with EY there are several work streams which are now underway to address the components which influence the delivery of the access target

Twice daily meetings/communication with our partners to ensure clear lines of responsibility and actions for the delays

Strategic Objective(s)
(*The content provides evidence for the following Trust strategic objectives for 2017/18)*

☐ **SO1** Agree with partners a long term acute services strategy
X **SO2** Improve clinical outcomes and patient safety
☐ **SO3** Provide care within agreed financial limit
X **SO4** Deliver high quality, well-performing services
☐ **SO5** Ensure staff feel valued in a culture of open and honest communication
☐ **SO6** Establish a stable, compassionate leadership team

Governance *(the report supports a…..)*

☐ Statutory requirement
☐ Annual Business Plan Priority
X Linked to a Key Risk on BAF / HLRR Ref: _____
☐ Service Change
☐ Best Practice
☐ Other List (Rationale) _____

Impact *(is there an impact arising from the report on the following?)*

X Quality ☐ Finance ☐ Workforce ☐ Equality	☐ Risk X Compliance ☐ Legal
Equality Impact Assessment *(If there* is *an impact on E&D, an Equality Impact* Assessment *must accompany the report)*	☐ Strategy ☐ Policy ☐ Service Change
Next Steps *(List the required actions following agreement by Board/Committee/Group)*	
Previously Presented at:	
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Southport and Ormskirk Hospital NHS Trust

Performance Review January – February 2018

1. Attendances by hour of day
2. A&E performance
3. Breach Reasons
4. 12 Hour Breach Performance
5. Admissions
6. Outliers
7. Discharges (hourly by day)
8. Length of Stay
9. Stranded Patients & Super Stranded
10. Medically Optimised Patients
11. Delayed Transfers of Care Patients
12. Summary of Actions

1 Introduction

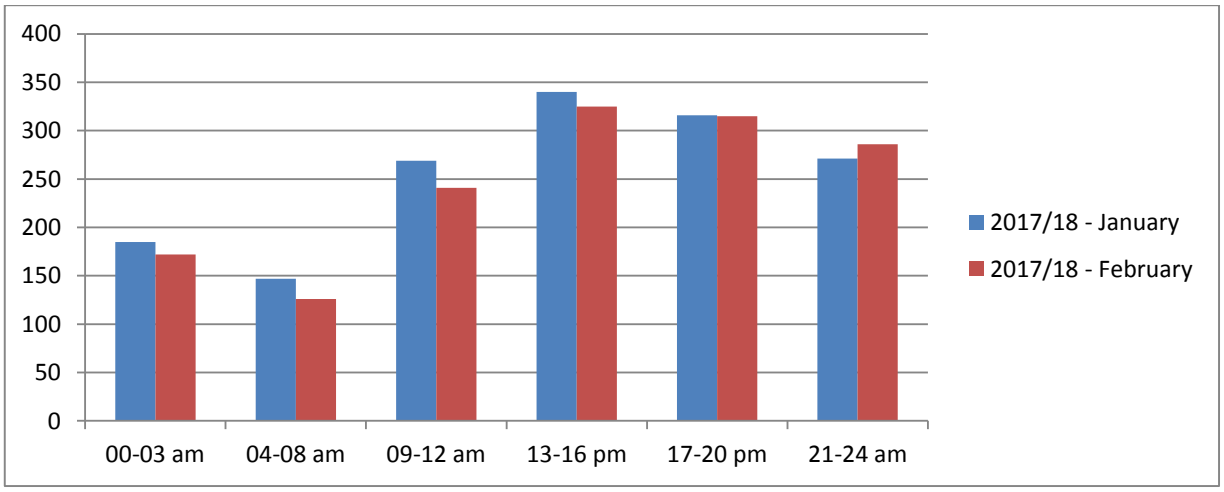
The report reflects the key elements which impact on the delivery of the 4 hour access target between the months of January and February. It should be noted that that the data is a reflection of the Southport site unless clearly stated otherwise.

Pressures in the system continued throughout February as in previous months, however the number of 12 hour breaches was limited to a particularly challenging weekend when the rest of the region also had significant difficulties although ward reconfigurations saw the closure of E ward, G ward continues to take medical outliers to support demand. Most elective work was significantly reduced or cancelled to manage demand although no cancers or urgent surgery were cancelled for bed pressures

2 Attendances by Hour of Day

February saw a slight drop in attendances throughout the day and into late evening compared to January but a peak later in the evening and into the night of ambulance arrivals was consistent. This caused significant issues with overcrowding and patients being bedded in the corridor due to lack of capacity in the department and the unavailability of beds on either Trust site.

Table 1 Attendances by Hour January to February Comparison



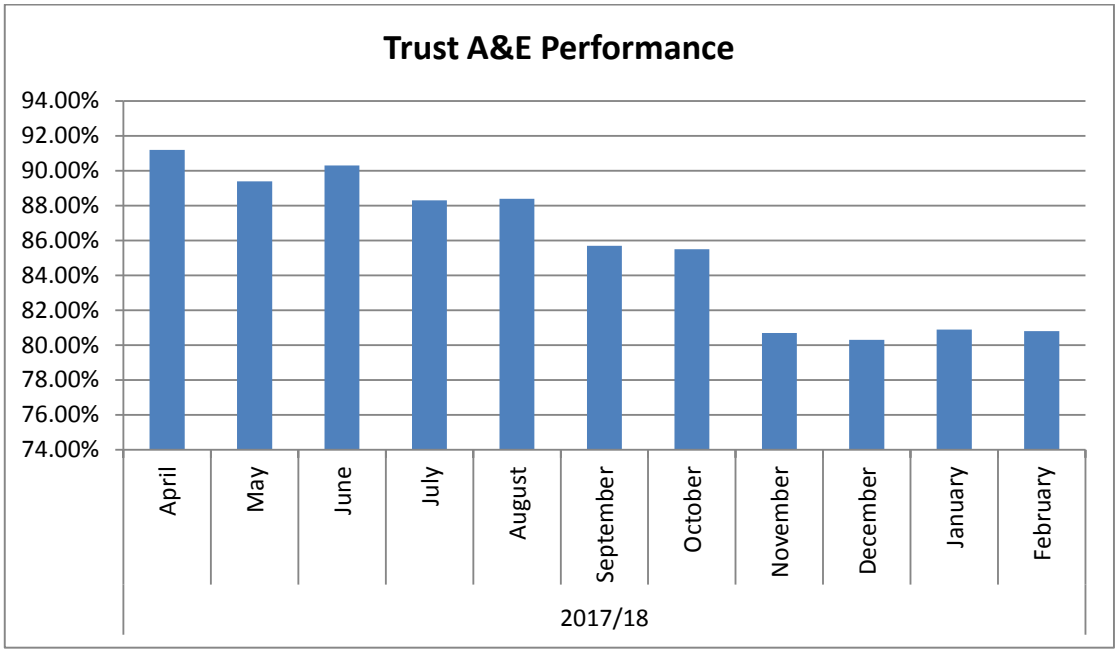
3 A&E Performance

There has been a steady downward trend on the performance since September. As reported at the last Board in partnership with EY and through their analysis of the root cause of problems, the Trust is implementing actions for recovery of performance. There is new capital funding to expand the department in addition to the Clinical Decisions Unit (in the form of a modular unit) which will be functioning from April 2018.

The Tables below are a summary of the overall performance between April 2017 and February 2018 for the both sites. The overall performance has remained just above 80% for the last 4 months.

Table 2a and Table 2b A& E Performance

Month	April	May	June	July	August	September	October	November	December	January	February
2017/18	91.20%	89.40%	90.30%	88.30%	88.40%	85.70%	85.50%	80.70%	80.30%	80.90%	80.80%



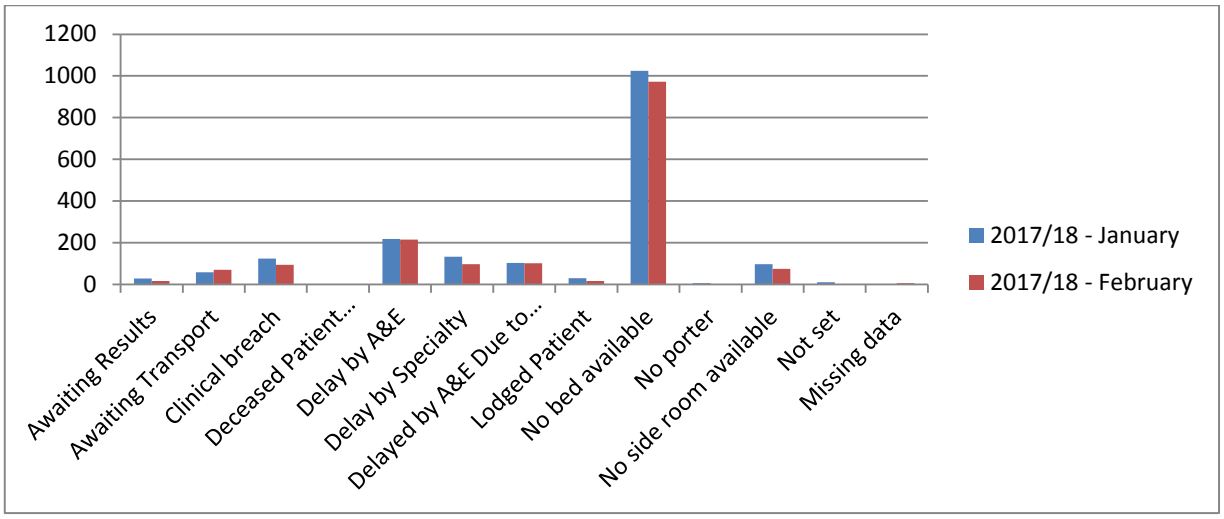
4 Breaches Southport January- February Comparison

The majority of the breach reasons remain due to the lack of beds available in a timely manner which also impacts on the ability to assess patients in the department as it remains over crowded.

Despite the overall performance reaching a plateau the Trust (SDGH site) has seen a reduction in breaches overall from a total of 1813 in January to 1644 in February and the reasons for breaches is set out below. ** The reason Trust performance plateaued is due to the West Lancs Walk in Centre on the Ormskirk Site having 33 more breaches but 544 less attendances and when amalgamated into the Trust figures the overall performance does not change. ** 28 days in February.*

Plans are being drawn up as part of the patient flow work programme to avoid unnecessary breaches particularly those which breach within an hour of leaving the department and the non-admitted breaches.

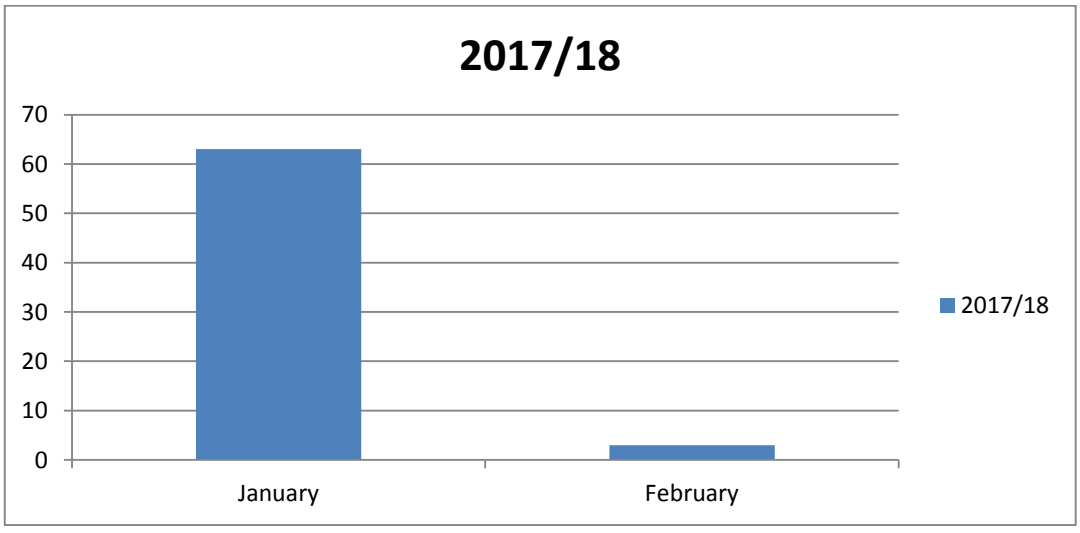
Table 3 Reason for breaches



5 12 Hour Breaches

The number of 12 hour breaches dropped significantly in February compared to previous months On February 5th 2018 the Trust implemented a Command and Control system to manage patient flow across both sites. The breaches below were at the beginning of the month. The senior "grip" ensured no further breaches despite significant challenges not just within the Trust but within the region.

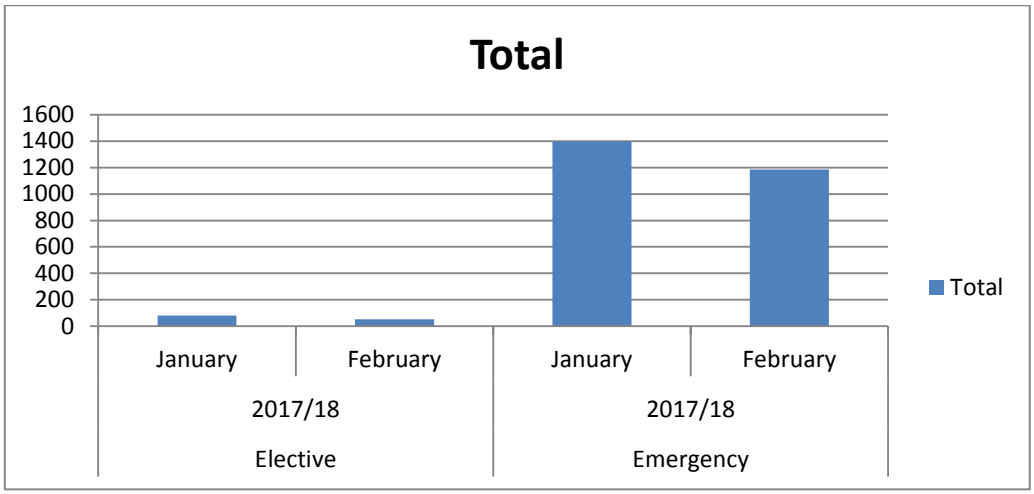
Table 4 12 hour breaches January –February



6 Admissions

February has seen a slight decrease in emergency admissions by just over 200, which as per the previous months' trend is due to a concerted effort to ambulate more patient however also as in previous months this is often bedded and used as escalation.

Table 5 Admission Trends

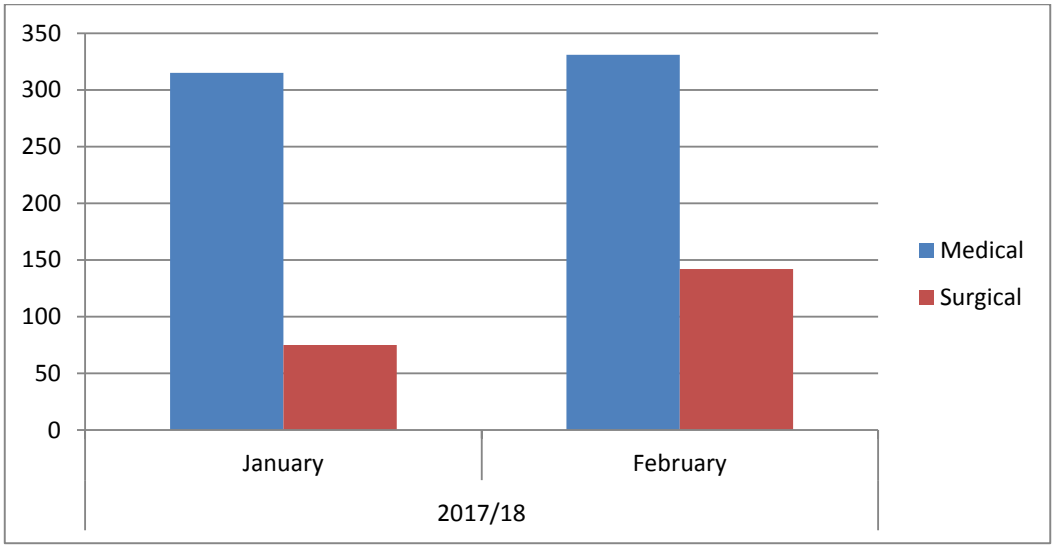


7 Outliers

Outliers continue to be relied upon in order to manage flow resulting in patients not in the right specialty beds. We saw a significant change between January and February within the surgical specialties, with the numbers almost doubling, medicine also saw an increase in its outliers.

While not formally recorded electronically, escalated areas continue to be significant at times up to 10% of the total bed base and averaging daily around 7%; a reflection of the continuous pressure the Trust is under.

Table 6 Outliers Medical and Surgical Specialties



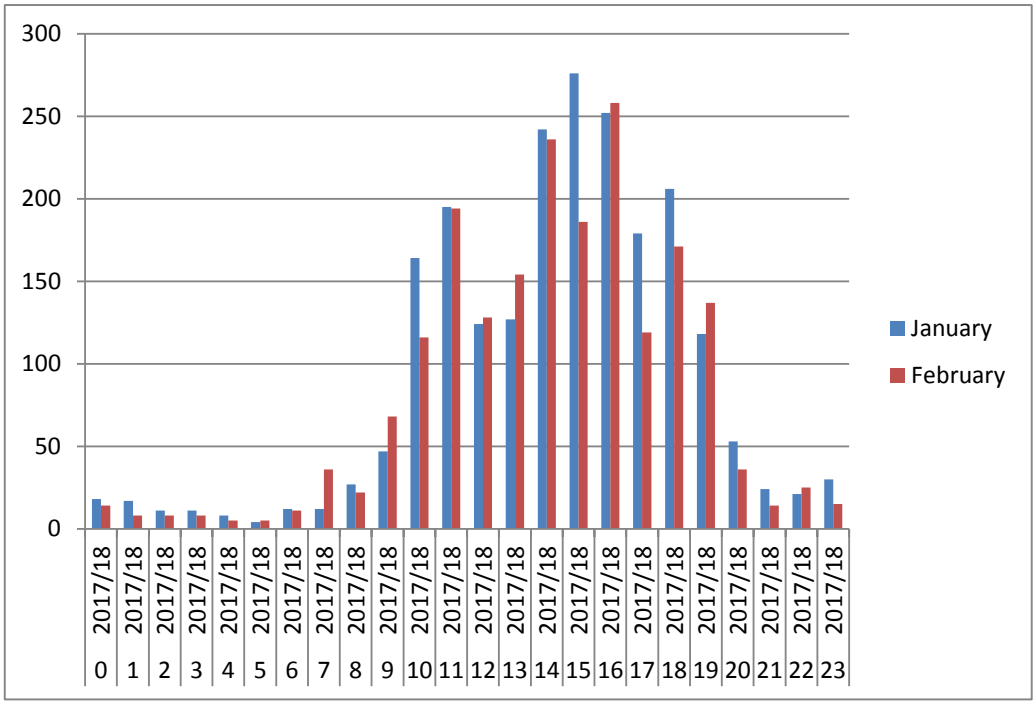
8 Hourly Discharges

Daily discharges as per previous months' continue to trend late afternoon and early evening, too late for the admissions and part of the cause for the overcrowded ED, which in turn impacts on breaches.

The patient flow work stream on SAFER has a specific focus to move discharges to earlier in the day. The Trust does not now have a substantive discharge lounge, the previous space on 7b is escalated, which exacerbates the issues. While temporary arrangements are made in various places when capacity allows, the senior nursing and management teams are working towards finding a permanent solution.

It must also be noted that data recording is not contemporaneous and relies heavily on the ward clerks who are a limited resource. The longer term solution of an electronic flow system within our current Medway system is being looked at.

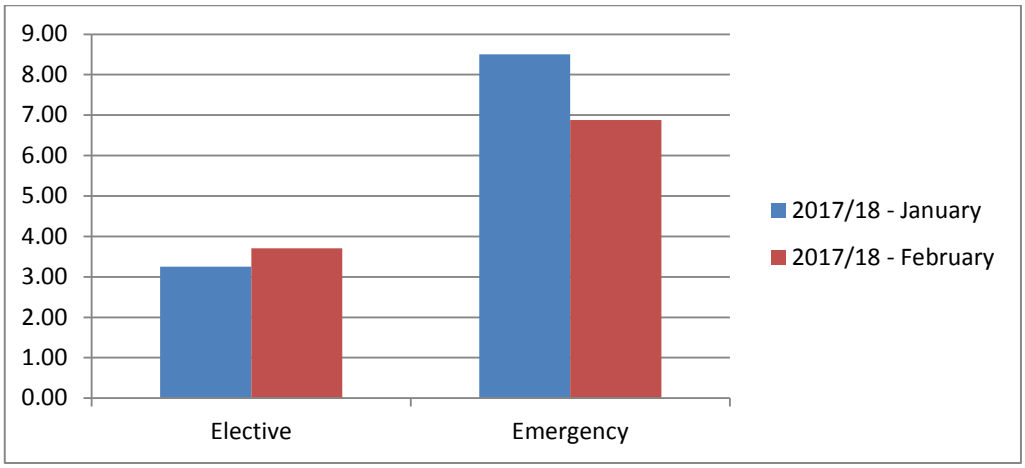
Table 7 Hourly Discharges



9 Length of stay

There was an improvement in the length of stay of emergency arrivals compared to January. Elective has increased slightly but a review of the data identified that one particular patient had an excess length of stay due to significant complications.

Table 8 Length of Stay Elective & Emergency

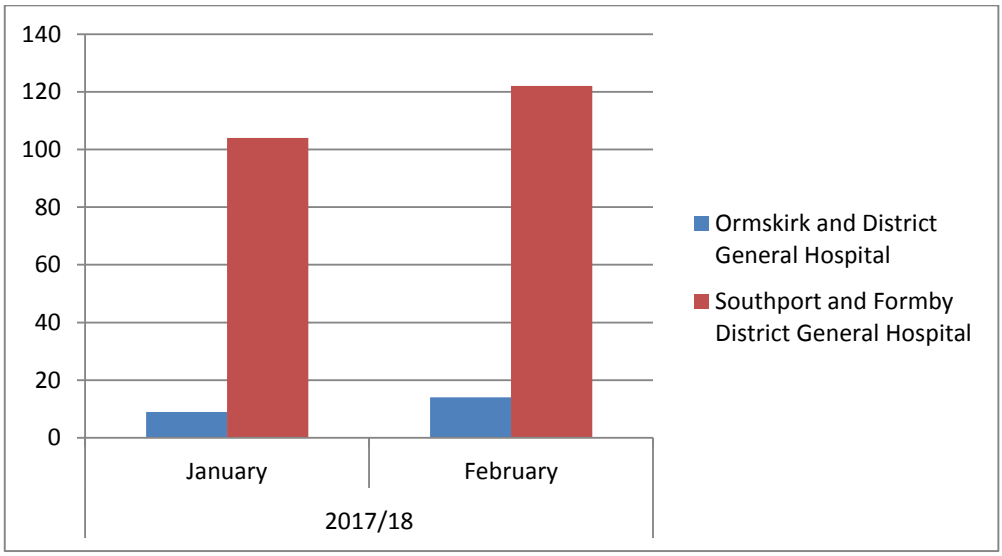


10 Super Stranded Patients (21 days plus)

In line with new national reporting requirements the Trust is expected to report on patients whose length of stay exceeds 21 days. Data for January and February shows and increase across both sites. Work continues with our partners to resolve these delays and it is anticipated as SAFER is rolled out across the hospital the potential to reduce unnecessary delays and bring the overall figure down from its current position. This will be a significant challenge for the Trust as the percentage averaged over 6 weeks of stranded patients is 54.7% and super stranded is 20.69%. We are tackling this also through our Patient Flow work streams.

The Trust is working with our CCG and Local Authority system wide leaders on practical improvements to be launched from April 2018. This includes further implementation of the ICRAS team (Integrated Community Reablement and Assessment Service) and creating a cohesive multi-disciplinary discharge team within the Trust to support the expedition of delayed discharges and the reduction of stranded patients. This will ensure that the Trust and its partners delivery against the national expectations.

Table 9a Super Stranded Patients

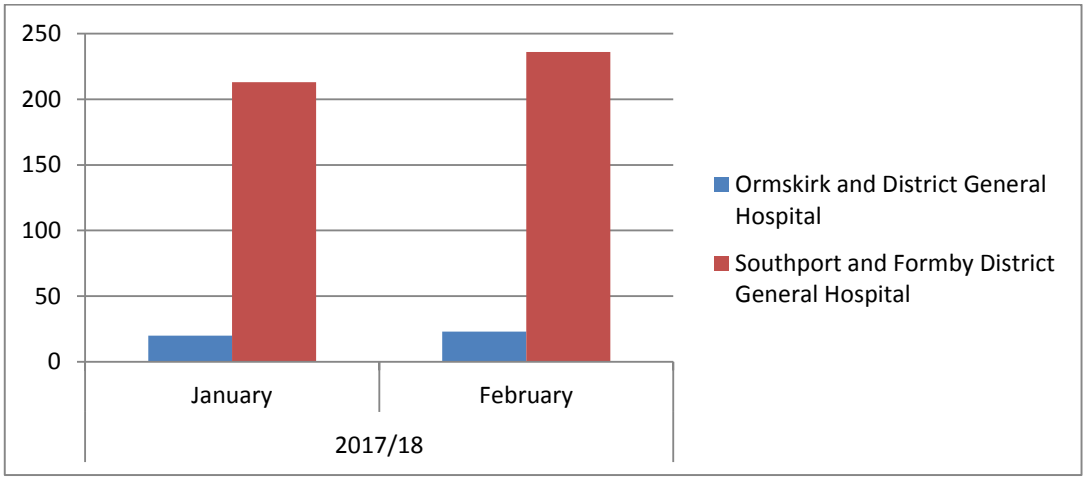


11 Stranded Patients (7 - 20 days)

Stranded patients continue to increase within February despite it being a shorter month.

In addition to the work we are undertaking (as defined above) we are working with our Local Authority, CCGs and other Community partners on a twice daily review of current delays. Every morning the multi agencies work together on the agreed list set clear actions to be reported at a further meeting in the afternoon with reasons for lack of progress which in turn will be escalated.

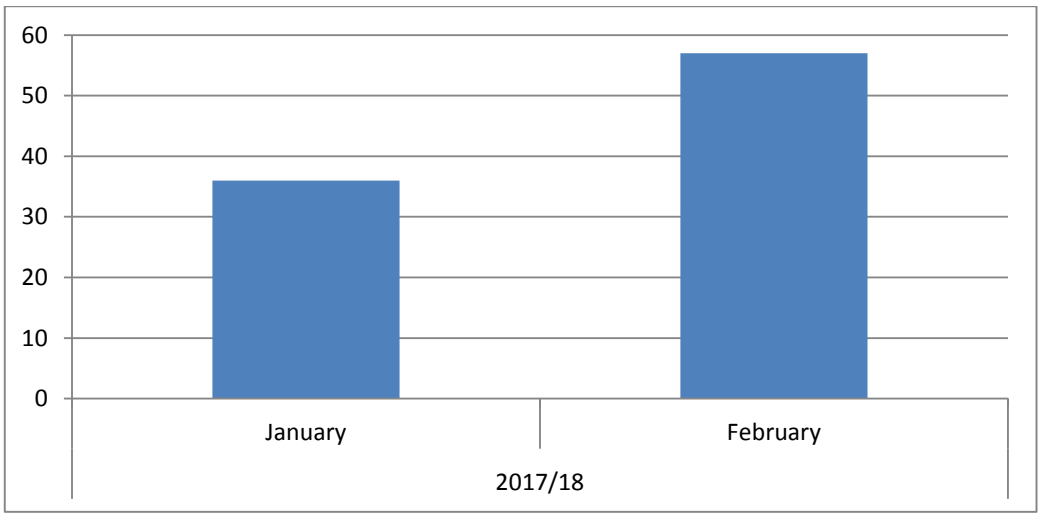
Table 9b Stranded Patients



10 Medically Optimised for Discharge (MOfD) Patients

MOfD increased in February despite dropping in January. Most of our partners pulled out from undertaking the daily ward rounds due to lack of capacity within their teams. Community capacity – packages of care and support for home continues to be pressures resulting in an increase in the number of patients. The Trust is waiting for approval to invest and recruit to a multi-disciplinary Integrated Discharge Team which will support expediting discharges.

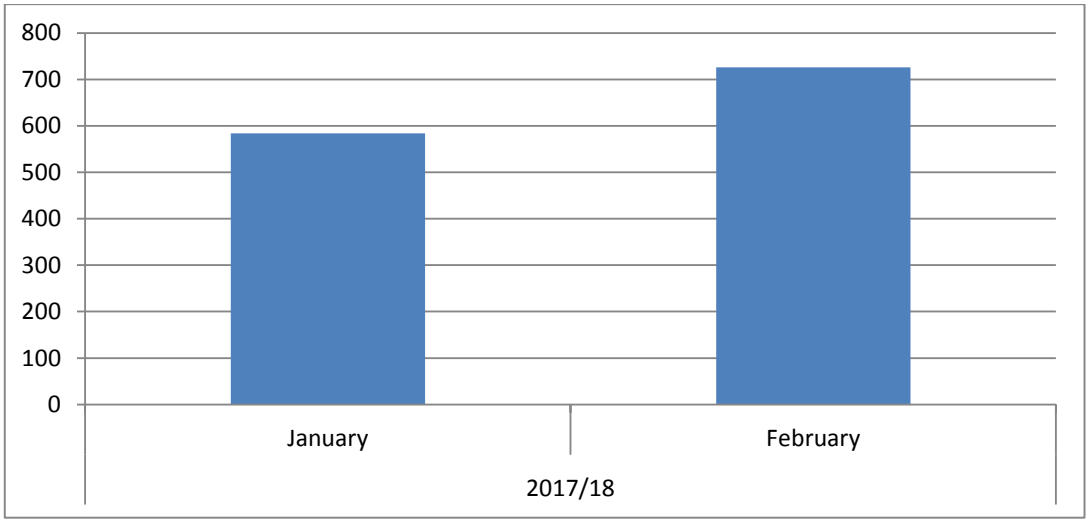
Table 10 January – February Comparison



11 Delayed Transfers of Care DToCs

Whilst MOfD patients have increased on the previous month, DTOCs also saw an increase in February. The plans and actions noted above will support a reduction through better control and monitoring.

Table 11 DToC December – January



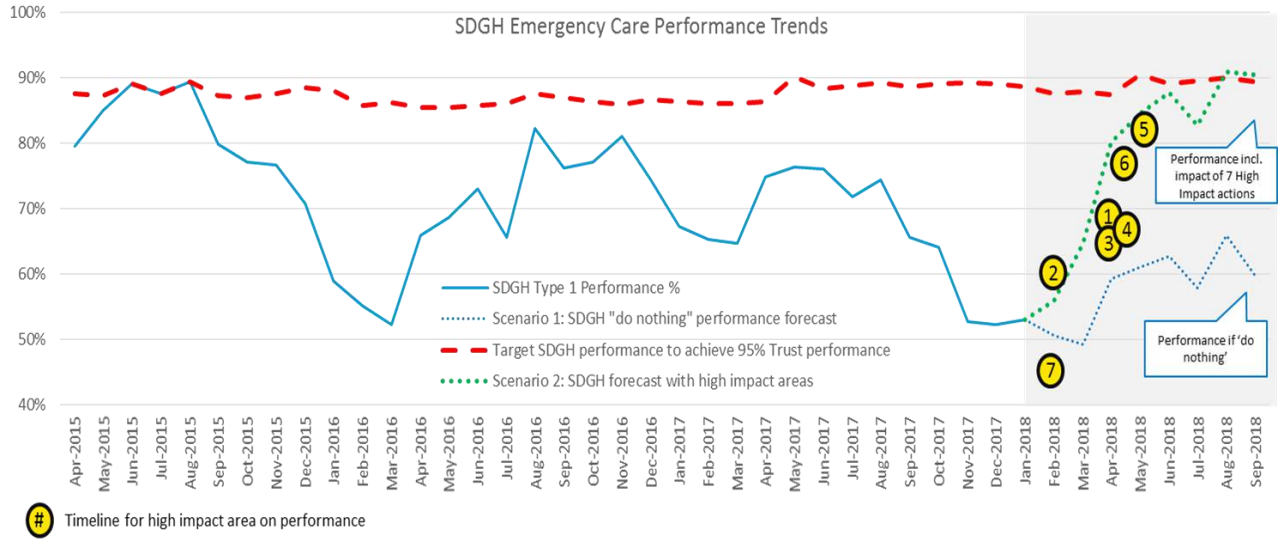
12 Actions to Improve Performance

The Patient Flow Improvement Board continues to meet and focus on the actions required for improvement in performance. We continue to focus on ensuring there is effective clinical engagement and leadership to drive forward improvements, which is supported by the senior management team.

The key areas of work are:

1. Improvement in triage processes
2. Improvement of ED co-ordination to accelerate decision making
3. Agree and implement Internal Professional Standards
4. Support planning and use of the modular unit
5. Maximising ambulatory pathways by improving streaming and assessment capacity
6. Improved pre-12pm and total discharges using tools such as SAFER
7. Best practice bed management

The improvement trajectory expected from the implementation of the seven work areas is shown on the diagram below.



Our partners have agreed to fund an integrated discharge team which will work closely with the already established ICRAS team. The decision to fund this team has gone to CCG Governing Bodies and we await the decision.

The Trust appointed a temporary Patient Flow Manager who has established twice daily meetings with our partners and identified “one version of the truth” around the number and type of delays which are attributable to our community partners. There is a very strong focus on managing 12 hour breaches and length of stay in the department. In addition, the COO and Medical Director are again reviewing the Full to Capacity Protocol to ensure senior consultant review is taking place on the wards in a timely and responsive manner.

The progress of the Patient Flow workstream is followed through the PFIP Dashboard:

NHS
Southport and Ormskirk Hospital
NHS Trust

A&E Weekly Summary - PFIP KPI

Summary (Key points):

1) The overall **SDGH 4 hr Target performance has deteriorated** over last 3 weeks since rapid improvement event and gap against trajectory is on increasing trend. Last week performance was however better than week before.
2) Triage times are now being **recorded for 99.9% patients but only 60% patients were triaged within 15 mins**.
3) Average time to be seen in ED has increased over last 4 weeks with last week being at **132 mins** on average.
4) Specialty response time for General Medicine has reduced last week and now general surgery has the highest time to response of 102 mins last week.
5) **Only 14.5% patients** were discharged between 8am -12am.

SNo	Metric	Trend	Target	31.12.2017	07.01.2018	14.01.2018	21.01.2018	28.01.2018	04.02.2018	11.02.2018	18.02.2018	25.02.2018	04.03.2018	11.03.2018	18.03.2018	25.03.2018
1	SDGH target A&E performance (Trajectory)		NA	53.1%	53.1%	53.1%	53.1%	53.1%	55.9%	55.9%	55.9%	55.9%	64.7%	64.7%	64.7%	64.7%
2	Difference from target		0%	-1.2%	-6.2%	10.7%	-4.3%	3.1%	-2.3%	-4.1%	0.0%	8.7%	-11.8%	-8.7%	-14.6%	-12.2%
3	SDGH A&E Performance		89%	51.86%	46.912%	63.763%	48.834%	56.193%	53.611%	51.766%	55.944%	64.608%	52.941%	55.979%	50.106%	52.45%
4	SDGH A&E Performance - Majors		NA	43.333%	38.062%	58.974%	37.086%	48.674%	42.791%	40.922%	49.114%	57.319%	41.782%	46.589%	39.398%	42.609%
5	SDGH A&E Performance - Minors		NA	89.189%	87.273%	95.105%	90.64%	90.173%	93.897%	90.213%	86.517%	94.298%	89.868%	91.00%	87.111%	90.654%
6	SDGH A&E 4Hr Breaches		103	466	490	312	439	382	424	478	378	361	440	416	470	456
7	SDGH A&E 12Hr Breaches		0	15	51			3	9		1		3	4		1
8	SDGH Conversion Rate		NA	33.368%	31.636%	39.141%	36.83%	35.092%	35.339%	30.373%	34.266%	33.333%	31.123%	33.228%	31.316%	32.221%
9	SDGH A&E Average Time In A&E		240	343	403	287	354	311	345	342	314	291	367	326	365	326
10	SDGH A&E Triage Within 15 Minutes %		100%	3.306%	3.034%	4.762%	10.373%	9.633%	4.376%	7.265%	10.956%	10.392%	5.348%	33.545%	56.688%	60.48%
11	SDGH A&E Triage = 0 Minutes %		0%	92.459%	94.691%	89.315%	84.499%	84.174%	91.247%	87.79%	79.371%	78.725%	84.813%	46.667%	0.743%	0.104%
12	SDGH A&E Average Time To DTA		195	301	307	238	272	240	257	290	237	253	301	251	283	270
13	SDGH A&E % Admitted With No DTA		0%	39.848%	32.597%	56.279%	34.264%	39.951%	35.663%	37.532%	36.911%	44.695%	31.117%	37.963%	38.384%	40.049%
14	SDGH A&E Average Time To Be Seen		60	116	138	106	134	103	114	130	107	109	132	117	135	132
15	SDGH A&E Average Time DTA To Departure		45	370	481	246	319	285	358	329	298	293	379	318	366	278
16	SDGH Average Specialty Review Time		60	113	99	94	104	95	108	113	84	92	123	89	129	82
17	SDGH Average Specialty Review Time - Gen Med		60	122	109	98	94	99	106	118	83	95	132	99	145	84
18	SDGH Average Specialty Review Time - Gen Surg		60	86	75	126	153	105	131	134	102	99	112	81	100	102
19	SDGH Average Specialty Review Time - T&O		60	94	45	43	76	37	44	26	55	54	81	45	66	56
20	SDGH Average Specialty Review Time - Other		60	77	94	55	98	113	76	124	51	121	153	62	132	77
21	SDGH % Admitted Directly To Base Ward		0%	45.706%	44.521%	30.347%	38.558%	29.073%	35.474%	28.99%	28.053%	30.435%	33.559%	35.11%	32.215%	32.484%
22	SDGH Discharges Between 8am-12noon (Excluding MDU			29	26	40	44	34	32	41	28	50	42	51	34	52
23	SDGH % Discharges Between 8am-12noon (Excluding MDU		33%	9.932%	8.874%	10.724%	13.293%	10.494%	9.302%	11.202%	8.333%	13.228%	13.861%	14.088%	10.462%	14.566%
24	Medically Fit Patients Weekly Snapshot		0	31	31	42	32	23	40	56	61	66	57	53	54	
25	Medical Outliers		0		21	10		11		11	19		10			9
26	Stranded Patients		0										221	207	221	
27	Corridor Patients		0	319	275	224	248	250	284	297	274	265	278	316	378	349
28	Corridor Patients - Average Time Mins		0	262	298	178	258	242	262	252	213	227	308	169	221	169

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

11th April 2018

Agenda Item	TB091/18	Report Title	Integrated Performance Report
Executive Lead	Steve Shanahan, Director of Finance		
Lead Officer	Mike Lightfoot, Head of Information		
Action Required *(Definitions below)*	☐ To Receive ☐ To Approve X To Assure	☐ To Note ☐ For Information	

Key Messages and Recommendations

The report highlights the indicators that require discussion by Trust Board. Some of these indicators require corrective action to be taken. A brief narrative has been provided in order to provide assurance that corrective measures are in place.

Indicators within the Integrated Performance Report form part of the Trust's new performance management framework and are discussed with the relevant teams in monthly performance forum meetings.

The front sheet overleaf outlines the key items to note.

The Board is asked to discuss the report and highlight any further assurance necessary in relation to areas of poor performance.

Strategic Objective(s)
(*The content provides evidence for the following Trust strategic objectives for 2017/18)*

☐ **SO1** Agree with partners a long term acute services strategy
X SO2 Improve clinical outcomes and patient safety
X SO3 Provide care within agreed financial limit
X SO4 Deliver high quality, well-performing services
☐ **SO5** Ensure staff feel valued in a culture of open and honest communication
☐ **SO6** Establish a stable, compassionate leadership team

Governance *(the report supports a…..)*

X Statutory requirement
☐ Annual Business Plan Priority
☐ Linked to a Key Risk on Board Assurance Frame / Extreme Risk Register:
(Please give reference no.) _____

☐ Service Change ☐ Best Practice ☐ Other List (Rationale) _____	
Impact *(is there an impact arising from the report on the following?)*	
☐ Quality ☐ Finance ☐ Workforce ☐ Equality	☐ Risk ☐ Compliance ☐ Legal
Equality Impact Assessment *(If there* is *an impact on E&D, an Equality Impact* Assessment *must accompany the report)*	☐ Strategy ☐ Policy ☐ Service Change
Next Steps *(List the required actions following agreement by Board/Committee/Group)*	
Previously Presented at:	
☐ Audit Committee **X** Finance Performance & Investment Committee ☐ Quality & Safety Committee	☐ Workforce & OD Committee ☐ Mortality Assurance & Clinical Improvement Committee

GUIDE TO ACTIONS REQUIRED *(TO BE REMOVED BEFORE ISSUE)*:

Approve: To formally agree the receipt of a report and its recommendations OR a particular course of action

Receive: To discuss in depth a report, noting its implications for the Board or Trust without needing to formally approve

Note: For the intelligence of the Board without the in-depth discussion as above

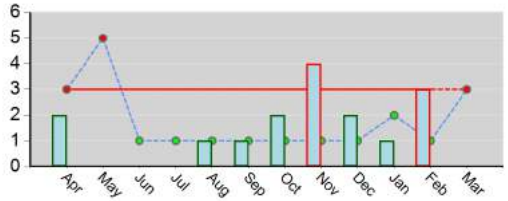
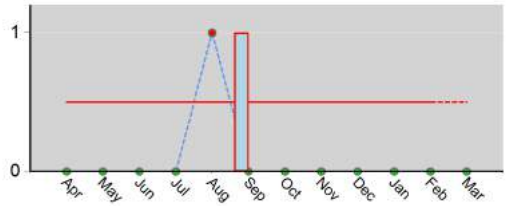
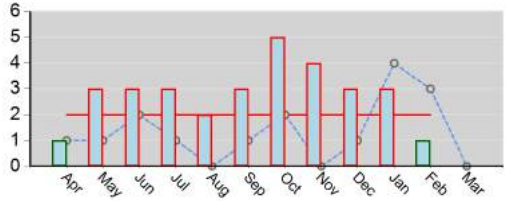
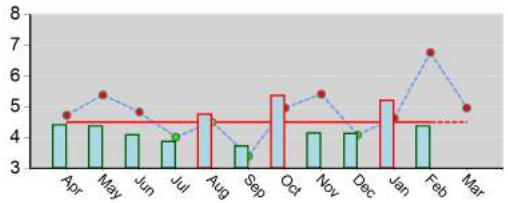
Assure: To apprise the Board that controls and assurances are in place

For Information: Literally, to inform the Board

NHS Southport and Ormskirk Hospital NHS Trust

Board Report - February 2018

Safe (Page 1 of 3)

Indicator Name	Description	Narrative	Responsible Committee	Month Trend
C-Diff	Number of Clostridium difficile (C. diff) infections for patients aged 2 or more on the date the specimen was taken. Trust target 36 for the year. Good performance is fewer than 36 for the year. Line = Last Financial Year Bar = This Financial Year	3 cases of C diff in February (one each on wards 14A, 11B and ITU). All patients eligible for appeal as no evident lapses in care.	Quality & Safety Committee	
MRSA	The number of Methicillin Resistant Staphylococcus Aureus (MRSA) test samples that were positive. The threshold is 0. Line = Last Financial Year Bar = This Financial Year	No MRSA bacteraemia in February.	Quality & Safety Committee	
E. Coli	Number of Escherichia coli (E. Coli) infections for patients aged 2 or more on the date the specimen was taken. Indicator is for monitoring purposes as no formal target has been finalised with the CCGs. Good performance is low. Line = Last Financial Year Bar = This Financial Year	Of the 14 E coli cases in February, 1 was considered hospital acquired. All cases reviewed and treated in conjunction with Microbiologist. The source of the E coli case was likely to be chest infection.	Quality & Safety Committee	
Falls	The number of falls within the hospital per 1,000 bed days. Threshold: 4.5 per 1000 bed days. Good performance is lower. Line = Last Financial Year Bar = This Financial Year	In February, out of the 56 patient falls reported, there were none reported with a severity of harm at Moderate or higher. Overall Falls numbers have fallen by 17 since January.	Quality & Safety Committee	

NHS Southport and Ormskirk Hospital NHS Trust

Board Report - February 2018

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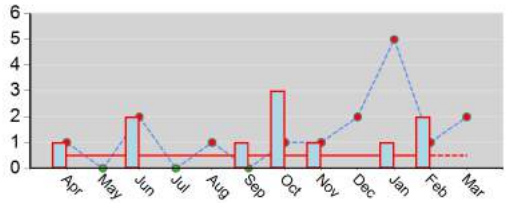
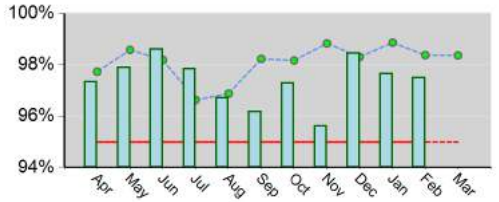
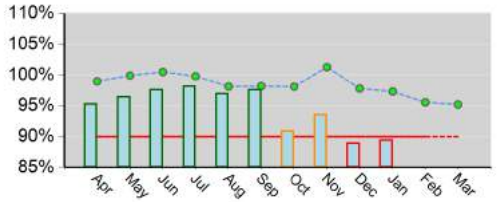
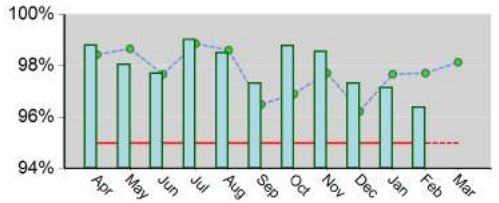
Indicator Name	Description	Narrative	Responsible Committee	Month Trend
Hospital Pressure Sores	Number of reported Trust acquired pressure sores graded between 3 and 4. Threshold: 0. Collaborative goal: Elimination of grade 3 and 4 pressure ulcers plus 25% reduction overall. Line = Last Financial Year Bar = This Financial Year	In February there were 2 grade 3 / 4 pressure sores, both on 14B. Both are awaiting review.	Quality & Safety Committee	
Harm Free	Safety Thermometer - Percentage of Patients With Harm Free Care. Threshold 98%. Higher is better. Line = Last Financial Year Bar = This Financial Year		Quality & Safety Committee	
Safe Staffing	The ratio between the proposed number of nursing staff to ensure a safe staffing level and the actual number of nurses working those shifts. Threshold: 95%, Fail 90%. Line = Last Financial Year Bar = This Financial Year	Awaiting confirmation of Februarys position.	Quality & Safety Committee	
VTE (Venous thromboembolism)	VTE risk assessment: all inpatient Service Users undergoing risk assessment for VTE. Threshold 95%. Good performance is higher. Line = Last Financial Year Bar = This Financial Year	Compliance for VTE assessment remains above the threshold of 95%. The Trust proforma for assessment of VTE continues to be monitored using an audit approach which includes monthly point of prevalence surveys as part of the NHS Safety thermometer. It is also now part of the Southport and Ormskirk Clinical Accreditation Scheme in line with the CQC's Key Lines of Enquiry, of which non-compliance is reported as part of feedback which initiates an individualised area action.	Quality & Safety Committee	

NHS Southport and Ormskirk Hospital NHS Trust

Board Report - February 2018

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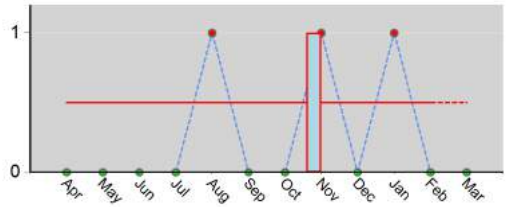
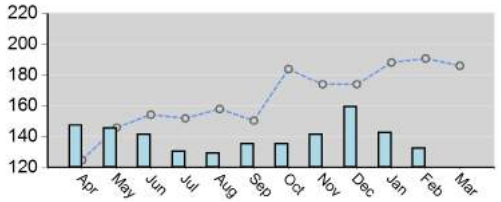
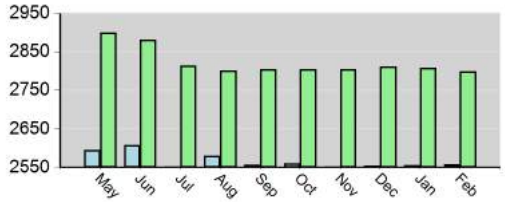
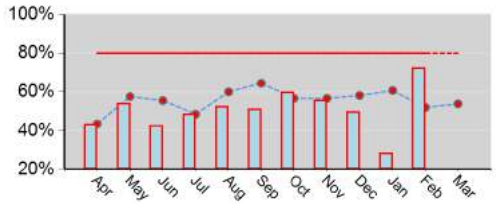
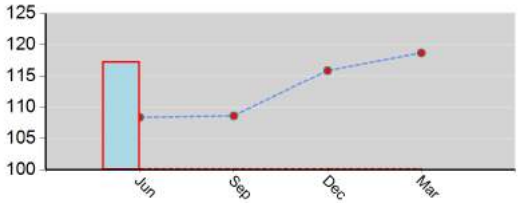
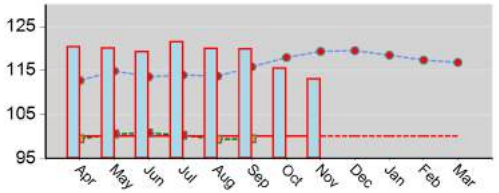
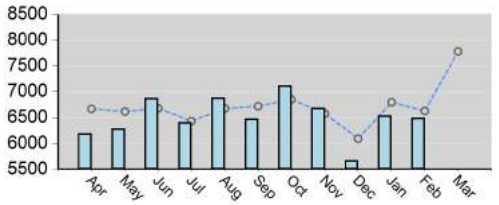
Indicator Name	Description	Narrative	Responsible Committee	Month Trend
Never Events	Never Events - A particular type of serious incident that is wholly preventable and has the potential to cause serious patient harm or death. Line = Last Financial Year Bar = This Financial Year	There were no Never Events reported in February.	Quality & Safety Committee	
Nursing vacancies	Number of nursing vacancies in month. Line = Last Financial Year Bar = This Financial Year		Finance, Performance & Investment Committee	
Establishment vs Actual	Number of WTE posts that are required to staff the Trust against the actual number of post employed substantively. Green = Funded, Blue = Contract Line = Last Financial Year, Bar = This Financial Year	The Trust headline vacancy factor is 8.5% (Down from January 8.9%). Total vacancy levels are down from 253 wte to 237 wte.	Finance, Performance & Investment Committee	

NHS Southport and Ormskirk Hospital NHS Trust

Board Report - February 2018

Effective (Page 1 of 3)

Indicator Name	Description	Narrative	Responsible Committee	Month Trend
Stroke 90% ward stay	Proportion of stroke patients who have 90% of their hospital stay on a dedicated stroke ward. Threshold 80%. Good performance is higher. Previously reported performance may change as a result of validation. Line = Last Financial Year Bar = This Financial Year	Our ability to achieve this standard is significantly impacted by the wider non-elective pressures experienced at Southport and the difficulties in discharging patients who no longer require inpatient care. The wider urgent care improvement work with E&Y should deliver improvements in all areas of performance impacted by non-elective pressures.	Finance, Performance & Investment Committee	
SHMI (Summary Hospital-level Mortality Indicator)	Summary Hospital-level Mortality Indicator (SHMI) is the standardised mortality both in hospital and within 30 days of discharge. Source = Dr. Foster. Please note: This indicator is reported quarterly and is 6 months behind due to when Dr Foster publish the data. Good performance is 100 or less. Line = Last Financial Year	The 12-month rolling SHMI, at 117.4, remains high and outside expected limits, but has reduced from the previous quarter level of 118.7. This is following the implementation of a comprehensive action plan, managed and monitored by the Mortality Operational Committee which reports to the Trust Board through Quality & Safety Committee.	Quality & Safety Committee	
HSMR - Rolling 12 Months (Hospital Standardised Mortality Ratio)	The ratio of the observed number of in-hospital deaths with a Hospital Standardised Mortality Ratio (HSMR) diagnosis to the expected number of deaths, multiplied by 100. At Trust level, good performance is 100 or less. Source = Dr. Foster. Please note: This indicator is reported monthly and is 3 months behind due to when Dr Foster publish the data. Line = Last Financial Year, Green = Previous Value, Blue = Corrected Value	The 12-month rolling HSMR, at 113.2, remains high and outside expected limits, and the reasons for this are being investigated. It is being addressed by a comprehensive action plan, managed and monitored by the Mortality Operational Committee which reports to the Trust Board through Quality & Safety Committee.	Quality & Safety Committee	
Referrals	Number of referrals received into the Trust. This will include referrals from GPs, other hospitals and internal referrals. Line = Last Financial Year Bar = This Financial Year	The Trend for fewer referrals than in the previous year continues. This is as a reduction in demand from South Sefton where the market for elective activity has reduced, and in specialties such as Orthopaedics and Dermatology.	Finance, Performance & Investment Committee	

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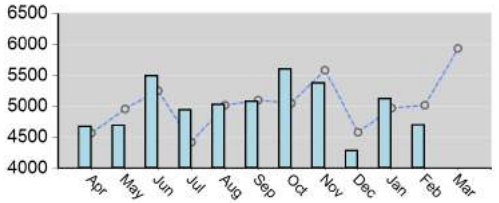
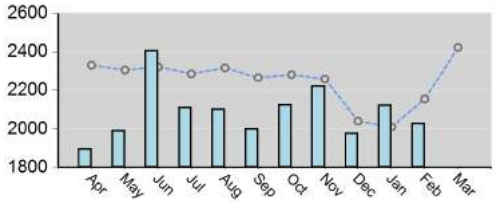
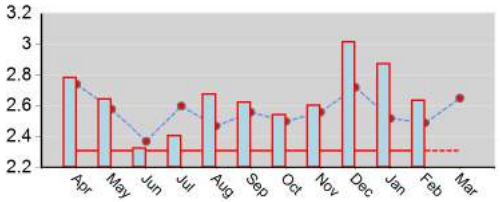
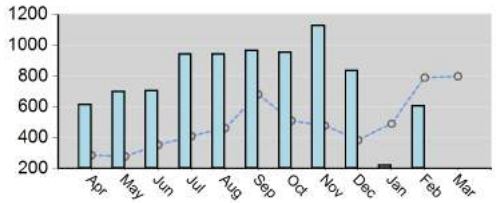
Indicator Name	Description	Narrative	Responsible Committee	Month Trend
First Appointments	The number of patients seen in a first appointment including where the patient is seen in an outpatient clinic and has a procedure undertaken. Line = Last Financial Year Bar = This Financial Year	First outpatient appointments have been impacted by a number of factors including: A move of more activity into the outpatient procedure (OPPROC) category, reduction in the number of referrals and reduction in capacity in areas such as paediatrics (staffing shortages), gynaecology (staffing shortages and CQC), General Surgery (loss of post on-call activity) and Dermatology (treatment only for urgent cases).	Finance, Performance & Investment Committee	
Daycase/Inpatient	The total number of patients treated as either a day case or an elective inpatient in month. Line = Last Financial Year Bar = This Financial Year	Underperformance against previous year of 120 cases. Of those, 81 are General Surgery. Due to pressures a higher volume of cancellations for this specialty have occurred.	Finance, Performance & Investment Committee	
Average Length of Stay	The average length of stay for all patients across the Trust. Lower is better. Line = Last Financial Year Bar = This Financial Year	Average length of stay saw a reduction compared to January, however remains higher than the same period last year. The continues to experience high bed occupancy levels and large numbers of patients identified as MOFD. The benefits that had been seen during the MADE reviews across December and January have not been sustained and the number of patients identified as being medically fit has continued to increase. Daily discharge meetings are held, facilitated by the Head of Patient Flow, in order to collectively escalate barriers for discharges across the system.	Finance, Performance & Investment Committee	
Bed days post MOFD (Medically Optimised for Discharge)	Number of beddays used for inpatients who have passed their medically optimised for discharge date. It is taken as a snapshot on the last working day of the month. Lower is better. Line = Last Financial Year Bar = This Financial Year		Finance, Performance & Investment Committee	

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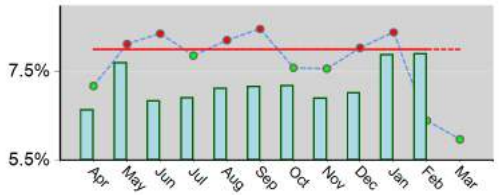
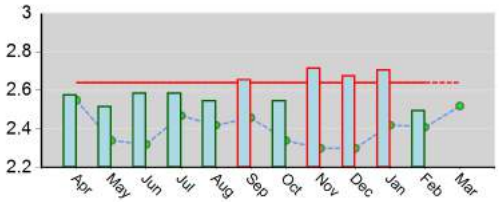
Indicator Name	Description	Narrative	Responsible Committee	Month Trend
DNA (Did Not Attend) rate	The proportion of patients of all those offered appointments or treatment dates that do not give notice of non-attendance irrespective of how short that notice is. Lower is better. Line = Last Financial Year Bar = This Financial Year		Finance, Performance & Investment Committee	
New:Follow Up	The Trust's overall ratio between new outpatient appointments and follow-up outpatient appointments. Threshold: monitor. Line = Last Financial Year Bar = This Financial Year		Finance, Performance & Investment Committee	

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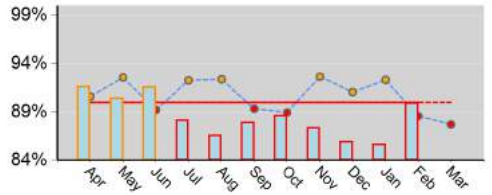
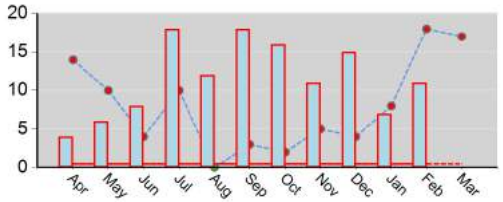
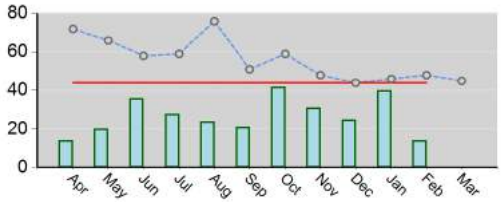
Indicator Name	Description	Narrative	Responsible Committee	Month Trend
Friends and Family Test	Friends and Family Test. The proportion of patients that would recommend the Trust to their friends and family. Threshold: 94%, Fail: 90%. Good performance is higher. Line = Last Financial Year Bar = This Financial Year	The percentage of patients that would recommend the Trust to Friends & Family rose to its highest monthly position since June 2017 with 90% recommending the Trust. This is against a Trust response rate of 3.7% which is 1% lower than January. For February CBU percentages are Specialist 94%, Planned care 93% and Urgent Care 85%.	Quality & Safety Committee	
DSSA (Delivering Same Sex Accommodation) Breaches - Trust	This indicator monitors the Trust's part in the NHS commitment to eliminate mixed sex accommodation. Each patient breaches each 24 hours. Line = Last Financial Year Bar = This Financial Year	In February there were 11 Mixed Sex Accommodation breaches, 10 on critical care and 1 on ACU. The majority of breaches on Critical Care are due to awaiting transfer to acute beds within the hospital. Actions to address poor flow are both system-wide and internal.	Quality & Safety Committee	
Complaints	The total number of complaints recieved. A lower number is good. Line = Last Financial Year Bar = This Financial Year	The complaint numbers are 18 for the month of February, this is 22 less than the previous month. The complaints will be reported in the Quality and Safety reports for each Clinical Business Unit. The Clinical Business Units continue to work through the complaints within the required timescales, and the adherence to these timescales is monitored through the monthly Quality and Safety reports.	Quality & Safety Committee	

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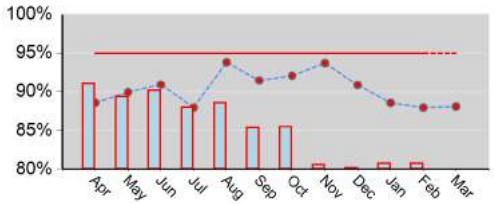
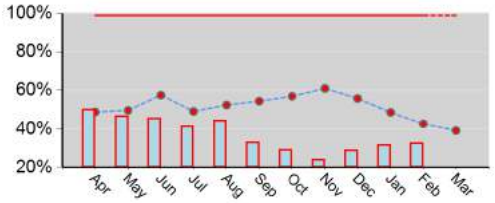
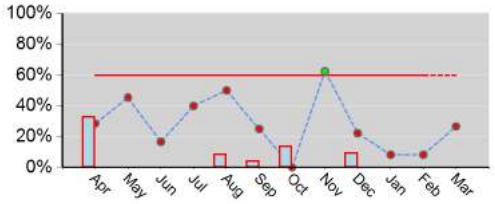
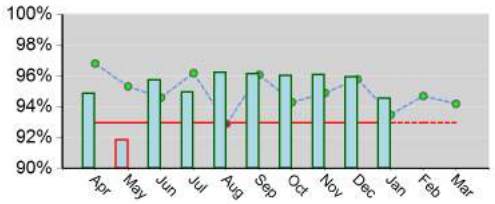
Indicator Name	Description	Narrative	Responsible Committee	Month Trend
Accident & Emergency - 4 Hour compliance	Percentage of patients spending less than 4 hours in a A&E department from arrival to discharge, transfer or admission. 95% target. Good performance is higher. Line = Last Financial Year, Bar = This Financial Year	Disappointingly, there were x3 12-hour breaches during the month of February which were all related to difficulties in inpatient flow, leading to over-occupancy in ED and extended waits for beds. Local system calls continue to be held seeking mutual aid from partners. Workstreams continue to progress their efforts in addressing barriers to discharges on the wards. This includes the roll out of daily ward/ board rounds (SAFER) across the wards.	Quality & Safety Committee	
Ambulance Handovers <=15 Mins	All handovers between ambulance and A&E staff to occur within 15 minutes. This measure looks at the percentage of handovers within 15 minutes. Line = Last Financial Year Bar = This Financial Year	Ambulance handover performance remains a significant concern with some significant delays in timely release of ambulance crews. The current ED estate is insufficient to meet the demands of the current case mix, given the month on month increase in majors category patients and the frailty of the local population. The new modular build will be operational by the end of April 18 to support earlier release of cubicles for appropriate patients; further capital work is planned to improve the triage capacity and ambulance assessment space later this year.	Quality & Safety Committee	
TIA (Transient ischaemic attack)	Proportion of patients diagnosed with a TIA Treated within 24 hours. Threshold 60%. Good performance is higher. Line = Last Financial Year Bar = This Financial Year	A review of the process has been undertaken finding that all the correct procedures and processes are being followed. There is a lack of capacity to review patients within 24 hours as clinics run Monday, Wednesday and Friday. The lead clinician is reviewing capacity and is working with the management team to identify spare OP space to increase clinic capacity to every week day. This should ensure that only delays in referral and weekend presentations should breach the standard. Whilst clinic space is at a premium it is anticipated that additional capacity is available from April.	Finance, Performance & Investment Committee	
14 day GP referral to Outpatients	Percentage of patients seen within two weeks of an urgent GP referral for suspected cancer. Target 93%. Good performance is higher. Line = Last Financial Year Bar = This Financial Year	Target was achieved in January with compliance at 94.6%.	Finance, Performance & Investment Committee	

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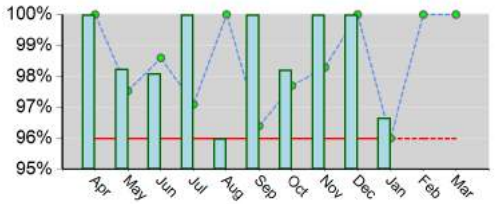
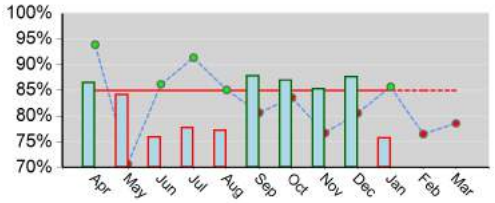
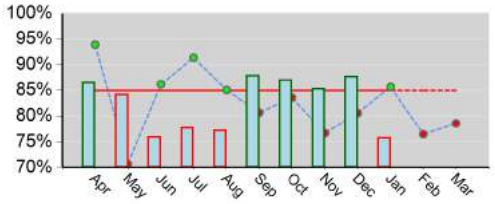
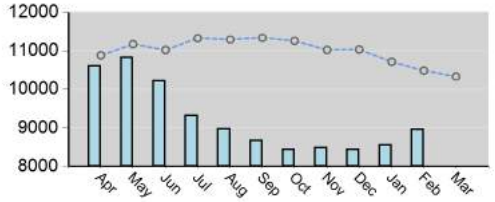
Indicator Name	Description	Narrative	Responsible Committee	Month Trend
31 day treatment	Percentage of patients receiving first definitive treatment within one month (31 days) of a cancer diagnosis (measured from 'date of decision to treat'). Target 96%. Good performance is higher. Line = Last Financial Year Bar = This Financial Year	Target was achieved in January with compliance at 96.7%.	Finance, Performance & Investment Committee	
62 day GP referral to treatment	Percentage of Patients receiving first definitive treatment for cancer within two months (62 days) of urgent GP referral for suspected cancer. Target 85%. Good performance is higher. Line = Last Financial Year Bar = This Financial Year	Compliance in January was recorded at 75.9%. IST review was undertaken on 20th February which demonstrated good practice within the Trust. Small improvement such as review of education with cancer services, accurate and timely reporting of potential risks which are challenged at weekly Cancer Performance meetings, therefore increasing the transparency of potential issues to be address in a more timely manner. Further improvement to be made include forward planning for bank holidays and reductions in working weeks in particular over Christmas and Easter periods where we have historically failed the subsequent months.	Finance, Performance & Investment Committee	
62 day pathway view	All Trust Boards should have sight of tumour specific performance against the 62 day GP referral to treatment. Target 85%. Good performance is higher. Line = Last Financial Year Bar = This Financial Year	Tumour group compliance in January was recorded at: Colorectal 64.3%, Gynae 72.7%, Haematology 100%, Head & Neck 100%, Lung 93.8%, Skin 100%, Upper Gi 87.5% and Urology 50%.	Finance, Performance & Investment Committee	
Waiting list size	The number of RTT patients currently waiting. Line = Last Financial Year Bar = This Financial Year	The overall RTT list size has reduced by c. 1,500 since April 2017. There are a number of contributory factors that have led to this reduction. The reduction in GP referrals compared to the previous year is 27% equating to an average of 1,215 referrals per month. Whilst activity is down it has not seen the same percentage reduction as referrals. DC/EL is down 10% and outpatients including procedures is down 9%. This has resulted in reduced lists in a number of areas. Restriction of Dermatology service – the number of RTT pathways has fallen from around 1,200 to 460 over that time period.	Finance, Performance & Investment Committee	

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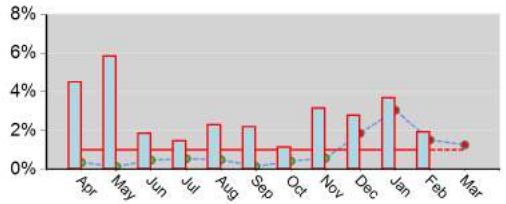
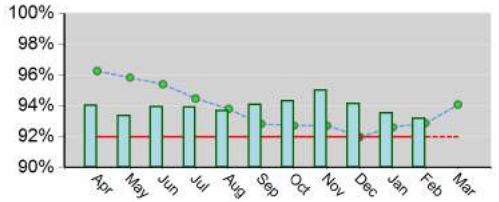
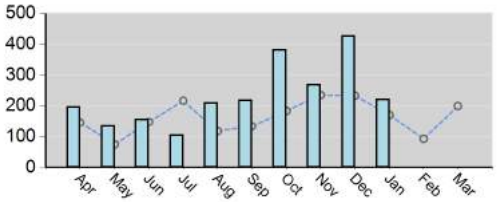
Indicator Name	Description	Narrative	Responsible Committee	Month Trend
Diagnostic waits	The number of patients waiting 6 weeks or more for a diagnostic test expressed as a percentage of all patients waiting. Threshold 1%. Good performance is lower. Line = Last Financial Year Bar = This Financial Year	Issues in a number of areas with the following having the most breaches: Cystoscopy – reduction in core WLI sessions has had a negative impact on capacity. There are capacity issues in both Urology and Urogynaecology.	Finance, Performance & Investment Committee	
Referral to treatment: on-going	Percentage of patients on an incomplete pathway with a current wait experience of 18 weeks or less. Threshold 92%. Good performance is higher. Line = Last Financial Year Bar = This Financial Year		Finance, Performance & Investment Committee	
DTOC (Delayed Transfers of Care)	Total number of Delayed Days during the reporting period. A patient is ready for transfer when: a. A clinical decision has been made that patient is ready for transfer; and b. A multi-disciplinary team decision has been made that patient is ready for transfer;and c. The patient is safe to discharge/transfer. Line = Last Financial Year Bar = This Financial Year	In January there were 223 delayed bed days due to delayed transfers of care. 80 bed days were due to patient/family choice, 49 days due to awaiting assessment, 24 due to awaiting a place within a Nursing Home, 22 due to awaiting further non-acute NHS care, 19 due to awaiting community equipment/adaptations,17 due to awaiting care package in own home and 16 due to awaiting a place within a Residential Home.	Quality & Safety Committee	

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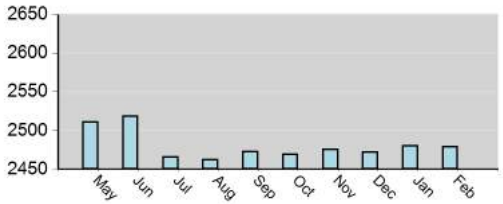
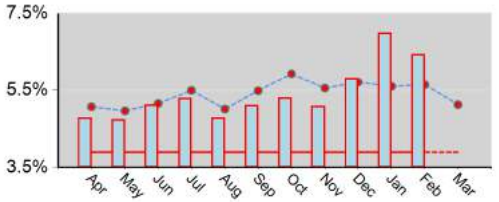
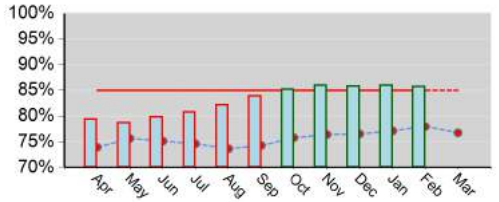
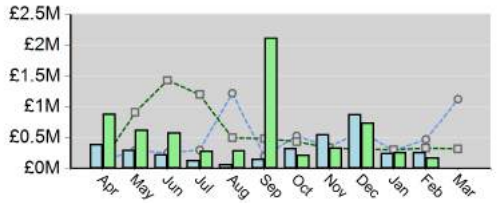
Indicator Name	Description	Narrative	Responsible Committee	Month Trend
WTE (Whole time equivalents) in post	The number of WTE staff with substantive and fixed-term contracts employed directly by the Trust. Line = Last Financial Year Bar = This Financial Year Note: The reduction since May 2017 is due to the transfer of 550 Community staff to Lancashire Care and Virgin Healthcare.		Finance, Performance & Investment Committee	
Sickness rate	The proportion of the substantive WTE in month who were unavailable for work. Threshold: 3.7%. Lower is better. Line = Last Financial Year Bar = This Financial Year	The Sickness rate in February was recorded at 6.45% which is a decrease from Januarys position of 7%. Corporate (7.94%) and Planned Care (7.05%) report the highest CBU sickness rates in February. The Sickness Absence Administration team are ensuring compliance with the Trust's current policy and that sickness absence reasons are recorded properly.	Finance, Performance & Investment Committee	
Mandatory Training	The percentage of staff with upto date Mandatory Training. Threshold: 85%. Line = Last Financial Year Bar = This Financial Year	The Trust has maintained mandatory training compliance above the Trust target of 85% for the 5th consecutive month. The ESR Manager & Employee Self Service project continues to roll out across the organisation with 76% of staff now registered on the system allowing staff access to 100's of free eLearning modules including core mandatory training and the ability to view their own compliance online. Since its launch in Jan 2018, over 676 mandatory modules have been completed online. It is expected that eLearning will become the preferred choice, allowing staff 24/7 access and instant update to training records.	Finance, Performance & Investment Committee	
Spend against capital plan	Actual spend against the capital budget plan for the year. Green = Budget, Blue = Actual Line = Last Financial Year, Bar = This Financial Year	Although the spend is still below target, there has been extensive detailed work with Procurement, Estates, IT and the Business Units to ensure that the Trust fully utilises its capital resource on risk-assessed priorities. The plan is monitored daily, therefore this metric is RAG rated green.	Finance, Performance & Investment Committee	

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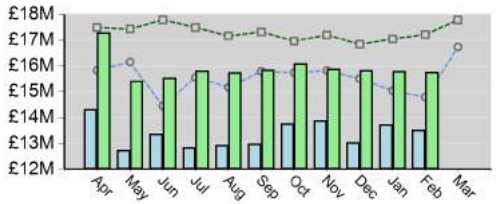
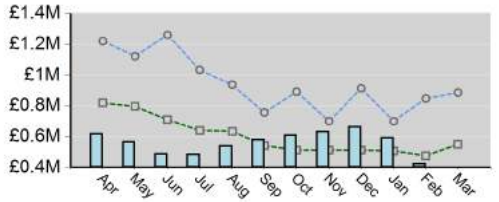
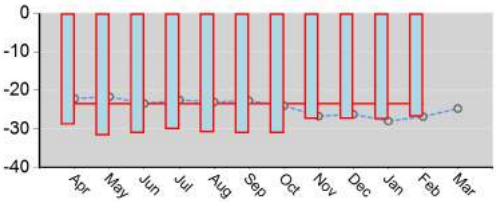
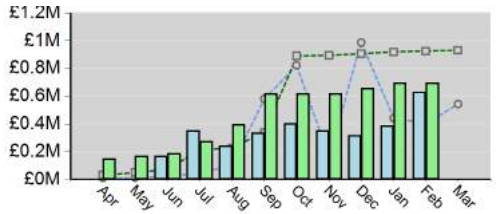
Indicator Name	Description	Narrative	Responsible Committee	Month Trend
Income & Expenditure	This indicator looks at the relationship between Trust income and Trust expenditure at monthly intervals. Green = Expenditure, Blue = Income Line = Last Financial Year, Bar = This Financial Year	The plan for January was a deficit of £1.38m. The actual in month deficit was £2.26m an adverse variance of £0.87m. The month 11 year to date (YTD) deficit is £27.98m against a plan of £16.87m giving an adverse variance of £11.1m. The Trust has committed to deliver a deficit of £29.2m at the year end and the month 11 position is on target to achieve this.	Finance, Performance & Investment Committee	
Agency Spend	The Total spend on agency staff compared to previous year. Line = Last Financial Year, Bar = This Financial Year Green = Trajectory, Blue = Actual	For 2017/18 NHSI set the Trust a full year agency spend target of £7.2m (same as 2016/17). The month 11 YTD financial position is £6.245m. It is likely that agency spend will be contained within this target. The introduction of the Trust's new bank system (TempRE) has had a positive impact on the level of medical agency staff being recruited. Work is ongoing to fill gaps in problem specialties with more medium term solutions rather than relying on premium rate agency tariffs.	Finance, Performance & Investment Committee	
Liquidity	Liquidity (days) Liquidity indicates whether the provider can meet its operational cash obligations.	Some further improvements in liquidity (-26.8 days in February against -27.5 days in January). The Trust can meet its operational cash obligations as it is being supported with loan funding up to its revised forecast outturn. This would indicate a green rating, however, given that liquidity in the single oversight framework should be better than -14 days, this metric has been highlighted amber.	Finance, Performance & Investment Committee	
CIP (Cost Improvement Programme) delivery	Actual delivery in financial terms vs. the plan for delivery over the same period. Line = Last Financial Year, Bar = This Financial Year Green = Plan, Blue = Actual	The CIP plan for 2017/18 is £5.6m. The original plan profiled £4.9m to be delivered at the end of February but the actual delivery is £2.97m; an adverse variance on the plan of £2.0m. Following a revision to the CIP plans the new trajectory will not deliver at the rate originally envisaged. The plan is now forecast to deliver a risk adjusted figure of £3.28m (CYE) and £3.22m (FYE).	Finance, Performance & Investment Committee	

NHS Southport and Ormskirk Hospital NHS Trust

Board Report - February 2018

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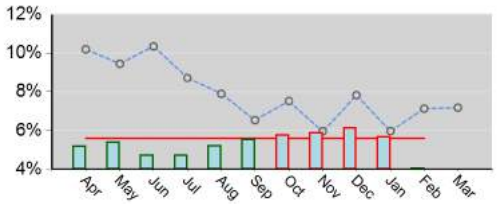
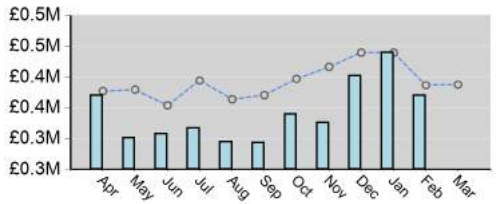
Indicator Name	Description	Narrative	Responsible Committee	Month Trend
% Agency Staff (cost)	The cost of agency staff as a proportion of the total cost of the workforce. Reliant on finance system to monitor spend rather than the HR system. Line = Last Financial Year Bar = This Financial Year	The proportion of the workforce spend made up of Agency workers decreased significantly to 4.1% in February 18 and is the lowest figure since 16/17. 2.13% was accounted for Doctors, 1.17% Nurses, 0.59% Admin staff, 0.12% AHP's and 0.09% Other.	Finance, Performance & Investment Committee	
Cost of staff sickness	In month based on staff sickness records. Line = Last Financial Year Bar = This Financial Year Note: The reduction since May 2017 is due to the transfer of 550 Community staff to Lancashire Care and Virgin Healthcare.	The cost of Staff Sickness remains at around £400,000 in month.	Finance, Performance & Investment Committee	

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD
11th April 2018

Agenda Item	**TB092/18**	**Report Title**	**Director of Finance Report Month 11**
Executive Lead	Steve Shanahan, Director of Finance		
Lead Officer	Kevin Walsh, Deputy Director of Finance		
Action Required *(Definitions below)*	☑ To Receive ☐ To Approve ☐ To Assure		☑To Note ☐ For Information

Key Messages and Recommendations

Key messages:

- The Trust planned a deficit of £1.38m in month 11; the actual deficit was £2.26m.
- The actual year to date (YTD) deficit is £28.0m which is £11.1m worse than plan.
- The YTD variance is split evenly between income shortfall and excess expenditure against budget.
- CIP shortfall is forecast to be £2.3m
- Agency spend remains at lower levels than last year and is forecast to remain within the cap.
- Month 11 YTD deficit of £28.0m indicates the Trust's revised forecast outturn of £29.2m (excluding contract risk) will be delivered.
- Commissioners are required to impose sanctions on the Trust as it did not sign up to its control total in line with the national contract; it is estimated that this will increase the Trusts forecast outturn deficit by up to a further £3.0m
- Trust's two main Commissioners did not agree offer to settle outstanding disputes from previous years and 2017/18 dispute on a coding and counting issue (GP Assessment Unit). This has been referred to the Expert Determination Process.
- The process was activated by regulators to resolve all the disputes by 31 March 2018; value of disputes considered through this process is £6.4m; this is not included in the Trust current forecast outturn.

Recommendations:

The Board is asked to **NOTE** that the Forecast Outturn deficit remains at £29.2m but is before the application of sanctions and the outcome of the Expert Determination Process.

Strategic Objective(s)
(*The content provides evidence for the following Trust strategic objectives for 2017/18)*

- ☐ **SO1** Agree with partners a long term acute services strategy
- ☐ **SO2** Improve clinical outcomes and patient safety
- ✓ **SO3** Provide care within agreed financial limit
- ☐ **SO4** Deliver high quality, well-performing services
- ☐ **SO5** Ensure staff feel valued in a culture of open and honest communication
- ☐ **SO6** Establish a stable, compassionate leadership team

Governance *(the report supports a…..)*

- ☑ Statutory requirement
- ☐ Annual Business Plan Priority
- ☐ Linked to a Key Risk on BAF / HLRR Ref: _____
- ☐ Service Change
- ☐ Best Practice
- ☐ Other List (Rationale) _____

Impact *(is there an impact arising from the report on the following?)*

☐ Quality ☑ Finance ☐ Workforce ☐ Equality	☐ Risk ☐ Compliance ☐ Legal
Equality Impact Assessment *(If there* is *an impact on E&D, an Equality Impact* Assessment *must accompany the report)*	☐ Strategy ☐ Policy ☐ Service Change

Next Steps *(List the required actions following agreement by Board/Committee/Group)*

Previously Presented at:

☐ Audit Committee ☐ Finance Performance & Investment Committee ☐ Quality & Safety Committee	☐ Workforce & OD Committee ☐ Mortality Assurance & Clinical Improvement Committee

1. Introduction

1.1. This report provides the Board with the financial position of the Trust for the financial period ending 28th February 2018.

1.2. The report asks the Board to discuss the contents, note the financial performance at month 11 and the forecast year end financial position.

1.3. The Trust has planned for a deficit of £18.1m (the control total of £15.1m was not accepted) a revised forecast of £31.7m was agreed at the December Trust Board.

1.4. NHS Improvement expectation with the appointment of the Financial Improvement Director is that the Trust will outturn below £30 million. The Trust has now informed NHS Improvement that the forecast deficit is £29.2m. This is due to the following:-

1. Winter pressures funding which not required in revenue expenditure (£0.9m of £1.2m)
2. Technical adjustment relating to the accounting treatment of the energy centre as recommended by the Trust's external auditors, Mazaars (£1.3m).
3. Further improvement due to impact of Four Eyes phase 2 work (£0.3m)

2. Month 11 Financial Performance

2.1. The Trust has performed as follows:

- **In month -** Deficit of £2.256m against a £1.383m deficit plan delivering an adverse variance of £0.975m.
- **Year to date (YTD) -** Deficit of £27.981m against a £16.871m deficit plan delivering an adverse variance of £11.110m.

2.2. The YTD position excludes any risk from the Expert Determination Process (up to £6.4m) and the imposition of sanctions for non performance of operational and national standards (up to £3m).

2.3. The table below is the I&E statement for February:

I&E (including R&D)	Annual Budget £000	Year to Date			In Month		
		Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Operating Income							
Commissioning Income	150,223	137,728	133,841	(3,887)	12,155	12,368	213
PP, Overseas & RTA	2,320	2,127	1,326	(801)	196	79	(117)
Other Income	14,342	13,156	12,050	(1,106)	1,221	1,081	(140)
Total Income	**166,885**	**153,010**	**147,217**	**(5,794)**	**13,572**	**13,528**	**(44)**
Operating Expenditure							
Pay	(122,526)	(112,401)	(116,915)	(4,514)	(9,626)	(10,471)	(845)
Non-Pay	(53,235)	(49,009)	(49,396)	(387)	(4,560)	(4,533)	27
Total Expenditure	**(175,761)**	**(161,410)**	**(166,311)**	**(4,901)**	**(14,186)**	**(15,004)**	**(818)**
EBITDA	**(8,877)**	**(8,400)**	**(19,095)**	**(10,695)**	**(614)**	**(1,476)**	**(862)**
Non-Operating Expenditure	(9,237)	(8,467)	(9,533)	(1,066)	(769)	(813)	(146)
Retained Surplus/(Deficit)	**(18,114)**	**(16,867)**	**(28,628)**	**(11,761)**	**(1,383)**	**(2,289)**	**(1,008)**
Technical Adjustments	(5)	4	647	651	0	33	33
Break Even Surplus/(Deficit)	**(18,119)**	**(16,871)**	**(27,981)**	**(11,110)**	**(1,383)**	**(2,256)**	**(975)**

2.4. Commissioning income levels exceeded the levels expected within the Financial Recovery Plan (FRP). Waiting list funding is assisting with £0.486m of the £1.2m brought into the month 11 YTD position (with no budget).

2.5. Whilst the YTD adverse position has been mainly driven by activity and income shortfalls the proportion relating to expenditure has increased due mainly from the impact of the CIP profile.

2.6. Total expenditure levels (pay and non pay) remain been consistent across the last few months (once non recurrent issues have been excluded).

3. Income

3.1. Commissioning Income

3.2. Commissioning income levels marginally exceeded those planned in the FRP

3.3. The improvement is being sustained by the clinical review in conjunction with consultants.

3.4. Winter pressures of £1.2m have been secured and are being brought into the income position (without budget) over quarter four. £486k has been accrued in the month 11 YTD income position.

3.5. Private Patients (PP), Overseas and Road Traffic Accident (RTA)

3.6. Income from Road Traffic Accidents (RTA) has under-performed against budget in February.

3.7. The A&E reception staff are promoting the compensation recovery scheme to patients to give details to enable the Trust to work with HCR to recover income due, however, patients are reluctant to pursue any claims.

3.8. Private patients and overseas visitors remain at a consistent level.

3.9. **Other income**

3.10. See attached appendices for details

4. Expenditure

4.1. **Pay Expenditure**

4.2. Pay expenditure in February is consistent with January's performance.

4.3. All pay budgets are overspent in month with the exception of Scientific, Technical and Therapeutic.

4.4. In December the physicians and A&E consultants were paid £200k additional arrears relating to last year's job planning. Therefore, the total unbudgeted spend in 2017/18 is £900,000 in the full year (£700,000 arrears to 1st April 2017 and £200,000 pre 1st April 2017).

4.5. Pay on medical staff has increased in February reflecting an increase in bank usage with a proportion of this being offset by a reduction in agency.

4.6. CIP unachieved in month £242k, year to date £1.728m.

4.7. The back pay for consultant PA's (wef 1st April 2017) was unfunded and this will continue to be part of the monthly adverse variance (circa £58k per month).

5. Agency spend

5.1. At the month 11 YTD position the Trust has spent £6.25m on agency staff.

5.2. This compares favourably with the same period in 2016/17 (£10.4m).

5.3. The Trust is on target to achieve its agency control total set by NHS Improvement (£7.2m) although agency levels are increasing month on month with pressures within medical staff and other staff such as key senior manager and A&C posts.

5.4. The agency cap for 2018/19 has been reduced to £5.6m so further agency reduction will be required in 2018/19.

5.5. **Nurse Agency**

5.6. Nurse agency levels reduced slightly in February although the Trust has not managed to reduce monthly agency spend below £120,000 for some time.

5.7. The majority of the monthly nurse agency spend continues to be incurred within A&E; with the remaining spend incurred in medical wards, ITU, spinal injuries and theatres.

5.8. Bank levels remain high and the focus continues to be recruiting to substantive posts and filling with bank wherever possible with agency being the last resort. Medical wards and A&E also have high bank usage.

5.9. **Medical Agency**

5.10. The Trust has introduced a medical staff bank using the TempRE platform from November 2017; this should ensure more shifts are filled at the bank rate.

5.11. A new set of rates has been set for bank staff which is consistent with the rates offered by St Helens and Knowsley NHS Trust. The Trust is in the process of reviewing bank rates for medical staff to ensure they are competitive but also reflect the pool of staff willing to do additional shifts.

5.12. In February bank expenditure has remained high with agency costs reducing.

5.13. The Trust has also had success in the recruitment of temporary staff on longer term contracts to reduce the reliance on daily agency rates.

6. Cost Improvement Plan (CIP)

6.1. The Trust's efficiency requirement for 2017/18 is £5.6m.

6.2. A saving of £4.9m was planned for February 2018 against actual saving of £2.974m delivered.

6.3. The table below gives the updated detailed performance by CBU the forecast outturn is the risk adjusted figure based on confidence of delivery.

CBU	Plan			MONTH 11 YTD PERFORMANCE Identified Plan			FOT		
	Plan £000	Identified £000	Gap £000	Plan £000	Actual £000	Variance £000	Plan £000	Forecast £000	Variance £000
Corporate	524	1,397	873	1,280	1,303	23	524	1,405	881
Planned	2,100	1,017	(1,083)	869	507	(362)	2,100	582	(1,518)
Specialist	930	653	(277)	567	816	249	930	952	22
Urgent	2,046	719	(1,327)	576	306	(270)	2,046	337	(1,709)
Total	**5,600**	**3,786**	**(1,814)**	**3,292**	**2,932**	**(360)**	**5,600**	**3,276**	**(2,324)**

6.4. As can be seen above, the CIP delivery at month 11 YTD is not achieving the planned position with a shortfall of £360k against the identified plan.

6.5. The forecast outturn position is £3,276k (FYE £3.4m) giving an overall shortfall of £510k against the identified plan and £2,324k against target plan.

6.6. Progress on the Four Eyes Insight cross cutting schemes is set out below:

Project	Annual Plan £000	YTD Plan £000	YTD Actual £000	Comment
Job Planning	225	18	18	Recharge of one session only achieved to date
Theatre Efficiency	93	80	80	On track to deliver
Outpatient Programme	300	250	75	Saving from WLI reduction only, more lost in income
Endoscopy WLI	217	180	0	Delay in implementation due to staff sickness
Total	**835**	**528**	**173**	

6.7. Four Eyes schemes have not delivered as anticipated which has been detailed previously.

6.8. The Trust targeted some of the job planning elements in quarter 4 as part of its recovery plan but this has not been actioned and will now form part of the 2018/19 CIP.

6.9. Other cross cutting schemes:

Project	Annual Plan £000	YTD Plan £000	YTD Actual £000	Comment
Reconfigure G,H & E wards	356	312	74	Commenced Feb-18
Reduce Drugs Expenditure in CBU	300	270	490	Ongoing
Procurement Work Plan	180	158	150	Ongoing
Total	**836**	**740**	**714**	

6.10. The Trust introduced fortnightly run rate meetings for each CBU, chaired by the Turnaround Director, these commenced 9th January 2018

6.11. The CBUs have been tasked with reviewing their use of bank, agency, overtime and waiting list initiatives and reducing these where possible.

7. Cash

7.1 The Trust continues to require cash support as it is trading with a deficit each month.

7.2 A rolling 13 week cash forecast is updated monthly and sent to NHS Improvement usually in the second working week of the month and this forms the basis of any cash draw downs in the future month (February's cash flow was sent on 11th January).

7.3 The Trust borrowed £2.545m in February. This is higher than the projected in month deficit due to the annual lease payment on the Corporate Office/wards 14A/B modular building (£550k). Note that as the Trust has not agreed its control total with NHS Improvement, there is a punitive interest rate charge of 3.5% (normally 1.5%).

7.4 Performance against the cash target in February was as follows:

Description	Target £'000s	Actual £'000s	Comments
Opening balance	1,300	1,097	Brought forward balance.
Cash inflows	16,286	16,891	NHSI receipt of £220k received (not in February's plan), Health Education England receipt £200k higher than expected.
Cash outflows	-16,586	-15,990	Included an additional payment run (£800k) which didn't take place.
Closing balance	**1,000**	**1,998**	

7.5 Cash is monitored daily and plans are adjusted to reflect any changes in month to ensure that the Trust does not breach the loan condition of having £1m bank balance at the end of the month.

7.6 March's loan request of £3.048m was approved using the Board's emergency powers and was drawn down on 12th March.

7.7 This takes the total value of loan draw downs in 2017/18 to £30.804m. Note, this was based on a forecast outturn of £31.7m but then adjusted for £896k winter pressure monies.

8. Capital

8.1 In month capital spend at £269k remains low but there are plans in place that are being monitored daily to ensure that at the end of the financial year the Trust has spent in line with its capital resource limit. Note that this takes into account additional capital monies received in March.

8.2 The Trust was successful with a number of capital bids and received the following public dividend capital in March: A&E streaming £850k, paediatric safe room £37k and cyber-security £152k.

8.3 Analysing the capital report at February which includes goods ordered not received, commitments and future estimates, the spend required in March to achieve the capital resource limit target is £2.846m.

8.4 Whilst this is a substantial sum in one month, the Board should note that £2.094m of that sum has either been ordered or an order is imminent. The remaining amount of £751k is a realistic estimate.

8.5 As the Trust nears the end of the financial year, there is a constant dialogue between Procurement, Finance and the Project teams to ensure delivery.

9. Commissioning for Quality and Innovation payments (CQUINS)

9.1. Quarter 3 results were shared with the FPI committee last month. It is expected that £72k will be actioned in month 12 for quarter 3 performance. An estimate will be made for quarter 4 performance and also actioned in month 12 (could be up to £300k).

10. Financial Risks

10.1. The following risks have not been included in the forecast outturn deficit of £29.2m.

10.2. **Previous years outstanding contract disputes**

10.3. The Trust is in dispute with both Southport & Formby CCG and West Lancashire CCG relating to CQUIN and coding and counting issues from 2015/16 and 2016/17.

10.4. The CCGs have turned down an offer to settle and the issues will now be resolved by Expert Determination.

10.5. A 2017/18 dispute will also be considered as part of this process (GP assessment unit-GPAU for month 1-6)

10.6. NHSE AND NHSI have appointed the Expert and it is anticipated that the process will be concluded by 31 March 2018.

10.7. The value of the dispute for the Expert Determination process is £6.4m.

10.8. The process included disputes up to and including month 6 of this financial year.

10.9. The dispute regarding GPAU for months 7-12 is expected to generate a further £0.878m (value of the month 6 YTD positon).

10.10. **2017/18 Sanctions (penalties)**

10.11. As reported last month, the Trust was notified on 17th December 2017 that the CCG's would be applying sanctions against the Trust for breaches against operational and national standards.

10.12. The value of the penalties is forecast for the full year at £3.0m (the amount is capped at 2.5% per quarter of CCG contract value) with the majority of the target relating to the four hour A&E target and ambulance handovers

10.13. The Trust asked the CCG how they intended to reinvest the sanctions and their response has been that they are not obliged to respond to our question.

10.14. Given the lateness of the CCG's notification of their intention to deduct funding the Trust believes that it will be impossible for the CCG to reinvest this funding in full.

10.15. Discussions have taken place between the Trust's CEO and the Accountable officer for Southport & Formby CCG in order to resolve this issue.

10.16. In addition, the CCSG regulators NHS England have been in dialogue with NHS Improvement.

10.17. At this stage the likelihood is that the CCG's will issue the sanctions resulting in a reduced income of up to £3m in 2017/18.

10.18. **Additional pressures**

10.19. CQUN performance in quarter four is not yet known but is likely to result in a further income shortfall of up to £300k. However, it is expected that this can be absorbed within the forecast

10.20. CCG's have suggested that the Trust is being funded twice for activity associated with winter pressures funding. The Trust is resisting this claim on the basis that premium expenditure has been incurred on dealing with additional pressures across the whole of the winter period.

11. Forecast Outturn

11.1. The Trust submitted a recovery plan with a revised year end forecast of £29.2m deficit to NHS Improvement.

11.2. The month 11 YTD deficit is £0.77m better than the recovery plan.

11.3. The trust is on trajectory to achieve this revised year end forecast (excluding risk)

12. Recommendations

12.1. The FPI committee is asked to discuss the contents of the report and in particular:

- The YTD deficit of £27.981m is £11.11m worse than plan, but £0.77m better than the cumulative recovery plan
- The likelihood of delivering the improved year end forecast deficit of £29.2m and the impact of associated risk from the expert determination process and application of contract penalties.

Southport and Ormskirk Hospital NHS Trust

Statement of Comprehensive Income (Income & Expenditure Account)

I&E (including R&D)	Annual Budget £000	Year to Date Budget £000	Year to Date Actual £000	Year to Date Variance £000	In Month Budget £000	In Month Actual £000	In Month Variance £000	
Operating Income								
Commissioning Income	150,223	137,728	133,841	(3,887)	12,155	12,368	213	• Winter pressures funding
PP, Overseas & RTA	2,320	2,127	1,326	(801)	196	79	(117)	• As previous months
Other Income	14,342	13,156	12,050	(1,106)	1,221	1,081	(140)	• As previous months
Total Income	**166,885**	**153,010**	**147,217**	**(5,794)**	**13,572**	**13,528**	**(44)**	
Operating Expenditure								
Pay	(122,526)	(112,401)	(116,915)	(4,514)	(9,626)	(10,471)	(845)	• YTD adverse variance consists of CIP underperformance along with pressure in month from all staff groups.
Non-Pay	(53,235)	(49,009)	(49,396)	(387)	(4,560)	(4,533)	27	• Benefit in month on CIP
Total Expenditure	**(175,761)**	**(161,410)**	**(166,311)**	**(4,901)**	**(14,186)**	**(15,004)**	**(818)**	
EBITDA	**(8,877)**	**(8,400)**	**(19,095)**	**(10,695)**	**(614)**	**(1,476)**	**(862)**	
Non-Operating Expenditure	(9,237)	(8,467)	(9,533)	(1,066)	(769)	(813)	(44)	
Retained Surplus/(Deficit)	**(18,114)**	**(16,867)**	**(28,628)**	**(11,761)**	**(1,383)**	**(2,289)**	**(906)**	
Technical Adjustments	(5)	4	647	651	0	33	33	
Break Even Surplus/(Deficit)	**(18,119)**	**(16,871)**	**(27,981)**	**(11,110)**	**(1,383)**	**(2,256)**	**(873)**	

Statement of Financial Position (Balance Sheet)

Southport and Ormskirk Hospital NHS Trust

	Opening balance	Closing balance	Movement	Mvt in month
	01/04/2017	28/02/2018		
	£'000s	£'000s	£'000s	£'000s
NON CURRENT ASSETS				
Property plant and equipment/intangibles	123,991	124,638	647	2,887
Other assets	1,267	1,611	344	(71)
TOTAL NON CURRENT ASSETS	**125,258**	**126,249**	**991**	**2,816**
CURRENT ASSETS				
Inventories	2,586	2,405	(181)	(18)
Trade and other receivables	8,042	4,354	(3,688)	755
Cash and cash equivalents	1,623	1,998	375	901
Non current assets held for sale	0	0	0	0
TOTAL CURRENT ASSETS	**12,251**	**8,757**	**(3,494)**	**1,638**
CURRENT LIABILITIES				
Trade and other payables	(21,083)	(17,483)	3,600	(1,398)
Provisions	(164)	(136)	28	0
Borrowings	(1,559)	(1,667)	(108)	0
DH Capital loan	(400)	(400)	0	0
TOTAL CURRENT LIABILITIES	**(23,206)**	**(19,686)**	**3,520**	**(1,398)**
NET CURRENT ASSETS/(LIABILITIES)	(10,955)	(10,929)	26	**240**
TOTAL ASSETS LESS CURRENT LIABILITIES	**114,303**	**115,320**	**1,017**	**3,056**
NON CURRENT LIABILITIES				
Trade and other payables	0	0	0	0
Provisions	(303)	(294)	9	(1)
Borrowings (incl working cap facility)	(40,031)	(67,787)	(27,756)	(2,545)
PFI/Finance lease liabilities	(15,716)	(14,879)	837	335
DH Capital loan	(1,800)	(1,400)	400	0
TOTAL NON CURRENT LIABILITIES	**(57,850)**	**(84,360)**	**(26,510)**	**(2,211)**
TOTAL ASSETS EMPLOYED	**56,453**	**30,960**	**(25,493)**	**845**
FINANCED BY TAXPAYERS EQUITY				
Public Dividend Capital	96,202	96,202	0	0
Retained earnings	(49,977)	(78,482)	(28,505)	(2,290)
Revaluation reserve	10,228	13,240	3,012	3,135
TOTAL TAXPAYERS EQUITY	**56,453**	**30,960**	**(25,493)**	**845**

In month material movements are as follows:

A desktop revaluation of the Trust's land and buildings as at 1st Jan 2018 was transacted in the ledger. This resulted in an upward movement of £3.135m. This can be seen on the revaluation reserve and also on the property, plant and equipment line.

The Trust borrowed £2.545m in February and also paid the annual leave on the Corporate Office/14a/14b modular building (PFI/Finance lease liability line).

Cash outflows were £900k less than outflows and this was mostly around timing of payment runs. This explains the increase in cash and the increase in trade payables.

Statement of cash flows

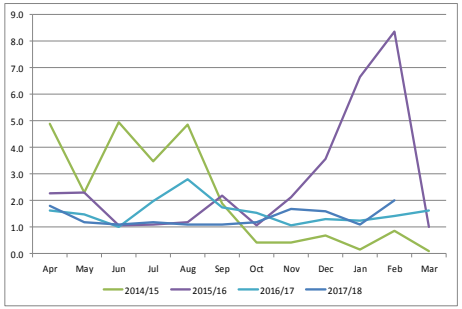
Southport and Ormskirk Hospital NHS Trust

	Actual Apr-17	Actual May-17	Actual Jun-17	Actual Jul-17	Actual Aug-17	Actual Sep-17	Actual Oct-17	Actual Nov-17	Actual Dec-17	Actual Jan-18	Actual Feb-18	Plan Mar-18	Total
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Cash Flows from Operating Activities													
Operating Surplus/(Deficit)	(2,681)	(2,357)	(1,859)	(2,688)	(2,501)	(2,556)	(1,938)	(1,640)	(2,481)	(1,781)	(1,990)	758	(23,714)
Income recognised in respect of capital donat	0	(13)	(5)	(14)	(25)	0	(91)	(30)	(17)	0	0	(73)	(268)
Depreciation and Amortisation	486	485	486	485	487	489	487	487	489	488	515	474	5,858
Impairments and Reversals	0	0	0	0	0	0	0	0	0	0	0	0	0
(Increase) in Inventories	(37)	59	100	(45)	130	(3)	72	(6)	(72)	(35)	18	119	300
(Increase) in Trade and Other Receivables	2,279	796	(593)	565	769	674	(487)	103	(2,640)	2,562	(683)	(2,638)	707
Increase in Trade and Other Payables	(614)	(927)	(486)	(1,077)	(744)	80	924	(2,297)	3,178	(3,969)	1,710	465	(3,757)
Increase in Provisions	(24)	0	(6)	(21)	8	26	8	(3)	(6)	(20)	1	(36)	(73)
Net Cash Inflow/(Outflow) from Operating Activities	(591)	(1,957)	(2,363)	(2,795)	(1,876)	(1,290)	(1,025)	(3,386)	(1,549)	(2,755)	(429)	(931)	(20,947)
Cash Flows from Investing Activities													
Interest Received	2	2	0	2	(1)	1	1	1	3	3	2	1	17
(Payments) for Intangible Assets	(165)	(80)	(12)	(25)	(66)	(14)	(13)	(11)	(64)	37	(12)	(725)	(1,150)
(Payments) for PPE and investment property	(177)	(314)	(93)	(136)	(137)	(118)	(416)	(6)	(894)	84	(210)	(2,426)	(4,843)
Receipts from disposal of fixed assets	0	13	0	(13)	49	0	3	0	0	0	0	0	52
Receipt of cash donations to purchase capital assets	0	0	0	36	21	0	91	30	17	0	0	73	268
Net Cash Inflow/(Outflow) from Investing Activities	(340)	(379)	(105)	(136)	(134)	(131)	(334)	14	(938)	124	(220)	(3,077)	(5,656)
Cash Flows from Financing Activities													
Public dividend capital received	0	0	0	0	0	0	0	0	0	0	0	1,039	1,039
Public dividend capital repaid	0	0	0	0	0	0	0	0	0	0	0	0	0
Loans received from DH	1,413	1,800	2,436	3,355	1,998	2,532	2,743	4,048	2,687	2,199	2,545	3,048	30,804
Loans repaid to DH	(200)	0	0	0	0	0	(200)	0	0	0	0	0	(400)
Capital element of finance leases	0	0	0	(32)	32	0	(505)	(109)	0	(81)	(288)	(8)	(991)
Capital element of PFI, LIFT	(6)	(6)	(6)	(130)	(6)	(6)	(130)	(6)	(131)	(6)	(76)	(137)	(646)
Interest Paid	(30)	0	(56)	(8)	(57)	(371)	(53)	(33)	(100)	100	(261)	(415)	(1,284)
Interest element of finance lease	0	0	0	0	0	0	(283)	(9)	0	0	(187)	0	(479)
Interest element of PFI, LIFT	(49)	(49)	(50)	(116)	(66)	(15)	(100)	(49)	(99)	(49)	(183)	(111)	(936)
PDC dividend (paid)/refunded	0	0	0	0	0	(721)	0	0	0	0	0	(406)	(1,127)
Net Cash Inflow/(Outflow) from Financing Activities	1,128	1,745	2,324	3,069	1,901	1,419	1,472	3,842	2,357	2,163	1,550	3,010	25,980
NET INCREASE/(DECREASE) IN CASH	**197**	**(591)**	**(144)**	**138**	**(109)**	**(2)**	**113**	**470**	**(130)**	**(468)**	**901**	**(998)**	**(623)**
Cash - Beginning of the Period	1,623	1,820	1,229	1,085	1,223	1,114	1,112	1,225	1,695	1,565	1,097	1,998	1,623
Cash - End of the Period	**1,820**	**1,229**	**1,085**	**1,223**	**1,114**	**1,112**	**1,225**	**1,695**	**1,565**	**1,097**	**1,998**	**1,000**	**1,000**

The Trust held enough cash to cover 4 days of operating expenditure at the end of February 2018 (January = 2 days).

Cashflow forecast includes latest loan request to DH and new capital investment.

Month end cash balances held in the last 3 years



Capital Programme

Southport and Ormskirk Hospital NHS Trust

Gross capital spend	2017/18 Plan	Mth 11 YTD Actual	Ordered not received	Committed	Estimated future spend	Total forecast
	£000's	£000's	£000's	£000's	£000's	£'000s
Electronic Patient Record (EPR)	465	170	1	91	20	282
Telephony system replacement	440	424				424
Data warehouse infrastructure incl storage	75	41	42			83
Desktop devices/network readiness	60	23	18	4	42	87
Vitalpac	45	33	11			44
eDMS (Evolve)	164	82	22	12		116
Wheelchair Database * ±	45	23	6			29
Capital Team	150	137			19	156
Estates schemes	50	37	3	3		43
Fire precautions - Dampers	0	0				0
Fire Precautions - Compartmentation	387	435		19		454
Spinal pool filter replacement * =	75	0	70			70
Xray room works	36	37				37
Ward Reconfiguration * ≥	245	81	5	55	105	246
Catering equipment	50	52				52
Legionella preventions	165	42		2		44
Medical Gasses * ≤	60	4	22			26
UPS Theatre	160	7	146			153
Medical equipment including beds	1,145	732	563	330		1,625
Contingency / Prior Year	308	299	206	78	42	625
Board approved capital programme	**4,125**	**2,659**	**1,115**	**594**	**228**	**4,596**
Additional schemes						
A&E Streaming	850	4		347	48	399
CAMHS Safe Room	37	34			4	38
Cyber security	152		39		112	151
Additional estates works **	20					0
	1,059	**38**	**39**	**347**	**164**	**588**
Donate assets/IFRIC12						0
Donated assets	268	195			73	268
GE radiology equipment	1,932	775			286	1,061
	2,200	**970**	**0**	**0**	**359**	**1,329**
Gross Capital Spend	**7,384**	**3,667**	**1,154**	**941**	**751**	**6,513**
Available capital resources						**6,513**
Remaining capital resources						**0**

* New scheme for 17/18
± Funded by a reduction in EPR planned spend
≥ Funded by a reduction in planned spend on medical equipment
≤ Funded by a reduction in legionalla prevention planned spend
= Funded by deferring the fire dampers to 18/19
** Net asset disposals

The Trust has been successful in securing additional investment for cyber-security of £152k and this has now been built into the plan.

We continue to monitor to monitor the capital plan daily and with the support of Procurement, Estates, IT and the CBUs we will ensure that the capital resource available is fully utilised.

Key

YTD Actuals - includes paid invoices, Good received not yet invoiced and additional Non PO accruals

Ordered not received - PO raised but the goods have not been received

Committed - either a letter of intent has gone out or the CIG has made a purchase decision but PO been raised yet.

Estimated future spend - To be based on discussions with the relevant Project Managers. Over time this column will be populated more fully.

Remaining balance - Value left against the revised budget agreed by the Board.

NHS
Southport and Ormskirk Hospital
NHS Trust

PUBLIC TRUST BOARD

11th April 2018

Agenda Item	**TB092/18**	**Report Title**	**Five year capital plan 2018 to 2023**
Executive Lead	Steve Shanahan, Director of Finance		
Lead Officer	Mark Wilson, Assistant Director of Finance		
Action Required *(Definitions below)*	☐ To Receive ✓ To Approve ☐ To Assure		✓ To Note ☐ For Information

Key Messages and Recommendations

Key messages:

- 5 year capital plan submitted to NHS Improvement on 8th March 2018.
- Taken a risk-based approach in deciding the schemes to go forward.
- Annual capital spend is consistently between £4m and £4.2m per annum (excluding donations and managed service contracts).
- Capital Investment Group is refining the initial plan ready for the final NHSI submission due 30th April 2018 but in the interim the Board need to approve the initial capital plan so that urgent schemes can continue.
- This interim plan and the final plan will not be materially different.

Recommendations:

- The Board is recommended to approve the initial capital plans shown in appendix 1 so that urgent schemes can continue.

Strategic Objective(s)
(*The content provides evidence for the following Trust strategic objectives for 2017/18)*

- ☐ **SO1** Agree with partners a long term acute services strategy
- ✓ **SO2** Improve clinical outcomes and patient safety
- ✓ **SO3** Provide care within agreed financial limit
- ✓ **SO4** Deliver high quality, well-performing services
- ☐ **SO5** Ensure staff feel valued in a culture of open and honest communication
- ☐ **SO6** Establish a stable, compassionate leadership team

Governance *(the report supports a…..)*

- ✓ Statutory requirement
- ☐ Annual Business Plan Priority
- ☐ Linked to a Key Risk on BAF / HLRR Ref: _____

☐ Service Change ☐ Best Practice ☐ Other List (Rationale) _____	
Impact *(is there an impact arising from the report on the following?)*	
✓ Quality ✓ Finance ☐ Workforce ☐ Equality	☐ Risk ☐ Compliance ☐ Legal
Equality Impact Assessment *(If there* is *an impact on E&D, an Equality Impact* Assessment *must accompany the report)*	☐ Strategy ☐ Policy ☐ Service Change
Next Steps *(List the required actions following agreement by Board/Committee/Group)*	
Allows urgent capital spend to take place, for example the continuance of the A&E redesign project. Capital Investment Group will continue to refine the plan and will agree the final schemes to go forward to Finance Committee (23rd April) and then to Board for final approval before the NHSI submission due on 30th April 2018.	
Previously Presented at:	
☐ Audit Committee ✓ Finance Performance & Investment Committee ☐ Quality & Safety Committee	☐ Workforce & OD Committee ☐ Mortality Assurance & Clinical Improvement Committee

GUIDE TO ACTIONS REQUIRED *(TO BE REMOVED BEFORE ISSUE)*:

Approve: To formally agree the receipt of a report and its recommendations OR a particular course of action

Receive: To discuss in depth a report, noting its implications for the Board or Trust without needing to formally approve

Note: For the intelligence of the Board without the in-depth discussion as above

Assure: To apprise the Board that controls and assurances are in place

For Information: Literally, to inform the Board

1. Introduction

1.1 The Trust submitted the 5 year capital plan shown in appendix 1 as part of its draft financial plan submission to NHS Improvement on 8th March 2018.

1.2 Individual schemes were selected on a risk-based approach and the calculation for the available capital resources (excluding donations and managed service IFRIC 12 contracts) was estimated to be in the £4m to £4.2m range.

1.3 This initial plan was based on information known at the time and further refinements are currently being undertaken by the Capital Investment Group.

1.4 Corporate governance requires that the Board approve the annual capital plan before any spending can take place.

2. Capital Investment Group

2.1 The Capital Investment Group (CIG) met on 23rd March 2018. The following was agreed:

- Highlight schemes which are CQC must dos.
- Approval of spinal isolation facilities (£200k) with a consequent reduction in medical equipment budget.
- Given that there has been significant investment in medical equipment over recent years that any equipment from now on would be subject to a bidding process through the group.
- The use of a new form to capture key decision-making criteria for the utilisation of capital contingency spending.

2.2 CIG will meet again in mid-April to finalise the plan ready to go to Finance Committee and then to Board for final approval.

2.3 The overall value of the plan is unlikely to change materially and the majority of schemes will remain as they currently are shown in this initial plan.

3. Conclusion

3.1 In order for the Trust to be able to spend essential capital monies in 2018/19, the Trust Board need to approve the initial plans contained in appendix 1.

3.2 The Board should note that an updated capital plan will be required to be submitted to NHSI by 30th April 2018. This updated plan will not be materially different to the one in appendix 1.

4. Recommendations

4.1 The Board is recommended to approve the initial capital plans shown in appendix 1 so that urgent schemes can continue.

Appendix 1 – 5 year capital plan 2018 to 2023

Capital scheme descriptions	Plan 30/04/2018 Month 1 £'000	Plan 31/05/2018 Month 2 £'000	Plan 30/06/2018 Month 3 £'000	Plan 31/07/2018 Month 4 £'000	Plan 31/08/2018 Month 5 £'000	Plan 30/09/2018 Month 6 £'000	Plan 31/10/2018 Month 7 £'000	Plan 30/11/2018 Month 8 £'000	Plan 31/12/2018 Month 9 £'000	Plan 31/01/2019 Month 10 £'000	Plan 28/02/2019 Month 11 £'000	Plan 31/03/2019 Month 12 £'000	Plan 31/03/2019 Year Ending £'000	Plan 31/03/2020 Year Ending £'000	Plan 31/03/2021 Year Ending £'000	Plan 31/03/2022 Year Ending £'000	Plan 31/03/2023 Year Ending £'000	Plan 31/03/2023 5 Year Plan £'000
Medical equipment		100		50	500		50		150		100		**950**	1,150	1,000	1,150	1,200	**5,450**
Beds / Trolleys		50											**50**	50	50	50	100	**300**
Electronic Patient Record				45	25	25	40	10	25	10	10		**190**	635	995	370	325	**2,515**
Vitalpac		3	3	3	3	3	3	3	3	3	3		**30**	10	30	10	30	**110**
eDMS	13	14	13	14	13	13	14	13	13	14	13	13	**160**	80	80	40	40	**400**
Wireless network upgrade	150												**150**	150	150	0	0	**450**
Server warehouse infrastructure incl storage	75												**75**	75	75	320	320	**865**
Telephony system replacement	120												**120**	60	60	60	30	**330**
Cyber security	5	4	4	4	4	5	4	4	4	4	4	4	**50**	80	25	25	25	**205**
Fixed network infrastructure	8	8	8	8	10	8	8	8	10	8	8	8	**100**	50	0	250	150	**550**
Datacentre			25	25									**50**	0	0	0	150	**200**
Virtual desktop infrastructure		3	2	3	2	3	2	3	2	3	2		**25**	0	0	140	0	**165**
Equipment refresh	4	4	5	4	4	5	4	4	4	4	4	4	**50**	30	30	50	50	**210**
GE Turnkey works		50	100				250						**400**	40			250	**690**
Southport A&E Redesign		100	100	50	50	50							**350**					**350**
Ward reconfigurations	100	45											**145**					**145**
Medical gasses	20	20											**40**					**40**
UPS Theatre		40											**40**					**40**
Waste management	100												**100**	80				**180**
Theatre airplant controls				45									**45**					**45**
Generator connectors			65										**65**	65				**130**
Fire comparmentation	30	30	30	30	45								**165**	350	350	350	350	**1,565**
Fire Precautions - Fire Doors					45								**45**	300	300	300		**945**
Nurse call replacement						40	40						**80**	42	42	42	42	**248**
Estates schemes		30			30		30		30				**120**	120	120	120	150	**630**
Capital Team	15	15	15	13	13	12	12	12	12	12	12	12	**155**	155	155	160	160	**785**
Catering equipment			60			40							**100**	75	75	75	75	**400**
Laundry equipment				50									**50**	50		50		**150**
Contingency	50	30	30	30		26	26	26	26	25	25		**294**	300	300	300	350	**1,544**
Legionella prevention													**0**	60		60		**120**
Fire alarm programme													**0**	50	50	50	50	**200**
Fire dampers													**0**	50				**50**
CCTV													**0**	25	25	25	25	**100**
Vehicle replacement													**0**		100		100	**200**
Accomodation refurbishment													**0**	30	30	30	30	**120**
Capital plan excluding donations and IFRIC 12	**690**	**546**	**460**	**374**	**744**	**230**	**483**	**83**	**279**	**83**	**181**	**41**	**4,194**	**4,162**	**4,042**	**4,027**	**4,002**	**20,427**
Donated equipment			30			30			30			30	**120**	150	150	150	150	**720**
GE Radiology equipment replacement programme (IFRIC 12)			175	350	95			716	173				**1,509**	319	514	39	902	**3,283**
Donations and IFRIC 12	**0**	**0**	**205**	**350**	**95**	**30**	**0**	**716**	**203**	**0**	**0**	**30**	**1,629**	**469**	**664**	**189**	**1,052**	**4,003**
Total capital spend	**690**	**546**	**665**	**724**	**839**	**260**	**483**	**799**	**482**	**83**	**181**	**71**	**5,823**	**4,631**	**4,706**	**4,216**	**5,054**	**24,430**

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

11th April 2018

Agenda Item	**TB093/18**	**Report Title**	**Trust Board Risk Register**
Executive Lead	Gill Murphy, Director of Nursing, Midwifery, Therapies and Governance		
Lead Officer	Mandy Power, Assistant Director Integrated Governance		
Action Required *(Definitions below)*	☐ To Receive ☐ To Approve **X To Assure**	☐ For Note ☐ For Information	

Key Messages and Recommendations

Since the last meeting, no new risk has been added to the risk register.

2 risks have been closed on the risk register, following a new risk being added, details as follows:

- 1641 and 482 Bed occupancy and patient flow closed. New risk 1815 patient flow added to risk register.

1 risk closed

- 1640 Diabetic eye screening and amalgamated into 1664 Inability to provide outpatient review appointments to the required timescales.

The Committee is asked to:

- Review the Risk Register.
- Review the risk noting the new Strategic Objectives.
- Approve the changes that have been made to the Risk Register.

Strategic Objective(s)
(*The content provides evidence for the following Trust strategic objectives for 2017/18)*

☐ **SO1** Agree with partners a long term acute services strategy
X SO2 Improve clinical outcomes and patient safety
☐ **SO3** Provide care within agreed financial limit
X SO4 Deliver high quality, well-performing services
☐ **SO5** Ensure staff feel valued in a culture of open and honest communication
☐ **SO6** Establish a stable, compassionate leadership team

Governance *(the report supports a…..)*

X Statutory requirement
☐ Annual Business Plan Priority
☐ Linked to a Key Risk on BAF / HLRR Ref: _____
☐ Service Change
☐ Best Practice

☐ Other List (Rationale) _____	
Impact *(is there an impact arising from the report on the following?)*	
X Quality ☐ Finance ☐ Workforce ☐ Equality	X Risk X Compliance ☐ Legal
Equality Impact Assessment *(If there* is *an impact on E&D, an Equality Impact* Assessment *must accompany the report)*	☐ Strategy ☐ Policy ☐ Service Change
Next Steps *(List the required actions following agreement by Board/Committee/Group)*	
Review of the Risk register on a monthly basis.	
Previously Presented at:	
☐ Audit Committee ☐ Finance Performance & Investment Committee ☐ Quality & Safety Committee	☐ Workforce & OD Committee ☐ Mortality Assurance & Clinical Improvement Committee

GUIDE TO ACTIONS REQUIRED:

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Note: For the intelligence of the Board without the in-depth discussion as above

Assure: To apprise the Board that controls and assurances are in place

For Information: Literally, to inform the Board

Board/Sub-Board Committee: Trust Board Risk Register

NHS Southport and Ormskirk Hospital NHS Trust

Strategic Objective		SO1 - Agree with partners a long term acute services strategy SO2 - Improve clinical outcomes and patient safety SO4 - Deliver high quality, well-performing services SO5 - Ensure staff feel valued in a culture of open and honest communication		Link to BAF	
Opened	**ID**	**ADO/Exec Lead**	**Risk Lead**	**Title**	
25/04/2017	1549	Executive Medical Director	Sanjeev Sharma	Postgraduate Medical Education 'enhanced monitoring' GMC/HENW	
Description	Health Education England and the GMC have placed Southport & Ormskirk NHS Trust under enhanced monitoring. 'Enhanced monitoring' is the process the GMC uses to ensure resolution of significant concerns that that they believe could adversely affect our patient safety, doctors' progress in training, or the quality of the training environment. If we fail to meet the compulsory requirements that HEE and the GMC have set then this may lead to the removal of trainees from the Trust with the resulting impact of the inability to provide safe patient care, sustainability of services, reputational damage and potential recruitment and retention issues.				
Controls	Medical Education is reported at CBU Governance Monthly Meetings The Director of Medical Education meets weekly with the CBU AMD's and has a fast track process directly to the Board The DoME prepares a report to update the Workforce Committee on a monthly basis The DoME attends the Board on a bi-monthly basis to provide an update Junior Doctors Forum (monthly) - trainees able to raise concerns directly with the GOSW GOSW presents a monthly exception report to Board Quarterly online healthcheck requesting trainee views- shared with Specialty Leads		**Gaps in Controls**	Trainees are not completing their Work Place Based Assessments in a timely way The Trust has failed to respond to the GMC Survey specifically its red outliers Trainers do not maintain up to date trainer status with the GMC Job planning for educators has not been fully reviewed to ensure sufficient time to support their roles Improvement to the trainee in Paeds and O&G has not been made Under resourced administrative team and associated infrastructure - specifically for the recording, management and monitoring of quality assurance processes No confirmed action leads to own and drive the HENW Action Plan Lack of CBU ownership of action plan and its resolution Insufficient number of trainees to fill the rotas safely Trainees failing to complete ciritical incident forms as they do not like the Datix system Trainees do not receive timely feedback following submission of Datix reporting No evidence to support that trainees are learning from critical incident reporting Service pressures adversely impact on trainees experience and stop trainees attending local and regional teaching Lack of evidence of effective supervision in clinics and constructive feedback Trainees being asked to work without supervision or working outsde of their level of competence Trainer disengagement - not responding to GMC Survey or completing/returning Specialty lead quarterly/annual reports Medical Education Committee does not address the HENW

							Action Plan The Trust does not have safe and compliant rotas to allow for a good trainee experience There is little evidence of how trainees input in to education governance Poor education governance structures and reporting in place - lack of CBU understanding Impact of TUPE transfer of administrative team to StHK			
Risk Levels	**Likelihood**	**Consequence**	**Risk Rating (Initial)**	**Risk Rating (Current)**	**Risk Level (Current)**	**Risk Rating (Target)**	**Risk Level (Target)**	**Date of Last Review**	**Date of Next Review**	
	Possible (3)	Catastrophic (5)	15	15	Extreme risk	5	Moderate risk	14/03/2018	13/04/2018	
Assurance	Medical Education Committee minutes of meetings Medical Education Governance Reports - CBU Governance Meetings (monthly) Regular meetings with the CEO and Executive MD to discuss progress on HENW Action Plan and organisational change The Job Planning Policy has been agreed with recognition of educational roles for Clinical/Educational Supervisors and Specialty Leads forming part of the job planning process up to March 2018 Full review of medical education governance structure to ensure that the Trust meets the GMC Standards and there is effective assurance from floor to Board Workforce Committee papers - minutes of meetings						**Gaps in Assurance**			
Action Plan	The Trust must provide evidence that it is on track in ensuring that all named clinical and educational supervisors have 'full' recognised status by the GMC deadline of July 31st 2016. The Trust must ensure that SAS doctors meet the requirements to be a named supervisor and that the HEE NW policy on SAS doctors as supervisors is applied accordingly. The Trust must ensure that long-term locum consultants with clinical supervision responsibilities are competent to do so and meet the necessary criteria. The Trust must work to eliminate the use of the term SHO and GPVTS to ensure all staff understand the differing roles and responsibilities of foundation, hospital specialty and GP specialty trainees. The Trust must ensure that all documentation and rotas use the correct nomenclature for each level of trainee to ensure clear differentiation between roles. The Trust should ensure that all trainees understand the process for submitting critical incident forms and the importance of doing so in respect of patient safety and lessons learned. The Trust should also ensure that trainees know how to seek feedback following submission of a critical incident form and that feedback enhances learning. The Trust should ensure that the system is not used by other healthcare professionals as a threat to manage the trainees. The Trust must ensure that trainees are appropriately supervised in clinics and that they receive constructive feedback on their work. ST3 paediatric trainees must not be left to run solo clinics without direct supervision. The Trust must ensure that trainees are able to complete the required Work-Place Based Assessments The Trust should respond to the issues highlighted in the Junior Doctors Advisory Team (JDAT) report to ensure safe and compliant rotas. The Trust must ensure that service pressures do not impact adversely on the training experience of medical trainees and that trainees are able to gain sufficient experience to meet the requirements of their curriculum. The Trust must ensure all trainees at both sites are able to access formal regional and local teaching. The Trust must continue to improve its internal quality control process including systematic collation of information from departments, to evidence that postgraduate medical education is being delivered effectively. This must include a process for ensuring that actions are taken to address negative outliers that						**Action Plan Due Date**	31/03/2018 04/01/2018 21/06/2018 21/06/2018 21/06/2018 29/06/2018 21/06/2018 31/03/2018 21/06/2018 21/06/2018 21/06/2018 31/03/2018 04/05/2018 21/06/2018 31/03/2018 21/06/2018	**Action Plan Rating**	Completed Completed Moderate Progress Made Actions Almost Completed Actions Almost Completed Moderate Progress Made Moderate Progress Made Actions Almost Completed Moderate Progress Made Actions Almost Completed Actions Almost Completed Actions Almost Completed Moderate Progress Made Moderate Progress Made Moderate Progress Made Moderate Progress Made

	may result from the GMC NTS with measures put in place to identify improvements. The Trust must ensure that all trainees at both sites are able to access formal regional and local teaching The Trust must present HEE with comprehensive evidence of how trainees input into educational governance with examples of improvements being made, by the beginning of March 2018 The Trust must present HEE with comprehensive evidence of how the senior team has addressed a lack of trainer engagement by the beginning of March 2018 The Trust must review their governance structures to ensure they are fit for purpose in relation to education matters. The Trust must present HEE with comprehensive evidence of Board engagement and examples of how the structures are working by the beginning of March 2018. The Trust produce comprehensive evidence which shows how it has resolved the issue of the impact of the transfer of the education and training department on the administration of education by the beginning of March 2018. The Trust must present HEE with comprehensive evidence on how trainees are learning from critical incidents following its new process by the beginning of March 2018. The Trust must present HEE with comprehensive evidence that shows the job planning process is appropriately supporting educators to undertake their roles by the beginning of March 2018. The Trust must present HEE with comprehensive evidence of improvement in the trainee experience in the Paediatrics and O&G programmes by the beginning of March 2018.				

Strategic Objective		SO2 - Improve clinical outcomes and patient safety SO3 - Provide care within agreed financial limit SO4 - Deliver high quality, well-performing services					Link to BAF			
Opened	**ID**	**ADO/Exec Lead**	**Risk Lead**	**Title**						
20/10/2017	1664	Chief Operating Officer	Therese Patten	Inability to provide out patient review appointments in the required timescales.						
Description	If the Trust does not review patients in Out Patients in the time frames identified by their treating clinicians, then there is a risk that patients may be harmed due to delays instigating required treatment.									
Controls	Only accept choose and book out patient referrals Review staffing in all affected services To analyse each waiting list and prioritise patient based on clinical need.						**Gaps in Controls**			
Risk Levels	**Likelihood**	**Consequence**	**Risk Rating (Initial)**	**Risk Rating (Current)**	**Risk Level (Current)**	**Risk Rating (Target)**	**Risk Level (Target)**	**Date of Last Review**	**Date of Next Review**	
	Likely (4)	Major (4)	20	16	Extreme risk	4	Moderate risk	20/02/2018	31/03/2018	
Assurance	Review at Governance Committees						**Gaps in Assurance**			
Action Plan	To source external support to assist the Trust in prioritising and treating the patients. Risk stratification complete for all areas and plans in place to clear backlog. Weekly calls with NHSI and NHSE continue with assurance from them to CQC.						**Action Plan Due Date**	30/03/2018	**Action Plan Rating**	Moderate Progress Made

Strategic Objective		SO2 - Improve clinical outcomes and patient safety SO3 - Provide care within agreed financial limit SO4 - Deliver high quality, well-performing services SO5 - Ensure staff feel valued in a culture of open and honest communication					Link to BAF	BAF010
Opened	**ID**	**ADO/Exec Lead**	**Risk Lead**	**Title**				
22/09/2016	1368	Director of HR	Jane Royds	Safe Staffing Levels - Impact on Quality and Finance				
Description	If the Trust is not able to attract and recruit nursing and medical staff with the knowledge, skills and experience required there is a risk to the Trust of not providing safe levels of staffing and an impact on finance due to reliance on agency staff.							
Controls	Introduction of a nationally capped rate for agency for both medical and nursing staff Policies and processes around bank/agency staff usage Development of a nurse bank in conjunction with existing NHSP bank supply Edge Hill additional cohort for training nurses Executive oversight at weekly meetings Monthly review at FP & I Committee Monthly review at Board Individual authorisation of requests above cap for agency staff Strategic Alliances with other health care providers Targeted advertising campaign for qualified nursing staff (HEI) Workforce planning methodology agreed Planned recruitment campaigns agreed NHSP cohorts for HCA recruitment Recruitment and Selection Policy Assistant Director of Nursing role leads on Nurse recruitment Discussions with Southport College regarding "Acorns" project for Nurse development Consider joint consultant appointments with local partners, either in specialty units or within the Local Delivery Service framework						**Gaps in Controls**	Draft HR Strategy requires approval Further work to be commenced around more robust workforce planning, engaging service managers. Continuing staff groups that are difficult to recruit to requiring different solutions
Risk Levels	**Likelihood**	**Consequence**	**Risk Rating (Initial)**	**Risk Rating (Current)**	**Risk Level (Current)**	**Risk Rating (Target)**	**Risk Level (Target)**	**Date of Last Review**	**Date of Next Review**
	Likely (4)	Major (4)	20	16	Extreme risk	12	High Risk	14/03/2018	19/04/2018
Assurance	Monitoring of fill rates of bank and agency staff through weekly ED meetings Monitoring of fill rates through monthly Trust Board Shared arrangements with other Trusts for Consultant posts Agency Spend Review Undertaken. Project Co-Ordinator appointed for 6 months to progress actions Monitoring of Recruitment Action Plan through quarterly HR Report to Trust Board Workforce Plan submitted to HE England as approved by the Medical Director. Ongoing targeted advertising campaigns. Trust HR Governance Committee provided with information on Workforce Plan Nurse recruitment campaigns in Higher Education institutes. DON working with NHSP Joint appointments for Senior Consultant with St Helens & Knowsley Hospital NHS Trust, Liverpool Heart & Chest Exit interview process review carried out, with action plan as a result. 2017 - 2019 Workforce Plan submitted to NHSI						**Gaps in Assurance**	Status of workforce plan	
Action Plan							**Action Plan Due Date**		**Action Plan Rating**

Strategic Objective	SO2 - Improve clinical outcomes and patient safety SO4 - Deliver high quality, well-performing services							Link to BAF	
Opened	**ID**	**ADO/Exec Lead**	**Risk Lead**	**Title**					
19/03/2018	1815	Chief Operating Officer	Tracey Edwards	Patient Flow					
Description	If ability to egress out of A&E is compromised, then the department is overcrowded, resulting in patients waiting to be reviewed by medical staff exceeding national safety standards (4hr quality indicators), risk to patient's safety, privacy and dignity. Can result in patients being placed in the incorrect specialty ward bed without the correct nursing and medical skill mix, insufficient nursing staff to care for them and medical teams unable to review patients in a timely manner.								
Controls	Escalation policy in place Full to capacity protocol in place Infection control policy Daily huddles in place in ED Safer Staffing review Twice daily discharge meetings with external partners Three x daily escalation meetings Agreed SOP for escalation areas Aim to maximise limited capacity in ODGH EY partnership working System leadership support ED Safety Checklist Intentional rounding for ambulance queues SAFER now in place on wards, supporting expediting discharge						**Gaps in Controls**	Delay to see the patient in ED may cause harm to the patient Insufficient medical and nursing staff, particularly in ED Insufficient realtime bed availability data No permanent Integrated Discharge Team Lack of community/social care capacity No Discharge Lounge	
Risk Levels	**Likelihood**	**Consequence**	**Risk Rating (Initial)**	**Risk Rating (Current)**	**Risk Level (Current)**	**Risk Rating (Target)**	**Risk Level (Target)**	**Date of Last Review**	**Date of Next Review**
	Likely (4)	Major (4)	20	16	Extreme risk	12	High Risk	19/03/2018	19/04/2018
Assurance	Safecare/Acuity/Staffing monitoring Command and control system to support escalation by a Senior Manager Harm meetings across all CBU's Monitoring of bed occupancy Daily meetings at EMS 3 or above with regional partners Infection control monitoring						**Gaps in Assurance**		
Action Plan	Additional building to create more capacity in ED and modular building to create a CDU. External partners have agreed to fund an Integrated Discharge Team. To deliver and embed the 'Safe at all Times' project, to improve the recognition and response to the deteriorating patient. Improving ways of working, particularly in ED						**Action Plan Due Date**	31/05/2018 31/07/2018 01/06/2018 29/06/2018	**Action Plan Rating** Moderate Progress Made Moderate Progress Made Moderate Progress Made Little or No Progress Made

Strategic Objective		SO2 - Improve clinical outcomes and patient safety SO4 - Deliver high quality, well-performing services						Link to BAF	
Opened	**ID**	**ADO/Exec Lead**	**Risk Lead**	**Title**					
21/11/2017	1701	Director of Finance	Joyce Jordan	Failure of equipment, central monitoring suite ITU/HDU/CCU which could be fatal for the patient					
Description	Modules (MMS)which cables attach to , have come loose and fallen to the floor resulting in loss of vital haemodynamic monitoring which potentially could result in death. (Some MMS have to be taped to reduce this risk which is poor practice).MMS also can become faulty for other reasons which means having to be checked by EBME and if not repairable having to be replaced . Central monitoring suite will reach end of recommended life cycle in Jan 2020. Therefore replacement is required for 18 monitors and modules, 2 central monitors and 10 telemetry units. Risk of fault, failure, unable to replace parts.								
Controls	Equipment monitored through asset register Equipment discussed at medical device committee (life expectancy and replacement programme) Equipment currently being taped to keep in place Bid submitted for capital funds to replace all monitoring suite, including telemetry						**Gaps in Controls**	modules taped in place are a risk to the patient as this is not an adequate solution If tape comes away, unable to monitor patient, this could lead to fatal incident if funding not approved, monitors will have to be replaced but they become obsolete at the end of 2019	
Risk Levels	**Likelihood**	**Consequence**	**Risk Rating (Initial)**	**Risk Rating (Current)**	**Risk Level (Current)**	**Risk Rating (Target)**	**Risk Level (Target)**	**Date of Last Review**	**Date of Next Review**
	Possible (3)	Catastrophic (5)	20	15	Extreme risk	5	Moderate risk	14/03/2018	23/04/2018
Assurance	From company Philips Medical equipment discussed at Medical device committee Escalated to CBU governance Incidents discussed at harm meeting Incidents discussed at unit safety meeting and lessons learned shared						**Gaps in Assurance**	Issues if meetings cancelled due to winter pressures - incidents not discussed	
Action Plan	Mindray monitoring has been trialled on ITU, quotes have been obtained, case submitted to captital committee. To obtain quotes from Mindray installation programme to be developed with time line with EBME and Mindray to install all the new equipment to meet with IT, EBME, clinical team to ensure all equipment required is within the most recent quote						**Action Plan Due Date**	10/12/2018 21/11/2017 01/05/2018 05/03/2018	**Action Plan Rating** Completed Completed Little or No Progress Made Completed

Strategic Objective		SO2 - Improve clinical outcomes and patient safety SO4 - Deliver high quality, well-performing services SO5 - Ensure staff feel valued in a culture of open and honest communication					Link to BAF	
Opened	**ID**	**ADO/Exec Lead**	**Risk Lead**	**Title**				
12/09/2017	1624	Director of Nursing & Quality	Jacqui Flynn	Lack of evidence of professional curiosity				
Description	A reduction in safeguarding referrals from Emergency Care and a Local Authority audit into Child Criminal Exploitation lead to a Trust safeguarding audit to benchmark on professional curiosity where attendance to the Trust would indicate further questioning should be required / evidenced. Audit results indicated a lack of routine enquiry / lack of documentation if enquiry occurs into high risk cases.							
Controls	Safeguarding training and monitoring of compliance Safeguarding Audit Safeguarding policy Review and monitoring of incidents and compliants					**Gaps in Controls**	Missed opportunities- no real time monitoirng Staff not using documentation to indicate questioning and IT system does not support mandatory field. New documentaion should support inclusion of routine enquiry.	
Risk Levels	**Likelihood**	**Consequence**	**Risk Rating (Initial)**	**Risk Rating (Current)**	**Risk Level (Current)**	**Risk Rating (Target)**	**Risk Level (Target)**	**Date of Last Review**	**Date of Next Review**
	Possible (3)	Catastrophic (5)	20	15	Extreme risk	5	Moderate risk	27/03/2018	30/04/2018
Assurance	Mandatory training reports Safeguarding Board- reporting of Audit finndings Audit CQC inspection Incident/ SUI reviews- reported in Q&S						**Gaps in Assurance**		
Action Plan	To incorporate checks into audit of casenotes monthly Revised documentation with specific prompts to be introduced in April AED mandatory safeguarding training needs to be completed by all staff The Safeguarding team will increase visibility in department and be on hand to offer advice and support Harm meeting will involve safeguarding incidents and management of cases will be reflected on in order to learn lessons from incidents/ complaints						**Action Plan Due Date**	28/02/2018 21/05/2018 29/05/2018 01/10/2018 09/01/2018	**Action Plan Rating** Completed Actions Almost Completed Moderate Progress Made Completed Completed

Strategic Objective		SO2 - Improve clinical outcomes and patient safety SO4 - Deliver high quality, well-performing services SO5 - Ensure staff feel valued in a culture of open and honest communication SO6 - Establish a stable, compassionate leadership team					Link to BAF	
Opened	**ID**	**ADO/Exec Lead**	**Risk Lead**	**Title**				
18/12/2017	1760	Jane Royds	Jane Royds	Lack of Trust Equality & Diversity Lead				
Description	Following the National Guardians Office (NGO) Report published on the 15th November 2017 the Trust is required to undertake the following recommendations: Recommendation 12 The trust should ensure that it provides appropriate resources for the role of Freedom to Speak Up Guardian, in line with guidance provided by the National Guardian's Office, including sufficient cover to support their work in their absence, and alternative routes to handle speaking up matters to overcome any possible conflicts. Recommendation 14 Within six months the Trust should trust look again at its appointment process for the role of Freedom to Speak Up Guardian and ensure a Guardian is appointed using a process that is open and fair. Recommendation 21 Within six months the trust should appoint an equality and diversity lead and ensure that position is appropriately resourced. The Trust must comply with the recommendations as laid out in the NGO report failure to do so would ensure further criticism of the Trust from the NGO, CQC, press etc. It could also impact of the CQC report findings of the Trust going forward. The Trust would be at risk of being Unable to fulfil E&D legislation, regulations and agenda.							
Controls	E&D post agreed at star chamber Post out to advert						**Gaps in Controls**	No E&D Lead in Trust during recruitment process

Risk Levels	Likelihood	Consequence	Risk Rating (Initial)	Risk Rating (Current)	Risk Level (Current)	Risk Rating (Target)	Risk Level (Target)	Date of Last Review	Date of Next Review
	Almost Certain (5)	Major (4)	20	20	Extreme risk	1	Low risk	18/12/2017	30/03/2018

Assurance		**Gaps in Assurance**			
Action Plan		**Action Plan Due Date**		**Action Plan Rating**	

Strategic Objective		SO2 - Improve clinical outcomes and patient safety SO4 - Deliver high quality, well-performing services SO5 - Ensure staff feel valued in a culture of open and honest communication SO6 - Establish a stable, compassionate leadership team					Link to BAF	BAF008
Opened	**ID**	**ADO/Exec Lead**	**Risk Lead**	**Title**				
22/09/2016	1367	Director of HR	Audrey Cushion	Failure to have a motivated and engaged workforce (culture).				
Description	If we have lack of engagement with staff this will result in low productivity, lack of efficiency, high absence, high turnover.							
Controls	Leadership Master Classes Annual Pride Awards Workforce Strategy Junior Doctors Survey Engagement and Culture Strategy Equality and Diversity Working Group New post created for support of records system, recruitment process is on going.						**Gaps in Controls**	Uncertainty of CEO post
Risk Levels	**Likelihood**	**Consequence**	**Risk Rating (Initial)**	**Risk Rating (Current)**	**Risk Level (Current)**	**Risk Rating (Target)**	**Risk Level (Target)**	**Date of Last Review**	**Date of Next Review**
	Likely (4)	Major (4)	16	16	Extreme risk	8	High Risk	14/02/2017	30/03/2018
Assurance	Quarterly HRD report to Trust Board Result of Staff Attitude Survey Coaching in the workplace Values based recruitment based on guidance from NHS England PDR Process which includes Trust values Charter for Staff and Managers Review of culture in the Trust, being carried out by external adviser. HR Director agreed extension of project, report is expected in February 2017.						**Gaps in Assurance**	Nil Identified	
Action Plan	Cultural Review as commissioned by the Board						**Action Plan Due Date**	02/02/2018	**Action Plan Rating** Completed

Strategic Objective		SO3 - Provide care within agreed financial limit					Link to BAF	BAF007
Opened	**ID**	**ADO/Exec Lead**	**Risk Lead**	**Title**				
10/05/2016	1329	Director of Finance	Steve Shanahan	Returning to financial balance by 2021				
Description	If we do not have a plan to return to financial balance by 2021, then potentially the organisation will not exist in it's current form.							
Controls	Long term financial model and an estate solution based on the sustainability report completed by the Deloitte in 2015. The Care for You programme built on the Deloitte findings. This has now been supported by the Northern Clinical Senate report. Trust is part of the Cheshire & Mersey Health & Social Care Partnership (STP); the Sefton Transformation Board provides oversight of the Care for You Programme Trust is member with Alliance LDS .						**Gaps in Controls**	The need to model the STP/LDS assumption in LTFM Accuracy of PLICS data and Model Hospital West Lancashire CCG member of Healthier Lancashire & South Cumbria (STP)
Risk Levels	**Likelihood**	**Consequence**	**Risk Rating (Initial)**	**Risk Rating (Current)**	**Risk Level (Current)**	**Risk Rating (Target)**	**Risk Level (Target)**	**Date of Last Review**	**Date of Next Review**
	Likely (4)	Major (4)	16	16	Extreme risk	6	Moderate risk	03/03/2017	16/04/2018
Assurance	Monthly report to Trust Board re Progress of the Sefton Transformation Board Long Term Financial Model (LTFM)						**Gaps in Assurance**	No agreed clinical model for reconfiguration of services	
Action Plan	Development of Estate plan for reconfiguration of services; identification of land sales to support capital development costs Development of a financial revenue plan with savings for the reconfiguration of services Submission of Trust 2 year operational plans by 23/12/16. Submission of STP plan.						**Action Plan Due Date**	01/09/2018 23/12/2016 16/10/2016	**Action Plan Rating** Moderate Progress Made Completed Completed

NHS
Southport and Ormskirk Hospital
NHS Trust

PUBLIC TRUST BOARD
11th April 2018

Agenda Item	**TB094/18**	**Report Title**	**Compliance with NHSI's Provider Licence**
Executive Lead	Silas Nicholls, Chief Executive		
Lead Officer	Audley Charles, Interim Company Secretary		
Action Required *(Definitions below)*	✓ To Receive ✓ To Approve ☐ To Assure	☐ For Note ☐ For Information	

Key Messages and Recommendations

The Trust is required to submit a return as part of its annual reporting process.

Under Guidance issued by NHS Improvement (NHSI), the Regulator, the Trust is required to self-certify regarding compliance with Provider Licence Conditions: **G6 and FT4.** Where the Trust is not compliant it is required to explain why and develop an action plan to achieve compliance.

This report relates to **Condition G 6** and **FT4** of The NHS Provider Licence with evidence of the Trust's compliance.

The Board is required sign off on the self-certifications by the following deadlines:

- ***Condition G6: 31 May 2018***
- ***Condition FT4: 30 June 2018***

NHS Trusts are not required to submit their reports of compliance to NHSI but from July 2018, it may be asked to provide evidence of that compliance as part of a sample test by the regulator. Despite the deadlines for submission being different, it is recommended that the Board signs off both at the same time as the evidence for both have been provided.

This paper asserts that there is substantial evidence to suggest that the Trust is compliant with both Conditions.

Recommendation:
The Board is asked to **review** the evidence and **approve** the self-certification

Strategic Objective(s)
(*The content provides evidence for the following Trust strategic objectives for 2017/18)*

- ✓ SO1 Agree with partners a long term acute services strategy
- ✓ **SO2** Improve clinical outcomes and patient safety
- ✓ **SO3** Provide care within agreed financial limit
- ✓ **SO4** Deliver high quality, well-performing services
- ✓ **SO5** Ensure staff feel valued in a culture of open and honest communication
- ✓ **SO6** Establish a stable, compassionate leadership team

Governance *(the report supports a…..)*

- ✓ Statutory requirement
- ☐ Annual Business Plan Priority
- ✓ Linked to a Key Risk on BAF / HLRR Ref: _____ALL_____
- ☐ Service Change
- ✓ Best Practice
- ☐ Other List (Rationale)

_____

Impact *(is there an impact arising from the report on the following?)*

✓ Quality	
✓ Finance	✓ Risk
✓ Workforce	✓ Compliance
✓ Equality	✓ Legal
Equality Impact Assessment *(If there* is *an impact on E&D, an Equality Impact* Assessment *must accompany the report)*	☐ Strategy ☐ Policy ☐ Service Change

Next Steps *(List the required actions following agreement by Board/Committee/Group)*

Previously Presented at:

☐ Audit Committee	☐ Workforce & OD Committee
☐ Finance Performance & Investment Committee	☐ Mortality Assurance & Clinical Improvement Committee
☐ Quality & Safety Committee	

Introduction

Last year was the first year that NHS Trusts self-certified. Although NHS Trusts are exempt from needing the provider licence, they are required to comply with conditions equivalent to the licence that NHSI has deemed appropriate.

The *Single Oversight Framework* (SOF) bases its oversight on the NHSI Provider Licence. NHS Trusts are therefore legally subjected to the equivalent of certain provider licence conditions (**including Conditions G6 and FT4**) and must self-certify under these licence provisions.

NHS Trusts are required to self-certify that they can meet the obligations set out in the NHS Provider Licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009 and the Health and Social Care Act 2012, and to have regard to the NHS Constitution) and that they have complied with governance requirements. **The self-certification requirement set out in Condition CoS7(3) does not apply to NHS Trusts.**

The aim of self-certification is for providers to carry out assurance that they are in compliance with the conditions.

Southport and Ormskirk Hospital NHS Trust is required to self-certify against two of the original 6 categories of Conditions issued by NHSI and last updated in 2013.

The Trust is required to self-certify against the following two Conditions:

Condition G6- G6 (2) requires NHS Trusts to have processes and systems that:

- identify risks to compliance
- take reasonable mitigating actions to prevent those risks and a failure to comply from occurring.

The Trust must answer a series of statements as "***Confirmed***", if Compliant and "***Not Confirmed"*** if Non-compliant". It there is non-compliance, the Trust must explain why and list actions to achieve compliance

Condition FT4 (8)

Despite not being a Foundation Trust NHSI requires the Trust to self-certify against this condition as well which requires that:

- Providers should review whether their governance systems achieve the objectives set out in the licence condition.

- Compliant approach to involve effective board and committee structures, reporting lines and performance and risk management systems.

The Board must sign off on the self-certifications by the following deadlines:

- ***Condition G6: 31 May 2018***
- ***Condition FT4: 30 June 2018***

NHS Trusts are no longer required to return their completed licence self-certifications or templates to NHSI; instead, from July 2018, NHSI will contact a select number of NHS Trusts and Foundation Trusts to ask for evidence that they have self-certified. This could be done by either providing the completed templates, if used, or relevant Board minutes and papers recording sign-off.

Appendix 1 below is used as a self-certification against the two conditions.

Recommendations:

The Board is asked to **review** and **approve** the self-certification

Appendix 1 KEY: C=Confirmed NC=Not Confirmed

SELF ASSESSMENT OF COMPLIANCE WITH NHSI PROVIDER LICENSE CONDITIONS G6 and FT4 2017-18						
	License Condition	**Executive Lead**	**Compliance C/NC**	**Narrative**	**Evidence of Assurance**	**Identified Further Actions**
	G6: Systems for Compliance with Licence Related Conditions and Related Obligations *Requires providers to take all reasonable precautions against the risk of failure to comply with the license and other important requirements* 1 a) the Conditions of this Licence, these being: (i) the Trust must be registered with the Care Quality Commission (CQC); and (ii) the directors of the Trust must meet the regulator's fit and proper persons' test. 1 b) any requirements imposed on it under the NHS Acts 1 c) the requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS	CEO	**C**	The Trust has remained registered with the Care Quality Commission throughout 2016-17 There is a robust Fit and Proper Persons Regulation Policy (FPPR) in place. There were no additional requirements imposed on the Trust under the NHS Acts during 2016/17 The Trust continues to have regard to the provisions contained within the NHS Constitution through the formulation and adoption of Trust policies and procedures. The NHS Constitution is in line with the Trust's overall values and vision of high quality care for all. The Trust's governance structure reflects the needs of the NHS Constitution and	CQC Registration Certificate Directors' FPPT signed Declaration DBS Certificates Regulation 3 Pre-Employment checks-Personnel File Patient Experience Group	None

	2) Without prejudice to the generality of paragraph 1, the steps that the Licensee must take pursuant to that paragraph shall include: 2a) the establishment and implementation of processes and systems to identify risks and guard against their occurrence		**C**	the rights and pledges of patients and staff. The Trust has an approved Risk Management Strategy and approach to identifying, managing and escalating risk. This has recently been brought to the Board for ratification after it was reviewed and updated. Risk registers are maintained by each Clinical Business Unit and Corporate Directorates. Regular review of these enables the escalation of risk that is above acceptable levels to the Executive Team. Risk Registers are reviewed by the Quality and Safety Committee and Finance and Performance Committee on a monthly basis and by the Audit Committee quarterly. The Trust Board reviews the highest risks facing the organisation on a monthly basis and where required requests further action to be taken. The Board developed a Board Assurance Framework (BAF) for 2017-18 based on the Trust's refreshed and refined strategic objectives. This is reviewed by the Board on a quarterly basis; and the Board Committees on a monthly basis and at the Audit Committee quarterly. The Audit Committee receives assurance of the effectiveness of the system of internal control	Pledge Group Trust's Statutory Instruments Trust's Prime Policies Risk Management Strategy and Policy Governance Structure Board Assurance Framework Board Reports Audit Committee Reports	

	2b) regular review of whether those processes and systems have been implemented and of their effectiveness.		**C**	The Trust has in place an incident management process which incorporates root cause analysis and lessons learned. There are mechanisms in place to ensure that lessons from any incidents are cascaded throughout the organisation although these are being improved. The Chief Accounting Officer's Annual Governance Statement considers the effectiveness and implementation of the Trust's processes and systems each year. In addition to this the Audit Committee oversees the delivery of the Programme of Internal Audit which focuses on any areas of the control system where independent assurance is required. The Board and its Committees undertake a review of their performance and effectiveness on an annual basis and identifies areas for improvement. Their revised Terms of Reference have suggested that the review should be undertaken twice annually.		
	NHSFT4: Foundation Trust Governance *Enables NHSI to continue oversight of governance of NHS Foundation Trusts.*	Company Secretary	**C**	The Trust is compliant with this condition. NHSI plays a pivotal role in the governance of the Trust. It supports the Trust in its turnaround programmes and initiatives by seconding experts into the Trust in such areas as service improvement and redesign. Mandatory reports are submitted to NHSI as required and self-	• NHSI Self-certification Reports • Documentary evidence of NHSI's	.

				certifications completed as prescribed.	personnel supporting the Trust's Executives • NHSI's Involvement in recruitment of NEDs and Executives including the CEO	

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

11 April 2018

Agenda Item	**TB095/18**	**Report Title**	**Draft Board Development Programme**
Executive Lead	*Silas Nicholls, Chief Executive*		
Lead Officer	*Audley Charles, Interim Company Secretary*		
Action Required *(Definitions below)*	✓ To Receive ✓ To Approve ☐ To Assure	☐ For Note ☐ For Information	

Key Messages and Recommendations

The Board has been meeting on a monthly basis and little time was devoted to Board Development Programme, Board Timeout and Board Seminars. It is felt that the Board's Annual Programme and Business Cycle may need adjustment to allow time for the Board to spend time as a unitary body to reflect on some of the key improvement challenges the Trust faces outside the formal confines of the public Board. Not having planned or devoted the time for the Board to engage in this is a governance gap in itself.

The attached report lists some of the achievements the Trust has made and actions that are needed to close gaps.

The Board has not had many formal Board Development sessions in 2017/18. The report attempts to make a case for this to be formalised and lists two options for the Board to consider in order for this to be realised.

The report is recommending Option 1 as this seems to be best fit.

Recommendations:

The Board is asked to:

- **Review** the report and make recommendations for improvement
- **Approve** the proposed Board Development Programme
- **Approve** one of the Options proposed

Strategic Objective(s)
(*The content provides evidence for the following Trust strategic objectives for 2017/18)*

- ✓ **SO1** Agree with partners a long term acute services strategy
- ✓ **SO2** Improve clinical outcomes and patient safety
- ✓ **SO3** Provide care within agreed financial limit
- ✓ **SO4** Deliver high quality, well-performing services
- ✓ **SO5** Ensure staff feel valued in a culture of open and honest communication

✓ **SO6** Establish a stable, compassionate leadership team
Governance *(the report supports a…..)*
☐ Statutory requirement ☐ Annual Business Plan Priority ☐ Linked to a Key Risk on BAF / HLRR Ref: __ALL_____ ☐ Service Change ✓ Best Practice ☐ Other List (Rationale) _____
Impact *(is there an impact arising from the report on the following?)*

✓ Quality ✓ Finance ✓ Workforce ✓ Equality	✓ Risk ✓ Compliance ✓ Legal
Equality Impact Assessment *(If there* is *an impact on E&D, an Equality Impact* Assessment *must accompany the report)*	☐ Strategy ☐ Policy ☐ Service Change

Next Steps *(List the required actions following agreement by Board/Committee/Group)*
Previously Presented at:

☐ Audit Committee ☐ Finance Performance & Investment Committee ☐ Quality & Safety Committee	☐ Workforce & OD Committee

GUIDE TO ACTIONS REQUIRED:

Approve: To formally agree the receipt of a report and its recommendations OR a particular course of action

Receive: To discuss in depth a report, noting its implications for the Board or Trust without needing to formally approve

Note: For the intelligence of the Board without the in-depth discussion as above

Assure: To apprise the Board that controls and assurances are in place

For Information: Literally, to inform the Board

NHS
Southport and Ormskirk Hospital
NHS Trust

BOARD DEVELOPMENT PROGRAMME

2018-2019

Programme Sponsor: Richard Fraser, Trust Chairman

Executive Lead: Silas Nicholls, Chief Executive

Author: Audley Charles, Interim Company Secretary

1.Introduction and Setting

The Trust has undergone some difficulties over the last few years which resulted in a whole sale change of the top leadership in 2015. Since then there has not been long term sustained leadership at the top of the Trust for the last two years. This has impacted on the planning and embedding of the long term strategic direction of the organisation. There was also a noticeable gap in sound governance arrangements in the Trust.

In September 2017 the Board of Directors approved the strategic objectives and principal risks and a Board Assurance Framework model for 2017-2018. It also approved a number of key policies which were developed to ensure compliance with the legal and regulatory framework as a result of an on-going review of the governance arrangement in the Trust by the Interim Company Secretary.

In December 2017, the Care Quality Commission undertook a number of unannounced visits and a planned Well Led Review of the Trust. In its report issued 13 March 2018, the Trust was rated as *Requiring Improvement*.

The Board's challenge is two-fold - lead the improvement in CQC ratings for clinical services (Requires Improvement) and to improve Well Led which is inadequate (focusing on strategic and operational delivery of a plan and the supporting approach to governance from Board to Ward). Underpinning this is executive and NED recruitment and maintaining stability - building leadership and visibility.

The Board may want to think about how to develop the Board relationships and dynamics to enable it to be equally focused on future direction as well as ensuring strategic planning and very high risks are being managed - this means developing the way in which individuals contribute and interact with one another and developing constructive challenge. It may be prudent to discuss the proposal regarding the bi-monthly format with the Trust's NHSI Director of Improvement Development (Jill Copeland) and get her feedback before moving to the new approach proposed below.

The Board has been meeting on a monthly basis and little time was devoted to Board Development Programme, Board Timeout and Board Seminars. It is felt that the Board's Annual Programme and Business Cycle may need adjustment to allow time for the Board to spend time as a unitary body to reflect on some of the key improvement challenges the Trust faces outside the formal confines of the public Board. Not having planned or devoted the time for the Board to engage in this is a governance gap in itself.

The Executive Team has developed a Single Executive Improvement Plan

This Single Executive Improvement Plan for 2018/19, confirms the Executive Team's determination of the broad range of quality, financial and core performance measures that need to be transformed to strive to achieve a continuous improvement, ultimately leading to the recognition of a Good range of service in the short to medium term and for this to be sustained in the longer term. This would be of material benefit for patients and our local population. There are a number of improvements that are more important and of greater urgency and these are listed below (*The full Plan is attached*):

(i) Reduce harm and mortality by improved clinical processes and behaviours
(ii) Substantially improve the urgent and emergency patient flow in the Trust and system-wide
(iii) Implement a better hospital frailty pathway and design and implement a system-wide frailty pathway
(iv) Long-term financial planning and decisions by the Trust and the system partners from now
(v) CQC must dos are delivered rapidly and the solutions are sustainable
(vi) Organisational development and staff engagement are key to our success

It is against this background and framework that this *Board Development Programme* is proposed.

2.Setting the Culture of the Trust

What we have already achieved:

- Commenced the process of developing, refreshing and approving the Trust's Vision and Values
- Developed and approved strategic objectives and principal risks to inform the BAF and the strategic direction of the Trust
- Approved a Board Assurance Framework (BAF) which is continually being developed to ensure synergy with the Trust's risk register
- Developed close working relationships with commissioners via the Care for You programme
- Engaged in close working relationships with provider partners through the Health and Care Partnership
- Appointed a substantive Chief Executive
- Commissioned a Cultural Review in light of concerns by members of staff under the old leadership team exclusion.
- Began to take steps to address the concerns raised by the National Guardian's Office (NGO) report on Equality and Diversity Action Plan and approved by NHSI
- Appointed an Interim Freedom to Speak Up Guardian, developed and approved a Freedom to Speak Up (Raising Concerns) Policy

- A programme of Quality Visits to wards and services whereby an executive director is teamed up with a non-executive director
- Engagement with clinicians strengthened through the Leadership Engagement Group between the executive team, senior management and lead clinicians
- Developed a Single Executive Improvement Plan submitted to and approved by NHSI
- Developed a Single Leadership Plan submitted to and approved by NHSI

What we will do:

- Develop a cultural change programme to underpin our values in light of NGO's report and Cultural Review
- Appoint an Equality and Diversity (E & D) Lead to ensure that the NGO's report's recommendations are fulfilled and that the work of E & D is embedded in the Trust
- Celebrate the work of staff through annual awards, employee and team of the month, Chair's award, CEO's award and Southport and Ormskirk's Heroes/Champions
- Become more strategic and less operational by continuing to review the Trust's strategic objectives and focus the board's agenda to include a review of these objectives on a annual basis
- Consider more reflective discussion at board meetings by undertaking case studies
- Strengthen engagement with patients by developing a robust Patient Experience and Carer Strategy and maximising the benefits of the *Friends and Family Test and monitor against pledges.*

3. Transparency, Sound Governance Structures and Processes

What we have already achieved:

- Established statutory and assurance committees with fit for purpose Terms of Reference including review of their performance and effectiveness bi-annually
- Developed a Governance and Assurance Framework
- Developed a board and committee structure including links to external relationships
- Developed and approved a number of prime governance policies including Fit & Proper Person Requirements, Standard of Business Conduct, Declaration of Interests and Anti-Fraud, Bribery & Corruption.
- Developed an Induction Pack for NEDs
- Introduced Board Evaluation Form to aid in quality of board meetings, business conduct and their effectiveness

- Reviewed Standing Orders, Scheme of Delegation and Standing Financial Instructions
- Developed a robust risk escalation framework aligned to the Board Assurance Framework and Corporate Risk Register

What we will do:

- Develop succession plans for board members through the Remuneration and Nominations Committee
- Develop a robust appraisal programme of executives by the Chief Executive
- Undertake annual skills mix of non-executive directors to aid in their development and board development and timeout
- Have individual, tailored skills development by agreeing individual plans and 360 degrees appraisals
- Develop a Performance Management Framework for the Trust
- Continue to ensure that the Trust's business systems are effective and support good governance
- Review information needs to the board with review of Integrated Performance Report
- Develop Committee Governance Packs and Committee Effectiveness Assessment Tools
- Continue to reinforce the Standard Operating Procedure
- Embed an Induction Programme for NEDs and Executive Directors

4. Best Practice in Risk Management and Assurance Processes

What we have already achieved:

- Began to embed risk management in the Trust in a more robust manner
- Review of strategic risks using a new BAF model at Board
- Improve the BAF to ensure synergy between BAF & Risk Register
- Review of strategic risks scrutinised by the statutory and assurance committees
- Review of operational risks by the Board through the Trust's Risk Register at Executive Management Team and by statutory and assurance committees
- Established *Floor to Board Risk Escalation Framework* showing risk management responsibility at all levels in the Trust
- Operational risks owners manage risks on *Datix,* the Trust's risk management system; this to be done for the BAF from March 2018

What we will do:

- Identify and regularly review our principal risks linked to our strategic objectives by revising the BAF and identifying key risks that need further examination via deep dives at board timeout or development session
- Add the BAF to the *Datix* system to enable strategic risk owners to update their risk status on the Trust's electronic risk management system
- Learning from Deaths and Safeguarding issues to be monitored via Datix
- Annually refresh strategic objectives and principal risks as part of the annual planning process to inform the Strategic Plan and Operational Plan
- Review the Annual Business Cycle of the Board to build in time out for Board development and seminars
- Undertake Deep Dive of Risks not deeply scrutinised at Board of Directors.

5. Effective Meetings

What we have already achieved:

- Developed an Annual Business Cycle for the Board and its statutory and assurance committees
- Benchmarked our Trust with others and adopted elements of good practice on board architecture and management.
- Developed and approved a Standard Operating Procedure
- Developed a preparation and submission Flowchart for preparation and submission of reports to the Board and its committees
- Agreed an agenda setting process (see Standard Operating Procedure)
- Reviewed and updated Terms of Reference for statutory and assurance committees.
- Reviewed and updated Terms of Reference for the Board (to be approved)

What we will do:

- Review the size and composition of the Board to align executives with the Trust's portfolio
- Put immediate plans in place to recruit a NED due to the resignation of the Vice Chair and a Director of Nursing and Midwifery, who has resigned to take up another role.
- Put plans in place for succession planning.
- Promote take up of Continuous Personal Development opportunities and maintain records of same.
- Reduce the size of the board pack by adopting better ways of reporting
- Reduce the length of the meetings by being more focused and more strategic
- Plan meetings schedules in such a way so that the Board has more time to discuss in detail key issues not dealt with in detail at Board meetings

6. Board Seminar Programme 2018-19

The Board of Directors meets every month, with a one hour private session in the morning followed by a three hour public session. In 2017-18 financial year there was a Board Timeout in July to discuss the key concerns the Trust faced and to suggest themes around the formulation of the Trust's strategic objectives and associated principal risks. After the formal board in March 2018 one short workshop on the BAF was conducted. Apart from these the Board has not had any other meaningful timeout or Board development sessions in 2017/18 due to the frequency of the Board on a monthly basis.

The Audit Committee at its meeting on 14th February 2018 recommended that the Board takes some time out to undertake a *Deep Dive* of the strategic and operational risks relating to quality. No formal planned Timeout or development session has yet been planned for 2018/19 financial year. Below is a suggestion to correct this.

7. Options Appraisal

In order to allow time for the Board to engage in having meaningful and detailed discussions about key issues facing the Trust and detailed plans to address them, that the Board looks at different ways of working. The following options below are presented for consideration:

OPTION 1: ***Convene the Public Board bi-monthly with short Private Boards held monthly as is currently the case. The month in which the Public Board is not held is used for development, seminars and timeouts by the Board***

ADVANTAGES	DISADVANTAGES
1.Allows dedicated time for the Board to discuss a range of issues in detail outside of the formal confines of the Public Board	**1.** This option may meet with opposition from the Regulator which may feel that given the Trust's current position, the Board should convene monthly to receive assurance from its assurance committees and the executive
2. Closes a key gap and conforms with good practice as not having Board Development sessions is itself a risk	**2.** May be perceived as the Trust doing its business in private and not being as transparent as it should be
3. Still allows for urgent business and contingencies as the Private Board will also convene on Board Development days	**3**. Notwithstanding a Private Board being held every month, the agenda of the Public Board when it is convened bi-monthly may be too long and not providing enough time for scrutiny.
4. Provides time for seminars relating to the strategic objectives and team building exercises for members of the unitary board.	

5. The Board continues to receive assurance via its statutory and assurance committees (all assurance committees meet monthly)	
6. The Regulator may welcome this approach as it gives the Board time to discuss issues in detail because of the Board meetings being so frequent.	

OPTION 2: ***Continue to convene the Public Board monthly but with a shorter agenda focusing on strategic issues and a change of time slot, with the Board Development/Timeout/Seminar sessions being held in the morning and the Board meeting in the afternoon.***

ADVANTAGES	DISADVANTAGES
1. Resolves problem regarding frequency and not being able to scrutinise and receive assurance from Executives and committees	**1.** Members may find the day too long accommodating two short Boards and a Session.
2. Good practice maintained with time allotted for Board Development sessions	**2.** Due to shortened agenda some issues on the Annual Business Cycle may not make their way to the Board
3. Gives Board time to Deep Dive and discuss ways of growing together as a unitary Board	
4. Puts less strain on the time of executives and especially NEDs with an inordinately long agenda	

Recommendation:

The Board is asked to **approve** one of the Options shown above in order to allow time for Board Development. After looking at the advantages and disadvantages of the two Options it appears that the advantages in Option 1 outweigh the disadvantages; it is, therefore, recommended that **Option 1** be adopted.

The Board is also asked to **approve** the proposed content of the Board Development Programme

Figure 1: OPTION 1 BOARD DEVELOPMENT /TIMEOUT/SEMINARS-SUGGESTED PROGRAMME

Meeting	APR	MAY	JUN	JUL	SEP	OCT	NOV	DEC	JAN	FEB	MAR
Private Board/ Public Board/ Development Day/Timeout/ Seminars	Integrated Performance Report	2nd 23rd	Mortality Issues Patient Flow		BAF/RR Mid-Year Review/ Strategic Direction Mid-Year Review		Unitary Board- Growing Together		Sustainability Issues		Strategic Direction- Strategic Plan/ Review Statutory Instruments/Annual Business Cycle
	Board	Board		Board		Board		Board		Board	

[Convene the Public Board bi-monthly with short Private Boards held monthly as is currently the case. The month in which the Public Board is not held is used for development, seminars and timeouts by the Board]

Figure 2: OPTION 2: BOARD DEVELOPMENT /TIMEOUT/SEMINARS-SUGGESTED PROGRAMME

Meeting	APR	MAY	JUN	JUL	SEP	OCT	NOV	DEC	JAN	FEB	MAR
Private Board/ Public Board/ Development Day/Timeout/ Seminars	IPR	Strategic Direction- Strategic Plan	Patient Flow	Mortality Issues	BAF/RR Mid-Year Review/ Strategic Direction Mid-Year Review	Organisational Development	Unitary Board- Growing Together	Strategic Direction- Objectives Strategic Plan/ Operational Plan/ BAF	Sustainability Issues	Review Statutory Instruments/Annual Business Cycle	Strategic Direction- Strategic Plan
	Board	Board	Board	Board	Board	Board	Board	Board	Board	Board	Board

[Continue to convene the Public Board monthly but with a shorter agenda and a change of time slot with the Board Development/Timeout/Seminar being held in the morning and the Board meetings in the afternoon].

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

11th April 2018

Agenda Item	TB096/18	Report Title	Draft Annual Governance Statement-2017/18
Executive Lead	Silas Nicholls, Chief Executive		
Lead Officer	Audley Charles, Interim Company Secretary		
Action Required *(Definitions below)*	✓ To Receive ☐ To Approve ☐ To Assure	☐ For Note ☐ For Information	

Key Messages and Recommendations

The Department of Health and Social Care (DHSC)'s *Group Accounting Manua*l (GAM) details the requirements for NHS Trusts' Annual Reports

The GAM requires NHS Trusts to include an Annual Governance Statement (AGS) in their Annual Report. Trusts must follow guidance issued by NHS Improvement on the format of the AGS.

NHS trusts must note the requirement that **the conclusion section must either:**

- clearly state that no **significant internal control issues** have been identified or
- specifically list the **significant internal control issues** which have been identified in the body of the AGS**.**

Significant control issues are defined as the following factors:

- Might the issue prejudice achievement of priorities?
- Could the issue undermine the integrity or reputation of the NHS?
- What view does the Audit Committee take on this point?
- What advice has internal or external audit given?
- Could delivery of the standards expected of the Accountable Officer be at risk?
- Has the issue made it harder to resist fraud or other misuse of resources?
- Did the issue divert resources from another significant aspect of the business?
- Could the issue have a material impact on the accounts?
- Might national or data security or integrity be put at risk?

There are some changes compared to the 2016/17 requirements: They are:

- The requirement for a commentary on economy, efficiency and effectiveness of the use of resources was not explicit in the previous requirements, though NHS Trusts are likely to have been covering this. This relates to the achievement of value for money as stated in the *Statement of Accountable Officer responsibilities*.
- Please note the requirement for the 'conclusion' section, which has not always been clear in annual governance statements in the past.

The AGS was written adopting the outline as set out in the Model AGS for 2017/18. The key headings are:

- Scope of Responsibility
- Purpose of the system of internal control
- Capacity to handle risk
- The risk and control framework
- Internal and external stakeholders and service user and carer involvement
- Quality Governance Framework
- Information Governance
- Review of economy, efficiency and effectiveness of the use of resources
- Annual Quality Report
- Review of Effectiveness
- Conclusion

The conclusion should state if there are significant internal control issues. Given the definition of *significant control issues* above, the AGS has stated that no such issues exist.

Recommendation:

The Board is asked to **review** the Draft AGS and **make recommendations** for improvement if applicable

Strategic Objective(s)
(*The content provides evidence for the following Trust strategic objectives for 2017/18)*

- ☐ SO1 Agree with partners a long term acute services strategy
- ☐ **SO2** Improve clinical outcomes and patient safety
- ☐ **SO3** Provide care within agreed financial limit
- ☐ **SO4** Deliver high quality, well-performing services
- ☐ **SO5** Ensure staff feel valued in a culture of open and honest communication
- ☐ **SO6** Establish a stable, compassionate leadership team

Governance *(the report supports a…..)*

- ☐ Statutory requirement
- ☐ Annual Business Plan Priority
- ☐ Linked to a Key Risk on BAF / HLRR Ref: _____
- ☐ Service Change
- ☐ Best Practice
- ☐ Other List (Rationale) _____

Impact *(is there an impact arising from the report on the following?)*

☐ Quality	☐ Risk
☐ Finance	☐ Compliance
☐ Workforce	☐ Legal
☐ Equality	
Equality Impact Assessment *(If there* is *an impact on E&D, an Equality Impact* Assessment *must accompany the*	☐ Strategy ☐ Policy

report)	☐ Service Change
Next Steps *(List the required actions following agreement by Board/Committee/Group)*	
Previously Presented at:	
☐ Audit Committee ☐ Finance Performance & Investment Committee ☐ Quality & Safety Committee	☐ Workforce & OD Committee ☐ Mortality Assurance & Clinical Improvement Committee

GUIDE TO ACTIONS REQUIRED:

Approve: To formally agree the receipt of a report and its recommendations OR a particular course of action

Receive: To discuss in depth a report, noting its implications for the Board or Trust without needing to formally approve

Note: For the intelligence of the Board without the in-depth discussion as above

Assure: To apprise the Board that controls and assurances are in place

For Information: Literally, to inform the Board

3.24 Annual Governance Statement 2017/18

3.24.1 Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Accountable Officers' Memorandum*

3.24.2 The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Southport and Ormskirk Hospital NHS Trust, to evaluate the likelihood of those risks being realised and the impact, should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Southport and Ormskirk Hospital NHS Trust for the year ended 31 March 2018 and up to the date of approval of the Annual Report and Accounts.

The objectives for 2017/18 and the associated principal risks were approved by the Board at its 4 October 2017 meeting. They are shown below at **Table 1**.

Table 1

Approved Objective	Principal Risk
SO1 Agree with partners a long term acute services strategy	Absence of clear direction leading to uncertainty, drift of staff and declining clinical standards
SO2 Improve clinical outcomes and patient safety	Poor clinical outcomes and safety records
SO3: Provide care within agreed financial limit	Failure to live within resources leading to increasingly difficult choices for commissioners
SO4 Deliver high quality, well-performing services	Failure to meet key performance targets leading to loss of services
SO5 Ensure staff feel valued in a culture of open and honest communication	Failure to attract and retain staff
SO6 Establish a stable, compassionate leadership team	Inability to provide direction and leadership

The means by which strategic and operational risks are managed, monitored and reported in the Trust are set out below.

3.24.3 Capacity to handle risk

As Accountable Officer I am accountable for the quality of the services provided by the Trust. I have overall responsibility for risk management within the Trust and this responsibility is incorporated within the Risk Management Strategy. Elements of risk management are delegated to members of my Executive Management Team and designated specialist staff:

Overall Risk Management	Executive Director of Nursing
Clinical Governance	Executive Director of Nursing
Clinical Risk & Medical Leadership	Executive Medical Director (Caldicott Guardian)
Corporate Governance	Company Secretary
Board Assurance & Escalation	Company Secretary
Financial Risk	Executive Director of Finance
Compliance with NHSI Regulatory Framework	Executive Director of Finance & Company Secretary
Compliance with CQC Regulatory Framework	Executive Director of Nursing
Information Risk	Executive Director of Finance (*Senior Information Risk Officer*-(SIRO)

Our governance structure at **Figure 1** below illustrates the robustness and effectiveness of our risk management and performance processes via our governance structure. **Figure 2** gives a snapshot of our assurance framework and shows relationship with external stakeholders including regulators and inspectors.

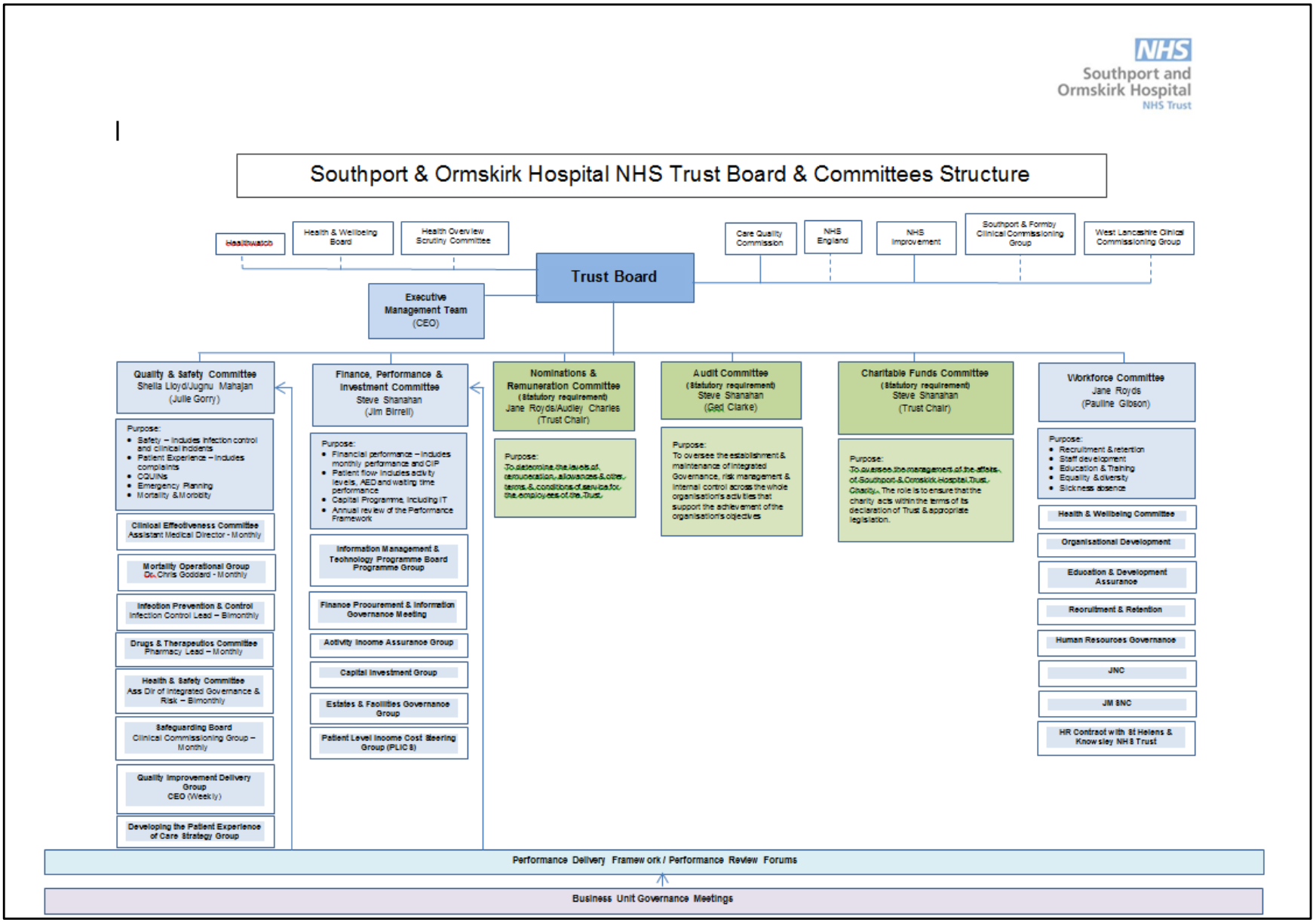

NHS
Southport and Ormskirk Hospital
NHS Trust
Southport & Ormskirk Hospital NHS Trust Board & Committees Structure
Healthwatch
Health & Wellbeing Board
Health Overview Scrutiny Committee
Care Quality Commission
NHS England
NHS Improvement
Southport & Formby Clinical Commissioning Group
West Lancashire Clinical Commissioning Group
Trust Board
Executive Management Team (CEO)
Quality & Safety Committee
Sheila Lloyd/Jugnu Mahajan (Julie Gorry)
Purpose:
Safety – includes infection control and clinical incidents
Patient Experience – includes complaints
CQUINs
Emergency Planning
Mortality & Morbidity
Clinical Effectiveness Committee
Assistant Medical Director - Monthly
Mortality Operational Group
Dr. Chris Goddard - Monthly
Infection Prevention & Control
Infection Control Lead – Bimonthly
Drugs & Therapeutics Committee
Pharmacy Lead – Monthly
Health & Safety Committee
Ass Dir of Integrated Governance & Risk – Bimonthly
Safeguarding Board
Clinical Commissioning Group – Monthly
Quality Improvement Delivery Group
CEO (Weekly)
Developing the Patient Experience of Care Strategy Group
Finance, Performance & Investment Committee
Steve Shanahan (Jim Birrell)
Purpose:
Financial performance – includes monthly performance and CIP
Patient flow includes activity levels, AED and waiting time performance
Capital Programme, including IT
Annual review of the Performance Framework
Information Management & Technology Programme Board Programme Group
Finance Procurement & Information Governance Meeting
Activity Income Assurance Group
Capital Investment Group
Estates & Facilities Governance Group
Patient Level Income Cost Steering Group (PLICS)
Nominations & Remuneration Committee
(Statutory requirement)
Jane Royds/Audley Charles (Trust Chair)
Purpose:
To determine the levels of remuneration, allowances & other terms & conditions of service for the employees of the Trust.
Audit Committee
(Statutory requirement)
Steve Shanahan (Ged Clarke)
Purpose:
To oversee the establishment & maintenance of integrated Governance, risk management & internal control across the whole organisation's activities that support the achievement of the organisation's objectives
Charitable Funds Committee
(Statutory requirement)
Steve Shanahan (Trust Chair)
Purpose:
To oversee the management of the affairs of Southport & Ormskirk Hospital Trust, Charity. The role is to ensure that the charity acts within the terms of its declaration of Trust & appropriate legislation.
Workforce Committee
Jane Royds (Pauline Gibson)
Purpose:
Recruitment & retention
Staff development
Education & Training
Equality & diversity
Sickness absence
Health & Wellbeing Committee
Organisational Development
Education & Development Assurance
Recruitment & Retention
Human Resources Governance
JNC
JM &NC
HR Contract with St Helens & Knowsley NH S Trust
Performance Delivery Framework / Performance Review Forums
Business Unit Governance Meetings

Figure 1

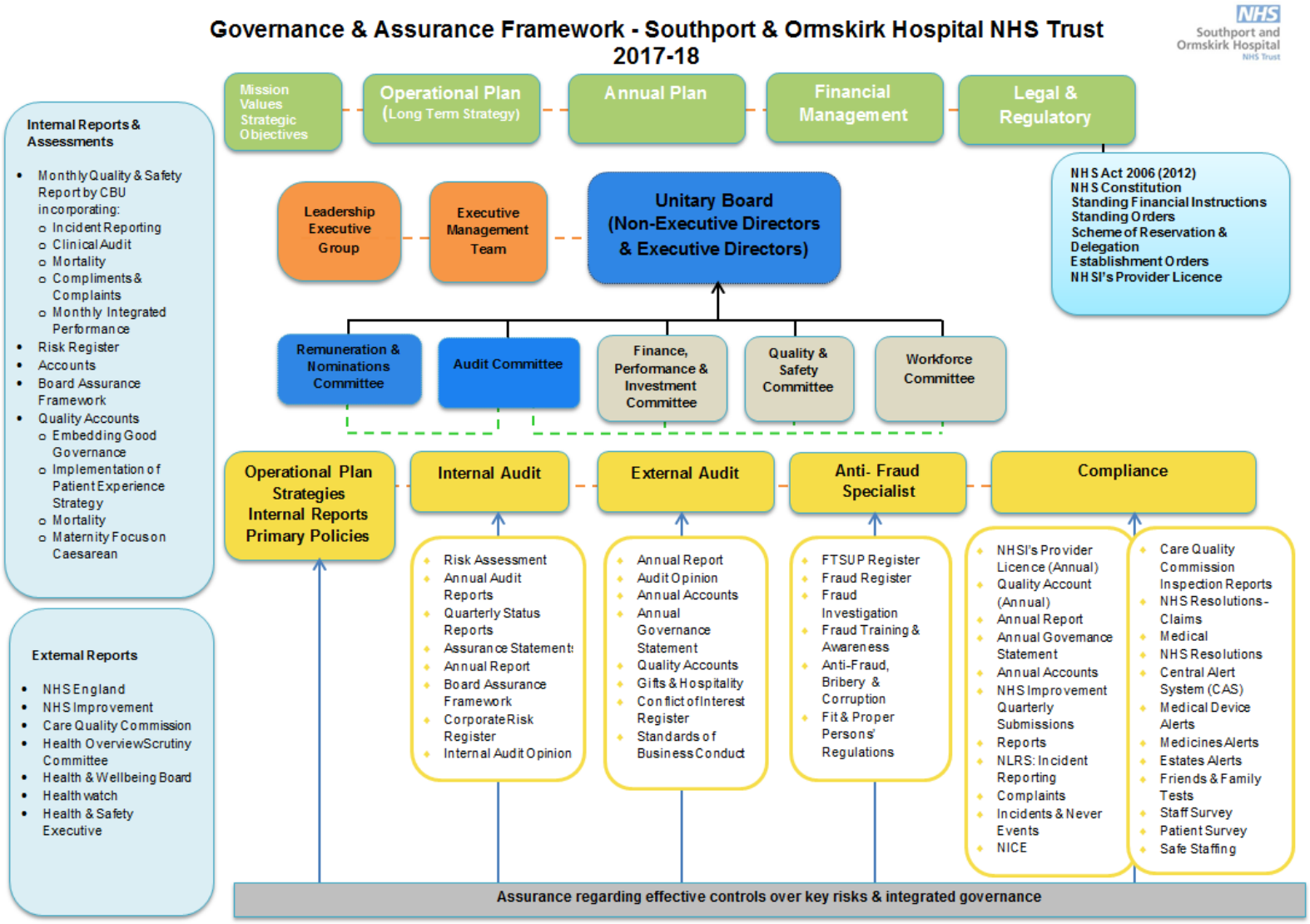

Governance & Assurance Framework - Southport & Ormskirk Hospital NHS Trust 2017-18
NHS Southport and Ormskirk Hospital NHS Trust
Mission Values Strategic Objectives
Operational Plan (Long Term Strategy)
Annual Plan
Financial Management
Legal & Regulatory
NHS Act 2006 (2012)
NHS Constitution
Standing Financial Instructions
Standing Orders
Scheme of Reservation & Delegation
Establishment Orders
NHSI's Provider Licence
Leadership Executive Group
Executive Management Team
Unitary Board (Non-Executive Directors & Executive Directors)
Remuneration & Nominations Committee
Audit Committee
Finance, Performance & Investment Committee
Quality & Safety Committee
Workforce Committee
Internal Reports & Assessments
Monthly Quality & Safety Report by CBU incorporating:
Incident Reporting
Clinical Audit
Mortality
Compliments & Complaints
Monthly Integrated Performance
Risk Register
Accounts
Board Assurance Framework
Quality Accounts
Embedding Good Governance
Implementation of Patient Experience Strategy
Mortality
Maternity Focus on Caesarean
External Reports
NHS England
NHS Improvement
Care Quality Commission
Health Overview Scrutiny Committee
Health & Wellbeing Board
Health watch
Health & Safety Executive
Operational Plan Strategies Internal Reports Primary Policies
Internal Audit
Risk Assessment
Annual Audit Reports
Quarterly Status Reports
Assurance Statements
Annual Report
Board Assurance Framework
Corporate Risk Register
Internal Audit Opinion
External Audit
Annual Report
Audit Opinion
Annual Accounts
Annual Governance Statement
Quality Accounts
Gifts & Hospitality
Conflict of Interest Register
Standards of Business Conduct
Anti- Fraud Specialist
FTSUP Register
Fraud Register
Fraud Investigation
Fraud Training & Awareness
Anti-Fraud, Bribery & Corruption
Fit & Proper Persons' Regulations
Compliance
NHSI's Provider Licence (Annual)
Quality Account (Annual)
Annual Report
Annual Governance Statement
Annual Accounts
NHS Improvement Quarterly Submissions
Reports
NLRS: Incident Reporting
Complaints
Incidents & Never Events
NICE
Care Quality Commission Inspection Reports
NHS Resolutions- Claims
Medical
NHS Resolutions
Central Alert System (CAS)
Medical Device Alerts
Medicines Alerts
Estates Alerts
Friends & Family Tests
Staff Survey
Patient Survey
Safe Staffing
Assurance regarding effective controls over key risks & integrated governance

Figure 2

In addition, the Chief Operating Officer is responsible for the day-to-day management of risk and performance within the Clinical Business Units and there are designated roles of Assistant Director, Safer Care and Standards and Deputy Director of Nursing providing leadership and support in their respective areas. The Associate Director of Human Resources is responsible for workforce and organisational development risks.

Staff members have a responsibility for handling the management of clinical and non-clinical risks according to their roles and duties within the Trust. Mandatory training on key risk areas is undertaken by all staff at induction into the Trust and on a regular refresh basis.

Risk management training is part of the Trust's Induction programme and mandatory training for all staff throughout the Trust which includes health and safety, fire, security, incident reporting, claims and complaints.

In order to support staff with writing responses to complaints, formal training has been provided to support all Clinical Business Units and departments. Training on managing complaints on a face to face basis has been in place to support staff on the wards and departments across the Trust.

To support investigations of serious incident, *root cause analysis* training has been provided to all areas of the Trust and was well supported by the clinical teams across the Trust.

Sharing the learning through risk related issues, incidents, complaints and claims is an essential component of maintaining the risk management culture within the Trust. Learning is shared through Clinical Business Units Meetings and Trust wide Forums such as the Quality and Safety Committee and Clinical Excellence Committee. Learning is acquired from a variety of sources which include:

- Analysis of incidents, complaints, claims and acting on the findings of investigations.
- External Inspections.
- Internal and external audit reports.
- Clinical audits.
- Outcome of investigations and inspections relating to other organisations.

In accordance with its *Standing Orders* and as required by NHS Act 2006 (amended 2012), the Trust has an Audit Committee whose role is to review and report upon the adequacy and effective operation of the organisation's overall system of governance and internal control which encompasses risk management – both clinical and non-clinical.

In order to assist both the Board and the Audit Committee, specific risk management is overseen and scrutinised by three Board Assurance Committees:

- *Quality and Safety Committee* (which receives reports from the Mortality Operational Group and Clinical Excellence Committee) and has the specific purpose of delivering assurance to the Board on the management of clinical risk and operational performance against the CQC domains.
- *Finance, Performance and Investment Committee*, which provides assurance on management of risks relating to resources – both financial and human; and the strategic direction of the Trust
- *Workforce Committee, which provides*

Please see our Risk Management diagram at **Figure 3** below and our Risk Escalation Model at **Figure 4.**

3.24.4 The risk and control framework

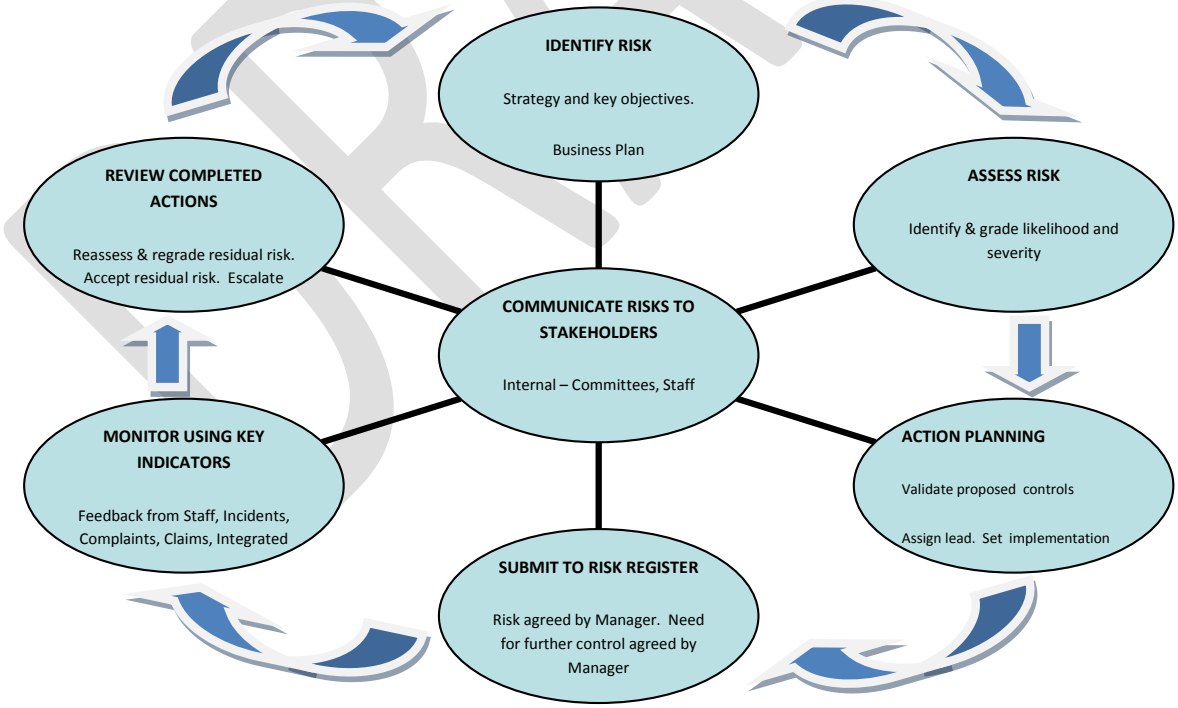
3.24.4.1. Risk management by the Board is underpinned by four (4) interlocking systems of internal control:

- The Board Assurance Framework
- Trust Risk Register (informed by Clinical Business Units, Departments and Teams)
- Audit Committee
- Annual Governance Statement

The *Risk Management Strategy* and Risk Management Policy, which are effective guides on risk management, have continued to work effectively during 2017-18. Our Risk Management System, Datix, has continued to be a source of effective risk management across all levels and a source of just-in-time reports when needed. The risk management processes remained the same as defined within the Board Assurance and Escalation Framework. This clearly outlines the leadership, responsibility and accountability arrangements. These responsibilities are then taken forward through the Board Assurance Framework, the Risk Registers, Business Planning and Performance Management processes enabling the coherent and effective delivery of risk management throughout the organisation.

As **Figure 3** below illustrates, risk management involves the identification, analysis, evaluation and treatment of risks – or more specifically recognising which events (hazards) may lead to harm and therefore minimising the likelihood (how often) and consequences (how badly) of these risks occurring:

Figure 3 – Risk Management Process.



Identifying Risks

Risk is managed at all levels, both up and down the organisation and in order to ensure triangulation between the *Operational Plan* and the *Board Assurance Framework (BAF),* the Trust produces an Integrated *Performance Report* for the Board on activity within the Trust's

Risk Register which details the risks that have either come onto the Trust risk register or those that the Executive Team has approved to come off the Risk Register.

The Audit Committee is responsible for scrutinising the overall systems of internal control (clinical and non-clinical) and for ensuring the provision of effective independent assurance via internal audit, external audit and local anti-fraud services. The Audit Committee reports to the Board quarterly via an Assure, Alert and Advise Highlight Report along with minutes from the meeting after every meeting and annually on its work via the Annual Report of the Audit Committee in support of the *Annual Governance Statement*, specifically commenting on the fitness for purpose of the BAF, the completeness and extent to which risk management is embedded in the Trust and the integration of governance arrangements.

The Committee met on a quarterly basis except for an extra meeting in May to review and make recommendations to the Board on the Annual Report, Annual Accounts and Quality Accounts. **Table 1** below shows membership and attendance for the reporting period:

Audit Committee Attendance 2017/18

	Role	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Members:												
Ged Clarke (Chair)	NED	✓				✓		✓			✓	
Jim Birrell	NED					✓		✓			✓	
Ann Pennell	NED	✓				✓		A				
In Attendance:												
Ian McInnes	Interim Chief Executive	✓										
Shelia Lloyd	Director of Nursing	A				A		A			A	
Steve Shanahan	Director of Finance	✓				A		✓			✓	
Audley Charles	Interim Company Secretary					✓		✓			✓	
Jane Hindle	Interim Company Secretary	✓										
KPMG	External Audit	✓										
Mazars	External Audit					✓		✓			✓	
MIAA	Internal Audit	✓				✓		✓			✓	
MIAA	Anti-Fraud Specialists					✓		✓			✓	

✓ = present A = apologies S = sickness absence DNA = did not attend

The *Quality and Safety Committee* scrutinises and gives overview on clinical risks and holds the Executives to account with ensuring that clinical risks processes as set out in the Risk Management Strategy are adhered to and how they are being managed and controlled. This includes oversight of the performance and quality dashboards which show compliance with CQC registration requirements and other statutory compliance with quarterly reports being scrutinised prior to their submission to the Board.

The Quality Committee's other duties include:

- Seeking and providing assurance to the Board in respect of the effectiveness of the Trust's Integrated Governance arrangements underpinned by organisational development.
- Overseeing the development and implementation of the Trust's Risk Management, Quality and Nursing and Care Strategies including the Quality Improvement Strategy.
- To provide the Board with assurance regarding the effectiveness of all aspects of mortality and morbidity in the Trust.
- Triangulate mortality and morbidity with patient safety, quality and risk issues with workforce performance addressing areas of concern or deteriorating performance as required.
- Reviewing mortality data
- Reviewing clinical outcomes

- Reviewing clinical service changes
- Seeking and providing assurance to the Board in respect of the effectiveness of the Trust's risk management arrangements in respect of mortality.
- Reviewing forecasts of future performance and lessons learned from past performance.

Table 2 below shows membership and attendance of the committee for the reporting period:

Quality & Safety Committee Attendance 2017/18

	Role	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Members:			Meeting Stood Down			No meeting scheduled				No Meeting Scheduled			
Ann Pennell (Chair to Nov 17)	NED	✓		✓	✓		✓	✓	✓				
Carol Baxter	NED	✓		✓	✓		✓	A	✓		A		
Jim Birrell	NED										✓	✓	✓
Su Fowler-Johnson*	NED	A											
Julie Gorry (Chair from Jan 18)	NED			✓	✓		✓	✓	✓		✓	✓	✓
Karen Jackson	Interim Chief Executive	✓		A	✓		A	✓	A				
Rob Gilles	Medical Director	✓		✓	✓		A	A	A		A	A	A
Arpan Guha	Interim Medical Director							✓	A				
Jan Hornby	Interim Associate Director HR	A											
Sheila Lloyd	Director of Nursing	✓		✓							✓	✓	
Jugnu Mahajan	Interim Medical Director										✓	✓	✓
Therese Patten	Chief Operating Officer	✓		A	✓		✓	✓	✓		✓	✓	✓
Jane Royds	Associate Director of HR			A	✓		✓	A	✓		A	✓	✓
In Attendance													
Audley Charles	Interim Company Secretary										✓	✓	A

✓ = present, A = apologies, S = sickness absence, DNA = did not attend

The Finance, Performance and Investment Committee have delegated authority to monitor and scrutinise:

- Financial performance – includes monthly performance and CIP
- Patient flow- includes activity levels, AED and waiting time performance
- Capital Programme, including IT
- Annual review of the Performance Framework
- Investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any requests made by the Committee

Table 3 below shows membership and attendance of the committee for the reporting period:

Finance, Performance & Investment Committee Attendance 2017/18														
	Role	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan 4th	Jan 29th	Feb	Mar
Members:														
Richard Fraser (Chair to July 2017)	NED	✓		✓										
Jim Birrell (Chair from August 2017)	NED					✓	✓	✓	✓		✓	✓	✓	✓
Ged Clarke	NED	✓	✓	A	✓	✓	A	✓	A		✓	✓	A	A
Su Fowler-Johnson*	NED	A	✓											
Julie Gorry	NED						✓	✓	✓		✓	✓	✓	✓
Ann Farrar	Interim Chief Executive											A	A	A
Karen Jackson	Interim Chief Executive	✓	A	A	✓	✓	✓	✓	✓		✓			
Rob Gillies	Medical Director	✓	✓	A	A	A	A	A	A		A	A	A	A
Arpan Guha	Interim Medical Director	✓	✓	✓	✓	✓	✓	A	A					
Jan Hornby	Interim Associate Director HR	A	✓											
Shelia Lloyd	Director of Nursing						✓	A	A		A	A	A	
Jugnu Mahajan	Interim Medical Director											A	A	A
Therese Patten	Chief Operating Officer	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓
Jane Royds	Associate Director of HR			A	✓	✓	✓	✓	✓		✓	✓	✓	✓
Steve Shanahan	Director of Finance	✓	✓	✓	✓	A	✓	✓	✓		✓	✓	✓	✓
In Attendance														
Audley Charles	Interim Company Secretary					✓	A	✓	A		✓	✓	✓	A
Jane Hindle	Interim Company Secretary	A	✓	✓	A									
Lee Threlfall	Contracts & Performance Manager						✓	✓	✓		A	✓	✓	
Kevin Walsh	Deputy Director of Finance	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓
✓ = present; A = apologies; S = sickness absence; DNA = did not attend														

The Workforce Committee has delegated authority to:

- Review evidence relating to external standards, including NHS Resolution (formerly NHS Litigation Authority (NHSLA) (NHSR), Safe, Effective, Quality Occupational Health Service (SEQOHS), NHS Employers Guidance and CQC standards, raising any concerns regarding non-compliance in a timely manner and focusing on outcomes and improvements to the quality of patient and staff experience
- Review performance data and quality indicators covering key aspects of the Trust-wide workforce matters, identifying areas for action at a corporate and local level, ensuring follow up takes place:
    - Appraisal
    - Mandatory Training
    - Sickness
    - DBS
    - Staff Survey
    - Flu Vaccination
    - Recruitment & Staffing levels
    - CQUINs
    - Staff friends & family test
    - Bank & Agency
    - Volunteers

- Monitor the achievement of action plans covering key people management activities, including response to the annual Staff Survey, Staff Engagement Strategy, Recruitment & Retention Strategy, Equality Strategy (Equality Delivery Scheme (EDS2), Workforce Race Equality Standard (WRES) the Health Work and Well Being agenda and other strategic workforce priorities including national recommendations, e.g. the *Francis, Berwick, Cavendish, Saville and Keogh reports*
- Review and take appropriate action based on reports from the Workforce Committee sub-groups
- With delegated authority from the Trust Board ratify relevant policies and procedures approved by Workforce Committee sub-groups
- Provide a report on activities of the Committee to the Trust Board on a monthly basis.
- Ensure any areas of risk relating to HR practices and activities are highlighted and escalated as appropriate

Table 4 below shows membership and attendance of the committee for the reporting period:

Workforce Committee Attendance 2017/18

	Role	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Members:													
Carol Baxter (Chair to December 2017)	NED							✓	✓	No Meeting Scheduled			
Jim Birrell (Chair, January 2018)	NED										✓		
Pauline Gibson* (Chair from February 2018)	NED							A	✓		A	✓	
Julie Gorry	NED							A					
Sheila Lloyd	Director of Nursing							A	A		✓	A	
Gill Murphy	Acting Director of Nursing							✓	A		A	A	
Therese Patten	Chief Operating Officer							✓	✓		✓	A	
Jane Royds	Associate Director of HR							A	✓		✓	✓	
Helen Baythorpe	AD of Operations, Planned Care							✓	✓		A	A	
Audrey Cushion	Acting AD of HR Governance & Quality							A	✓		✓	✓	
John Flannery	Unison Officer							A	A		A	✓	
Laura Hilton	Acting Head of HR							✓	✓		✓	A	
Linda Lewis	Head of Health & Wellbeing							✓	✓		✓	✓	
Adam Ruddock	AD of Organisational Development, STHK							✓					
Simon Williams	Facilities Manager							✓	✓		✓	A	
In Attendance:													

✓ = present A = apologies S = sickness absence DNA = did not attend

The Trust recognises the need for a robust focus on the identification and management of risks and therefore risk is an integral part of our overall approach to quality and the management of risk is an explicit process in every activity in which the Trust and its employees take part.

Risk management in the Trust is discharged through clearly focusing executive responsibility for all clinical and corporate governance and risks with the respective Executive Directors. The Directors, working closely with the Chief Executive, have responsibility for all Trust's clinical services and supporting corporate functions in this context. The management lead for clinical risk rests with the Director of Nursing and Medical Director, who is also the Caldicott Guardian.

The Trust has a good track record in the identification and mitigation of risks, and when there have been untoward and serious incidents, responding to them quickly and ensuring that the lessons learned from them are being implemented swiftly across the organisation. The processes for these are embedded in the culture of the organisation and through robust processes and procedures such as concerns at work and the '*floor to board'* assurance and risk escalation processes.

Discussions have taken place at board meetings concerning the Trust's appetite for risk, the strategic parameters within which decisions involving various types of risks can then be made on a sound and consistent basis. There is a clear process for escalating risks (see **Figure 4** below) from Ward to Clinical Business Units and onto the Corporate Risk Register. There is a clear process for escalating high or significant risks (see **Figure 4** below).

Risk Appetite is *'The level of risk that an organisation is willing to accept'*. The appropriate level will depend on the nature of the work undertaken and the objectives pursued. Precise measurement is not always possible and risk appetite may be defined by a broad statement of approach. The Trust has an appetite for some types of risk and may be averse to others, depending on the context of the risk and the potential losses or gains.

The Trust will develop measures for different categories of risk. For example it may inform a project to know what level of delay or financial loss it is permitted to bear, in

the addition to using measures described in the *'Risk Matrix Severity definitions'* to define the likelihood and impact of risks; this can be used to define the maximum level of risk tolerable before action should be taken to lower it [Risk Appetite]. By defining its risk appetite, the Trust can arrive as an appropriate balance between uncontrolled innovation and excessive caution. It can be used to guide managers on the level of risk permitted and encourage consistency of approach across the Trust, and ensure that resources are not spent on further reducing risks that are already at an acceptable level.

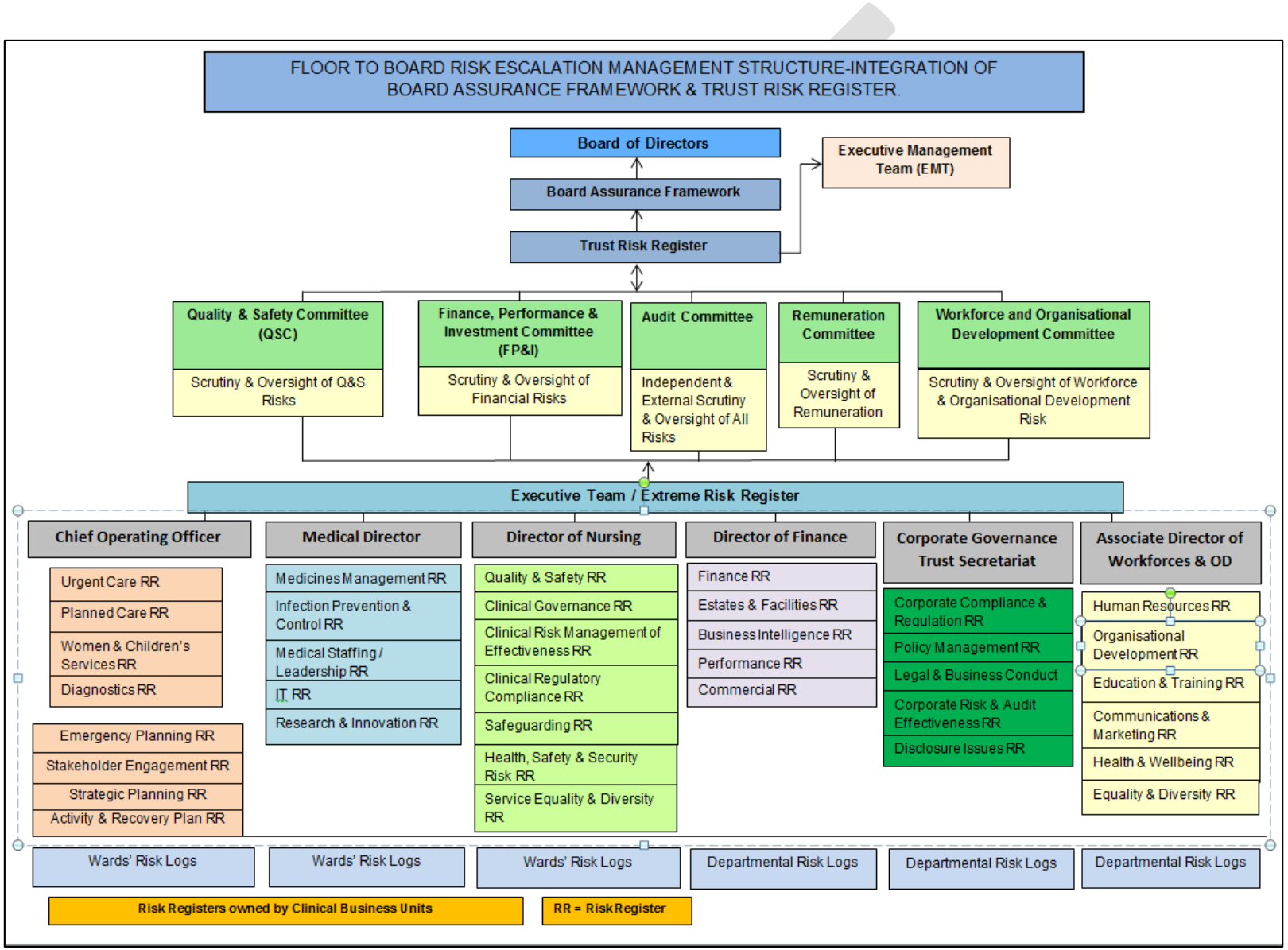

FLOOR TO BOARD RISK ESCALATION MANAGEMENT STRUCTURE-INTEGRATION OF BOARD ASSURANCE FRAMEWORK & TRUST RISK REGISTER.
Board of Directors
Executive Management Team (EMT)
Board Assurance Framework
Trust Risk Register
Quality & Safety Committee (QSC)
Scrutiny & Oversight of Q&S Risks
Finance, Performance & Investment Committee (FP&I)
Scrutiny & Oversight of Financial Risks
Audit Committee
Independent & External Scrutiny & Oversight of All Risks
Remuneration Committee
Scrutiny & Oversight of Remuneration
Workforce and Organisational Development Committee
Scrutiny & Oversight of Workforce & Organisational Development Risk
Executive Team / Extreme Risk Register
Chief Operating Officer
Urgent Care RR
Planned Care RR
Women & Children's Services RR
Diagnostics RR
Emergency Planning RR
Stakeholder Engagement RR
Strategic Planning RR
Activity & Recovery Plan RR
Medical Director
Medicines Management RR
Infection Prevention & Control RR
Medical Staffing / Leadership RR
IT RR
Research & Innovation RR
Director of Nursing
Quality & Safety RR
Clinical Governance RR
Clinical Risk Management of Effectiveness RR
Clinical Regulatory Compliance RR
Safeguarding RR
Health, Safety & Security Risk RR
Service Equality & Diversity RR
Director of Finance
Finance RR
Estates & Facilities RR
Business Intelligence RR
Performance RR
Commercial RR
Corporate Governance Trust Secretariat
Corporate Compliance & Regulation RR
Policy Management RR
Legal & Business Conduct
Corporate Risk & Audit Effectiveness RR
Disclosure Issues RR
Associate Director of Workforces & OD
Human Resources RR
Organisational Development RR
Education & Training RR
Communications & Marketing RR
Health & Wellbeing RR
Equality & Diversity RR
Wards' Risk Logs
Wards' Risk Logs
Wards' Risk Logs
Departmental Risk Logs
Departmental Risk Logs
Departmental Risk Logs
Risk Registers owned by Clinical Business Units
RR = Risk Register

Figure 4

3.24.4.2 Board Assurance Framework (BAF)

Board assurance is a systematic method of:

- Identifying
- Analysing
- Evaluating, treating, monitoring, reviewing; and
- Communicating all risks-clinical and non-clinical and the integration and management of both types of risks.

The requirement to develop a Board Assurance Framework (BAF) was established by the Department of Health (now NHS England), *Assurance: The Board Agenda (July 2002).* The BAF is a tool for the Board to satisfy itself that risks are being managed and strategic objectives are being achieved. The Board has established a robust BAF so that I, as Chief Executive, can confidently sign the *Annual Governance Statement* which deals with statements of internal control.

A Board Assurance Framework has been in place throughout the year which is designed and operating to meet the requirements of the 2017/18 *Annual Governance Statement*. The BAF, which is Board owned, provides a vehicle for the Board to be assured that the systems, policies and procedures in place are operating in a way that is effective and focussed on the key strategic risks which might prevent the Trust's strategic objectives being achieved.

The BAF is robustly discussed and analysed at the Board. Updates of progress against actions are provided at each meeting of the IGC, Audit Committee and quarterly by the Board.

Risks monitored over the year included:

- Strategic Direction
- Financial Resources
- Workforce-recruitment and retention
- Breach of performance data
- Leadership and culture
- Quality, patient safety and clinical outcomes

The BAF has been reviewed by the Board on a quarterly basis during 2016/17 and provides a structure and process to enable the organisation to focus on the risks that might compromise the achievement of its strategic objectives and therefore, the operational plan. It maps out the key controls to mitigate the risks and provide a mechanism to inform the Board of the assurances received about the effectiveness of these controls. The Board receives assurances directly or via its statutory and assurance Committees-Audit, Remuneration, Integrated Governance and Finance and Investment.

It is a dynamic tool which supports the Chief Executive to complete the *Annual Governance Statement* at the end of each financial year. It is part of this wider 'Assurance and Escalation Framework' to ensure the Trust's performance across the range of its activities is monitored and managed; resulting in targets being met, objectives achieved, and good outcomes for service users.

The formation and maintenance of the BAF is the responsibility of the Company Secretary and is regularly reviewed by each Principal Risk Owner (Executive Directors). This is to ensure the controls and assurances remain valid and any identified gaps are mitigated by timely implementation of clearly defined actions.

3.24.4.3 Trust's Risk Monitoring Escalation and Assurance Process

The Risk Management Strategy sets out how risk is identified and assimilated into the Risk Registers and reported, monitored and escalated throughout the directorate and corporate governance structures.

In addition to the Board Assurance Framework (BAF), the Trust operates five tiers of risk management which are all interlinked via an escalation process. The escalation of a risk is dependent upon the level of the risk, or on whether it is felt that the risk needs specialist management at a higher tier, such as the risk requiring a multi-directorate approach to its management.

The registers are recorded using a standardised risk matrix and the severity of each risk is rated according to the Consequence x Likelihood risk assessment matrix within the Risk Management Strategy to establish the risk score which helps guide action at the appropriate level.

3.24.4.4 Local and Directorate Risk Registers

Each ward team or department produces a local risk register. The register is developed in response to the identification of local risks that may impact on the delivery of their immediate service. Local risk registers are recorded using the Risk module on Datix.

Appropriate steps have been taken to ensure that processes are in place at both clinical service and departmental levels to update and maintain their risk registers. Monthly updates from local and directorate risk registers are provided via the Risk & Compliance Manager for inclusion into the Trust's Risk Register.

All local risks are systematically reviewed within a specified time frame by the local teams to ensure that controls in place are effective, and assess whether the risk changes over time.

Risks may be identified through internal processes e.g. complaints, incidents, claims, service delivery changes, risk assessments or financial interests. They may also be identified by external factors e.g. national reports and recommendations or regulatory and enforcement notices etc.

3.24.4.5 Care Quality Commission essential standards of quality

The Trust is fully compliant with the registration requirements of the Care Quality Commission.

The Trust registered with the Care Quality Commission (CQC) on 1st April 2010 and was inspected in December 2017 as part of a planned comprehensive inspection. The Trust achieved an overall rating of 'Good'. The Action Plan which emerged from the inspection focused on some 'Must Dos' and 'Should Dos'. The Quality and Safety Committee has received monthly updates on the CQC action plan and so has the Board.

3.24.4.6 Pension Schemes

As an employer with staff entitled to membership of the NHS Pension Scheme and the Local Government Pension Scheme, control measures are in place to ensure all employer obligations contained within the Schemes regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Schemes are in accordance with each Scheme's rules, and that member Pension Scheme

records are accurately updated in accordance with the timescales detailed in the Regulations.

3.24.4.7 Equality, Diversity and Human Rights

Control measures are in place to ensure that the organisation complies with all relevant equality, diversity and human rights legislation.

The Trust is committed to its duties under the *Equality Act 2010* and ensures that all of its service changes, organisational changes and transformation programmes are assessed to ensure that there is no detriment to any protected characteristic groups through the use of Equality Impact Assessments (EQUIA). Where the EQUIA identifies a potential detriment, consideration is given to appropriate mitigation or potential withdrawal of the service, organisational or transformation change.

With regards to the *Modern Slavery and Human Trafficking Act 2015*, we are committed to maintaining and improving systems, processes and policies to avoid complicity in human rights violation. We realise that slavery and human trafficking can occur in many forms, such as forced labour, domestic servitude sex trafficking and workplace abuse.

Our policies and governance and legal arrangements are robust, ensuring that proper checks and due diligence take place in our employment procedures to ensure compliance with this legislation set out in the *Modern Slavery and Human Trafficking Act 2015..*

3.25.1 Internal and external stakeholders and service user and carer Involvement

Within the Trust we have a Patient Experience Group which meets monthly and a Pledge Group which meets quarterly. They raise and discuss a variety of topics with Trust staff at all levels, and are vital critical friends that the Trust can approach for honest feedback and comment from the perspective of lived experience.

3.25.2 Quality Governance Framework

The Trust's Risk Management Strategy details the relationship between the Trust's strategic objectives, principal risks and the Board Assurance Framework. **The Risk Management Policy** outlines the process for assessing, prioritising and managing all types of risks through risk registers and includes:

- Risk Assessment and Risk Register flow charts
- Risk definitions including Risk Appetite
- Duties and responsibilities of individuals and committees
- The risk assessment process
- The risk management process
- The Integrated Governance and Risk Management Structure
- Board Assurance Framework and risk register templates

The Risk Management Strategy and Policy are enhanced by the Practice Governance Framework and the Quality Strategy.

The principal strategic and operational risks are outlined in the Risk Strategy and sets out how the Trust endeavours to ensure that they do not prevent the Trust from achieving its strategic objectives. The Strategy, therefore, sets out the role of the Board, its statutory and

assurance committees in the identification, management and mitigation of risks. **Figure 3** above illustrates the risk escalation process.

The Strategy emphasises role of the Board Assurance Framework and Risk Register in the management of strategic and operational risks respectively.

The Internal Audit Plan has as part of its remit audit of the Rik Management processes and the Board Assurance Framework. The Integrated Governance Committee, The Finance and Investment Committee and the Audit Committee scrutinise and monitor clinical and non-clinical risks where appropriate, on behalf of the Board. **Figure 2,** our governance structure above depicts the role of Board Committees and their inter-relationship in the management of quality and risk. The whole corporate and clinical structure is designed to ensure that the Trust has and maintain robust quality governance arrangements.

3.25.3 Information governance

All new staff are provided with Information Governance (IG) training at corporate induction. This includes an outline of the relevant legal position, NHS guidance and the Trust's polices relating to the safe and appropriate processing, handling and storage of information.

Additionally, in accordance with the requirements of the IG Toolkit, all existing staff are required to undergo IG training on an annual basis. This training is available as classroom training, workbook or E-learning.

Information security-related incidents are reported via the Trust's incident reporting system. Incidents are reviewed by the Information Governance Steering Group which has been chaired by the Head of Information and the Executive Medical Director. Where an ongoing information risk is identified, this is recorded on the relevant risk register, along with a note of actions to be taken to minimise the chances of re occurrence and impact.

There were Six Serious Incidents Requiring Investigation during the period from April 2017 to March 2018, Five of which were reported to the Office of the Information Commissioner.

All six Incidents related to patient sensitive information, therefore the Caldicott Guardian advised on the incident grading and approved the reporting to the ICO.

Two of these incidents related to the theft or loss of a work diary and laptop which contained information relating to a number of patients. Both of these incidents were closed by the ICO and a robust action plan was developed by the Trust to install measures to prevent any future incidents.

The third incident related to the loss of a blood sample and request form and occurred shortly after the first two incidents.

The fourth incident related to the disclosure of patient information in error via email to an NHS employee outside of the Trust. This incident has been closed by the ICO and no further action taken.

The fifth and sixth incidents relate to the wrong hand held maternity record being given to a patient after attending the Trust.

All six incidents occurred within the same business Unit.

All the patients involved in the incidents were contacted by the Trust and received apologies.

The incidents have all been discussed at length with actions implemented to prevent re occurrence.

3.25.5 Review of economy, efficiency and effectiveness of the use of resources

The key financial policies and processes

As Accounting Officer I have responsibility to the Board for the economy, efficiency and effectiveness of the use of resources. This is achieved operationally through good governance and systems of internal control designed to ensure that resources are applied efficiently and effectively.

The effective and efficient use of resources is managed by the following key policies:

Standing Orders

The *Standing Orders* are contained within the Trust's legal and regulatory framework and set out the regulatory processes and proceedings for the Board of Directors and its committees and working groups including the Audit Committee, whose role is set out below, thus ensuring the efficient use of resources.

Standing Financial Instructions (SFIs)

The SFIs detail the financial responsibilities, policies and principles adopted by the Trust in relation to financial governance. 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 do this by laying out very clearly who have responsibility for all the key aspects of policy and decision making in relation to the key financial matters. This ensures that there are clear divisions of duties, very transparent policies in relation to competitive procurement processes, effective and equitable recruitment and payroll systems and processes. The budget planning and allocation process is clear and robust and ensures costs are maintained within budget or highlighted for action.

The SFIs are to be used in conjunction with the Trust's *Standing Orders* and the Scheme of Reservation and Delegation and the individual detailed procedures set by directorates.

Scheme of reservation and Delegation

This sets out those matters that are reserved to the Board and the areas of delegated responsibility to committees and individuals. The document sets out who is responsible and the nature and purpose of that responsibility. It assists in the achievement of the efficient and effective resources by ensuring that decisions are taken at an appropriate level within the organisation by those with the experience and oversight relevant to the decision being made. It ensures that the focus and rigor of the decision making processes are aligned with the strategic priorities of the Trust and it ensures that the Trust puts in place best practice in relation to its decision making.

Anti-Fraud, Bribery and Corruption Policy

The Bribery Act which came into force in April 2011 makes it a criminal offence for commercial organisations to fail to prevent bribes being paid on their behalf. Failure to take appropriate measures to avoid (or at least minimise) the risk of bribery taking place could

lead to the imposition of fines, or imprisonment of the individuals involved and those who failed to act to prevent it. This will help ensure that the taking or receiving of bribes is less likely and improve the integrity and transparency of the Trust's transactions and decisions.

The Trust Board places reliance on the *Audit Committee* to ensure appropriate and sound governance arrangements are in place to deliver the efficient and effective use of resources and the Trust's internal control systems are robust and can be evidenced.

The Audit Committee agrees an annual work programme for the Trust's Internal Auditors and the Anti-Fraud Service, and reviews progress on implementation of recommendations following audit and other assurance reports and reviews.

Independent assurance is provided through the Trust's internal audit programme and the work undertaken by NHS Counter Fraud Authority (formerly NHS Protect), reports from which are reviewed by the Audit Committee. In addition, further assurance on the use of resources is obtained from external agencies, including the external auditors and the Regulators.

3.25.6 Annual Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year.

The Trust has continued with following these steps to assure the Board that the Quality metrics present a balanced view:

- A stakeholder consultation process to agree quality priorities for the reporting and coming year, involving service users, carers, staff and partner agencies
- A review of all Trust services before the priorities are agreed
- A monthly report via the Integrated Performance Report to the Board leading to scrutiny of whether the focus is right
- Sharing the draft Quality Account with partner agencies for comment, with the primary commissioners having the legal right to point out inaccuracies.

Processes are established to monitor compliance against Care Quality Commission (CQC) regulations (Health and Social Care Act 2008 Regulated Activities, Regulations 2014) using the updated Well Led Review Action Plan process which is based on the CQC's key lines of enquiry.

The content of the Quality Account has been prepared within the established Governance structures and framework and in accordance with the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) and other guidance from NHS Improvement. The Draft Quality Account is shared with partner agencies and stakeholders and commissioners for comment. Leadership comes from the Board of Directors with clearly devolved responsibility and accountability for individual quality improvement priorities.

Quality improvement priorities informed the Trust's Quality Strategy and reflected the priorities of the Trust. These measurable goals, against which progress can be monitored, are overseen by the Quality and Safety Committee.

The Director of Nursing is responsible for the preparation of the Quality Account and for ensuring that the document presents a balanced view of quality within the Trust. The Quality Account is prepared with contributions from all responsible and accountable leads.

The Quality and Safety Committee is responsible for reviewing the report prior to submission with the Annual Report and Accounts to the Audit Committee and then the Board of Directors. The Trust's External Auditors KPMG (until 31 March 2017). In December 2016, MAZARS was appointed as External Auditors of the Trust to take effect from 1 April 2017 in line with the changes to the local external audit arrangements from the Local Audit Accountability Act 2014.

MAZARS undertook a limited review of the arrangements around the data quality and information included in the Quality Account and assess whether a balanced view of quality is presented based on other information.

Progress against the Quality Account priorities for the reporting period, 2017/18, has been reported through the Trust's governance framework via the Annual Business Cycles of the Quality and Safety Committee and the Board of Directors receiving monthly reports on:

- Implementing the Patient Experience Strategy - The patient experience Pledge Group work commenced in October 2017 with the aim of each pledge group meeting bi-monthly. The groups are led by the matron for patient experience and also have a further matron aligned. The majority of groups also have patient representatives. For those that have not, there are links into the appropriate patient forums for any consultation. The Pledge Groups are now regularly reporting into the Trust Patient Experience Group and Quality and Safety Committee using the AAAs highlight reports.

- Mortality: Implement national guidance and focus on the deteriorating patient. Mortality data was reported at the Mortality Assurance and Clinical Improvement Committee, a committee dedicated solely to look at Mortality issues. The Mortality Operational Group, chaired by the Associate Medical Director for Patient Safety, was reintroduced to deal with these issues. The Group now reports into the Quality and Safety Committee

- Maternity: focus on Caesarean section and forceps delivery rates – Performance is reported through Quality and Safety Committee There has been an improvement in the overall caesarean section rate over the last year with the year to date rate (including December 2017) at 23.7%, which is significantly below the most recent national average of 27.1% (2015-16).
    - The overall caesarean section rate has been green for 5 out of 6 months.
    - The elective caesarean section rate has been green for 3 out of the last 6 months
    - The trust continues to have a higher than average elective caesarean section rate with the year to date rate at 13.57%, compared to a rate of 11.5% in England (2015-16) although there is a downwards trend seen throughout 2017.
    - The emergency caesarean section rate is significantly lower than average (see page 2) with the year to date rate at 10.15%, compared to a rate of 15.6% in England (2015-16) and a downwards trend is also noted throughout 2017.

Internal Audit provides further assurance regarding the systems in place to ensure that the Quality Account is compliant with national guidance and that adequate data quality controls are in place to ensure that performance data is accurate and complete.

This year the Trust has worked closely with the NHSI Intensive Support Team (IST) to ensure the validity and accuracy of our elective waiting times data. This has involved rigorous data quality and validation checks over the year on all aspects of waiting time information including recording, processing and reporting. Where advice was given additional training and processes have been embedded to mitigate any risks to quality and accuracy of this data.

Priorities for 2018/19 have been developed in line with the Trust's draft Quality Improvement Strategy 2018-2021and include:

- *Preventing harm*
- *Reducing mortality*
- *Safer staffing at all times*
- *Developing the experience of care*
- *Delivering care for you*

Robust outcome metrics will be set for each priority and action to identify progress and success in achieving this improvement Strategy. The metrics we will use will be meaningful to both staff and patients. Measurement will be used to demonstrate the impact of change and then continued as on-going performance measures following the implementation of successful change, quarterly reports will be reported via Quality and Safety Committee to Board. Processes are established, previously set up to collect evidence of compliance in line with the CQC Inspection recommendations (Must and Should Dos) from 2016 and 2017. The new CQC Insight Reports are used to check our performance and anticipate any potential risks in the future. The Quality and Safety Committee is kept informed of the completeness of the data and any breaches.

3.25.7 Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Quality Report/Account attached to this Annual Report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee and the Integrated Governance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

In describing the process that had been applied in maintaining and reviewing the effectiveness of the system of internal control, I have set out below some examples of the work undertaken and the roles of the Board and Committees in this process:

- The Board reviews the Board Assurance Framework on a quarterly basis along with the Risk Register on a monthly basis.

- A programme of Risk Management training for all staff

- The internal audit plan which is risk based, is approved by the Audit Committee at the beginning of each year. Progress reports are then presented to the Audit Committee on a quarterly basis with the facility to highlight any major issues. The Chair of the

Audit Committee can, in turn, quickly escalate any areas of concern to the Board via a Committee Report and produces an annual report on the work of the Committee and a self-evaluation of its effectiveness.

- The Executive Team meets on a weekly basis and has a process whereby key issues such as performance management, serious incidents, recruitment and retention, safe staffing, action plans arising from external reviews and risk management are considered both on a planned timetable and an ad-hoc basis if there is a need. It also reviews the Trust Risk Register on a monthly basis.

- The Board and its statutory and assurance committees have a clear cycle of business and reporting structure to allow issues to be escalated via the *'ward to board'* risk escalation framework.(**see Figure 3**) The purpose of each committee is outlined in the Governance Structure at **Figure 1** and their work summarised at section 3.24.4 above.

The Board Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by the work of internal and external audit, the external review processes for the Clinical Negligence Scheme along with the NHS Resolution and the Care Quality Commission.

In 2017-18, a Well Led Review was undertaken by the Board in preparation of a planned inspection by the Care Quality Commission in December 2017. The CQC published its Report in March 2018. A summary of the Report's findings is set out below:

Ratings	
Overall rating for this trust	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Requires improvement
Are services well-led?	Inadequate

Work has commenced on a robust action plan to address the Must Dos and other recommendations. The Executive Team has prepared a robust action plan to meet the recommendations made by the CQC and this is monitored at each Executive Team meeting. Updates on the CQC Action Plan are discussed on a monthly basis at both the Quality and Safety Committee and the Board of Directors.

There are internal discussions on-going to ensure that the response to the recommendations should be used as an opportunity to move from *Inadequate* to *Good.*

3.25.8 Head of Internal Audit Opinion

Internal Audit reviews the system of internal control during the course of the financial year and report accordingly to the Audit Committee. The Head of Internal Audit has provided an overall opinion of TBA assurance based on their work during 2017-18, which gives me confidence that we have a TBA foundation on which to build our improvement work.

Specifically, the Head of Internal Audit has stated: TO BE ADDED
In addition, the Head of Internal Audit confirmed: TO BE ADDED

3.25.9 Conclusion

There are no significant *internal control issues* that have been identified.

Accounting Officer (from 1 April 2018 and not for the 2017/18 period of the Accountability Report)

Silas Nicholls

Chief Executive

Date: 23 May 2018

Statement of the Chief Executive's responsibilities as the Accountable Officer of the Trust

The Chief Executive of NHS Improvement, in exercise of powers conferred on the NHS Trust Development Authority, has designated that the Chief Executive should be the Accountable Officer of the trust. The relevant responsibilities of Accountable Officers are set out in the *NHS Trust Accountable Officer Memorandum.* These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;
- value for money is achieved from the resources available to the trust;
- the expenditure and income of the trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;
- effective and sound financial management systems are in place; and
- annual statutory accounts are prepared in a format directed by the Secretary of State to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

Signed.....Chief Executive

Date...23 May 2018.....

Southport and Ormskirk Hospital NHS Trust

PUBLIC TRUST BOARD

11th April 2018

Agenda Item	TB097/18	Report Title	Draft Board's Annual Assessment of its Performance and Effectiveness Tool
Executive Lead	*Silas Nicholls, Chief Executive*		
Lead Officer	*Audley Charles, Interim Company Secretary*		
Action Required *(Definitions below)*	✓ To Receive ✓ To Approve ☐ To Assure	☐ For Note ☐ For Information	

Key Messages and Recommendations

The Board of Directors aims to improve its individual and collective effectiveness as a means of improving the overall performance of the Trust.

This paper sets out a process for members to periodically assess the performance and effectiveness of the Board.

The self-assessment process is intended to help improve performance in the following ways:

- Refresh the Board's understanding of its own responsibilities;
- Identify important areas of board operation that need attention or improvement;
- Measure progress toward existing plans and objectives;
- Shape the future operations of the Trust;
- Define criteria for an effective and successful Board;
- Build trust, respect and communication between the Board's Executive and Non-Executive Directors and the Chief Executive and the Chairman;
- Enable individual Board Members to work more effectively as part of a team

The areas of responsibility against which members will assess their performance and effectiveness are as set out in the draft Terms of Reference for the Board.

After each assessment exercise a composite report will be written and the Board will be asked to approve any attached action plan for improvement.

Recommendation:

The Board is asked to **approve** the Performance and assessment tool.

Strategic Objective(s)
(*The content provides evidence for the following Trust strategic objectives for 2017/18)*

- ✓ SO1 Agree with partners a long term acute services strategy
- ✓ **SO2** Improve clinical outcomes and patient safety
- ✓ **SO3** Provide care within agreed financial limit
- ✓ **SO4** Deliver high quality, well-performing services
- ✓ **SO5** Ensure staff feel valued in a culture of open and honest communication
- ✓ **SO6** Establish a stable, compassionate leadership team

Governance *(the report supports a…..)*

- ☐ Statutory requirement
- ☐ Annual Business Plan Priority
- ☐ Linked to a Key Risk on BAF / HLRR Ref: _____
- ☐ Service Change
- ✓ Best Practice
- ☐ Other List (Rationale) _____

Impact *(is there an impact arising from the report on the following?)*

✓ Quality ✓ Finance ✓ Workforce ✓ Equality	✓ Risk ✓ Compliance ✓ Legal
Equality Impact Assessment *(If there* is *an impact on E&D, an Equality Impact* Assessment *must accompany the report)*	☐ Strategy ☐ Policy ☐ Service Change

Next Steps *(List the required actions following agreement by Board/Committee/Group)*

If the Board approves the Tool, it is proposed that it be circulated to Board members and officer attendees for completion and a composite report brought to the 2 May Board.

Previously Presented at:

☐ Audit Committee ☐ Finance Performance & Investment Committee ☐ Quality & Safety Committee	☐ Workforce & OD Committee ☐ Mortality Assurance & Clinical Improvement Committee

GUIDE TO ACTIONS REQUIRED:

Approve: To formally agree the receipt of a report and its recommendations OR a particular course of action

Receive: To discuss in depth a report, noting its implications for the Board or Trust without needing to formally approve

Note: For the intelligence of the Board without the in-depth discussion as above

Assure: To apprise the Board that controls and assurances are in place

For Information: Literally, to inform the Board

Southport and Ormskirk Hospital NHS Trust

BOARD OF DIRECTORS

Terms of Reference

MEETING	**Board of Directors**
ESTABLISHED BY /REPORTING TO:	Board of Directors
Author:	Audley Charles - Interim Company Secretary
Review:	March 2019
ASSOCIATED DOCUMENTS:	Standing Orders Scheme of Reservation and Delegation Standing Financial Instructions Quality Improvement Strategy Risk Management Strategy Risk Management Policy Extreme Risk Register Board Assurance Framework Safeguarding Policy Freedom to Speak Up/Raising Concerns Policy Anti-Fraud, Bribery and Corruption Policy Fit and Proper Persons' Regulation Policy and Procedure
RELATED COMMITTEES/GROUPS	Audit Committee Remuneration and Nominations Committee Quality and Safety Committee Finance, Performance and Investment Committee Charitable Funds Committee Workforce Committee

Document Control	
Document Name	BOARD OF DIRECTORS ToRs Mar18
File Name	**\\datamart1\Shared Files\Company Secretarial\ TERMS OF REFERENCE COMMITTEES\BOARD OF DIRECTORS ToRs Mar18**
Version/Revision Number	V1.0

Version Control		
Version Ref	**Amendment**	**Date Approved by Trust Board**

Terms of Reference of the Board of Directors

1. Authority

1.1 The Board of Directors is established as set out in the *Health and Social Care Act 2008 (as amended 2012)* and its *Establishment Orders*

1.2 These Terms of Reference describe the role and working of the Board and also provide guidance and information for the Trust as a whole and serve as the foundation for the Terms of Reference for the Board's own statutory and assurance committees.

1.3 The Board's relationship with its statutory and assurance committees and external stakeholders is at **Figure 1** below:

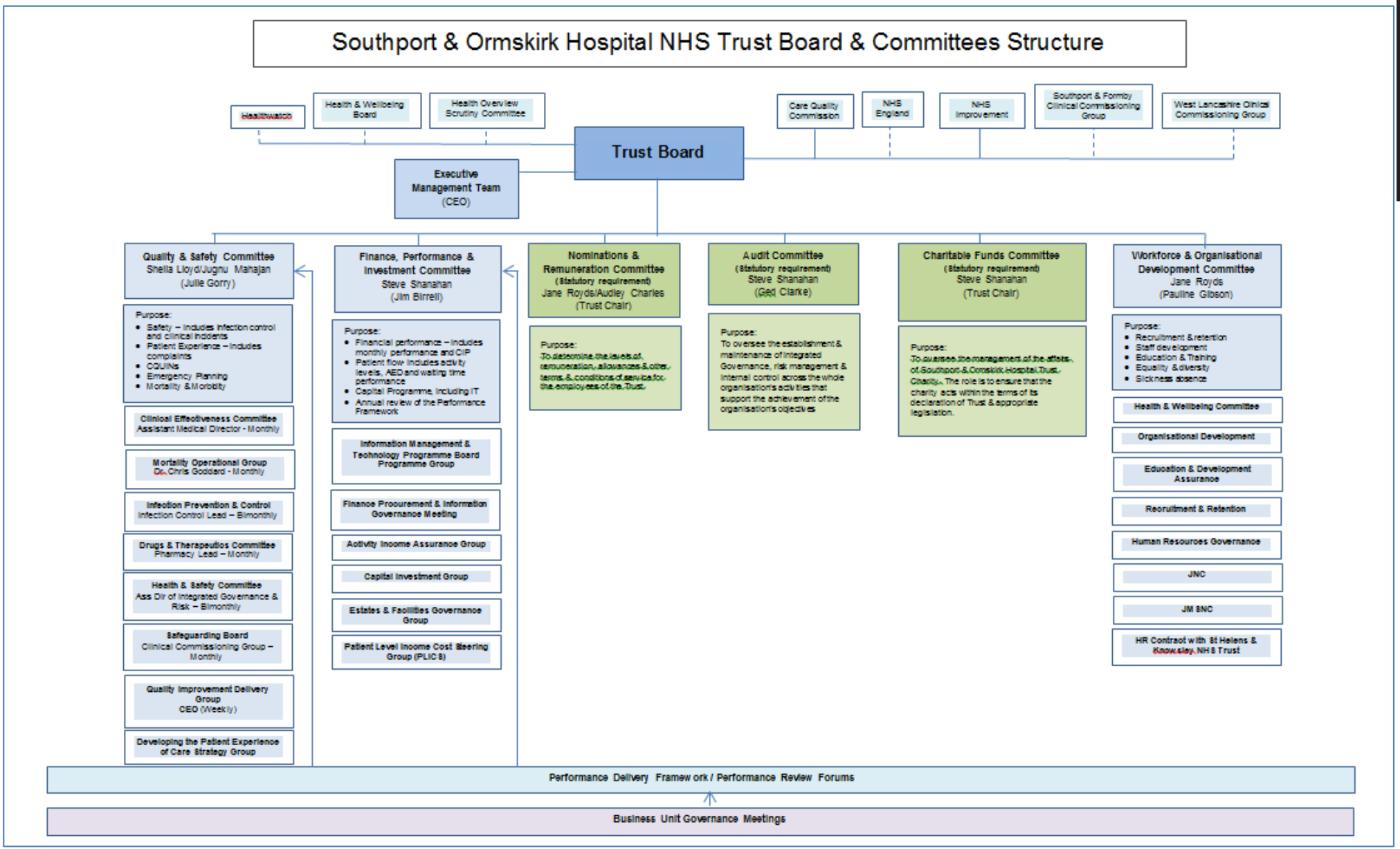

Southport & Ormskirk Hospital NHS Trust Board & Committees Structure
Healthwatch
Health & Wellbeing Board
Health Overview Scrutiny Committee
Care Quality Commission
NHS England
NHS Improvement
Southport & Formby Clinical Commissioning Group
West Lancashire Clinical Commissioning Group
Trust Board
Executive Management Team (CEO)
Quality & Safety Committee
Sheila Lloyd/Jugnu Mahajan
(Julie Gorry)
Purpose:
Safety – includes infection control and clinical incidents
Patient Experience – includes complaints
CQUINs
Emergency Planning
Mortality &Morbidity
Clinical Effectiveness Committee
Assistant Medical Director - Monthly
Mortality Operational Group
Dr. Chris Goddard - Monthly
Infection Prevention & Control
Infection Control Lead – Bimonthly
Drugs & Therapeutics Committee
Pharmacy Lead – Monthly
Health & Safety Committee
Ass Dir of Integrated Governance & Risk – Bimonthly
Safeguarding Board
Clinical Commissioning Group – Monthly
Quality Improvement Delivery Group
CEO (Weekly)
Developing the Patient Experience of Care Strategy Group
Finance, Performance & Investment Committee
Steve Shanahan
(Jim Birrell)
Purpose:
Financial performance – includes monthly performance and CIP
Patient flow- includes activity levels, AED and waiting time performance
Capital Programme, including IT
Annual review of the Performance Framework
Information Management & Technology Programme Board Programme Group
Finance Procurement & Information Governance Meeting
Activity Income Assurance Group
Capital Investment Group
Estates & Facilities Governance Group
Patient Level Income Cost Steering Group (PLICS)
Nominations & Remuneration Committee
(Statutory requirement)
Jane Royds/Audley Charles
(Trust Chair)
Purpose:
To determine the levels of remuneration, allowances & other terms & conditions of service for the employees of the Trust.
Audit Committee
(Statutory requirement)
Steve Shanahan
(Ged Clarke)
Purpose:
To oversee the establishment & maintenance of integrated Governance, risk management & internal control across the whole organisation's activities that support the achievement of the organisation's objectives
Charitable Funds Committee
(Statutory requirement)
Steve Shanahan
(Trust Chair)
Purpose:
To oversee the management of the affairs of Southport & Ormskirk Hospital Trust, Charity. The role is to ensure that the charity acts within the terms of its declaration of Trust & appropriate legislation.
Workforce & Organisational Development Committee
Jane Royds
(Pauline Gibson)
Purpose:
Recruitment & retention
Staff development
Education & Training
Equality & diversity
Sickness absence
Health & Wellbeing Committee
Organisational Development
Education & Development Assurance
Recruitment & Retention
Human Resources Governance
JNC
JM SNC
HR Contract with St Helens & Knowsley NHS Trust
Performance Delivery Framework / Performance Review Forums
Business Unit Governance Meetings

Figure 1

2. **Role and Purpose**

2.1 The Trust exists to 'provide goods and services for any purposes related to the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and the promotion and protection of public health.'

2.2 The Trust has a Board of Directors which exercises all of the powers of the Trust on its behalf, but the Board may delegate any of those powers to a committee of directors or to an executive director. These are outlined in the *Scheme of Reservation and Delegation.*

2.3 The Board consists of executive directors, one of whom is the Chief Executive, and non-executive directors, one of whom is the Chair. The *Health and Social Care Act 2008 (amended 2012)* also stipulates that one of the executive directors must be a finance director, one a chief nurse and one a medical director.

2.4 The Board leads the Trust by undertaking five (5) key responsibilities:

- *Determine the Trust's Vision and objectives*
- *Match the Trust's objectives to its resources and ensure that risks to objectives are properly managed.*
- *Formulate the Trust's long-term Strategic Plan* and Annual *Operational Plan*
- *Ensure that there is accountability by holding the executive directors to account for the delivery of the strategy and through the assurance committees seeking assurance that systems of control are robust and reliable.*
- *Shape a positive culture for the Board and the organisation*.

2.5 The general duty of the Board of Directors and of each director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for patients of the Trust as a whole and for the public in general.

2.6 The practice and procedure of the meetings of the Board – and of its committees – are not set out here but are described in the Trust's Standing Orders and the committees' Terms of Reference.

3. **General Responsibilities**

3.1 The general responsibilities of the Board are:

- To work in partnership with service users, carers, local health organisations, local government authorities and others to provide safe, accessible, effective and well governed services for [patients] [service users] and [carers];
- To ensure that the Trust meets its obligations to the population served, its stakeholders and its staff in a way that is wholly consistent with public sector values and probity; and
- To exercise collective responsibility for adding value to the Trust by promoting its success through direction and supervision of its affairs in a cost effective manner.

3.2 In fulfilling its duties, the Board will work in a way that makes the best use of the skills of non- executive and executive directors.

4. Leadership

The Board provides active leadership to the organisation by:

- Ensuring there is a clear vision and strategy for the Trust that people know about and that is being implemented within a framework of prudent and effective controls which enable risk to be assessed and managed.
- Ensuring the Trust is an excellent employer by the development of a Workforce Strategy and its appropriate implementation and operation.

5. Strategy

The Board:

- Sets and maintains the Trust's vision and strategic objectives ensuring the necessary financial, physical and human resources are in place for it to meet them.
- Monitors and reviews management performance to ensure the Trust's objectives are met.
- Oversees both the delivery of planned services and the achievement of objectives, monitoring performance to ensure corrective action is taken when required and lessons are learned.
- Develops and maintains a long-term Strategic Plan and an Annual Operational Plan and ensures its delivery as a means of taking forward the strategy of the Trust to meet the expectations and requirements of its stakeholders.
- Ensure that national policies and strategies are effectively adopted and implemented within the Trust.

6. Culture

The Board is responsible for setting values, ensuring they are widely communicated and that its behaviour is entirely consistent with those values.

7. Governance

The Board:

- Ensures that the Trust has sound governance arrangements in place that guarantee that the resources vested in the Trust are appropriately managed and deployed, that key risks are identified and effectively managed and that the Trust fulfils its accountability requirements.
- Ensures that the Trust complies with its governance and assurance obligations in the delivery of clinically effective, personal and safe services taking account of patient and carer experiences.
- Ensures compliance with the principles of corporate governance and with appropriate Codes of Conduct, accountability and openness applicable to NHS Trusts.
- Formulates, implements and reviews Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation, as a means of regulating the conduct and transactions of the Trust's business.
- Ensures that the statutory duties of the Trust are effectively discharged.
- Acts as Corporate Trustee for the Trust's Charitable Funds.

8. Risk management

The Board:

- Ensures an effective system of integrated governance, risk management and internal control across the whole of the Trust's clinical and corporate functions.
- Ensures that there are sound processes and mechanisms in place to ensure effective user and carer involvement with regard to development of care plans, the review of quality of services provided and the development of new services.

- Ensures there are appropriately constituted appointment arrangements for senior positions such as consultant medical staff and executive directors.

9. Ethics and integrity

The Board:

- Ensures that high standards of corporate governance and personal integrity are maintained in the conduct of NHS Trusts business.
- Has in place a robust system to ensure those appointed to the Board and other positions are fit and proper in accordance with Regulation 3 of the *Fit and Proper Persons Regulation 2014*
- Ensures that directors and staff adhere to codes of conduct adopted by the Trust.

10. Committees

The Board is responsible for establishing committees of the Board with delegated powers as prescribed by the Health and Social Care Act, the Trust's Standing Orders and the Scheme of Reservation and Delegation. These committees provide assurance to the Board.

11. Communication

The Board:

- Ensures that an effective communication channel exists between the Trust, its staff and the local community.
- Ensures the effective dissemination of information on service strategies and plans and also provides a mechanism for feedback.
- Ensures that those Board proceedings and outcomes that are not confidential are communicated publicly, primarily via the Trust's website.
- Publishes an Annual Report, Quality Account and Annual Accounts.

12. Financial and Quality Success

The Board:

- Ensures that the Trust operates effectively, efficiently and economically
- Ensures the continuing financial sustainability of the organisation.
- Ensures the proper management of resources and that financial and quality of service responsibilities are achieved.
- Ensures that the Trust achieves the targets and requirements of stakeholders within the available resources.
- Reviews performance, identifying opportunities for improvement and ensuring those opportunities are taken.

13. Membership

The members of the Board of Southport and Ormskirk Hospital NHS Trust shall be comprised of: Non-Executive Directors, one of whom is the Chair and Executive Directors from which the following must be in place:

- Chief Executive
- Director of Finance
- Chief Nurse
- Medical Director

Other Directors or Senior Officers may be added as voting or non-voting members.

13.1. Role of the Chair

- The Chair is responsible for leading the Trust Board and for ensuring that it successfully discharges its overall responsibilities for the Trust as a whole.
- The Chair reports to the Regulator, NHS Improvement and is responsible for the effective running of the Board.
- The Chair is responsible for ensuring that the Board as a whole plays a full part in the development and determination of the Trust's strategic objectives and Strategy.
- The Chairman is the guardian of the Board's decision-making processes and provides general leadership of the Board.
- The Chair seeks advice on governance and business conduct issues from the Company Secretary.

13.2 Role of the Chief Executive

- The Chief Executive (CEO) reports to the Trust Chairman but is also held to account by the Board.
- The CEO is the Accountable Officer of the Trust.
- All members of the Executive Team report directly to the CEO.
- The CEO is responsible to the Board for running the Trust's business and for proposing and developing the Trust's strategic objectives and Strategy for approval by the Board.
- The CEO is responsible for implementing the decisions of the Board and its committees, providing information and support to the Board.

14. Quorum

A quorum shall be not less than five (5) members at least three (3) of which must be NEDs which may include the Chair and two Executive Directors which may include the Chief Executive.

In the event of a tie, the Chair will have a casting vote

In the absence of the Chair, the Deputy Chair shall chair the meeting; if there is not a named Deputy, the members shall elect one of their members, who must be a NED, to Chair the meeting.

The Trust's Standing Orders stipulate attendance rules for members of the Board and its committees.

15. Other matters

15.1 The Trust Board shall be supported administratively and professionally by the Company Secretary whose duties in this regard include:

- Advising the Board on governance matters and business conduct.
- Agreement of agenda for Board and Board committee meetings with the Chair and Chief Executive
- Arranging for collation of reports and papers for Board meetings.
- Ensures that there are arrangements in place so that suitable minutes are taken, keeping a record of matters arising and issues to be carried forward.

15.2 A full set of papers including the agenda, minutes, reports and papers will be sent at least five (5) working days prior to the Board meeting as set out in these Terms of Reference and in the Trust's Standing Orders, to all directors and other stakeholders.

16. Review

These Terms of Reference shall be reviewed at least annually.

17. Assessment

The Board shall self-assess its performance and effectiveness at least twice annually.

Southport and Ormskirk Hospital NHS Trust

Board Assessment

of Performance and Effectiveness

INTRODUCTION

The Board of Directors aims to improve its individual and collective effectiveness as a means of improving the overall performance of the Trust.

PURPOSE

This paper sets out a process for members to periodically assess their own performance and that of the Board as a whole.

The self-assessment process is intended to help improve performance in the following ways:

- Refresh the Board's understanding of its own responsibilities;
- Identify important areas of board operation that need attention or improvement;
- Measure progress toward existing plans and objectives;
- Shape the future operations of the Trust;
- Define criteria for an effective and successful Board;
- Build trust, respect and communication between the Board's Executive and Non-Executive Directors and the Chief Executive and the Chairman;
- Enable individual Board Members to work more effectively as part of a team.

METHOD

1. The assessment is designed around a questionnaire which covers the core responsibilities of the board and allows Board Members to think strategically about their governing role and identify areas where they could improve performance.

2. The Company Secretary will analyse the responses to the questionnaire and present the findings to the Board.

3. The Board as a whole will review the outcomes of the collective self-assessment and decide on appropriate action plan in a board meeting.

4. Individual NEDs and Executive Directors will determine what actions they need to take personally as a result of their own self-assessment agreed with the Chairman and Chief Executive respectively.

How to complete the questionnaire

The questionnaire is based on the work of the Board and its Annual Business Cycle and is designed to help members assess how well the Board is functioning and to identify areas where the Board can improve its performance. It is expected to take between 30 and 60 minutes to complete.

To encourage candour, the questionnaire doesn't ask for your name so please indicate whether you are a Non-Executive or Executive on each sheet. Your anonymous responses and those of your colleagues will be pulled together and analysed before the results are distributed for discussion.

The Tool is structured around the board responsibilities with a set of statements designed to elicit your response in each area. Each section begins with a description of one of the core board responsibilities. Please read it and respond to the statements that follow. The answers range on a scale from **1 to 4**, with **1 representing 'strongly disagree'** and **4 representing 'strongly agree'.** You may choose to answer '**not sure'** and '**not applicable'**. Tick one box that best expresses your candid response to each statement.

Each section ends with the question ***'How can the Board do better in this area?'*** This gives you the opportunity to add questions, ideas and suggestions in your own words. Please take time to answer the last question in each section since your answers will be helpful in formulating ideas to improve Board's performance.

The purpose of the Individual Evaluation is to give you an opportunity to give your own views as a Board Member rather than being influenced by colleagues. You may want to keep a copy of your replies to this section to assess your own personal progress or as part of your appraisal with the Trust Chairman. The composite report will be discussed by the whole Board which will approve an Action Plan for improvement.

It is a good idea to leaf through the questionnaire before beginning to answer the questions. When you have completed the questionnaire, **return it to the Company Secretary** who is responsible for the oversight and conduct of the process. Your responses will remain confidential.

Individual Evaluation Questionnaire

Non-Executive	Executive

Responsibility 1: **Determine and establish the Trust's vision and objectives**.

The Board is responsible for establishing the Trust's overall vision, values and strategic objectives. In addition, the Board should periodically review the Trust's vision, values and objectives and revise them if necessary. The objectives should be clear and concise. Every Board Member should understand and support them.

Evaluation Rating: 1= Strongly Disagree 4= Strongly Agree							
		1	2	3	4	Not Sure	N/A
1.1	All Board Members are familiar with the current objectives of the Trust.						
1.2	All Board Members support the current strategic objectives.						
1.3	The current objectives are appropriate for the next year.						
1.4	The programmes and services of the Trust reflect and serve the strategic objectives.						

How can the Board do better in this area?

Individual Evaluation Questionnaire

Non-Executive	Executive

Responsibility 2: **Match the Trust's objectives to its resources and ensure that risks to objectives are properly managed.**

Having agreed the Trust's strategic objectives the board must undertake a sense check by matching the objectives to the Trust's resources-human, financial systems and processes.

The board is responsible for preserving the Trust's resources and assets. The board is also required to establish budget guidelines, approve an annual operating budget and then monitor performance against that budget throughout the year.

The Board should also comply with regulations governing the audit of accounts to verify to itself and to the public that the Trust is accurately reporting the sources and uses of its funds.

In order to serve the organisation well, the Board must have a clear understanding of the differences between its role and those of management and operations.

The Board functions as a unitary Board with Non-Executive and Executive Directors being jointly and severally responsible for the decision the Board makes.

Evaluation Rating: 1= Strongly Disagree 4= Strongly Agree							
		1	2	3	4	Not Sure	N/A
2.1	The Board ensures that the Trust have an adequate financial reserves policy which the board monitors on a regular basis.						
2.2	The Board ensures that the Trust have a strategy to ensure income generation.						
2.3	The Board understands the Trust's income generation strategy.						
2.4	The Board contributes to the income generation efforts by providing leadership and approving effective policies.						
2.5	The Board ensures that the budget reflects the priorities established in the Operational Plan.						
2.6	The Board receives financial information on a regular basis.						
2.7	The Board finds the financial reports timely, understandable and accurate.						
2.8	The Board exercises appropriate financial controls.						
2.9	The Board complies with regulations governing the audit of accounts and considers all recommendations made in the auditor's report and management letter.						

2.10	The Board has approved policies and processes that enable the Trust to manage its financial risks and mitigate their impact.						
2.11	The Board has approved policies and processes that enable the Trust to manage risks and mitigate their impact.						
2.12	The respective roles of the NEDs and the Executive directors are clearly defined and understood.						
2.13	There is a climate of mutual respect between the NEDs and the Executive Directors.						
2.14	The Board functions effectively as a unitary board.						

How can the Board do better in this area?

Individual Evaluation Questionnaire

Non-Executive	Executive

***Responsibility 3*: Engage in strategic planning by formulating the Trust's long-term Strategic Plan and Annual Operational Plan.**

The most important task that a board can make is to establish the Trust's direction and major goals. At least once per year the Board should engage in a formal planning process.

Changes in the national, regional or local health environment or new challenges may require changes in the strategic objectives or the way in which the Trust does its work. Changes in Trust's leadership and other internal factors may also affect the Trust's long term plans.

Evaluation Rating: 1= Strongly Disagree 4= Strongly Agree							
		1	2	3	4	Not Sure	N/A
3.1	The Board has a clear understanding of whom the Trust is intended to serve.						
3.2	The Board has a strategic vision of how the Trust should evolve over the next three to five years.						
3.3	The Board periodically engages in a strategic planning process that helps it to consider how the Trust should meet new opportunities and challenges.						
3.4	The Board ensures that the Trust has a robust Strategic Plan.						
3.5	The Board understands the Operational Plan and has plans for monitoring its achievement.						
3.5	The Board is knowledgeable about the Single Executive Improvement Plan and considers it in its planning agenda.						
3.6	The Board has identified key indicators for monitoring progress of the Trust's strategic objectives.						
How can the Board do better in this area?							

Individual Evaluation Questionnaire

Non-Executive	Executive

Responsibility 4: **Ensure that there is accountability by holding the Executive Directors to account for the delivery of the strategy and through the Assurance Committees receives assurance that systems of control are robust and reliable.**

The Board is also responsible for monitoring and evaluating the programmes and services which the Trust provides and ensuring that there is a robust governance structure in place so that it can receive the assurance it needs.

The following statements apply to the programmes of the Trust and to those for which it has a direct or shared responsibility.

Evaluation Rating: 1= Strongly Disagree 4= Strongly Agree							
		1	2	3	4	Not Sure	N/A
4.1	The Board is satisfied that the Trust's Integrated Performance Report provides it with the information it needs to enable it to be satisfied that performance is being satisfactorily managed.						
4.2	The Board is knowledgeable about the Trust's compliance and regulatory framework.						
4.3	The Board receives the assurance, via the Board Assurance Framework and Risk Register that risks are properly managed in the Trust.						
4.4	The Board has an effective system for monitoring programme performance.						

How can the Board do better in this area?

Individual Evaluation Questionnaire

Non-Executive	Executive

Responsibility 5: **Shape a positive culture for the Board and the organisation.**

The Board is responsible for the selection of the Chief Executive. When necessary, the Board will draft a clear job description that outlines the duties of the Chief Executive and will undertake a carefully planned search and recruitment process.

The Board will support the Chief Executive by working in partnership with her or him, providing constructive feedback, conducting regular evaluation and offering development opportunities.

Evaluation Rating: 1= Strongly Disagree 4= Strongly Agree							
		1	2	3	4	Not Sure	N/A
5.1	The Board functions well as a unitary Board.						
5.2	The Board assesses the NEDs and Executive's performance in a systematic and fair way and on a regular basis						
5.3	The members of the Board uphold the Nolan Principles of public life.						
5.4	.Board members are approachable and are known across the Trust.						
5.5	There is a mechanism for messages from the Board to be communicated to the staff team.						

How can the Board do better in this area?

Non-Executive	Executive

LOGISTICAL ISSUES

CARRYING OUT BOARD BUSINESS EFFICIENTLY

The Board of Southport and Ormskirk Hospital NHS Trust carries out much of its work in meetings. To make meetings effective, participants should receive and review agendas and background materials in advance. Effective boards work with meeting agendas that focus on strategic issues, allow for discussion and lead to action.

Evaluation Rating: 1= Strongly Disagree 4= Strongly Agree							
		1	2	3	4	Not Sure	N/A
1	Board Members receive clear and succinct agendas and written materials in sufficient time before meetings.						
2	The Board focuses most of its attention on long-term, significant policy issues rather than short-term administrative matters.						
3	Board Members have adequate opportunities to discuss issues and ask questions.						
4	The Board meets frequently enough to fulfil its responsibilities.						
5	The Board is the right size to govern effectively.						
6	Most Board Members are actively engaged in the work of the Board.						
7	The Board creates and periodically reviews and updates the instruments governing its own procedures.						
8	The Board has an effective conflict of interest policy in place for itself and staff.						
9	The Board receives material in the right format and of the right quality to enable it to make the right decisions.						
How can the Board do better in this area?							

NHS
Southport and Ormskirk Hospital
NHS Trust

Standing Orders

CONTENTS

Definition of Terms

Term	Definition
Accountable Officer	The Chief Executive who is accountable for the public funds entrusted to the Trust in accordance with the Accounting Officer Memorandum.
Board	The Board of Directors comprising the Chair, Executive Directors and Non-Executive Directors collectively as a unitary body.
Budget	A resource, expressed in financial or manpower terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust;"
Budget holder	The member of staff with delegated authority to manage finances (income and expenditure) for a specific area of the organisation.
Chair of the Board of Directors	The person appointed by the Secretary of State to lead the Board and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. This expression will also apply to the Vice-Chair when they are acting in the Chair's absence.
Chief Executive	The chief officer of the Trust.
Committee	A committee required by statute or locally appointed by the Board, which reports to the Board.
Company Secretary	The person appointed to act independently of the Board to provide advice on corporate governance issues to the Board and the Chair and monitor the Trust's compliance with legislation, regulation and national guidance.
Contracting & Procuring	The systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets.
Director	A member of the Board of Directors;
Director of Finance	The chief finance officer of the Trust.
Funds held on Trust	Those funds which the Trust holds at its date of incorporation, receives on distribution by statutory instrument, or chooses subsequently to accept under powers derived S.90 of the NHS Act 1977, as amended. Such funds may or may not be charitable.
Member	An Executive or Non-Executive member of the Board as the context permits. Member in relation to the Board does not include its Chair.
Motion	A formal proposition to be discussed and voted on during the course of the Board meeting.
Nominated Officer	An officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions.
Officer	An employee of the Trust or any other person holding a paid appointment or office with the Trust.
Partner	In relation to another person, a member of the same household living together as a family unit;
Standing	(SFIs) regulate the conduct of the Trusts financial matters

Term	Definition
Financial Instructions	
Standing Orders	(SOs) regulate the business conduct of the Trust
Trust	Southport & Ormskirk Hospital NHS Trust

All references to the masculine gender will be deemed to apply equally to the feminine gender when used within these instructions.

SO1 Introduction

1.1 Purpose

1.1.1 These Standing Orders form a fundamental part of Southport & Ormskirk Hospital NHS Trust (the Trust) Governance Framework. Together with the Standing Financial Instructions and Scheme of Reservation and Delegation, when adhered to, they protect the Trust's interests and protect officers from possible accusation that they have acted improperly.

1.1.2 All Executive and Non-Executive Members and officers should be aware of the existence of these documents and be familiar with their detailed provisions.

1.2 Interpretation

1.2.1 Any queries relating to the contents of these documents should be directed to the Company Secretary in the first instance who will be pleased to provide clarification.

1.2.2 Save as otherwise permitted by law, at any meeting, the Chair of the Trust shall be the final authority on the interpretation of the Standing Orders (on which he should be advised by the Chief Executive or Company Secretary).

1.3 Statutory Framework

1.3.1 Southport & Ormskirk Hospital NHS Trust (the Trust) is a body corporate which was established under the Southport & Ormskirk Hospital NHS Trust *National Health Service Trust* (Establishment) Order 1999 No 890 (the Establishment Order). The principal place of business of the Trust is Southport District General Hospital, Town Lane, Kew, PR8 6PN.

1.3.2 NHS Trusts are governed by statute, latterly the National Health Service Act 2006 and the Health and Social Care Act 2012 and by secondary legislation made under these Acts. The statutory functions are conferred on the Trust by this legislation[1].

1.3.3 As a statutory body the Trust has specific 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.

1.3.4 The Code of Accountability (See Appendices) requires the Trust to adopt Standing Orders (SOs) for the regulation of its proceedings and business. The Trust must also adopt Standing Financial Instructions (SFIs) as an integral part of Standing Orders setting out the responsibilities of individuals.

1.3.5 The Trust is also bound by such other statutes and legal provisions which govern the conduct of its affairs.

1.4 NHS Framework

1.4.1 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.

1.4.2 Other documents of particular significance are:

[1] Older primary legislation includes the National Health Service and Community Care Act 1990 (NHS & CC Act 1990) and the National Health Service Act 1977 (NHS Act 1977) the NHS Act 1999, the Health and Social Care Act 2001.

- *The Code of Practice on Openness in the NHS*
- *The Code of Accountability for NHS Boards*
- *The Code of Conduct for NHS Managers*
- *The Code of Conduct for NHS Boards*
- *Standards of Business Conduct and Managing Conflicts of Interest*
- *The Trust's Code of Conduct*
- *The Fit and Proper Persons' Requirement*

1.5 Delegation of Powers

1.5.1 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 (SO4) 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 (SO5) 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".* Delegated powers are covered in a separate document (*Scheme of Reservation and Delegation*. This document has effect as if incorporated into the *Standing Orders*.)

1.5.2 Officers only have the authority to exercise powers specifically delegated to them, as summarised in the *Scheme of Reservation & Delegation*.

1.5.3 Wherever a title is used, such as Chief Executive or Director of Finance, in the *Scheme of Delegation* it will be deemed to include officers who have been duly authorised to deputise, in accordance with the principles of SO4.5.

1.6 Standing Orders

1.6.1 It is the duty of the Chief Executive to ensure that existing and new Members and senior officers are notified of and understand their responsibilities within *Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation*. Updated copies shall be issued to Members and senior officers. The Company Secretary will maintain a record of all recipients.

1.6.2 The *Standing Orders* shall be reviewed annually by the Trust. The requirement for review extends to all documents having the effect as if incorporated in SOs.

1.6.3 The Trust Board will from time to time agree and approve policy statements/ procedures which will apply to all or specific groups of staff employed by the Trust. The decisions to approve such policies and procedures will be recorded in an appropriate Trust Board minute and will be deemed where appropriate to be an integral part of the Trust's *Standing Orders and Standing Financial Instructions.*

1.7 Failure to comply with the Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation

1.7.1 Failure to comply with these *Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation* is a disciplinary matter and may result in dismissal in accordance with the Trust's disciplinary policy. Any financial or other irregularities or impropriety, which involves evidence or suspicion of fraud, bribery or corruption, will be reported to NHS Protect with a view to a criminal investigation being conducted and potential prosecution being sought.

1.7.2 If for any reason these *Standing Orders, Standing Financial Instructions and Scheme*

of Reservation and Delegation are not complied with, including the exercise of powers without due authority, all staff have a duty to report full details of the non-compliance to the Chief Executive, Chief Financial Officer or Company Secretary as soon as it becomes known.

1.7.3 Full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Audit Committee for it to recommend action or ratification to the Board.

SO2 The Board: Composition, tenure and role of members

2.1 Composition of the Board

2.1.1 In accordance with *paragraph 3 of Schedule 4 part 1 of the NHS Act 2006* and the *NHS Trusts' Membership and Procedure Regulations 1990* the composition of the Board of the Trust shall be:

- A Non-Executive Chair, appointed by NHS Improvement on behalf of the Secretary of State
- Up to 5 Non-Executive Members excluding the Chair, appointed by NHS Improvement on behalf of the Secretary of State
- Up to 5 Executive Members (but not exceeding the non-executive membership) including:-
    - the Chief Executive
    - the Director of Finance
    - a medical practitioner
    - a registered nurse or midwife

The Trust shall have not more than 11 and not less than 8 Members (unless otherwise determined by the Secretary of State for Health and set out in the Trust's *Establishment Order* or such other communication from the Secretary of State).

2.1.2 The Board operates as a unitary Board, which means that all Board Members, Non-executive and Executive, operate as equal members of a single decision making body and are jointly and severally responsible for the decisions made by the board.

2.2 Terms of Office

2.2.1 The regulations governing the period of tenure of office of the Chair and members and the termination or suspension of office of the Chair and Members are contained in the *NHS Trusts' Membership and Procedure Regulations 1990* (as amended).

2.3 Appointment and Termination of office of the Chair and Non-Executive Members

2.3.1 The Chair and Non-Executive Members shall be appointed for a term of office not exceeding four years as the Secretary of State may specify on making the appointment.

2.3.2 The Chair may resign their office at any time during the period of which they were appointed by giving notice in writing to the Secretary of State. The Non-Executive

Members may resign their office at any time during the period of which they were appointed by giving notice in writing to the Chair.

2.3.3 Where during the period of directorship a Non-Executive Member of a trust is appointed Chair of the trust, their tenure of office as a Non-Executive Member shall be terminated when their appointment as the Chair takes effect.

2.3.4 If the Secretary of State is of the opinion that it is not in the interests of the health service for a person appointed as a Chair or non-executive Member of an NHS Trust to continue to hold office, they may forthwith terminate the person's tenure of office.

2.3.5 If a Chair or Non-Executive Member of an NHS trust has not attended a meeting of the Trust for a period of three months, the Secretary of State shall forthwith terminate their tenure of office unless the Secretary of State is satisfied that-

(a) the absence was due to a reasonable cause; and

(b) the Chair or Non-Executive member will be able to attend meetings of the trust within such period as the Secretary of State considers reasonable.

2.3.6 Where a person has been appointed the Chair or Non-Executive member of an NHS trust-

(a) if he becomes disqualified for appointment under regulation 11 Membership and Procedure Regulations 1990 (as amended) the appointing authority shall forthwith notify them in writing of such disqualification; or

(b) if it comes to the notice of the appointing authority that at the time of their appointment he was so disqualified it shall forthwith declare that he was not duly appointed and so notify them in writing, and upon receipt of any such notification, their tenure of office, if any, shall be terminated and he shall cease to act as Chair or non-executive member.

2.3.7 If it appears to the Secretary of State that the Chair or Non-Executive member of an NHS trust has failed to comply with regulation 20 (disclosure etc. on account of pecuniary interest) he may forthwith terminate that person's tenure of office.

2.4 Appointment of the Vice-Chair

2.5.1 For the purpose of enabling the proceedings of the Trust to be conducted in the absence of the Chair, the Board may appoint a Non-Executive Member from amongst them to be Vice-Chair. Any appointment will be for such a period, not exceeding the remainder of their term as Non-Executive Member, as they may specify on appointment.

2.5.2 Any Non-Executive Member so elected may at any time resign from the office of Vice-Chair by giving notice in writing to the Chair and the Members of the Trust may thereupon appoint another Non-Executive Member as Vice-Chair in accordance with *Standing Order 3.5.1.*

2.5.3 In order to appoint the Vice-Chair, nominations, including self-nominations, will be invited within a period of time set by the Board. Where there is more than one nomination a postal vote will be conducted and the results announced at the subsequent meeting of the Board. In the event of there being only one nomination and this being acceptable to the Directors present, the Board will be requested to confirm that person as Vice-Chair at the meeting in which the nomination is made.

2.5.4 In the event of nominations recording equal number of votes the Chair of the Board will use a casting vote following the postal vote.

2.5 Powers of Vice-Chair

2.5.1 Where the Chair of an NHS Trust has died or has otherwise ceased to hold office or where he has been unable to perform his duties as Chair owing to illness, absence from England and Wales or any other cause, references to the Chair in the Schedule to these Regulations shall, so long as there is no Chair able to perform their duties, be taken to include references to the Vice-Chair.

2.6 Appointment of the Senior Independent Director

2.6.1 The Board may appoint a Non-Executive Member from amongst them to be Senior Independent Director. Any appointment will be for such a period, not exceeding the remainder of their term as Non-Executive Member, as they may specify on appointment.

2.6.2 Any Non-Executive Member so elected may at any time resign from the office of Senior Independent Director by giving notice in writing to the Chair and the Members of the Trust may thereupon appoint another Non-Executive Member as Senior Independent Director in accordance with *Standing Order 2.6.1.*

2.6.3 In order to appoint the Senior Independent Director, nominations, including self-nominations, will be invited within a period of time set by the Board. Where there is more than one nomination a postal vote will be conducted and the results announced at the subsequent meeting of the Board. In the event of there being only one nomination and this being acceptable to the Members present, the Board will be requested to confirm that person as Senior Independent Director at the meeting in which the nomination is made.

2.6.4 In the event of nominations recording equal number of votes the Chair of the Board will use a casting vote following the postal vote.

2.7 Appointment and Termination of Office of the Chief Executive, Other Executive Members and the Company Secretary

2.7.1 The Trust shall appoint a Nominations committee whose members shall be the Chair and Non-Executive Members of the Trust whose function will be to appoint the Chief Executive as a Director of the Trust. The Committee will co-opt the Chief Executive as a member when appointing the Executive Members and Company Secretary of the Trust.

2.7.2 If an Executive Member is suspended from their post in the Trust they shall be suspended from performing their function as a Board member for the period of the suspension.

2.7.3 An executive director may resign their office at any time by giving notice in writing to the Chief Executive, who will in turn notify the Remuneration & Nominations Committee. The Chief Executive may resign their office at any time by giving notice in writing to the Chair who will in turn notify the Remuneration & Nominations Committee.

2.8 Appointment of the Deputy Chief Executive

2.8.1 The Chair, Non-Executive Members and Chief Executive may appoint an Executive Member from amongst them to be Deputy Chief Executive. Any appointment will be for such a period, not exceeding their term as an Executive Member.

2.9 Joint Members

2.9.1 Where more than one person is appointed jointly to a post on the Board those persons will be appointed as a Joint Member and will count for the purpose of *SO3.1* as one person.

2.9.2 Where the office of a member of the Board is shared jointly by more than one person:

(a) either both of those persons may attend or take part in meeting 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 *SO3.11 Quorum*.

2.10 Disqualification as a Member

2.10.1 The following may not become or continue as a Member:

(a) A person who has received a prison sentence or suspended sentence of three months or more in the last five years.

(b) A person who has been the subject of a bankruptcy restriction order or interim order.

(c) Anyone who has been dismissed (except by redundancy) by any NHS body.

(d) Anyone who is under a disqualification order under the Company Directors Disqualification Act 1986.

(e) Anyone who has been removed from trusteeship of a charity.

2.11 Role of Members

2.11.1 The Board will function as a unitary Board, Non-Executive and Executive Members will be full and equal members. Their role as members of the Board of Directors will be to consider the key strategic and managerial issues facing the Trust in carrying out its statutory and other functions.

2.11.2 Chief Executive

2.11.2.1 The Chief Executive will be responsible for the overall performance of the executive functions of the Trust. He/she is the Accountable Officer for the Trust and will 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.*

2.11.3 Director of Finance

2.11.3.1 The Director of Finance will 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. He/she is the Chief Financial Officer for the Trust and will be responsible

along with the Chief Executive for ensuring the discharge of obligations under relevant Financial Directions.

2.11.4 Executive Members

2.11.4.1 Executive Members will exercise their authority within the terms of these *Standing Orders and Standing Financial Instructions and Scheme of Reservation and Delegation*.

2.11.5 Non-Executive Members

2.11.5.1 The Non-Executive Members will not be granted nor will they seek to exercise any individual executive powers on behalf of the Trust. They may however, exercise collective authority when acting as members of the Board or when chairing a committee of the Trust which has delegated powers.

2.11.6 Chair

2.11.6.1 The Chair is responsible for the operation of the Board and will chair all Board meetings, when present.

2.11.6.2 The Chair has certain delegated executive powers.

2.11.6.3 The Chair must comply with their terms of appointment and with *these Standing Orders.*

2.11.6.4 The Chair will liaise with NHS Improvement over the appointment of Non-Executive Members and once appointed will take responsibility either directly or indirectly for their induction, their portfolios of interests and assignments, and their performance.

2.11.6.5 The Chair will work in close harmony with the Chief Executive and will 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.

2.11.7 Non-Voting Members

2.11.7.1 Non-voting members may exercise their authority within the terms of these *Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation.* Non-voting members may participate in discussions at Board but do not have voting rights. They may, however, have voting rights on any of the Trust's statutory or assurance committees of which they are members

2.11.8 Company Secretary

2.11.8.1 The Company Secretary is accountable to the Board, Chair and Chief Executive for leading the highest standards of corporate governance as the custodian of these *Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation*.

2.11.8.2 The Company Secretary acts as the 'conscience' of the Board by promoting transparency, probity and accountability in the conduct of the Trust's business.

2.11.8.3 The Company Secretary is responsible for ensuring that the Trust operates in accordance with statutory and regulatory provisions, ensuring that the Trust is legally constituted and operates within its authority as a sovereign body.

2.12 Lead Roles for Board Members

2.12.1 The Chair will ensure that the designation of lead roles or appointments of Board Members as required by any statutory or regulatory guidance will be made in accordance with relevant requirements.

2.13 The Corporate Role of the Board

2.13.1 The Board is the senior decision-making authority in the Trust. It provides strategic leadership to the Trust and in support of that:

- Sets the overall direction of the Trust, within the context of NHS mandate, by setting strategic objectives
- Approves the Annual Business Plan, which is designed to support the achievement of strategic objectives and monitors the Trust's performance against them
- Holds the Executive Team to account for the performance and running of the Trust (including compliance with legislative and regulatory requirements)
- Determines a *Scheme of Reservation and Delegation*
- Ensures the highest standards of corporate governance and personal conduct
- Ensures the highest standards of quality care are delivered
- Provides effective financial stewardship
- Promotes effective dialogue with external and internal stakeholders

2.13.2 All business of the Trust is conducted in the name of the Board.

2.13.3 The functions conferred upon the Board will be exercised by the Board meeting in public session, except as otherwise provided for in *SO3.1.*

2.14 Schedule of Matters Reserved to the Board and Scheme of Delegation

2.14.1 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 Delegation* and shall have effect as if incorporated into the *Standing Orders.*

SO3 Meetings of the Board

3.1 Openness

3.1.1 All ordinary meetings of the Board are open meetings and members of the public can attend these meetings. As such they are considered to be meetings where the public may observe the decision-making process of the Trust. They are not open meetings where the public have a right to contribute to the debate. Contributions from the public at such meetings can be considered at the discretion of the Chair.

3.1.2 Exceptionally, there may be items of a confidential nature on the agenda of these ordinary meetings from which the public may be excluded. The exemptions set out within the *Freedom of Information Act 2000* will be used as the basis for deciding which items may be excluded from discussion in public. Such items will be business that:-

- relates to a member of staff;
- relates to a patient;
- are still in draft form and will at a future date feature on the agenda of the Board meeting held in public.
- would commercially disadvantage the Trust if discussed in public; or,
- would be detrimental to the operation of the Trust if discussed in

public.

3.1.3 Members and officers 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.

3.1.4 Before each meeting of the Trust a public notice of the time and place of the meeting, and the public part of the agenda, shall be published on the Trust's website *at least three clear days before the meeting* (required by the *Public Bodies (Admission to Meetings) Act 1960 SI(4)(a).*

3.1.5 Admission of the Public and the Press – The public and representatives of the press shall be afforded facilities to attend all formal meetings of the Board but shall be required to withdraw upon the Board resolving as follows:

"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 (Administration to Meetings) Act 1960).

3.1.6 The Chair shall give such directions as he thinks fit in 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:

"That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Board to complete business without the presence of the public" *(Section 1 (8) Public Bodies (Administration to Meetings Act 1960).*

3.1.7 Nothing in the *Standing Orders* shall require the Board to allow members of the public or representatives of the press to record proceedings in any manner whatsoever, other than in writing, or to make any oral report of proceedings as they take place without the prior agreement of the Board.

3.2 Calling Meetings

3.2.1 The ordinary meetings of the Board shall be held at regular intervals unless the Board shall by resolution otherwise decide. There will be *no fewer than six meetings per year.*

3.2.2 The Chair may call a meeting of the Board at any time by appropriate means, including but not limited to, by email.

3.2.3 One third or more Members of the Board may requisition a meeting by giving written notice to the Company Secretary specifying the business to be carried out. 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.

3.3 Notice of Meetings

3.3.1 Regular Meetings of the Board

3.3.1.1 The Company Secretary will send a written notice of the dates, times and locations of meetings to all Board Members with as much notice as possible but not less than fourteen days' notice. Failure to service such notice on more than three Members will invalidate the meeting. A notice shall be presumed to have been served at the time one day after posting or emailing.

3.3.2 Exceptional Meetings of the Board

3.3.2.1 In exceptional circumstances, where there is an urgent need to call a meeting, the Chair may authorise calling a meeting with less than fourteen days' notice and in such circumstances as much notice as possible will be given of the meeting to each Member.

3.3.2.2 Lack of service of the notice on any Member shall not affect the validity of a meeting being called in exceptional circumstances. Failure to serve notice on more than three Members will invalidate the meeting.

3.3.3 Meetings Called By Members

3.3.3.1 In the case of a meeting called by Members in the event the Chair has not called the meeting, the notice shall be signed by those Members and no business shall be transacted at the meeting other than that specified in the notice.

3.3.4 Public Notice of Meetings

3.3.4.1 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 published on the Trust's website at least three clear days before the meeting. (Required under the *Public Bodies' Admission to Meetings Act 1960 S.I. (4) (a).*

3.4 Agendas and Petitions

3.4.1 Agendas and supporting papers will be sent to members at least 6 days before the meeting and no later than 3 clear days before the meeting, except in an exceptional circumstances and with express agreement of the Chair.

3.4.2 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.

3.4.3 In accordance with SO3.4.2 the following items may appear on every agenda for a meeting of the Board:

- Minutes of the previous meeting
- Matters arising
- Declaration of Interests
- Chief Executive's Report
- Reports from Board Committees
- Trust's Risk Register

3.4.4 A Member desiring a matter to be included on an agenda shall make their request in writing to the Chair, via the Company Secretary 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 Chair who will approve the agenda 9 clear days before the meeting.

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

3.5 Notice of Motions

3.5.1 Subject to the provision of *SO 3.7(Motions*: Procedure at and during a meeting) and SO 3.8 (Motions to rescind a resolution) a Member of the Board wishing to move a motion shall send a written notice to the Company Secretary at least 10 clear days before the meeting who will ensure that it is brought to the immediate attention of the Chair.

3.5.2 The Company Secretary shall include on the agenda all notices received that are in order and permissible under governing regulations. This *Standing Order* shall not prevent any motion being withdrawn or moved without notice on any business mentioned on the agenda for the meeting.

3.6 Emergency Motions

3.6.1 Subject to the agreement of the Chair, and subject also to the provision of *SO3.7 '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 Chair's decision to include the item shall be final.'*

3.7 Motions: at and during a meeting

3.7.1 **Who may propose?**

3.7.1.1 A motion may be proposed by the Chair of the meeting or any Member present. It must also be seconded by another Member.

3.7.2 **Procedure**

3.7.2.1 When a motion is under discussion or immediately prior to discussion it will be open to a Member to:

i) amend the motion;

ii) adjourn the discussion;

iii) request that the meeting proceed to the next item of business*;

iv) that the question being considering should be now put*;

v) the appointment of an 'ad hoc' Committee to deal with the specific item of business;

vi) a motion under *Section I (2) or Section I (8) of the Public Bodies (Admissions to Meetings) Act 1960* resolving to exclude the public, including the press.

** Motions may only be put by a member who has not previously taken part in the debate.*

3.7.2.2 The mover of a motion shall have the right to reply at the close of any discussion on the motion or any amendment thereto.

3.7.2.3 If a motion is to proceed to the next item of business or that the question should be now put, once the mover of the motion has had the right to reply, the matter should then be put to the vote.

3.7.2.4 A motion or an amendment to a motion may be withdrawn.

3.7.2.5 No amendment to the motion will be admitted if, in the opinion of the Chair, the amendment negates the substance of the motion.

3.8 Motion to Rescind a Resolution

3.8.1 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 three 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.

3.8.2 When any such motion has been dealt with by the Board it shall not be competent for any Member other than the Chair to propose a motion to the same effect within six months. This *Standing Order* shall not apply to motions moved in pursuance of a report or recommendations of a Committee or the Chief Executive.

3.9 Chair of Meeting

3.9.1 At any meeting of the Board, the Chair, if present, shall preside. If the Chair is absent from the meeting the Vice-Chair, if there is one and he is present, shall preside.

3.9.2 If the Chair and Vice-Chair are both absent such Non-Executive Member as the Chair has previously designated may preside, or in the absence of such designation the Members present shall choose a Non-Executive Director to preside.

3.10 Chair's Ruling

3.10.1 The decision of the Chair of the meeting on questions of order, relevancy, regularity (including procedure on handling motions) and any other matters, including their interpretation of the Standing Orders and Standing Financial Instructions, shall be final.

3.11 Quorum

3.11.1 No business shall be transacted at a meeting of the Board *unless one third of the whole number of voting Members are present* including *at least two Executive Members and two Non-Executive Members.* Members attending via video or telephone conferencing will be considered present and count towards the quorum.

3.11.2 An officer in attendance for an Executive Member but without formal acting up status may not count towards the quorum.

3.11.3 If the Chair or a Member has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest *SO7* he 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.

3.11.4 The above requirement for *at least two Executive Members to form part of the quorum shall not apply where the Executive Members are excluded from a meeting due to a conflict of interests.*

3.11.5 In the case of joint members the presence of one or both Members will count as one Member towards the quorum.

3.12 Voting

3.12.1 Save as provided under *SO3.15 Suspension of Standing Orders* - If a consensus decision is not reached at a meeting then the question shall be determined by a majority of the votes of the Members present. Members attending via telephone or video conferencing are considered present and therefore have a vote.

3.12.2 In the case of any equality of votes, the Chair presiding the meeting shall have a second and casting vote.

3.12.3 All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the Members present so request. Members attending via telephone or video conferencing will cast their vote verbally (such vote to be recorded in the minutes).

3.12.4 If at least one-third of the Members present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Member present voted or abstained.

3.12.5 If a Member so requests, their vote shall be recorded by name.

3.12.6 In no circumstances may an absent Member vote by proxy. Absence is defined as being absent at the time of the vote.

3.12.7 An officer who has been appointed formally by the Board to act up for an Executive Member during a period of incapacity or temporarily to fill an Executive Member vacancy, shall be entitled to exercise the voting rights of the Executive Member. An officer attending the Board to represent an Executive Member without formal acting up status may not exercise the voting rights of the Executive Member. An officer's status when attending a meeting shall be recorded in the minutes.

3.12.8 Non-voting Members are able to take part within Board discussions and provide their opinion but do not have voting rights.

3.12.9 In the case of joint members if both are present they should cast one vote if they are in agreement. In the case of disagreements no vote should be cast.

3.13 Minutes

3.13.1 The Minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they will be approved by the Board.

3.13.2 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded as actioned at the next meeting.

3.13.3 The names of the Chair and Members present and those in attendance at the meetings shall be recorded.

3.13.4 Any matters arising from the Minutes shall be subject to discussion at Chair's discretion. 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).*

3.14 Annual General Meeting

3.14.1 The Trust will publicise and hold an Annual General Meeting in accordance with the *NHS Trusts' (Public Meetings) Regulations 1991 (SI(1991)482*). The meeting shall take place no later than 30 September each year. The Annual Report and Annual Accounts of the preceding year shall be presented at that meeting.

3.15 Suspension of Standing Orders

3.15.1 Except where this would contravene any statutory provision or any direction made by the Secretary of State, any one or more of the Standing Orders may be suspended at any meeting, *provided that at least two-thirds of the Board are present, including one Executive Member and one Non-Executive Member*, and that a majority of those present vote in favour of suspension.

- A decision to suspend SOs shall be recorded in the minutes of the meeting.
- A separate record of matters discussed during the suspension of SOs shall be made and shall be available to the Directors.
- No formal business may be transacted while SOs are suspended.
- The Audit Committee shall review every decision to suspend SOs.

3.16 Variation and Amendment of Standing Orders

3.16.1 These Standing Orders shall be amended only if:

- *a notice of motion under SO 3.5 has been given; and*
- *upon recommendation of the Chair or Chief Executive* included on the agenda for the meeting; and
- no fewer than half the total of the Trust's Non-Executive Members vote in favour of amendment; and
- at least two-thirds of the Members were present at the meeting where the variation or amendment was being discussed; and that at least half of the Board's Non-Executive Members vote in favour of the amendment; and
- the variation proposed does not contravene a statutory provision or direction made by the Secretary of State.

SO4 Arrangements for the exercise of functions by delegation

4.1 Introduction

4.1.1 Subject to the *Scheme of Reservation and Delegation*, and such directions as may be given by the Secretary of State, the Board may make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee or sub-committee, appointed by virtue of SO5 or by a Member or an officer of the Trust. In each case such delegation will be subject to such restrictions and conditions as the Board thinks fit.

4.1.2 *Schedule 4 of the NHS Act 2006* allows for regulations to provide for the functions of Trusts to be carried out for the Trust by third parties in the following ways:

(i) by another Trust;

(ii) jointly with one or more NHS Trust;

(iii) by arrangement with the appropriate Trust, by a joint committee or joint sub-committee of the Trust and one or more other health service bodies;

(iv) in relation to arrangements under s63 (1) of the *Health Services and Public Health Act 196*8, jointly with one or more Trusts.

4.1.3 Where a function is delegated by these regulations to another NHS body, then that Trust or health service body exercises the function in its own right; the receiving Trust has responsibility to ensure that the proper delegation is in place. In other situations, i.e. delegation to committees, sub committees or officers, the Trust delegating the function retains full responsibility.

4.2 Framework for Delegation of Board Authority

4.2.1 The ultimate responsibility for decisions taken under delegated powers remains with the Board, and the Trust must ensure that due regard has been given and can clearly demonstrate it has not come to an unreasonable decision.

4.2.2 To avoid possible allegations of unlawful exercise of discretion by the Board, a committee or Member acting under delegated powers should record in writing the matters which have been taken into account in reaching that decision, especially where significant sums or legal commitments are involved.

4.2.3 In making any decisions under delegated powers, a committee or Member must have due regard to the established policies of the Trust and not depart from them without due reason and consideration. Any such departure and the reason for it shall be drawn to the attention of the Board at the earliest opportunity.

4.2.4 In exercising any delegated power a committee or Member must comply with any statutory provisions or requirements.

4.2.5 In cases of doubt or difficulty and/or where no policy guidelines exist, decisions should be referred to the Board.

4.2.6 The Board may require any particular delegated matter to be referred back to them for a decision and reserves the ability to, at any time, withdraw a function, duty or power it has delegated and then to exercise the function, duty or power itself or to delegate it elsewhere.

4.3 Emergency Powers and Urgent Decisions

4.3.1 The powers which the Board has retained to itself within these *Standing Orders* may in an emergency or when there is a need for an urgent decision be exercised by the Chair and the Chief Executive after having consulted at least two Non-Executive Directors. The exercise of such powers by the Chair and the Chief Executive shall be reported to the next formal meeting of the Board for ratification.

4.4 Delegation to Committees

4.4.1 The Board shall agree from time to time to the delegation of executive powers to be exercised by committees, sub-committees or joint committees which it has formally constituted in accordance with directions issued by the secretary of State. The constitution and terms of reference of these committees, sub-committees or joint committees, and their specific executive powers shall be approved by the Board, or in respect of sub-committees by the appropriate Board Committee.

4.5 Delegation to Officers

4.5.1 Those functions of the Trust which have not been retained as reserved by the Board or delegated to other committee, sub-committee or joint committee shall be exercised on behalf of the Board by the Chief Executive.

4.5.2 The Chief Executive shall determine which functions he/she will perform personally and shall nominate officers to undertake the remaining functions for which he/she will still retain accountability to the Board.

4.5.3 The Chief Executive shall prepare a Scheme of Delegation (as detailed within the *Scheme of Reservation and Delegation*, identifying his/her proposals which shall be considered and approved by the Board, subject to any amendment agreed during the discussion.

4.5.4 The Chief Executive may periodically propose amendment to the *Scheme of Reservation and Delegation* which shall be considered and approved by the Board as indicated above.

4.5.5 In delegating to employees reference will be made to job titles rather than individuals. The delegation will cover the substantive post-holder, any interim employee appointed to the post or any employee formally deputising into the post during a period of absence of the substantive post holder or to cover a vacant post. This is subject to the interim or deputising arrangements being formally documented and signed off by the appropriate Director with records retained for audit purposes.

4.5.6 The Trust does not have statutory authority to delegate powers to officers who are not employees other than Non-Executive Members.

4.5.7 Where a power has not been specifically delegated to an officer under the procedures set out in *SO4.5* they have no authority under these *Standing Orders, Standing Financial Instructions or the Scheme of Delegation* to exercise that power.

In the event of powers being exercised without due authority refer to *SO1.7*.

4.5.8 Nothing in the *Scheme of Delegation* will impair the discharge of the direct accountability to the Board of the Director of Finance, in their capacity as Chief Financial Officer, and the Company Secretary to provide information and advise the Board in accordance with statutory or other requirements. Outside of these statutory requirements the Chief Financial Officer is accountable to the Chief Executive for operational matters.

4.5.9 The arrangements made by the Board as set out in the *Scheme of Reservation and Delegation* shall have effect as if incorporated in these *Standing Orders.*

4.6 Ability to delegate delegated functions, duties and powers

4.6.1 The Board, Committees and officers may not delegate functions, duties or powers that have been delegated to them under *SO4.4 and SO4.5* unless specifically authorised to do so as part of the delegation of that function, duty or power.

4.6.2 Where the *Scheme of Delegation* refers to non-post specific terminology the Director(s) identified in accordance with 4.5.2 may prepare an operating framework that will identify their proposed downward delegation to specific post(s) within their area of responsibility.

SO5 Appointment of Committees and Sub-committees

5.1 Appointment of Committees

5.1.1 Subject to such directions (and to guidance issued by the Department of Health) as may be given by the Secretary of State, the Board may appoint committees of the Board. The Board shall determine the membership and terms of reference of committees and sub-committees and shall if it requires to, receive and consider reports of such committees.

5.2 Joint Committees

5.2.1 Joint committees may be appointed by the Board by joining together with one or more other Trusts or health service bodies, consisting wholly or partly of the Chair and Members of the Board or other health service bodies or wholly of persons who are not members of the Board or other health service bodies in question.

5.2.2 A committee or joint committee appointed under this regulation may, subject to such directions as may be given by the Secretary of State or the Trust or other health service bodies in question, appoint sub-committees consisting wholly or partly of members of the committee or joint committee (whether or not they are members of the Trust or other health service bodies in question); or wholly of persons who are not members of the Trust or other health service bodies or the committee of the Trust or other health service bodies in question.

5.3 Applicability of Standing Orders and Standing Financial Instructions to Committees

5.3.1 The Standing Orders and Standing Financial Instructions of the Trust apply to the meetings of any committees or sub-committee established by the Trust. The term "*Chair*" is to be read as a reference to the Chair of other committee and the term "*member*" is to be read as a reference to a member of other committee, as the context permits.

5.3.2 There is no requirement to hold meetings of committees established by the Board in public.

5.3.3 The *Standing Orders and Standing Financial Instructions* of the Trust apply to the meetings of any joint committees where alternative governance arrangements have not been established and agreed by the Board.

5.4 Terms of Reference

5.4.1 Each committee or sub-committee shall have terms of reference clearly stating any delegated authority and be subject to conditions (such as reporting to the Board) as the Board shall decide. Such terms of reference shall be in accordance with any legislation and regulation or direction issued by the Secretary of State.

5.4.2 Where committees are authorised to establish sub-committees the committee will also have the authority to determine the terms of reference of each sub-committee established within its delegated authority, taking into account any conditions as the Board shall decide, legislation or direction issued by the Secretary of State.

5.4.3 Such terms of reference shall have effect as if incorporated into the *Standing Orders*.

5.5 Delegation of powers by Committees to Sub-Committees

5.5.1 Committees may establish sub-committees but may not delegate their executive powers to a sub-committee unless expressly authorised by the Board.

5.6 Approval of Appointments to Committees

5.6.1 The Board shall approve the appointments to each of the committees which it has formally constituted.

5.6.2 Where committees are authorised to establish sub-committees the committee will also have the authority to determine the membership of the sub-committee it establishes.

5.6.3 Where the Board determines and regulations permit, that persons, who are neither Directors nor officers, shall be appointed to a committee, the terms of such appointment shall be within the powers of the Board as defined by the Secretary of State.

5.6.4 The Board shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with national guidance.

5.6.5 The appointment of Board members to the committees and sub-committees of the Trust comes to an end on the termination of their term of office as Board members.

5.7 Appointments for Statutory Functions

5.7.1 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.

5.8 Committees Established by the Board

5.8.1 The committees established by statute the are:

5.8.2 Audit Committee

5.8.2.1 In line with the requirements of the NHS Audit Committee Handbook, NHS Codes of Conduct and Accountability and the Higgs report, an Audit Committee will be established and constituted to provide the 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 will be approved by the Board and reviewed on a periodic basis.

5.8.2.2 The Board will appoint a minimum of three Non-Executive Members of which one must have significant, recent and relevant financial experience.

5.8.3 Remuneration and Nominations Committee

5.8.3.1 In line with the requirements of the NHS Codes of Conduct and Accountability and the Higgs report a Remuneration and Nominations Committee will be established and constituted.

5.8.3.2 The Board has determined that the Remuneration & Nominations Committee will comprise all of the Non-Executive Members and as such will have fully delegated powers from the Board.

5.8.3.3 The purpose of the Committee will be to decide appropriate remuneration and terms of service for the Chief Executive and other Executive Members 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;
- ensure a formal, rigorous and transparent procedure for Board appointments is followed;
- consider Board succession planning; and
- review Board composition.

5.8.4 Charitable Funds Committee

5.8.4.1 In line with its role as a corporate trustee for any funds held in trust, either as charitable or non-charitable funds, the Trust Board will establish a Charitable Funds Committee to administer those funds in accordance with any statutory or other legal requirements or best practice required by the Charities Commission.

The Committees appointed by the Board are:

5.8.5 Finance, Performance & Investment Committee

5.8.5.1 The Committee is established on behalf of the Board to provide oversight, challenge and assurance regarding the use of resources and sustainability. The Committee will be chaired by a Non-Executive Member.

5.8.6 Quality & Safety Committee

5.8.6.1 The Committee is established to provide the Board with assurance regarding the effectiveness of all aspects of the clinical governance arrangements of the Trust, with a particular focus on quality and risk management. The Committee will be chaired by a Non-Executive Member.

5.8.7 Workforce & Organisational Development Committee

5.8.7.1 The committee is established to provide assurance that the Workforce and Organisational Development Strategies are effectively developed and implemented and that staff are competent and confident to meet the requirements of the Trust workforce. The Committee will be chaired by a Non-Executive Member.

5.8.8 Mortality Assurance and Clinical Improvement Committee

5.8.8.1 The Committee is established to help reduce mortality within the Trust. It will oversee the work streams identified in the mortality action plan. The Committee will be chaired by a Non-Executive Director.

5.9 Other Committees

5.9.1 The Board may also establish other committees as required to discharge the Trust's responsibilities.

5.10 Confidentiality

5.10.1 A member or person in attendance at 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.

5.10.2 A Member of the Board or a member of 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 resolves that it is confidential.

SO6 Overlap with other policy statements, procedures, regulations and standing financial instructions

6.1 Policy Statements: General Principles

6.1.1 The Board will put in place arrangements for agreeing and approving policy statements and procedures for the Trust.

6.1.2 The decisions to approve such policies and procedures will be recorded in the minutes of the Board or committee and thereafter such policy statements will be deemed to be an integral part of these Standing Orders and the Standing Financial Instructions.

6.2 Specific Policy Statements

6.2.1 Notwithstanding SO6.1 the following policy statements shall have effect as if incorporated in these Standing Orders:

- Standards of Business Conduct and Managing Conflicts of Interest
- Staff Disciplinary and Appeals Policy

6.3 Specific Guidance

6.3.1 Notwithstanding SO6.1 these Standing Orders will be read in conjunction with all applicable law and guidance issued by the Secretary of State for Health.

SO7 Duties and Obligations of Board Members under these Standing Orders

7.1 Declaration of Interests

7.1.1 The Code of Accountability requires Board Members to declare interests, annually or as and when they arise, which are relevant and material to the NHS board of which they are a member. All existing Board Members should declare such interests. Any Board Members appointed subsequently should do so on appointment. Anyone declaring an interest should refer to the Trust's Policy for *Standards of Business Conduct and Managing Conflicts of Interest.*

7.1.2 Interests, which should be regarded as "relevant and material", are:

a) Directorships, including Non-Executive Directorships held in private companies or PLCs (with the exception of those of dormant companies).

b) Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.

c) Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.

d) A position of authority in a charity or voluntary organisation in the field of health and social care.

e) Any connection with a voluntary or other organisation contracting for NHS services.

f) Research funding/grants that may be received by an individual or their department.

g) Interests in pooled funds that are under separate management.

7.1.3 Any Board Member who becomes aware that the Trust has entered into or proposes to enter into a contract in which he/she or any person connected with him/her (as defined in SO7.1.2 or elsewhere) has any pecuniary interest, direct or indirect, the Board Member should declare his/her interest by giving notice in writing of such fact to the Board as soon as practicable.

7.2 Advice on Interests

7.2.1 If Board Members have any doubt about the relevance of an interest, this should be discussed with the Chair or Company Secretary.

7.2.2 Financial Reporting Standard No 8 (issued by the Accounting Standards Board) specifies that influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The test of relevance is whether the interest might reasonably be thought by the public to affect the way in which an individual discharges his or her duties. The test therefore is not just whether an individual's actions will be influenced by the interest but whether the public might reasonably think this may be the case. The interests of partners in professional partnerships including general practitioners should also be considered.

7.3 Recording of Interests in Board minutes

7.3.1 At the time Board Members' interests are declared, they should be recorded in the Board minutes

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

7.3.3 Board Members' directorships of companies likely or possibly seeking to do business with the NHS should be published in the Trust's Annual Report. The information should

be kept up to date for inclusion in succeeding Annual Reports.

7.3.4 During the course of a Board meeting, if a conflict of interest is established, the Members concerned should declare such likely conflict of interest and withdraw from the meeting, unless requested to remain by the Board members present. The Member should play no part in the relevant discussion or decision.

7.4 Register of Interests

7.4.1 The Company Secretary will ensure that a Register of Interests is established to record formally declarations of interests of Board. In particular the Register will include details of all directorships and other relevant and material interests which have been declared by both Executive and Non-Executive Directors, as defined in SO 7.1.2.

7.4.2 These details will be kept up to date by means of an annual review of the Register in which any changes to interests declared during the preceding twelve months will be incorporated.

7.4.3 The Register will be available to the public and published in the Annual Report and on the Trust's website.

7.5 Exclusion of the Chair and/or Members from proceedings on Account of Pecuniary Interest

7.5.1 Definitions

7.5.1.1 'Person connected with a Member' shall include 'spouse' (as defined below) and any other person with whom the Member has a personal or professional relationship, including but not limited to a family member, friend or acquaintance.

7.5.1.2 'Spouse' shall include any person living in the same household and any pecuniary interest of a person living in the same household, if known to the Member, shall be deemed to be an interest of the Member.

7.5.1.3 'Contract' or 'Grant' shall include any proposal contract or grant or other course of dealing.

7.5.1.4 '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, proposed contract or other matter if:

- He, or a nominee of his, is a Director of a company or other body, not being a public body, with which the contract was made or is proposed to be made which has a direct pecuniary interest in the other matter under consideration; or
- he is a partner of, or is in the employment of a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration.

7.5.1.5 'Exception to pecuniary interests'. A person will not be regarded as having pecuniary interest in any contract or grant if:

a) neither he nor any person connected with him has any beneficial interest in any securities of the company of which he or such person appears as a Member; and

b) any interest that he or any person connected with him may have in the contract or grant is so remote or insignificant that it cannot reasonably be regarded as likely to influence a member in the consideration or discussion of or in voting on that contract or matter; and

c) those securities of any company in which he (or any person connected with him) has a beneficial interest does not exceed £5,000 in nominal value or 1% of the total nominal value of the issued share capital of the company or body, whichever is the less. Provided that where this applies the person is nevertheless obliged to declare their interest in accordance with SO7.1.

7.5.2 Exclusion in proceedings of Board

7.5.2.1 Subject to the provisions of this Standing Order, if the Chair or a Member 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, he shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

7.5.2.2 The Board may exclude the Chair or a Member of the Trust Board from a meeting of the Board while any contract, proposed contract or other matter in which that person has a pecuniary interest is under consideration.

7.5.2.3 Any remuneration, compensation or allowances payable to the Chair or a Member by virtue of the NHS (consolidation) Act 2006 Schedule 3 Part 1 para 10. (shall not be treated as pecuniary interest for the purpose of this regulation.

7.5.2.4 This Standing Order applies to a Committee, sub-committee and joint committee as it applies to the Board and to any Member of such (whether or not he is also a Member of the Board).

7.5.2.5 The Secretary of State may, subject to such conditions as he may think fit to impose, remove any disability imposed by this Standing Order in any case in which it appears to him in the interests of the National Health Service that the disability shall be removed.

7.6 Standards of Business Conduct

7.6.1 Policy

7.6.1.1 All staff must comply with the national guidance contained in HSG(93)5 `Standards of Business Conduct for NHS Staff' and with the Trust's Code of Personal and Business Conduct provided in the Appendices to the Corporate Governance Manual.

7.6.1.2 It is an offence under the Bribery Act 2010 (previously the Prevention of Corruption Acts 1906 and 1916) for an employee of the Trust to accept corruptly any inducement or reward for doing, or refraining from doing, anything in their official capacity, or corruptly showing favour or disfavour in the handling of contracts. Breach of the provision of these Acts renders staff liable to prosecution and may also lead to the termination of their contracts of employment and superannuation rights within the NHS.

7.6.2 Interest of Officers in Contracts

7.6.2.1 If it comes to the knowledge of a Member or an officer of the Trust that the Trust has entered into or proposes to enter into a contract in which he or any person connected with him has any pecuniary interest he shall give notice of such fact in writing to the

Chief Executive or Company Secretary as soon as practicable.

7.6.2.2 A member or officer must also declare to the Chief Executive any other employment or business or other relationship of their partner, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

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

7.6.3 Canvassing of, and Recommendations by, Members in Relation to Appointments

7.6.3.1 Canvassing of Members of the Board or members of any committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates.

7.6.3.2 A Member of the Trust shall not solicit for any person any appointment under the Trust or recommend any person for such appointment. This shall not preclude a Member from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

7.6.3.4 Unsolicited informal discussions outside appointments panels or committees, should be declared to the panel or committee.

7.6.4 Relatives of Members or Officers

7.6.4.1 Candidates for any staff appointment shall when making application disclose in writing 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 dismissal.

7.6.4.2 The Chair and every Member and officer of the Trust shall disclose to the Board any relationship with a candidate of whose candidature that Member or officer is aware. It shall be the duty of the Chief Executive to report to the Trust any such disclosure made.

7.6.4.3 On appointment, Members (and prior to acceptance of an appointment in the case of Executive Members) should disclose to the Trust whether they are related to any other Member or officer of the Trust.

7.6.4.4 Where the relationship of an officer or another Member to a Member of the Trust is disclosed SO7.5 shall apply.

SO8 Custody of Seal, Sealing of Documents and Signature of Documents

8.1 Custody of Seal

8.1.1 The Common Seal of the Trust shall be kept by the Company Secretary in a secure place.

8.2 Sealing of Documents

8.2.1 The seal will not be affixed to any document without the prior authorisation of the Board, Board Committee or Executive Member duly authorised under the Scheme of Delegation.

8.2.2 Where it is necessary that a document shall be sealed, the seal shall be affixed in the presence of two persons duly authorised by the Chief Executive, and not from the originating department, and shall be attested by them.

8.2.2 The Executive Members and Company Secretary are authorised by the Chief

Executive to use the Seal of the Trust.

8.2.3 Before any building, engineering, property or capital document is sealed it must be approved and signed by the Director of Finance (or an officer nominated by them) and authorised and countersigned by the Chief Executive (or an officer nominated by them who shall not be within the originating directorate).

8.3 Register of Sealing

8.3.1 The Company Secretary on behalf of the Chief Executive shall keep a register of sealings. 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.

8.3.2 A report of all sealings shall be made to the Board at least annually.

8.4 Signature of documents

8.4.1 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, an Executive Member or the Company Secretary, unless any enactment otherwise requires or authorises, or the Board shall have given the necessary authority to some other person for the purpose of such proceedings.

8.4.2 The Chief Executive, Executive Members or Company Secretary 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, as per the Reservation of Powers and Scheme of Delegation.

8.4.3 In land transactions, the signing of certain supporting documents will be delegated to managers and set out clearly in the Scheme of Delegation but will not include the main or principal documents effecting the transfer (e.g., sale/purchase agreement, lease, contracts for construction works and main warranty agreements or any document which is required to be executed as a deed).

SO9 Legal Proceedings

9.1 The Company Secretary is authorised to accept service of all legal proceedings on behalf of the Trust. The address for the acceptance of all legal proceedings is: Company Secretary, Corporate Management Office, Southport Hospital, Town Lane, Kew, Southport, PR8 6PN.

9.2 The Company Secretary is authorised to instruct solicitors to advise the Trust or defend the Trust from any legal proceedings or formal alternative dispute resolution in any case where such action is necessary to protect the Trust's interests, unless an Act of Parliament requires some other person to do so or the Board gives express authority to another officer.

NHS
Southport and Ormskirk Hospital
NHS Trust

Standing Financial Instructions

CONTENTS

Definition of Terms

Term	Definition
Accountable Officer	The Chief Executive who is accountable for the public funds entrusted to the Trust in accordance with the Accounting Officer Memorandum.
Board	The Board of Directors comprising the Chair, Executive Directors and Non-Executive Directors collectively as a unitary body.
Budget	A resource, expressed in financial or manpower terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust;"
Budget holder	The member of staff with delegated authority to manage finances (income and expenditure) for a specific area of the organisation.
Chair of the Board of Directors	The person appointed by the Secretary of State to lead the Board and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. This expression will also apply to the Vice-Chair when they are acting in the Chair's absence.
Chief Executive	The chief officer of the Trust.
Committee	A committee appointed by the Board, which reports to the Board.
Company Secretary	The person appointed to act independently of the Board to provide advice on corporate governance issues to the Board and the Chair and monitor the Trust's compliance with legislation, regulation and national guidance.
Contracting & Procuring	The systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets.
Director	A member of the Board of Directors;
Director of Finance	The chief finance officer of the Trust.
Funds held on Trust	Those funds which the Trust holds at its date of incorporation, receives on distribution by statutory instrument, or chooses subsequently to accept under powers derived S.90 of the NHS Act 1977, as amended. Such funds may or may not be charitable.
Member	An Executive or Non-Executive member of the Board as the context permits. Member in relation to the Board does not include its Chair.
Motion	A formal proposition to be discussed and voted on during the course of the Board meeting.
Nominated Officer	An officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions.
Officer	An employee of the Trust or any other person holding a paid appointment or office with the Trust.
Partner	In relation to another person, a member of the same household living together as a family unit;
Standing	(SFIs) regulate the conduct of the Trusts financial matters

Term	Definition
Financial Instructions	
Standing Orders	(SOs) regulate the business conduct of the Trust
Trust	Southport & Ormskirk Hospital NHS Trust

All references to the masculine gender will be deemed to apply equally to the feminine gender when used within these instructions.

SFI1 Introduction

1.1 Purpose

1.1.1 These Standing Financial Instructions (SFIs) form part of the Trust's Corporate Governance Manual for the purpose of regulating the conduct of its members and officers in relation to all financial matters with which they are concerned. They shall have effect as if incorporated in the Standing Orders (SOs).

1.1.2 These SFIs detail the financial responsibilities, policies and procedures 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 of Directors and the Scheme of Reservation and Delegation (SORD) adopted by the Trust.

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

1.2 Interpretation

1.2.1 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.

1.3 Duty to report non-compliance with the Standing Financial Instructions

1.3.1 All Members of the Board of Directors and officers have a duty to disclose any non-compliance with these Standing Financial Instructions to the Director of Finance and Chief Executive as soon as practicable. If the Standing Financial Instructions are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Audit Committee for them to recommend action or ratification to the Board.

1.3.2 **Failure to comply with the Standing Financial Instructions is a disciplinary matter, which could result in dismissal.**

1.4 Terminology

1.4.1 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 directors or employees who have been duly authorised to represent them.

1.4.2 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. Including nursing and medical staff and consultants practising on the Trust premises and members of staff of the PFI contractor or trust staff working the contractor under retention of employment model.

1.5 Responsibilities and Delegation

1.5.1 The Board of Directors exercises financial supervision and control by:

a) formulating the financial strategy;
b) requiring the submission and approval of budgets within overall income;
c) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money)
d) ensuring appropriate audit provision; and
e) defining specific responsibilities placed on directors and employees as indicated in the Scheme of Delegation document

1.5.2 The Board of Directors has resolved that certain powers and decisions may only be exercised by the Board of Directors in formal session. These are set out in the "Scheme of Reservation to the Board of Directors" document. The Board of Directors will delegate responsibility for the performance of its functions in accordance with the Scheme of Delegation document adopted by the Trust.

1.5.3 Within the SFIs, it is acknowledged that the Chief Executive is ultimately accountable to the Board of Directors, and for ensuring that the Board of Directors meets its obligation to perform its functions within the available financial resources, ensuring that financial obligations and targets are met, and that an effective system of internal control is in place.

1.5.4 The Chief Executive and Director of Finance will, as far as possible, delegate their detailed responsibilities but they remain accountable for financial control.

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

1.5.6 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; (The SFIs themselves do not provide detailed procedural advice. These statements should therefore be read in conjunction with the detailed departmental and financial procedure notes).

b) maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

c) ensuring that sufficient records are maintained to show and explain the 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 other members of the Board of 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 financial reports as the Trust may require for the purpose of carrying out its statutory duties.

1.5.7 All directors and employees, individually and collectively, are responsible for:

a) the security of the property, assets and resources of the Trust;

b) avoiding loss;

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

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

1.5.8 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.

1.5.9 For all members of the Board and any 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.

SFI2 Audit

2.1 Audit Committee

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

a) overseeing Internal and External Audit and Counter Fraud services;

b) reviewing financial and information systems and monitoring the integrity of the financial statements and reviewing of significant financial reporting judgements;

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

d) reviewing schedules of losses and compensation and making recommendations to the Board of Directors.

e) reviewing the effective implementation of corporate governance measures to enable the Trust to implement best practice as set out in appropriate guidance. This will include the Assurance Framework and control related

disclosure statements, for example the Annual Governance Statement and supporting assurance processes; together with any accompanying audit statement, prior to endorsement by the Board of Directors.

f) reviewing schedules of debtors/creditors balances over 6 months and £5,000 old and explanations / action plans.

g) review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.

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

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

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

2.2 Director of Finance

2.2.1 The Director of Finance is responsible for:

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

b) ensuring that the internal audit is adequate and meets the NHS Internal Audit Standards;

c) ensuring that the Trust maintains adequate Counter Fraud and Corruption arrangements and deciding at what stage to involve the police in cases of fraud, misappropriation, and other irregularities not involving fraud or corruption;

d) ensuring that an annual internal audit report is prepared for the consideration of the Audit Committee. The report must cover:

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

ii) major internal financial control weaknesses discovered,

iii) progress on the implementation of internal audit recommendations,

iv) progress against plan over the previous year,

v) strategic audit plan,

vi) a detailed plan for the coming year.

2.2.2 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, Board Members or employee of the Trust;

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

d) explanations concerning any matter under investigation.

2.3 Internal Audit

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

2.3.2 Role of Internal Audit

The role of internal audit embraces two key areas:

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

Internal Audit will review, appraise and report upon:

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

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

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

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

i) fraud and other offences,

ii) waste, extravagance, inefficient administration,

iii) poor value for money or other causes.

e) Internal Audit shall also independently verify the Board Assurance Framework and other assurance statements in accordance with guidance from the Department of Health.

2.3.3 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Director of Finance must be notified immediately.

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

2.3.5 The Head of Internal Audit shall be accountable to the Director of Finance. The reporting system for internal audit shall be agreed between the Director of Finance, the Audit Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Internal Audit Manual. The reporting system shall be reviewed at least every 3 years. Where, in exceptional circumstances, the use of normal reporting channels is thought to limit the objectivity of the audit, the Head of Internal Audit shall have access to report direct to the Chair or a Non-Executive Member of the Trust's Audit Committee.

2.3.6 Managers in receipt of audit reports referred to them, have a duty to take appropriate remedial action within the agreed time-scales specified within the report. The Director of Finance shall identify a formal review process to monitor the extent of compliance with audit recommendations. Where appropriate, remedial action has failed to take place within a reasonable period, the matter shall be reported to the Director of Finance.

2.4 External Audit

2.4.1 The External Auditor is appointed by the Audit Committee and paid for by the Trust. The Audit Committee must ensure a cost-efficient service. If there are any problems relating to the service provided by the External Auditor, then this should be raised with the External Auditor via the Director of Finance and referred on to the Audit Committee if the issue cannot be resolved.

SFI3 Fraud, Bribery and Corruption

3.1 The Director of Finance is responsible for overseeing and ensuring compliance with the NHS Contractual requirements for countering fraud, bribery and corruption, as well as any other requirements as may be instructed by NHS Protect periodically.

3.2 All anti-fraud, bribery and corruption services are provided under arrangements proposed by the Director of Finance and approved by the Audit Committee, on behalf of the Board.

3.3 The Director of Finance will appoint a suitable person as Local Counter Fraud Specialist (LCFS). The LCFS shall report to the Director of Finance and shall work with the staff in NHS Protect, in accordance with the Department of Health Fraud and Corruption Manual.

3.4 The Local Counter Fraud Specialist will provide a written report and action plan to the Audit Committee, at least annually, on counter fraud and corruption work within the Trust.

3.5 All Members and officers have a duty to ensure Trust resources are appropriately protected from fraud, bribery and corruption.

3.6 All members and officers having evidence of, or reason to suspect, financial or other irregularities or impropriety in relation to these instructions to report these suspicions to the Director of Finance, Company Secretary or the LCFS or directly to NHS Protect.

3.7 Under no circumstances will a Member or officer commence any investigation into suspected or alleged crime, as this may compromise any further investigation.

SFI4 Security Management

4.1 The Director of Finance is responsible for overseeing the provision of security management arrangements compliant with Directions issued by the Secretary of State for Health on NHS security management.

4.2 The Director of Finance will appoint a suitable person as Local Security Management Specialist (LSMS). The LSMS shall report to the Director of Finance.

4.3 The Local Security Management Specialist will produce an annual assessment of security management arrangements. The outcome of the assessment, together with an action plan to address areas of weakness, will be reported to the Audit Committee.

4.4 All members and officers have a responsibility for ensuring that the security of Trust property and safety of staff is not compromised.

SFI5 Resource Limits, Business Planning, Budgets, Budgetary Control and Monitoring

5.1 Resource Limits

5.1.1 The Trust has a statutory duty not to exceed resource limits. The Chief Executive has overall responsibility for the Trust's activities and is accountable to the Board for ensuring that the Trust stays within resource limits.

5.1.2 The Director of Finance will:

- Provide reports to NHS Improvement in the form required.
- Provide regular financial reports to the Board.
- Ensure money drawn against cash forecasts is required for approved expenditure only, and is drawn only at the time of need, following best practice as set out in 'Cash Management in the NHS'.
- Be responsibility for ensuring that an adequate system for monitoring financial performance is in place to enable the Trust to fulfil its statutory responsibility not to exceed its annual revenue and capital resource limits and cash forecast.

5.2 Preparation and approval of business plans / Service Development Strategy (Local Delivery Plan) and budgets

5.2.1 The Chief Executive will compile and submit to the Board of Directors an Annual Business Plan that 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.

5.2.2 Prior to the start of the financial year the Director of Finance will, on behalf of the Chief Executive, prepare and submit budgets relating to income and expenditure for approval by the Board of Directors. Such budgets will:

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

b) accord with workload and manpower plans;

c) be produced following discussion with appropriate budget holders;

d) be prepared within the limits of available funds;

e) identify potential risks; and

f) be based on reasonable and realistic assumptions.

5.2.3 The Director of Finance shall monitor the financial performance against budgets, periodically review it and report to the Board of Directors. Any significant variances should be reported by the Director of Finance to the Board of Directors as soon as they come to light and the Board of Directors shall be advised of action to be taken in respect of such variances.

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

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

5.2.6 The Director of Finance has a responsibility to ensure that adequate training is delivered on an on-going basis to all budget holders to help them manage successfully.

5.3 Budgetary delegation

5.3.1 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.

5.3.2 Delegated budget holders must not exceed the budgetary total or virement limits set by the Board of Directors.

5.3.3 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.

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

5.4 Budgetary control and reporting

5.4.1 The Director of Finance will devise and maintain systems of budgetary control. These will include:

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

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

ii) balance sheet, including movements in working capital,

iii) cash flow statement and details of performance within Prudential Borrowing Code.

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

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

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, and workload budgets;

d) the monitoring of management action to correct variances;

e) arrangements for the authorisation of budget transfers;

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

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

5.4.2 Each budget holder is responsible for ensuring that:

a) any likely overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the Board of Directors;

b) officers shall not exceed the budget limit set;

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

d) 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 of Directors.

5.4.3 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Annual Business Plan and a balanced budget.

5.5 Capital expenditure

5.5.1 The general rules applying to delegation and reporting shall also apply to capital expenditure. (The particular applications relating to capital are contained in Section 11.) A Project Manager will be identified who will assume responsibility for the budget relating to the scheme.

5.6 Monitoring returns

5.6.1 The Director of Finance is responsible for ensuring that the appropriate monitoring forms are submitted to the requisite monitoring organisation within the specified time-scales.

SFI6 Annual Accounts and Reports

6.1 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;

(c) submit financial returns to the Department of Health for each financial year in accordance with the timetable prescribed by the Department of Health.

The Trust's annual accounts must be audited by an auditor appointed by the Audit Commission. The Trust's audited annual accounts must be presented to a public meeting and made available to the public.

6.2 The Company Secretary, on behalf of the Trust, will prepare an Annual Report, in accordance with guidelines on local accountability. The Annual Report will be published for access by the public and presented at a public meeting. The document will comply with the Department of Health's Manual for Accounts.

SFI7 Banking Arrangements

7.1 General

7.1.1 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, including the provision of banking services and operation of accounts, including the provision and use of procurement or other card services. This advice will take into account guidance/directions issued by the Department of Health and HM Treasury.

7.1.2 In line with 'Cash Management in the NHS' Trusts should minimize the use of commercial bank accounts and consider using Governance Banking Service (GBS) accounts for all banking services.

7.1.3 The Board of Directors shall approve the banking arrangements.

7.2 Commercial Bank and Government Banking Service Accounts

7.2.1 The Director of Finance is responsible for:

a) Commercial bank accounts and GBS accounts; and other forms of working capital financing that may be available from the Department of Health.

b) Establishing separate bank accounts for the Trust's non-exchequer funds, including charitable funds;

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

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

e) Ensuring there are arrangements in place for the monitoring of compliance with the Department of Health guidance on the level of cleared funds; and

f) Ensure that to action transactions governed by the bank mandates there must be two approved signatories which are listed on the mandates and one of the signatories must be the Director of Finance.

7.2.2 All accounts should be held in the name of the Trust. No officer other than the Director of Finance shall open any account in the name of the Trust or for the purpose of furthering Trust activities.

7.3 Banking procedures

7.3.1 The Director of Finance is responsible for ensuring that detailed instructions on the operation of bank and GBS accounts are prepared, which must include:

a) the conditions under which each bank and GBS 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.

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

7.3.3 The Director of Finance shall approve security procedures for any cheques issued without a hand-written signature e.g. lithographed. Manually produced cheques shall be signed by the authorised officer(s) in accordance with the bank mandate.

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

7.4 Tendering and Review

7.4.1 The Director of Finance will review the commercial banking arrangements of the Trust at regular intervals not exceeding five years to ensure they reflect best practice and represent best value for money. This will include seeking competitive tenders for the Trust's commercial banking business. This review is not necessary for GBS banking.

7.4.2 The results of the tendering exercise should be reported to the Board of Directors.

SFI8 Income, Fees and Charges, and Security of Cash, Cheques and other Negotiable Instruments

8.1 Income systems

8.1.1 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.

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

8.1.3 The Director of Finance is also responsible for ensuring systems are in place for the prompt banking of all monies received.

8.1.4 The Director of Finance will arrange to register with HM Revenues and Customs if required under money laundering legislation.

8.2 Fees and charges other than Trust Contract.

8.2.1 The Trust shall follow the Department of Health's advice in the 'Costing Manual' in setting prices for NHS service agreements.

8.2.2 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.

8.2.3 Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered the guidance in the Department of Health's Commercial Sponsorship – Ethical standards in the NHS shall be followed.

8.2.4 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.

8.3 Debt recovery

8.3.1 The Director of Finance is responsible for ensuring systems are in place for the appropriate and timely recovery action on all outstanding debts, including a formal follow up procedure for all debtor accounts.

8.3.2 Where it is necessary to use the services of a professional debt recovery agency and/or the courts to recover an outstanding debt, the Trust will seek to recover the associated costs from the debtor concerned.

8.3.3 The Director of Finance will confirm any Employee(s) authorised to sign court documentation in relation to the recovery of outstanding debts on behalf of the Trust.

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

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

8.4 Security of cash, cheques and other negotiable instruments

8.4.1 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; (No form of receipt which has not been specifically authorised by the Director of Finance should be issued).

b) ordering and securely controlling any such stationery;

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

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

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

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

8.4.4 All cheques, postal orders, cash etc., shall be banked promptly intact under arrangements approved by the Director of Finance.

8.4.5 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.

8.4.6 Any loss or shortfall of cash, cheques or other negotiable instruments, however occasioned, shall be the monitored and recorded within the Finance Department. Any significant trends should be reported to the Director of Finance and Internal Audit via the incident reporting system. Where there is prima facie evidence of fraud, bribery or corruption this should be reported in accordance with the Trust's Fraud and Corruption Reporting Arrangements (See Appendices) and the guidance provided by NHS Protect. Where there is no evidence of fraud or corruption the loss should be dealt with in line with the Trust's Losses and Compensations Procedures.

SFI9 NHS Service Agreements for Provision of Services

9.1 Service Level Agreements

9.1.1 The Chief Executive, as the Accountable Officer, is responsible for ensuring the Trust enters into suitable Service Level Agreements (SLA) with service commissioners for the provision of NHS services.

9.1.2 All SLAs should aim to implement the agreed priorities contained within the Annual Plan and wherever possible, be based upon integrated care pathways to reflect expected patient experience. In discharging this responsibility, the Chief Executive should take into account:

- the standards of service quality expected;
- the relevant national service framework (if any);
- the provision of reliable information on cost and volume of services;
- the NHS National Performance Assessment Framework;
- that SLAs build where appropriate on existing Joint Investment Plans;
- that SLAs are based on integrated care pathways.

9.1.3 A good SLA 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.

9.1.4 The SLA 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.

9.1.5 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 SLA. 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 SLAs.

SFI10 Terms of Service, Allowances and Payment of Members, Officers and Others

10.1 Remuneration Committee

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

10.1.2 The Committee will:

a) agree 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) agree 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;

c) monitor and evaluate the performance of individual executive directors (and other senior employees); and

d) 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.

10.1.3 The Committee shall be accountable for taking decisions on the remuneration and terms of service of executive directors. Minutes of the Committee meetings should record such decisions.

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

10.1.5 The Trust will pay allowances to the Chair and Non-Executive Members of the Board in accordance with instructions issued by the Secretary of State for Health

10.2 Funded establishment

10.2.1 The staffing plans incorporated within the annual budget will form the funded establishment.

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

10.3 Staff appointments

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

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

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

10.3.2 Any exceptions to SFI10.3.1 must be approved in advance and in writing by the Chief Executive.

10.3.3 The Board of Directors will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc., for employees.

10.4 Processing of the payroll

10.4.1 All employees will be paid via bank credit transfer, unless otherwise agreed with the Director of Finance.

10.4.2 The Associate Director of Human Resources in conjunction with the Director of Finance is responsible for:

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

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

c) making payment on agreed dates.

10.4.3 The Associate Director of Human Resources will issue instructions regarding:

a) verification and documentation of data;

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

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

d) security and confidentiality of payroll information;

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

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

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

h) pay advances and their recovery.

10.4.3 The Director of Finance will ensure arrangements are in place to issue instructions regarding:

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

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

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

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

e) a system to ensure the recovery from leavers of sums of money, including overpayments, and property due by them to the Trust.

10.4.4 Appropriately nominated managers have delegated responsibility for:

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

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

c) completing time records and other notifications in accordance with the Associate Director of Human Resource's instructions and in the form prescribed by the Associate Director of Human Resources; and

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

10.4.5 Regardless of the arrangements for providing the payroll service, the Associate Director of Human Resources in conjunction with 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.

10.5 Contracts of employment

10.5.1 The Associate Director of Human Resources is responsible for:

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

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

c) ensuring that all volunteers and lay members receive a contract which appropriately reflects their status and entitlement, or not, to pay and/or expenses.

10.6 Expenses

10.6.1 Managers are accountable for approving appropriate expenses incurred in line with the Trust Expenses Policy, Agenda for Change rates and based on their financial delegations set out in the Scheme of Delegation.

10.6.2 Expenses are reimbursed to Employees via payroll.

10.6.3 The expenses system is only for the reimbursement of expenses associated with travel and subsistence, and should never be used to reimburse items that should have been and could have been purchased via the Trust's purchasing system.

10.7 Salary Sacrifice Schemes

10.7.1 A salary sacrifice happens when an employee gives up the right to receive part of their cash pay due under their contract of employment. The sacrifice is made in return for the Trust agreeing to provide some form of non-cash benefit (e.g., child care vouchers, car, etc). The sacrifice is achieved by varying the employee's terms and conditions of employment relating to pay.

10.7.2 Salary sacrifice is a matter of employment law not tax law. Where an employee agrees to a salary sacrifice in return for a non-cash benefit they give up their contractual right to future cash remuneration. Therefore, an employee wishing to enter into a salary sacrifice will be required to complete and sign an appropriate amendment to their employment contract.

10.7.3 The Trust may offer employees access to a range of salary sacrifice schemes. Any proposal to offer or withdraw a particular salary sacrifice scheme requires the agreement of both the Director of Finance and the Associate Director of Human Resources.

10.7.4 All salary sacrifice schemes will be open to all employees of the Trust who hold either a permanent contract or a fixed term contract with more than one year remaining at the point of joining the scheme (not some schemes may be for a longer period than one year and termination before lease end may incur a penalty which is not eligible for salary sacrifice).

10.7.5 For all schemes an employee is required to enter into an arrangement for a finite period of time.

10.7.6 The law governing salary sacrifice schemes does not allow an employee to opt out of most salary sacrifice schemes before the end of the agreed term, other than in the case of an 'unforeseen life changing event'. An employee wishing to opt out of a

salary sacrifice agreement before the end of its term will therefore have to sign an appropriate amendment to their employment contract and demonstrate that they meet one of the criteria laid down in law

10.7.7 Because of the implications for pension entitlement, tax credits and state benefits (e.g., maternity pay, sick pay, etc) employees wishing to enter into a salary sacrifice agreement will be encouraged to seek independent financial advice before entering into the agreement.

10.7.8 A salary sacrifice cannot reduce an employee's gross pay below the national minimum wage. Where this would occur the salary sacrifice will be restricted to an amount that reduces gross pay to the national minimum wage, and any excess will be deducted from net pay. This will be clearly highlighted to an employee before then enter into any agreement.

10.8 Payments to Volunteers and Lay Members

10.8.1 In accordance with tax law, volunteers and lay members can only be reimbursed, without the deduction of income tax and national insurance, for expenses incurred.

10.8.2 Tax law allows for this reimbursement to be:

a) on the basis of actual costs incurred, which require supporting receipts and should be in line with agenda for change expense rates and the Trust's Expenses Policy; or

b) as a round sum allowance which reasonably reflects the costs that are likely to have been incurred and is not time related. Payment of an allowance on a time related basis is deemed to be payment for time and subject to income tax and national insurance.

10.8.3 Where it is proposed to pay a round sum allowance this should be approved in accordance with the process laid down by the Director of Finance, before an offer of payment occurs. As an exception to this, volunteers working at the Trust should submit expenses based on the Trust's Policy for the Recruitment and Management of Volunteers.

10.8.4 All reimbursements or expenses to volunteers and lay members should be made following the submission of a Volunteer Expenses Claims Form in line with the Trust's Policy for the Recruitment and Management of Volunteers.

10.8.5 Where it is proposed to pay a volunteer or lay member an involvement payment this will be classed as income by HMRC.

10.8.6 Some patient volunteers will be in receipt of state benefits or insurance payments. Job Centre Plus and insurance companies may consider any involvement payments made as income. Any recipients of such payments must be informed of their duty to declare the income in writing to the relevant authorities. Individuals failing to declare this income can put themselves at financial risk, their benefits or insurance payments could be suspended or stopped.

10.8.7 The Associate Director of Human Resources must approve all decisions to offer an involvement payment to a volunteer or lay member. Decisions to do so must be

recorded in writing detailing the payment offer and the requirement upon the recipient to declare this offer in writing.

10.9 Payments to other non-employed officers

10.9.1 An officer who is not an employee of the Trust (e.g., an officer on secondment to the Trust) should only receive payment from their employing organisation and not from the Trust.

10.9.2 This means that in addition to their employing organisation paying their salary they should also pay any expenses incurred by the office (where appropriate, and agreed, recharging them to the Trust).

10.9.3 The Trust should only pay costs associated with a non-employed officer that are invoiced by their employing organisation.

10.10 Staff Redundancy, Severance, Incentive and Retention Payments

10.10.1 Regulatory/Department of Health and/or HRM Treasury approval is required for all of the following:

a) Redundancies (subject to a capitalised cost de-minimus);

b) Ten or more redundancies, irrespective of capitalised cost;

c) Payments in lieu of notice (subject to a de-minimus);

d) All special severance payments;

e) Financial incentive/retention payments;

f) All novel, contentious or repercussive cases;

g) Change programmes/major restructuring;

h) Voluntary redundancy schemes;

i) Where a decision to terminate employment has been overturned;

j) Has a proposed settlement payment of £100,000 (at any grade); and

k) Confidentiality clauses.

10.10.2 Advice should be sought well in advance of the need to undertake any of the above. The timescales required to obtain all necessary approvals may be considerable.

SFI11 Non-Pay Expenditure

11.1 Delegation of authority

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

11.1.2 The Chief Executive will set out:

a) the list of managers who are authorised to place requisitions for the supply of goods and services should be updated and reviewed on an ongoing basis and annually by the Supplies Department; and

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

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

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

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

11.2.1 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 advisor shall be sought. Where this advice is not acceptable to the requisitioner, the Director of Finance (and/or the Chief Executive) shall be consulted.

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

11.2.3 The Director of Finance will:

a) advise the Board of Directors regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in the Scheme of Reservation and Delegation 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 approve or incur expenditure. Where the authorisation

system is computerised the list will be maintained within the computerised system and the 'signature' will be in the form of electronic authorisation in accordance with the access and authority controls maintained within the computerised system.

ii) Certification that:

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

iii) A timetable and system for submission to the Director of Finance of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

iv) Instructions to employees regarding the handling and payment of accounts within the Finance Department.

e) be responsible for ensuring that payment for goods and services is only made once the goods and services are received, (except as below).

11.2.4 Prepayments outside of normal commercial arrangements, for example fully comprehensive maintenance contracts, rental, insurance are only permitted where exceptional circumstances apply. In such instances:

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

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

e) the Director of Finance will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the EU public procurement rules where the contract is above a stipulated financial threshold);

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

11.2.5 Official Orders must:

a) be consecutively numbered;

b) be in a form approved by the Director of Finance;

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

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

11.2.6 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;

Where an officer certifying accounts relies upon other officers to do preliminary checking, they shall wherever possible, ensure that those who check delivery or execution of work act independently of those who have placed orders and negotiated prices and terms.

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

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

ii) conventional hospitality, such as lunches in the course of working visits;

g) no requisition/order is 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;

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

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 un-competitive 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;

l) petty cash records are maintained in a form as determined by the Director of Finance; and,

j) orders are not required to be raised for utility bills, NHS Recharges; audit fees and ad hoc services such as private hospital fees. Payments must be authorised in accordance with the delegated limits set for non pay.

11.2.7 The Chief Executive and 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 the NHS Trust Capital Accounting Manual. The technical audit of these contracts shall be the responsibility of the relevant Director.

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

11.3 Joint finance arrangements with local authorities and voluntary bodies

11.3.1 Payments to local authorities and voluntary organisations made under the powers of section 28A of the NHS Act shall comply with procedures laid down by the Director of Finance which shall be in accordance with these Acts.

SFI12 External Borrowing and Investments

12.1 Public Dividend Capital

12.1.1 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.

12.1.2 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.

12.1.3 The Director of Finance must prepare detailed procedural instructions concerning applications for loans and overdrafts.

12.1.4 All short-term borrowings should be kept to the minimum period of time possible, consistent with the overall cashflow position, represent good value for money, and comply with the latest guidance from the Department of Health.

12.1.5 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.

12.1.6 All long-term borrowing must be consistent with the plans outlined in the current Annual Plan and be approved by the Board.

12.2 Investment

12.2.1 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.

12.2.2 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.

12.2.3 The Director of Finance will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

SFI13 Capital Investment, Private Financing, Fixed Asset Registers and Security of Assets

13.1 Introduction

13.1.1 Capital commitments typically cover land, buildings, equipment and IT, including:

a) Authority to spend capital

b) Authority to enter into a leasing agreement

13.1.2 Advice should be sought from the Director of Finance if there is any doubt as to whether the particular proposal is a capital commitment requiring formal approval under SFI 13.

13.1.3 No procurement should be undertaken or commitment given to purchase from a supplier prior to approval being received. Failure to comply will be a breach of the SFIs.

13.2 Capital investment

13.2.1 Before the start of the financial year the Board is responsible for approving the annual capital plan.

13.2.2 The Director of Finance:

a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities, based on the Estates Strategy and with the involvement of the Director of Finance, Medical Director, Estates Team and IT Team, 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;

c) shall ensure that a Project Board is established for schemes over £500,000;

d) each individual scheme is identified and has a monthly expenditure profile; and

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

13.2.3 For capital expenditure proposals the Director of Finance shall ensure (in accordance with the limits outlined in the Scheme of Delegation):

a) that a business case (in line with the guidance contained within the NHS Trust Capital Accounting 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

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

b) that the Director of Finance has certified professionally to the costs and revenue consequences detailed in the business case.

13.2.4 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of “CONCODE/Estatecode” and the NHS Trust Capital Accounting Manual.

13.2.5 The Director of Finance shall assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme in accordance with Inland Revenue guidance.

13.2.6 The Director of Finance shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

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

13.2.8 The Director of Finance 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

13.2.9 The Director of Finance will issue a scheme of delegation for capital investment management in accordance with "CONCODE/Estatecode" and the NHS Trust Capital Accounting Manual guidance and the Trust's Standing Orders.

13.2.10 The Director of Finance shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.

13.3 Estates Capital Schemes

13.3.1 Project Managers must engage a Quantity Surveyor where the overall scheme cost (including VAT, equipment and fees) exceeds £100,000. The role of the Quantity Surveyor is to value stage payments and to challenge and support the value for money of the agreed works costs. In addition the Quantity Surveyor should aid the Project Manager in forecasting final outturn figures for the scheme.

13.3.2 The Project Manager has the authority to sign off staged payment certificates for their own schemes up to £100,000. Certificates above this value need to be authorised by the Director of Finance.

13.3.3 If the Quantity Surveyor or the Project Manager (if the scheme is below £100,000) forecasts that the outturn is likely to be in excess of the budgeted scheme value then a request must be made to use the capital contingency budget.

13.3.4 A detailed explanation of why the capital contingency budget is needed will be required. In all cases the use of the capital contingency budget will be reported to the Board.

13.4 IT Capital Schemes

13.4.1 Smaller IT projects can be managed using the current controls in place, i.e., requisition and purchase order authorisation and monthly monitoring with the Capital Accountant.

13.4.2 Larger IT projects will have a Project Manager who will report to a Project Board on a regular basis. The Project Manager must provide forecast outturn figures to the Project Board at each meeting. If an overspend is predicted then a request must be made to use the capital contingency budget.

13.4.3 A detailed explanation of why the capital contingency budget is needed will be required. In all cases the use of the capital contingency budget will be reported to the Board.

13.5 Medical Equipment

13.5.1 There is an allocation made each year for medical equipment and it is the responsibility of the Medical Director to ensure each clinical area provides details of the medical equipment required.

13.5.2 A standard form should be completed for each piece of equipment requested detailing why it is required, its cost (including VAT) together with a quote, any ongoing revenue consequences and a priority ranking as follows:

1. Equipment not functioning, service halted
2. Equipment unsafe – about to be withdrawn
3. Equipment giving sub-standard results – clinical risk acknowledged
4. Enhancement of service
5. New service: it is unlikely that any bid which falls into this category would be supported. Any new service would be subject to a Business Case, which would include costs of equipment.

13.5.3 All the forms will be collated and all requesters are invited to present their case and provide evidence of the priority rankings above.

13.5.4 Based on the information received, the Committee will decide which pieces of equipment can be funded from the capital allocation provided and will write out to the successful bidders with instructions on how to purchase.

13.5.5 Purchasing will follow the normal controls of an electronic requisition to the Capital Accountant.

13.6 Private finance

13.6.1 The Trust should normally test for PFI when considering capital procurement. When the Board proposes, or is required, to use finance provided by the private sector the following should apply:

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

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

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

13.7 Asset registers

13.7.1 The Chief Executive is responsible for the assets of the Trust.

13.7.2 The Director of Finance is responsible for the maintenance of registers of assets and will determine 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 over a cycle agreed by the Audit Committee.

13.7.3 The Director of Finance is responsible for ensuring there are processes in place to define the items of equipment which will be recorded on the Asset Register. As a minimum, the minimum data set to be held within these registers shall be as specified in the Capital Accounting Manual as issued by the Department of Health.

13.7.4 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.

13.7.5 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).

13.7.6 The Director of Finance shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed Asset Registers.

13.7.7 The value of each asset shall be adjusted to current values in accordance with methods specified in the Capital Accounting Manual issued by the Department of Health.

13.7.8 The value of each asset shall be depreciated using methods and rates as specified in the Capital Accounting Manual issued by the Department of Health.

13.7.9 Budget holders will ensure that the respective assets for their areas are physically checked annually.

13.7.10 The Director of Finance is responsible for ensuring there are processes in place to maintain an up to date register of properties owned or leased by the Trust. This should include details of location, tenancy and custody of the deeds and lease documents.

13.7.11 The Director of Finance shall calculate and pay capital charges as specified by the Department of Health.

13.8 Security of assets

13.8.1 The overall control of fixed assets is the responsibility of the Chief Executive advised by the Director of Finance.

13.8.2 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.

13.8.3 All discrepancies revealed by verification of physical assets to fixed Asset Register shall be notified to the Director of Finance.

13.8.4 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 of Directors. Any significant breach of agreed security practices must be reported to the Director of Finance, who will determine the necessary action, including reference to the Local Security Management Specialist.

13.8.5 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.

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

SFI14 Stock, Stores and Receipt of Goods

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

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

b) Wards & departments- goods required for immediate usage to support operational services.

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

14.2 Such stocks should be kept to a minimum and for;

a) controlled stores and other significant stores (as determined by the Director of Finance) should be subjected to an annual stocktake or perpetual inventory procedures; and

c) valued at the lower of cost and net realisable value.

14.3 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 them to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Director of Finance.

14.4 The control of any Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of any fuel oil of a designated estates manager.

14.5 The responsibility for security arrangements and the custody of keys for all stores and locations shall be clearly defined in writing by the designated manager. Wherever practicable, stocks should be marked as NHS property.

14.6 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. 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.

14.7 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Director of Finance.

14.8 The designated manager 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 SFI15, 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.

14.9 Receipt of Goods

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

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

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

14.10 Issue of Stocks

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

14.10.2 All transfers and returns shall be recorded on forms/systems provided for the purpose and approved by the Director of Finance.

SFI15 Disposals and Condemnations, Insurance, Losses and Special Payments

15.1 Disposals and condemnations

15.1.1 The Director of Finance is responsible for ensuring detailed procedures for the disposal of assets including condemnations, and for the recording and accounting for the disposal.

15.1.2 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.

15.1.3 All unserviceable articles shall be:

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

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

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

15.2 Losses

15.2.1 Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the Trust or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared to the generality of payments, and special notation in the accounts to bring them to the attention of Parliament.

15.2.2 The Director of Finance must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments. Trust senior management must comply with NHS contractual requirements in ensuring that suspected fraud, bribery or corruption is reported and investigated by the Trust LCFS.

15.2.3 Managing Public Money defines losses as including, but not limited to:

a) Cash losses (physical loss of cash and its equivalents, e.g., credit cards, electronic transfers;

b) Bookkeeping losses (un-vouched or incompletely vouched payments, including missing items or inexplicable or erroneous debit balances);

c) Exchange rate fluctuations;

d) Losses of pay, allowances and superannuation benefits paid to employees (including: overpayments due to miscalculation, misinterpretation or missing information; unauthorised issue and other causes)

e) Losses arising from overpayments;

f) Losses from failure to make adequate charges;

g) Losses of accountable stores (through fraud, theft, arson, other deliberate act or other cause)

h) Fruitless payments and constructive losses; and,

i) Claims waived or abandoned (including bad debts);

j) Losses that are subject to insurance cover should be accounted for on a net basis (i.e. after any insurance pay-out).

k) Fruitless payments include payments for rail fares and hotels that are not required but could not be cancelled without a partial or full charge being incurred.

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

15.2.4 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 or corruption or of anomalies which may indicate fraud, bribery or corruption, the Director of Finance must inform their Local Counter Fraud Specialist who will report the incident on the NHS Protect case management database.

15.2.5 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 Board of Directors, and

b) the External Auditor.

c) NHS Protect (if appropriate, through the Local Security Management Specialist)

15.2.6 Within limits delegated by the Department of Health the Board of Directors shall approve the writing-off of all losses and special payments in accordance with the Scheme of Delegation.

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

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

15.2.9 The Director of Finance shall maintain a *Losses and Special Payments Register* in which write-off action is recorded. All losses and special payments must be reported to the Audit Committee.

15.3 Special Payments

15.3.1 The Director of Finance is responsible for ensuring that detailed procedural instructions for the recording and accounting for special payments are prepared and notified to officers.

15.3.2 The Scheme of Delegation sets out delegated approval limits for officers to authorise special payments.

15.3.3 All special severance payments and retention payments require the approval of the Remuneration and Nominations Committee.

15.3.4 Managing Public Money defines special payments as:

a) Extra-contractual payments: payments which, though not legally due under contract, appear to place an obligation on a public sector organisation which the courts might uphold. Typically these arise from the organisation's action or inaction in relation to a contract. Payments may be extra-contractual even where there is some doubt about the organisation's ability to pay, e.g. where the contract provides for arbitration but a settlement is reached without it. A payment made as a result of an arbitration award is contractual;

b) Extra-statutory and extra-regulatory payments: are within the broad intention of the statute or regulation, respectively, but go beyond a strict interpretation of its terms;

c) Compensation payments: are made to provide redress for personal injuries (except for payments under the civil service injury benefits scheme), traffic accidents, and damage to property etc., suffered by civil servants or others. They include other payments to those in the public service outside statutory schemes or outside contracts;

d) Special severance payments: are paid to employees, contractors and others outside of normal statutory or contractual requirements when leaving employment in public service whether they resign, are dismissed or reach an agreed termination of contract; and

e) Ex gratia payments: go beyond statutory cover, legal liability, or administrative rules, including: payments made to meet hardship caused by official failure or delay; out of court settlements to avoid legal action on grounds of official inadequacy; and, payments to contractors outside a binding contract, e.g., on grounds of hardship.

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

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

- Adopting prudent risk management strategies including continuous review.
- Implementing in full the NHS Complaints Procedure, thus providing an alternative remedy for some potential litigants.
- Adopting a systematic approach to claims handling in line with the best current and cost effective practice.
- Following guidance issued by the NHSLA relating to clinical negligence.
- Achieving the Care Quality Commission Fundamental Standards for Quality and Safety.
- Implementing an effective system of Quality Governance

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

SFI16 Procurement Procedures

16.1 The Procurement Manager is responsible to the Director of Finance for providing management, governance and assurance of the procurement function to ensure:

a) the buying and contract management of goods, services and works is undertaken in accordance with procurement rules and the Standing Orders and Standing Financial Instructions.

b) compliance with HM Treasury Managing Public Money (2015) which requires that all public sector organisations be able to demonstrate value for money for their expenditure.

c) compliance as far as is practicable with the requirements of the Department of Health "Capital Investment Manual" and “Estate code” in respect of capital investment and estate and property transactions.

16.2 All expenditure is subject to the annual budget allocation and delegated limits set out in the Scheme of Delegation.

16.3 EU Directives Governing Public Procurement

16.3.1 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 the Standing Orders and Standing Financial Instructions. Procedure notes detailing EU thresholds and the differing procedures to be adopted must be maintained within the Trust.

16.4 Formal Competitive Tendering

16.4.1 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 Department of Health);

- for the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); and for disposals.

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

16.4.2 Formal tendering procedures are not required where:

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

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

(c) regarding disposals as set out in Standing Financial Instruction 'Disposals and Condemnations'.

Formal tendering procedures **may be waived** in the following circumstances:

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

(e) where the requirement is covered by an existing contract;

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

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

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

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

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

(k) for the provision of legal advice and services providing that any legal firm or partnership commissioned by the Trust is regulated by the Law Society for England and Wales for the conduct of their business (or by the Bar Council for England and Wales in relation to the obtaining of Counsel's opinion) and are generally recognised as having sufficient expertise in the area of work for which they are commissioned.

The Director of Finance will ensure that any fees paid are reasonable and within commonly accepted rates for the costing of such work.

(l) where allowed and provided for in the NHS Trust Capital Accounting Manual.

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

The Procurement Manager and Head of Technical Services can authorise waiving of competitive procedures up to £25,000. The Director of Finance can authorise waiving of competitive tendering procedures up to £75,000. Waiving of competitive tendering procedures above £75,000 requires sign off by the Chief Executive and Director of Finance.

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

16.3.3 Fair and Adequate Competition

Where the exceptions set out in SFI Nos. 16.4.2 apply, the Trust shall ensure that invitations to tender are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate, and in no case less than two firms/individuals, having regard to their capacity to supply the goods or materials or to undertake the services or works required.

16.3.4 Building and Engineering Construction Works

Competitive Tendering cannot be waived for building and engineering construction works and maintenance (other than in accordance with Concode) without Departmental of Health approval.

16.3.5 Items which subsequently breach thresholds after original approval

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

16.5 Contracting/Tendering Procedure

16.5.1 Invitation to tender

(i) All invitations to tender shall state the date and time as being the latest time for the receipt of tenders and be published via EU-Supply website and/or Contracts Finder website.

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

(iii) Every tender for building or engineering works (except for maintenance work, when Estmancode guidance shall be followed) shall embody or be in the terms of the current edition of one of the Joint Contracts Tribunal Standard Forms of Building Contract or Department of the Environment (GC/Wks) Standard forms of contract amended to comply with concode; or, when the content of the work is primarily engineering, the General Conditions of Contract recommended by the Institution of Mechanical and Electrical Engineers and the Association of Consulting Engineers (Form A), or (in the case of civil engineering work) the General Conditions of Contract recommended by the Institute of Civil Engineers, the Association of

Consulting Engineers and the Federation of Civil Engineering Contractors. These documents shall be modified and/or amplified to accord with Department of Health guidance and, in minor respects, to cover special features of individual projects.

16.5.2 E-tendering solutions

The Trust obtains support from the North of England Commercial Procurement Collaborative.

16.5.3 Expressions of Interest/Invitations to Tender:

Expressions of interest shall be invited via the OJEU website, the national advertising portal services for healthcare services.

Invitations to tender shall be sent out electronically via EU-supply. Evidence of the invitation process and a full audit trail will be held electronically by EU-supply.

16.5.4 Receipt of tenders/tender opening:

EU-supply is a secure website which ensures that tenders are held in safekeeping before being opened. Access is restricted to the Trust Procurement Manager and Deputy Procurement Manager. Tender opening is restricted to the Director of Finance and Deputy Director of Finance. An audit trail is automatically generated which includes date and time of receipt.

16.5.5 Admissibility

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

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

16.5.6 Acceptance of formal tenders

(i) Any discussions with a tenderer which are deemed necessary to clarify technical aspects of their tender before the award of a contract will not disqualify the tender. All clarification questions received and responses given must be recorded.

(ii) The lowest tender, if payment is to be made by the Trust, or the highest, if payment is to be received by the Trust, shall be accepted unless there are good and sufficient reasons to the contrary. Such reasons shall be set out in either the contract file, or other appropriate record.

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

(a) experience and qualifications of team members;

(b) understanding of client's needs;

(c) feasibility and credibility of proposed approach;

(d) ability to complete the project on time.

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

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

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

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

(b) that best value for money was achieved.

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

16.5.7 Tender reports to the Board of Directors will be made on an exceptional circumstance basis only.

16.5.8 List of approved firms

(a) Responsibility for maintaining list

A manager nominated by the Chief Executive shall on behalf of the Trust maintain lists of approved firms from who tenders and quotations may be invited. These shall be kept under frequent review. The lists shall include all firms who have applied for permission to tender and as to whose technical and financial competence the Trust is satisfied. All suppliers must be made aware of the Trust's terms and conditions of contract.

(b) Building and Engineering Construction Works

(i) Invitations to tender shall be made only to firms included on the approved list of tenderers compiled in accordance with this Instruction or on the separate maintenance lists compiled in accordance with Estmancode guidance (Health Notice HN(78)147).

ii) Firms included on the approved list of tenderers shall ensure that when engaging, training, promoting or dismissing employees or in any conditions of employment, shall not discriminate against any person because of colour, race, ethnic or national origins, religion or sex, and will comply with the provisions of the Equal Pay Act 1970, the Sex Discrimination Act 1975, the Race Relations Act 1976, and the Disabled Persons (Employment) Act 1944 and any amending and/or related legislation.

iii) Firms shall conform at least with the requirements of the Health and Safety at Work Act and any amending and/or other related legislation

concerned with the health, safety and welfare of workers and other persons, and to any relevant British Standard Code of Practice issued by the British Standard Institution. Firms must provide to the appropriate manager a copy of its safety policy and evidence of the safety of plant and equipment, when requested.

(c) Financial Standing and Technical Competence of Contractors

The Director of Finance may make or institute any enquiries they deems appropriate concerning the financial standing and financial suitability of approved contractors. The Director with lead responsibility for clinical governance will similarly make such enquiries as is felt appropriate to be satisfied as to their technical / medical competence.

16.5.9 Exceptions to using approved contractors

If in the opinion of the Chief Executive and the Director of Finance or the Director with lead responsibility for clinical governance it is impractical to use a potential contractor from the list of approved firms/individuals (for example where specialist services or skills are required and there are insufficient suitable potential contractors on the list), or where a list for whatever reason has not been prepared, the Chief Executive should ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote.

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

16.6 Quotations: Competitive and non-competitive

16.6.1 General Position on quotations

Quotations are required where formal tendering procedures are not adopted and where the intended expenditure or income exceeds, or is reasonably expected to exceed the sum defined In the Scheme of Reservation and Delegation.

16.6.2 Competitive Quotations

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

(ii) Quotations should be in writing unless the Chief Executive or their nominated officer determines that it is impractical to do so in which case quotations may be obtained by telephone. Confirmation of telephone quotations should be obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in a permanent record.

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

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

16.6.3 Non-Competitive Quotations

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

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

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

(iii) miscellaneous services, supplies and disposals;

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

16.6.4 Quotations to be within Financial Limits

No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with Standing Financial Instructions except with the authorisation of either the Chief Executive or Director of Finance.

16.7 Authorisation of Tenders and Competitive Quotations

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

16.8 Instances where formal competitive tendering or competitive quotation is not required

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

(a) the Trust shall use the NHS Supply Chain, North of England Commercial Procurement Collaborative or Crown Commercial Services for procurement of all goods and services unless the Chief Executive or nominated officers deem it inappropriate. The decision to use alternative sources must be documented.

(b) If the Trust does not use the NHS Supply Chain, North of England Commercial Procurement Collaborative or Crown Commercial Services - where tenders or quotations are not required, because expenditure is below the levels defined in the Scheme of Reservation and Delegation, the Trust shall procure goods and services in accordance with procurement procedures approved by the Director of Finance.

16.9 Private Finance for capital procurement

16.9.1 The Trust should normally market-test for PFI (Private Finance Initiative funding) when considering a capital procurement. 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, a business case must be referred to the appropriate Department of Health for approval or treated as per current guidelines.

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

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

16.10 Compliance requirements for all contracts

16.10.1 The Board may only enter into contracts on behalf of the Trust within the statutory powers delegated to it by the Secretary of State 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 NHS Trust Capital Accounting Manual, Estatecode and guidance on the Procurement and Management of Consultants;

(d) NHS Standards of Business Conduct

(e) such of the NHS Standard Contract Conditions as are applicable.

(f) contracts with Trusts must be in a form compliant with appropriate NHS guidance.

(g) 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.

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

16.11 Personnel and Agency or Temporary Staff Contracts

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

16.12 Healthcare Services Agreements

16.12.1 Service agreements with NHS providers for the supply of healthcare services shall be drawn up in accordance with the NHS and Community Care Act 1990 and administered by a trust. Such service agreements are not contracts in law and therefore not enforceable by the courts. However, a contract with a Foundation Trust, being a Public Benefits Corporation, is a legal document and is enforceable in law.

The Chief Executive shall nominate officers to commission service agreements with providers of healthcare in line with a commissioning plan approved by the Board of Directors (refer to Scheme of Reservation and Delegation).

16.13 Disposals

16.13.1 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 their 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 that defined on the Scheme of Delegation, this figure to be reviewed on a periodic basis;

(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 DH guidance has been issued but subject to compliance with such guidance.

16.14 In-house Services

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

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

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

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

(c) Evaluation team, comprising normally a specialist officer, a supplies officer and a Director of Finance representative.

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

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

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

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

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

SFI17 Patients' Property

17.1 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.

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

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

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

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

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

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

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

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

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

17.5 The record shall be completed by a member of the hospital staff in the presence of a second member of staff and the patient (or representative) where practicable. It shall then be signed by both members of staff and by the patient, except where the latter is restricted by physical or mental incapacity. Any alterations shall be validated by signature as required in the original entry on the record.

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

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

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

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

17.10 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.

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

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

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

17.14 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.

17.15 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.

SFI18 Funds Held on Trust (including Charitable Funds)

18.1 Corporate Trustee

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

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

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

18.1.4 The over-riding principle is that the integrity of each trust must be maintained and statutory and trust obligations met with adherence to general principles of financial regulatory, prudence and propriety.

18.1.5 Materiality must be assessed separately from exchequer activities and funds.

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

18.1.7 The Director of Finance shall ensure that each fund which the Trust is responsible for managing is managed appropriately to its purpose and to its requirements and will maintain such accounts and records as may be necessary to record and protect all transactions and funds of the Trust as trustees of non-exchequer funds, including an Investment Register.

18.2 Existing Charitable Funds

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

18.2.2 The Director of Finance shall periodically review the funds in existence and shall make recommendations to the Charitable Funds Committee regarding the potential for rationalisation of such funds within statutory guidelines.

18.2.3 The Director of Finance shall ensure that all funds are currently registered with the Charities Commission in accordance with the Charities Act 1993 or subsequent legislation.

18.3 New Charitable Funds

18.3.1 The Director of Finance shall, recommend the creation of a new fund where funds and/or other assets, received for charitable purposes, cannot adequately be managed as part of an existing fund. All new funds must be covered by a Deed of Establishment and must be formally approved by the Charitable Funds Committee.

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

18.4 Sources of New Funds

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

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

18.4.3 In respect of Donations, the Director of Finance shall:-

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

i) the identification of the donor's intentions;

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

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

iv) sources of immediate further advice; and

v) treatment of offers for personal gifts.

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

18.4.4 In respect of Legacies and Bequests, the Director of Finance shall be kept informed of and record all enquiries regarding legacies and bequests. Where required, the Director of Finance shall:-

a) provide advice covering any approach regarding:-

i) the wording of wills;

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

b) after the death of a testator all correspondence concerning a legacy shall be dealt with on behalf of the Charity by the Director of Finance who alone shall be empowered to give an executor a good discharge.

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

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

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

18.4.5 In respect of fund-raising, the final approval for major appeals will be given by the Board of Directors. Final approval for smaller appeals will be given by the Charitable Funds Committee. The Director of Finance shall:-

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

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

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

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

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

18.4.6 In respect of Trading Income (see also NHS Charitable Funds Guidance Chapter 6), the Director of Finance shall:-

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

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

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

18.5 Investment Management

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

a) the formulation of investment policy which meets statutory requirements (Trustee Investment Act 1961) with regard to income generation and the enhancement of capital value;

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

i) the Director of Finance shall recommend the terms of such appointments; and for which

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

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

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

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

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

g) the reporting of investment performance.

18.5.2 The Director of Finance shall prepare detailed procedural instructions concerning the receiving, recording, investment and accounting for Charitable Funds.

18.6 Expenditure from Charitable Funds

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

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

b) the availability of liquid funds within each trust;

c) the powers of delegation available to commit resources;

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

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

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

18.6.2 Delegated authority to incur expenditure which meets the purpose of the funds are set out in the Scheme of Delegations; exceptions are as follows:-

a) Any staff salaries/wages costs require Charitable Funds Committee approval

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

18.7 Banking Services

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

18.8 Asset Management

18.8.1 Assets in the ownership of or used by the Trust, shall be maintained along with the general estate and inventory of assets of the Trust. The Director of Finance shall ensure:-

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

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

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

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

18.9 Reporting

18.9.1 The Director of Finance shall ensure that regular reports are made to the Charitable Funds Committee and Board of Directors with regard to, inter alia, the receipt of funds, investments and expenditure.

18.9.2 The Director of Finance shall prepare annual accounts in the required manner, which shall be submitted, to the Board of Directors within agreed timescales.

18.9.3 The Director of Finance shall prepare an annual trustees' report and the required returns to the Charity Commission for adoption by the Charitable Funds Committee.

18.10 Accounting and Audit

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

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

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

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

18.11 Taxation and Excise Duty

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

SFI19 Acceptance of Gifts and Hospitality and link to Standards of Business Conduct

19.1 The Company Secretary shall ensure that all staff are made aware of the Trust's policy on acceptance of gifts and other benefits in kind by staff.

19.2 The Trust's policy follows the guidance contained in the Department of Health Standards of Business Conduct for NHS Staff and is deemed to be an integral part of the Standing Orders and Standing Financial Instructions.

19.3 All hospitality and gifts accepted by Members and Officers will be recorded by the Company Secretary on the Register of Gifts and Hospitality and will be available for public inspection on request.

SFI20 Declarations of Interest

20.1 The Company Secretary shall ensure that all staff are made aware of the Trust's Policy for Management of Conflicts of Interest.

20.2 The Trust's policy follows the guidance contained in the Department of Health Standards of Business Conduct for NHS Staff and is deemed to be an integral part of the Standing Orders and Standing Financial Instructions.

20.3 All interests declared by Members and Officers will be recorded by the Company Secretary on the Register of Interests and will be published at least annually.

SFI21 Information Governance

21.1 Responsibilities

21.1.1 The Chief Executive is responsible for ensuring that the Trust has registered with the Information Commissioner's Office for compliance with the Data Protection Act 1998 and for ensuring that there are systems in place to ensure that information is published and maintained in accordance with the requirements of the Freedom of Information Act 2000.

21.1.2 The Director of Finance is primarily responsible for the accuracy and security of the financial data of the Trust in accordance with Trust's security retention and data protection policies and ensuring that adequate controls exist to maintain the security, privacy, accuracy and completeness of financial data sent via transmission networks.

21.1.3 The Director of Finance and Associate Director of Workforce are jointly responsible for the accuracy and security of the computerised payroll data of the Trust in accordance with Trust security and data protection policies.

21.1.14 The Director of Finance is the Trust Senior Information Risk Officer and as such is responsible for:

a) ensuring that necessary procedures are devised and implemented to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which they are responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft

or damage, having due regard for the Data Protection Act 1998 (updated 2000) and the Computer Misuse Act 1990.

b) ensuring 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) ensuring that contracts for computer services 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.

d) where another health organisation or any other agency provides a computer service, periodically seeking assurances that adequate controls are in operation.

e) advising the Board in relation to information risk and advising how information security risks could impact upon the Trust's operations and strategic goals.

SFI22 Information Technology

22.1 In order to ensure compatibility and compliance with the Trust's IT Strategy, no corporate IT hardware, software or facility should be procured without the authorisation of the Director of Finance.

22.2 The Director of Finance is the responsible Director for Information Technology within the Trust and is responsible for:

a) ensuring that adequate controls exist for all corporate IT services and systems deployed, to support the business requirements of the Trust.

b) ensuring that systems are in place to 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 business continuity and disaster recovery plans.

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

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

22.3 In the case of computer systems being proposed 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.

22.4 The Director of Finance shall satisfy himself that new computerised financial systems and amendments to current computerised 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.

22.5 Where computer systems have an impact on corporate financial systems the Director of Finance shall satisfy them self 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) Finance staff have access to such data; and

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

22.6 All contractors must agree to, and sign copies of the Trust's IT security policy before accessing any of the Trust's IT systems.

SFI23 Retention of Documents

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

23.2 The Chief Executive and senior managers are personally accountable for records management within the organisation. Additionally, the organisation is required to take positive ownership of, and responsibility for, the records legacy of predecessor organisations and/or obsolete services.

23.3 Under the Public Records Act all NHS employees are responsibility for any records that they create or use in the course of their duties. Thus any records created by an employee of the NHS are public records and may be subject to both legal and professional obligations.

23.4 The Chief Executive is responsible for ensuring systems are in place for maintaining archives for all documents required to be retained under the direction contained in Department of Health guidance, 'Records Management Code of Practice'.

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

- Patient health records (electronic or paper based)
- Records of private patients seen on NHS premises;

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

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

23.7 Documents held in accordance with the Records Management Code of Practice shall only be destroyed in line with the Trust's Records Management Policy. Records shall be maintained of documents so destroyed.

SFI24 Risk Management and Insurance

24.1 Programme of Risk Management

24.1.1 The Chief Executive shall ensure that the Trust has a programme of risk management, in accordance with current Department of Health assurance framework requirements, which must be approved by the Board of Directors and monitored by the Audit Committee.

The programme of risk management shall include:

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

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

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

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

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

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

g) arrangements to review the Risk Management programme.

24.1.2 The existence, integration and evaluation of the above elements will assist in providing a basis to make an *Annual Governance Statement* within the Annual Report and Accounts as required by current Department of Health guidance.

24.2 Insurance: Risk Pooling Schemes administered by NHSLR

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

24.2.2 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.

24.3 Insurance arrangements with commercial insurers

24.3.1 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:

(1) Trust's may enter commercial arrangements for **insuring motor vehicles** owned by the Trust including insuring third party liability arising from their use;
(2) 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
(3) where **income generation activities** take place. Income generation activities should normally be insured against all risks using commercial insurance. If the income generation activity is also an activity normally carried out by the Trust for a NHS purpose the activity may be covered in the risk pool. Confirmation of coverage in the risk pool must be obtained from the NHS Resolution. In any case of doubt concerning a Trust's powers to enter into commercial insurance arrangements the Director of Finance should consult the Department of Health.

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

24.4.1 Where the Board decides to use the risk pooling schemes administered by NHS Resolution the Company Secretary 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.

24.4.2 Where the Board decides not to use the risk pooling schemes administered by NHS Resolution 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 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.

24.4.3 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.

24.5 Professional Services: Legal

24.5.1 Legal services are subject to both centralised procurement and efficiency controls.

24.5.2 All spend for external legal advice must be approved by the Company Secretary.

NHS
Southport and Ormskirk Hospital
NHS Trust

Schedule of Reservation and Scheme of Delegation

1 Introduction

1.1 For effective governance the Board of Directors must have in place arrangements to ensure that there is clarify about how decisions are made and who makes them.

1.2 No matter how effective a board of directors may be it is not possible for it to have hands-on involvement in every area of the company's business. An effective board controls the business but delegates day to day responsibility to executive management. That said, there are a number of matters which are required to be or, in the interests of the company, should only be decided by the board of directors as a whole. It is incumbent upon the board to make it clear what these matters reserved for the board are. *The UK Corporate Governance Code* states that *'There should be a formal schedule of matters specifically reserved for [the board's] decision' and that the annual report should contain a 'high level statement of which types of decisions are to be taken by the board and which are to be delegated to management.'*

1.3 The Trust's *Standing Orders* (SO4.1) and the *NHS Code of Conduct* and *Code of Accountability* require that the Trust:

- Clearly identifies the types of decisions which are to be reserved for the Board; and
- Ensures that arrangements are in place to enable responsibility for other decisions to be clearly delegated to executive management, officers and committees.

1.4 The formal *Schedule of Reservation of Powers to the Board* outlines the decisions reserved for the Board.

1.5 The formal *Scheme of Delegation* details those decisions which the Board delegates to Officers through the Executive Management Structure and to Committees through the Governance Structure.

1.6 The purpose of the *Scheme of Delegation* is to empower Directors, and those managers who have been given authority to act on their Director's behalf, to take appropriate decisions within a robust corporate framework.

1.7 The Board remains accountable for all of its functions even those delegated to Committees, individual Executive Directors and Officers and would therefore expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

2 Role of the Chief Executive

2.1 All powers of the Trust which have not been retained as reserved by the Board of Directors or delegated to an executive committee or sub-committee shall be exercised on behalf of the Board of Directors by the Chief Executive.

2.2 All powers delegated by the Chief Executive can be re-assumed by the board should the need arise. As Accountable Officer, the Chief Executive is accountable to the Department of Health for the funds devolved to the Trust.

3 Considerations when Using Delegated Powers

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

3.2 All those exercising authority delegated by this framework have a duty to observe the wider regulatory framework outlined in the following:

- *Standing Orders*

- *Standing Financial Instructions*
- *Standards of Business Conduct and Managing Conflicts of Interest*
- *Trust Policies*

3.3 It will be the responsibility of each Executive Director to ensure that those staff members to whom they have delegated authority to exercise decision making powers are capable and competent to do so.

3.4 Although the Trust operates with a number of Directorates it is vital that Directorate Managers and Service Leads recognise that their area of responsibility is an integral part of the Trust and they should not therefore act in the interests of their Directorate alone but in the interests of the corporate Trust.

4 Absence of Directors or Officer to Whom Powers have been Delegated

4.1 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 formal acting up arrangements have been put in place or alternative arrangements have been approved by the Board of Directors.

4.2 If the Chief Executive is absent powers delegated to them may be exercised by the nominated officer acting in their absence usually the Deputy Chief Executive.

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

5. Schedule of Reservation of Powers to the Board of Directors

5.1 Accountability

5.1.1 The *NHS Code of Conduct and Code of Accountability* which has been adopted by the Trust requires the Board of Directors to determine those matters on which decisions are reserved unto itself. Board members share corporate responsibility for all decisions of the Board. These reserved matters are set out in paragraphs 5.4 to 5.10 below.

5.1.2 Decisions reserved to the board generally represent 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 individual committees, sub-committees, directors or officers and would therefore expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

5.2 Duties

5.2.1 It is the Board's duty to:

- act within statutory financial and other constraints;
- be clear what decisions and information are appropriate to the Board of Directors and draw up *Standing Orders*, *A Schedule of Decisions Reserved to the Board* and *Standing Financial Instructions* to reflect these,
- ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives for the main programmes of action and for performance against programmes to be monitored and senior executives held to account;
- establish performance and quality measures that maintain the effective use of resources and provide value for money;
- specify its requirements in organising and presenting financial and other information succinctly and efficiently to ensure the Board can fully undertake its responsibilities;

- establish Audit and Remuneration Committees on the basis of formally agreed terms of reference that set out the membership of the committee, the limit to their powers, and the arrangements for reporting to the main Board.

5.3 General Enabling Provision

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

5.4 Regulations and Control

5.4.1 Approval of Standing Orders (SOs), a schedule of matters reserved to the Board of Directors and *Standing Financial Instructions* for the regulation of its proceedings and business.

5.4.2 Suspend the *Standing Orders*.

5.4.3 Vary or amend the *Standing Orders.*

5.4.4 Note any urgent decisions taken by the Chair and Chief Executive in accordance with SO4.3.

5.4.5 Approval of a *Scheme of Delegation of Powers* from the Board of Directors to Committees.

5.4.6 Receiving the declaration of Board members' 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.

5.4.7 Approval of the disciplinary procedure for officers of the Trust.

5.4.8 Disciplining Directors who are in breach of statutory requirements of the *Standing Orders or Standing Financial Instructions.*

5.4.9 Approval of arrangements for dealing with complaints.

5.4.10 Adoption of the Trust's organisational structures, processes and procedures to facilitate the discharge of Trust's business and to agree any significant modifications.

5.4.11 Receiving reports from Committees, including those which the Trust is required by legislation or regulation to establish and to take appropriate action thereon.

5.4.12 Approving the recommendations of the Trust's Committees where the Committees themselves do not have executive powers.

5.4.13 Approval of arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on Trust.

5.4.14 To establish terms of reference and reporting arrangements of all committees established by the Board of Directors.

5.4.15 Approve arrangements to enable the Trust to discharge its responsibilities as a bailer, for patients' property.

5.4.16 Authorise the use of the Trust's Seal.

5.4.17 Ratify or otherwise instances of failure to comply with *Standing Orders* brought to the Chief Executive's attention in accordance with *Standing Orders*.

5.4.18 Approve the Trust's Major Incident Plan.

5.5 Appointments / Dismissal

5.5.1 Appoint the Vice Chair of the Board of Directors.

5.5.2 Appoint the Senior Independent Director.

5.5.3 The establishment and disestablishment of committees of the Board.

5.5.4 The appointment of members of committees of the Board.

5.5.5 The dismissal of Executive Directors.

5.6 Policy Determination

5.6.1 The approval of Human Resources policies incorporating the arrangements for the appointment, dismissal and remuneration of staff.

5.6.2 The approval of the *Raising Concerns (Whistleblowing) Policy.*

5.6.3 The approval and monitoring of the *Risk Management Strategy.*

5.7 Strategy and Business Plans and Budgets

5.7.1 Definition of the strategic aims and objectives of the Trust.

5.7.2 Approval annually of plans in respect of the application of available financial resources.

5.7.3 Overall approval of programmes of investment to guide the letting of contracts for the supply of clinical services.

5.7.4 Approve the Capital Expenditure Programme.

5.7.5 Approve budgets.

5.7.6 Approve the *Annual Business Plan* for submission to the Independent Regulator, which includes:

- Assumptions on service delivery requirements
- Contract and associated income assumptions
- Expenditure plans and associated assumptions
- Savings plans on revenue
- Capital Expenditure Programmes
- Plans for managing working capital and cash
- Any non-revenue financing arrangements.

5.8 Direct Operational Decisions

5.8.1 Acquisition, disposal or change of use of land and/or buildings.

5.8.2 Approve Private Finance Initiative (PFI) proposals.

5.8.3 The introduction or cessation of any significant action or operation. An activity or operation shall be regarded as significant if it has gross annual income or expenditure in excess of £2.5m.

5.8.4 Approval of any contracts, including purchase orders (other than NHS contracts) amounting to, or likely to amount to, over £500,000 per annum or £2.5m in total.

5.8.5 Approval of individual losses, write offs and special payments in line with the Standing Financial

Instructions.

5.8.6 Agreeing action on litigation not covered by the NHS Resolution risk pooling schemes.

5.9 Financial and Performance Reporting Arrangements

5.9.1 Continuous appraisal of the affairs of the Trust by means of the receipt of reports as it sees fit from directors, committees and officers of the Trust including but not limited to finance, quality, workforce and operational performance.

5.9.2 Oversight, at least in summary form, of monitoring returns required by the Independent Regulators.

5.9.3 Receipt and approval of the Trust's *Annual Report and Annual Accounts*.

5.9.4 Receipt and approval of the *Annual Report and Annual Accounts* for funds held on Trust.

5.9.5 Approval of the opening or closure of any bank or investment account.

5.10 Audit Arrangements

5.10.1 To approve audit arrangements (including arrangements for separate audit funds held on trust) and receive reports of the Audit Committee meetings and take appropriate action:

5.10.2 Receive the annual management letter received from the external auditor and agreement of proposed action, taking account of the advice, where appropriate, of the Audit Committee.

5.10.3 Receive an annual report from the Internal Auditor and agree action on recommendations where appropriate of the Audit Committee.

6 Scheme of Delegation of Powers

6.1 Delegation to Committees

6.1.1 The Board of Directors may determine that certain of its powers shall be exercised by Standing Committees. The composition, terms of reference and reporting requirements of such committees will be approved by the Board of Directors.

6.1.2 In accordance with the Standing Orders committees may not delegate executive powers to sub-committees unless expressly authorised by the Board of Directors.

6.2 Delegation to Officers

6.2.1 The *Trust Standing Orders and Standing Financial Instructions* set out in some detail the financial responsibilities of the Chief Executive, the Director of Finance and other directors.

6.2.2 The following responsibilities are derived from the *Accountable Officer Memorandum for Chief Executives of NHS Trusts:*

6.2.3 The Accountable Officer has responsibility for ensuring that the Trust carries out its' functions in a way that ensures proper stewardship of public money and assets.

6.2.4 The specific personal responsibilities of a Trust's Accountable Officer:

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

6.2.5 Accountable Officers must make sure that their arrangements for delegation promote good management and are supported by the necessary staff with an appropriate balance of skills.

6.2.6 This Scheme of Delegation only covers matters delegated by the Board to the Chief Executive and by the Chief Executive to the Executive Directors and Company Secretary, as well as specific matters set out in the *Standing Orders and Standing Financial Instructions.*

7.0 Relationship of the Scheme of Delegation to Organisational Structure

7.1 Each Director is responsible for the delegation within their Directorate and should produce a *Directorate Scheme of Delegation* to this effect.

7.2 The *Directorate Scheme of Delegation* should be aligned to the *Operational Scheme of Delegation* regarding financial matters set out in 10.9.

8.0 Scheme of Delegation aligned with the Trust's Standing Orders

SO Ref	Delegated to	Duties Delegated
1.2.2	Chair	Final authority in the interpretation of the *Standing Orders.*
1.6.1	Chief Executive	Ensure that existing officers and new officers are notified of, and understand, their responsibilities set out in the *Standing Orders and Standing Financial Instructions.*
2.11.3.1	Director of Finance	Responsible for the provision and supervision of financial control and accounting systems.
2.11.6	Chair	Chair all Board meetings (and associated responsibilities).
3.2	Chair	Call meetings of the Board of Directors.
4.3	Chair and Chief Executive in consultation with two Non-Executive Members	Exercise the emergency powers of the Board.
7.4	Company Secretary	Maintain a Register of members' and other officers' Interests.
8.1 and 8.3	Company Secretary	Keep the Trust Seal in a safe place and maintain a register of sealings.
8.4.1	Chief Executive / Executive Members / Company Secretary	Approve and sign all documents which will be necessary in legal proceedings.
8.4.3	Chief Executive / Executive Members /Company Secretary	Sign on behalf of the Trust any agreement or document not requested to be executed as a deed.
9.1	Company Secretary	Accept service of all legal proceedings on behalf of the Trust via a *Freedom to Engage process*
9.2	Company Secretary	Authorised to instruct solicitors to advise the Trust or defend the Trust, or in the matter of formal dispute resolution procedures.

9.0 Scheme of Delegation aligned with the Standing Financial Instructions

SFI Ref	Delegated to	Duties Delegated
1.5.5	Chief Executive	Ensure all officers, present and future, are notified of, and understand, the *Standing Financial Instructions*.
1.5.6	Director of Finance	Responsible for implementing the Trust's financial policies and co-ordinating corrective action, and ensuring detailed financial procedures and systems are prepared and documented.
1.5.6	Director of Finance	Maintain appropriate systems of financial control and record keeping to meet the requirement of the regulators.
1.5.7	All Directors and officers	Responsible for the security of Trust property, avoiding loss, exercising economy and efficiency in using resources and conforming to *Standing Orders, Standing Financial Instructions* and financial procedures.
2.1	Audit Committee	Provide an independent and objective view on the system of internal control and probity, including assurance statements.
2.1.4	Director of Finance	Ensure adequate internal and external audit services (in accordance with NHS Internal Audit Standards).
3	Director of Finance	Ensure there are adequate counter-fraud and corruption arrangements, including the investigation of cases of fraud or other irregularity.
4	Director of Finance	Ensure adequate security management arrangements.
5.1.1	Chief Executive	Overall responsibility for financial management and the Trust operating within resource limits.
5.1.2	Director of Finance	Submit financial plans and any adjustments to previously agreed financial plans for Board approval.
5.1.2	Director of Finance	Providing financial reports to the regulator.
5.2	Chief Executive	Preparation of Annual Business Plan.
5.2.3	Director of Finance	Monitor performance against plans and budget, and submit to Board financial estimates and forecasts.
5.2.6	Director of Finance	Ensure adequate training for budget holders.

5.3.1	Chief Executive	Delegate budget to budget holders.
5.4.1	Director of Finance	Devise and maintain system of budgetary control.
5.4.3	Chief Executive	Cost Improvement Plans and income generation initiatives.
6.1	Director of Finance	Responsible for the preparation and publishing of the Annual Accounts.
6.2	Company Secretary	Responsible for the preparation and publishing of the *Annual Report.*
7	Director of Finance	Trust Banking Arrangements.
8	Director of Finance	Income systems including debt recovery.
9.1	Chief Executive	Ensure the Trust enters into appropriate *Service Level Agreements* for the provision of services and report performance against such to the Board.
10.1.2	Remuneration Committee	Agree remuneration and terms of service for Executive Members.
10.4	Director of Finance and Associate Director of HR	Appropriate processing of payroll.
10.5	Associate Director of HR	Responsible for ensuring all officers have a contract of employment.
10.8.7	Associate Director of HR	Approve all decisions to offer an involvement payment to a volunteer or lay member, ensuring records of kept of any such payments.
11.1.1	Chief Executive	Determine, and set out, the level of delegation of non-pay expenditure to budget managers.
11.2.2	Director of Finance	Prompt payment of appropriately authorised supplier accounts and invoices.
11.2.7	Director of Finance	Ensure that arrangements for the financial control and audit of building and engineering contracts comply with best practice.
12	Director of Finance	Advise the Board on borrowing and investment needs and prepare procedural instructions.
13.2.6	Director of Finance	Developing procedures for monitoring the capital programme.
13.7.1	Chief Executive	Overall responsibility for assets.

13.7.2	Director of Finance	Maintenance of asset registers, including the register of properties.
13.7.11	Director of Finance	Calculate and pay capital charges in accordance with the Independent Regulator's requirements.
13.8.4	All Staff	Responsibility for the security of Trust assets including reporting losses in accordance with Trust procedure.
14.6	Director of Finance	System of control over stores and receipt of goods.
15	Director of Finance	Preparing procedures for recording and accounting for losses and special payments and for management of all frauds/thefts.
16.1	Director of Finance	Ensure procurement procedures are compliant with legislation and HMT Managing Public Money.
16.4.1	Chief Executive	Determining exceptional circumstances under which the formal tendering processes can be waived.
16.5.8	Chief Executive	Nomination an officer to maintain a list of approved firms who may be invited to tender or provide a quote.
16.5.9	Chief Executive	Approve the use of firms not on the list of approved contractors.
16.11.1	Chief Executive	Nominate officers with delegated authority to enter into contracts for employment of other officers, to authorise re-grading of staff, and enter into contracts for the employment of agency staff or temporary staff.
16.12.1	Chief Executive	Nominate officers with power to negotiate for the provision of healthcare services with purchasers of healthcare.
16.14.1	Chief Executive	Demonstrate best value for money for all in-house services provided.
16.14.5	Chief Executive	Nominate an officer to oversee and manage each contract on behalf of the Trust.
17.2	Chief Executive	Responsible for ensuring patients and guardians are informed about patients money and procedures on admission.
18.1.7	Director of Finance	Ensure each fund held on Trust is managed appropriately.
19.1	Company Secretary	Ensure all staff are aware of the Trust's Policy for the Standard of *Business Conduct Policy and Managing Conflict of Interest.*
19.3	Company Secretary	Maintain a Register of Gifts and Hospitality and Sponsorships.
20.1	Company Secretary	Ensure all staff are aware of the Trust's Policy for Managing Conflicts of Interest.
20.3	Company Secretary	Maintain the Register of Interests.
	Company Secretary	Fulfil the responsibilities of the Trust's Data Protection Officer
21	Chief Executive	Ensure the Trust is registered with the Information Commissioner's Office, publishes information in line with the Freedom of Information Act requirements, and maintains and stores information in line with the Data Protection Act.
21.1.2	Director of Finance	Responsible for the accuracy and security of computerised financial data.

21.1.13	Associate Director of HR	Responsible for the accuracy and security of the payroll system.
21.1.14	Director of Finance	Fulfil the responsibilities of the Senior Information Risk Officer on behalf of the Trust.
22.1	Medical Director	Authorise procurement of IT hardware, software or facility.
22.2	Medical Director	Ensure adequate arrangements for disaster recovery and business continuity.
22.4	Director of Finance	Ensure new computerised financial systems and amendments to current computerised financial systems are developed in a controlled manner and thoroughly tested prior to implementation.
23	Chief Executive	Responsible for records management including systems for record retention.
24.1.1	Chief Executive	Risk Management Framework
24.4	Company Secretary	All insurance arrangements and liaison with NHS Resolution.
24.5.3	Company Secretary	Authorise all spend on external legal advice.

10.0 Operational Scheme of Delegation - Introduction

10.1 The Board delegates budgetary responsibility to the Chief Executive who in turn delegates to the Executive Directors.

10.2 The Trust has six Executive Directors who are classified as **Prime Budget Holders**. The officers are personally responsible to the Chief Executive for the directorate/business units budgets delegated to them.

10.3 Within the Business Units there is a triumvirate of the Associate Medical Directors, Associate Directors of Operations and Heads of Nursing who are appointed to lead management within each Business Unit. However, ultimate budgetary responsibility remains with the respective prime budget holders.

10.4 Prime budget holders can delegate management of specific budgets or elements of budgets to **Budget Managers** (i.e., Deputy Directors or Senior Managers) and these arrangements should be set out in a locally developed *Directorate Scheme of Delegation*, which should be effectively maintained and reviewed on an annual basis.

10.5 The *Directorate Scheme of Delegation* must be aligned to the *Operational Scheme of Delegation* set out in 10.9.

10.6 By exception and in accordance with the locally developed *Directorate Scheme of Delegation*, budget managers can delegate management of specific budgets or elements of budgets to **Delegated Budget Managers** (i.e., Department Managers). Budgets must NOT be delegated below this level.

10.7 **Authorised signatories** may be assigned. These are staff members assigned to sign against a budget manager's or delegated budget manager's budget but who are NOT responsible for budget management.

10.8 Locally developed *Directorate Schemes of Delegation*, developed within the parameters of this *Operational Scheme of Delegation,* must be approved by the Chief Executive.

10.9 Operational Scheme of Delegation

Delegated Matter:	Authority Delegated to:
1 Management of Revenue Budgets a) Responsibility for maintaining compliance with budgetary allocation limits:	
• For the totality of the Trust	Chief Executive
• At Directorate level	Prime Budget Holder
• At individual budget level (pay and non-pay)	Budget Manager or Delegated Budget Manager
• For all central income budgets	Director of Finance
• For all other areas	Director of Finance
b) Responsibility for transfers between budgets:	
• Transfers between budgets within one area of responsibility[clarify pay or non pay]	Budget Manager
• Transfers between budgets beyond area of responsibility but within Directorates	Prime Budget Holder
• Transfers between Directorate Allocations	Director of Finance and Chief Executive
2 Budget setting and monitoring	
• Agreeing budgetary allocations including savings and efficiency targets	Trust Board
• Monitoring of budgetary performance	Director of Finance
• Performance delivery framework	Director of Finance escalated to Chief Executive
3.Maintenance/Operation of Bank Accounts Managing banking arrangements	Director of Finance
Operation of bank accounts	Assistant Director of Finance/Deputy Financial Accountant
Local commercial bank account with (BACS and cheque payments)	Director of Finance (managed in accordance Bank mandate limits)

Setting up direct debits/ Standing orders limits	Assistant Director of Finance/Deputy Financial Accountant (in accordance with Bank mandate)
Use of the corporate credit card (held by Director of Finance)	Assistant Director of Finance/Deputy Financial Accountant (subject to card limit)
4 Non Pay Revenue Expenditure / Requisitioning / Ordering / Payment of Goods & Services	
a) • All requisitions (stock/non-stock) up to £4,999	Authorised budget signatory
• All requisitions from £5,000 to £24,999	Budget Manager or Delegated Budget Manager
• All requisitions from £25k to £99,999	Two Prime Budget Holder
• All requisitions from £100k to £499,999 total cost	Chief Executive or Director of Finance
• Requisitions above £500,000 ** For operational purposes, the Director of Finance has a £10m approval limit on the finance system. However, approvals above the DoF limit of £500k are subject to Board approval.	Trust Board approval
b) Non-pay expenditure for which no specific budget has been set up and which is not subject to funding under delegated powers of virement	Chief Executive and Director of Finance
c) Subsequent variations to contract: • With a value not exceeding £99,999	Prime Budget Holder or Director of Finance
• With a value exceeding £100k up to £0.5m per annum	Director of Finance or Chief Executive
d) Purchase order approval (including pharmacy) Up to £10,000 Up to £20,000 Up to £50,000 Up to £100,000 Over £100,000	Purchasing officer/Senior Pharmacy Technicians Senior Purchasing Officer/Deputy Pharmacist Deputy Procurement Manager/Chief Pharmacist Procurement Manager Director of Finance

e) Payments Calculation of payment values based on cashflow forecast	Assistant Director of Finance/Deputy Financial Accountant
Approval of payment runs	Assistant Director of Finance/Deputy Financial Accountant Payable Manager
5 Capital Schemes	
a) Approving the annual capital programme	Trust Board (within the Annual Financial Plan)
b) Variation to the total agreed capital statutory programme	Trust Board (subject to compliance with the capital resource limit)
c) Selection of architects, quantity surveyors, consultant engineers and other professional advisors within EU regulations	Head of Estates & Facilities or Director of Finance
Approval of schemes: • Schemes up to £2.5m contained within the approved capital investment programme	Finance, Performance & Investment Committee
• Schemes above £2.5m or not included within the approved capital investment programme	Trust Board (via the capital programme progress updates)
d) Variation within programme greater than £100k	Chief Executive through the auspices of the Executive Team
e) Variation within programme less than £100k	Capital Investment Group
f) Capital requisition approval limits Up to £100,000 Up to £500,000 Over £500,000	Deputy Financial Accountant/Assistant Director of Finance Chief Executive/Director of Finance Trust Board
g) Estates stage payment certificates Up to £100,000 Up to £500,000 Over £500,000	Project Scheme Manager Chief Executive/Director of Finance Trust Board
h) Capital contingency authorisation Up to £50,000 Up to £100,000 Up to £250,000 Over £250,000	Director of Finance Capital Investment Group Finance, Performance & Investment Committee Trust Board
i) Private Finance Initiative (PFI) Demonstrate that the use of private finance represents best value for money and transfers risk to the private sector.	Director of Finance

Proposal to use PFI	Trust Board
6 Authority to Obtain Quotation, Tendering and Contract Procedures	
a) Obtaining informal quotations for goods/ services £5,000 - £25,000	Budget Manager
b) Obtaining competitive tenders for goods/ services £25,001 to EU limit (please check relevant EU threshold for goods or services as these are regularly revised). *These must be advertised through Contracts Finder or obtained via an accessible framework.*	Prime Budget Holder via Procurement
c) Obtaining competitive tenders over EU limit (please check relevant EU threshold for goos or services as these are regularly revised). *These must be advertised through OJEU and Contracts Finder or obtained via an accessible framework.*	Prime Budget Holder via Procurement
d) Waivering of quotations and tenders subject to SFI 16.8: • Up to £74,999 • £75k up to EU thresholds	Director of Finance Director of Finance and Chief Executive
e) Opening electronic and manual/hard tenders	Deputy Director of Finance or Director of Finance and Company Secretary [Cannot be from same directorate. The Company Secretary provides independent scrutiny]
f) Balance sheet Approve payment of PAYE, National Insurance, Superannuation	
• Authorisation of NHS Shared Business Services	Assistant Director of Finance/ Deputy Financial Accountant
• Reconciliation of payments for PAYE, national Insurance and superannuation. Value limited to BACS threshold of £7m	Financial Accountant
• Approve payment of payroll pay-overs	
Authorisation of payments for court orders, Union fees, Medicash and other payroll Deductions. Limit for each individual payover is up to £20,000.	Assistant Director of Finance/Deputy Financial Accountant
• Approve payment of Balance sheet	Assistant Director of Finance/Deputy Financial Accountant

items Up to £200,000. Payment limit applies to Alliance Healthcare monthly agreement, weekly Liaison Staff flow payroll service and monthly Disbursement service. d) Approve payment of salary advances Up to £10,000	 Assistant Director of Finance/Deputy Financial Accountant
7. Charitable Fund approvals Up to £2,500 Up to £10,000 Over £10,000	 Director of Finance Up to £10,000 Over £10,000
8 Setting of Fees and Charges a) Price of NHS Contracts with commissioners b) External fees, private patient, overseas visitors, income generation and other patient related services c) Fees for items of a sensitive nature	 Director of Finance Director of Finance Chief Executive
8 Engagement of personnel not employed by the Trust a) Non-Medical Consultancy Staff b) Engagement of Trust Solicitors c) Engaging of staff not on Trust establishment	 Prime Budget Holder in line with delegated financial limits Company Secretary**[in absence, Chief Executive or Director of Finance]** Prime Budget Holder with Director of Finance and current regulator
9 Agreements / Licenses a) Preparation and signature of all tenancy agreements/licenses for all staff subject to Trust Policy on accommodation for staff b) Extensions to existing property and equipment leases c) Establishing or terminating leases with annual rental up to £199,999 d) Establishing or terminating leases with annual value between £200k and £500k	 Director of Finance Director of Finance Director of Finance Chief Executive Director of Finance

e) Granting of use of Trust property under license	Director of Finance
10 Condemnations and Disposals Items (excluding land and buildings) that are obsolete, redundant, irreparable or cannot be cost effectively repaired:	
a) With current/estimated value <£100 as determined by the budget holder	Delegated budget holder
b) with current/estimated value >£100 up to £4,999 as determined by the budget holder	Prime Budget Holder
c) with current/estimated value >£5k as determined by the budget holder	Director of Finance
d) disposal of mechanical and engineering plant and all equipment (subject to estimated income of less than £5k per sale) as determined by the budget holder	Director of Finance
e) disposal of mechanical and engineering plant and all equipment (subject to estimated income exceeding £5k per sale) as determined by budget holder	Director of Finance
11 Losses, Write-offs and Compensations	
a) Losses (inc. cash) due to theft, fraud, overpayment and others up to £49,999: • Less than £4,999 • £5k to £49,999	Director of Finance or Deputy Director of Finance Chief Executive or Director of Finance
b) Fruitless payments (including abandoned capital schemes) up to £49,999: • Less than £4,999 • £5k to £49,999	Director of Finance or Deputy Director of Finance Chief Executive or Director of Finance
c) All bad debts and claims abandoned, private patients, overseas visitors and other up to £49,999: • Less than £4,999 • £5k to £49,999	Director of Finance or Deputy Director of Finance Chief Executive or Director of Finance
d) Damage to buildings, fittings, furniture and equipment and loss of equipment and property in stores and in use due to culpable causes (e.g., fraud, arson, theft) or other up to £49,999: • Less than £4,999 • £5k to £49,999	Director of Finance or Deputy Director of Finance Chief Executive or Director of Finance Director of Finance or Deputy Director of Finance

e) Compensation payments made under legal obligation: • Less than £4,999 • £5k to £49,999	Chief Executive or Director of Finance
f) Extra contractual payments to contractors up to £49,999: • Less than £4,999 • £5k to £49,999	Director of Finance or Deputy Director of Finance Chief Executive or Director of Finance
Ex-gratia payments g) Staff and patients for loss of personal effects: • Less than £999 • £1,000 to £4,999 • £5,000 to £49,999	Prime Budget Holder Director of Finance or Deputy Director of Finance Chief Executive or Director of Finance
h) Other: • Less than £4,999 • More than £5,000	Director of Finance or Deputy Director of Finance Chief Executive or Director of Finance
12 Reporting of Incidents to the Police a) Fraud b) Other	Company Secretary/Director of Finance/ Executive Directors
13 Petty Cash Disbursements (other than through central cashiers office at each site) a) Expenditure up to £14.99 per item b) Expenditure over £15 per item	Petty Cash Holder Budget Manager or Delegated Budget Manager
14 Implementation of Internal and External Audit Recommendations	Director of Finance/Company Secretary and Lead Executive, monitored by the Audit Committee
15 Maintenance and Update of Trust Financial Procedures	Director of Finance
16 Investment of Funds (including charitable and endowment funds) a) Exchequer b) Funds held on Trust	Director of Finance Charitable Trustees (Board of Directors)
17 External Borrowing Advise Trust Board of the requirements to repay / draw down Public Dividend Capital. Application for draw down of Public Dividend Capital, overdrafts, DH loans and other forms of External borrowing.	Director of Finance Trust Board
18 Personnel & Pay	

a) Authority to fill funded post to the establishment with permanent staff.	Budget Manager or Delegated Budget Manager
b) Authority to alter funded establishment: • Additional staff to the agreed establishment with specifically allocated finance • Additional staff to the agreed establishment without specifically allocated finance	Prime Budget Holder Prime Budget Holder
c) Additional increments: • The granting of additional increments to staff within budget where acting up • The granting of additional increments to staff within budget on permanent basis	Prime Budget Holder Prime Budget Holder, on advice from HR and authorization from Finance
d) Upgrading and re-grading • Approval of market supplements and other variations to terms and conditions	Associate Director of HR
e) Establishments: • Approval of consultants posts (medical/nursing and other clinical)	Appropriate Prime Budget Holder
f) Pay: • Authority to complete standing data forms effecting pay, new starters, variations and leavers • Authority to authorize overtime • Authority to authorize travel and subsistence expenditure • Authority to agree local pay uplifts including allowances that form part of pay	Budget Manager or Delegated Budget Manager Budget Manager or Delegated Budget Manager Budget Manager or Delegated Budget Manager Associate Director of HR
g) Redundancy/early retirement: • Chief Executive or Executive Director • Other member of staff	Remuneration Committee Chief Executive and Director of HR
19 Authorisation of New Drugs	
a) Drugs approved by Medicines and Therapeutic Committee	Prime Budget Holder and Associate Medical Directors
b) Research/clinical trials: • Ethical approval • Funding	Medicines and Therapeutics Committee Prime Budget Holder and Associate Medical Directors

20 Authorisation of Sponsorship Deals	Company Secretary [In accordance with Standards of Business Conduct and Managing Conflict of Interest Policy]
21 Authorisation of Research Projects	Director of Nursing & Midwifery
22 Authorisation of Clinical Trials	Director of Nursing & Midwifery
23 Governance / Risk Management a) Overall responsibility for ensuring that appropriate and effective governance / risk management arrangements, policies and procedures and meeting structures, including the provision of advice and support to the Trust b) Responsibility for ensuring that governance is 'owned by all' and for the identification of leads to co-ordinate governance activities at a local level	 Chief Executive Company Secretary/All Executive Directors/ Associate Medical Directors/ Heads of Nursing and Associate Directors of Operations
24 Insurance Policies • Medico-legal • All other insurance	 Company Secretary Company Secretary
25 Management of Incidents, Serious Untoward Incidents, Complaints, Concerns and Claims <u>Incidents</u> a) Overall responsibility for ensuring that systems and processes are in place to report and respond to incidents and SUIs b) Responsibility for ensuring that incidents and SUIs are investigated thoroughly and in a timely manner and that appropriate remedial action is taken / lessons learnt are shared <u>Complaints / Concerns</u> a) Overall responsibility for ensuring that all complaints and concerns are dealt with effectively b) Responsibility for ensuring complaints relating to a Directorate / Group are investigated thoroughly and within agreed timescales and that appropriate remedial action is taken / lessons learnt are shared <u>Claims</u>	 Director of Nursing & Midwifery All Executive Directors, Associate Medical Directors, Heads of Nursing and Associate Directors of Operations Director of Nursing & Midwifery All Executive Directors, Associate Medical Directors, Heads of Nursing and Associate Directors of Operations

a) Responsibility for ensuring that claims are dealt with effectively and within accordance with agreed procedures and timescales	Company Secretary
b) Responsibility for ensuring the provision of timely information to enable the Trust to respond effectively to claims and for ensuring that appropriate remedial action is taken / lessons learnt are shared	Company Secretary/All Executive Directors, Associate Medical Directors, Heads of Nursing and Associate Directors of Operations
26 Media Relations	
a) Within working hours	Head of Communications and Marketing
b) Out of hours	On-Call Director / Head of Communications and Marketing
27 Infectious Diseases and Notifiable Outbreaks	Medical Director or Control of Infection Doctor
28 Facilities for staff not employed by the Trust to gain practice experience and/or to provide services	
a) Clinical staff	Director of Nursing & Midwifery or Medical Director
b) Other staff	Appropriate Executive Director
29 Review of Fire Precautions (Nominated Fire Officer)	Director of Finance
30 Review of Medicines Inspectorate regulations	Chief Pharmacist
31 Review of compliance with environmental regulations	Director of Finance
32 Information Governance	Company Secretary
33 Declarations of Interest Register, including Gifts and Hospitality and Sponsorships	Company Secretary
34 Attestation of Sealings in accordance with the Standing Orders, including the keeping of the Register of Sealings	Company Secretary
35 Retention of Records	
a) clinical	Chief Operating Officer
b) financial	Director of Finance
c) other	Executive Directors and Company Secretary

d) Retention and Management of Policy	Company Secretary
36 Caldicott Guardian	Medical Director
37 Audit and Quality, including implementation of NICE guidance	Director of Nursing & Midwifery
38 Use of borrowing as financing mechanism	Trust Board
39 Intellectual Property a) Approval of license agreements b) Material changes to IP policy c) Departure from inventor reward in IP policy	 Chief Executive and Director of Finance Trust Board Executive Team
40 Compliance with the requirements of the Civil Contingencies Act	Trust Board
41 Approval of creating, sellling or ceasing joint ventures	Trust Board
42 Director of Infection Prevention and Control	Medical Director

NHS
Southport and Ormskirk Hospital
NHS Trust

Anti-Fraud, Bribery & Corruption Policy

CORP 66

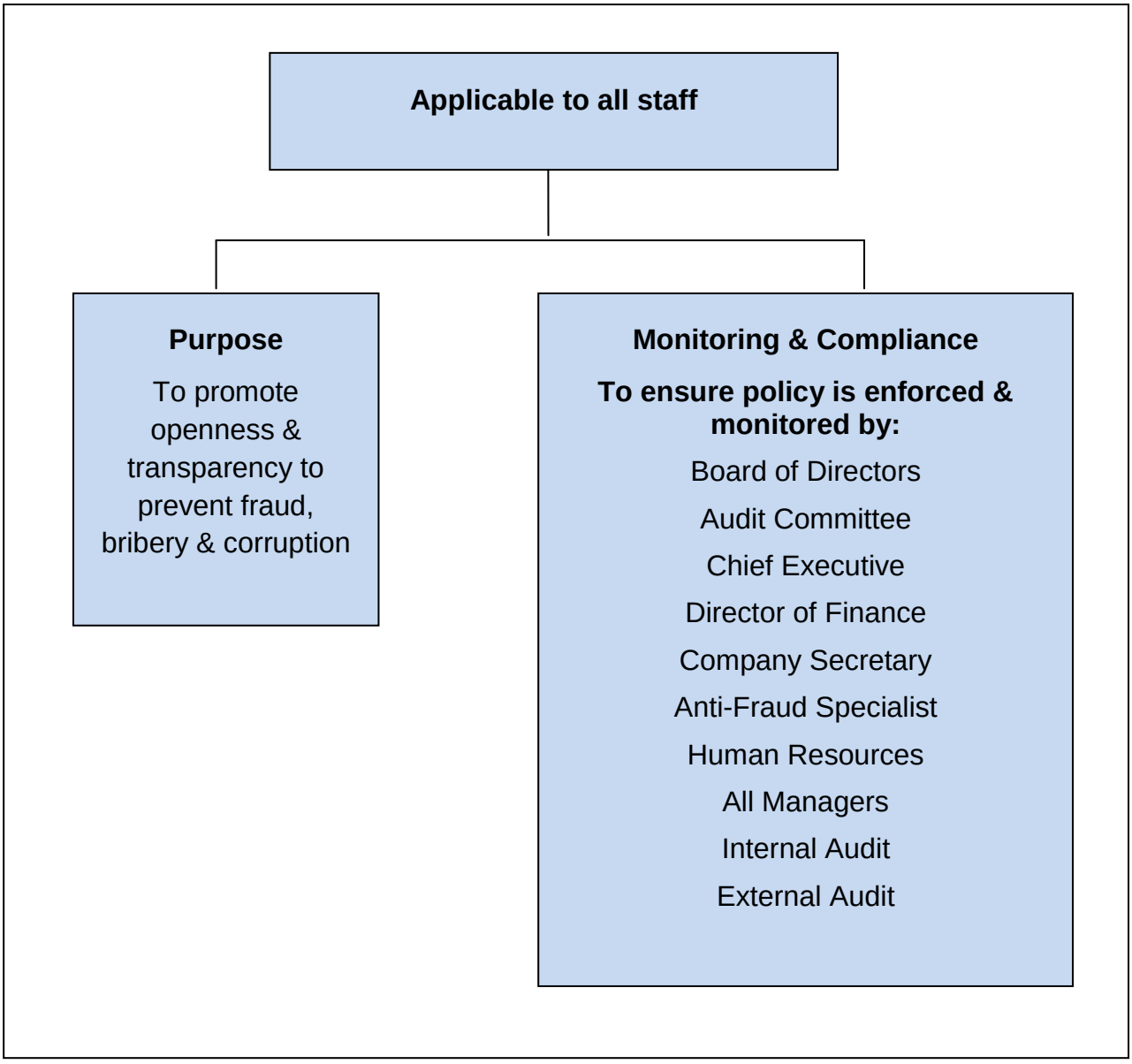
Target Audience - All staff				
Who should read this policy:	**Planned Care CBU**	**Urgent Care CBU**	**Specialist Services CBU**	**Corporate**
All Staff	✓	✓	✓	✓

CONTENTS

1. EXPLANATION OF TERMS USED IN THIS POLICY

Terminology	Explanation
Bribery	*The giving or receiving a financial or other advantage in connection with the "improper performance" of a position of trust, or a function that is expected to be performed impartially or in good faith.*
Fraud	*A false representation of a matter of fact — whether by words or by conduct, by false or misleading allegations, or by concealment of what should have been disclosed — that deceives and is intended to deceive another so that the individual will act upon it to her or his **legal** injury.*
Corruption	*An act done with intent to give some advantage inconsistent with official duty and the rights of others. It includes bribery, but is more comprehensive; because an act may be corruptly done, though the advantage to be derived from it not being offered by another. It is an abuse of public trust.*
Criminal prosecution	*The act or process of holding a trial against a person who is accused of a **crime** to see if that person is guilty. The **prosecution**: the side of a legal case which argues that a person who is accused of a **crime** is guilty: the lawyer or lawyers who **prosecute** someone in a court case.*
Civil prosecution	*A term used in some jurisdictions to describe a **civil** court action brought by one person against another that may result in money damages being paid example a libel action or an action for wrongful death.*
Local Anti-Fraud Specialist (AFS)	*An individual performing proactive and reactive Anti-Fraud work. To be considered for this post the individual will be an Accredited Anti-Fraud Specialist. All AFSs have to be nominated to NHS Anti-Fraud Authority by the NHS organisation(s) which employs them (or contracts them in).*

2. FLOWCHART FOR ANTI-FRAUD, BRIBERY AND CORRUPTION POLICY



3. INTRODUCTION

Southport and Ormskirk Hospital NHS Trust is committed to reducing the level of fraud, bribery and corruption within both the Trust and the wider 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 and 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. It is also the Trust's policy that no employee will suffer in any way as a result of reporting reasonably held suspicions.

All members of staff can therefore be confident that they will not suffer in any way as a result of reporting reasonably held suspicions. This protection is given under the Public Interest Disclosure Act that the Trust is obliged to comply with.

For the purposes of this policy "reasonably held suspicions" shall mean any suspicions other than those which are totally groundless (and/or raised maliciously).

This policy has been produced by the Anti-Fraud Specialist (AFS) and is intended as both a guide for all employees on the Anti-Fraud, bribery and corruption activities being undertaken within the Trust and NHS; as well as informing all Trust staff how to report any concerns or suspicions they may have.

The Trust's AFS service is provided under contract by Mersey Internal Audit Agency (MIAA), an NHS agency. **The Trust's nominated AFS is Paul Bell**.

All genuine suspicions of fraud, bribery or corruption can be reported to the AFS directly, via MIAA, on 0161 206 1909 (or 0151 285 4523). If the Trust's AFS is not available, please report your concerns to another member of the MIAA Anti-Fraud Team.

Alternatively, report your suspicions through the NHS Fraud and Corruption Reporting Line (FCRL) (Mon-Fri 8am-6pm) on Freephone 0800 028 40 60; or, via the NHS Online Fraud Reporting Form www.reportnhsfraud.nhs,uk; or, via the Trust's Director of Finance.

4. PURPOSE

This policy relates to all forms of fraud, bribery and corruption and is intended to provide direction and help to all interested/concerned parties who may identify suspected criminality. It provides a framework for responding to suspicions of fraud, bribery and corruption, as well as advice and information on various aspects of those offences and the implications of an investigation. It is not intended, in itself, to provide a comprehensive approach to preventing and detecting all NHS fraud, bribery and corruption.

The overall aims of this policy are to:

- Improve the knowledge and understanding of everyone in Southport and Ormskirk Hospital NHS Trust, irrespective of their position, about the risk of fraud, bribery and corruption within the organisation and make clear its unacceptability.
- Assist in promoting a climate of openness and a culture and environment where staff members feel able to raise concerns sensibly and responsibly, yet discreetly.
- set out Southport and Ormskirk Hospital NHS Trust's responsibilities in terms of the deterrence, prevention, detection and investigation of fraud, bribery and corruption.
- Ensure the appropriate sanctions are considered following an investigation, which may include any or all of the following:
  - criminal prosecution
  - civil prosecution
  - internal (Trust) / external (professional body) disciplinary action

5. SCOPE

This policy applies to all employees, including volunteers of Southport and Ormskirk Hospital NHS Trust, regardless of position held, as well as non-executives, consultants, vendors, contractors, interims and/or other parties who have a business relationship with the Trust. It will be brought to the attention of all employees by various methods and will form part of the induction process for new staff.

6. FRAUD, BRIBERY AND CORRUPTION

6.1. 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 investigate by the AFS:

- Fraud by false representation (section 2) i.e. lying on a CV or NHS job application form.
- Fraud by failing to disclose information, when under a legal obligation to do so (section 3) i.e. failing to declare a conviction, disqualification or commercial interest when such information may have an impact on your NHS role, duties or obligations and where you are required to declare such information as part of a legal commitment to do so.
- Fraud by abuse of a position of trust (section 4) i.e. a carer abusing their access to patients' monies, or an employee using commercially confidential NHS information to make a personal gain. (The abuse of position occurs where there is an expectation on the individual to safeguard the financial interests of another person or organisation, i.e. the NHS.)

It should be noted that successful prosecutions under the *Fraud Act 2006* may result in an unlimited fine and/or a potential custodial sentence of up to 10 years.

6.2. Bribery & Corruption

Bribery and corruption prosecutions can be brought using specific pieces of legislation:

- *Prevention of Corruption Acts 1906 and 1916*, for offences committed prior to 1st July 2011, and,
- *Bribery Act 2010*, for offences committed on or after 1st July 2011.

The Bribery Act 2010 ['the Act'] has updated UK law by making it a criminal offence to:

- Offer, promise, or give a bribe [section 1]; and/or,
- Request, agree to receive, or accept a bribe [section 2].

Corruption is generally considered to be an "umbrella" term covering such various activities as bribery, corrupt preferential treatment, kickbacks, cronyism, graft or embezzlement.

Under the 2010 Act, however, bribery is now a series of specific offences. Generally, bribery is defined as: an inducement or reward offered, promised or provided to someone to perform their functions or activities improperly in order to gain a personal, commercial, regulatory and/or contractual advantage.

Examples of bribery in 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.

Staff members are reminded to ensure that they are transparent in respect of recording any gifts, hospitality or sponsorship. They should refer to the separate Trust policy on *Standards of Business Conduct and Managing Conflicts of Interest*.

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

In addition, the Act introduces a new 'corporate offence' [section 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 Act, a senior officer of the organisation (eg 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 is applicable to NHS organisations including Southport and Ormskirk Hospital 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, Governors, agents, subsidiaries, contractors and suppliers (regardless of whether they are incorporated or not). The term 'associated persons' has an intentionally wide interpretation under the Act.

Southport and Ormskirk Hospital NHS 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 NHS Protect, seek to obtain the strongest penalties – including criminal prosecution, disciplinary and/or civil sanctions – against anyone associated with Southport and Ormskirk Hospital NHS Trust who is found to be involved in any bribery or corruption activities.

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

[NB. For staff awareness, theft issues are usually dealt with by security management (the 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.]

6.3. Employees

For the purposes of this policy, '*employees*' includes all Southport and Ormskirk Hospital NHS Trust staff and volunteers, as well as executive and non-executive directors.

7. DUTIES

7.1. Responsibility of Trust Board

The Board has a duty to ensure that it provides a secure environment in which to work and one where people are confident about raising 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.

The Chief Executive is ultimately responsible for specific failures in Southport & Ormskirk Hospital NHS Trust's systems of internal control. However, responsibility for the operation and maintenance of controls and procedures falls directly to line managers and requires the involvement and support of all the Trust's 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.

7.2. Director of Finance

The Director of Finance monitors and ensures compliance with the Anti-Fraud and corruption requirements included in the NHS contract.

The Director of Finance will:

- Provide any necessary Trust support to the AFS required to pursue an investigation.
- Depending on the outcome of investigations (whether on an interim or concluding basis) and/or the potential significance of suspicions that have been raised, inform appropriate senior management colleagues accordingly.
- Be responsible, in consultation with the AFS, for informing third parties such as external audit or the police at the earliest opportunity, as circumstances dictate.
- Inform and consult the Chief Executive in cases where the Trust loss may be excessive, or where the incident may lead to adverse publicity.
- Inform the Head of Internal Audit if an investigation identifies significant control failings in key business areas.
- Consult and take advice from the Associate Director of HR if a member of staff is to be interviewed, suspended or disciplined. The Director of Finance or AFS will not conduct a disciplinary investigation, but the employee may be the subject of a parallel investigation by HR.

7.3. Company Secretary

The Company Secretary will support the Director of Finance by liaising with the AFS and **r**eceive reports from referrers if the Chief Executive and/or Director of Finance are involved.

7.4. Anti-Fraud Specialist (AFS)

The AFS is operationally accountable to the Director of Finance and reports on the progress of all Anti-Fraud and corruption activity to the Audit Committee.

With regard to their investigatory remit, 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 and relevant criminal law.
- In consultation with the Director of Finance, report any relevant case to the police or NHS Protect.
- Report and update any case and the outcome of an investigation through NHS Protect's National Case Management System (FIRST).
- Ensure that other relevant parties are informed of investigations where necessary, e.g. Human Resources (HR), if an employee is the subject of a referral.

- Ensure that Southport and Ormskirk Hospital NHS Trust's incident and losses reporting systems are followed.
- Ensure that any systems weaknesses identified as part of an investigation are followed up with management and reported to internal audit.
- At all times, adhere to the Anti-Fraud Professional Accreditation Board (CFPAB)'s Principles of Professional Conduct, as set out in the NHS Anti-Fraud and Corruption Manual, which are – professionalism, objectivity, fairness, expertise, propriety and vision.
- Ensure that the Director of Finance is informed of regional NHS Protect investigations which may impact upon the Trust.

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 annual work plan.

The AFS will not have responsibility for, or be in any way engaged in, the management of security for any NHS body.

7.5. NHS Protect Area Anti-Fraud Lead (AAFL)

Each AAFL works as part of the NHS Protect Operations Directorate, whose key objective is to combat fraud, bribery and corruption in the NHS within a specific geographical region. The AAFL liaises closely with both the AFS and the Trust on a range of required Anti-Fraud and corruption activities, including investigations.

7.6. Internal & External Audit

Any incident or suspicion of fraud, bribery or corruption that comes to internal or external audit's attention will be passed immediately to the AFS. The outcome of the investigation may necessitate further work by audit to review systems and procedures.

7.7. Human Resources (HR)

HR will liaise closely with managers and the AFS from the outset if an employee is suspected of being involved in fraud, bribery or corruption, in accordance with agreed protocols. HR staff are responsible for ensuring the appropriate use of Southport and Ormskirk Hospital NHS Trust's disciplinary policy. HR will advise those involved in the investigation on matters of employment law and other procedural issues, such as disciplinary and complaints procedures, as required. 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 while necessary enquiries are on-going. Close liaison will also be necessary to ensure that any

parallel sanctions (ie 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.

7.8. Head of Information Security

The Head of Information Security (or equivalent) will contact the AFS immediately in all cases where there is suspicion that Trust IT is being used for fraudulent purposes. 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 IT resources is suspended or removed where an investigation identifies that it is appropriate to do so.

7.9. 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 or corruption. If they have any doubts, they must seek advice from the AFS, Director of Finance or Company Secretary.

Managers must instil and encourage an open, honest and transparent culture within their team and ensure that information on any necessary policy or procedure is made available to all employees. The AFS will proactively assist the embedding of this culture by undertaking work that will raise awareness of the risks of fraud, bribery and corruption.

All instances of actual or suspected fraud, bribery or corruption which come to the attention of a manager must be reported immediately. It is appreciated that some employees will initially raise concerns with their manager. However, in such cases, managers must not attempt to investigate allegations themselves; they have the clear responsibility to refer the concerns to the AFS or Director of Finance as soon as possible.

Line managers at all levels have a responsibility to ensure that an adequate system of internal control exists and operates effectively within their areas of responsibility to help prevent fraud, bribery and corruption from occurring – and to mitigate its impact if it does occur.

As part of that responsibility, line managers need to:

- Inform staff for whom they are accountable of the requirements of Southport and Ormskirk Hospital NHS Trust's Anti-Fraud, Bribery and Corruption Policy and also other relevant Trust policies and procedures (including Standing Orders and Standing Financial Instructions), as part of the staff induction process.
- Assess the types of possible fraud and corruption risks which may impact on the operations for which they are responsible.
- Ensure that adequate control measures are put in place to minimise those risks. This must include clear roles and responsibilities, supervisory checks, staff rotation (particularly in key posts) and separation of duties wherever possible so that control of a key function is not invested in one individual; as well as regular reviews,
- Reconciliations and testing checks to ensure that control measures continue to operate effectively.
- Ensure that any access to and use of computers by employees is linked to the performance of their recognised duties within the Trust.
- Contribute to any assessment of the risks and controls within their business area, which feeds into Southport and Ormskirk Hospital NHS Trust's and the Department of Health Accounting Officer's overall statements of accountability and internal control.

7.10. Employees

All employees are obliged to act in accordance with the Trust's Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation. Employees are expected to familiarise themselves with and abide by the Code of Conduct for NHS Boards and NHS Managers and the Staff Code of Personal and Business Conduct.

Employees also have a duty to protect the assets of Southport and Ormskirk Hospital NHS Trust, including information assets, 'goodwill' and any tangible (i.e., property) assets. 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 suspect or accuse them of dishonesty
- Behave in a way that would not give cause for others to doubt that Southport & Ormskirk NHS Trust's employees deal fairly and impartially with official matters; and,
- Be alert to the possibility that others might be attempting to deceive the Trust/NHS.

All employees have a duty to ensure that public funds are safeguarded, whether or not they are involved with cash or payments systems, managing budgets or dealing with contractors or suppliers. If an employees suspects that there has

been (or might be) fraud, bribery or corruption against the Trust or wider NHS, or has seen any suspicious acts or events, they must report the matter to the AFS or via one of the other appropriate channels specified within this policy.

8. POLICY CONTENT

This section outlines the action to be taken if fraud, bribery or corruption is discovered or suspected. If an employee holds any of the concerns or suspicions referred to in this document, they must report it immediately.

The Trust's AFS is Paul Bell. His contact details are:

Telephone: 0151 285 4523

Mobile: 07837 747 333

Email: paul.bell@miaa.nhs.uk

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 Company Secretary in the first instance and the Chief Executive and/or Audit Committee Chair if the Company Secretary is unavailable. They will then inform the NHS Protect Area Anti-Fraud Lead.

If the referrer believes that the Chief Executive is involved they should inform the Company Secretary who will liaise with NHS Protect Area Anti-Fraud Lead.

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 0800 028 4060 (Mon-Fri 8am-6pm) or report their concerns via the NHS Online Fraud Reporting Form www.reportnhsfraud.nhs.uk**

These NHS reporting options provide easily accessible routes for the reporting of genuine suspicions of fraud, bribery or corruption within or affecting the Trust or wider NHS. It allows NHS staff members 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 may not wish to identify themselves for whatever reason. While the suspicions may be erroneous or unsubstantiated, they may also reflect a genuine cause for concern and will always be taken seriously and investigated.

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 and, if they originate with a Trust employee, disciplinary action will be instigated.

Staff members are encouraged to report all reasonably held suspicions directly to the AFS.

Appendix 1 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 document to staff and to place it on staff notice boards.

Southport and Ormskirk Hospital NHS Trust wants all employees to feel confident that they can expose any wrong doing without any risk to themselves. In accordance with the provisions of the *Public Interest Disclosure Act 1998*, Southport and Ormskirk Hospital NHS Trust has produced a *Freedom to Speak Up (Raising Concerns) Policy* and a *Fit and Proper Persons' Policy and Procedure*. These policies and procedures are intended to complement the Trust's *Anti-Fraud, Bribery & Corruption Policy*, as well as other relevant Trust policies. Corporate policies can be found on the Trust's Intranet site.

9. CONSULTATION

This policy has been developed by the Interim Company Secretary and has been consulted on with the Director of Finance, Executive Team and Leadership Executive Group (LEG) and AFS to ensure understanding of their responsibilities and the key principles of the policy and alignment to the Trust's *Standing Orders*, *Standing Financial Instructions and Scheme of Reservation and Delegation*. In addition, there has been consultation with the Audit Committee.

10. EQUALITY ANALYSIS ASSESSMENT

Southport and Ormskirk Hospital NHS 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, pregnancy / maternity and marriage/civil partnership.

The Trust is committed to equality of opportunity and anti-discriminatory practice both in the provision of services and in its 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.

EQUALITY IMPACT ASSESSMENT	
Impact Assessment Completed By	Audley Charles, Interim Company Secretary
Date Completed	30 November 2017
Relevance Shown	N/A
Action Plan Completed	N/A
Nominated lead for Managing Action Plan	AFS
Completed Assessments held by	Policy Coordinator

11. DISSEMINATION AND IMPLEMENTATION

The dissemination process for this policy is through Trust Team Brief / Trust News and Anti-Fraud Specialist Briefings and Fraud Awareness Sessions.

During the Induction Programme all new staff will be made aware of the key policies and the location of all policies within the Trust.

12. MONITORING COMPLIANCE WITH THIS DOCUMENT

Monitoring and / or Audit					
Criteria	**Measurable**	**Lead Officer**	**Frequency**	**Reporting to**	**Action Plan / Monitoring**
Fraud Awareness	Feedback and evaluations from Fraud Awareness Training Staff Corporate Induction	AFS Director of Finance/ Company Secretary/ AFS	Ongoing Ongoing	Audit Committee via the Anti-Fraud Annual Report Audit Committee via Mandatory Training Report	Audit Committee Education & Training
Fraud Awareness	Annual Staff Fraud Survey	AFS	Annually	Audit Committee via the Anti-Fraud	Audit Committee

				Annual Report	
Fraud Awareness	Increased reports demonstrating increased awareness and policy compliance	AFS	Ongoing	Audit Committee via the Anti-Fraud Annual Report	Audit Committee

13. REFERENCES

Codes of Conduct for Trust Board and NHS Managers

NHS Standards of Business Conduct and Managing Conflicts of Interest

Fraud Act 2006

Prevention of Corruption Acts 1906 and 1916

Bribery Act 2010

14. ASSOCIATED DOCUMENTS

Trust Board Code of Conduct

Staff Code of Personal and Business Conduct

Anti-Fraud Strategy

Acceptance of Gifts Policy Corp 05

Declaration of Interests Policy Corp 78

Freedom to Speak Up/Raising Concerns (Whistleblowing Policy) Corp 69

Standards of Business Conduct and Managing Conflicts of Interest

Fit and Proper Persons' Policy and Procedure

Safeguarding Policy

Disciplinary and Grievance Policies

APPENDIX 1

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 (or risk of loss) to, another person or party through false representation, failing to disclose information or by abuse of position.**

CORRUPTION **is the deliberate use of bribery or payment of a benefit-in-kind to influence an individual to use their position in an unreasonable way to help gain an unfair or illegal advantage for oneself or another.**

DO

- Note down 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 in any way.
- Report your suspicions promptly and appropriately
  Confidentiality will be respected – delays may lead to further loss or harm. Report through one of the contact options below.
- Be discreet
  Don't discuss your concerns with anyone who doesn't need to know.

DO NOT

- Confront the suspect(s) or convey your 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. Criminal investigations must be conducted to specific legal standards.
- 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 or corruption against the NHS has taken (or is taking) 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 NHS Fraud Reporting Form; or,
- Contacting the Director of Finance and Company Secretary.

Report NHS Fraud, Bribery & Corruption - Contact Details:

- Your Trust's AFS: 0161 206 1909 or 0151 285 4500 (MIAA)
- NHS Fraud, Bribery and Corruption Reporting Line: 0800 028 40 60
- NHS Online Reporting Form: www.reportnhsfraud.nhs.uk

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

If you would like further information about NHS Protect, or the work of the AFS, please visit www.nhsbsa.nhs.uk/fraud

Policy Details

Title of Policy	**Policy for Anti-Fraud and Corruption Policy**
Unique Identifier for this policy	Corp 66
State if policy is **New** or **Revised**	Revised and Updated
Previous Policy Title where applicable	Corp 66 Anti-Fraud, Corruption & Bribery Policy
Policy Category *Clinical, HR, Corporate, Infection Control, Finance etc.*	Corporate
Executive Director *Whose portfolio this policy comes under*	Chief Executive
Policy Lead/Author *Job titles only*	Company Secretary
Committee/Group responsible for the approval of this policy	Board of Directors, Audit Committee, Executive Team
In consultation with	Executive Team, Leadership Executive Team and Anti-Fraud Specialist at Internal Audit
Month/year consultation process completed	November 2017
Month/year policy approved	December 2017
Month/year policy ratified and issued	December 2017
Next review date	December 2019
Implementation Plan completed	YES
Equality Impact Assessment completed	YES
Previous version(s) archived	YES
Disclosure status	Full
Key words for this policy	Business Conduct/Conflicts of Interests/ Gifts and Hospitality/ Sponsorship/ Bribery and Corruption

NHS
Southport and Ormskirk Hospital
NHS Trust

Risk Management Strategy 2018-2021

Policy Author	**Assistant Director Integrated Governance**
Reviewed by	**Interim Company Secretary**
Date Reviewed	**28 March 2018**
Version	**6**
Date Approved	**TBC**
Review date	**March 2021**

CONTENTS

1. Introduction

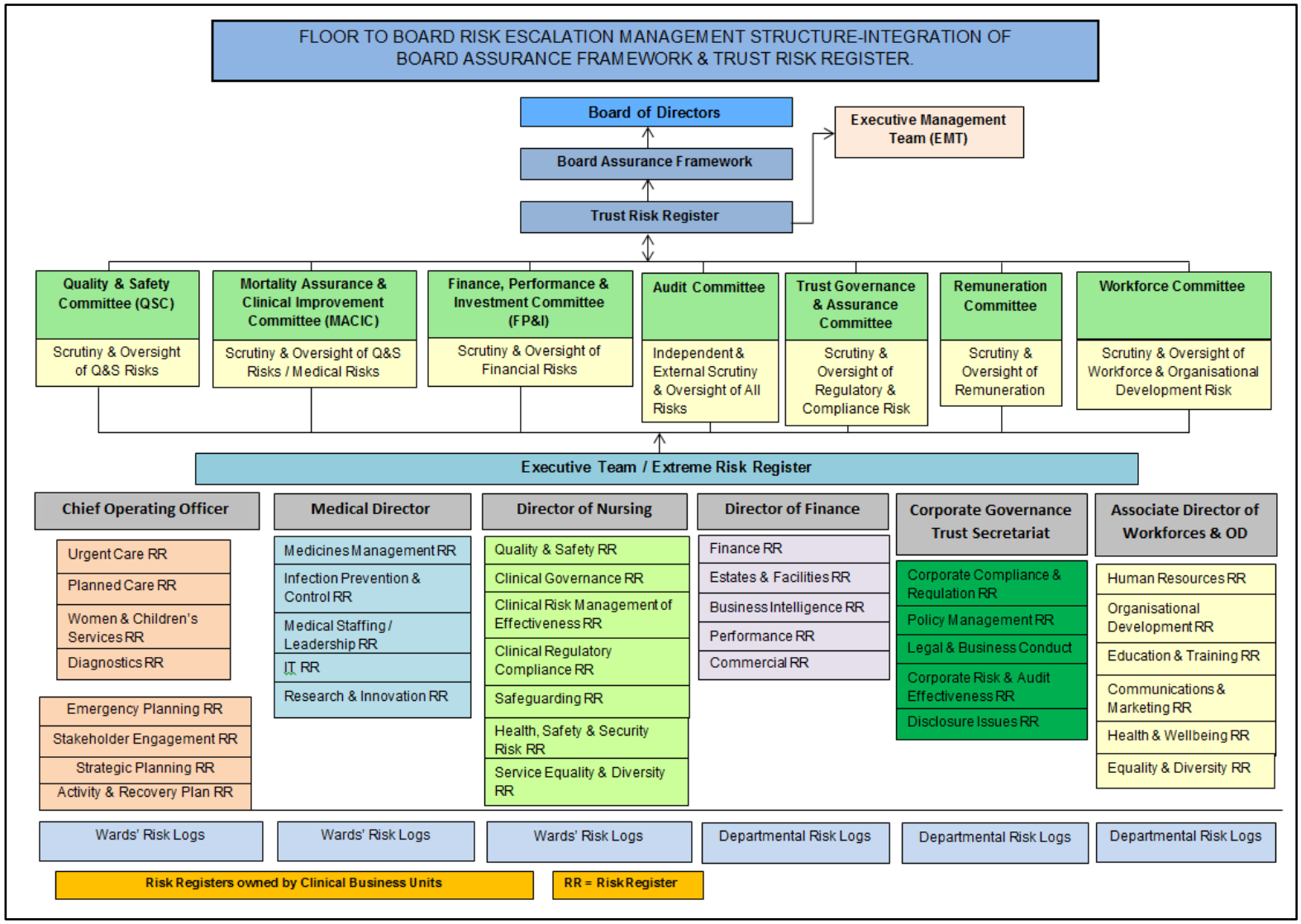
Risk Management is an integral part of Southport and Ormskirk Hospital NHS Trust management activity and is a fundamental pillar in delivering the Trust vision of ***providing safe, high quality services*** for the people of Southport and Ormskirk. As a complex organisation delivering a range of services in a challenging financial environment we accept that risks are an inherent part of the everyday life of the Trust. Effective risk management processes are central to providing Southport and Ormskirk Hospital NHS Trust Board with assurance on the framework for clinical quality and corporate governance.

Southport and Ormskirk Hospital NHS Trust is committed to a Risk Management Strategy which minimises risk to all of its stakeholders through a comprehensive system of internal controls, whilst maintaining the potential for flexibility, innovation and best practice in delivery of its strategic objectives around delivering high quality care. The *Risk Management Strategy* provides a framework for taking this forward through internal controls and procedures which encompass strategic, financial, quality, reputational, compliance and health & safety risks. Its aim is to ensure the safety of patients, staff and the public and to deliver quality, patient-centred services that achieve excellent results and promote the best possible use of public resources, through an integrated approach to managing risks from all sources.

The strategy also seeks to support consistency and standardisation through the gathering and dissemination of intelligence on risks and mitigation control measures amongst all staff.

The Risk Management Strategy should be read in conjunction with the Floor to Board Risk Escalation Framework which includes the process to identify and manage local risks and the systematic means by which these local risks are escalated to Board level attention through the Trust Risk Register and how risks are controlled and monitored as shown at **Figure 1** below:

Figure 1


FLOOR TO BOARD RISK ESCALATION MANAGEMENT STRUCTURE-INTEGRATION OF BOARD ASSURANCE FRAMEWORK & TRUST RISK REGISTER.
Board of Directors
Board Assurance Framework
Trust Risk Register
Executive Management Team (EMT)
Quality & Safety Committee (QSC)
Scrutiny & Oversight of Q&S Risks
Mortality Assurance & Clinical Improvement Committee (MACIC)
Scrutiny & Oversight of Q&S Risks / Medical Risks
Finance, Performance & Investment Committee (FP&I)
Scrutiny & Oversight of Financial Risks
Audit Committee
Independent & External Scrutiny & Oversight of All Risks
Trust Governance & Assurance Committee
Scrutiny & Oversight of Regulatory & Compliance Risk
Remuneration Committee
Scrutiny & Oversight of Remuneration
Workforce Committee
Scrutiny & Oversight of Workforce & Organisational Development Risk
Executive Team / Extreme Risk Register
Chief Operating Officer
Urgent Care RR
Planned Care RR
Women & Children's Services RR
Diagnostics RR
Emergency Planning RR
Stakeholder Engagement RR
Strategic Planning RR
Activity & Recovery Plan RR
Medical Director
Medicines Management RR
Infection Prevention & Control RR
Medical Staffing / Leadership RR
IT RR
Research & Innovation RR
Director of Nursing
Quality & Safety RR
Clinical Governance RR
Clinical Risk Management of Effectiveness RR
Clinical Regulatory Compliance RR
Safeguarding RR
Health, Safety & Security Risk RR
Service Equality & Diversity RR
Director of Finance
Finance RR
Estates & Facilities RR
Business Intelligence RR
Performance RR
Commercial RR
Corporate Governance Trust Secretariat
Corporate Compliance & Regulation RR
Policy Management RR
Legal & Business Conduct
Corporate Risk & Audit Effectiveness RR
Disclosure Issues RR
Associate Director of Workforces & OD
Human Resources RR
Organisational Development RR
Education & Training RR
Communications & Marketing RR
Health & Wellbeing RR
Equality & Diversity RR
Wards' Risk Logs
Wards' Risk Logs
Wards' Risk Logs
Departmental Risk Logs
Departmental Risk Logs
Departmental Risk Logs
Risk Registers owned by Clinical Business Units
RR = Risk Register

Risk is an inherent part of the delivery of healthcare. This Risk Management Strategy outlines the Trust's approach to risk management throughout the organisation

Achievement of objectives is subject to uncertainty, which gives rise to threats and opportunities. Uncertainty of outcome is how risk is defined. Risk management includes identifying and assessing risks, and responding to them.

Southport and Ormskirk Hospital NHS Trust is committed to developing and implementing a Risk Management Strategy that will *identify, analyse, evaluate and control* the risks that threaten the delivery of its strategic and other objectives.

The Board Assurance Framework (BAF) will be used by the Board and its committees to identify, monitor and evaluate risks to the achievement of the strategic objectives. It will be used alongside other key management tools, such as integrated performance reports, quality dashboards, and financial reports, to give the Board a comprehensive picture of the organisational risk profile.
The Trust's strategic objectives are:

- ***Agree with partners a long term acute services strategy***
- ***Improve clinical outcomes and patient safety***
- ***Provide care within agreed financial limit***
- ***Deliver high quality, high performing services***
- ***Ensure staff feel valued in a culture of open and honest communication***
- ***Establish a stable, compassionate leadership team***

The Trust believes that effective risk management is imperative to not only provide a safe environment and improved quality of care for service users and staff, it is also significant in the financial and business planning process where a successful and competitive edge and public accountability in delivering health services is required. This illustrates that risk management is the responsibility of all staff.

The risk management process involves the identification, evaluation and treatment of risk as part of a continuous process aimed at helping the Trust and individuals reduce the incidence and impacts of risks that they face. Risk management is therefore a fundamental part of both the operational and strategic thinking of every part of the service delivery within the organisation. This includes clinical, non-clinical, corporate, business and financial risks. This risk assessment process is described in more detail in the Trust *RM026 Risk Assessment and Risk Register Process Policy.*

The Trust is committed to working in partnership with staff to make risk management a core organisational process and to ensure that it becomes an integral part of the Trust values which are:

Supportive	***Caring***	***Open and Honest***
Professional	***Efficient***	

The Risk Management Strategy represents a developing and improving approach to risk management which will be achieved by building and sustaining an organisational culture, which encourages appropriate risk taking, effective performance

management and accountability for organisational learning in order to continuously improve the quality of services.

The Trust Board recognises that complete risk control and/or avoidance is impossible, but the risks can be minimised by making sound judgments from a range of fully identified options and having a common understanding on risk appetite..

The Trust Risk Management Strategy is built around the following statement:

"Southport and Ormskirk Hospital NHS Trust is committed to the control of risks in a structured and organised manner to ensure that risks can be eliminated, reduced and /or controlled to an acceptable level thereby improving the experience and safety of patients, visitors and staff. This commitment is commensurate with the Trust's objective to "deliver high quality, well-performing services."

2. Definitions

Risk is defined as '*the chance of something happening, or a hazard being realised that will have an impact upon objectives'* (NPSA). It is measured in terms of consequence and likelihood.

Risk management therefore encompasses:

The process of minimizing risk to an organisation by developing systems to identify and analyse potential hazards to prevent accidents, injuries and other adverse occurrences, and by attempting to handle events and incidents which do occur in such a manner that their effect and cost are minimised. (MeSH 2009 cited in Dückers 2009, p.1)

Effective risk management can therefore be described as a systematic process for pro-actively identifying risks and opportunities, by assessing and removing the uncertainty they pose whilst minimising their potential consequences, likelihood and impact on the achievement of strategic objectives.

Effective management of operational risks is very important here as this refers to the robust mitigation of risks associated with the delivery of key business processes and high quality patient-centred care within a safe environment. Operational risks may include:

- Clinical Risks: These are risks which relate to the provision of high quality patient-centred care e.g. Medication Errors, Patient Falls, and Patient Safety Risks
- Non-clinical Risks: These are risks associated with the environment in which patient care takes place including the use of facilities by staff, patients, contractors and other visitors e.g. Health and Safety Risks, Financial Risks, Reputational Risks, Information Governance Risks etc.

Risk can mean different things in different contexts. For the purposes of this Strategy and the associated operational procedures, the risks faced by the Trust have been refined into four (4) categories. Boundaries between the categories are not always clear and some risks may fall into more than one category:

Quality	These relate to risks which would impact on; • Patient safety and experience, • Clinical outcomes • Compliance issues, for example, meeting statutory and non-statutory standards set by the Care Quality Commission, NICE, the NHS Resolution (formerly NHS Litigation Authority) and other regulatory or enforcement bodies. • Reputational risks for example events which may damage the credibility or good name of the Trust
Health & Safety	Infrastructure, • Employee safety, • The safety of visitors to the trust's premises • Compliance issues, for example, meeting statutory and non-statutory standards set by health and safety executive and other regulatory or enforcement bodies such as the Information Commissioner's Office and local fire authority
Strategic	These relate **to** risks which would impact on the long term strategic objectives of the Trust, which may be affected by legal and regulatory changes and changes in the business environment
Financial	These relate **to** risks which would impact on;: • Income, • Expenditure, • Fulfilment of contracts • The correct application of standing orders, standing financial instructions and the scheme of delegation

3. Strategic Aims and Objectives of the Strategy

The Trust's key aims are to manage risks where they occur as part of normal line management responsibilities, and appropriately prioritise resources to address risk issues through the operational management and business planning processes.

Strategic aims for the Risk Management Strategy are;

- Compliance with relevant statutory, mandatory and professional requirements and maintenance of the Trust's registration with the Care Quality Commission (CQC)
- Consistent and effective risk management processes at all levels of the organisation
- Open culture where people feel encouraged to take responsibility for minimising risks

- The development of a learning culture to support improvements to the safety of services
- Integration of risk management into business processes, such as ensuring service developments, do not adversely impact on safety

Specific objectives for **2018** to **2021** are set out below. These objectives will be reviewed annually by the Quality and Safety Committee, Audit Committee and Board of Directors, Progress against them will be assessed six monthly by the above. They are:

- To maintain compliance with regulatory requirements
- To ensure robust governance arrangements and structures are in place
- To strengthen the incident and Serious Incidents investigation process so that investigations and actions are more robust.

Other key aims of the Strategy will be to:

- provide the highest quality care without risk to the health of those involved and within resource allocations;
- understand the risks that the Trust faces, their causes and measures to control them so that resources can be appropriately directed;
- enhance the Trust's stakeholder confidence;
- ensure that the Trust is compliant with statutory and regulatory requirements;
- achieve best value for money, thereby maximising resources for patient services and care;
- minimise the total cost of claims and other losses to the Trust through negligence and fraud and ensure that lessons are learned and changes in practice are implemented;
- encourage and develop risk management as an integral part of the Trust's culture; and ensure links to the strategic objectives;
- Clearly define the organisational arrangements to promote Clinical Business Units (CBUs)/ Business Units (BUs) and the individual's responsibilities in order to maintain an active risk register which is reviewed, monitored, and updated to ensure that actions are implemented to control, reduce and/or eliminate identified risks.
- Ensure that the *Board Assurance Framework* is utilised by the Trust Board as a planned, systematic approach to the identification, assessment, and mitigation of the risks that could hinder the Trust achieving its strategic objectives, providing assurances that the risks are being adequately controlled.

4. Scope

The objective of the *Risk Management Strategy* is to promote an integrated and consistent approach across all parts of the organisation to managing risk.

The strategy applies to all Trust staff, contractors and other third parties, including honorary contract holders, working in all areas of the Trust. Risk Management is the

responsibility of all staff and managers at all levels are expected to take an active lead to ensure that risk management is a fundamental part of their operational area.

The Trust encourages an open culture that requires all Trust employees, contractors and third parties working within the Trust to operate within the systems and structures outlined in this strategy.

Managers at all levels are expected to make risk management a fundamental part of their approach to clinical and corporate governance.

5. Organisational risk management structure

All staff in the Trust have responsibilities relating to risk management. The key risk management responsibilities are documented below:

Role	Responsibility
Chief Executive Officer	The Chief Executive Officer, as "*Accountable Officer*" has overall accountability and responsibility for risk management within the Trust, ensuring the implementation of an effective risk management system.
Executive Directors with Specific Responsibilities for Risk Management	The Executive Director of Nursing and the Company Secretary have responsibility to ensure that the Trust has a robust Risk Management Strategy and Policy in place, integrated with the Trust's strategic objectives and governance structure. The Executive Medical Director has a responsibility to work with the Executive Director of Nursing and the Company Secretary on all aspects of risks-clinical and corporate.
Executive Director of Finance/Senior Information Risk owner (SIRO)	The Director of Finance has overall responsibility for overseeing management of financial risks and advising the Trust Board of their implications directly and through the Audit Committee and the Finance, Performance and Investment Committee and ensuring that financial risks are clearly listed in the Board Assurance Framework.
Executive Directors / CBU Triangles (Associate Directors, Associate Medical Directors, Head of Nursing/Service)	These staff are responsible for the implementation of the risk management strategy and policy at corporate and service level including the establishment and continuous management of CBU and Directorate risk registers. They are responsible for managing risk within their Directorates and CBUs.
Company Secretary	The Company Secretary is responsible for development, monitoring and maintenance of the Board Assurance Framework (BAF) document and the management of corporate risks.

	The Company Secretary will also undertake the role of Senior Information Risk Owner (SIRO) which is one of several nationally recognised controls to strengthen data handling and ensure accountability of information risk at Board Level.
Assistant Director Integrated Governance	The Assistant Director, Integrated Governance supports the Executive Director of Nursing to review, develop and embed the Risk Management Strategy and policy across the Trust to ensure that there is an effective risk management system in place.
All Staff	Management of risk is a fundamental duty of all staff. All staff must ensure that identified risks and incidents are reported in order to ensure appropriate actions are taken. These requirements also extend to agency staff.
Board of Directors	The Board of Directors is accountable and responsible for ensuring that the Trust has an effective process in place for identifying and managing all types of risk. The Board of Directors receives and considers reports from its committees as necessary.
Quality & Safety Committee	The Committee is established to provide assurance to the Trust Board on all aspects of quality and safety within the organisation. The Committee will operate as an oversight and scrutiny body recognising that the Executives are responsible for day to day operational delivery and management.
Finance, Performance and Investment Committee	The Committee is established to provide assurance to the Board on all aspects of finance, performance and integrated governance. The Committee will operate as an oversight and scrutiny body recognising that the Executives are responsible for day to day operational delivery and management.
Workforce Committee	The Committee is established to provide assurance to the Board on all aspects of workforce and organisational development. The Committee will operate as an oversight and scrutiny body recognising that the Executives are responsible for day to day operational delivery and management.
Audit Committee	The Audit Committee is a committee of the Board and is responsible for providing an independent and objective view of internal control and integrated governance.

6. The Board, Statutory and Assurance Committees with Overarching Responsibility for Risk Management

The high level committees with overarching responsibility for risk management are:
The Trust Board is responsible for establishing strategic objectives and for driving the organisation forward to achieve these. It is also responsible for ensuring that there are effective systems in place to identify and manage the risks associated with the achievement of these objectives through the Board Assurance Framework and through the Trust Risk Register.

The Audit Committee, on behalf of the Board, reviews the establishment and maintenance of an effective system of internal control and risk management across the whole of the Trust's activities (both clinical and non-clinical), that supports the achievement of the Trust's objectives and also ensures effective internal and external audit.

The Quality and Safety Committee (QSC) provides assurance to the Trust Board that there are adequate controls in place to ensure high quality care is provided to the patients using the services provided by Trust.

The Finance, Performance and Investment Committee is responsible for scrutinising aspects of financial and other performance as requested by the Board. It will conduct detailed scrutiny of major business cases and proposed investment decisions on behalf of the Board and will regularly review commissioning contracts.

The Executive Management Team (EMT) is the core leadership team for the Trust, and is responsible for developing, maintaining and supporting appropriate leadership behaviours and visibility within the Trust. It is responsible for ensuring the fullest clinical contribution to determining the strategic direction and its operational delivery.

The Committee monitors the delivery of the organisation's operational, quality, financial and performance targets, ensuring corrective strategies are agreed where required. It will:

- Implement this Strategy and in doing so encourage and foster greater awareness of risk management throughout the Trust
- Routinely review the Trust Risk Register.
- Ensure systems are in place to support delivery of compliance with legislation, mandatory NHS Standards, NHS Improvement, Care Quality Commission, NHS Resolution and other relevant bodies.
- Identify risks to compliance with the various statutory bodies.
- Monitor past and future external visits and any action plans in place to respond to any risks.
- Oversee implementation of the Trust wide policy management process.

7. Risk Management Policy Statement

Within the context of this commitment, the Trust will comply with all statutory and mandatory requirements creating the management arrangements and environment which recognises the management of risk as a key organisational responsibility. This requires that all managers and clinicians accept the contents of the strategy statement and the principles of risk management as one of their fundamental duties.

In addition, every member of staff will be encouraged to recognise their personal obligations and responsibilities for identifying and minimising risks. This requires a robust and on-going process whereby risks are not only identified but also assessed with the objective of securing improvements to service delivery and practices. The reporting of serious incidents, near misses, and errors is fundamental to this purpose.

The Trust has therefore adopted the following risk management statement and it is upon this that the Risk Management Strategy is based:

"Southport and Ormskirk Hospital NHS Trust is committed to the control of risks in a structured and organised manner to ensure that risks can be eliminated, reduced and /or controlled to an acceptable level thereby improving the experience and safety of patients, visitors and staff. This commitment is commensurate with the Trust objective to "deliver high quality, well-performing services."

The Trust is committed to having a risk management culture that underpins and supports the business of the Trust. The Trust intends to demonstrate an ongoing commitment to improving the management of risk throughout the organisation.

Where this is done well, this ensures the safety of our patients, visitors, and staff, and that as an organisation the Board and management is not surprised by risks that could, and should, have been foreseen.

Strategic and business risks are not necessarily to be avoided, but, where relevant, can be embraced and explored in order to grow business and services, and take opportunities in relation to the risk.

Considered risk taking is encouraged, together with experimentation and innovation within authorised and defined limits. The priority is to reduce those risks that impact on safety, and reduce our financial, operational and reputational risks.

Senior management will lead change by being an example for behaviour and culture; ensuring risks are identified, assessed and managed.

Line managers will encourage staff to identify risks to ensure there are no unwelcome surprises. Staff will not be blamed or seen as being unduly negative for identifying risks.

All Staff should have an awareness and understanding of the risks that affect patients, visitors, and staff and are encouraged to identify risks.

Staff will be competent at managing risk. In order to facilitate this, staff will have access to comprehensive risk guidance and advice; those who are identified as requiring more specialist training to enable them to fulfil their responsibilities will have this provided internally

There will be active and frequent communication between staff, stakeholders and partners.

8. Compliance and Assurance

NHS Improvement (NHSI) have implemented a 'Single Oversight Framework' to ensure there is a clear compliance framework which ensures that all Trusts are able to demonstrate that they are remaining within their agreed provider licence. It is therefore imperative that the Trust is aware of any risks (e.g. associated with new business or service changes) which may impact on its ability to adhere to this framework.

The Board Assurance Framework (BAF) is designed and operates to meet the requirements of the 2017/18 *Annual Governance Statement*. The BAF, which is board owned, provides a vehicle for the Board to be assured that the systems, policies and procedures in place are operating in a way that is effective and focussed on the key strategic risks which might prevent the Trust's strategic objectives being achieved.

The BAF is determined by the Board of Directors and is approved by the Trust Board. It is the means by which the Board holds itself to account and identifies the principal risks that could prevent the Trust delivering its strategic objectives and therefore the operational plan. It also provides a structure for the evidence to support the Chief Executive's *Annual Governance Statement (AGS)* within the *Annual Report.* The BAF maps out the control systems in place to mitigate these risks and confirms the assurances that the Board wishes to receive either directly or via its statutory and assurance Committees (Audit; Quality & Safety; Nomination & Remuneration; Finance Performance & Investment (FP&I) and Workforce & Organisational Development) to evidence the effective operation of these controls.

There is a clear process for escalating high or significant risks to the Board. The Trust does not have a static risk appetite. The Board may vary the amount of risk that it is prepared to tolerate depending on the circumstances at the time. In any event there must be consultation with the Board if there needs to be material altering of significant risk scores by directorates, CBUs or departments. The statutory and assurance committees have regular oversight and scrutiny of all relevant risks from the corporate trust risk register and hold the relevant executive directors to account for the management of their directorate risks.

Allied to the management of risk is learning from situations. Sharing the learning through risk related issues, incidents, complaints and claims is an essential component of maintaining the risk management culture within the Trust. Learning is shared through Clinical Business Units Meetings and Trust wide Forums such as the Quality and Safety Committee and Clinical Excellence Committee. Learning is acquired from a variety of sources which include:

- Analysis of incidents, complaints, claims and acting on the findings of investigations.
- External Inspections.
- Internal and external audit reports.
- Clinical audits.
- Outcome of investigations and inspections relating to other organisations.

The Trust's goal is to be able to demonstrate this with practical examples of how working practices have changed as a consequence of good risk management.

9. Ensuring Compliance with National Standards

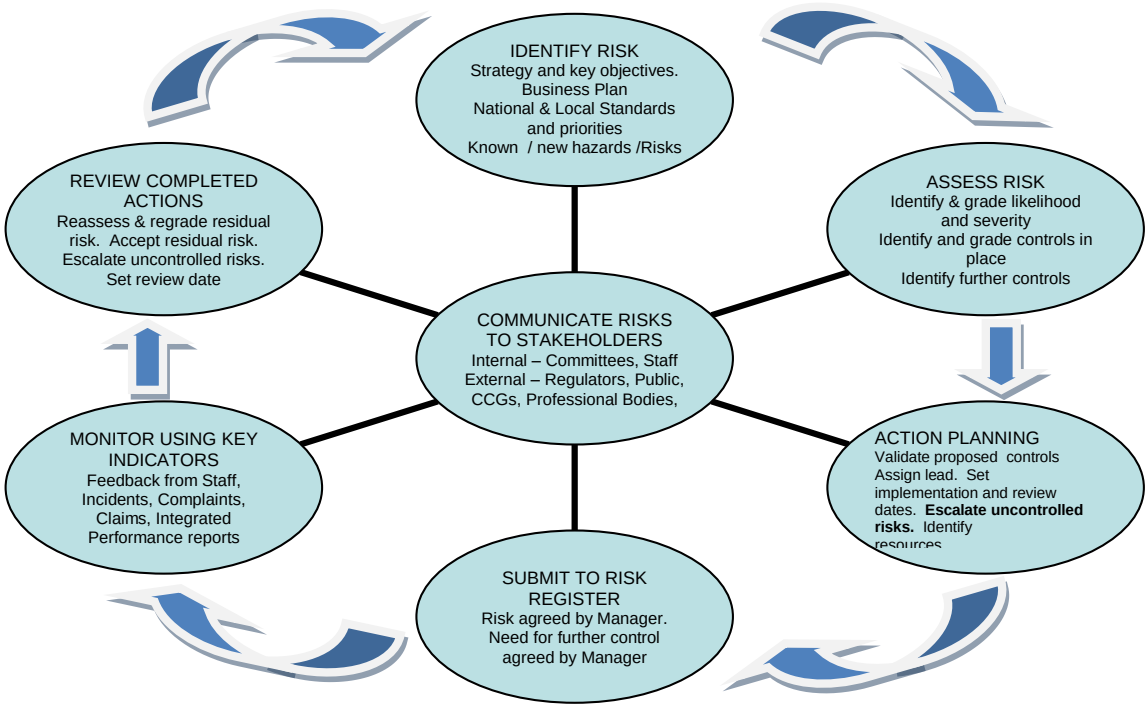
The Risk Team is responsible for facilitating and ensuring compliance with core risk standards this includes working in collaboration with the Assistant Director of Quality to ensure compliance with the Care Quality Commission outcomes, and formulates and monitors action plans pertinent to risk and the Assistant Director of Integrated Governance to ensure compliance with Health & Safety.

10. Risk Management System

The Institute of Risk Management defines Risk Management as: "*the process which aims to help organisations understand, evaluate and take action on all their risks with a view to increasing the probability of success and reducing the likelihood of failure".*

Figure 2 below shows, risk management involves the identification, analysis, evaluation and treatment of risks or more specifically recognises which events may lead to harm and therefore minimising the likelihood (***how often***) and consequences (***how bad***) of these risks occurring. This risk assessment process is described in more detail in the Trust's *RM026 Risk Assessment and Risk Register Process Policy.*

Figure 2 – Risk Management Process.



Identifying Risks

The Trust has a standardised risk assessment tool to provide structure and a systematic approach to risk assessment however the content of each assessment may vary and will depend on the nature of the undertaking and the type and extent of the hazards and risks.
Risks facing the organisation will be identified from a number of sources, for example:

- Risk arise out of the delivery of day to day work related tasks or activities.
- The review of strategic or operational ambitions.
- As a result of an incident or the outcome of investigations.
- Following a complaint, claim or patient feedback.
- As a result of a health and safety inspection/assessment, external review or audit report.
- National requirements and guidance.

11. Analysing/Assessing Risks

Risks and hazards are identified on a daily basis throughout the Trust by all staff members and the risks/hazards will vary significantly in consequence/severity and likelihood and hence the measures for addressing them will also vary. The purpose of assessing and scoring a risk is to estimate the level of exposure to a particular risk, which will then help to inform where responses to reduce or better manage a risk can be taken.

12. Risk Evaluation and Scoring

Risks are scored using a risk scoring matrix. The Trust has adopted a 5x5 matrix with the risk scores taking into account the impact and likelihood of a risk occurring. Each risk is assessed by estimating the likelihood of a risk happening and multiplying it by the impact of the risk if it did happen.

Previous Risk Rating and **Current Risk Rating** - these columns are mirror images of each other. Each time the register is reviewed or updated the risk register should move the current rating into the previous column and recalculate the current rating. This is so the history and progress of a risk can be reviewed. The Trust's guidance on the matrix and advice on scoring in contained in Figure 3.

Trend shows the movement compared to the previous review – rising, stable, or reducing, and will be represented by an appropriate arrow.

Review Date should be used to indicate when this risk was reviewed, i.e. the date of the latest information including rating and key controls.

Risk Target is the amount of risk that is accepted or tolerated, or the level that has been decided to manage a risk down to. When deciding the risk target, consider the following:

- What risk rating should an individual risk be managed down to in an ideal world?
- What level can the risk actually and practicably be managed down to? Remember that costs can be attached with managing a risk downwards as this may ultimately affect what level the risk target is set at.
- Given that there may be limited resources to use to counter this risk, what level of risk is acceptable and affordable?

Having considered the above, assign the risk target a colour that best represents what is possible and practical to manage it down to using the existing risk matrix. If the risk target is:

RED represents a very high level of the risk; that is a risk rated with either a very high likelihood or consequence (or both).

YELLOW – represents a reasonably high level of concern of the threat occurring, often if there are operational or resourcing constraints.

GREEN – represents a lower level of threat.

BLUE – averse to the risk as if the risk materialises this cannot be tolerated.

The risk evaluation and scoring grid is set out below and can be found in the Trust's *RM026 Risk Assessment and Risk Register Process Policy.*

Figure 3 **Risk Scoring Matrix**

Likelihood (L)	Severity (S) Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)
Almost certain (5)	5 (M)	10 (H)	15 (Ex)	20 (Ex)	25 (Ex)
Likely (4)	4 (M)	8 (H)	12 (H)	16 (Ex)	20 (Ex)
Possible (3)	3 (L)	6 (M)	9 (H)	12 (H)	15 (Ex)
Unlikely (2)	2 (L)	4 (M)	6 (M)	8 (H)	10 (H)
Rare (1)	1 (L)	2 (L)	3 (L)	4 (M)	5 (M)

Risk equals Likelihood (L) multiplied by Severity (S)

RISK GRADE	LOW RISK (Score of 1- 3)	MODERATE RISK (Score of 4- 6)	HIGH RISK (Score 8- 12)	EXTREME RISK (Score > 15)

Risk Grade / Colour Code	Risk Grade	Risk Score	Priority for Action
Red	Extreme	15 – 25	Immediate Action required
Yellow	High	8 – 12	Senior Management Attention needed
Green	Moderate	4 – 6	Management responsibility must be specified
Blue	Low	1 - 3	Management by routine procedures

Likelihood (L) of Occurrence: -

Rating	Description	Narrative
1	Rare	Highly unlikely, but it may occur in exceptional circumstances. It could happen but probably never will.
2	Unlikely	Not expected but there is a slight possibility it may occur at some time.
3	Possible	The event might occur at some time as there is a history of casual occurrence

		at the Trust or within the NHS.
4	Likely	There is a strong possibility the event will occur as there is a history of frequent occurrence at the Trust or within the NHS.
5	Almost certain	Very likely. The event is expected to occur in most circumstances as there is a history of regular occurrence at the Trust or within the NHS.

Severity (S) of possible outcome

Domains	1	2	3	4	5
	Insignificant	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/ psychological harm).	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional Intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 Days RIDDOR/agency reportable incident An event which impacts on a small number of patients.	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects A serious event which impacts on a large number of patients
Quality / complaints / audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal Standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards

Domains	1	2	3	4	5
	Insignificant	**Minor**	**Moderate**	**Major**	**Catastrophic**
Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of Statutory Legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breaches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation.

Domains	1	2	3	4	5
	Insignificant	Minor	Moderate	Major	Catastrophic
		expectation not being met			MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project Budget Schedule slippage	5–10 per cent over project budget Scheduled slippage	Non-compliance with national 10– 25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25percent of total revenue budget Claim up to £10,000	Loss of 0.25–0.5 per cent of total revenue budget Claim(s) between £10,000 and £50,000 Debtor Invoice - <500k	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of total revenue budget Claim(s) between £50,000 and £100,000 Debtor Invoice ->500k	Non-delivery of key objective/ Loss of >1 per cent of total revenue budget Failure to meet specification/ slippage Claims - > £100,000 Loss of contract / payment by results Claim(s) >£1 million Debtor Invoice >1 million
Service/business Interruption **Environmental impact**	Loss/interruption of >1 Hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

13. Controls and Mitigation (Action Planning)

When considering the likelihood of a risk occurring, staff need to develop and consider the actions that can be put in place this may include consideration of the avoidance of risk – by not proceeding with an action which can produce the risk, reduction of the likelihood or impact of the risk occurring, transfer of a risk to another party or removal or elimination of the risk.

These plans to avoid or reduce risk are more commonly referred to as the risk action plan and are held on **DATIX** which is the system used to record risks within the Trust.

14. Assurance on Controls

Assurances on controls are the methods by which the organisation measures the effectiveness of the controls in place.

Assurance on the effectiveness of the controls is provided at all levels of the organisation through;

- Internal and external audit of control mechanisms
- Key Performance Indicators
- Benchmarking and Peer reviews
- Performance review processes
- Self-assessment and internal challenge

A key element of the Trust's risk management system is providing assurance that we manage risks effectively by ensuring the effectiveness of controls and actions being put in place to mitigate the impact of any risks.

15. Risk Registers

The Trust has a number of risk registers which are a log of risks of all kinds which threaten the delivery of services or objectives. It should be a live document which is populated through the risk assessment process. Risk registers operate at all levels in the Trust – at local level, CBU / BU level and Corporate level and are held on DATIX which is the system used to record risks within the Trust.

16. Board Assurance Escalation Framework

The Assurance Escalation Framework document contains information regarding internal and external assurances that organisational strategic domains are being met. Where risks to the organisational strategic domains and themes from the corporate risk register are identified, mitigations and subsequent action plans are mapped against them. The Assurance Framework will be used to inform the production of the Annual Governance Statement and will be interrogated by the Trust Board on a quarterly basis each year and quarterly by the Audit Committee.

17. Risk Appetite

Risk Appetite is *'The level of risk that an organisation is willing to accept'*. The appropriate level will depend on the nature of the work undertaken and the objectives pursued. Precise measurement is not always possible and risk appetite may be defined by a broad statement of approach. The Trust has an appetite for some types of risk and may be averse to others, depending on the context of the risk and the potential losses or gains.

The Trust will develop measures for different categories of risk. For example it may inform a project to know what level of delay or financial loss it is permitted to bear, in the addition to using measures described in the *'Risk Matrix Severity definitions'* to define the likelihood and impact of risks; this can be used to define the maximum level of risk tolerable before action should be taken to lower it [Risk Appetite]. By defining its risk appetite, the Trust can arrive as an appropriate balance between uncontrolled innovation and excessive caution. It can be used to guide managers on the level of risk permitted and encourage consistency of approach across the Trust, and ensure that resources are not spent on further reducing risks that are already at an acceptable level.

18. Monitoring

Element to be Monitored	Lead	Tool	Frequency	Reporting	Lead for Actions
Objectives	CEO	Review progress in achieving objectives via BAF and Risk Register	6 monthly	Executive Management Team (EMT)	Company Secretary (CoSec)
Governance structure – Risk Management Strategy: • The organisation's risk management structure, detailing all those committees and groups which have some responsibility for risk • How the board or high level risk committee(s) review the organisation-wide risk register • How risk is managed locally • Duties of the key individuals for risk management activities	CEO	Review of committee structure and Terms of Reference	Annually	EMT/Audit/ QSC/FPI/ Board	Company Secretary/ Director of Nursing
Governance structure - TORs for the statutory and	CoSec	Terms of Reference	Annually	Board	Company Secretary

assurance committees committee(s) with overarching responsibility for risk: • Duties • Who the members are, including nominated deputies where appropriate How often members must attend • Requirements for a quorum • How often meetings take place • Reporting arrangements into the high level risk committee(s) • Reporting arrangements into the board from the high level risk committee(s)		of Board Committees are reviewed at least annually Annual reports for each committee reporting to EMC demonstrate -ing compliance with terms of reference, reporting and attendance.	Annually	EMT	Committee Chairs/ CoSec
Risk management process: • How all risks are assessed • How risk assessments are conducted consistently • Authority levels for managing different levels of risk within the organisation • How risks are escalated through the organisation	DoN/ CoSec	Review of risk management process /Audit	Annually	EMT	CoSec/ DoN
Board Assurance Framework	CoSec	Review of BAF risks and actions progress/ Audit	Quarterly	Board	CoSec

19. Education and Training

The Clinical Governance Team provides a programme of training in the use of risk assessment techniques to nominated risk assessors in the Trust. Risk awareness training is also provided at induction and mandatory training.

20. Dissemination

This Strategy will be circulated to all staff and uploaded onto the staff and public website.

21. Links to other policies

In order to support the risk management processes the Trust has systems in place to facilitate the management of risk in the organisation and they are described in detail in the following policy documents:

RM 06	Policy for Reporting and Management of Incidents (Including Serious Incidents, never Events and information Incidents).
RM 10	Policy and Procedure for Handling of Clinical Negligence/Employers and Public Liability Claims
RM 19	Concerns, Complaints and Compliments Policy
RM 22	Policy for Central Alerting System (CAS)
RM 24	Being Open and Duty of Candour Policy.
RM 26	Risk Assessment and Risk Register Process Policy
Corp 69	Freedom to Speak up: Raising Concerns Policy

22. Review

In order that this Strategy remains current, any of the Appendices to the Risk Management Strategy can be amended and approved during the life time of the Strategy, without the entire document having to return to the Trust Board for approval. The Strategy will be reviewed and ratified every three years by the Trust Board or sooner if there are significant changes to policy at a national level.

Monitoring how this Strategy is working in practice

What key elements will be monitored? (measurable policy objectives)	All aspects of the Strategy
Where is this described in policy?	Section 13
How will they be monitored? (method + sample size)	Review of BAF, Risk Register and Risk Management Policy
Who will monitor?	Executive Team
How Frequently?	Quarterly
Forum/Committee that will receive and review results	Internal Audit (MIAA), Audit Committee
Forum/Committee to ensure actions are completed	Executive Team, Audit Committee and Board of Directors
Evidence this has happened	MIAA Annual Audit Report on Risk Management; Reports and Minutes to Audit Committee, Quality and Safety Committee and Board of Directors -quarterly