NHS
Southport and
Ormskirk Hospital
NHS Trust

Corporate Governance Manual

2019-2020

Contents

1. Foreword by Chair & Chief Executive

1.1. Southport and Ormskirk Hospital NHS Trust (the Trust) is a public sector organisation that was established in accordance with the provisions of the National Health Service Act 2006 and 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.

As a body corporate the Trust has specific powers to contract in its own name and to act as a corporate trustee.

1.2. Corporate governance is the system by which an organisation is directed and controlled, at its most senior levels in order to achieve its objectives and meet the necessary standards of accountability and probity. Effective corporate governance, along with clinical governance, is essential for the Trust to achieve its clinical, quality, regulatory, compliance and financial objectives. Fundamental to effective corporate governance is having the means to verify the effectiveness of this direction and control. This is achieved through integrated governance.

1.3. The NHS Act 2006 (amended Health & Social Care Act 2012) and subsequent regulations set out the legal framework within which the Trust operates. The Accountable Officers' Memorandum requires Trust Boards of Directors to adopt schedules of reservation and delegation of powers, set out the financial framework within which the organisation operates and how business is conducted and decisions made. These are incorporated into three (3) key documents: Scheme of Reservation & Delegation (SORD), Standing Financial Instructions (SFIs) and Standing Orders (SOs). Implementation of these key statutory instruments will only be effective when there is synergy between them. As well as being incorporated in this Manual, these documents can be accessible via the Trust's website and Intranet.

1.4. This Manual also contains a number of other extremely useful documents which provide valuable information about the Trust's corporate governance systems and processes. Having in one place key documents like the Integrated Governance Framework, the Assurance Framework, the statutory and assurance committees' terms of reference, their annual work plans and their performance and assessment tool provide a snapshot of the role and function of the Board and its committees.

1.5. All staff, especially senior managers, who have decision-making powers are encouraged to read these key documents so that they can be fully apprised of the context in which decisions are made in the Trust and be in a position to advise their direct reports.

1.6. This document is not only a useful reference guide but a tool that provides valuable information for preparation for CQC Well Led and being able to speak eloquently about how the Trust is governed and its key governance principles.

1.7. Compliance with these documents is required of the Trust, its Executive and Non-Executive Directors, officers and employees, all of whom are also required to comply with the Trust's Legal and Regulatory Framework

1.8. We strongly recommend the 2019/20 Corporate Governance Manual to all staff, managers and Board members and encourage you to familiarise yourself with its contents.

Neil Masom

Chair

Silas Nicholls

Chief Executive

2. Definitions

2.1. Unless the contrary intention appears or the context otherwise requires, words or expressions contained in this corporate governance manual bear the same meaning as in the NHS Act 2006 and the Standing Orders. References to legislation include all amendments, replacements, or re-enactments made.

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

2.3. In this ***Corporate Governance Manual*** the following definitions apply:

	Definition
Governance	
Corporate Governance	
Integrated Governance	
Nolan Principles	
The 2012 Act	The Health and Social Care Act 2012
The 2006 Act	The National Health Service Act 2006
The 1977 Act	The National Health Service Act 1977
Accountable Officer	The person who from time to time discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act; they shall be the Officer responsible and accountable for funds entrusted to the Trust in accordance with the NHS Trust Accounting Officer Memorandum. They are responsible for ensuring the proper stewardship of public funds and assets. The NHS Act 2006 designates the Chief Executive of the NHS
Agenda Item	Board of Directors - an item from a Board member (notice of which has been given) about a matter over which the Board has powers or duties or which affects the services provided by the Trust
The Board	The Board of Directors of the Trust as constituted in accordance with the Trust's Standing Orders
Bribery Act	The Bribery Act 2010
Budget	A resource, expressed in financial or workforce terms, proposed by the Board of Directors for the purpose of carrying out, for a specific period, any or all of the functions of the Trust
Budget holder	The Director or employee with delegated authority to manage finances (income and expenditure) for a specific area of the organisation
The Chair	Is the person appointed by NHS Improvement to lead the Board and ensure it successfully discharges its overall responsibility for the Trust as a whole. It means the Chair of the Trust or, in relation to the function of presiding at or chairing a meeting where another person is carrying out that role as required by the Standing Orders.

	Definition
Chief Executive	The chief officer of the Trust
Committee	A committee or subcommittee created and appointed by the Trust
Contracting and 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
External auditor	The person appointed to audit the accounts of the Trust, who is called the auditor in the 2006 Act
Financial year	Successive periods of twelve months beginning with 1 April and ending 31 March
Trust	Southport and Ormskirk NHS Trust
Trust contract	Agreement between the Trust and Clinical Commissioning Groups and/or others for the provision and commissioning of health services
Funds held on Trust	Those Trust funds which the Trust holds at its date of incorporation, receives on distribution by statutory instrument, or chooses subsequently to accept under powers derived under the 2006 Act. Such funds may or may not be charitable
Legal advisor	A properly qualified person appointed by the Trust to provide legal advice
NHS Improvement	The independent regulator (NHS Improvement) for the purposes of the 2006 Act
Meeting	Board of Directors – a duly convened meeting of the Board of Directors
Motion	A formal proposition to be discussed and voted on during the course of a meeting
Nominated Officer	An officer charged with the responsibility for discharging a specific function or specific tasks within Standing Orders and Standing Financial Instructions
Non-commissioner contract	Agreements with non-Clinical Commissioning Group, the organisations covering the variety of services that the Trust provides and charges for.
Officer	An employee of the Trust
Partner	In relation to another person, a member of the same household living together as a family unit
Protected property	This will generally be property that is required for the purposes of providing the mandatory goods and services and mandatory training and education
Registered medical practitioner	A fully registered person within the meaning of the Medicines Act 1983 who holds a license to practice under that Act
Registered nurse or midwife	A nurse, midwife or health visitor registered in accordance with the Nurses, Midwives and Health Visitors Act 1997

	Definition
Company Secretary	The Secretary appointed under the Standing Orders, the Secretary of the Trust or any other person appointed to perform the duties of the Secretary, including a joint, assistant or deputy secretary.
Standing Financial Instructions	(SFIs) regulate the conduct of the Trust's financial matters
Standing Orders	The Standing Orders of the Trust as amended from time to time. Describes the type of organisation, its primary purpose, governance arrangements and membership (SOs) to regulate the business conduct of the Trust
Scheme of Reservation and Delegation	The Scheme of Reservation and Delegation is to provide details of the powers reserved to the Board of Directors, and those delegated to the appropriate level for the detailed application of Trust policies and procedures and decision-making. The Board of Directors, however, remains accountable for all of its functions, including those which have been delegated, and would therefore expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role. All powers of the Trust which have not been retained as reserved by the Board of Directors or delegated to a committee or sub-committee of the Board of Directors shall be exercised on behalf of the Board of Directors by the chief executive. The scheme of delegation identifies those functions, which the chief executive shall perform personally and those which are delegated to other Directors and Officers. All powers delegated by the Chief Executive can be re-assumed by him/her should the need arise.

3. Introduction

3.1. This *Corporate Governance Manual* comprises among others key statutory instruments and guidance from the NHS:

- Schedule of matters reserved to the Board of Directors (Scheme of Reservation and Delegation)
- Matters delegated by the Board of Directors to its committees
- Standing Financial Instructions
- Standing Orders for the Board of Directors
- Code of Conduct for the Board of Directors
- Conduct Code of Conduct for NHS Managers

3.2. Compliance with these documents is required of the Trust, its Executive and Non-Executive Directors, officers and employees, all of whom are also required to comply with:

- The Trust's Legal and Regulatory Framework

.

3.3 The Trust must also have agreed its own Standing Orders as a framework for internal governance. Standing Orders for the Board of Directors are included in this Corporate Governance Manual.

3.4 All of the above-mentioned documents together provide a regulatory framework for the business conduct of the Trust.

3.5 The Trust's Board of Directors also has in place Audit, Remuneration and Nominations, Quality and Safety, Finance, Performance and Workforce Committees and an established framework for managing risks.

3.6 It is essential that all Directors, officers and employees know of the existence of these documents and are aware of their responsibilities included within. A copy of **this Manual is available on the Trust's website and intranet** and has been explicitly brought to the attention of key staff within the organisation and to all staff via the internal communication routes.

3.7 Any queries relating to the contents of these documents should be directed to the Company Secretary, who will be pleased to provide clarification

3.8 Governance

Governance has to do with steering an organisation in the right direction and involves the establishment of policies and continuous monitoring of their proper implementation by the members of the governing body of an organization. It includes the mechanisms required to balance the powers of the members (with the associated accountability), and their primary duty of enhancing the prosperity and viability of the organisation. This involves having a balance between the interests of the ***Agents*** (shareholders or in NHS and other public bodies, tax payers) and the ***Stewards***, that is management, charged with running the business. Agents, or those charged with governance ensure that the business is run properly by holding management, who run the business to account. Governance can be subdivided into different sections:

a. ***Corporate governance*** is the system by which organisations are directed and controlled. Boards of directors are responsible for the **governance** of their organisations. The shareholders' (public' for NHS) role in **governance** is to appoint the directors and the auditors and to satisfy themselves that an appropriate **governance** structure is in place. In the NHS, the public is represented by a Council of Governors and Non-Executive Directors in a Foundation Trust whereas in an NHS Trust (that is Non FT) the Non-Executive Directors represent the interests of the public. These are appointed by the Regulator, NHS England/NHS Improvement.

b. ***Clinical governance*** is the system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which **clinical** excellence will flourish (***Department of Health).***

c. ***Financial governance*** refers to the way an organisation collects, manages, monitors and controls **financial** information. **Financial IT** includes how organisations track **financial transactions**; manage performance and control data, compliance, operations, and disclosures.

d. ***Information governance***, or IG, is the management of **information** in an organization. It balances the use and security of **information**. An organisation can establish a consistent and logical framework for employees to handle data through their **information governance** policies and procedures these include compliance with the General Data Protection Regulations, Data Protection Act and Freedom of Information.

e. ***Integrated governance*** can be defined as the interrelation between different forms of governance approaches combining the principles of corporate, financial, clinical, information and other types of governance to enable a risk sensitive approach to enable the delivery of the organisation's strategic objectives.

3.9 Schedule of matters reserved to the Board of Directors

3.9.1. General enabling provisions

The Board of Directors may determine any matter it wishes, for which it has authority, in full session within its statutory powers. In accordance with the Code of Conduct and Accountability adopted, the Board explicitly reserves that it shall itself approve or appraise, as appropriate, the following matters detailed in paragraph 3.3 below. All Board members share corporate responsibility for all decisions of the Board and the Board remains accountable for all of its functions, even those delegated to individual committees, subcommittees, directors or officers.

3.9.2. Duties

It is the Board's duty to:

- Act within statutory financial and other constraints
- Be clear what decisions and information are appropriate to the Board of Directors and draw up Standing Orders, a schedule of decisions reserved to the Board and Standing Financial Instructions to reflect these
- Ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives for the main programmes of action and for performance against programmes to be NHS Improvement 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 sub-committee, the limit to their powers, and the arrangements for reporting back to the main Board.

3.10 Reserved matters

3.10.1 Standing Orders

Approval of and changes to Board Standing Orders.

3.10.2 Matters of Governance

- Approval of and changes to the schedule of matters reserved to the Board of
- Directors
- Approval of and changes to the standing financial instructions
- Suspension of Board standing orders
- Ratify or otherwise instances of failure to comply with standing orders brought to the Chief Executive's attention in accordance with Standing Orders
- Ratification of any urgent decisions taken by the Chair and Chief Executive, in accordance with the standing orders
- Approval of and changes to codes of conduct
- Approval of the Trust's risk assurance framework
- Approval of the Board's scheme of reservation and delegation
- Adoption of the organisational structures, processes and procedures to facilitate the discharge of business by the Trust and approval of any changes Approval of the remit and membership of Board committees, including approval of terms of reference and reporting arrangements of all committees and sub-committees that are established by the Board of Directors
- To confirm the recommendations of committees where they do not have executive powers
- To receive reports from committees including those which the Trust is required by the National Health Service Act 2006 or other regulation to establish and to take appropriate action thereon
- Audit arrangements
- Clinical audit arrangements
- The annual audit letter
- Annual report (including quality report/accounts) and statutory financial accounts of the Trust
- Annual report and accounts for funds held on trust (charitable funds) Approval of arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust
- Approval of arrangements relating to the discharge of the Trust's responsibilities as a bailer for patients' property
- Disciplining Board members or employees who are in breach of statutory requirements or Standing Orders.

3.10.3 Important regulatory matters

- Compliance with the Trust's License or any document which replaces it and all statutory and regulatory obligations
- Directors' and officers' declaration of interests and determination of action if required

- Arrangements for dealing with complaints
- Disciplinary procedures for officers of the Trust.

3.10.4 Appointments and dismissals

- Appointment and dismissal of committees (and individual members) that are directly accountable to the Board of Directors excluding the Audit Committee, the Remuneration and Nominations Committee (Executive Directors) and the Remuneration and Nominations Committee. This does not imply that individual members of all Committees can be dismissed
- Appointment, appraisal, disciplining and dismissal of Executive Directors Confirm the appointment of members of any committee of the Trust as representatives on outside bodies
- Appoint, appraise, discipline and dismiss the Trust Secretary
- Approve proposals received from the Remuneration and Terms of Service
- Committee regarding the Chief Executive, Directors and senior employees.

3.10.5 Strategic direction

- Strategic aims, direction and objectives of the Trust
- Financial plans and forecasts
- Approval of the Trust's annual plan, strategic developments and associated business plans
- Approval of annual revenue and capital budgets
- Approval of all Trust strategies to include, but not be limited to the risk management strategy and human resources strategy
- Approval of capital plans including:
    - Proposals for acquisition, disposal or change of use of land and/or buildings
    - Private finance initiative (PFI) proposals
    - Individual contracts, including purchase orders of a capital or revenue
    - nature in accordance with Delegated Financial Limits, Table B, section 2.
    - Approve proposals for action on litigation against or on behalf of the Trust where the likely financial impact is as shown in the Delegated Financial Limits, Table B, section 2 or contentious or likely to lead to extreme adverse publicity, excluding claims covered by the NHS Risk Pooling Schemes.

3.10.6 Monitoring Performance

Operational and financial performance arrangements at intervals that it shall determine.

3.10.7 Other matters

- Appointment of bankers
- Approve the opening of bank accounts.
  Approve individual compensation payments.

3.11 Objectives & Risks – 2019/20

Priorities 2019/20

As part of the operational planning process for 2019/20, we have had a number of conversations to clearly describe the Trust's priorities for the coming year. The priority headlines which have informed the formulation of the strategic objectives for 2019/20 are as follows:

1 Quality

- Recognition and care of the deteriorating patient
- Care of the older person
- Infection prevention and control
- Medicines management

2 *Operations*

- Achievement of quality targets for ED, RTT, cancer and diagnostics
- Clinical documentation focus on accuracy, completion and safe storage

3 *Workforce*

- Culture – organisational development, staff engagement and FTSU
- Clinical workforce strategy to ensure the right numbers of skilled staff

4 *Finance*

- Deliver our control total
- Maximize capacity using transformative efficiency and productivity tools

5 *Strategy*

- Engage with partners to develop opportunities for joint working
- Develop an affordable, sustainable acute services model

Each priority has a named executive director who will be responsible for delivering against the priority actions during the year. There will also be a number of enabling work streams that will need to be implemented to support these priorities. These include the IM&T programme, the estates development programme and communications.

Strategic Objective	**Principal Risk**
1.Improve clinical outcomes and patient safety to ensure we deliver high quality services by recognizing *and care of the deteriorating patient, improved focus on the care of the older person, preventing and controlling infection and*	1. If quality is not maintained in line with regulatory standards this will impede clinical outcomes and patient safety and may have the following: **Potential Effect:** • Poor reputational image • Inaccurate information about the Trust in the public domain • Reduction or loss of public support generally and in consultations regarding service improvement and design. • Poor staff morale resulting in poor quality of service • Poor Friends & Family Test response **Potential Impact:**

managing medicines efficiently within the specified timeline as set out in the Board Assurance Framework (BAF)	• Potential loss of good will locally, regionally and nationally with negative political input. • Negative impact on quality of patient services • Negative impact on recruitment and retention of staff due to poor image.
2. Deliver services that meet NHS constitutional and regulatory standards by the achievement of *quality targets for ED, RTT, cancer and diagnostics within the specified timeline as set out in the BAF.*	2. If the Trust cannot achieve its key performance targets it may lead to loss of services and may have the following: **Potential Effect:** • Poor patient experience and standards of care. • Inaccurate or inappropriate media coverage or reputational damage • Duplication of services with negative impact on CIP **Potential Impact:** • Potential loss of provider licence to practise. • Potential loss of reputation. • Financial penalties may be applied. • Poor NHSI Governance Risk Rating • Increased Agency Fees due to staff shortage
3.Efficiently and productively provide care within agreed financial limits by delivering the Trust's control total and minimize capacity by using transformative efficiency and productivity tools within the specified timeline as set out in the BAF	3. If the Trust cannot meet its financial regulatory standards and operate within agreed financial resources the sustainability of services will be in question and may have the following: **Potential Effect:** • High numbers of people waiting for transfer from inpatient care. • Poor quality of service due to pressure on recruiting the right staff. • Delays in patient flow, patients not seen in a timely way. • Reduced patient experience. • Failure of KPIs and self- certification • Reputational damage leading to difficulty in recruitment. **Potential Impact**: • Services may be unaffordable. • Quality of care provided to patients may fall. • Loss in reputation and market share. • Failure to meet contractual requirements.

4. Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated by improving the culture of the Trust via organizational development, staff engagement and Freedom to Speak Up and having a clinical workforce strategy to ensure right numbers of skilled staff are in place within the specified timeline as set out in the BAF.	4. If the Trust does not attract, develop, and retain a resilient and adaptable workforce with the right capabilities and capacity there will be an impact on clinical outcomes and patient experience and may have the following: **Potential Effect** • Low staff morale, • Poor outcomes & experience for large numbers of patients; • Less effective teamwork; • Reduced compliance with policies and standards; • High levels of staff absence; and • High staff turnover **Potential Impact** • Poor quality of patient service • Poor recruitment and retention of staff • Poor staff Survey • Inability to provide viable patient care • Possible suspension of provider License
5. Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values embodied within SCOPE within the timeline as set out in the BAF.	5. If the Trust does not have leadership at all levels patient and staff satisfaction will be negatively impacted and may have the following: **Potential Effect:** • Low levels of staff involvement and engagement in the Trust's business and performance agenda. • Higher than average vacancy rates. • Failure to deliver required activity levels / poor staff effectiveness • Higher than average sickness rates **Potential Impact:** • Poor patient experience and outcomes • Poor CQC assessment results • Poor patient survey results • Poor staff survey results • Poor Friends & Family Test results • Loss of reputation • Reduced ability to embed new ways of working
6.Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire to develop opportunities for joint working and developing an affordable, sustainable acute services model within the timeframe as set out	6. If the system does not have an agreed acute services strategy it may lead to non-alignment of partner organisations plans resulting in the inability to develop and deliver sustainable services and may have the following: **Potential Effect:** • Loss of existing market share. • Stranded fixed costs due to poor demand management and QIPP. • Difficulty managing capacity plans **Potential Impact:**

in the BAF.	• Reduced financial sustainability. • Inability to meet quality goals. • Reduced operational performance

3.11 The Principles of Public Life

The NHS and other public sector organisations are expected to abide by the seven (7) Principles of Public Life. The 7 principles of public life apply to anyone who works as a public office-holder. This includes people who are elected or appointed to public office, nationally and locally, and all people appointed to work in:

- the civil service
- local government
- the police
- the courts and probation services
- non-departmental public bodies
- health, education, social and care services

They were first set out by Lord Nolan in 1995 and they are included in the Ministerial Code.

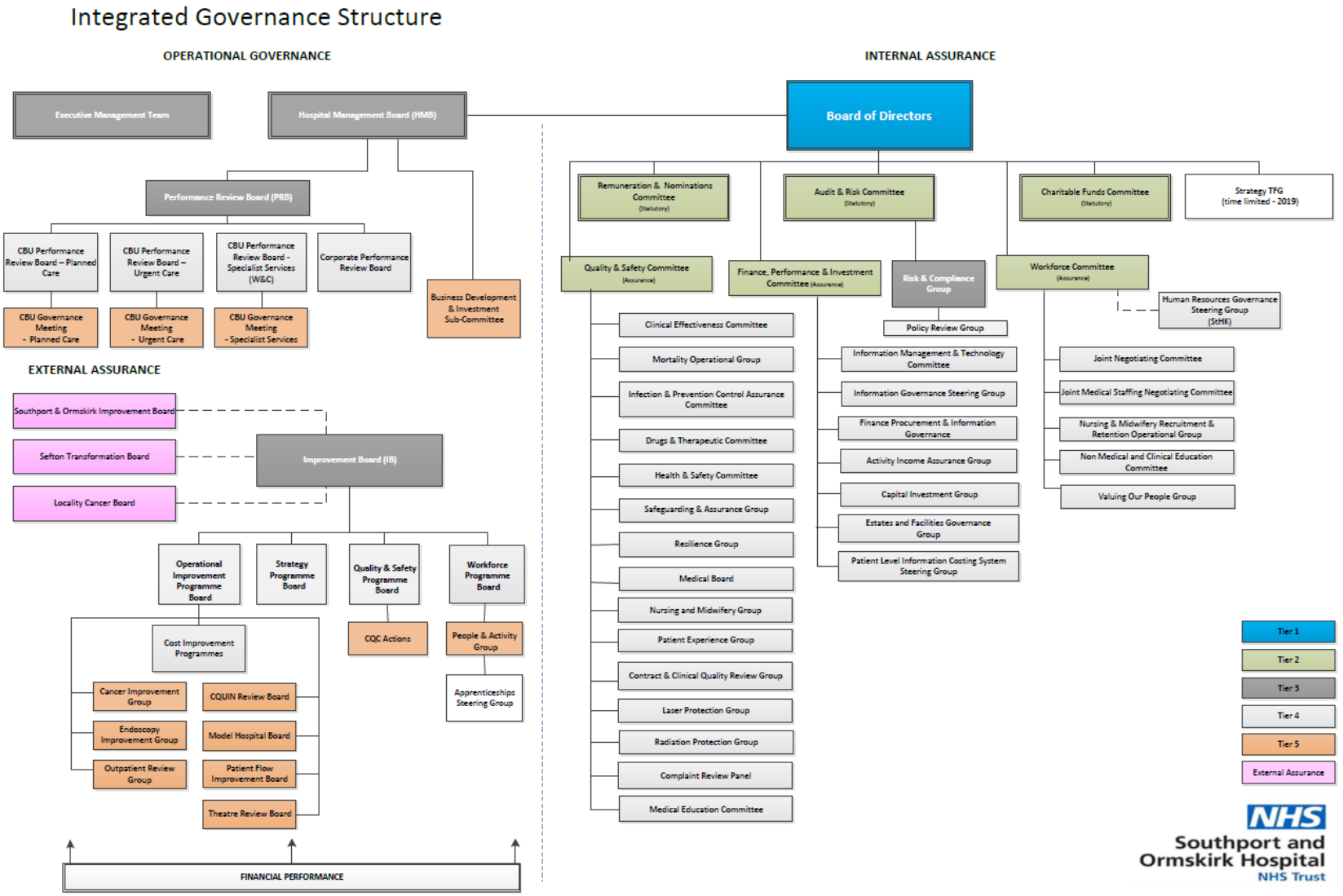
The 7 Principles of Public Life are:

PRINCIPLE	DUTY
Selflessness	Holders of public office should act solely in terms of the public interest.
Integrity	Holders of public office must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions in order to gain financial or other material benefits for themselves, their family, or their friends. They must declare and resolve any interests and relationships.
Objectivity	Holders of public office must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias
Accountability	Holders of public office are accountable to the public for their decisions and actions and must submit themselves to the scrutiny necessary to ensure this.
Openness	Holders of public office should act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for so doing.
Honesty	Holders of public office should be truthful.
Leadership	Holders of public office should exhibit these principles in their own behaviour. They should actively promote and robustly support the principles and be willing to challenge poor behaviour wherever it occurs.

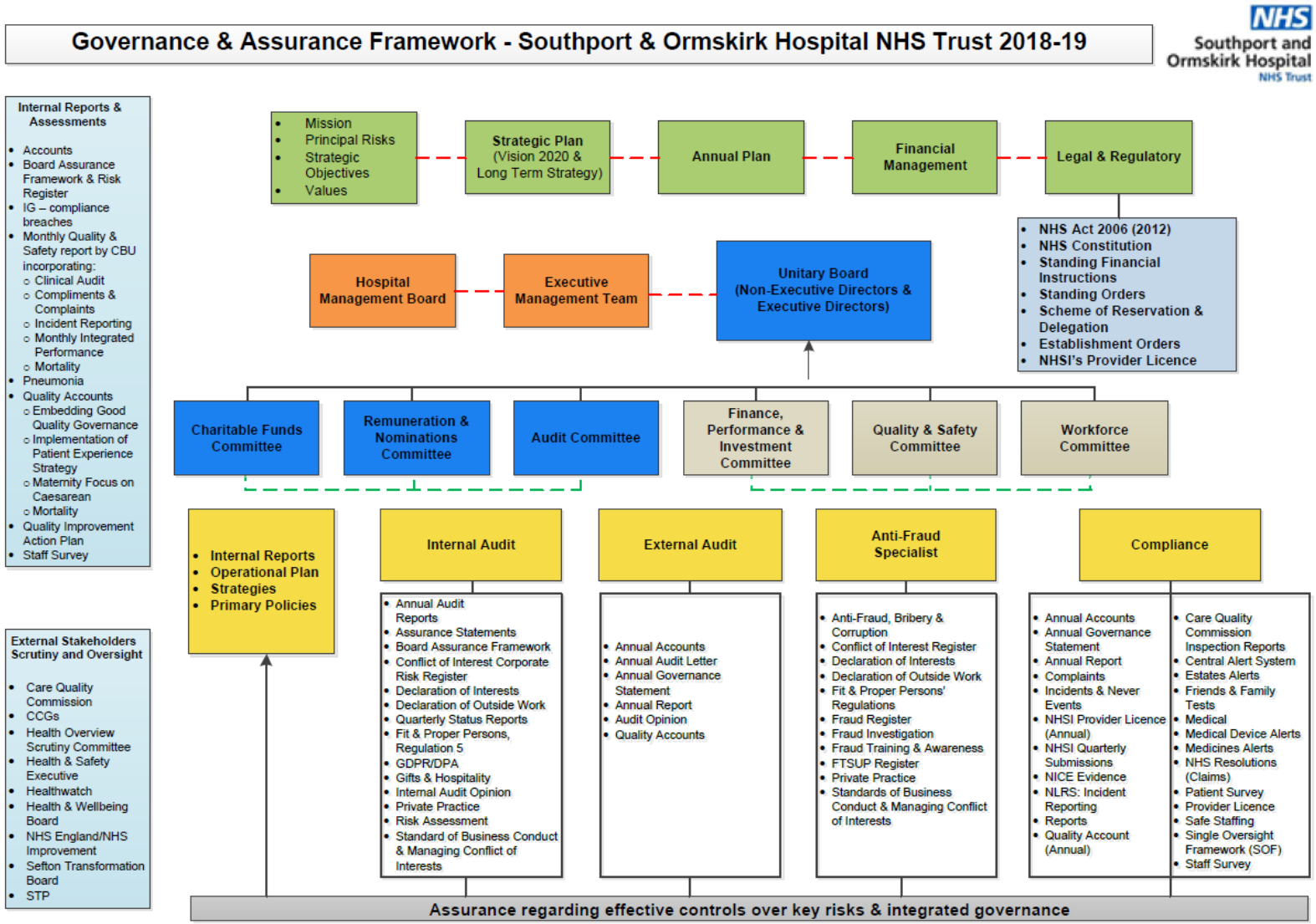
The Trust's Statutory Instruments are summarised and set out in full as well as its Integrated Governance Structure and Assurance Framework. The Prime Policies are also set out

below. These enable the Trust to ensure there is a structured way to enable sound governance to take place.

4 The Trust's Integrated Governance Structure

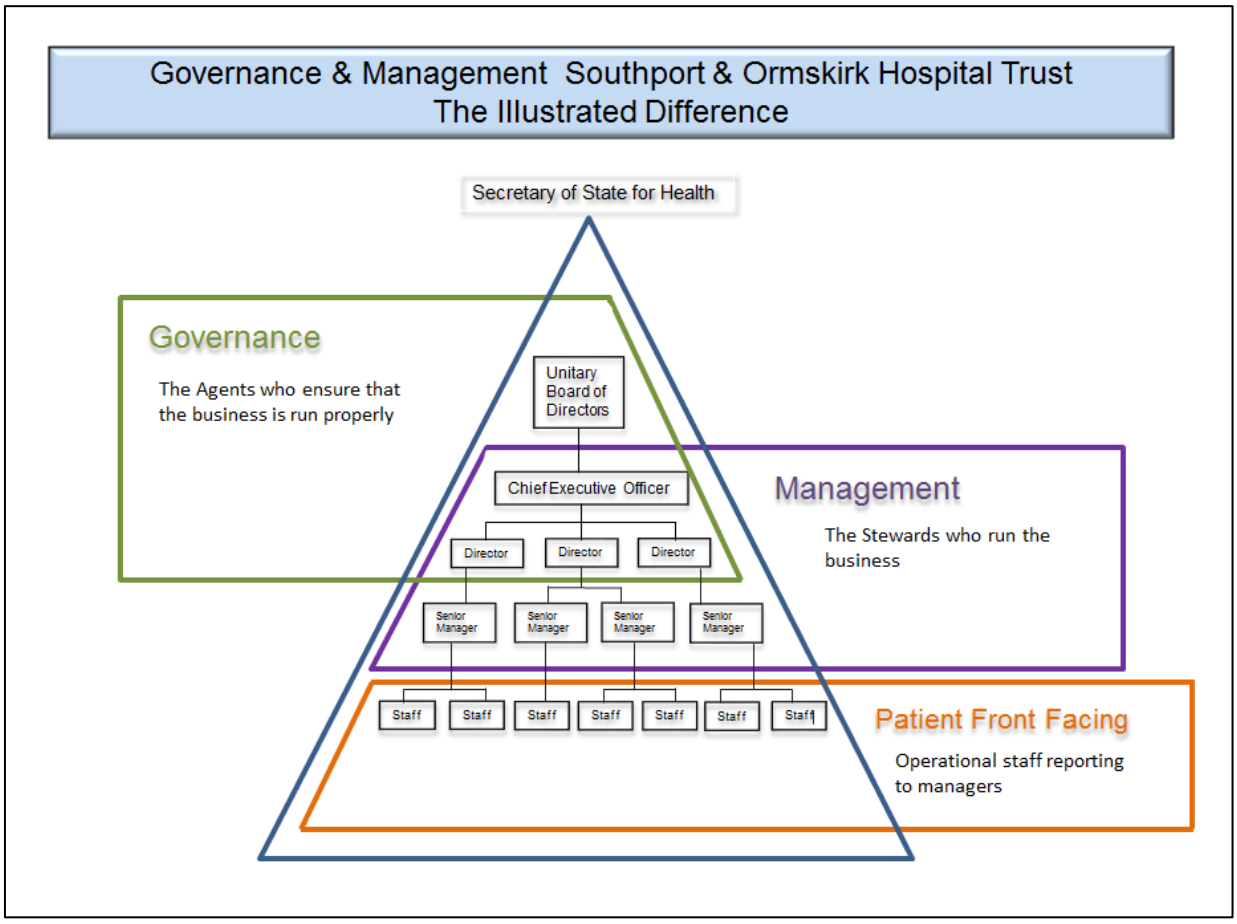


5 The Trust's Assurance & Governance Framework



6 The Role, Structure and Composition of the Board

It is the Board's role to effectively govern the organisation ensuring that strategic objectives are met and high quality care is delivered whilst ensuring best value for taxpayers money. It is not the Board's role to manage the organisation, this is the remit of the Executive Team (Management). The difference between governance and management is illustrated below:



The Board is a unitary Board which means that when Executive Directors are in the boardroom they are Board Directors with the same responsibilities as every other Board member, namely, Non-Executive Directors and Executive Directors and not just acting in their capacity as responsible for their portfolio areas. Further, by functioning as a unitary Board, Directors, Non-Executive and Executive are jointly and severally responsible for actions and decisions made at and on behalf of the Board.

Under a unitary board structure there is a single board of directors, comprising Executive and Non-Executive Directors (NEDs).

By comparison, there are two separate boards under the two-tier structure:

- The ***Management (Operating) Board*** which is responsible for the day-today running of the business, consisting of Executives only and led by the Chief Executive.

- The ***Supervisory (Corporate) Board*** with a wider membership, responsible for the strategic oversight of the organisation and led by the Chair.

The NEDs on a unitary Board will be, largely classified as independent NEDs, stressing the fact that they will act in the best interests of the wider shareholder population.

The supervisory Board under a two-tier structure will include representatives of major shareholders, environmental groups, employees (possibly from trade unions) and providers of finance. These individuals, although not holding executive positions within the business, are definitely not considered to be 'independent' and will be acting in the interest of their own group.

Under a two-tier Board structure the two Boards meet separately, so executive discussion around running the business will not be heard by the higher board members, and vice versa. This is unlike the single Board meeting that will be held as a unitary Board.

Advantages and Disadvantages between the Unitary Board and the two-tier system

The unitary Board dominates most British companies and is favoured by the *UK Corporate Governance Code*. The advantages and disadvantages of the Dual and Unitary approaches are illustrated below:

DUAL AND UNITARY BOARD COMPARED AND CONTRASTED	
Advantages	**Disadvantages**
DUAL	**DUAL**
Clear separation in roles	Bureaucracy, as size of supervisory element is unwieldy with former managers in conflict
Greater focus on stakeholder inclusion through NEDs	Stagnation/infrequent meeting/required good relations between Chairman and CEO)
UNITARY	**UNITARY**
All major decisions taken in one forum	Less independence and separation of duties
Close Executive relations	Lacks clear division of responsibilities
Effective communication and information flow as one board	
Enhance efficiency/easy to operate	

The Trust's senior management structure can be found on the Trust's website at: http://www.southportandormskirk.nhs.uk/whos_who.asp

The publication '*Healthy NHS Boards 2013'* from the NHS Leadership Academy is a useful reference for providing further information on the roles of boards when formulating strategy, ensuring accountability and shaping culture. A copy is available from the Company Secretary.

Profile of the Board

The Board of Directors is a unitary board and comprises a Chair, an additional five (5) Non-Executive Directors and five (5) Executive Directors[1].

The Executive Team members are:

- Chief Executive
- Deputy Chief Executive & Executive Director of Strategy
- Executive Director of Finance
- Executive Medical Director
- Executive Director of Nursing, Midwifery & Therapies
- Chief Operating Officer
- Director of Human Resources & Organisational Development
- Company Secretary

The Company Secretary attends the Board to offer advice on the Trust's statutory instruments, corporate governance and business conduct.

Non-Executive Directors

The Board is comprised of six NEDs, one of whom is the Chair and there is also a NED Designate; their profile, portfolio and tenure are set out below

[1] Further information regarding individual Board members can be found within the document 'Board Profiles' available from the Company Secretary.

Southport and Ormskirk Hospital NHS Trust

Non-Executive Directors' Tenure, Skills Mix, Portfolio and Champions Role as at June 2019

NAME	DATE APPOINTED	TERM	Expiry of Tenure & Plans to fill where applicable	KEY SKILLS/EXPERIENCE	BOD CoSec	REM COM DoHR/ CoSec	AUDIT DoF	FP&I DoF	Q&S DoN	WFC DoHR	CFC DoF	Champion
Mr Neil MASOM (Trust Chair)	01/12/18	1st of 2	30/11/20	An engineer by profession, Neil Masom OBE, began his career with the former Hawker Siddeley Aviation aircraft company in 1977 before going on to gain more than 30 years' experience with BAE Systems, primarily in Manchester and Lancashire, holding three managing director posts at the company between 2000 and 2009. He has held and continues to perform a number of non-executive posts, including as chairman of the Foreign and Commonwealth Office Services Organisation (2000-2006) and as a non-executive director at East Cheshire NHS Trust in Macclesfield (2009-2013). He is currently senior independent director at WYG plc, a successful international engineering consultancy, and was for four years audit committee chair at HS2 Limited, the company responsible for designing and building the UK's new high-speed rail network.	**Chair**	**Chair**		*Rotate with Audit Chair & CEO*	*Rotate with Audit Chair & CEO*	*Rotate with Audit Chair & CEO*	**Chair**	**Organ Donation**
Mr Jim BIRRELL	04/07/17	1st of 2	**Ends: 03/07/19** In first term which ends July 2019. Very committed; here for the long-term	Jim qualified as an accountant in local government before moving into the NHS in 1983. Following periods as the Finance Director at Alder Hey and then North West Regional Director of Finance, Jim spent 10 years as Chief Executive at Aintree University Hospitals NHS Foundation Trust. In the latter role he	✔	✔	**Chair**	*Rotate with Chair & CEO*	*Rotate with Chair & CEO*	*Rotate with Chair & CEO*	✔	**Anti-Fraud, Bribery & Corruption/Design, Energy & Sustainability and Security 7 Estates.**

NAME	DATE APPOINTED	TERM	Expiry of Tenure & Plans to fill where applicable	KEY SKILLS/EXPERIENCE	BOD CoSec	REM COM DoHR/ CoSec	AUDIT DoF	FP&I DoF	Q&S DoN	WFC DoHR	CFC DoF	Champion
				developed a keen interest and commitment to improving quality. Since retiring from Aintree in 2011, Jim has undertaken a number of management consultancy assignments, including work for NHS Improvement.								
Dr David BRICKNELL	09/04/18	1st of 1	**Ends:08/04/21** In first term which ends April 2021	David spent his career as a solicitor in industry and for 40 years has sat in the boardroom, either as company secretary or director, for commercial companies, charities and a hospital. He also has a recent PhD for research in strategic decision making.	✔	✔			**Chair**	✔	✔	Workforce
Mrs Pauline GIBSON*	05/07/17	1st of 2	**Ends: 04/07/19** Associate NED D	Pauline is director of Staffordshire-based Excel Coaching and Consulting. She is a fellow of Chartered Institute of Personnel and Development. She is an experienced board director specialising in executive coaching, strategic leadership development, transformational teams and culture change. Pauline has spearheaded significant culture change programmes and is skilled in developing a high performing leadership cadre and driving catalytic team performance.	✔	✔		✔		**Chair**	✔	Freedom to Speak Up Equality and Diversity
Mrs Julie GORRY	02/08/17	2nd of 2	**Ends: 01/08/21** In 2nd of 2 terms. Confirmed by NHSI 18/06/18	Julie was Chief Executive of Wirral Hospice for 12 years and has more than 20 years' experience as an Executive Director in the independent sector and the NHS. Previously, she was North West regional representative for the National Council for Palliative Care for more than 15 years before its merger with Hospice UK in summer 2017. She was also Chair of the Hospice Chief	✔	✔	✔		✔		✔	End of Life Care Dementia

NAME	DATE APPOINTED	TERM	Expiry of Tenure & Plans to fill where applicable	KEY SKILLS/EXPERIENCE	BOD CoSec	REM COM DoHR/ CoSec	AUDIT DoF	FP&I DoF	Q&S DoN	WFC DoHR	CFC DoF	Champion
				Executive Advisory Group for the North West Strategic Clinical Network for Palliative and End of Life Care. Julie, who is a practicing nurse, is a specialist advisor for Care Quality Commission. She has a Masters of Arts in Strategic Human Resources and a passion for improving quality, patient safety and patient experience.								
Mrs Joanne MORGAN	08/04/19	1st of 1	**Ends: 07/04/22** (In first term of 3 years.)	Joanne Morgan has had a successful career at senior management and board level in a variety of organisations. These include local government providing public services, national regulated utility companies and both major and medium-sized contractors. Following a number of senior leadership roles, her most recent appointment was as operations director for a worldwide FTSE 200 organisation. She had overall responsibility for the oversight of multiple contracts and latterly was business excellence director which was a more strategic role in shaping a business, helping to establish the vision and creating the values essential for success. Joanne also has her own business. She was born and lives in Lancashire	✔	✔	✔	**Chair**			✔	
Mr Gurpreet SINGH	09/04/18	1st of 1	**Ends: 08/10/19** In first term of 18 months.	Gurpreet Singh is a former Trust surgeon and has more than 25 years' experience in general urology. He has been an executive member for The British Association of Urological Surgeons where he helped write the curriculum for functional and neuro-	✔	✔			✔	✔	✔	Safeguarding ^Organ Donation

NAME	DATE APPOINTED	TERM	Expiry of Tenure & Plans to fill where applicable	KEY SKILLS/EXPERIENCE	BOD CoSec	REM COM DoHR/ CoSec	AUDIT DoF	FP&I DoF	Q&S DoN	WFC DoHR	CFC DoF	Champion
				urology. He has been the chair of the surgical speciality group for Urology for the Royal College of Surgeons, Edinburgh, leading on patient safety and training. He has an active research interest, predominately clinical, with more than 150 peer-reviewed publications.								

EXECUTIVE DIRECTORS

NHS
Southport and Ormskirk Hospital
NHS Trust

Silas Nicholls
Chief Executive

Therese Patten
Deputy Chief Executive

Steve Christian
Chief Operating Officer

Juliette Cosgrove
Director of Nursing

Dr Terry Hankin
Medical Director

Jane Royds
Director of HR and OD

Steve Shanahan
Director of Finance

NHS
Southport and Ormskirk Hospital
NHS Trust

EXECUTIVE TEAM'S TENURE, PORTFOLIO AND SKILLS MIX AS AT June 2019

NAME	DATE APPOINTED	KEY SKILLS/EXPERIENCE	BOD	REM COM AdHR/ CoSec	AUDIT DoF	FP&I DoF	Q&S DoN	WFC ADHR	CFC DoF
Mr Silas NICHOLLS (Chief Executive)	1 April 2018	Silas brings with him a wealth of experience to the Trust and a strong track record of achievement, most recently at Manchester University NHS Foundation Trust where he was Group Deputy Chief Executive. Silas, who lives locally, is an experienced chief executive who began his NHS career as a graduate trainee. He is a former Director of Operations and Performance at Clatterbridge Cancer Centre NHS Foundation Trust, Wirral, and Deputy Chief Executive and Director of Strategy at Wrightington, Wigan and Leigh NHS Foundation Trust.	✔	By Invitation		✔			
Mr Audley CHARLES (Company Secretary & Data Protection Officer)	1 June 2018	Audley joined the Trust as Interim Company Secretary in August 2017. He joined the NHS in 1996 after a period in academia and Executive roles in Social Housing and the voluntary sector. He initially undertook leadership roles in strategic and business planning, information governance and assurance. He was one of the first waves of Company Secretaries to be recruited at the introduction of Foundation Trusts. He has been involved with the Foundation Trust Network helping aspirant Foundation Trusts and Company Secretaries. Audley has also helped to input into ICSA's curriculum for NHS Company Secretaries programme. He has worked in a number of Foundation and NHS Trusts. In this capacity, Audley also headed up corporate governance (as he does now) and has an academic interest in the subject, having researched extensively in the field and lectured to undergraduates on the subject.	✔	✔	✔	✔	✔		✔
Mr Steve CHRISTIAN (Chief Operating Officer)	1 October 2018	Steve Christian returns to the Trust from NHS Improvement where he was the Regional Director of Improvement. His appointment follows a secondment to the post during the summer of 2018.	✔			✔			✔

NAME	DATE APPOINTED	KEY SKILLS/EXPERIENCE	BOD	REM COM AdHR/ CoSec	AUDIT DoF	FP&I DoF	Q&S DoN	WFC ADHR	CFC DoF
		Steve lives locally and is a former Trust operational manager. He brings a wealth of experience and recently led the Action on A&E programme across the North of England.							
Ms Juliette COSGROVE (Director of Nursing, Midwifery & Therapies)	1 May 2018	Juliette has more than 30 years' nursing experience, most recently as Assistant Director of Quality and Safety at Calderdale and Huddersfield NHS Foundation Trust in West Yorkshire where she led on quality, governance and improvement. In addition, she was a member of the North East Lincolnshire NHS Clinical Commissioning Group governing body from April 2013 and was also chair of the quality committee. Prior to this, Juliette held a number of senior nursing posts including deputy chief nurse at Leeds Teaching Hospital NHS Trust and head of nursing quality at the former Yorkshire and Humber NHS Strategic Health Authority. She has extensive experience at working at a trust rated "requires improvement" by the Care Quality Commission and was instrumental in helping them to make significant improvements in a relatively short period of time.	✔		✔		✔		✔
Dr Terry HANKIN Medical Director /Caldicott Guardian and Responsible Officer	7 January 2019	Dr Terry Hankin joined the Trust from St Helens and Knowsley Teaching Hospitals NHS Trust where he was deputy medical director for five years. He was also the Responsible Officer and Medical Director for the Lead Employer Organisation. In these roles he gained extensive experience of supporting and managing clinicians in the workplace. He has a proven record in improving patient care, and as an active critical care physician and anesthetist has a clear understanding of the challenges of the clinical workplace. As Medical Director for the Lead Employer, he worked with the HR team and contributed to the development of an outstanding team managing more than 5,000 trainees. Dr Hankin is dedicated to improving patient care and supporting the both the medical, nursing and the wider workforce in delivering such improvements. He has a particular affiliation with Southport hospital having completed some of his training there.	✔		✔		✔		✔

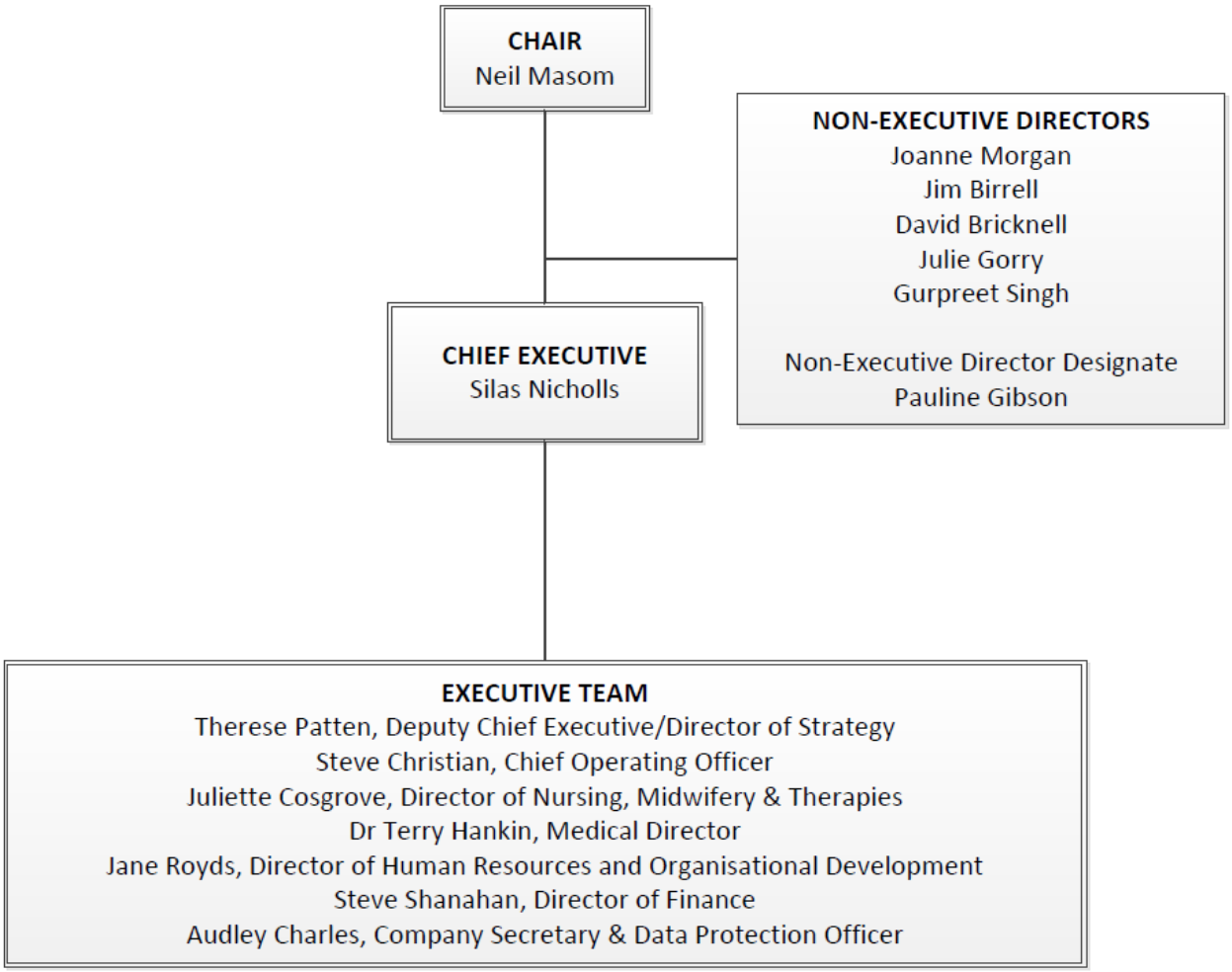
NAME	DATE APPOINTED	KEY SKILLS/EXPERIENCE	BOD	REM COM AdHR/ CoSec	AUDIT DoF	FP&I DoF	Q&S DoN	WFC ADHR	CFC DoF
Ms Therese PATTEN Director of Strategy/Deputy CEO	1 October 2016 Appointed DCEO: 1 October 2018	Therese joined the Trust from Liverpool's Alder Hey Children's Hospital NHS Foundation Trust in Liverpool where she was Associate Director Strategic Development and Partnership. This was an executive role leading on the delivery of the strategic plan which included delivering strategic local and international partnerships. Therese has worked in the NHS, private health and international aid sectors. She has more than 20 years' experience in healthcare, more recently in board positions as Chief Operating Officer and Commercial Director. Before that she worked in Liverpool, including a community Trust, and for a time in the private healthcare sector. In the 1990s, she worked in Somaliland and Zimbabwe in health education and nutrition, and later for the Department for International Development in Pakistan.	✔					✔	✔
Mrs Jane ROYDS Director of Human Resources & OD	1 November 2018	Jane was previously Executive Director of Non-clinical Services at Queenscourt Hospice in Southport. She has worked 27 years in human resources (HR) for the NHS across community, primary care and mental health organisations prior to joining the hospice. She is a Fellow of the CIPD and has a MA in Strategic HR.	✔	By invitation				✔	✔
Mr Steve SHANAHAN Director of Finance/Senior Information Risk Officer (SIRO)	5 September 2016	Steve Shanahan was Executive Director of Finance at North Cumbria University Hospitals NHS Trust before joining the Trust on secondment in November 2015. He was made substantive in August 2016. He had a career at Board level in the private sector before joining the NHS in 2005 when he was appointed Finance Director at Shrewsbury and Telford Hospital NHS Trust. He lives in West Lancashire.	✔		✔	✔			✔

7. Who's Who

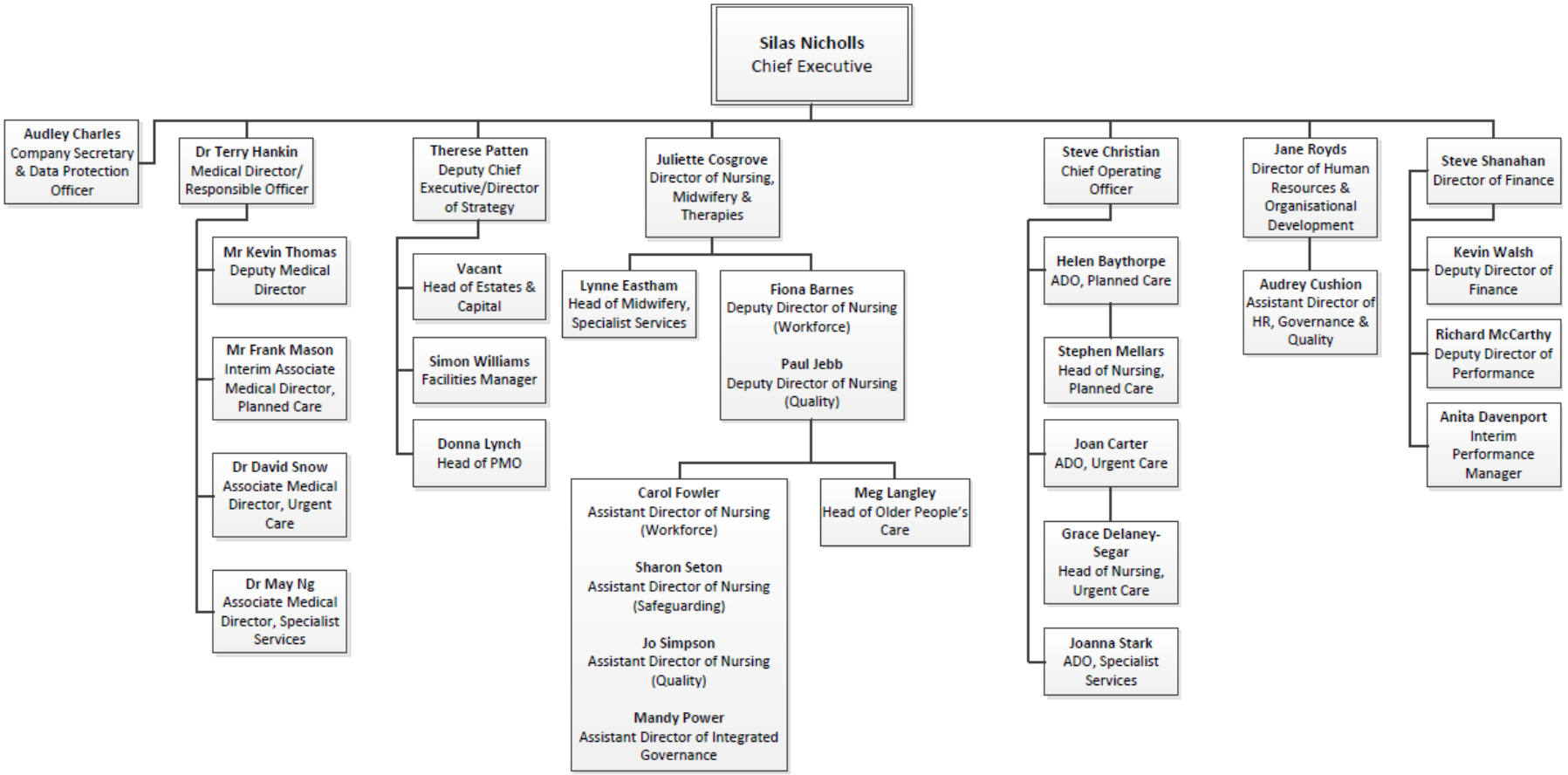
NHS
Southport and Ormskirk Hospital
NHS Trust

WHO'S WHO
May 2019

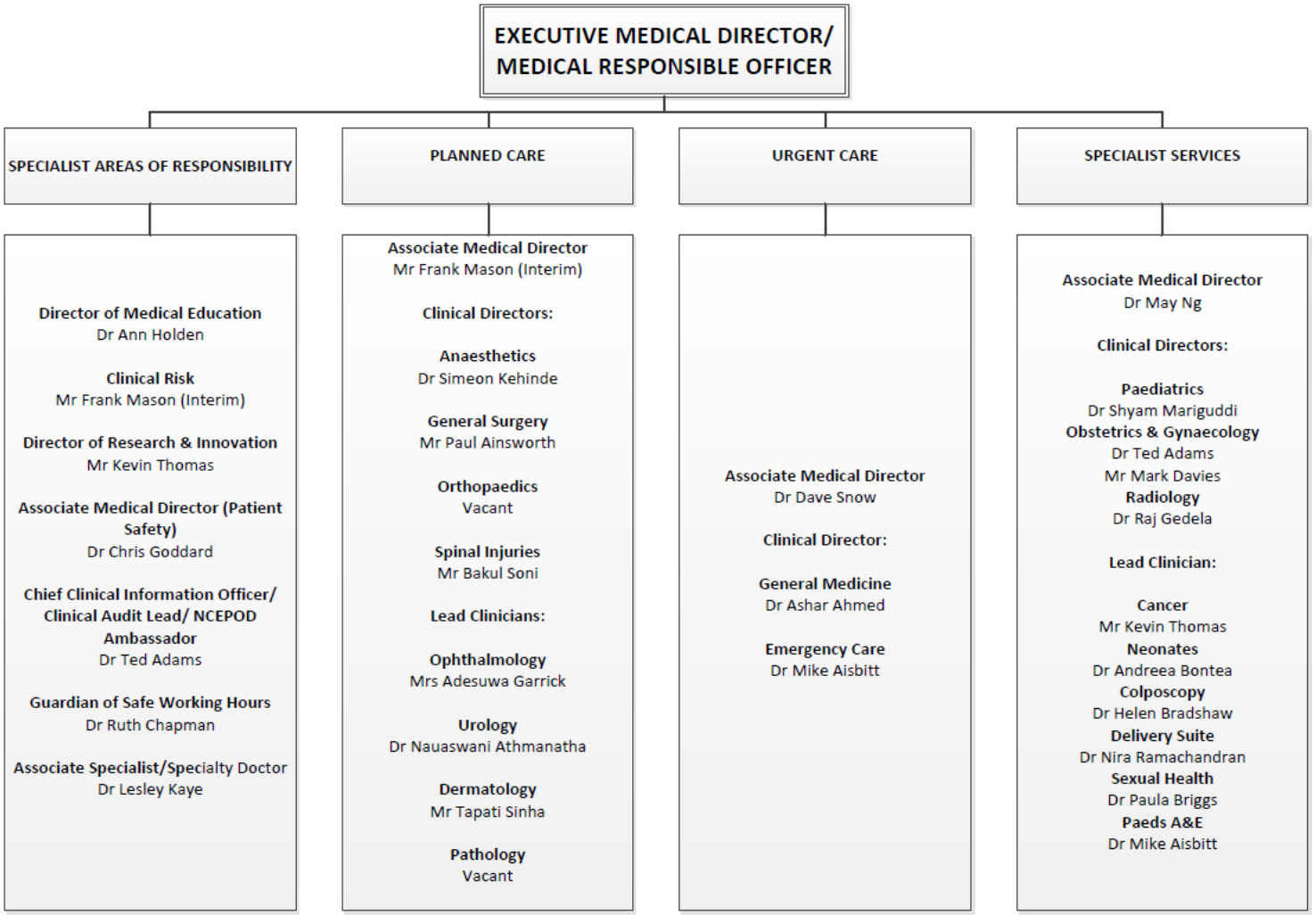
Trust Board


CHAIR
Neil Masom
NON-EXECUTIVE DIRECTORS
Joanne Morgan
Jim Birrell
David Bricknell
Julie Gorry
Gurpreet Singh
Non-Executive Director Designate
Pauline Gibson
CHIEF EXECUTIVE
Silas Nicholls
EXECUTIVE TEAM
Therese Patten, Deputy Chief Executive/Director of Strategy
Steve Christian, Chief Operating Officer
Juliette Cosgrove, Director of Nursing, Midwifery & Therapies
Dr Terry Hankin, Medical Director
Jane Royds, Director of Human Resources and Organisational Development
Steve Shanahan, Director of Finance
Audley Charles, Company Secretary & Data Protection Officer

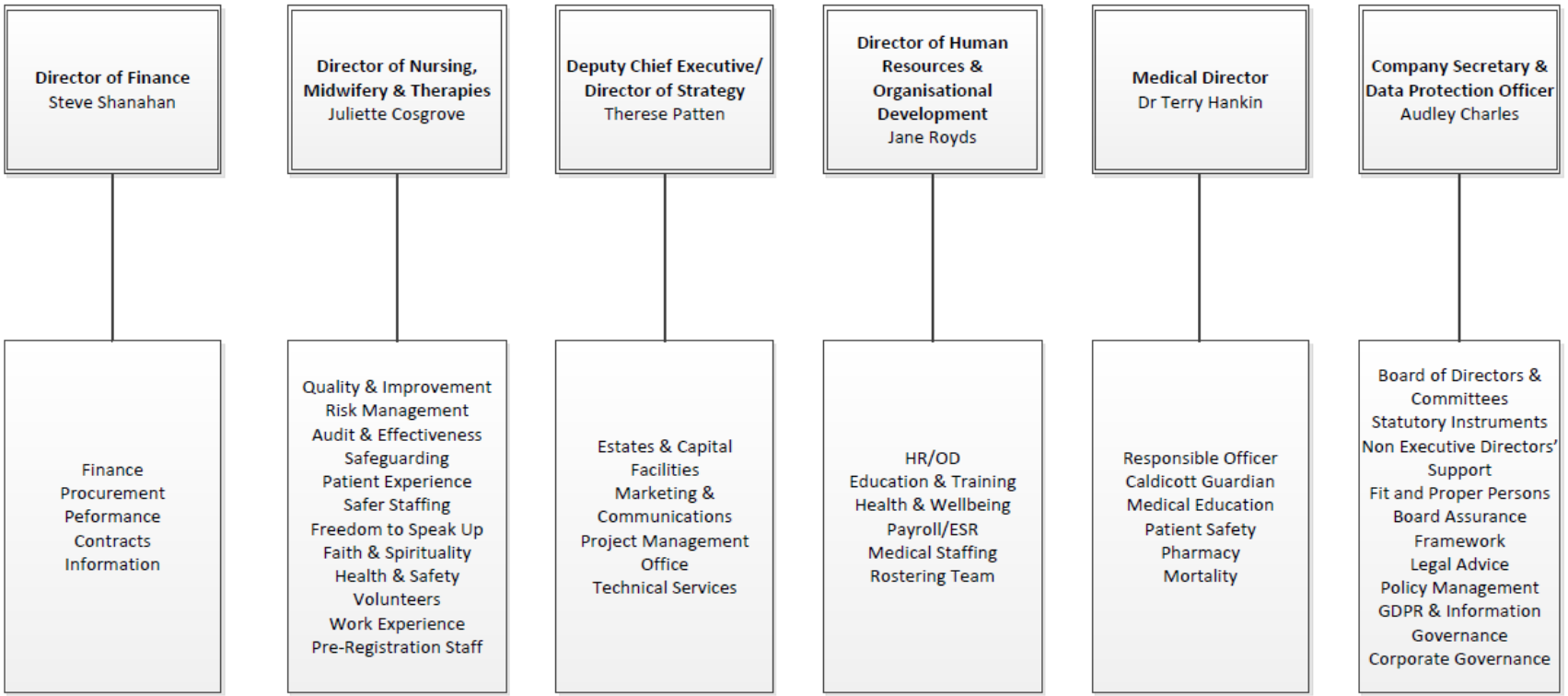
Senior Management Team



Medical Management

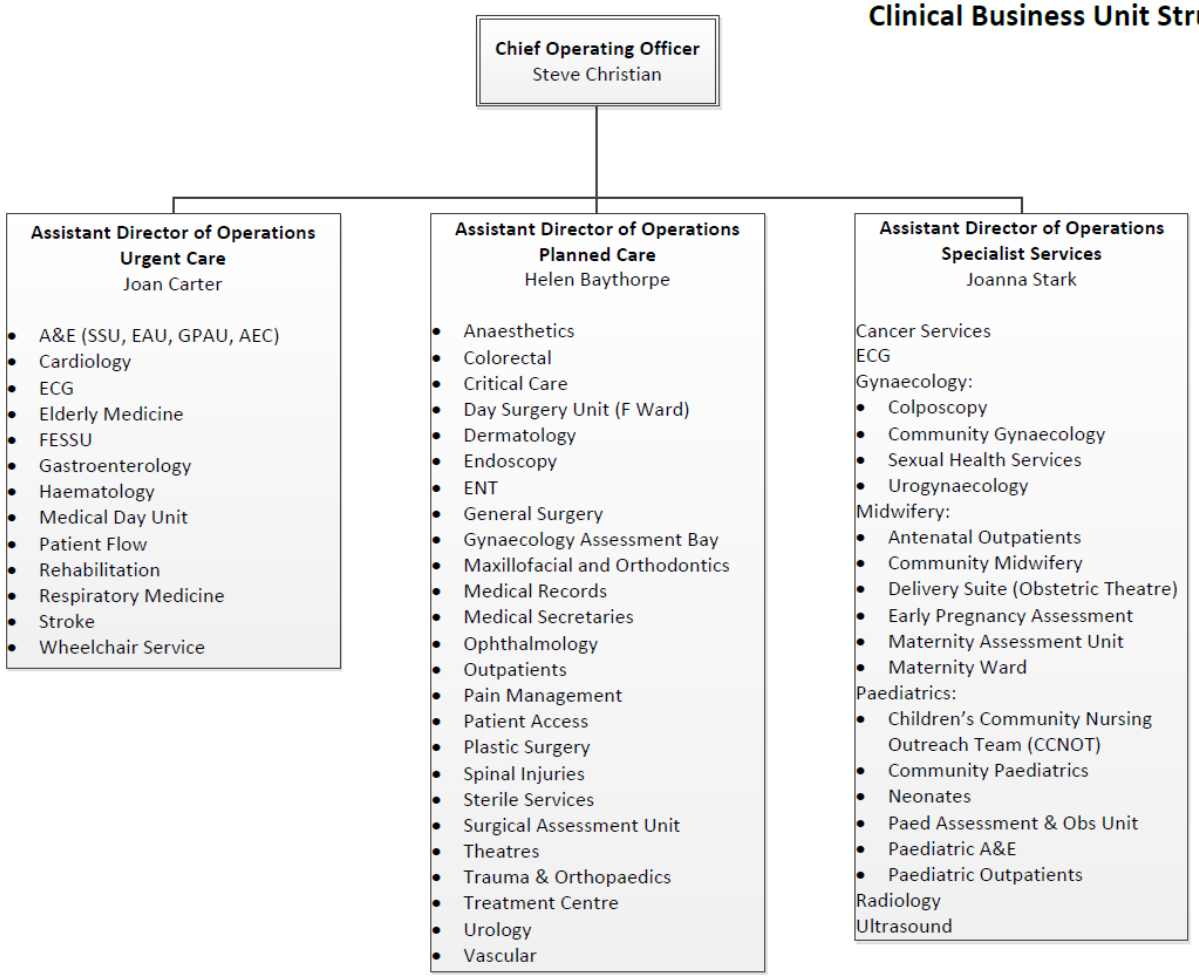


Corporate Business Unit Structure

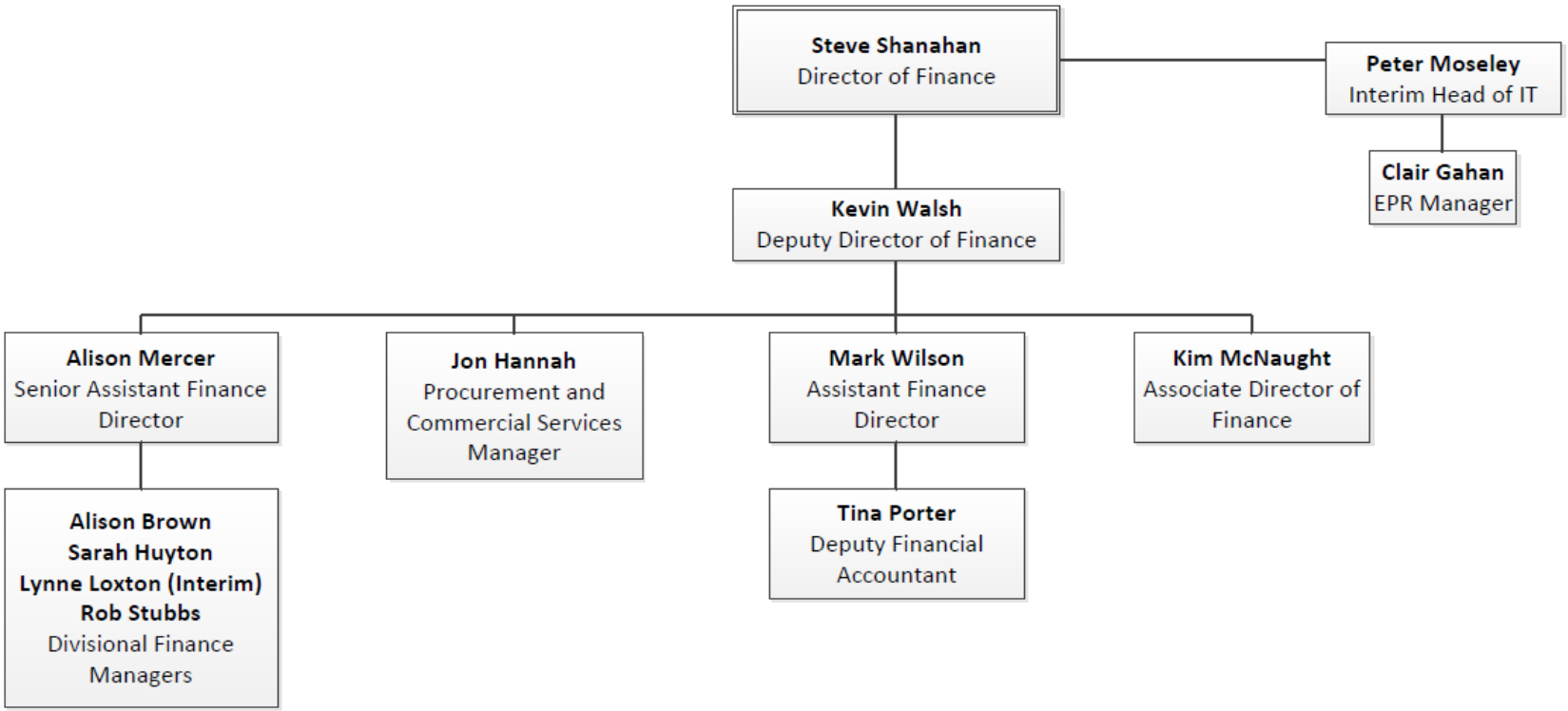


Chief Operating Officer, Steve Christian – See next page

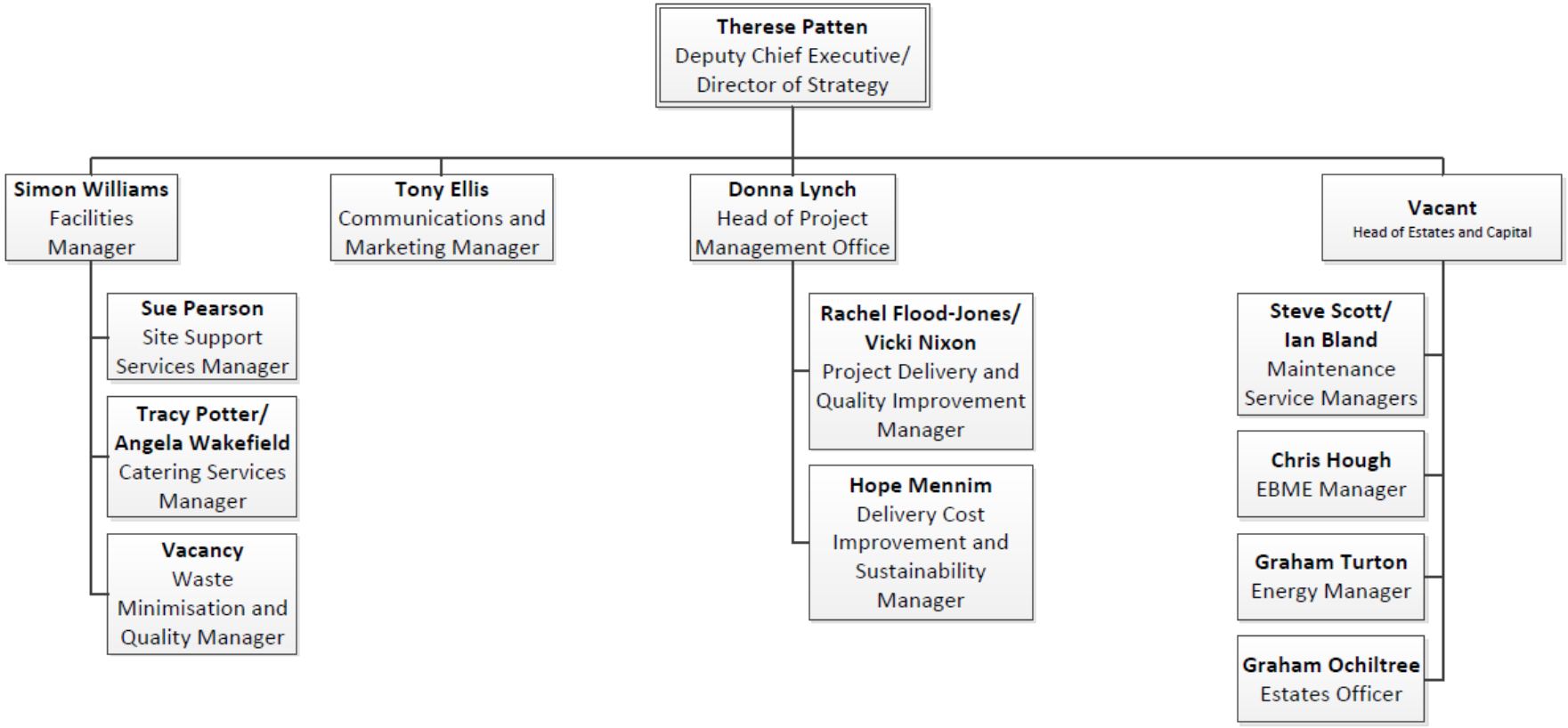
Clinical Business Unit Structure



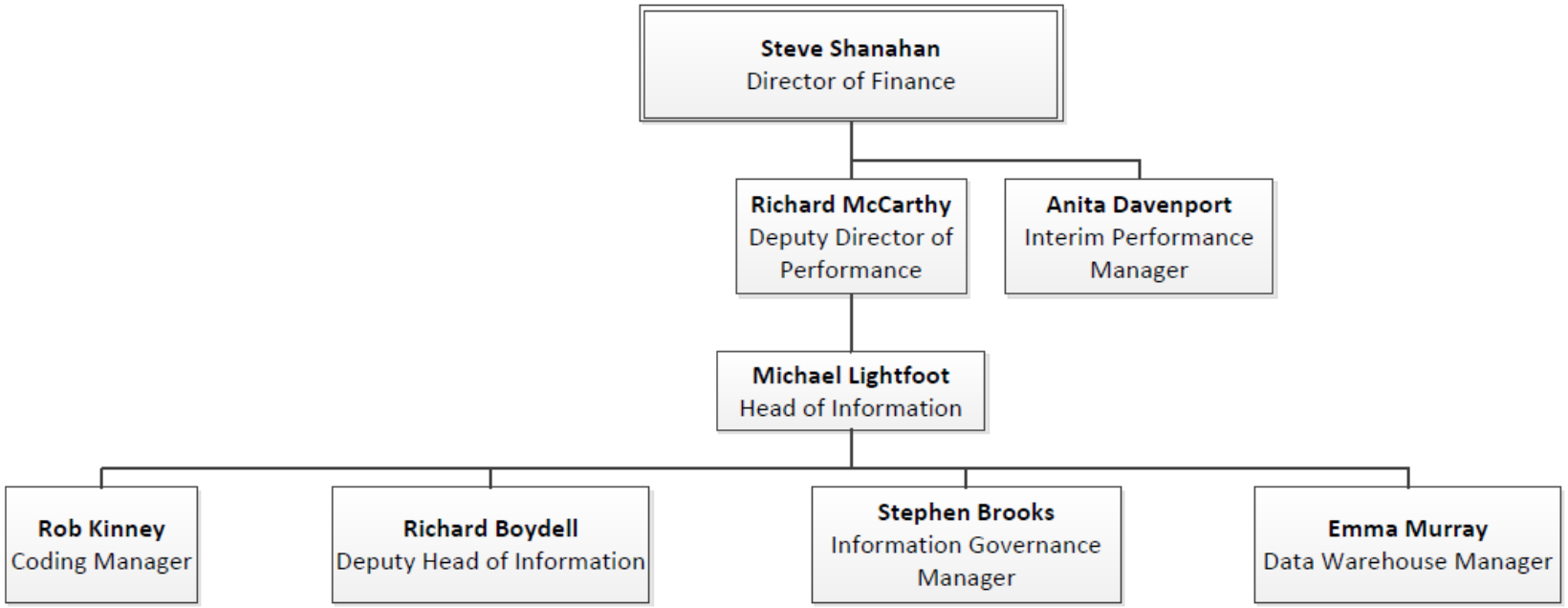
Director of Finance



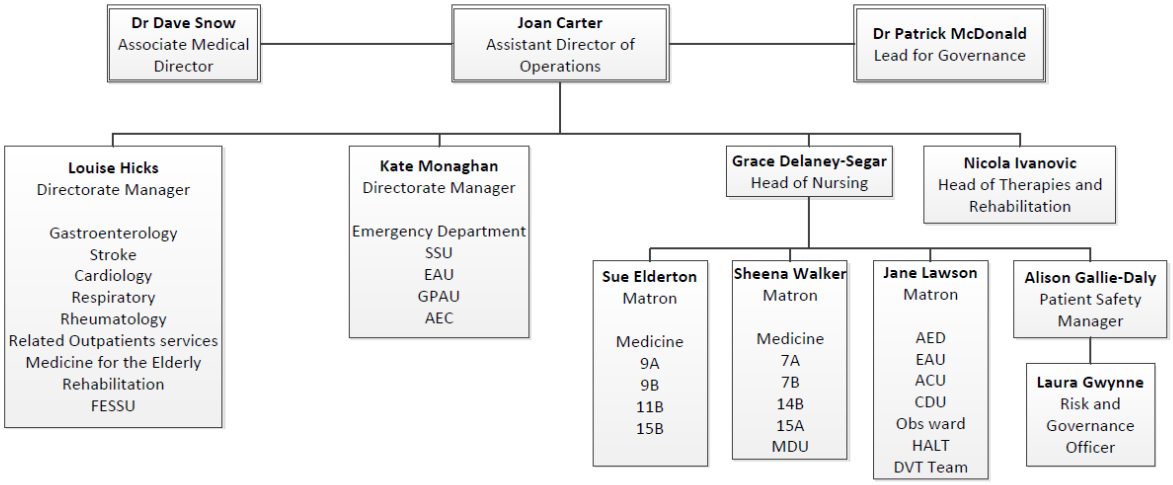
Director of Strategy



Information and Performance Managment

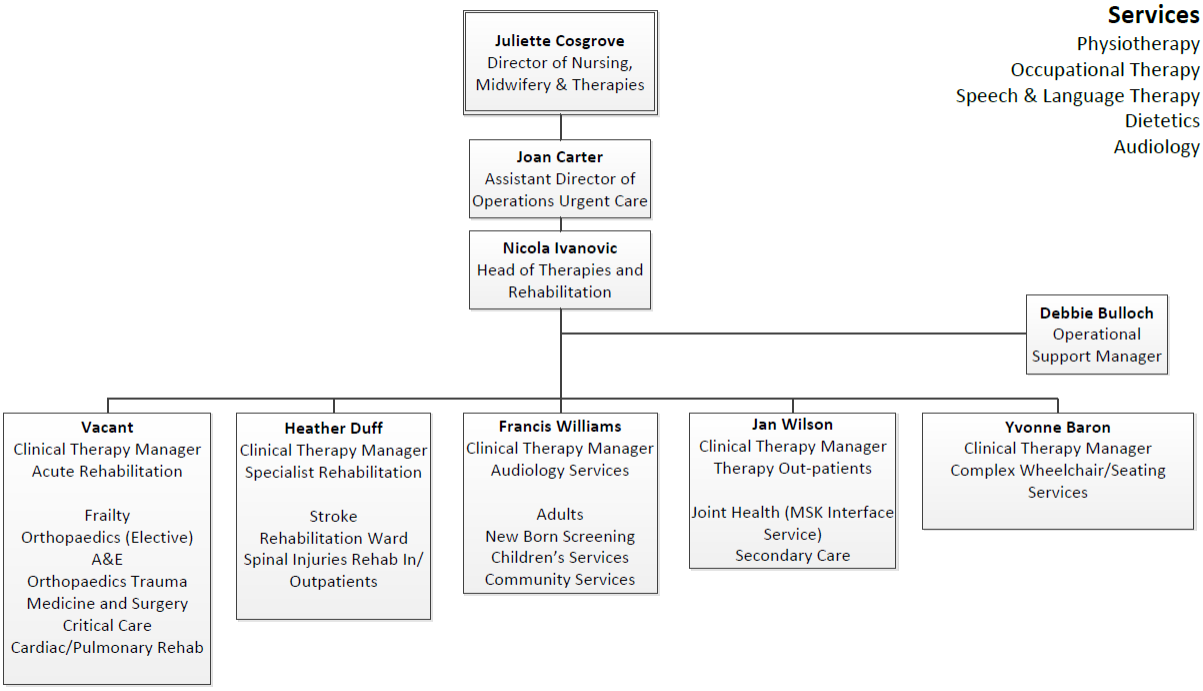


Urgent Care

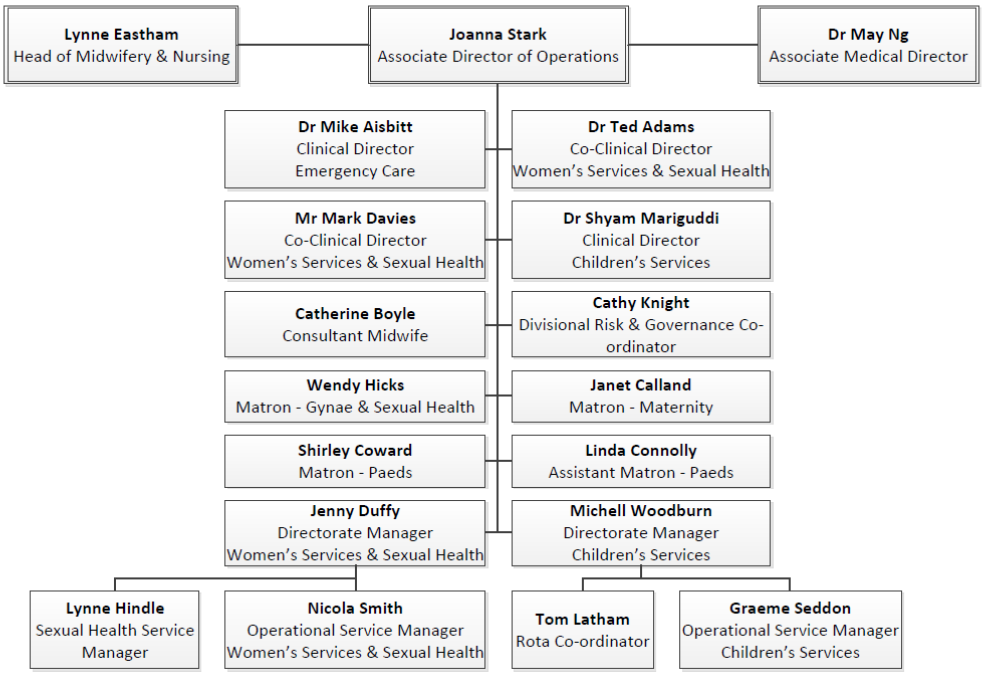

Dr Dave Snow
Associate Medical Director
Joan Carter
Assistant Director of Operations
Dr Patrick McDonald
Lead for Governance
Louise Hicks
Directorate Manager
Gastroenterology
Stroke
Cardiology
Respiratory
Rheumatology
Related Outpatients services
Medicine for the Elderly
Rehabilitation
FESSU
Kate Monaghan
Directorate Manager
Emergency Department
SSU
EAU
GPAU
AEC
Grace Delaney-Segar
Head of Nursing
Nicola Ivanovic
Head of Therapies and Rehabilitation
Sue Elderton
Matron
Medicine
9A
9B
11B
15B
Sheena Walker
Matron
Medicine
7A
7B
14B
15A
MDU
Jane Lawson
Matron
AED
EAU
ACU
CDU
Obs ward
HALT
DVT Team
Alison Gallie-Daly
Patient Safety Manager
Laura Gwynne
Risk and Governance Officer

Therapy & Rehabilitation Services

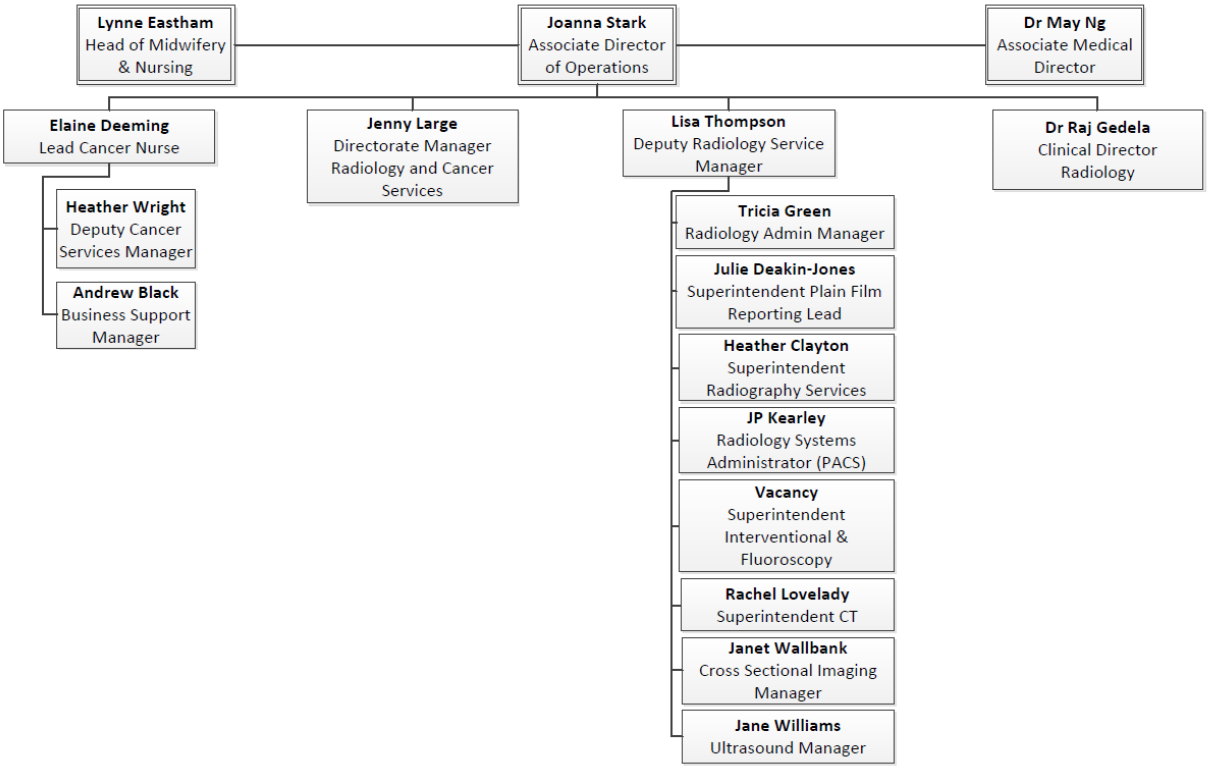
Physiotherapy
Occupational Therapy
Speech & Language Therapy
Dietetics
Audiology



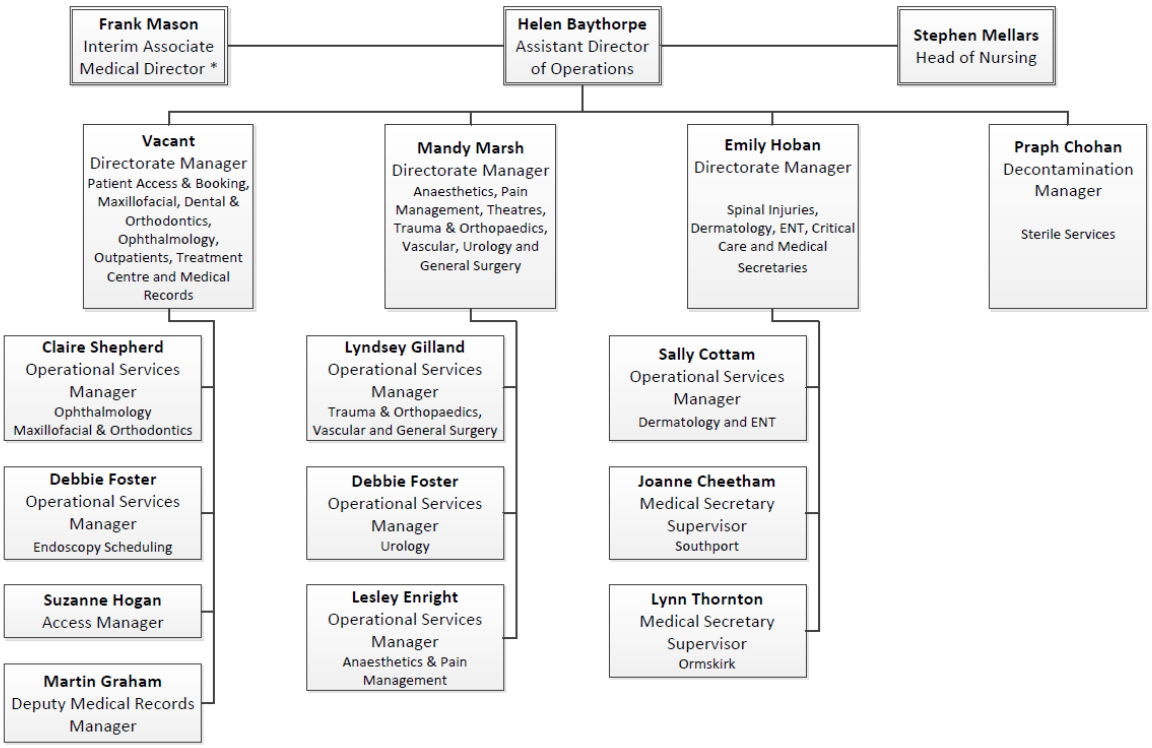
Specialist Services
Women's & Children's



Specialist Services

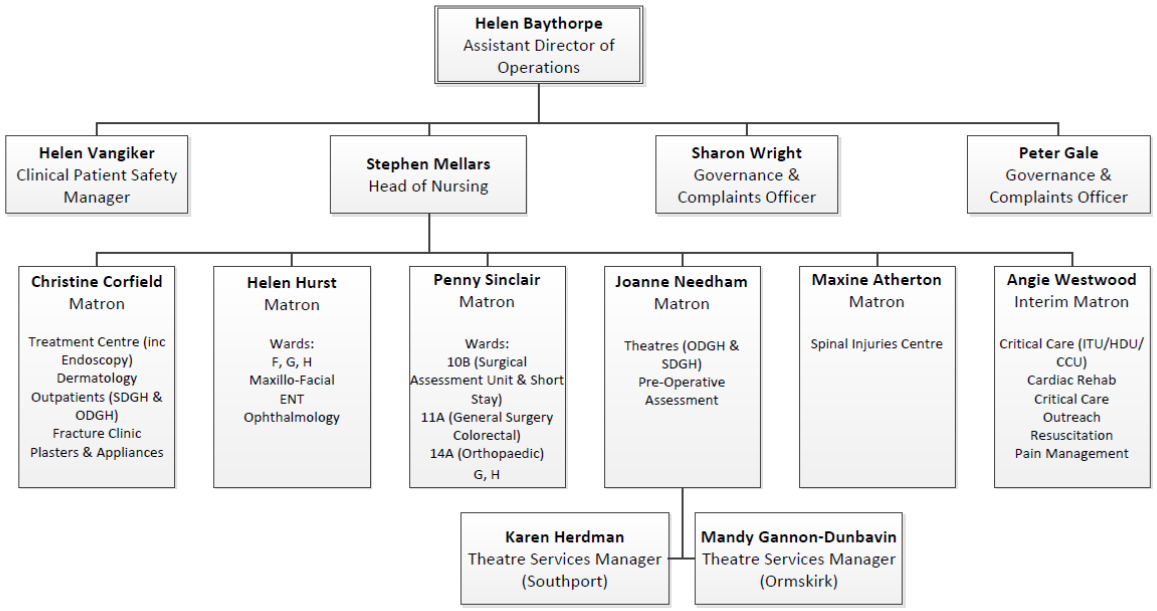


Planned Care

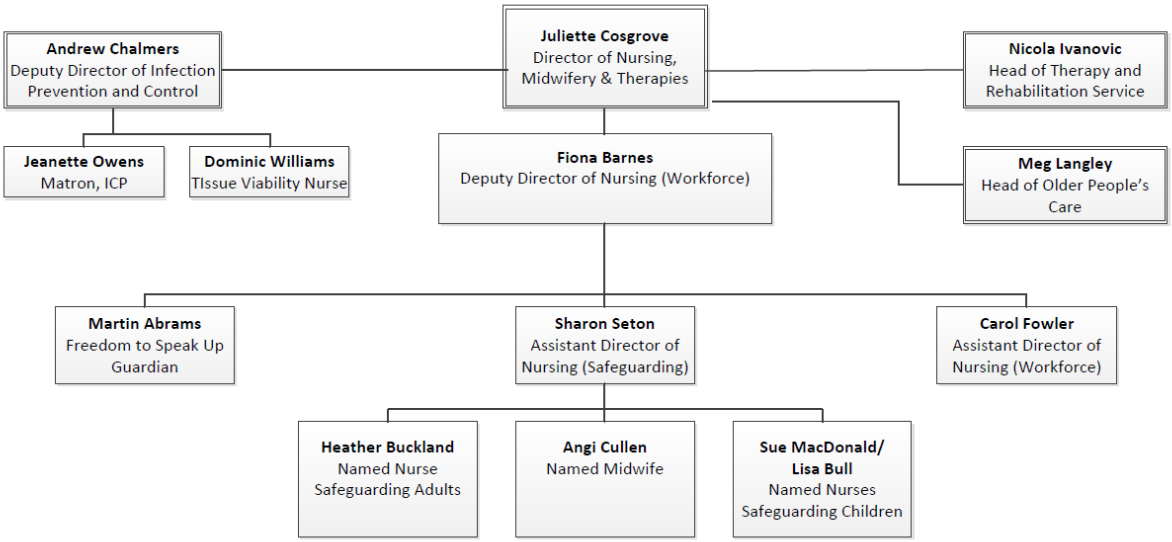


* For Clinical Directors, see Medical Management Arrangements chart

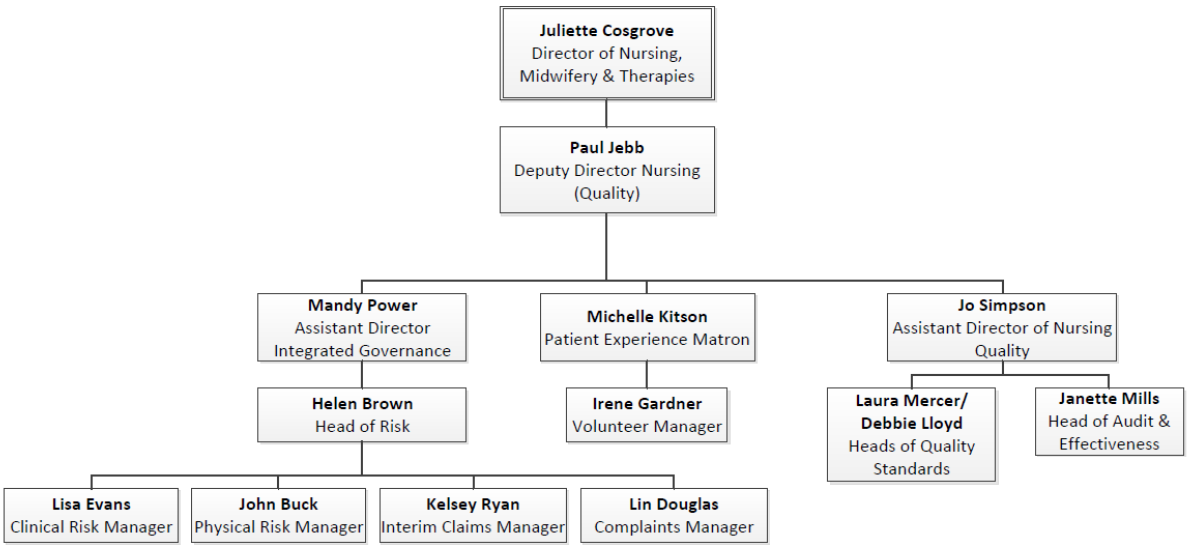
Planned Care (continued)



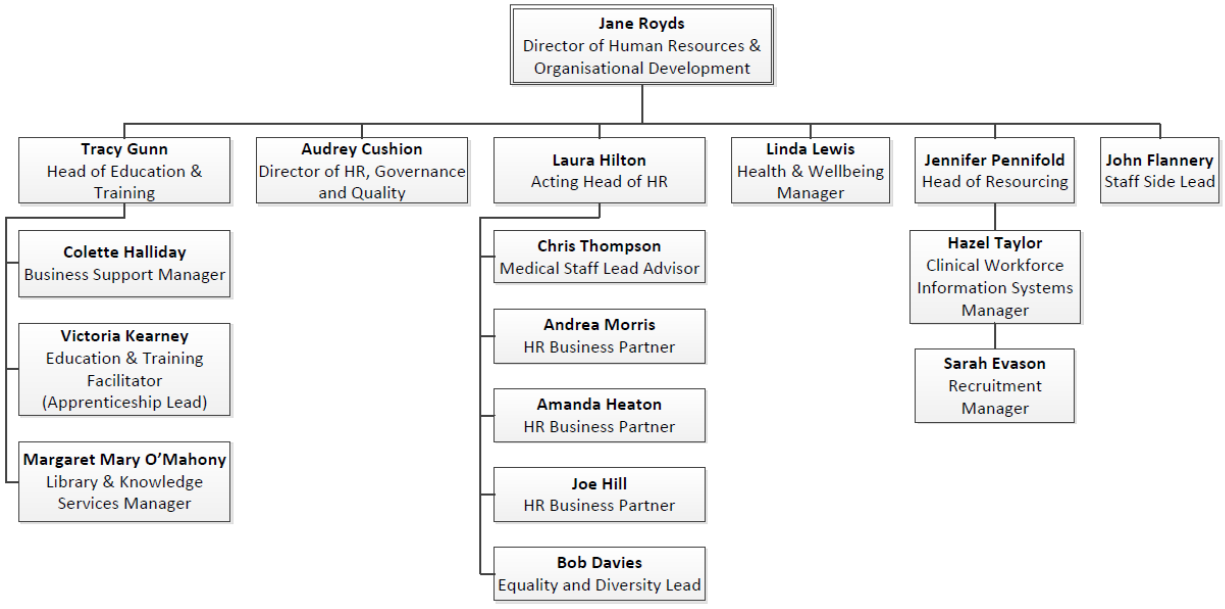
Nursing, Midwifery, Therapies & Governance



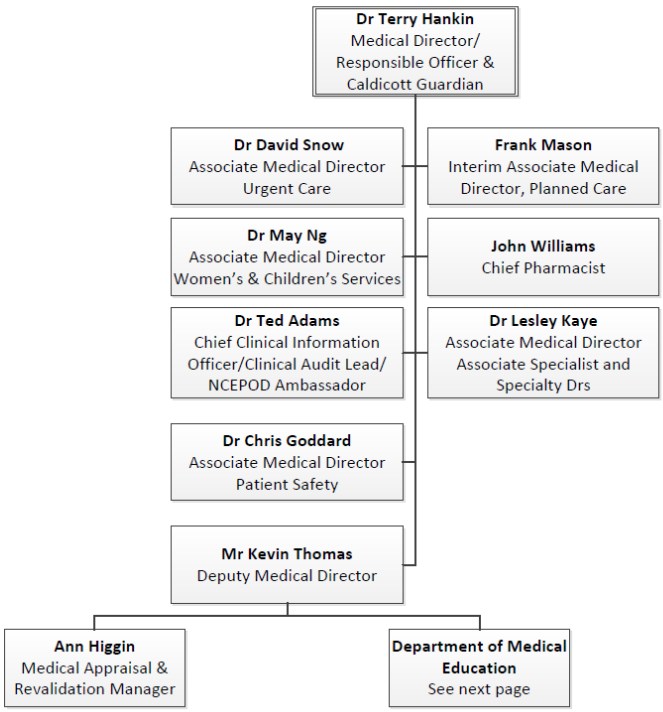
Quality & Integrated Governance



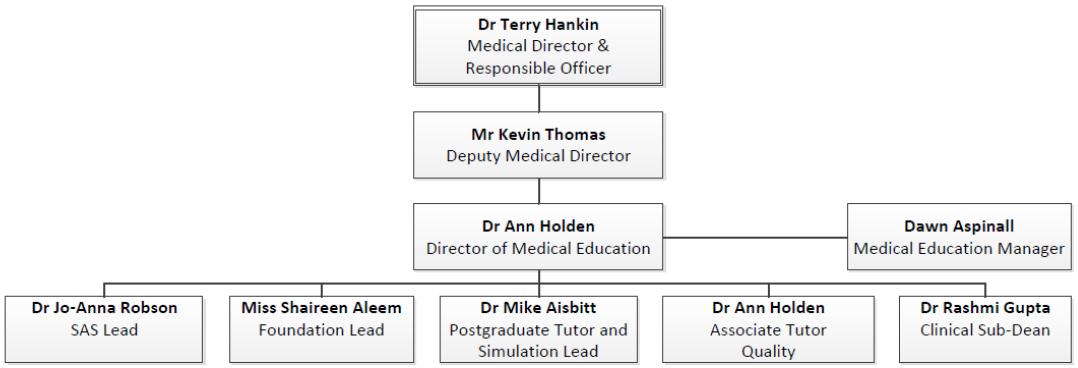
HR, Health & Wellbeing, Education & Training



Medical Director/Responsible Officer/ Caldicott Guardian



Department of Medical Education



Southport and Ormskirk Hospital NHS Trust

Standing Orders 2019/20

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 or equivalent	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 Financial Instructions	(SFIs) regulate the conduct of the Trust's financial matters
Standing	(SOs) regulate the business conduct of the Trust

Term	Definition
Orders	
Scheme of Reservation & Delegation	**(**SORD**)** powers the Board reserves for itself and those delegated to committees and officers
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 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 or equivalent 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 or equivalent).

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[2].

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 and Social Care.

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:

- *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*

[2] 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 Fit and Proper Persons' Regulations*
- *The Fit and Proper Persons' Policy and Procedure*

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 or equivalent 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 Counter Fraud Authority 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 or equivalent 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 Social Care 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

2.4.1 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.

2.4.2 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.*

2.4.3 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.

2.4.4 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 or equivalent

2.7.1 The Trust shall appoint a Remuneration and 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 or equivalent 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.

(f) Anyone who has failed the fit and proper persons test as set out in Schedule 5 of the Fit and Proper Persons' Regulations

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 or equivalent

2.11.8.1 The Company Secretary or equivalent 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 or equivalent 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 or equivalent 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 (Operational 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 Media – The public and representatives of the Media 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 Media 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 or equivalent 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 or equivalent 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 or equivalent 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 or equivalent 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 or equivalent 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 or equivalent 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 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 at least one of which 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 and the Company Secretary or equivalent 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 as assurance committees 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, risk management and mortality and morbidity. The Committee will be chaired by a Non-Executive Member.

5.8.7 Workforce 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.

5.9 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
- Anti-fraud, Bribery and Corruption Policy
- 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 and Social Care.

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 or equivalent.

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 or equivalent 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 they or 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 or equivalent 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 or equivalent 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 or equivalent 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 or equivalent 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 or equivalent, 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 or equivalent 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 Scheme of Reservation and 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 Reservation and 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 or equivalent 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 or equivalent, Corporate Management Office, Southport Hospital, Town Lane, Kew, Southport, PR8 6PN.

9.2 The Company Secretary or equivalent 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.

9. Scheme of Reservation & Delegation

NHS
Southport and Ormskirk Hospital
NHS Trust

Scheme of Reservation and Delegation 2019/20

CONTENTS

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 *Scheme of Reservation and Delegation* outlines the decisions reserved for the Board and those delegated to Committees and officers.

1.5 The formal *Scheme of Reservation and 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 Reservation and Delegation* is to empower Directors, and those managers who have been given authority to act on their Directors' 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 assurance 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*
- *Fit and Proper Persons' Regulations*
- *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 Officers 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 than four weeks during which they cannot be contacted.

5. Scheme of Reservation and Delegation

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*, Standing Financial Instructions and 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 & Nominations 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

The Board of Directors has reserved the following powers unto itself:

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 and officers.

5.4.6 **Receiving the declaration of Board members' interests which may conflict with those of the Trust's business 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 assurance and statutory Committees 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 approve 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 in a transparent and honest way to avoid collusion and corruption.

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

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.

Dismissals

5.5.5 The dismissal of Executive Directors and the Company Secretary or equivalent.

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 Ensure there is 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 Reservation and 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 Reservation and Delegation only covers matters delegated by the Board to the Chief Executive and by the Chief Executive to the Executive Directors and Company Secretary or equivalent, as well as specific matters set out in the *Standing Orders and Standing Financial Instructions.*

7.0 Relationship of the Scheme of Reservation and Delegation to Organisational Structure

7.1 Each Director is responsible for the delegation within their Directorate and should produce a *Directorate Scheme of Reservation and Delegation* to this effect.

7.2 The *Directorate Scheme of Reservation and Delegation* should be aligned to the *Operational Scheme of Reservation and Delegation* regarding financial matters set out in **10.9.**

8.0 Scheme of Reservation and 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 or equivalent	Maintain a Register of members' and other officers' Interests.
8.1 and 8.3	Company Secretary or equivalent	Keep the Trust Seal in a safe place and maintain a register of sealings.
8.4.1	Chief Executive / Executive Members / Company Secretary or equivalent	Approve and sign all documents which will be necessary in legal proceedings.
8.4.3	Chief Executive / Executive Members / Company Secretary or equivalent	Sign on behalf of the Trust any agreement or document not requested to be executed as a deed.
9.1	Company Secretary or equivalent	Accept service of all legal proceedings on behalf of the Trust via a *Freedom to Engage Process*
9.2	Company Secretary or equivalent	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 Reservation and 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 in line with the requirements 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 or equivalent	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 and Company Secretary or equivalent.
10.4	Director of Finance and Director of HR & OD	Appropriate processing of payroll.
10.5	Director of HR & OD	Responsible for ensuring all officers have a contract of employment.
10.8.7	Director of HR & OD	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	Maintenance of asset registers, including the register of

	Finance	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 of 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 or equivalent	Ensure all staff are aware of the Trust's Policy for the Standard of *Business Conduct and Managing Conflict of Interest Policy.*
19.2	Company Secretary or equivalent	Maintain a Register of Gifts and Hospitality and Sponsorships.
19.3	Company Secretary or equivalent	Fulfil the responsibilities of the Trust's Data Protection Officer
20	Chief Executive/ Company Secretary or equivalent	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.

20.1.2	Director of Finance	Responsible for the accuracy and security of computerised financial data.
21.1.13	Director of HR & OD	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 or equivalent	All insurance arrangements and liaison with NHS Resolution.
24.5.3	Company Secretary or equivalent	Authorise all spend on external legal advice.

10. Operational Scheme of Reservation and 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 five Directors, (one of which is the chief Executive), who are classified as *Executive Directors*. Two others, the Chief Operating Officer and the Director of Human Resources & Organisational Development are Directors but has no voting rights on the Board. The officers are personally responsible to the Chief Executive for their 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 their Unit. Ultimate budgetary responsibility, however, remains with the respective Executive Directors.

10.4 Executive Directors 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 Reservation and Delegation*, which should be effectively maintained and reviewed on an annual basis.

10.5 The *Directorate Scheme of Reservation and Delegation* must be aligned to the *Operational Scheme of Reservation and Delegation* set out in 10.9.

10.6 By exception and in accordance with the locally developed *Directorate Scheme of Reservation and 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 Reservation and Delegation* must be approved by the Chief Executive.

10.9 Operational Scheme of Reservation and 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	Executive Director
• 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-non pay only:	
• Transfers between budgets within one area of responsibility	Budget Manager
• Transfers between budgets beyond area of responsibility but within Directorates	Executive Director
• Transfers between Directorate Allocations	Director of Finance and Chief Executive

2. Budget setting and monitoring • Agreeing budgetary allocations including savings and efficiency targets • Monitoring of budgetary performance • Performance delivery framework	Trust Board Director of Finance Director of Finance escalated to Chief Executive
3.Maintenance/Operation of Bank Accounts Managing banking arrangements Operation of bank accounts Local commercial bank account With (BACS and cheque payments) Setting up direct debits/ Standing orders limits Use of the corporate credit card (held by Director of Finance)	Director of Finance Assistant Director of Finance/Deputy Financial Accountant Director of Finance (managed in accordance Bank mandate limits) Assistant Director of Finance/Deputy Financial Accountant (in accordance with Bank mandate) 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 £499 • All requisitions from £500 to £9,999 • All requisitions from £10k to £49,999 • All requisitions from £50k to £499,999 total cost • Requisitions above £500,000 ** For operational purposes, the Director of Finance has a £10m approval limit on	Authorised budget signatory Budget Manager or Delegated Budget Manager Executive Director Chief Executive or Director of Finance Trust Board approval

the finance system. However, approvals above the DoF limit of £500k are subject to 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	
c) Subsequent variations to contract:	Chief Executive and Director of Finance
• With a value not exceeding £99,999	
• With a value exceeding £100k up to £0.5m per annum	Executive Director or Director of Finance
d) Purchase order approval (including pharmacy) Up to £10,000	Director of Finance or Chief Executive
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 cash flow 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 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	Facilities Manager, Technical Services or Deputy CEO/Director of Strategy
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.*	Executive Director via Procurement
c) Obtaining competitive tenders over EU limit (please check relevant EU threshold for goods or services as these are regularly revised). *These must be advertised through OJEU and Contracts Finder or obtained via an accessible framework.*	Executive Director 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 or equivalent
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	Assistant Director of Finance/ Deputy 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 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 Assistant Director of Finance/Deputy Financial Accountant
7. Charitable Fund approvals Up to £5,000 Up to £20,000 Over £20,000	Director of Finance Chair of Charitable Fund Committee Trust Board acting as Corporate Trustee
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
9. 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	Executive Director in line with delegated financial limits Company Secretary or equivalent [in their absence, Chief Executive, Director of Finance, Director of Nursing, Midwifery & Therapies and Director of Human Resources & Organisational Development**]** Executive Director with Director of

	Finance and current regulator
10. 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 e) Granting of use of Trust property under license	 Director of Finance Director of Finance Director of Finance Chief Executive Director of Finance
11. 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 b) with current/estimated value >£100 up to £4,999 as determined by the budget holder c) with current/estimated value >£5k as determined by the budget holder 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 d) disposal of mechanical and engineering plant and all equipment (subject to estimated income	 Delegated budget holder Executive Director Director of Finance Director of Finance Director of Finance

exceeding £5k per sale) as determined by budget holder e)	
12. 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 b) Fruitless payments (including abandoned capital schemes) up to £49,999: • Less than £4,999 • £5k to £49,999 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 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 e) Compensation payments made under legal obligation: • Less than £4,999 • £5k to £49,999 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 Director of Finance or Deputy Director of Finance Chief Executive or Director of Finance Director of Finance or Deputy Director of Finance Chief Executive or Director of Finance Director of Finance or Deputy Director of Finance Chief Executive or Director of Finance Director of Finance or Deputy Director of Finance Chief Executive or Director of

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 h) Other: • Less than £4,999 • More than £5,000	Finance Director of Finance or Deputy Director of Finance Chief Executive or Director of Finance Executive Director Director of Finance or Deputy Director of Finance Chief Executive or Director of Finance Director of Finance or Deputy Director of Finance Chief Executive or Director of Finance
13. Reporting of Incidents to the Police a) Fraud b) Other	 Company Secretary or equivalent /Director of Finance/ Executive Directors
14. Petty Cash Disbursements (through central cashiers office at each site) Expenditure up to £50	 Budget Manager or Delegated Budget Manager
15. Implementation of Internal and External Audit Recommendations	Director of Finance/ Company Secretary or equivalent and Lead Executive, monitored by the Audit Committee
16. Maintenance and Update of Trust Financial Procedures	Director of Finance
17. Investment of Funds (including charitable and endowment funds) a) Exchequer b) Funds held on Trust	 Director of Finance Charitable Trustees (Board of Directors)
18. External Borrowing	

Advise Trust Board of the requirements to repay / draw down Public Dividend Capital.	Director of Finance
Application for draw down of Public Dividend Capital, overdrafts, DH loans and other forms of External borrowing.	Trust Board
19. Personnel & Pay	
a) Authority to fill funded post to the establishment with permanent staff.	Budget Manager or Delegated Budget Manager for Band 5 nurses- all other posts must have Executive Directors' approval via PAG
b) Authority to alter funded establishment:	
• Additional staff to the agreed establishment with specifically allocated finance	Executive Director
• Additional staff to the agreed establishment without specifically allocated finance	Executive Director
c) Additional increments:	
• The granting of additional increments to staff within budget where acting up	Executive Director
• The granting of additional increments to staff within budget on permanent basis	Executive Director, 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 Executive Director
f) Pay:	
• Authority to complete standing data forms effecting pay, new starters, variations and leavers	Budget Manager or Delegated Budget Manager
• Authority to authorize overtime	Budget Manager or Delegated Budget Manager
• Authority to authorize travel and subsistence expenditure	Budget Manager or Delegated Budget Manager
• Authority to agree local pay uplifts including allowances that form part of pay	Budget Manager or Delegated Budget Manager
g) Redundancy/early retirement:	
• Chief Executive or Executive Director	

• Other member of staff	Associate Director of HR Remuneration Committee Chief Executive and Director of HR
20. Authorisation of New Drugs a) Drugs approved by Medicines and Therapeutic Committee b) Research/clinical trials: • Ethical approval • Funding	 Executive Director and Associate Medical Directors Medicines and Therapeutics Committee Executive Director and Associate Medical Directors
21. Authorisation of Sponsorship Deals	Company Secretary or equivalent [In accordance with Standards of Business Conduct and Managing Conflict of Interest Policy]
22. Authorisation of Research Projects	Director of Nursing, Midwifery & Therapies
23. Authorisation of Clinical Trials	Medical Director
24. 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 or equivalent /All Executive Directors/ Associate Medical Directors/ Heads of Nursing and Associate Directors of Operations
25. Insurance Policies • Medico-legal • All other insurance	 Company Secretary or equivalent Company Secretary or equivalent
26. Management of Incidents, Serious Untoward Incidents, Complaints, Concerns and Claims	

Incidents a) Overall responsibility for ensuring that systems and processes are in place to report and respond to incidents and SUIs	Director of Nursing, Midwifery & Therapies
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	All Executive Directors, Associate Medical Directors, Heads of Nursing and Associate Directors of Operations
Complaints / Concerns a) Overall responsibility for ensuring that all complaints and concerns are dealt with effectively	Director of Nursing, Midwifery & Therapies
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	All Executive Directors, Associate Medical Directors, Heads of Nursing and Associate Directors of Operations
Claims a) Responsibility for ensuring that claims are dealt with effectively and within accordance with agreed procedures and timescales	Company Secretary or equivalent
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 or equivalent /All Executive Directors, Associate Medical Directors, Heads of Nursing and Associate Directors of Operations
27. Media Relations a) Within working hours b) Out of hours	Head of Communications and Marketing On-Call Director / Head of Communications and Marketing
28. Infectious Diseases and Notifiable Outbreaks	Medical Director or Control of Infection Doctor
29. Facilities for staff not employed by the Trust to gain practice experience	

and/or to provide services	
a) Clinical staff	Director of Nursing, Midwifery & Therapies or Medical Director
b) Other staff	Appropriate Executive Director
30. Review of Fire Precautions (Nominated Fire Officer)	Director of Finance
31. Review of Medicines Inspectorate regulations	Chief Pharmacist
32. Review of compliance with environmental regulations	Director of Finance
33. Information Governance	Senior Information Risk Officer/Data Protection Officer (DPO)
34. Declarations of Interest Register, including Gifts and Hospitality and Sponsorships	Company Secretary or equivalent
35. Attestation of Sealings in accordance with the Standing Orders, including the keeping of the Register of Sealings	Company Secretary or equivalent
36. Retention of Records	
a) clinical	Chief Operating Officer
b) financial	Director of Finance
c) other	Executive Directors and Company Secretary or equivalent
d) Retention and Management of Policy	Company Secretary or equivalent
37. Caldicott Guardian	Medical Director
38. Audit and Quality, including implementation of NICE guidance	Director of Nursing, Midwifery & Therapies
39. Use of borrowing as financing mechanism	Trust Board
40. Intellectual Property	
a) Approval of license agreements	Chief Executive and Director of Finance

b) Material changes to IP policy c) Departure from inventor reward in IP policy	Trust Board Executive Team
41. Compliance with the requirements of the Civil Contingencies Act	Trust Board
42. Approval of creating, selling or ceasing joint ventures	Trust Board
43. Director of Infection Prevention and Control	Medical Director

Standing Financial Instructions 2019/20

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 Financial Instructions	(SFIs) regulate the conduct of the Trusts financial matters
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) 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 wishes to raise, the Chair of the Audit Committee should raise the matter with the Director of Finance in the first instance or at a full meeting of the Board of Directors if still required.

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 in conjunction with the Audit Committee, ©-Updated to read: "is responsible for:-day to day

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 after they have been scrutinised by the Finance, Performance & Investment Committee, 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 Board of Directors on the recommendation of the Audit Committee. 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 stated in 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 a number of issues which may involve:

- 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;

.

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 and Nominations Committee

10.1.1 In accordance with Standing Orders, the Board shall establish a Remuneration and Nominations 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 consider 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 be asked to 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 Director of Human Resources and Organisational Development and Organisational Development 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 Director of Human Resources and Organisational Development and Organisational Development will issue instructions regarding:

a) verification and documentation of data;

b) the timetable for receipt and preparation of payroll data and the payment of employees and allowances;

c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

d) security and confidentiality of payroll information;

e) checks to be applied to completed payroll before and after payment;

f) authority to release payroll data under the provisions of the Data Protection Act;

g) methods of payment available to various categories of employee; 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 Director of Human Resources and Organisational Development and Organisational Development 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 Director of Human Resources and Organisational Development must be informed immediately. In circumstances where fraud might be expected this must be reported to the Director of Finance.

10.4.5 Regardless of the arrangements for providing the payroll service, the Director of Human Resources and Organisational Development 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 Director of Human Resources and Organisational Development 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 Director of Human Resources and Organisational Development.

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 Her Majesty's Revenue & Customs (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 Director of Human Resources and Organisational Development 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 Unless specific arrangements have been made, 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) Where 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 legal 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

12.1Public 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.

12.2Investment

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

13.1Introduction

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 Capital schemes with a total value of less than £25,000 should be managed according to normal Procurement rules (3 quotes, electronic requisition to the Deputy Financial Accountant, Purchase Order raised)

13.3.2 Capital schemes exceeding £25,000 must follow Procurement rules and go out to formal tender. The Project Manager has the authority to raise stage payment certificates for the main contractor appointed.

13.3.3 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.

13.3.4 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.

13.3.5 Where the total value of a capital scheme exceeds £500,000, it is mandatory to appoint a Project Board to oversee the project. The Project Board will include representatives from Estates, Procurement, Finance, Risk, Control of Infection, IT and main contractor.

13.3.6 The Project Manager will report to the Project Board on a regular basis. The Project Manager must provide forecast outturn figures to the Project Board at each meeting. If an over spend is predicted then this must be brought to the attention of the Capital Investment Group (CIG) and approval sought for further expenditure with an explanation of why additional funds are required.

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 Deputy Financial Accountant. Projects will have a small, and less formal, Project Board to oversee, control and monitor the project.

13.4.2 Larger IT projects will have a Project Manager who will report to a Project Board on a regular basis. Purchasing controls as above will apply - requisition, purchase order authorisation and monthly monitoring with the Deputy Financial Accountant.

13.4.3 The Project Manager must provide forecast outturn figures to the Project Board at each meeting. If an over-spend is predicted then this must be brought to the attention of CIG.

13.4.3 A detailed explanation of why additional capital funding is needed must be provided to CIG.

13.5 Medical Equipment

13.5.1 CIG determines the overall capital plan each year which then goes to Trust Board for final approval.

13.5.2 The plan includes an allocation for Medical Equipment. Not all the equipment required in the year will be known at the planning stage and clinical areas need to complete a case of need to apply for capital funding.

13.5.3 The case of need must include the following:

- Details of Medical equipment required, including VAT inclusive cost and copies of any quotes obtained.
- An explanation of why the equipment is required
- Risk rating
- Clinical impact
- Details of any ongoing revenue consequences

13.5.4 Clinical areas will be invited to present their case at CIG.

13.5.5 Once capital funding has been approved, purchasing will follow the normal controls of an electronic requisition to the Deputy Financial Accountant.

13.5.6 Business cases go to the Business Development & Investment Sub-Committee (BDISC). However BDISC can only make decisions on revenue expenditure. If an approved business case has an element of capital funding then it must also go to CIG for the approval of the capital element.

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 Group Accounting Manual as issued by the Department of Health & Social Care.

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 Land and buildings assets are revalued annually by independent surveyors. Equipment and intangible assets are reviewed for signs of impairment. The value of each asset will be adjusted to current values in accordance with methods specified in the Group Accounting Manual issued by the Department of Health & Social Care.

13.7.8 The value of each asset shall be depreciated using methods and rates as specified in the Group Accounting Manual as issued by the Department of Health & Social Care.

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 & Social Care.

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 Company Secretary or equivalent is responsible 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 **<u>may be waived</u>** 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.

16.4.3 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.

16.4.4 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.

16.4.5 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 Expressions of Interest/Invitations to Tender:

Expressions of interest shall be invited via the OJEU website or Contracts Finder, the national advertising portal services for healthcare services should the appropriate value be met or no applicable Framework Agreement is sourced.

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.

16.5.3 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.

16.5.4 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.

16.5.5 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.

(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.

16.6 Authorisation of Tenders and Competitive Quotations

16.6.1 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.

16.7 Instances where formal competitive tendering or competitive quotation is not required

16.7.1 Where competitive tendering or a competitive quotation is not required the Trust should adopt one of the following alternatives:

(a) the Trust shall use an appropriate Framework Agreement 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 an appropriate Framework Agreement 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.

16.8 Private Finance for capital procurement

16.8.1 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.

16.9 Compliance requirements for all contracts

16.9.1 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.

16.10 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.

16.11 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).

16.12 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.

16.13 In-house Services

16.13.1 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.

16.13.2 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.

16.13.3 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.

16.13.4 The evaluation team shall make recommendations to the Board of Directors.

16.13.5 The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.

16.14 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, budget setting, 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 to enable computer operations to be 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 and other 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 himself that:

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

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

c) 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, including risk appetite 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 or equivalent.

11. Terms of Reference for the Board, Statutory, Assurance and other Key Committees and Groups

Southport and Ormskirk Hospital NHS Trust

Board of Directors
Terms of Reference Document Control Sheet

MEETING	Board of Directors
ESTABLISHED BY /REPORTING TO:	Board of Directors
Author:	Audley Charles - Company Secretary
Review:	December 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 ToR - Jun 19
File Name	\\datamart1\shared files\Company Secretarial\18. TERMS OF REFERENCE (COMMITTEES)\ Board of Directors ToR - Jun 19
Version/Revision Number	3.2

Version Control		
Version Ref	**Amendment**	**Date Approved by Trust Board**
V3.1	3.1 Added new governance structure showing reporting arrangements	2019
V3.2	• Added time limited Strategy Committee to Governance Structure • Section 13.1. Updated membership to reflect current position	2019

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 **Diagram 1** below.

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.

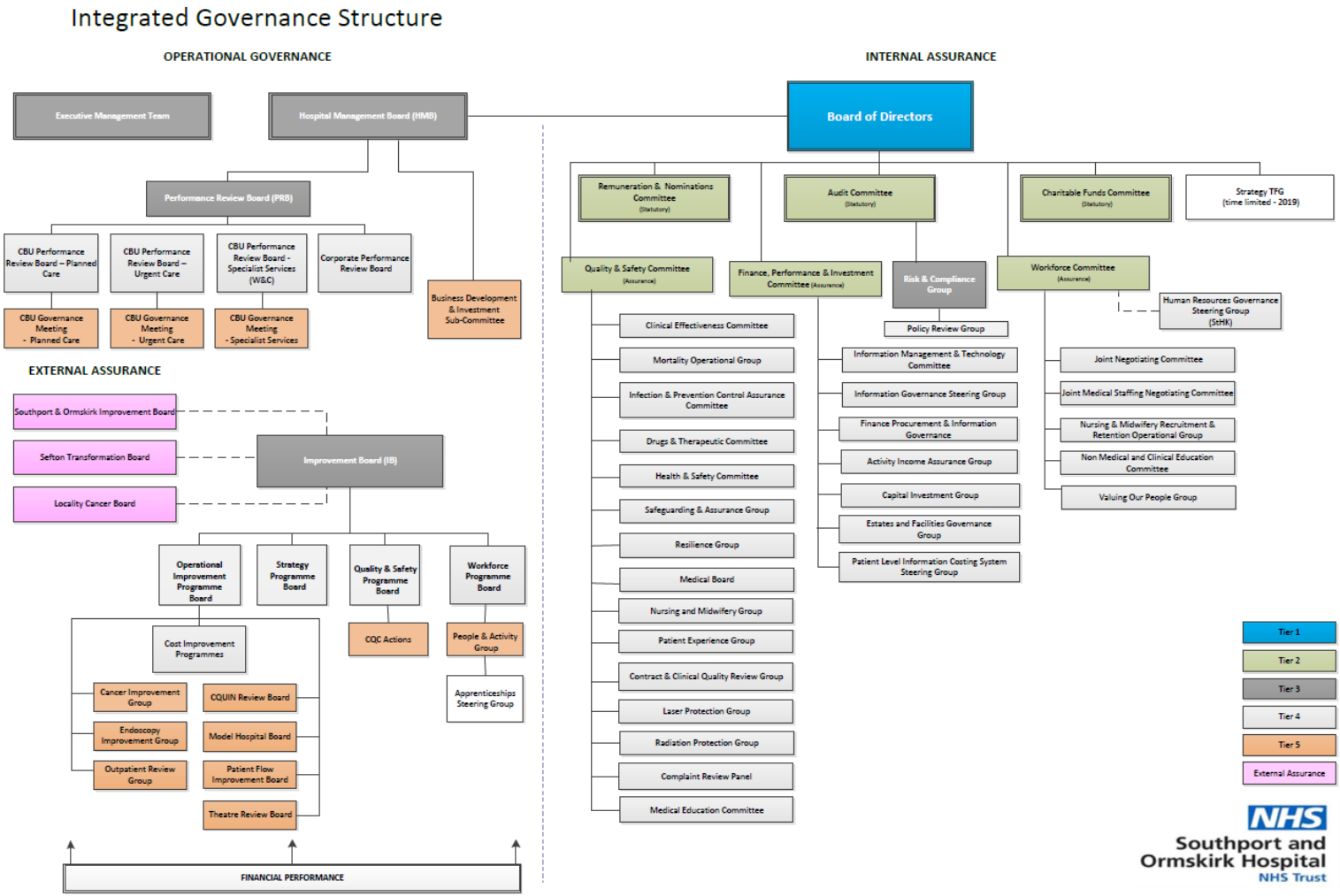
2.4 The Board leads the Trust by undertaking five (5) key responsibilities:

- *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.

Diagram 1. The relationship between the Board and other Trust committees.



3. **Role and Purpose**

3.1 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.'

3.2 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.*

3.3 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.

3.4 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*.

3.5 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.

3.6 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.

4. **General Responsibilities**

4.1 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 5 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
- Deputy Chief Executive/Director of Strategy
- Director of Finance
- Director of Nursing, Midwifery & Therapies
- 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, if applicable, shall chair the meeting; if there is not a named Deputy, the Chair shall nominate a Deputy or 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 once annually.

Approved by:

Date of approval:

Date for review:

Southport and Ormskirk Hospital NHS Trust

Audit Committee
Terms of Reference Document Control Sheet

MEETING	Audit Committee
ESTABLISHED BY/REPORTING TO:	Trust Board
Reviewer	Audley Charles – Company Secretary
REVIEW	December 2019
ASSOCIATED DOCUMENTS	Standing Orders Standard Financial Instructions Scheme of Reservation and Delegation Risk Management Strategy Corporate Risk Register Board Assurance Framework
RELATED Forums/COMMITTEES/GROUPS	Trust Board Quality and Safety Committee Finance, Performance and Investment Committee Remuneration and Nominations Committee Charitable Funds Committee Workforce Committee

Document Control	
Document Name	Audit Committee – Jun 19
File Name	\\datamart1\shared files\Company Secretarial\18. TERMS OF REFERENCE (COMMITTEES)\ Audit Committee – Jun 19
Version/Revision Number	V7.2

Version Control

Version Ref	Amendment	Date Approved
V5.0	All. Sections rearranged so the document runs logically 1.1 Authority strengthened by showing by reference to oversight role and relationship with other statutory and assurance committees. Workforce Committee and Mortality Assurance and Clinical Improvement Committee added 1.2 Removal of *NHS Litigation Authority* and replace with *NHS Resolution*. 1.3 Remove *Whistleblowing* and replace with *Freedom to Speak Up* 1.4 Reference to CEO being called by the Committee	2017

	if it wishes and certainly to present the *Annual Governance Statement* at year end 1.5 Added review of performance and effectiveness twice annually-at mid-year and end of the year	
V6.0	2.1 Added Remuneration and Nominations Committee and Charitable Funds Committee 2.2 Diagram 1 updated to remove MACIC which is subsumed to QSC 2.3 Removal of *Mortality Assurance and Clinical Improvement Committee*	2018
V7.0	3.1 Added new governance structure showing reporting arrangements 3.2 (c) Showing reports received from Risk and Compliance Group 3.3 (e) Added report relating to fitness to remain registered with the CQC as recommended by the Audit Committee Handbook 3.4 (f) Added receipt of Sustainability & Transformation Partnership Dashboard as recommended by the Audit Committee Handbook 3.5 (g) Added receipt of Quarterly Clinical Audit Progress Report as recommended by the Audit Committee Handbook 3.6 (h) Changed *Secretary of State for Health* to *Secretary of State for Health and Social Care* and changed Counter Fraud to Anti-Fraud 3.7 External Audit (h) Changed *Those Charged with Governance* to *Audit Completion Report*	
V7.1	Added new governance structure showing reporting arrangements	2019
V7.2	• Added time limited Strategy Committee to Governance Structure • Added at 2.2 (j) ' Claims & Litigation Activities' • Updated membership to read 4 NEDs	2019

Terms of Reference of the Audit Committee

1 Authority

1.1 The Trust Board hereby resolves to establish a Committee to be known as the Audit Committee (the Committee) to carry out the duties set out at Clause 6 of these Terms of Reference. The Committee is a statutory committee of the Board and has no executive powers, other than those limited to these Terms of Reference.

1.2 The Audit Committee provides an 'oversight' role on behalf of the Board, reviewing the adequacy and effectiveness of controls. It is supported by the Quality and Safety Committee, Finance and Performance and Investment Committee, Workforce Committee (assurance committees), Remuneration and Nominations Committee and Charitable Funds Committee (statutory committees) which carry out their duties in reviewing systems of control and governance in relation to all matters of clinical quality and safety, financial control and investment and workforce and organisational development. See **Diagram 1.**

1.3 The Committee has the delegated authority to:

a) Investigate any activity within its Terms of Reference. It can request information, reports, and assurances from any employee in relation to those areas within these Terms of Reference and all employees are directed to co-operate with any request made by the Committee.

b) Obtain within the limits set out in the Trust's *Scheme of Delegation*, outside legal or other independent professional advice on any matter within its terms of reference and to secure the attendance of external persons with relevant experience and expertise if it considers this necessary

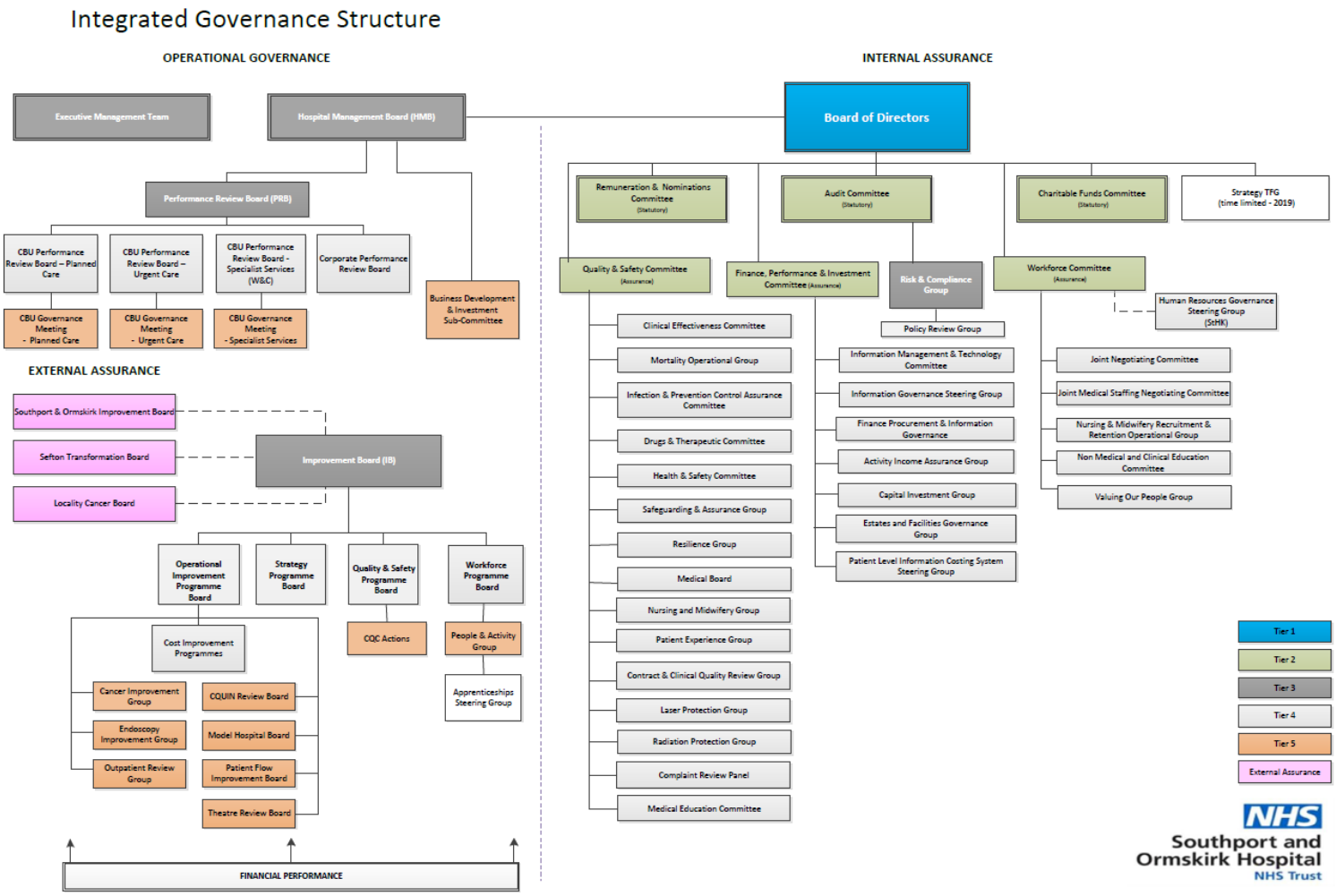
1.4 The Committee operates within the Trust's Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation.

1.5 Any changes to these Terms of Reference must be approved by the Trust Board.

2 Purpose and Duties

2.1 The Committee is established to critically review governance and assurance processes on which the Board places reliance. In particular, this requires the Audit Committee to understand and scrutinise the Trust's overarching framework of governance, risk and control. Its role is to satisfy itself that the same level of scrutiny and independent audit over controls and assurances is applied across all of the Trust's activities. These should be set out in an Annual Business Cycle.

Diagram 1. The relationship between the Audit Committee, the Board and other Trust committees.



2.2 The duties of the Committee are categorised as follows:

In order to achieve its purpose the duties of the Committee are:

Governance, risk management and internal control:

The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (clinical and non-clinical), that supports the achievement of the organisation's objectives.

In particular the Committee will review the adequacy and effectiveness of:

a) All risk and control related disclosure statements (in particular the *Annual Governance Statement*), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to submission to the Board.
b) The underlying assurance processes that indicate the degree of achievement of corporate objectives, for example progress reports against delivery of the Annual Plan, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.
c) The Committee will receive quarterly reports from the Risk and Compliance Group and an Annual Report
d) The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification
e) Fitness to remain registered with the Care Quality Commission
f) Receive the Sustainability & Transformation Partnership Dashboard
g) A quarterly Clinical Audit Progress Report
h) The policies and procedures for all work related to fraud and corruption as set out in the Secretary of State for Health and Social Care's Directions and as required by NHS Anti-fraud Authority (formerly NHS Protect).
i) Review the Trust's Losses and Special Payments report twice per annum.
j) The Claims & Litigation activities.

In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, including the Chairs of the Board Committees, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

The Committee may also request specific reports from individual functions within the organisation (for example, clinical audit).

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

As part of its integrated approach the Committee will have effective relationships with other key committees (see 1.1 above) so that it understands processes and linkages. However, these other Committees must not usurp the Audit Committee's role.

Internal Audit

The Committee shall ensure that there is an effective internal audit function that meets the mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Accountable Officer and Board. This will be achieved by:

a) Consideration of the provision of internal audit service, the cost of the audit and any questions of resignation and dismissal.
b) Review and approval of the internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework.
c) Considering the major findings of internal audit work (and management's response), and ensuring co-ordination between the internal and external auditors to optimise audit resources.
d) Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation.
e) Monitor the effectiveness of internal audit and carry out an annual review.

External Audit

The Committee shall review and monitor the external auditors' independence and objectivity and the effectiveness of the audit process. The Committee shall review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

a) Consideration of the appointment and performance of the external auditors, as far as the rules governing the appointment permit.
b) Discussion and agreement with the external auditors, before the audit commences, of the nature and scope of the audit as set out in the annual plan
c) Discussion with the external auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee.
d) Review of all external audit reports, including the Audit Completion Report, agreement of the annual audit letter before submission to the Board and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.
e) Ensuring that there is a clear policy in place for the engagement of external auditors to supply non audit services.

Other assurance functions

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

These will include, but will not be limited to, any reviews by Department of Health arm's length bodies or regulators/inspectors (for example, the Care Quality Commission, NHS Resolution, etc.) and professional bodies with responsibility for the performance of staff or functions (for example, Royal Colleges, accreditation bodies, etc.)

In addition, the Committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own scope of work. In particular, this will include the Quality and Safety Committee and, Finance, Performance and Investment Committee. This will be achieved by the consideration of minutes and Assure, Alert, Advise (AAAs) reports submitted from the aforementioned Committees and through common membership.

In reviewing issues around clinical risk management, the Audit Committee will wish to satisfy itself on the assurance that can be gained from the Quality & Safety Committee which has oversight of the clinical audit function that adequate arrangements are in place for undertaking clinical audits and implementing the learning from those reviews.

The Committee will also review the Trust's Losses and Special Payments report twice per annum.

Anti- Fraud

The Committee shall satisfy itself that the organisation has adequate arrangements in place for anti-fraud, corruption and security that meet NHS Protect's standards and shall review the outcomes of work in these areas.

Financial Reporting

The Audit Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance.

The Committee should ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

The Audit Committee shall review the annual report, and financial statements before submission to the Board, focusing particularly on:

a) The wording in the *Annual Governance Statement* and other disclosures relevant to the terms of reference of the Committee.
b) Changes in, and compliance with, accounting policies, practices and estimation techniques.
c) Unadjusted mis-statements in the financial statements.
d) Significant judgements in preparation of the financial statements.
e) Significant adjustments resulting from the audit.
f) Letters of representation.
g) Explanations for significant variances.

Freedom to Speak Up

The Committee shall review the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in financial, clinical or safety matters and ensure that any such concerns are investigated proportionately and independently.

3 Reporting

3.1 The minutes of Audit Committee meetings shall be formally recorded and submitted to the Trust Board**.** The Chair of the Committee shall produce a highlight report Alert, Advise and Assurance (AAAs) to draw the attention of the Trust Board to any issues that require disclosure to the full Board or require executive action.

4 Monitoring Compliance

4.1 Meetings of the Committee shall be conducted in accordance with the provisions of the *Standing Orders, Scheme of Reservation and Delegation* and Standing Financial Instructions approved by the Trust Board.

5 Membership

5.1 The membership of the Committee shall be comprised of four Non-Executive Directors (NEDs). In addition one of the members shall be appointed as Chair of the Committee by the Trust Board.

5.2 The Committee shall be appointed by the Trust Board from amongst its independent non-executive directors and shall consist of not less than three members one of whom shall have relevant recent financial experience. The Chairman of the Trust many not be a member of the Audit Committee.

5.3 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.

6 Attendance

6.1 In addition, other senior specialist officers may attend from time to time to provide specialist advice and support.

6.2 The following persons shall be expected to normally be in attendance at meetings of the committee:

- Director of Finance
- Director of Nursing, Midwifery and Therapies
- Company Secretary
- Internal Audit representative(s) including Anti- Fraud Specialist
- External Audit representative (s)

The Chief Executive may be called by the Committee at any time and certainly to present the Annual Governance Statement when the Annual Report and Accounts are reviewed at the end of the year (usually May).

The Committee shall also meet with the auditors at least once a year or on request of the Chair of the Committee, without management being present; to discuss their remit and raise any issues arising from the Trust's. In addition the Lead Partner of external audit shall be given the right of direct access to the Chair of the Committee and to the Committee members.

7 Quorum

7.1 A quorum will be not less than two members. In order for the decisions of the committee to be valid the meeting must be quorate.

7.2 Members should normally attend meetings, and it is expected that members will attend a minimum of 75% of meetings held per annum.

7.3 Should a member not be able to attend a Committee meeting, apologies in advance must be provided to the Chair. Deputising arrangements must be agreed by the Chair prior to the meeting and any formal acting up status will be recorded in the minutes.

8 Frequency

8.1 The Committee shall meet not less than four times per year; a schedule of pre- arranged meetings will be distributed to all members on an annual basis along with a proposed annual work plan.

8.2 The Board, Accountable Officer (CEO), Chair of the Committee, may arrange extraordinary meetings at his/her discretion or at the request of Committee members.

8.3 The Committee will report to the Board at least annually on its work in support of the *Annual Governance Statement*, specifically commenting on:

- the fitness for purpose of the Assurance Framework
- the completeness and 'embeddedness' of risk management in the organisation
- the integration of governance arrangements
- the appropriateness of the evidence that shows the organisation is fulfilling regulatory requirements relating to its existence as a functioning business
- the robustness of the processes behind the Quality Accounts.

The Annual Report will also describe how the Committee has fulfilled its duties as set out in the terms of reference including progress against its work plan, membership attendance, and give details of any significant issues that the Committee considered in relation to the financial statements and how they were addressed.

The Committee will develop an annual business cycle (work plan) mapping out how the Committee will fulfil its delegated duties. The Committee will also review its performance and effectiveness on an annual basis.

9 Conduct of Meetings

9.1 The agenda and supporting papers will be distributed no less than 4 days in advance of the meeting. Authors of papers must use the required template as set out in the Standard Operating Procedure. Papers must be received by the committee secretary in line with the published deadlines unless, in exceptional circumstances, explicit agreement has been reached with the Committee's Chair (or nominated Deputy).

9.2 The Committee will be supported by the Director of Finance and Company Secretary, whose duties in this respect will include:

- Agreement of the agenda with the Chair and attendees
- Advising the Chair on pertinent issues/areas of interests/policy development
- Helping the Chair prepare reports to the Board
- Enabling the development and training of Committee members
- Facilitating the Committee's review of its own performance and effectiveness
- Facilitating the review of the effectiveness of internal and external audit

9.3 The Personal Assistant to the Company Secretary shall provide administrative support to the meeting and duties will include:

- Formally recording the minutes of the Committee
- Collation and distribution of papers in good time
- Keep a record of matters arising and issues to be carried forward

9.4 Minutes of the meetings and action log will be circulated promptly to all members as soon as reasonably practical. Presenters of papers can expect all committee members to have read the papers and should keep to a summary that outlines the purpose of their paper/report and key issues. Committee members may question the presenter.

10 Reviewing Terms of Reference

10.1 The Terms of Reference of the Committee (including membership) shall be reviewed annually or in light of changes in practice or legislation and approved by the Trust Board**.**

11 Review of Performance and Effectiveness

11.1 The Committee shall undertake a review of its performance and effectiveness at least once annually.

Approved by:

Date of approval:

Date for review:

NHS
Southport and Ormskirk Hospital
NHS Trust

Remuneration and Nominations Committee

Terms of Reference Document Control Sheet

MEETING	**Remuneration and Nominations Committee**
ESTABLISHED BY/REPORTING TO:	Trust Board
Reviewer	Audley Charles – Company Secretary
REVIEW	December 2019
ASSOCIATED DOCUMENTS	Standing Orders Standard Financial Instructions Scheme of Reservation and Delegation Risk Management Strategy Corporate Risk Register Board Assurance Framework
RELATED FORUMS/COMMITTEES/GROUPS	Trust Board Quality and Safety Committee Finance, Performance and Investment Committee Remuneration & Nomination Committee Audit Committee Charitable Funds Committee Workforce Committee

Document Control	
Document Name	RemCom ToR Jun19
File Name	\\datamart1\Shared Files\Company Secretary Remuneration and Nominations Committee\Terms of Reference\ RemCom ToR Jun19
Version/Revision Number	3.2

Version Control

Version Ref	Amendment	Date Approved
V2.0	1.1 Authority strengthened by showing relationship with other statutory and assurance committees.	2017

	1.3 Added AAAs report to the board 1.4 Added that the committee should undertake a review of its performance and effectiveness at least twice annually	
V3.0	2.1 Related Forums/Committees/Groups: removed Mortality Assurance and Clinical Improvement Committee. Added 'and Safety' to Quality Committee; Remuneration & Nomination Committee and Charitable Funds Committee.	2018
V3.1	3.1 Added new governance structure showing reporting arrangements	2019
V3.2	• Added time limited Strategy Committee to Governance Structure	2019

Terms of Reference of the
Remuneration and Nominations Committee

1 Authority

1.1 The Board has established a Committee of the Trust to be known as the Remuneration and Nominations Committee, hereafter referred to within this document as the *Committee.* **See Diagram 1.**

1.2 The Committee has the delegated authority from the Board 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's *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.

1.3 Approved minutes of the Committee are to be circulated to the Board for information at the first formal Board meeting following approval. The Chair of the Committee shall provide an AAAs Highlight report on key issues to the Board at the Board meeting.

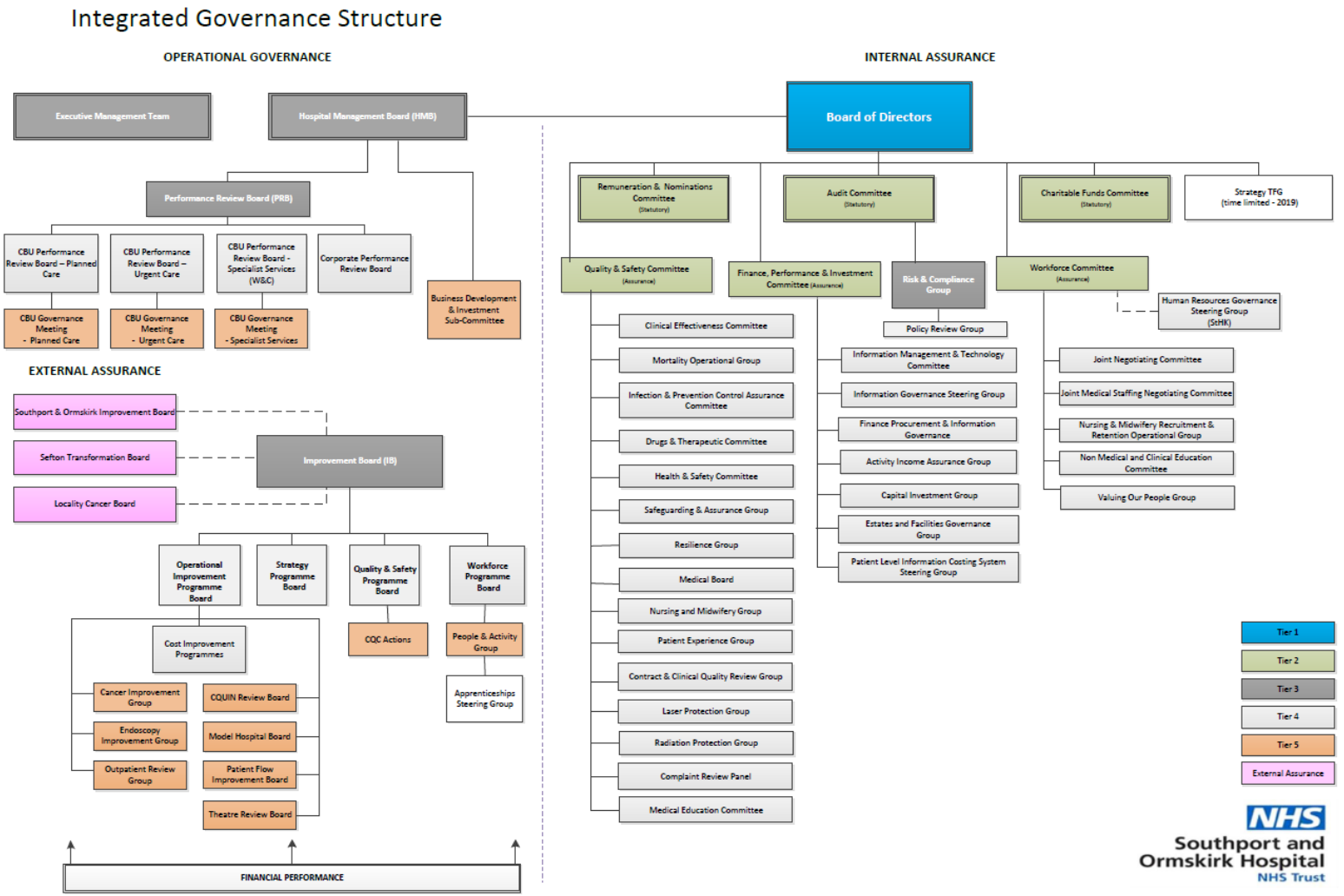
1.4 The Committee operates within the Trust's *Standing Orders* and *Standing Financial Instructions.*

1.5 The Committee will operate at a strategic level.

2 Purpose

The purpose of the Committee is to advise the Board on the appropriate remuneration and terms of service for Chief Executive and Executive Directors, ensure a formal, rigorous and transparent procedure for Board appointments is followed and consider Board succession planning.

Diagram 1. The relationship between the Renumeration & Nominations Committee, the Board and other Trust committees.



Principal Duties

In order to meet its purpose the Committee will, under the following headings:

Remuneration

a) Determine the framework for the remuneration of the Chief Executive, Executive Directors and Company Secretary including performance related elements, pensions and cars as well as arrangements for termination of employment and other contractual terms.
b) Take into consideration when determining performance related elements the performance of individual directors and senior managers
c) Oversee appropriate calculation and scrutiny of termination payments.

Nomination

a) Regularly review the structure, size and composition of the Board and make recommendations to it with regards to any changes.
b) Give full consideration to succession planning for Directors and other senior managers, taking into account current challenges and future opportunities.
c) Ensure appropriate job specifications are prepared for Board vacancies
d) Be responsible for identifying and nominating for approval of the Board, candidates to fill Board vacancies as and when they arise.
e) Review the results of Board performance evaluation as they relate to the composition of the Board.

3 Constitution

3.1 Chair

The Trust's Chairman shall chair the Committee. In the absence of the Chair another Non-Executive Director member will be nominated in advance, to chair the meeting.

3.2 Membership

The following will be members of the Committee:

- All Non-Executive Directors, including the Chair of the Trust, all of whom should be considered independent

In attendance at the invitation of the Committee for all or part of any meeting will be:

- Chief Executive
- Director of Human Resources & Organisational Development or equivalent
- Company Secretary

The Chief Executive and Director of HR & OD may not be present when the Committee is considering their remuneration.

Only members of the committee have the right to attend Committee meetings and have a single vote regarding any decisions to be taken by the Committee.

All members are required to attend at least 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 as required but no less than twice a year.

3.5 Organisation and Reporting to the Board

The minutes of Remuneration and Nominations 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 Company Secretary shall provide administrative support to the meeting and duties with include:

- Formally recording the minutes of the Committee
- Collation and distribution of papers
- Keeping a record of matters arising and issues to be carried forward

The agenda and papers for the meeting shall be distributed no less than 4 days in advance of the meeting.

The agenda for the meeting shall be drawn up by the Chair of the Committee in consultation with the Associate Director of Human Resources and Company Secretary. Meetings are not open to members of the public.

3.6 Review

The Terms of Reference shall be reviewed annually or in light of changes in practice or legislation.

The Committee shall undertake an annual review of its performance and effectiveness.

Approved by: **Board**

Date of approval:

Date for review:

Charitable Funds Committee

Terms of Reference Document Control Sheet

MEETING	**Charitable Funds Committee**
ESTABLISHED BY/REPORTING TO:	Trust Board
Reviewer	Audley Charles – Company Secretary
REVIEW	December 2019
ASSOCIATED DOCUMENTS	Standing Orders Standard Financial Instructions Scheme of Reservation and Delegation Risk Management Strategy Corporate Risk Register Board Assurance Framework
RELATED Forums/COMMITTEES/GROUPS	Trust Board Quality and Safety Committee Finance, Performance and Investment Committee Remuneration and Nominations Committee Audit Committee Workforce Committee

Document Control	
Document Name	Charitable Funds Committee ToR – Jun 19
File Name	\\datamart1\shared files\Company Secretarial\18. TERMS OF REFERENCE (COMMITTEES)\ Charitable Funds Committee ToR – Jun 19
Version/Revision Number	V2.2

Version Control

Version Ref	Amendment	Date Approved
V2.0	1.1 Authority strengthened by showing by reference to oversight role and relationship with other statutory and assurance committees. Workforce Committee and Mortality Assurance and Clinical	2017

	Improvement Committee added 1.2 Membership updated to read the members of the board as trustees of the fund are members of the committee. Add that the Company Secretary and Deputy Financial Accountant should be in attendance 1.3. Added that there should be a minimum of five members to form a quorum of which three must be NEDs 1.4 Added that the committee should undertake a review of its performance and effectiveness at least twice annually 1.5 Related Forums/Committees/Groups: removed Mortality Assurance and Clinical Improvement Committee. Added 'and Safety' to Quality Committee; added Remuneration & Nominations Committee and Audit Committee.	
V2.1	Added new governance structure showing reporting arrangements	2019
V2.2	• Added time limited Strategy Committee to Governance Structure	2019

Terms of Reference of the

Charitable Funds Committee

1 Authority

1.1 Southport & Ormskirk Hospital NHS Trust is appointed as the sole Corporate Trustee of The Southport & Ormskirk NHS Trust Charitable Fund (Charity No 1049227). The Board of Directors has responsibility for ensuring that the Trust discharges its responsibilities as Corporate Trustee. See **Diagram 1**.

1.2 The Board has established a Committee of the Trust to be known as the Charitable Funds Committee. The Board has 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:

d) seek any information it requires from any employee of the Trust in order to perform its duties as set out below
e) obtain, within the limits set out in the Trust's *Scheme of Delegation*, outside professional advice on any matter within its terms of reference
f) 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's *Standing Orders*, *Standing Financial Instructions and Scheme of Reservation & Delegation.*

2 Purpose

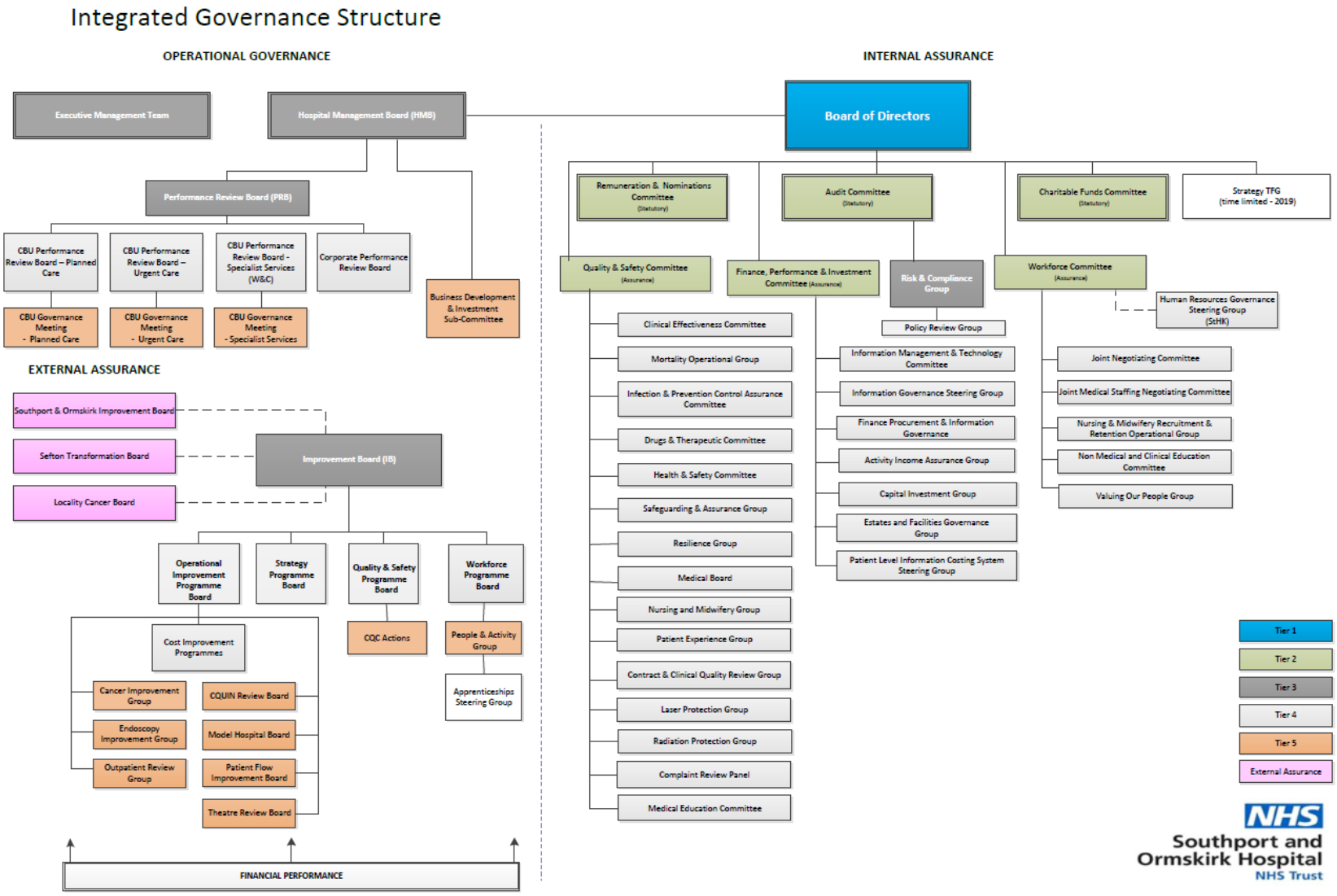
The Committee is established to manage the charitable funds on behalf of the Trustees in line with appropriate legislation, Charity Commission requirements and the Trust's Charitable Funds Governance Procedures.

3 Principal Duties

In order to achieve its purpose the Committee will:

k) Ensure that the charity is managed and administered in accordance with the requirements of the *Charities Act 1993* and *Charities Act 2006* (or any modification of that Act).
l) To agree appropriate limits, policies and procedures to ensure the effective distribution and management of the charitable funds.

Diagram 1. The relationship between the Charitable Funds Committee, the Board and other Trust's Committees.



m) 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:
    a. *Trustee Act 2000*
    b. *The Charities Act 1993 & 2006*
    c. *Charitable Fund Governance Procedures*
n) To receive reports for the ratification of investment decisions and action taken through delegated powers.
o) To recommend a *Scheme of Delegation* and authorisation limits to the Board of Directors as Corporate Trustee.
p) To monitor expenditure in line with the delegated authority.
q) To approve all individual charitable fund expenditure within appropriate limits defined by the *Scheme of Delegation*.
r) To ensure funding decisions are appropriate and consistent with the purpose of the fund, the donors' wishes and the Trust's objectives and values.
s) To receive the Annual Report and Annual Accounts of the Charity and recommend them for approval by the Board of Directors as Corporate Trustee.

3 Constitution

3.7 Chair

The Trust Chairman shall chair the committee. In the absence of the Chair the Trust's Vice Chair (if there is one) will chair the meeting; if both the Chair and Vice Chair are absent the Trustees will make a decision in advance of the meeting as to whom among the Non-Executive Directors will chair that particular meeting.

3.8 Membership

The following will be members of the committee:

- Members of the Board of Directors

In attendance:

- Company Secretary
- 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.

Other officers of the Trust may be invited to attend all or part of any meeting as and when appropriate and necessary.

All Board Members may attend any Committee meeting.

Each member is required to nominate a deputy to attend in their absence. Deputies shall not count towards the quorum of a meeting.

An officer formally acting up for a member will count towards a quorum and will be allowed to vote as though he or she is a member.

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

3.9 Quorum

A quorum will be no less than four (4) members, two of whom must be NEDs and the Director of Finance or a deputy nominated by him. In order for the decisions of the committee to be valid the meeting must be quorate.

If a decision is needed between meetings a Virtual meeting may be convened but the decision made at this meeting must be ratified by the next full meeting of the Committee.

3.10 Frequency of meetings

The Committee will meet as required but no less than two times a year.

3.11 Organisation

The minutes of the 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 of the charity 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 at least 7 days in advance of the meeting.

3.12 Review of Terms of Reference

These Terms of Reference shall be reviewed annually or in light of any changes in practice or legislation.

3.13 Performance and Effectiveness

The Committee shall undertake at least once annually a review of its effectiveness and performance and report its outcome and any associated action plan to the Board as Corporate Trustee for approval

Approved by:

Date of approval:

Date for review:

Southport and Ormskirk Hospital NHS Trust

Quality and Safety Committee
Terms of Reference Document Control Sheet

MEETING	Quality and Safety Committee
ESTABLISHED BY /REPORTING TO:	Trust Board
Reviewer:	Audley Charles - Company Secretary
REVIEW:	April 2019
ASSOCIATED DOCUMENTS:	Standing Orders Trust Board's Scheme of Reservation and Delegation Quality Improvement Strategy Risk Management Strategy Corporate Risk Register Board Assurance Framework Safeguarding Policy Freedom to Speak Up/Raising Concerns Policy
RELATED COMMITTEES/GROUPS	Trust Board Finance, Performance and Investment Committee Audit Committee Remuneration and Nominations Committee Charitable Funds Committee Workforce Committee **Sub Committees** Clinical Effectiveness Mortality Operational Group Safety Safeguarding Patient and Staff Experience Health & Safety

Document Control	
Document Name	Quality and Safety Committee- ToR Jun 19
File Name	**\\datamart1\Shared Files\Company Secretarial. Quality & Safety Committee\Terms of Reference\Quality and Safety Committee ToR – June 19**
Version/Revision Number	V3.3

Version Control		
Version Ref	**Amendment**	**Date Approved by Trust Board**
V2	1.1 Added authority and responsibility diagram	**2017**

	1.2 Purpose: Added four bullet points on purpose: 1.3 Replace *practical* with *practicable* *1.4 Replace Assistant Company Secretary taking minutes at committee* with *PA to Medical Director* 1.5 Added that the Committee should undertake a review of its performance and effectiveness at mid and year-end Added the Safeguarding and Freedom to Speak Up/Raising Concerns Policies	
V3.0	3.1 Front Page: Added the Mortality Operational Group and Charitable Funds Committee. Removed Mortality Assurance and Clinical Improvement Committee. Added Mortality Operational Group to Sub Committees. 3.2 Added Mortality Operational Group 3.4 Added Mortality Operational Group and its Principal Duties. 3.5 Membership updated	**2018**
V3.1	Added new governance structure showing reporting arrangements	**2019**
V3.2	• Removed the following from the membership: Chief Operating Officer Director of HR & OD Director of Strategy	**April 2019**
V3.3	• Added time limited Strategy Committee to Governance Structure • Updated membership to read 3 NEDs	**June 2019**

Terms of Reference of the Quality & Safety Committee

1 Authority

1.1 The Board hereby resolves to establish a Committee of the Trust to be known as the Quality & Safety Committee, hereafter referred to within this document as the *Committee.* See Diagram 1.

1.2 The Committee has the delegated authority to:

a) Seek any information it requires and/or call any employee of the Trust to a meeting of the Committee in order to perform its duties as set out below.
b) Obtain, within the limits set out in the Trust's Scheme of Delegation, outside professional advice on any matter within its terms of reference.

1.3 The Committee is a non-executive assurance committee of the Trust Board and has no executive powers other than those specifically delegated in these Terms of Reference. The Committee will operate at a strategic level as the Executives are responsible for the day to day operational delivery and management.

1.4 Any changes to these Terms of Reference must be approved by the Trust Board.

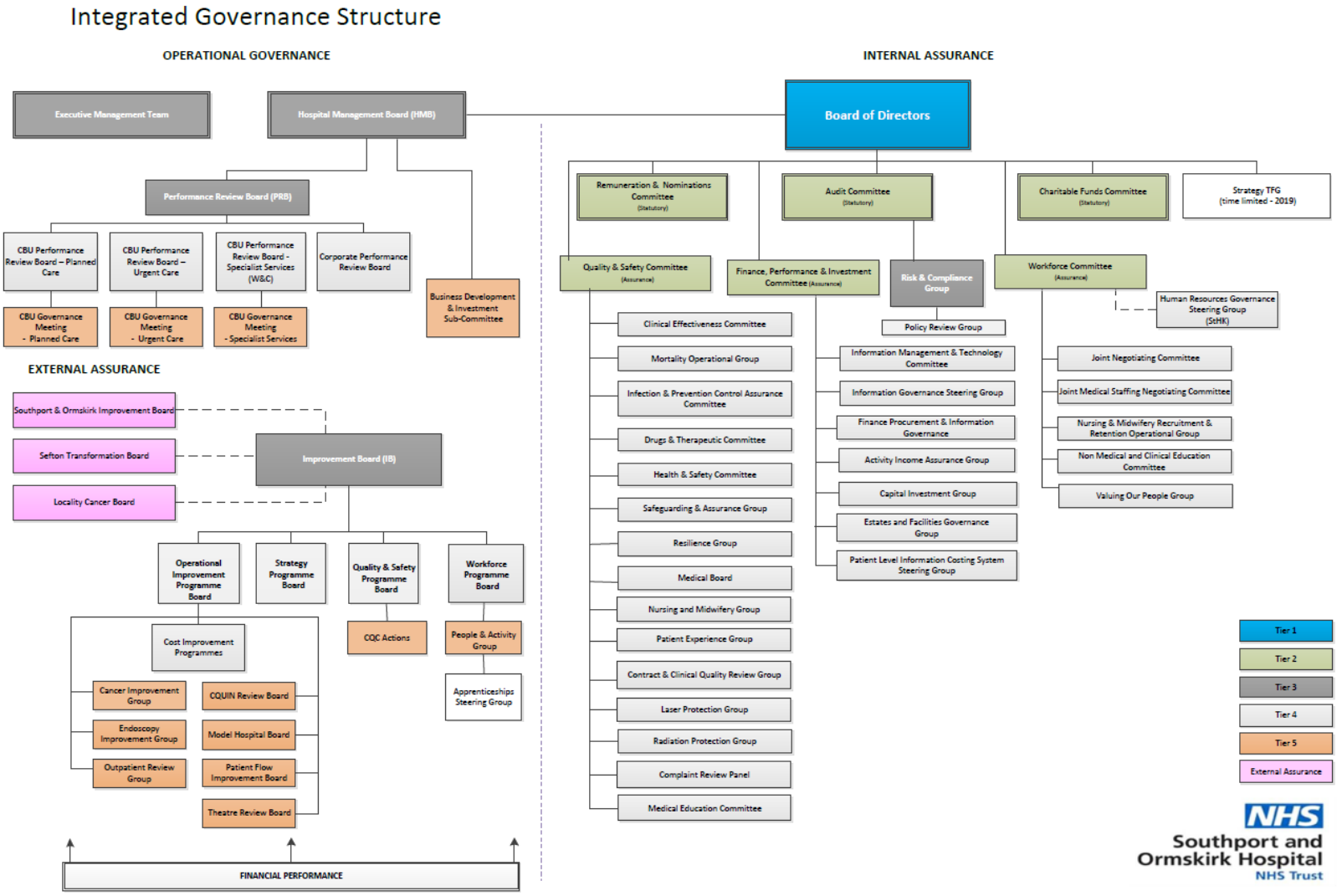
1.5 The Committee will operate within the Trust's Standing Orders and Standing Financial Instructions.

2 Purpose

2.1 The overall responsibility for clinical quality risk management, patient safety and quality of care delivery lies with the Trust Board; however, 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, risk management, mortality and morbidity.

2.2 The Committee will triangulate patient safety, quality and risk issues with operational, financial and workforce performance addressing areas of concern or deteriorating performance as required.

Diagram 1. The relationship between the Quality & Safety Committee, the Board and other Trust committees



3 Principal Duties

3.1 The duties of the Committee can be categorised as follows:

- 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.

3.2 Overseeing the work of the following reporting sub-committees:

- Clinical Effectiveness
- Mortality Operational Group
- Safety
- Safeguarding
- Patient and Staff Experience

3.3 Clinical Effectiveness & Patient Safety

a) Monitoring delivery of the priorities set out in the Quality Improvement Strategy, in particular those relating to mortality and the reduction of harm to patients.
b) Reviewing other key performance indicators in order to monitor and evaluate clinical quality and performance within the trust.
c) Reviewing the Trust Quality Account and recommending it for approval by the to the Board
d) Assessing the clinical and quality impact assessments of financial decisions within the Trust e.g. the impact of cost improvement programmes
e) Considering the resource implications for quality monitoring, improvement and risk control and advising the Board accordingly.
f) Receiving assurance that appropriate action is taken in response to adverse clinical incidents, complaints and litigation and ensuring learning is embedded across the Trust.
g) Reviewing trends in complaints, serious incidents, claims and litigation and receive assurance that examples of good practice are disseminated across the Trust.
h) Overseeing compliance with the Essential Standards of Quality and Safety and ensuring sufficient evidence of compliance is available to the Board.

i) Ensuring that the Trust by gathering, analysing and using information effectively takes action to improve patient safety and creates a climate of continuous learning and improvement
j) Overseeing the development of a clinical audit plan and keeping implementation of the plan under review.
k) Making recommendations to the Audit Committee concerning the annual programme of internal audit work to the extent that it applies to matters within these terms of reference.
l) Promoting within the Trust a culture of open and honest reporting and monitoring compliance against the CQC's Duty of candour requirement.

3.4 Mortality Operational Group

a) Mortality process and reviews.
b) 7 Day working.
c) Coding.
d) Clinical Pathways.
e) Reviewing other key performance indicators in order to monitor and evaluate mortality performance within the Trust.
f) Making recommendations to the Quality & Safety Committee concerning the annual programme of internal audit work to the extent that it applies to matters within these terms of reference.

3.5 Patient Experience

a) Act upon the results of surveys relating to the patients' care experience in order to improve quality of experience across the Trust.
b) Ensure the effectiveness of the organisational arrangements for measuring and acting on feedback from service users.

3.6 Safeguarding

a) Ensuring that the Trust has robust arrangements in place to safeguard patients.

3.7. Risk

b) Ensuring the identification, management and control of clinical risk is robust and cohesive, taking action where necessary and alerting the Board to any areas of concern.
c) Ensuring that the Trust has robust resilience plans in place.

3.8 Performance

Review stretch targets as they relate to quality of care provision, effectiveness and safety and monitor achievement against performance forecasts.

4 Constitution

4.1 Chair

The Committee will be comprised of three NEDs and two Executive Directors and will be chaired by a Non-Executive Director. In the absence of the Chair another Non-Executive Director member will be nominated in advance of the meeting to Chair it

4.2 Membership

The members of the Committee shall be appointed by the Trust Board in accordance with the *Standing Orders* and shall consist of the following members:

- Three (3) independent Non-Executive Directors, at least one of whom shall have a clinical background
- Director of Nursing, Midwifery & Therapies
- Medical Director
- Associate Medical Director for Patient Safety

In attendance:

- Deputy Director of Nursing
- Deputy/Associate Medical Directors
- Company Secretary
- Assistant Director of Integrated Governance
- Staff Side Representative
- Patient Representative

Only members of the Committee have the right to attend Committee meetings. Other officers of the Trust, however, may be invited to attend all or part of any meeting as and when appropriate and necessary.

To ensure that the Non-Executive Directors have the majority vote only the Director of Nursing, Midwifery & Therapies, the Medical Director and the Chief Operating Officer will have a vote within the Quality & Safety Committee. The Chair of the Committee will have a casting vote.

All Board Members may attend any Committee meeting.

Each member is required to nominate a deputy to attend in their absence. Deputies shall not count towards the quorum of a meeting.

An officer formally acting up for a member will count towards a quorum and will be allowed to vote as though he or she is a member.

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

4.3 Quorum

A quorum will be no less than three Members including two Non-Executive Directors (one of whom must be either the Chair of the Committee or the nominated Chair) and one Executive Director who must be either the Director of Nursing & Midwifery or the Medical Director.

In order for the decisions of the Committee to be valid the meeting must be quorate. In the event there are insufficient regular NED members, a rotating NED who is present will count towards the Quorum

4.4 Frequency of meetings

The Committee will meet no less than ten times a year, usually once a calendar month.

The Chair of the Committee may arrange extraordinary meetings at his/her discretion or at the request of Committee members.

4.5 Organisation and Reporting Structure

The minutes of Quality and Safety Committee meetings shall be formally submitted to the Board. The Chair of the Committee shall also draw to the attention of the Board any issues that require disclosure to the full Board, or require executive action via an Assure, Alert and Advise (AAAs) report and minutes.

The Committee will report to the Board at least annually on its work in support of the Quality Governance Framework self-certification and relevant Board Statements required by NHS Improvement and the Care Quality Commission.

The Committee will produce an annual work-plan/business cycle for the Board to approve at the beginning of each financial year, mapping out how the Committee will fulfil its delegated duties.

4.6 Conduct of Meetings

The PA to the Medical Director (in their absence the PA to the Director of Nursing & Midwifery) shall provide administrative support to the meeting and duties with include:

- Formally recording the minutes of the Committee
- Collation and distribution of papers
- Keeping a record of matters arising and issues to be carried forward

The agenda and papers for the meeting shall be distributed no less than four days in advance of the meeting.

The agenda for the meeting shall be drawn up by the Chair of the Committee in consultation with the Director of Nursing and Midwifery and Medical Director. Meetings are not open to members of the public.

Minutes of the meeting and the record of matters arising will be circulated promptly to all members as soon as reasonably practicable.

Presenters of papers can expect all committee members to have read the papers and should keep to a summary that outlines the purpose of their paper and the key issues. Committee members may question the presenter.

4.7 Review

The Terms of Reference shall be reviewed annually or in light of changes in practice or legislation.

4.8 Review of Performance and effectiveness Review

The Committee shall also undertake a review of its performance and effectiveness at least once annually.

Approved by: **Board of Directors**

Date of approval:

Date for review:

Finance, Performance and Investment Committee

Terms of Reference Document Control Sheet

MEETING	Finance and Investment Committee
ESTABLISHED BY /REPORTING TO:	Trust Board
Reviewer:	Audley Charles – Company Secretary
REVIEW:	April 2019
ASSOCIATED DOCUMENTS:	Scheme of Reservation and Delegation Standing Financial Instructions Standing Orders CIP Process IM&T Strategy Risk Management Strategy Extreme Risk Register Board Assurance Framework
RELATED FORUMS/COMMITTEES/GROUPS	Trust Board Quality and Safety Committee Remuneration & Nomination Committee Audit Committee Charitable Funds Committee Workforce Committee **Sub Committees** Transformation Committee IM&T Programme Board Finance, Procurement & Information Governance Capital Investment Group Estates and Facilities Governance Group Patient Level Income Cost (PLICs) Steering Group Activity & Income Assurance Group Information Governance Steering Group

Document Control	
Document Name	Finance Performance and Investment Committee ToR – Jun 19
File Name	\\datamart1\shared files\Company Secretarial\18. TERMS OF REFERENCE (COMMITTEES)\ Finance Performance and Investment Committee ToR –Jun 19
Version/Revision Number	**V3.3**

Version Control		
Version Ref	**Amendment**	**Date Approved by Trust Board**
V2.0	1.1 Added authority and responsibility diagram 1.2 Added more information on the purpose of the committee 1.3 Deleted *"by exception*" and added "*twice annually*" 1.4 Added that *the CEO is ex officio a member of the committee* and not a standing member Added: *An officer acting up for a member will count towards a quorum and will be allowed to vote* as though he or she is a member 1.5 Added that the Committee should review its performance and effectiveness twice annually-mid and year end 1.6 Added that the Committee will oversee the implementation of the IM&T and Estates Strategies 1.7 Added meeting attendance information 1.8 Added information regarding the agenda and distribution of papers	**2017**
V3.0	2.1 Related Committees/Forums, added Remuneration and Nominations Committee, Charitable Funds Committee and Workforce Committee	**2018**
V3.1	Added new governance structure showing reporting arrangements	**2019**
V3.2	1.Changed name to read Finance	**April 2019**

	& Investment 1.2 (b) Removed Patient flow- includes activity levels, AED and waiting time performance AND (d) Annual review of the Performance Framework 3.5 Removed Performance Section 3.6 Removed Information Governance Section 3.7 Removed Data Quality Section 4.3 Edited membership of Executives attending to read: Director of Finance and Deputy CEO/Director of Strategy and remove Chief Operating Officer 4.4 Edited Quorum to reflect change of membership	
V3.3	• Added 'Risk' to Committee name in narrative and governance structure • Added time limited Strategy Committee to Governance Structure 4.3 Updated membership to include NED with recent financial experience 4.4 Added that rotating NED will count towards a Quorum if needed.	**June 2019**

Terms of Reference of the
Finance and Investment Committee

1. Authority

1.1 The Board hereby resolves to establish a Committee of the Trust to be known as the Finance and Investment Committee [the Committee]. The Committee has no executive powers, other than those limited to these Terms of Reference. The accountability and responsibility structure is set out in Diagram 1.

1.2 The Committee has the delegated authority to monitor and scrutinise:

a) Financial performance – includes monthly performance and CIP
b) Patient flow- includes activity levels, AED and waiting time performance
c) Capital Programme, including IT
d) Annual review of the Performance Framework
e) 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.

1.3 The Committee can obtain, within the limits set out in the Trust's Scheme of Reservation and Delegation, legal or other independent professional advice on any matter within its terms of reference and to secure the attendance of external persons with relevant experience and expertise if it considers this necessary.

1.4 The Committee operates within the Trust's *Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation.*

1.5 The Committee will operate at a strategic level as the Executive are responsible for the day to day operational delivery and management.

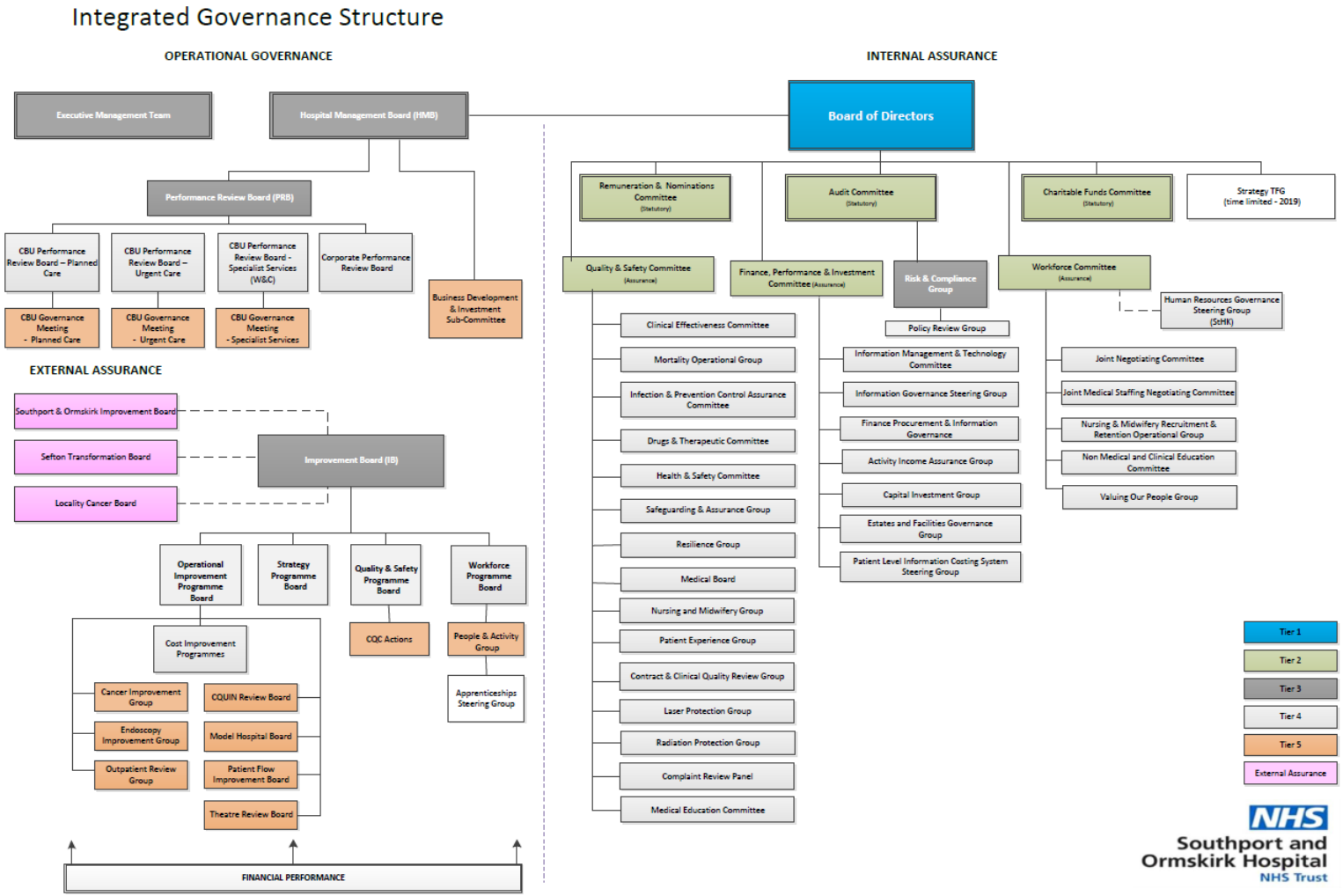
1.6 Any changes to these Terms of Reference must be approved by the Trust Board.

2.0 Purpose

2.1 The Committee is established to provide the Board with assurance regarding the Trust's finances, performance against national key financial indicators and approval of investment cases.

2.2 The Committee will oversee the implementation of the IM&T and Estates Strategies.

Diagram 1. The relationship between the Finance, Performance & Investment Committee, the Board and other Trust committees



3.0 Principal Duties

The duties of the Committee are as follows:

3.1 Financial planning and monitoring

a) Consider the Trust's financial plans (both revenue and capital) and approve key underpinning assumptions. Approve both revenue and capital budget.

b) Monitor monthly and year to date financial information including:-

- Performance against revenue budget at both Trust and Business Unit level.
- Run rate performance to date and forecast.
- Performance against the Cost Improvement Programme (CIP).
- Cash, liquidity and working capital.
- Performance against capital budget.
- Ensure the committee is advised of any significant variation in activity and its impact on income.
- Monitor compliance with contractual issues impacting on the Trust finances eg CQUIN performance targets and contract penalty issues, and consider the financial implications.

c) Consider the appropriateness of any corrective actions and undertake detailed scrutiny of the financial forward projections.

d) Review the Trust's Service Line Reporting (SLR) performance on a quarterly basis and consider implications for future viability.

e) Oversee the long term financial model.

3.2 Cost Improvement Programme

f) Where CIP schemes are at risk of delivery the Committee will seek assurance from Executive Director Leads that a plan is in place and being implemented to bring the schemes back on track.

g) Ensure that there is a CIP Programme in place for the financial year in line with the Trust's Annual Business Plan.

3.3 Contract monitoring

h) Approve the Trust's Contract Strategy and oversee the negotiation of contracts with the organisation's commissioners.

i) Review the systems in place to ensure compliance with the contract terms and monitor any impact of non-compliance on penalties.

3.4 Investment

j) Consider the recommendations of the Executive Management Team (EMT) when considering business cases for both capital and revenue investments.

k) Scrutinise all business cases for proposed investment that require Board approval, ensuring that outcomes and benefits are clearly defined, are measurable and support delivery of the Trust's key objectives.

l) Approve investment and expenditure on behalf of the Board as delegated to it.

m) Receive post implementation reviews to ensure benefits realisation.

3.5 Performance

n) Have oversight and review the national key performance indicators relevant to the remit of the Committee, paying particular attention to areas of deterioration and the potential financial impact of actions taken to address issues.

3.6 Information Governance

o) The Committee will receive at least twice annually, reports relating to the Trust's Compliance with the Freedom of Information Act 2000 and the Data Protection Act 1998

p) To receive and review the Trust's submission of the Information Governance Toolkit

3.7 Data Quality

q) To ensure that the Trust has in place effective arrangements for assuring the quality of its performance data

3.8 Procurement

r) Ensure the Trust has adequate oversight of procurement arrangements to ensure compliance with regulations and maximise value for money.

s) Have oversight of how the Trust's procurement of goods and services compare to others using national appropriate benchmarking.

t) Receive, on a quarterly basis, the Trust's register of tenders and contracts.

3.9 Risks

u) Consider any relevant risks within the Board Assurance Framework and corporate risk register as they relate to the remit of the Committee, as part of the reporting requirements, and report any areas of significant concern to the Audit Committee or the Board as appropriate.

v) Review all other significant–risks across finance, performance, IM&T, IG and data quality as highlighted in the monthly report

4.0 Business Conduct

4.1 Chair

One of the Non-Executive Directors, but not the Chair of the Audit Committee, shall chair the Committee. In the absence of the Chair, one of the other Non-Executive Directors, agreed in advance of the meeting, will chair that particular meeting.

4.2 Membership

4.3

The following will be members of the Committee:

- Three (3) independent Non-Executive Directors, one of whom shall be Chair, and one of whom shall be the Chair of the Audit Committee
- Director of Finance
- Chief Operating Officer

In attendance:

- Deputy Director of Finance
- Company Secretary
- Head of Information
- Deputy Director of Performance

Only members of the Committee have the right to attend Committee meetings. Other officers of the Trust may be invited to attend all or part of any meeting as and when appropriate and necessary.

To ensure that the Non-Executive Directors have the majority vote, only the Director of Finance and Chief Operating Officer will have a vote at the Finance, Performance & Investment Committee. The Chair of the Committee will have a casting vote in the event of a tie.

All Board Members may attend any Committee meeting.

Each member is required to nominate a deputy to attend in their absence. Deputies shall not count towards the quorum of a meeting.

An officer formally acting up for a member will count towards a quorum and will be allowed to vote as though he or she is a member.

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

4.4 Quorum

A quorum will be no less than three Members including two Non-Executive Directors (one of whom must be either the Committee Chair or Chair of the Audit Committee) and one Executive Director who must be either the Deputy CEO/Director of Strategy or Director of Finance. In order for the decisions of the Committee to be valid the meeting must be quorate. In the event there are insufficient regular NED members, a rotating NED will count toward the Quorum.

4.5 Frequency of meetings

The Committee will meet no less than ten times a year, usually once a calendar month.

The minutes of Finance, Performance & Investment Committee meetings shall be formally submitted to the Board along with a highlight report. 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 Committee will produce an annual workplan for the Board to approve at the beginning of each financial year, mapping out how the Committee will fulfil its delegated duties.

The sub-groups of the Committee will report via the formal submission of a AAAs report

4.6 Conduct of Meetings

The PA to the Director of Finance shall provide administrative support to the meeting and duties with include:

- Formally recording the minutes of the Committee
- Collation and distribution of papers
- Keeping a record of matters arising and issues to be carried forward

The agenda and papers for the meeting shall be distributed no less than 4 days in advance of the meeting.

The agenda for the meeting shall be drawn up by the Chair of the Committee in consultation with the Director of Finance. The agenda and papers for the meeting shall be distributed no less than 4 working days in advance of the meeting. Meetings are not open to members of the public.

Presenters of papers can expect all committee members to have read the papers and should keep to a summary that outlines the purpose of their paper and the key issues. Committee members may question the presenter.

4.7 Review of Terms of Reference

The Terms of Reference shall be reviewed annually or in light of changes in practice or legislation.

4.8 Review of Performance and Effectiveness

The Committee shall undertake a review of its performance and effectiveness at least once annually.

Approved by Board of Directors:

Date of approval: November 2017

Date for review: April 2019

Workforce Committee

Terms of Reference Document Control Sheet

MEETING	Workforce Committee
ESTABLISHED BY/REPORTING TO:	Trust Board
Reviewer	Audley Charles – Company Secretary
REVIEW	April 2019
ASSOCIATED DOCUMENTS	Standing Orders Standard Financial Instructions Scheme of Reservation and Delegation Risk Management Strategy Corporate Risk Register Board Assurance Framework
RELATED FORUMS/COMMITTEES/GROUPS	Trust Board Quality and Safety Committee Finance, Performance and Investment Committee Remuneration and Nominations Committee Audit Committee Charitable Funds Committee **Sub Committees** Health and Wellbeing Human Resources JNC JMSNC HR Contract with St Helens & Knowsley NHS Trust Medical Education Committee (MEC) Non-Medical Education Committee (NMCEC

Document Control	
Document Name	Workforce Committee ToR - Jun 19

File Name	\\datamart1\shared files\Company Secretarial\18. TERMS OF REFERENCE (COMMITTEES)\ Workforce Committee ToR - Jun 19
Version/Revision Number	V6.3

Version Control

Version Ref	Amendment	Date Approved
V5.0	**1.1** Added accountability and responsibility diagram 1.2 Differentiated between membership and those in attendance Membership edited 1.3 Added a quorum 1.4 Added review of Terms of Reference and the Committee's performance and effectiveness Related Forums/Committees/Groups: removed Mortality Assurance and Clinical Improvement Committee. 1.5 Added 'and Safety' to Quality Committee; added Remuneration & Nomination Committee and Charitable Funds Committee.	
V6.0	RELATED FORUMS/COMMITTEES/GROUPS Removed: • Organisation Development • Education & Development Assurance Group Added: • Medical Education Committee (MEC) • Non-Medical Education Clinical Committee (NMCEC) Diagram 1 revised to reflect above changes Other functions of the Workforce Committee Removed: • Education & Development Assurance Group Added: • Medical Education Committee (MEC) • Non-Medical Education Clinical Committee (NMCEC) Membership Replaced Assistant Director of Organisational Development with Head of Education & Training Groups reporting to Workforce Committee Removed:	2018

	• Education & Development Assurance Group Added: • Medical Education Committee (MEC) • Non-Medical Education Clinical Committee (NMCEC)	
V6.1 V6.2	Added new governance structure showing reporting arrangements 4.Removed Director of Nursing, Midwifery & Therapies Added Chief Operating Officer as substantive member from membership 4. Update title of Associate Director of HR to Director of HR & OD	2019
V6.3	• Added time limited Strategy Committee to Governance Structure • Added Deputy CEO to membership	June 2019

Terms of Reference of the

Workforce Committee

1 Authority

1.1 The Workforce Committee was established by the Board of Directors and has delegated authority from the Trust Board to investigate any issue that sits within its terms of reference. See Diagram 1.

1.2 The Workforce Committee will provide assurance to the Trust Board on matters within its remit and escalate any issues or risks to the Board of Directors.

1.3 The Chair of the Committee will escalate items to the Board using the *Alert* / *Advise* / *Assure Highlight Framework.*

2 Purpose

The purpose of the Committee is to ensure that the Trust complies with externally set standards and establish, monitor and review content and methods of providing assurance to the Trust Board in relation to all areas of people management

3 Principal Duties

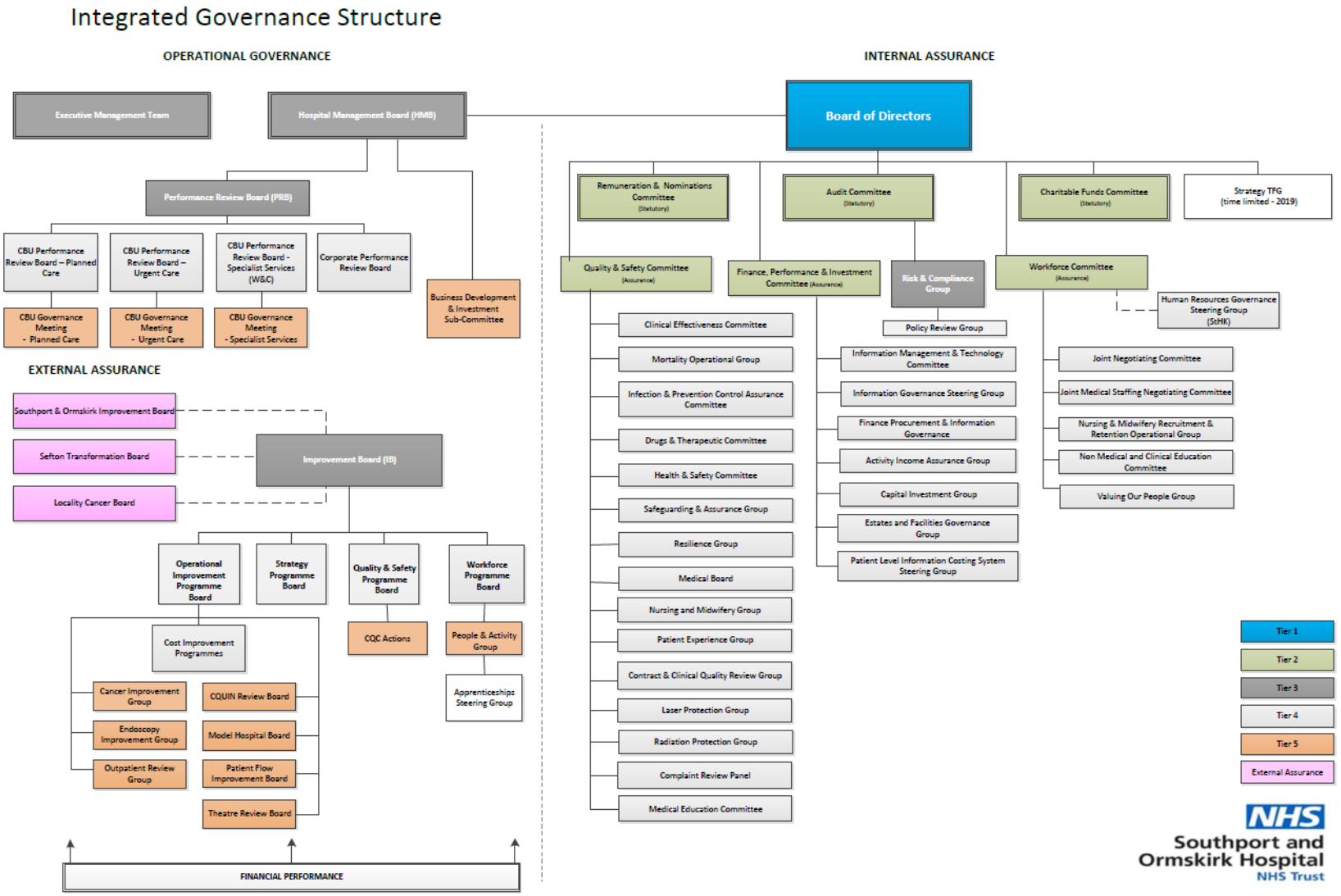
In order to achieve its purpose the Workforce Committee will:

- Review evidence relating to external standards, including NHS Resolution (formerly NHS Litigation Authority (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

Diagram 1. The relationship between the Workforce Committee, the Board and other committees



- 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

4 Other functions of the Workforce Committee

- Chair to produce summary AAAs Highlight report for Trust Board & identify issues to be escalated
- Review & approve policies relating to workforce and inform the Trust Board
- Report feedback from the Board & ensure messages / issues are feeding back to care groups & department meetings
- Review any other issues regarding workforce that are raised at meeting
- Volunteers

The following Sub-committees and Groups will report to the Workforce Committee

- Equality & Diversity Assurance Group
- Health & Safety
- HR Policy Development Sub Group
- Joint Negotiating Committee
- Joint Negotiation Medical Committee
- Health and Wellbeing Assurance
- Medical Education Committee (MEC)
- Non-Medical Education Committee (NMCEC

Membership

The core Members of the Committee will be:

- Non-Executive Director-Chair
- Non-Executive Director
- Non-Executive Director
- Director of Human Resources & Organizational Development
- Deputy Chief Executive
- Assistant Director of HR Governance and Quality
- Associate Director of Nursing **-** Workforce

In attendance

The following will be in attendance at the meeting:

- Head of Education & Training
- Head of HR
- Staff Side Chairperson
- BMA Representative
- Patient and Workforce Equality Lead
- Estates and Facilities Management Representative
- Head of Health, Work & Wellbeing
- Clinical Workforce Information Systems Manager
- Head of Quality (on request only)

Other key individuals will be co-opted to the Workforce Committee dependent on key work streams to be initiated.

The Deputy Chair or nominated individual will automatically assume the authority of the Chair should the latter be absent. Where there is no named deputy, members will select one of the NEDs to chair the meeting.

Members and attendees are responsible to provide feedback to their CBU / Teams / committees they represent, and any agreed actions or recommendations as required.

Each member is required to nominate a deputy to attend in their absence. Deputies shall not count towards the quorum of a meeting.

An officer formally acting up for a member will count towards a quorum and will be allowed to vote as though he or she is a member.

5 Quorum

A quorum will consist of four members, two of whom shall be NEDs and the Director of Human Resources & Organisational Development

Core Members (or an empowered deputy) are expected to attend a minimum of 70% of meetings. Chair or deputy will need to attend to ensure the meeting is quorate.
NEDs on rotation will count towards the quorum if required.

6 Frequency of Meetings

The Workforce Committee will meet a minimum of 5 times a year. The frequency of meetings will be reviewed annually.

7 Organisation

7.1 The Director of Human Resources & Organisational Development is responsible for setting the agenda, production and distribution of the minutes.

7.2 The PA to the Director of Human Resources & Organisational Development shall provide administrative support to the meeting

7.3 Documents submitted to the Committee should be identifiable by using a standard report cover sheet and structure; refer to the *Standing Operating Procedure*.

7.4 Policies approved by the Workforce Committee must adhere to the overall guidance document "Document Control Policy".

7.5 Chairs are responsible for ensuring that the Policy Equality Impact Assessment Checklist is completed in respect of each policy approved

7.6 The minutes and AAAs report are to be reported to the Trust Board and the Committee may escalate issues to the Executive Team for action. Reports from this Committee will be made available to the Audit Committee on matters relating to this Committee as required.

7.7 The Groups reporting their minutes to the Workforce Committee are:

- Education and Training Assurance Group
- Health & Safety
- HR Policy Development Sub Group
- Joint Negotiating Committee
- Joint Negotiation Medical Committee
- Medical Education Committee (MEC)
- Non-Medical Education Committee (NMCEC)

These Groups will provide a minimum annual update report to the Committee

8 Review

These Terms of reference will be reviewed annually

The Committee shall undertake a review of its performance and effectiveness at least once annually.

Approved by: **Workforce Committee 19 October 2017**

Submitted to: **Trust Board for Ratification 1 November 2017**

Date of approval: **October 2017**

Date for review: April 2019

STRATEGY TASK AND FINISH ASSURANCE GROUP

TERMS OF REFERENCE

1 Purpose:

The Strategy Task and Finish Assurance Group (STFAG) is a time limited sub-committee of the Southport and Ormskirk Hospital NHS Trust Board. The Assurance Group has been established to provide assurance to the Trust Board on the robustness of the development and delivery of the Acute Sustainability Programme.

The Acute Sustainability Programme aims to deliver the transformation of acute services for the populations of Southport, Formby and West Lancashire. This work is governed by the Sefton Transformation Board which has set out an ambitious programme of work to build a single system that brings together services from across the health, care and voluntary sectors to help residents manage their own health and wellbeing.

2 Aims:

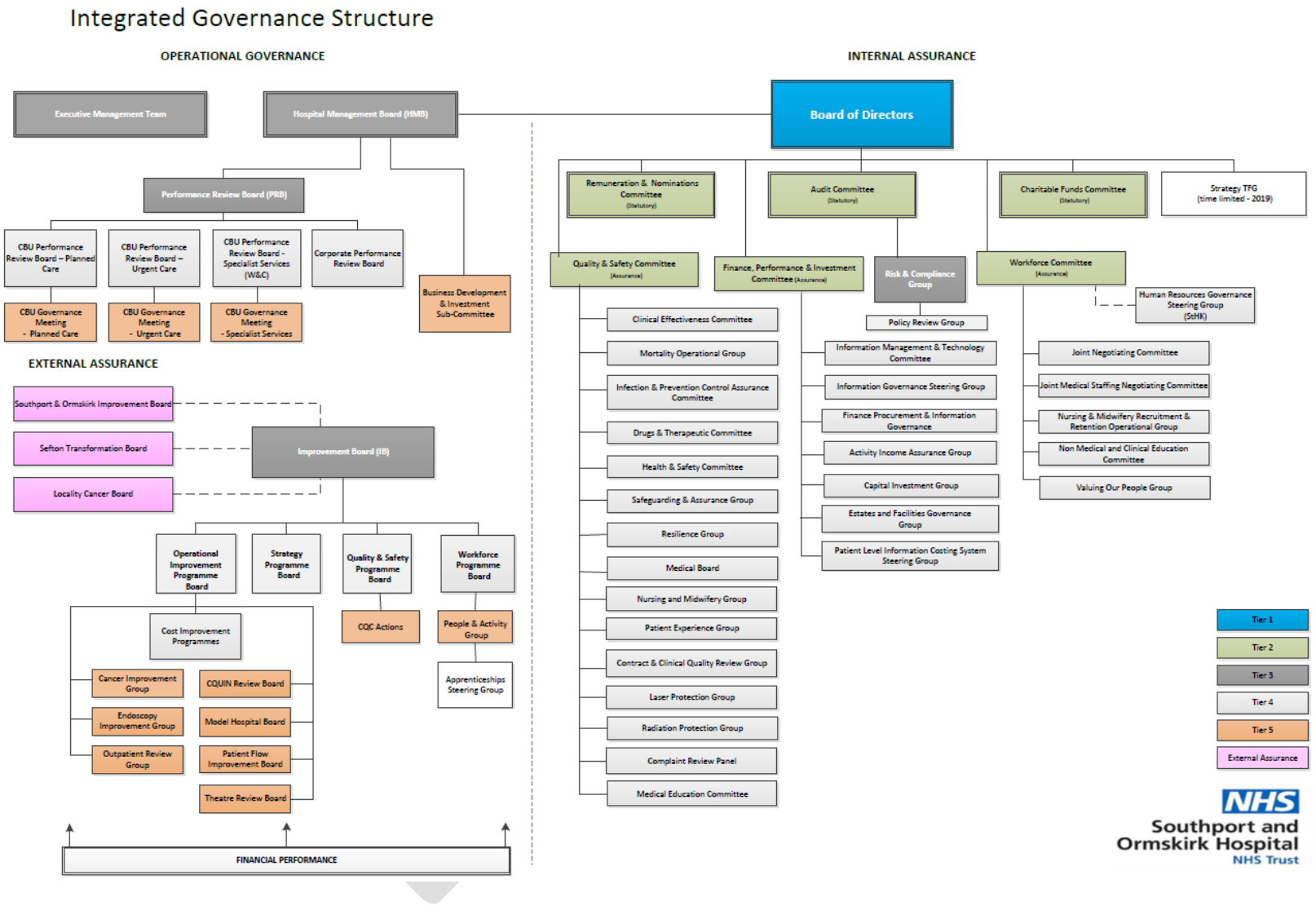
The Assurance Group will:

- provide representatives of the Trust Board with the space and time to check and challenge the development and delivery of the Acute Sustainability Programme
- ensure any products developed through the Acute Sustainability Programme, for example, an options appraisal process, meet the strategic needs of the Trust
- feed in any comments or concerns from the Trust Board into the programme governance structure (via Acute Sustainability Assurance and Oversight Group)

3 Governance:

The Strategy Task and Finish Assurance Group will be a time-limited group of the Southport and Ormskirk NHS Trust Board

Diagram 1. The relationship between the Strategy Task & Finish Group, the Board and other Trust committees



The Task and Finish Group will, on behalf of the Trust Board, raise any comments or concerns identified from its check and challenge processes via the ASP governance structure (i.e. the Assurance & Oversight Group)

The Task and Finish Group will present its overall findings to the Trust Board at the completion of the Acute Sustainability Programme in March 2020.

4 Membership

The Task and Finish Group will be comprised of the following members:

- Trust Board Chair
- Deputy Chief Executive/Director of Strategy
- Medical Director
- Director of Finance
- Non-Executive Director Representative
- Non-Executive Director Representative
- Programme Director
- Committee Secretary

Southport and Ormskirk Hospital NHS Trust

Hospital Management Board

Terms of Reference Document Control Sheet

MEETING	Hospital Management Board
ESTABLISHED BY/REPORTING TO:	Audit Committee
Author	EY
Reviewer	Audley Charles – Company Secretary
REVIEW	June 2019
ASSOCIATED DOCUMENTS	Standing Orders Standard Financial Instructions Scheme of Reservation and Delegation Risk Management Strategy Corporate Risk Register Board Assurance Framework Information Governance Strategy and Policy
RELATED FORUMS/COMMITTEES/GROUPS	Trust Board Quality and Safety Committee Finance, Performance and Investment Committee Remuneration and Nominations Committee Audit Committee Charitable Funds Committee **Sub Committees** IM&T

Document Control	
Document Name	**Hospital Management Board HMB ToR Jun 19**
File Name	**\\datamart1\shared files\Company Secretarial\18. TERMS OF REFERENCE (COMMITTEES)\ Hospital Management Board HMB ToR Jun 19**
Version/Revision	**V1.1**

Number	

Version Control

Version Ref	Amendment	Date Approved
V1.1	• Added time limited Strategy Committee to Governance Structure	June 2019

HOSPITAL MANAGEMENT BOARD
Terms of Reference

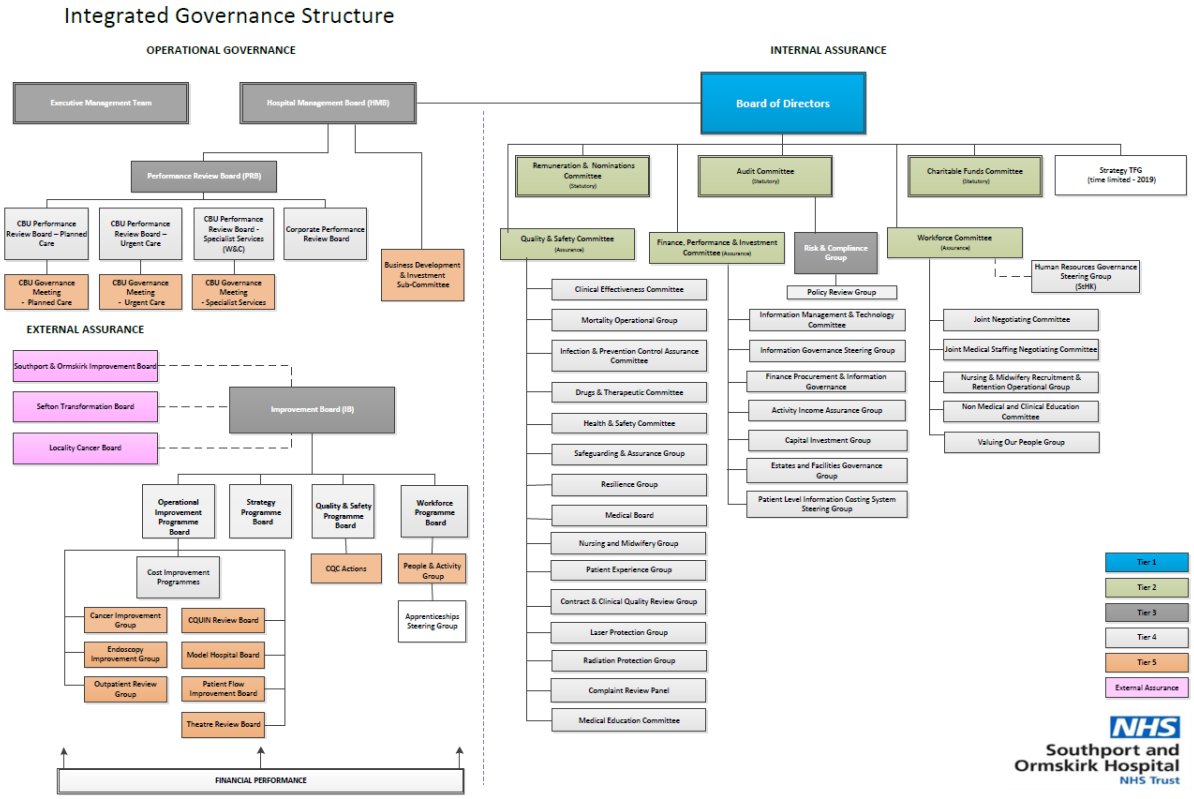
1. Authority

The Board hereby resolves to establish a Committee of the Trust to be known as the Hospital Management Board (HMB), hereafter referred to within this document as the *HMB.*

The HMB is authorised by the Board of Directors to investigate any activity within its terms of Reference.

The HMB has been established to oversee, coordinate, review and assess the effectiveness of operational activities within the Trust.

The HMB is authorised to create sub-groups or working groups, as are necessary to fulfil its responsibilities within its terms of reference. The HMB may not delegate executive powers and remains accountable for the work of any such group. Any sub-groups or working groups will report directly to HMB who will oversee their work.



2. Purpose

The purpose of the HMB is to:

- The HMB is accountable to the Board of Directors for the operational management of the Trust and the delivery of objectives set by the Board of Directors.
- The HMB will set appropriate frameworks and policies and procedures to support delivery of the organisational objectives. Using the frameworks in place the management Board will continually monitor and review the operational performance of the Trust and put in place corrective measures where necessary.
- The HMB will oversee the development of the Trust Annual Plan so that when it is presented to Board of Directors for approval it is robust in terms of its objectives, performance measures, investment priorities and affordability. The HMB plays a key role in developing the overall strategy of the Trust.

- It is also the formal route to support the Chief Executive in effectively discharging his responsibilities as Accounting Officer.

3. Principal Duties

The HMB has delegated powers from the Board of Directors to oversee the day to day management of an effective system of integrated governance, risk management and internal control across the whole organisation's activities (both clinical and non-clinical), which also supports the achievement of the organisation's objectives.

In particular HMB will review, approve and monitor:

- the Trust's performance against key targets, business plans, CQC and other corporate objectives and delegate and co-ordinate where appropriate;
- actions arising from the integrated balanced scorecard and to performance manage the delivery of those action plans;
- the capital programme prior to Board of Directors' approval;
- the effectiveness of the management of significant risks;
- the structures, processes and responsibilities for identifying and managing key risks facing the organisation, prior to discussion at the Board of Directors;
- the operational effectiveness of policies and procedures;
- all risk related disclosure statements, in particular the Annual Governance Statement, prior to approval by the Board of Directors;
- to scrutinise key reports prior to submission to the Board of Directors to ensure their accuracy and quality;
- to provide a corporate view on Trust wide issues of current concern ensuring co-ordination between CBU;
- to advise on planning, service level agreements and change management initiatives;
- to ensure that equality and diversity issues are continually considered and addressed throughout the work of the Management Board;
- to oversee the delivery of CIP within the Trust;
- to ensure that staff are kept up to date on Trust wide issues;
- to debate and discuss strategic issues affecting the Trust and the wider health economy;
- to identify any potential commercial and/or reputational opportunities arising from the Trust's work

HMB should ensure that governance and assurance systems operate effectively and thereby underpin clinical care. In order to achieve this HMB will need to agree strategies, policies and plans to ensure that the Trust has a proper system of controls in place to deliver this.

The agenda for HMB will be structured to allow time for strategic debate and discussion of current and future issues affecting the Trust and the wider Health Service/Health economy. Internal and external speakers may be invited to attend this section of the meeting to support discussion and debate as required.

4. Constitution

The Hospital Management Board (HMB) is established by Board of Directors as the senior operational board of Southport and Ormskirk Hospital NHS Trust.

The role of the Hospital Management Board is to oversee the effective operational and strategic site management including the achievement of statutory duties, clinical standards and targets, the delivery of high quality patient centred care and the delivery of the Service Strategy.

4.1 Chair

The HMB will be chaired by the Chief Executive.

4.2 Membership

- Chief Executive (Chair)
- Director of Strategy
- Chief Operating Officer
- Medical Director
- Director of Nursing and Midwifery
- Associate Director of Human Resources
- Director of Finance
- Company Secretary
- Head of Estates and Facilities
- Clinical Business Units Triangle:
    - -Associate Medical Directors of Clinical Business Units (CBUs)
    - -Assistant Directors of Clinical Business Units
    - -Heads of Nursing of Clinical Business Units

5. Quorum

A quorum will be no less than one third of the members which must include at least two (2) Executive Directors and at least one (1) representative from each CBU.

5.1 Attendance by Members

If a member is unable to attend a meeting, they can nominate a deputy (if an appropriate deputy is available) to attend the meeting in their place.

5.2 Attendance by Officers

The HMB may call upon any employee to attend the Board.

5.3 Frequency of meetings

The HMB will meet no less than 10 times per year, usually once per calendar month.

6. Organisation and Reporting Structure

The minutes of HMB meetings shall be formally submitted to the Executive Team and the Board. The Chair of the Committee shall also draw to the attention of the Board any issues that require disclosure to the full Board, or require executive action via an Alert, Advise and Assure (AAAs) report and minutes.

The HMB will produce an annual work-plan/business cycle for the Board to approve at the beginning of each financial year, mapping out how it will fulfil its delegated duties.

6.1 Conduct of Meetings

The PA to the Chief Executive shall provide administrative support to the meeting and duties will include:

- Formally recording the minutes of the meeting
- Collation and distribution of papers
- Keeping a record of matters arising and issues to be carried forward

The agenda and papers for the meeting shall be distributed no less than four working days in advance of the meeting.

The agenda for the meeting shall be drawn up by Company Secretary in conjunction with the Chair (CEO) and in consultation with the Executive Team. Meetings are not open to members of the public.

Minutes of the meeting and the record of matters arising will be circulated promptly to all members as soon as reasonably practicable.

6.2 The Company Secretary will advise the HMB on matters of governance and business conduct

7. Monitoring of Performance and Effectiveness

The HMB will undertake an annual review of its performance and effectiveness against its work plan as set out in the Terms of Reference and the Trust's Annual Plan in order to evaluate the achievement of its duties. This review will be received by the Board of Directors.

8. Review of Terms of Reference

These Terms of Reference will be reviewed at least annually as part of the monitoring effectiveness process.

Southport and Ormskirk Hospital NHS Trust

Mortality Operational Group
Terms of Reference Document Control Sheet

MEETING	Mortality Operational Group (MOG)
ESTABLISHED BY /REPORTING TO:	Trust Board via the Quality and Safety Committee
AUTHOR:	Julie Gorry, Non-Executive Director & Chair of Quality and Safety Committee
REVIEWER:	Audley Charles, Interim Company Secretary
ASSOCIATED DOCUMENTS:	Trust Board Scheme of Reservation and Delegation Trust Board Standing Orders Quality Improvement Strategy Risk Management Strategy Corporate Risk Register Board Assurance Framework
RELATED COMMITTEES/GROUPS/ WORKSTREAMS	Trust Board Quality & Safety Committee Audit Committee Finance, Performance and Investment Committee **Sub Committee** Clinical Experience Committee **Related Work streams**: Deteriorating Patient (including Sepsis) CBU Mortality & Morbidity Meetings by CBU Clinical Pathways by CBU Tumour Group

Document Control	
Document Name	**Mortality Operational Group ToRs – Mar 2018v2**
File Name	**\\datamart1\shared files\Company Secretarial\18. TERMS OF REFERENCE (COMMITTEES)\1 TOR Sub Committees and Groups\ Mortality Operational Group ToRs – Mar 2018v2**
Version Number	**V1.1**

Version Control		
Version Ref	**Amendment**	**Date Approved by The Quality & Safety Committee**
V1.1	• Added time limited Strategy Committee to Governance Structure	June 2019

Terms of Reference of the Mortality Operational Group (MOG)

1 Authority

1.1 The Quality & Safety Committee has established a sub-Committee to be known as the Mortality Operational Group, hereafter referred to within this document as the *Group.*

1.2 The Group has the delegated authority to:

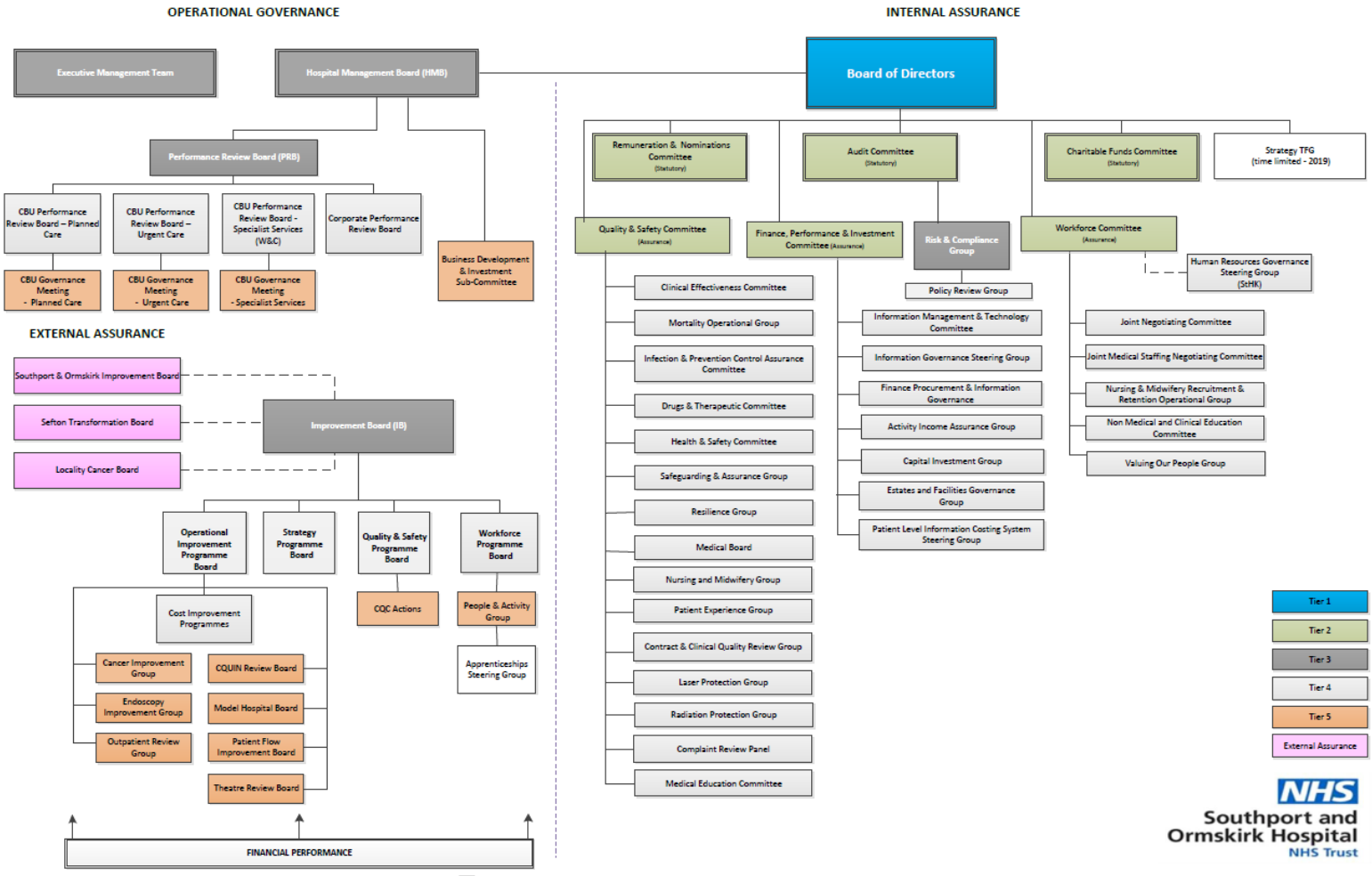
c) Seek any information it requires and/or call any employee of the Trust to a meeting of the Group in order to perform its duties as set out below.
d) Obtain, within the limits set out in the Trust's Scheme of Delegation, outside professional advice on any matter within its terms of reference.

1.3 The Group is a sub-committee of the Quality & Safety Committee (see **Diagram 1**) and has no executive powers other than those specifically delegated in these Terms of Reference. The Group will operate at an operational level.

1.4 Any changes to these Terms of Reference must be approved by the Quality & Safety Committee and ratified by the Board of Directors.

1.5 The Group will operate within the Terms of Reference of the Quality & Safety Committee.

Integrated Governance Structure



2 Purpose

2.1 The overall responsibility for managing and monitoring mortality and patient safety care lies with the Trust Board; however, the Quality & Safety Committee has established the Group to provide it with assurance regarding the effectiveness of all aspects of mortality and morbidity at an operational level within the Trust.

2.2 The Group will triangulate mortality and morbidity with patient safety, quality and risk issues with workforce performance addressing areas of concern or deteriorating performance as required.

2.3 The Group will consider diversity, inclusion and human rights throughout its assurance agenda

3 Principal Duties

3.1 The duties of the Group can be categorised as follows:

- Reviewing mortality data
- Specifically reviewing Tumour data
- Reviewing data from serious incident review, clinical simulation, exception reporting and freedom to speak up in so far as it relates to patient safety.
- Reviewing clinical outcomes
- Reviewing clinical service changes
- Seeking and providing assurance to the Quality & Safety Committee 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 deaths.

3.2 Specific Duties

m) Mortality process and reviews
n) Highlighting gaps in provision in 7 Day working and escalating same to Quality and Safety Committee
o) Coding
p) Reviewing other key performance indicators in order to monitor and evaluate mortality performance within the Trust
q) Making recommendations to the Quality and Safety Committee concerning the annual programme of internal audit work to the extent that it applies to matters within these terms of reference.

4 Constitution

4.1 Chair

The Group will be chaired by the Associate Medical Director for Patient Safety. In the absence of the Chair the Deputy Medical Director will be nominated in advance of the meeting to chair the meeting.

4.2 Membership

The members of the Group shall be appointed by the Quality and Safety Committee and ratified by the Board of Directors in accordance with the *Standing Orders* and shall consist of the following members:

- Associate Medical Director for Patient Safety (Chair)
- Trust Lead for clinical simulation and human factors
- Trust Lead for quality in education and training
- Freedom to Speak Up Guardian

- Chair, Medicines Safety Committee
- Project Lead and Quality Improvement Manager
- Chief Clinical Information Officer/ Trust Audit Lead
- Deputy Medical Director
- Deputy Director of Nursing & Midwifery
- Associate Medical Director, Urgent Care
- Associate Medical Director, Planned Care

In attendance:

- Assistant Director of Integrated Governance
- Head of Audit and Effectiveness
- Head of Risk Management
- Head of Information
- Quality Information Lead

Only members of the Group have the right to attend Group meetings. 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. Deputies shall not count towards the quorum of a meeting unless formal acting up status has been granted.

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

4.3 Quorum

A quorum will be no less than three Members (one of whom must be either the Chair of the Group or the nominated Chair) and one Deputy Director who must be either the Deputy Director of Nursing & Midwifery or the Deputy Medical Director. In the event of a tie, the Chair will have a casting vote.

In order for the decisions of the Group to be valid the meeting must be quorate.

4.4 Frequency of meetings

The Group will meet no less than ten times a year, usually once a calendar month for the first six months and then bi-monthly.

The Chair of the Group may arrange extraordinary meetings after consultation with the Medical Director or the Director of Nursing or both or at the request of Group members.

4.5 Organisation and Reporting Structure

The minutes of the Group meetings and an *Assure, Alert and Advise (AAAs)* report including minutes and highlighting key risks, shall be formally submitted to the Quality and Safety Committee. The Chair of the Group shall draw to the attention of the Committee any issues, including key risks that require disclosure to the full Committee, or require executive action.

The Group will report to the Committee after each meeting and annually on its work in support of the Mortality Agenda.

The Group will produce an annual work-plan or business cycle for the Quality and Safety Committee to approve at the beginning of each financial year, mapping out how the Group will fulfil its delegated duties.

4.6 Conduct of Meetings

The Personal Assistant to the Director of Nursing shall provide administrative support to the meeting. In their absence the Personal Assistant to the Director of Nursing and Midwifery will provide that support. Duties with include:

- Formally recording the minutes of the Group
- Collation and distribution of papers
- Keeping a record of matters arising and issues to be carried forward.

The agenda and papers for the meeting shall be distributed no less than five days in advance of the meeting.

The agenda for the meeting shall be drawn up by the Chair of the Group in consultation with the Medical Director.

Meetings are not open to members of the public.

Minutes of the meeting and the record of matters arising will be circulated promptly to all members as soon as reasonably practical.

Presenters of papers can expect all committee members to have read the papers and should keep to a summary that outlines the purpose of their paper and the key issues.

Group members may question the presenter.

4.7 Review of performance and effectiveness

The Group shall undertake a review of its performance and effectiveness twice annually, mid-year and at the end of the year.

4.8 Review

These Terms of Reference shall be reviewed twice annually Mid-year and end of year) or in light of changes in practice or legislation.

Approved by:

Date of approval:

Date of review:

Southport and Ormskirk Hospital NHS Trust

Clinical Effectiveness Committee
(CEC)

1 Authority

1.1 The CEC operates within the Trust Standing Orders and Standing Financial Instructions.

1.2 The CEC has the delegated authority to obtain, within the limits set out in the Trust Scheme of Delegation, outside professional advice on any matter within its terms of reference.

1.3 The board is established to act as a sub group of the Quality and Safety Committee, a sub-committee to the Trust Board of Southport and Ormskirk Hospital NHS Trust. See **Diagram 1**.

1.4 The Chair of the board escalates items using the Alert / Advise / Assure framework.

4 Purpose

4.1 The purpose of the CEC is to bring together the collective leadership voice in the delivery of high quality, effective and sustainable services.

4.2 The CEC will provide assurance to the QSC that the organisation is fulfilling its regulatory activity in line with CQC, NHSI and other statutory bodies.

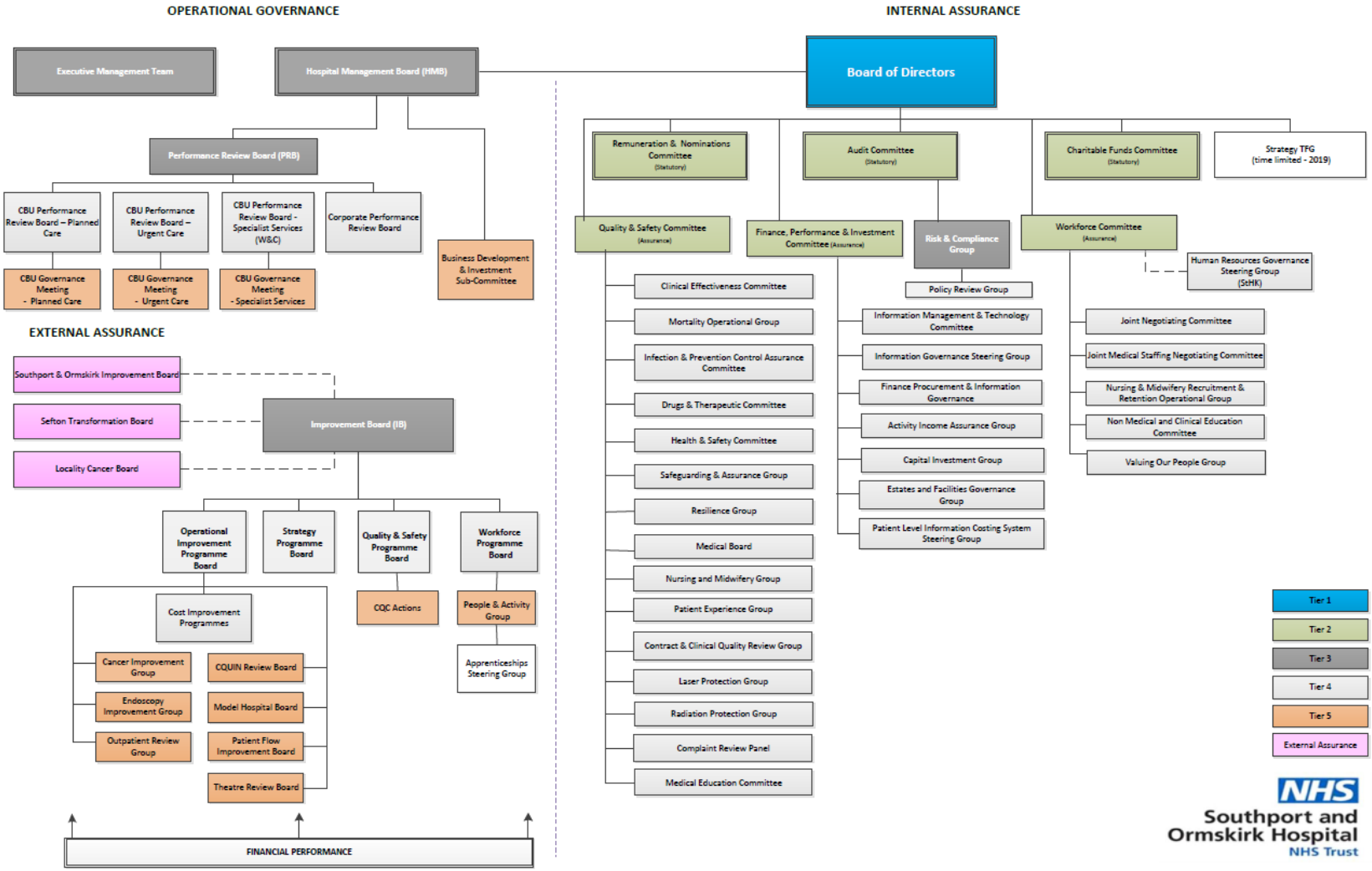
4.3 The CEC will promote, a representative and supported workforce built on inclusive leadership through focusing on the facets of high quality care, clinical effectiveness and patient safety

4.4 The CEC will provide professional advice to the Board of Directors on professional issues and provide assurance against key outcomes and objectives.

4.5 The CEC will provide a forum, in which best practice is shared and the requirements of the clinical strategy key initiatives and delivery of the trusts quality indicators are reviewed and driven through to implementation.

Diagram 1

Integrated Governance Structure



5 Principal Duties

In order to achieve its purpose the CEC will:

3.1 Ensure people's needs are assessed and care and treatment delivered in line with current legislation, standards and evidence-based guidance to achieve effective outcomes

3.2 Ensure people's care and treatment outcomes are monitored and how they compare with other similar services

3.3 In Liaison with professional boards, ensure staff have the skills, knowledge and experience to deliver effective care, support and treatment

3.4 Ensure services take account of the particular needs and choices of different people and have systems and processes in place to assess and meet their needs accordingly

3.5 Ensure staff, teams and services work together within and across the trust to deliver effective care and treatment

3.6 Ensure people are supported to live healthier lives and, where the trust is responsible, implement services, systems and processes to improve the health of its population

3.7 Ensure consent to care and treatment is always sought in line with legislation and guidance

3.8 Ensure there are robust systems and processes in place for learning, continuous improvement and innovation

3.9 Ensure there is a systematic programme of clinical and internal audit to monitor quality, operational and financial processes, and systems in place to identify where action should be taken

3.10 Ensure appropriate and accurate information is being effectively processed, challenged and acted on

3.11 Ensure information technology systems are used effectively to monitor and improve the quality of care

3.12 Ensure there are robust arrangements (including appropriate internal and external validation) to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems, in line with data security standards, are in place. Ensure lessons learned when there are data security breaches is shared and implemented

6 Membership

The CEC membership will be appointed by the Medical Director and will consist of:

4.1 Core Members:

- Medical Director - Chair
- Deputy Medical Director – Deputy Chair
- Director of Nursing, Midwifery, Therapies & Governance

- Deputy Director of Nursing, Midwifery, Therapies and Governance
- Clinical Audit lead and Chief Clinical Information Officer
- Head of Clinical Audit and Effectiveness
- Matron Patient Experience
- Assistant Director for Quality
- Assistant Director for Governance
- A representative from each CBU
- A representative from Estates and Facilities
- Lead for Consent
- Chair of Medical Devices
- End of Life Lead
- Lead for IM&T / EPR
- Lead for Organ Donation
- Lead for Human Tissue Act
- Lead for Transfusion
- Lead for Therapies
- Director of Research and Innovation
- Tissue Viability lead
- Lead for Pharmacy

4.2 Other key individuals will be co-opted to the CEC dependant on key work streams to be initiated.

4.3 The Deputy Chair or nominated individual will automatically assume the authority of the Chair should the latter be absent.

4.4 The chair of CEC is responsible to provide an AAA highlight report to the QSC

4.5 Chairs of groups which report into CEC will be responsible to provide and AAA highlight report to CEC

4.6 Members are responsible to provide feedback to their CBU / Teams / committees they represent, and any agreed actions or recommendations as required

4.7 Appropriate deputy to attend meeting when members unable to attend.

5 Quorum

5.1 A quorum will be no less than 5 members. In order for the decisions of the group to be valid the meeting must be quorate.

5.2 Chair or deputy will need to attend to ensure the meeting is quorate.

6 Frequency of Meetings

6.1 The group will meet no less than 10 times a year

6.2 The group may establish ‘task and finish’ groups to deliver specific actions

7 Organisation

7.1 The agenda and papers for the meeting shall be distributed 7 days in advance of the meeting.

7.2 The Terms of Reference shall be reviewed annually or in light of changes in practice or legislation.

7.3 The group will be supported by the Assistant Director of Governance, Personal Assistant.

Approved by: **CEC**
Submitted to: Quality and safety Committee

Date of approval: July 2017
Date for review: July 2019

RISK AND COMPLIANCE GROUP

Terms of Reference

Version:	1
Appendix	List of members
Approved by:	Audit Committee – TBC
Signed off by:	Risk and Compliance Group– TBC
Date issued:	18 October 2018
Review date:	TBC

RISK & COMPLIANCE GROUP

Terms of Reference

Constitution

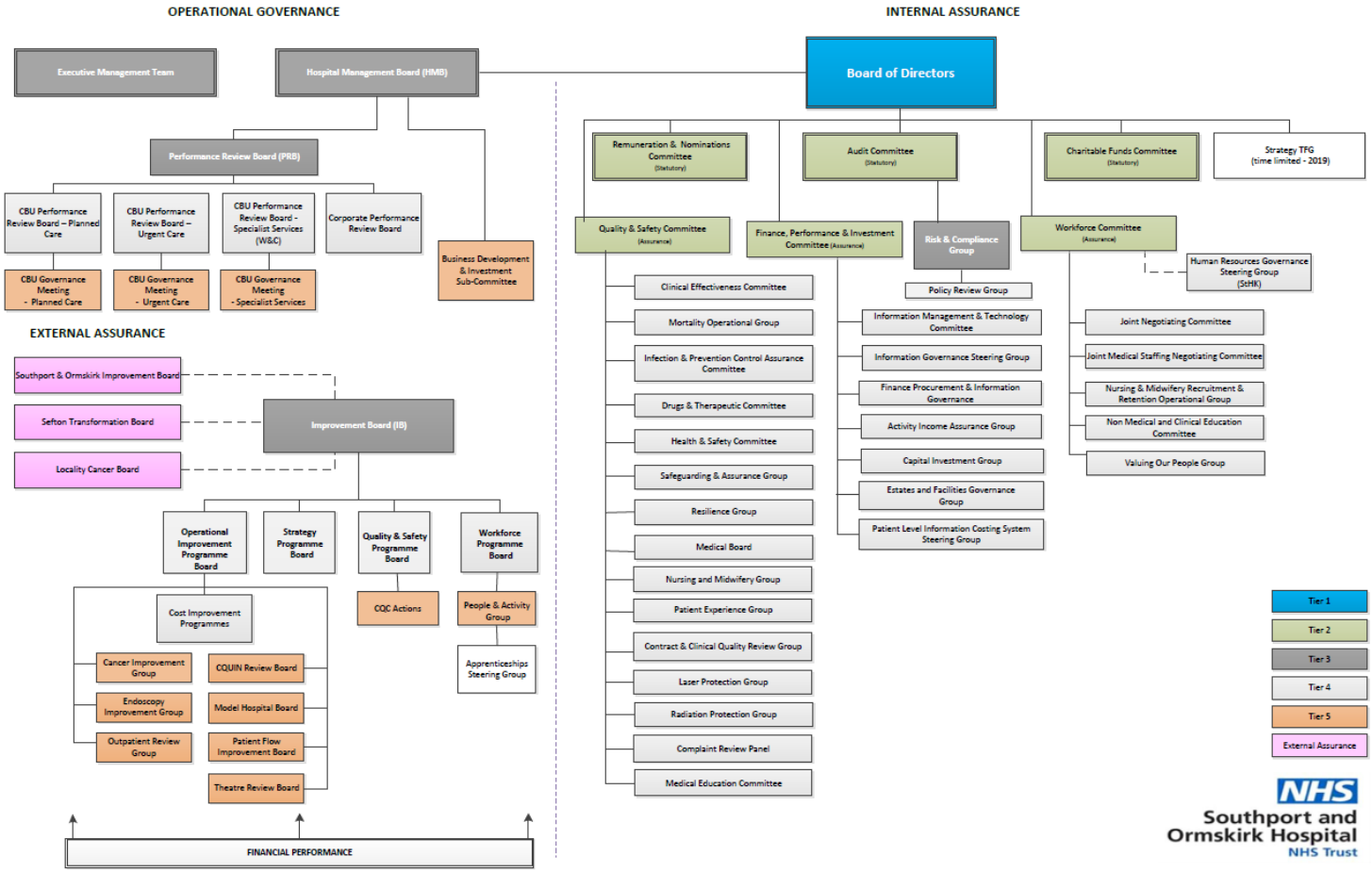
The Audit Committee hereby resolves to establish a Group to be known as the Risk and Compliance Group. The Risk and Compliance Group has no executive powers, other than those specifically delegated in these Terms of Reference.

1. Authority

The Group is authorised by the Audit Committee to which it is accountable, to investigate or approve any activity within its terms of reference. It is also authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Group.

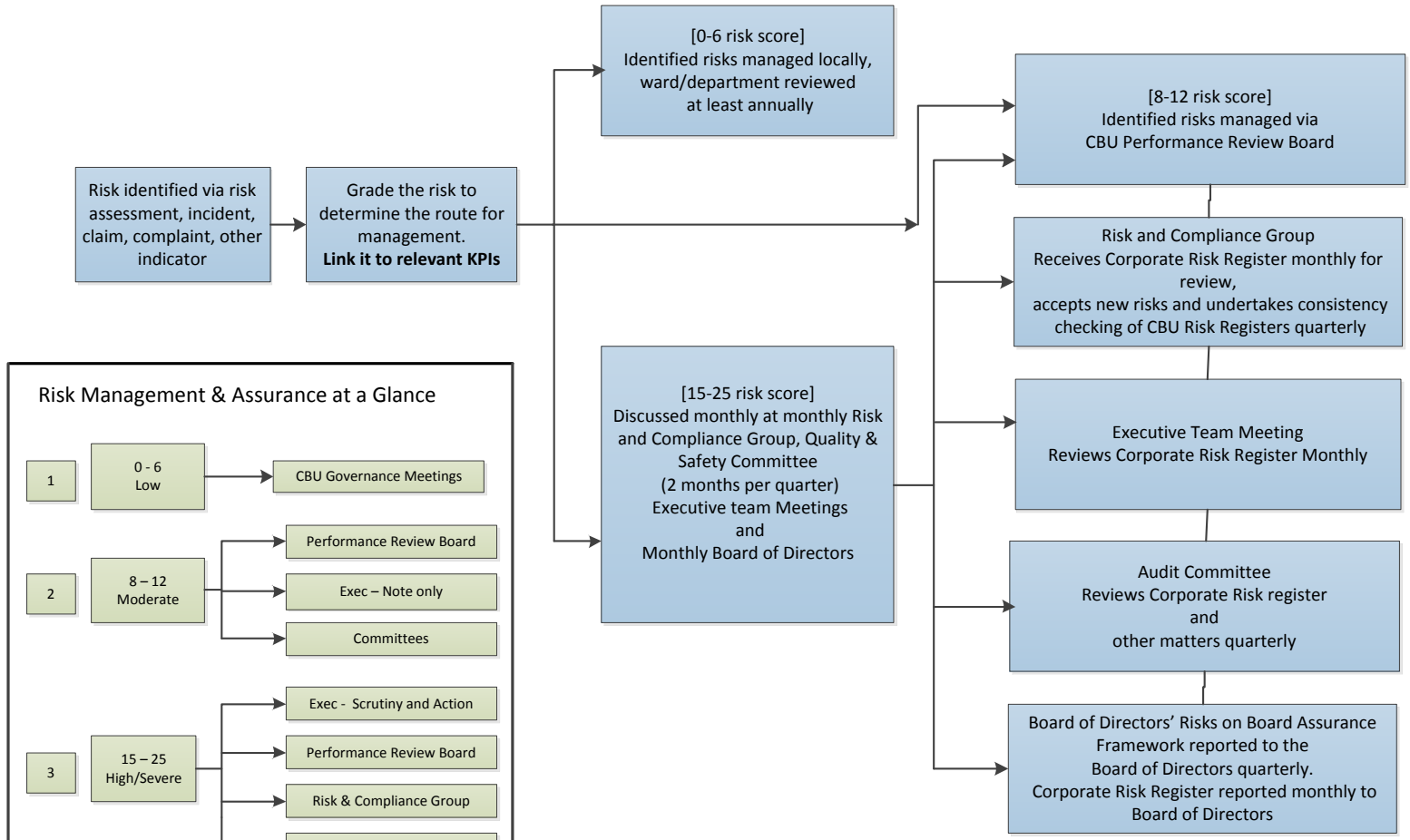
The Trust's Integrated Governance Structure illustrates its approach to governance and assurance and is shown below at **Figure 1**. **Figure 2** illustrates our approach to Management and Assurance of Risks.

Integrated Governance Structure



Management and Assurance of Risks

Southport and Ormskirk Hospital NHS Trust



2. Purpose

The purpose of the Group is to promote effective risk management, regulation and compliance and to maintain a dynamic Board Assurance Framework, risk registers and compliance and regulatory registers through which the Board can monitor the arrangements in place to achieve a satisfactory level of corporate integrated internal control, safety and quality.

The Group will promote local level responsibility and accountability and will challenge risk assessment and risk assurance arrangements in areas of Trust activity where robust controls are not evident, in order to raise standards and ensure continuous improvement.

3. Duties

The duties of the Group are compliance and monitoring related and are to:

Ensure there is an effective and comprehensive system in place for pro-actively managing compliance Trust-wide and within each Corporate Business Unit through compliance and regulation registers. This includes developing and maintaining systems for the regular evaluation and monitoring of compliance and regulation against any relevant internal and external audit recommendations, external assessments (e.g. Care Quality Commission (CQC)), accreditations, service reviews, standards and criteria; as directed by the Board of Directors. Compliance registers will be reviewed at every other meeting of the Group, Policy Management, compliance with Provider Licence and Annual Governance Statement.

Compliance

a) Identify associated compliance risks for inclusion on the risk register relating to compliance, regulation, accreditation or external review is a duty of the Group

b) Receive any reports from the CQC and monitor compliance with progress with CQC recommendations, compliance and action plans to maintain compliance.

c) Quarterly report on the Accountability Framework

d) Produce an annual report of the work of the Group to the Audit Committee

e) Receive and review quarterly reports on claims and legal advice and expenditure activity under the NHS Resolution insurance scheme and ensure a robust process is in place for the organisation to learn from claims to improve services and reduce future claims activity.

f) Develop and review progress against an annual governance and risk action plan, ensuring it supports the achievement of the Trust's corporate objectives.

g) Review the Annual Governance Statement and make recommendations before it is published in the Annual Report.

Risk Management

a) Oversee the development, maintenance and embedding of the Trust's Risk Management Strategy, Risk Management Policy and related risk management policies

b) Ensure that risks are taken and managed in line with the organisation's risk appetite approved by the Board.

c) Co-ordinate the identification of all risks: clinical, corporate, financial and organisational, and ensure that systems are in place to manage those risks effectively by:

- Monitoring and reviewing the composition and maintenance of the Board's Assurance Framework, the control and assurance mechanisms in place and the additional actions being taken to address gaps in control and assurance;

- Monitoring and reviewing the Trust's Risk Register, ensuring action is taken as appropriate and that unacceptable or serious risks are escalated as appropriate;

- Receiving and reviewing progress reports on the implementation of action plans resulting from risk assessments of the Trust's activities;

- Identify any risks occurring from other information sources, e.g. limited assurance, audit reports, training reports or compliance and regulation registers, serious incident investigations;

Policy Management

a) Ensure all procedural documents reviewed by the Policy Review Group (PRG) are scrutinised and monitored for compliance in accordance with the Policy for the Development and Management of Procedural Documents by receiving monthly reports from the PRG.

b) Receive an Annual report of its work from the PRG.

5. Membership and attendance

- Director of Nursing, Midwifery & Therapies (Chair)
- Company Secretary (Deputy Chair)
- Chief Operating Officer
- Deputy Director of Nursing (Quality)
- Assistant Director of Quality
- Assistant Director of Integrated Governance
- Performance Manager
- Assistant Director of Finance
- Assistant Director of Human Resources
- Head of Risk
- Information Governance Manager
- Clinical Business Unit Triumvirate representation – (one of either Associate Director of Operations, Assistant Medical Director and Head of Nursing from each CBU)
- Head of Estates and Facilities

- Head of Education & Training

Other members may be co-opted on to the Group as required: either for additional work or for the purpose of communication or presentation.

6. Attendance

Attendance is required by members (or nominated deputies) at 75% of meetings. Members unable to attend should indicate in writing to the Head of Risk, at least 7 days in advance of the meeting, except in extenuating circumstances of absence. In normal circumstances members who are unable to attend must nominate a deputy who is appropriately briefed to participate in the meeting.

A register of attendance will be maintained and the Chair of the Group will follow up any issues related to the unexplained non-attendance of members. Should continuing non-attendance by a member jeopardize the functioning of the Group, the Chair will discuss the matter with the member and, if necessary, seek a substitute or replacement.

7. Administration

The Group shall be supported by the PA to the Director of Nursing, whose duties in this respect will include:

- In consultation with the Chair and Deputy Chair, develop and maintain an annual reporting schedule for the Group
- Collation of papers and drafting of the agenda for agreement by the Chair and Deputy Chair of the Group;
- Taking the minutes and keeping a record of matters arising and issues to be carried forward;
- Develop an Action Plan (matters Arising) following each meeting of activities requested by the Group
- Advising the Group on scheduled agenda items; and
- Agreeing and circulating the action schedule following each meeting
- Maintaining a record of attendance.

In the absence of the PA to the Director of Nursing, the PA to the Company Secretary will deputise for him/her.

8. Meetings

- Will be held on a monthly basis;
- Will be no longer than two (2) hours;
- In the absence of the Chair the Deputy Chair will chair the meeting.
- Items for the agenda must be sent to the PA to the Director of Nursing a minimum of 14 days prior to the meeting: in exceptional circumstances urgent items may be raised under any another business;
- The agenda will be sent out to the Group's members at least two (2) weeks prior to the meeting date, together with the action schedule and other associated papers;
- Papers for the meeting will be circulated to members at least seven (7) days before the meeting

- An action schedule will be circulated to members following each meeting and must be duly completed and returned to the PA to the Director of Nursing for circulation with the following meeting's agenda and associated papers.

9. Reporting

The minutes of the Group meetings shall be formally recorded by the PA to the Director of Nursing and submitted to the Audit Committee members.

The Group will also provide an AAA Highlight Report quarterly and an Annual Report in support of its work on promoting good risk management and assurance processes to the Audit Committee. The Chair of the Risk and Compliance Group shall, however, at any time, draw to the attention of the Audit Committee any particular issue which requires the attention of that Committee.

The Group will receive reports as per the reporting schedule. These include, but are not limited to:

- Quarterly Board Assurance Framework
- Monthly high level risk register
- Quarterly report on the Accountability Framework
- Rolling program of risk reports from each Corporate Business Unit and corporate department.
- Rolling program of compliance registers from each Corporate Business Unit (alternate months)
- Quarterly update on risk management action plan
- Regular update on compliance and regulation with any Care Quality Commission recommendations, NHS Improvement issues, Health and Safety legislation.
- Compliance with Provider License
- Policy Management Reports from Policy Review Group

10. Quorum

A quorum shall be one third of the members (or nominated deputies) in attendance, of which one must be the Chair or Deputy Chair.

11. Review

These Terms of Reference shall be reviewed on an annual basis, approved by the Group and ratified by the Audit Committee

12. Monitoring Performance and Effectiveness

In order that the Group can be assured that it is performing at maximum effectiveness in discharging its responsibilities as set out in these terms of reference and if necessary, to recommend any changes to the Audit Committee, the Chair will ensure that twice a year a review of the following is undertaken and reported to the next meeting of the Group.

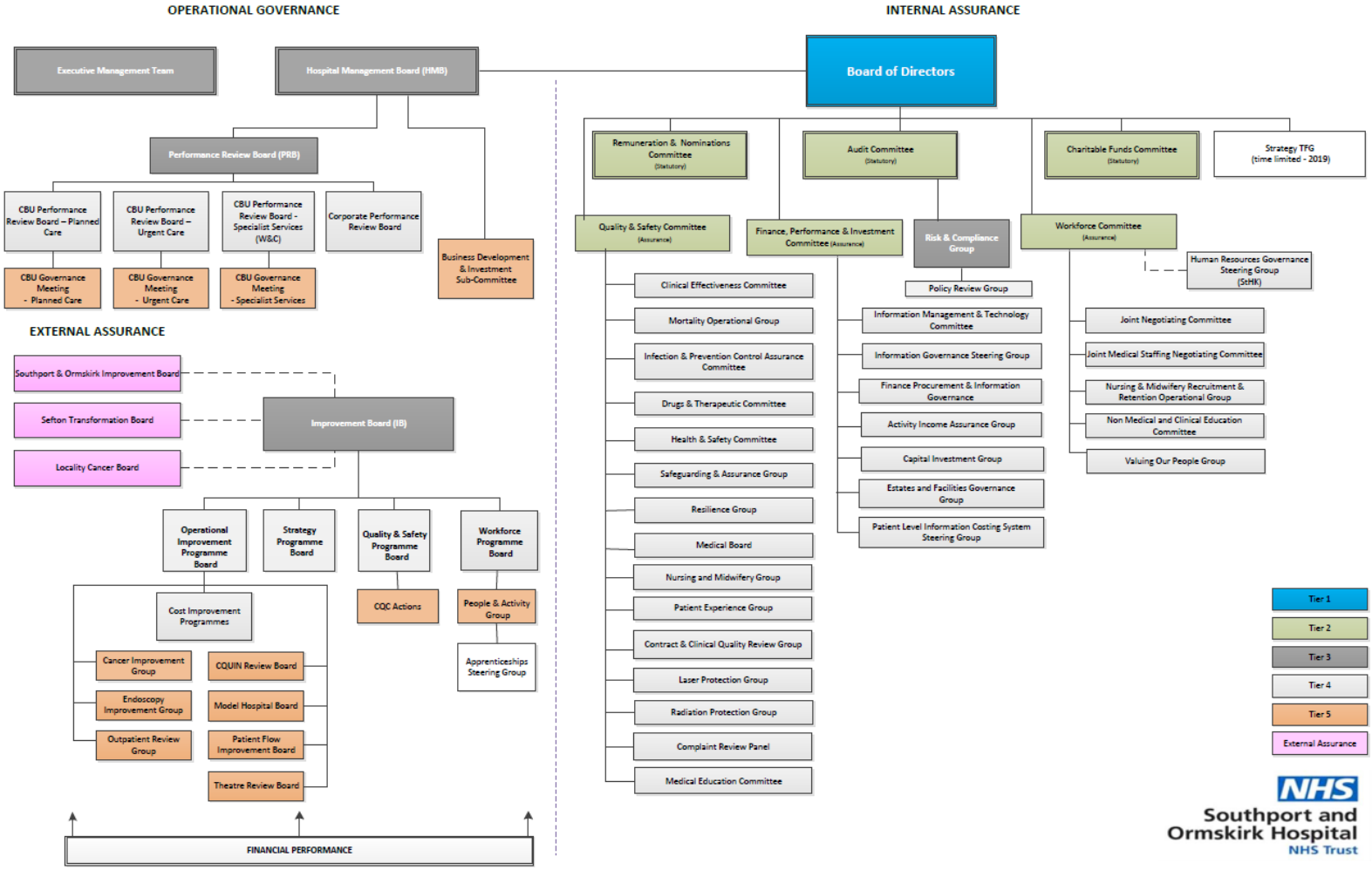
- The objectives set out in section three (3) were fulfilled.
- Members (or nominated deputies) attendance was achieved 75% of the time.
- Provide an Annual Report of its activities to the Audit Committee

Southport and Ormskirk Hospital NHS Trust

Policy Review Group
Terms of Reference

TOPIC AREAS	DETAILS
Responsibilities	To scrutinise and review Trust policies and related documentation and make recommendations for approval under authority delegated by the Board of Directors.
Remit	**The Group will**: • Scrutinise and review policies to ensure they follow NHS guidance and Trust's directives and provide the relevant assurance committee and the Board with a summary of its recommendations and the rationale for same (see **Diagram 1**) • Recommend related documentation for approval • Ensure that documentation is presented in the Trust format and has been catalogued on the Trust database • Monitor the adherence to the developmental processes to maintain the quality of documentation
Accountability Arrangements	The Group is accountable to the Board of Directors through its assurance Committees.

Integrated Governance Structure



Membership/Attendees	**Membership:** • Company Secretary (Chair) • Information Governance Manager (Deputy Chair) • Deputy Medical Director, or nominated representative • Head of Risk • Assistant Director of Nursing (Safer Staffing) • Assistant Director of Operations – rotational or nominated representative • Assistant Director of Human Resources Governance • Estates & Facilities Lead • Assistant Director of Finance **In Attendance:** Other staff of the Trust may be requested to attend for specific matters. Where a member is unable to attend routinely, an appropriate deputy, who will attend on a regular basis should be nominated and notified to the Chair.
Quorum	A quorum will consist of four members, one of whom must be the Chair or Deputy Chair and the Head of Risk.
Chair	The Company Secretary will chair the meeting
Administrative Support	Administrative support will be provided by the Trust Secretariat. Agenda and papers will be circulated not less than one week prior to the meeting.
Reporting Arrangements	The Group will provide a summary report outlining the policies recommended for approval to the Executive Management Team (ETM), Hospital Management Board (HMB) for review and the relevant assurance committee and to the Board of Directors if applicable.
Frequency of Meeting	The Group shall meet monthly but may move two-monthly once all policies are in date and systems and processes are working to their optimum. The Chair may call an additional or special purposes meeting if he/she considers one is necessary or evoke emergency powers as set out in Section: 7 of the Policy for Management of Policies where it is crucial for compliance and regulatory reasons that a policy be approved. Such powers may be exercised by the Chair, Vice Chair, a clinician on the Group and the Head of Risk
Standards	National Health Service Resolution Risk Management Standards, all standards at level 1.

12. Board & Committees Performance & Effectiveness Tool

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

BOARD OF DIRECTORS' CODE OF CONDUCT

1 Introduction

1.1 Public service values are and must remain at the heart of the National Health Service. High standards of corporate and personal conduct based on a recognition that patients come first are an essential component of public services. Moreover, since the NHS is publicly funded it must be accountable to Parliament for the services it provides and for the effective and economical use of those public funds.

1.2 As an NHS Trust, Southport and Ormskirk NHS Hospital Trust is required to comply with the principles of best practice applicable to corporate governance in the NHS/health sector and with any relevant code of practice.

1.3 The expectations of the NHS in respect of standards of corporate conduct are set out in guidance issued by the *Department of Health and in a Code of Conduct and Code of Accountability in the NHS issued by the Department of Health.* This Code is consistent with that guidance and, together with the *Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation*, *Fit and Proper Persons' Regulations Policy and Procedure, Standards of Business Conduct and Managing Conflict of Interests,* Anti-Bribery, *Fraud and Corruption Policy,* forms part of the framework designed to promote the highest possible standards of conduct and behaviour within the Trust. The Code applies at all times when directors and employees are carrying out the business of the Trust or representing the Trust.

2 Principles of Public Life

2.1 All directors and employees are expected to abide by the 'Nolan principles', which are the basis of the ethical standards expected of public office holders:

Nolan Principles

Selflessness
Holders of public office should act solely in terms of public interest. They should not do so in order to gain financial or other material benefits for themselves, their family or friends.

Integrity
Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.

Objectivity
In carrying out public business, including making public appointments, awarding contracts, recommending individuals for rewards and benefits, holders of public office should make choices on merit alone.

Accountability
Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

Openness
Holders of public office should be as open as possible about all the decisions and action they take: they should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

Honesty
Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

Leadership
Holders of the public office should promote and support these principles by leadership and example.

2.2 Board members are also expected to comply with the Professional Standards Authority's 'Standards for members of NHS Boards and Clinical Commissioning Group governing bodies in England'. (Appendix A).

3 General Principles

3.1 NHS Employees have a duty to conduct NHS business with probity, to respond to staff, patients and suppliers impartially, to achieve value for money from the public funds with which they are entrusted and to demonstrate high ethical standards of personal conduct. The general duty of the Board of Directors collectively, and of each Director individually, is to act with a view to promoting the success of the organisation so as to maximise the benefits for stakeholders as a whole, including the public. The Board of Directors undertakes to set a vigorous and visible example in the conduct of its business and to promote the highest corporate standards of conduct. The Board of Directors will lead in ensuring that the *Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation* conform to best practice and serve to enhance standards of conduct. The Board of Directors accepts its clear responsibility for corporate standards of conduct and expects that this Code will inform and govern the decisions and conduct of all Board directors.

3.2 Openness and Public Responsibilities

Health needs and therefore health services do not stand still. There should be a willingness to be open with the public, patients and staff as services develop and change. It is a statutory requirement that major changes are consulted upon before decisions are reached. Information supporting those decisions, and other decisions made by the Board of Directors, should be made available in way that is understandable. Positive responses should be given to reasonable requests for information and in accordance with the *Freedom of Information Act 2000* and other applicable legislation, and directors and employees must not seek to prevent a person from gaining access to information to which they are legally entitled.

NHS business should be conducted in a way that is socially responsible. As the largest employee in the local community the Trust wishes to maintain an open and positive relationship with the local community and work with staff and partners to set out a vision for the organisation in line with the expectations of patients and the public. The Trust will seek to demonstrate to the public that it is concerned with the

wider health of the population including the impact of the Trust's activities on the environment.

The Trust has adopted policies and procedures to protect confidentiality of personal information and to ensure compliance with the Data Protection Act, the Freedom of Information Act and other relevant legislation which will be followed at all times by Board Directors and all staff. Directors and employees must not disclose any confidential information except in specified lawful circumstances.

3.3 Public Services Values in Management

It is unacceptable for the Board of any NHS organisation, or any individual within the organisation for which the board is responsible, to ignore public service value in achieving results. Board Members have a duty to ensure that public funds are properly safeguarded and that at all times the Board conduct its business as economically, efficiently and effectively as possible – as required by statute.

Accounting, tendering and employment practices within the Trust must therefore reflect the highest professional standards. Public statements and reports issued by or on behalf of the Board should be clear, comprehensive and balanced, and should fully represent the facts. Annual and other key reports should be issued in good time to all individuals and groups in the community who have a legitimate interest in health issues to allow full consideration by those wishing to attend public meetings on local health issues.

The standards of conduct expected by the Trust are set out in the Standing Financial Instructions and accompanying Scheme of Reservation and Delegation which will be followed at all times by Board directors and all staff.

3.4 Public Business and Private Gain

The Chair and Board of Directors should act impartially and not be influenced by social or business relationships. Directors have a statutory duty to avoid a situation in which they have (or can have) a direct or indirect interest that conflicts (or may conflict) with the interests of the Trust. None should use their public position to further their private interests. Where there is potential for private interests to be material and relevant to NHS business the nature and extent of the relevant interests must be declared at the earliest opportunity and recorded in the Board minutes and entered into the register of interests which is available to the public.

When a conflict of interest is established the Board Director must withdraw and play no part in the relevant discussion or decision. The Chair will advise directors in respect of any conflicts of interest that arise during Board of Directors meetings, including whether the interest is such that the director should withdraw from the meeting for the period of the discussion. In the event of disagreement it is for the Board of Directors to decide whether a director must withdraw from the meeting. The Company Secretary will provide advice on any conflicts that arise between meetings.

The *Standards of Business Conduct and Managing Conflict of Interests Policy* define those interests which must be declared by Directors and will be followed at all times by Board directors and all staff. It is responsibility of each Director to update the

register entry if their interests change. A pro forma is available from the Company Secretary. Failure to register a relevant interest in a timely manner may constitute a breach of this code.

3.5 Hospitality and Other Expenditure

The Board will set an example in the use of public funds and the need for good value in incurring public expenditure, including hospitality at conferences or seminars, will be carefully considered. All expenditure on these items should be capable of justification as reasonable in the light of the general practice in the public sector. The Board is conscious of the fact that expenditure on hospitality or entertainment is the responsibility of management and is open to be challenged by the internal and external auditors and that ill-considered actions can damage the reputation of the Trust and respect for the NHS in the eyes of the community.

The Board has adopted the *Standards of Business Conduct and Managing Conflict of Interests Policy* which will be followed at all times by Board directors and all staff. Directors must not accept gifts or hospitality other than in compliance with this policy.

3.6 Relations with Suppliers

The Board acknowledges the need for an explicit procedure for the declaration of hospitality and sponsorship offered by, for example, suppliers. Their authorisation should be carefully considered and the decisions recorded. The Board is mindful of the risks in incurring obligations to suppliers at any stage of a contracting relationship. Directors have a statutory duty not to accept a benefit from a third party by reason of being a Director or for doing (or not doing) anything in that capacity. Suppliers should be selected on the basis of quality, suitability, reliability and value for money.

The Board has adopted *Standing Financial Instructions* and the Standards of Business Conduct and Managing Conflict of Interests Policy which will be followed at all times by Board Directors and all staff.

3.7 Freedom to Speak Up (Raising Concerns) (Whistleblowing)

The Board acknowledges that staff must have a proper and widely publicised procedure for voicing complaints or concerns about maladministration, malpractice, breaches of this Code and other concerns of an ethical nature.

The Board has adopted a whistleblowing policy on raising matters of concern which will be followed by the Board Directors and all staff when invoked.

The Board affirms that:

- Staff who have concerns should raise these reasonably and responsibly with the right parties as identified by the Trust.
- The Trust gives a clear commitment that staff concerns will be taken seriously and investigated.
- The Trust gives an unequivocal guarantee that staff who raise concerns responsibly and reasonably in accordance with its policies will be protected against victimisation.

4 Code Provisions

4.1 Directors are expected to conduct themselves in a manner that reflects positively on the Trust and not to conduct themselves in a manner that could reasonably be regarded as bringing the Trust into disrepute.

Directors must:

- Act in the best interests of the Trust and adhere to its values and this Code of conduct.

- Uphold the *SCOPE* values of the Trust (**see Appendix B**) and ensure that their conduct is at all times:

  Supportive
  Caring
  Open and Honest
  Professional
  Efficient

- Respect others and treat them with dignity and fairness.

- Seek to ensure that no one is unlawfully discriminated against and promote equal opportunities and social inclusion.

- Be honest and act with integrity and probity.

- Contribute to the workings of the Board of Directors in order for it to fulfil its role and functions.

- Recognise that the Board of Directors is collectively responsible for the exercise of its powers and the performance of the Trust, but, where appropriate, raise concerns and provide appropriate challenge regarding the running of the Trust or a proposed action.

- Whilst operating as a unitary Board recognise the differing roles of the Chair, Senior Independent Director, Chief Executive, Executive Directors and Non-Executive Directors.

- Make every effort to attend meetings where appropriate.

- Adhere to good practice in respect of the conduct of meetings and respect the views of others.

- Take and consider advice on issues where appropriate.

- Respect the confidentiality of the information they are made privy to as a result of their role as a director.

- Declare any conflict of interest to the Board of Directors as soon as they become aware of it.

- Not use their position for personal advantage or seek to gain preferential treatment.

- Comply with the Trust's Standard of Business Policy, as set out in the Standing Orders, in relation to the acceptance of gifts and hospitality.

- Conduct themselves in such a manner as to reflect positively on the Trust, and be ambassadors of the Trust when attending events in their role as a director.

- Accept responsibility for their performance, learning and development.

5 Compliance

5.1 The directors of the Board will satisfy themselves that the actions of the Board and its directors in conducting Board business fully reflect the values, general principles and provisions in this Code and, as far as is reasonably practicable, that concerns expressed by staff or others are fully investigated and acted upon.

5.2 All Board directors, on appointment, will be required to subscribe to this Code of Conduct. Compliance with the Code will be routinely monitored by the Chair and included as part of each Board director's annual appraisal.

Declaration:

I, (**print name**) agree to abide by the Board of Directors Code of Conduct of Southport & Ormskirk Hospital NHS Trust.

Signature:

Designation:

Date:

Appendix A

STANDARDS FOR MEMBERS OF NHS BOARDS AND CLINICAL COMMISSIONING GROUP GOVERNING BODIES IN ENGLAND

All members of NHS Boards and CCG governing bodies should understand and be committed to the practice of good governance and to the legal and regulatory frameworks in which they operate. As individuals they must understand both the extent and limitations of their personal responsibilities.

To justify the trust placed in me by patients, service users, and the public, I will abide by these Standards at all times when at the service of the NHS.
I understand that care, compassion and respect for others are central to quality in healthcare, and that the purpose of the NHS is to improve the health and well-being of patients and service users, supporting them to keep mentally and physically well, to get better when they are ill and, when they cannot fully recover, to stay as well as they can to the end of their lives.
I understand that I must act in the interests of patients, service users and the community I serve, and that I must uphold the law and be fair and honest in all my dealings.

PERSONAL BEHAVIOUR

1 As a Member of an NHS Board I commit to:

- The values of the NHS Constitution
- Promoting equality
- Promoting human rights
- In the treatment of patient and service users, their families and carers, the community, colleagues and staff, and in the design and delivery of services for which I am responsible.

2 I will apply the following values in my work and relationships with others:

- **Responsibility:** I will be fully accountable for my work and the decisions that I make, for the work and decisions of the Board, including delegated responsibilities, and for the staff and services for which I am responsible.

- **Honesty:** I will act with honesty in all my actions, transactions, communications, behaviours and decision-making, and will resolve any conflicts arising from personal, professional or financial interests that could influence or be thought to influence my decisions as a Board member.

- **Openness:** I will be open about the reasoning, reasons and processes and underpinning my actions, transactions, communications, behaviours and decision-making and about any conflicts of interest.

- **Respect:** I will treat patients and service users, their families and carers, the community, colleagues and staff with dignity and respect at all times.

- **Professionalism:** I will take responsibility for ensuring that I have the relevant knowledge and skills to perform as a Board member and that I reflect on and identify any gaps in my knowledge and skills, and will participate constructively in appraisal of myself and others. I will adhere to any professional or other codes by which I am bound.

- **Leadership:** I will lead by example in upholding and promoting these Standards, and use them to create a culture in which their values can be adopted by all.

- **Integrity:** I will act consistently and fairly by applying these values in all my actions, transactions, communications, behaviours and decision-making, and always raise concerns if I see harmful behaviour or misconduct by others.

TECHNICAL COMPETENCE

3 As a Board Member, for myself, my organisation, and the NHS, I will seek:

- Excellence in clinical care, patient safety, patient experience, and the accessibility of services.
- To make sound decisions individually and collectively.
- Long term financial stability and the best value for the benefit of patients, service users and the community.

4 I will do this by:

- Always putting the safety of patients and service users, the quality of care and patient experience first, and enabling colleagues to do the same.
- Demonstrating the skills, competencies and judgement necessary to fulfil my role, and engaging in training, learning and continuing professional development.
- Having a clear understanding of the business and financial aspects of my organisation's work and of the business, financial and legal contexts in which it operates.
- Making the best use of my expertise and that of my colleagues while working within the limits of my competence and knowledge.
- Understanding my role and powers, the legal, regulatory, and accountability frameworks and guidance within which I operate and the boundaries between the executive and non-executive.
- Working collaboratively and constructively with others, contributing to discussions, challenging decisions, and raising concerns effectively.
- Publicly upholding all decisions taken by the Board under due process for as long as I am a member of the Board.
- Thinking strategically and developmentally.
- Seeking and using evidence as the basis for decisions and actions.
- Understanding the health needs of the population I serve.
- Reflecting on personal, Board, and organisational performance, and on how my behaviour affects those around me, and supporting colleagues to do the same.
- Looking for the impact of decisions on the services we and others provide, on the people who use them, and on staff.
- Listening to patients and service users, their families and carers, the community, colleagues, and staff, and making sure people are involved in decisions that affect them.

- Communicating clearly, consistently and honestly with patients and service users, their families and carers, the community, colleagues, and staff, and ensuring that messages have been understood.
- Respecting patients' rights to consent, privacy and confidentiality, and access to information, as enshrined in data protection and freedom of information law and guidance.

BUSINESS PRACTICES

5 As a Board Member, for myself and my organisation, I will seek:

- To ensure my organisation is fit to serve its patients and service users, and the community.
- To be fair, transparent, measured, and thorough in decision-making and in the management of public money.
- To be ready to be held publicly to account for my organisation's decisions and for its use of public money.

6 I will do this by:

- Declaring any personal, professional or financial interests and ensuring that they do not interfere with my actions, transactions, communications, behaviours or decision-making, and removing myself from decision-making when they might be perceived to do so.
- Taking responsibility for ensuring that any harmful behaviour, misconduct, or systems weaknesses are addressed and learnt from, and taking action to raise any such concerns that I identify.
- Ensuring that effective complaints and whistleblowing procedures are in place and in use.
- Condemning any practices that could inhibit or prohibit the reporting of concerns by members of the public, staff, or Board Members about standards of care or conduct.
- Ensuring that patients and service users and their families have clear and accessible information about the choices available to them so that they can make their own decisions.
- Being open about the evidence, reasoning and reasons behind decisions about budget, resource and contract allocation.
- Seeking assurance that my organisation's financial, operational, and risk management frameworks are sound, effective and properly used, and that the values in these Standards are put into action in the design and delivery of services.
- Ensuring that my organisation's contractual and commercial relationships are honest, legal, regularly monitored, and compliant with best practice in the management of public money.
- Working in partnership and co-operating with local and national bodies to support the delivery of safe, high quality care.
- Ensuring that my organisation's dealings are made public, unless there is a justifiable and properly documented reason for not doing so.

Declaration:

I, (***print name***) agree to abide by the Standards for Members of NHS Boards and Clinical Commissioning Group Governing Bodies in England.

Signed:

Designation:

Date:

Appendix B

Trust's SCOPE values

Value	Description	Behaviours & Outcomes
Supportive	Teamwork, fairness, Helpful attitude, Respectful to colleagues, Tactfulness	Working together and valuing each other for the benefit of patients.
Caring	Compassionate, Desire for Best Care, Responsiveness, Sensitivity, Empathy, Thoughtfulness, Understanding	Caring for our patients as individuals, safely and with compassion.
Open and honest	Positively, Honesty, Frankness, Informative and knowledgeable, Transparency, Learning from Mistakes, Encouraging	Acting with highest standards of integrity, behaviour and accountability.
Professional	Recognition that working in Healthcare and undertaking Clinical Practice is a privilege, Good communication, Desirous of High Standards, Smartness, Well Mannered, Happy, Interested, Friendly, Helpful, Innovative	Aspiring to be the best in everything we do.
Efficient	Effectiveness, Timeliness, Willingness to look at new ways of working, Joined up working, Questioning, Desire for improvement	The best quality care within the resources available.

14. Code of Conduct for NHS Managers

October 2002

Introduction

1. As part of the response to the Kennedy Report, the attached *Code of Conduct for NHS Managers* has been produced by a Working Group chaired by Ken Jarrold CBE.

2. The Code sets out the core standards of conduct expected of NHS managers. It will serve two purposes:

- to guide NHS managers and employing health bodies in the work they do and the decisions and choices they have to make.
- to reassure the public that these important decisions are being made against a background of professional standards and accountability.

3. The environment in which the Code will operate is a complex one. NHS managers have very important jobs to do and work in a very public and demanding environment. The management of the NHS calls for difficult decisions and complicated choices. The interests of individual patients have to be balanced with the interests of groups of patients and of the community as a whole. The interests of patients and staff do not always coincide. Managerial and clinical imperatives do not always suggest the same priorities. A balance has to be maintained between national and local priorities.

Code of Conduct for NHS Managers

4. The Code should apply to all managers and should be incorporated in the contracts of senior managers at the earliest possible opportunity.

NIGEL CRISP 9 October 2002
NHS Chief Executive

Code of Conduct for NHS Managers

As an NHS manager, I will observe the following principles:

- make the care and safety of patients my first concern and act to protect them from risk;
- respect the public, patients, relatives, carers, NHS staff and partners in other agencies;
- be honest and act with integrity;
- accept responsibility for my own work and the proper performance of the people I manage;
- show my commitment to working as a team member by working with all my colleagues in the NHS and the wider community;
- take responsibility for my own learning and development.

This means in particular that:
I will:

- respect patient confidentiality;

- use the resources available to me in an effective, efficient and timely manner having proper regard to the best interests of the public and patients;
- be guided by the interests of the patients while ensuring a safe working environment;
- act to protect patients from risk by putting into practice appropriate support and disciplinary procedures for staff; and seek to ensure that anyone with a genuine concern is treated reasonably and fairly.

I will respect and treat with dignity and fairness, the public, patients, relatives, carers, NHS staff and partners in other agencies. In my capacity as a senior manager within the NHS I will seek to ensure that no one is unlawfully discriminated against because of their religion, belief, race, colour, gender, marital status, disability, sexual orientation, age, social and economic status or national origin. I will also seek to ensure that:

- the public are properly informed and are able to influence services;
- patients are involved in and informed about their own care, their experience is valued, and they are involved in decisions;
- relatives and carers are, with the informed consent of patients, involved in the care of patients;
- partners in other agencies are invited to make their contribution to improving health and health services; and
- NHS staff are:
  - valued as colleagues;
  - properly informed about the management of the NHS;
  - given appropriate opportunities to take part in decision making.
  - given all reasonable protection from harassment and bullying;
  - provided with a safe working environment;
- helped to maintain and improve their knowledge and skills and achieve their potential;
- and helped to achieve a reasonable balance between their working and personal lives.

I will be honest and will act with integrity and probity at all times.

I will not make, permit or knowingly allow to be made, any untrue or misleading statement relating to my own duties or the functions of my employer.

I will seek to ensure that:
- the best interests of the public and patients/clients are upheld in decision-making and that decisions are not improperly influenced by gifts or inducements;
- NHS resources are protected from fraud and corruption and that any incident of this kind is reported to the NHS Counter Fraud Services;
- judgements about colleagues (including appraisals and references) are consistent, fair and unbiased and are properly founded;
- and open and learning organisations are created in which concerns about people breaking the Code can be raised without fear.
- I will accept responsibility for my own work and the proper performance of the people I manage. I will seek to ensure that those I manage accept that they are responsible for their actions to:
  - the public and their representatives by providing a reasonable and reasoned explanation of the use of resources and performance;

- patients, relatives and carers by answering questions and complaints in an open, honest and well researched way and in a manner which provides a full explanation of what has happened, and of what will be done to deal with any poor performance and, where appropriate giving an apology; and
- NHS staff and partners in other agencies by explaining and justifying decisions on the use of resources and give due and proper consideration to suggestions for improving performance, the use of resources and service delivery.

- I will support and assist the Accountable Officer of my organisation in his or her responsibility to answer to Parliament, Ministers and the Department of Health in terms of fully and faithfully declaring and explaining the use of resources and the performance of the local NHS in putting national policy into practice and delivering targets.
- For the avoidance of doubt, nothing in paragraphs two to four of this Code requires or authorises an NHS manager to whom this Code applies to:
- make, commit or knowingly allow to be made any unlawful disclosure;
- make, permit or knowingly allow to be made any disclosure in breach of his or her duties and obligations to his or her employer, save as permitted by law.

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

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

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

Implementing the Code

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

2. In addition many NHS managers come from professional backgrounds and must follow the code of conduct of their own professions as well as this Code.

In order to maintain consistent standards, NHS bodies need to consider suitable measures to ensure that managers who are not their employees but who
(i) manage their staff or services; *or*
(ii) manage units which are primarily providing services to their patients also observe the Code.

3. It is important to respect both the rights and responsibilities of managers. To help managers to carry out the requirements of the Code, employers must provide reasonable learning and development opportunities and seek to establish and maintain an organisational culture that values the role of managers. NHS managers have the right to be:
   - treated with respect and not be unlawfully discriminated against for any reason;
   - given clear, achievable targets;
   - judged consistently and fairly through appraisal;
   - given reasonable assistance to maintain and improve their knowledge and skills and achieve their potential through learning and development; and
   - reasonably protected from harassment and bullying and helped to achieve a reasonable balance between their working and personal lives.

Breaching the Code

4. Alleged breaches of the Code of Conduct should be promptly considered and fairly and reasonably investigated. Individuals must be held to account for their own performance, responsibilities and conduct where employers form a reasonable and genuinely held judgement that the allegations have foundation. Investigators should consider whether there are wider system failures and organisational issues that have contributed to the problems. Activity, the purpose of which is to learn from and prevent breaches of the Code, needs to look at their wider causes.

5. Local employers should decide whether to investigate alleged breaches informally or under the terms of local disciplinary procedures. It is essential however that both forms of investigation should be, and be seen to be, reasonable, fair and impartial. If Chief Executives or Directors are to be investigated, the employing authority should use individuals who are employed elsewhere to conduct the investigation. The NHS Confederation, the Institute of Healthcare Management and the Healthcare Financial Management Association are among the organisations who maintain lists of people who are willing to undertake such a role.

Application of Code

6. This Code codifies and articulates certain important contractual obligations that apply to everyone holding management positions. These include Chief Executives and Directors who as part of their duties are personally accountable for achieving high quality patient care. The Department of Health will in the next few months issue a proposed new framework of pay and contractual arrangements for the most senior NHS managers. Under this framework the job evaluation scheme being developed as part of the 'Agenda for Change' negotiations is likely to be used as the basis for identifying which other managerial posts (in addition to Chief Executives and Directors) should be automatically covered by the Code. The new framework will also specify compliance with the Code as one of the core contractual provisions that should apply to all senior managers.

7. For all posts at Chief Executive/Director level and all other posts identified as in paragraph 6 above, acting consistently with the Code of Conduct for NHS Managers Directions 2002, employers should:
   - include the Code in new employment contracts;
   - incorporate the Code into the employment contracts of existing postholders at the earliest practicable opportunity.

Action

8. Employers are asked to:

(i) incorporate the Code into the employment contracts of Chief Executives and Directors at the earliest practicable opportunity *and* include the Code in the employment contracts of new appointments to that group;

(ii) identify any other senior managerial posts, i.e. with levels of responsibility and accountability similar to those of Director-level posts, to which they consider the Code should apply. (The new framework for pay and contractual arrangements will help more tightly define this group in due course.)

(iii) investigate alleged breaches of the Code by those to whom the Code applies promptly and reasonably as at paragraphs four to five;

(iv) provide a supportive environment to managers (see paragraph three above).

NATIONAL HEALTH SERVICE ACT 1977
NATIONAL HEALTH SERVICE AND COMMUNITY CARE ACT 1990
The Code of Conduct for NHS Managers Directions 2002

The Secretary of State for Health, in exercise of the powers conferred by section 17(**a**), paragraph 10(1) of Schedule 5(b) and paragraph 8(3) of Schedule 5A(c) to the National Health Service Act 1977, and paragraph 16(5) of Schedule 2 to the National Health Service and Community Care Act 1990(**b**), hereby gives the following Directions:

Application, commencement, interpretation

1.(1) These Directions apply to all NHS bodies in England and shall come into force on 9 October 2002.

(2) These Directions shall be referred to as The Code of Conduct for NHS Managers Directions 2002.

(3) In these Directions .NHS bodies. means:

(i) Strategic Health Authorities

(ii) Special Health Authorities

(iii) NHS Trusts

(iv) Primary Care Trusts

Implementation of Code of Conduct for NHS Managers

2. NHS bodies shall take all reasonable steps to comply with the requirements set out in the *Code of Conduct for NHS Managers* appended to these Directions.

Effect of Direction 2

3. The fact of compliance or non-compliance with Direction 2 shall in itself have no effect on the validity or enforceability of a contract entered into by an NHS body to which these Directions apply.

Signed by authority of the Secretary of State for Health

M G Sturges

4 October 2002 Department of Health

(**a**) 1977 c. 49. Section 17 was substituted by section 12(1) of the Health Act 1999 (c.8) and was amended by Schedule 5, Part 1, paragraph 5(1) and (3), to the Health and Social Care Act 2001 (c.15) and by Schedule 1, paragraph 7 to the NHS Reform and Health Care Professions Act 2002 (c.17).

(**b**) Paragraph 10(1) of Schedule 5(b) and paragraph 8(3) of Schedule 5A(c) to the National Health Service Act 1977 (1977 c.49), and paragraph 16(5) of Schedule 2 to the National Health Service and Community Care Act 1990 were amended by section 6 of the Health and Social Care Act 2001 (c.15).

Working Group Members 11

Working Group Members

Ken Jarrold CBE
Chief Executive
County Durham and Tees Strategic Health Authority

Dr Gill Morgan
Chief Executive
NHS Confederation

Stuart Marples
Chief Executive
Institute of Healthcare Management

Professor Jenny Simpson OBE
Chief Executive
British Association of Medical Managers

John Flook
Chairman
Healthcare Financial Management Association

Penny Humphris
Director
NHS Leadership Centre

Produced by Department of Health

15. **Prime Policies and Strategies**

Southport and Formby District General Hospital
Ormskirk and District General Hospital
North West Regional Spinal Injuries Unit

NHS Southport and Ormskirk Hospital NHS Trust

FIT AND PROPER PERSONS' POLICY AND PROCEDURE

For Compliance with the Fit and Proper Persons' Requirements (FPPR)
CORP 120

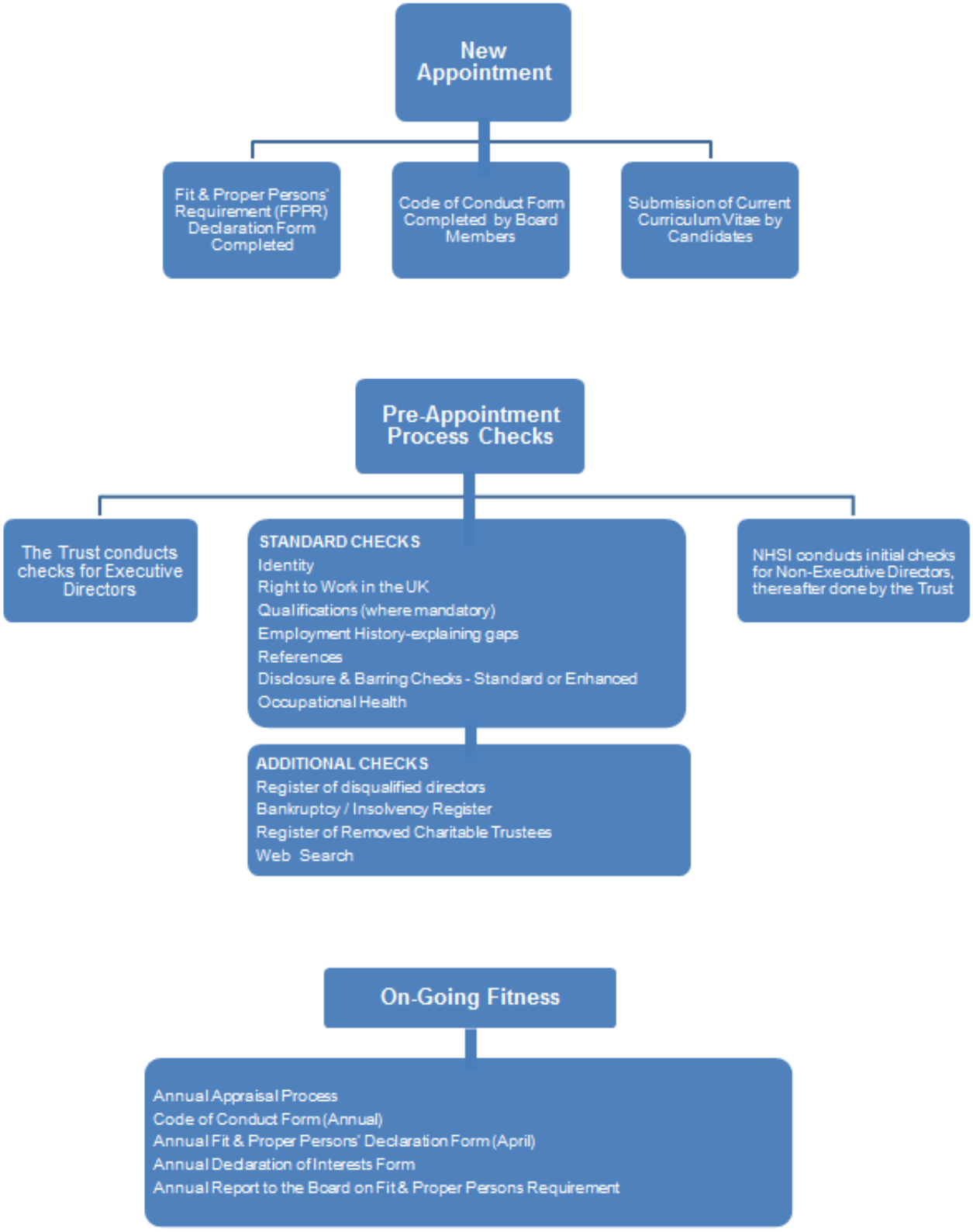
Who should read this SOP:	Planned Care CBU	Urgent Care CBU	Specialist Services CBU	Corporate
All trust Staff	✓	✓	✓	✓

CONTENTS (Ctrl + click on hyperlink to relevant section)

Explanation of terms used in this policy

Terminology	Explanation
Fit and Proper Persons' Regulations	A piece of regulation to ensure that people who have director level responsibility for the quality and safety of care and for meeting the fundamental standards are fit and proper to carry out this role
Fit and Proper Person's test	This is a test which aims to prevent corrupt or untrustworthy individuals serving on the boards of organisations including public sector ones.
Disclosure and Barring Service (DBS)	The DBS helps employers to make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups, including children. It replaces the Criminal Record Bureau check (CRB). A search against an individual's name may be standard or enhanced depending on the individual's responsibility and contact with vulnerable groups.
Disqualified directors	The *Company Directors' Disqualification Act 1986 (section 7)* allows for a court to make a disqualification order against a director in relation to fraud or wrongful behaviour
Removed Charity Trustees	The Charity Commission for England and Wales' Register lists the names of individuals who have been removed from a Charity as a trustee and lists the reasons for such removal, usually due to undesirable behaviour
Code of Conduct	A prescribed set of rules relating to behaviour to be read and signed by directors and senior managers in organisations especially public sector ones
Nolan Principles in public life	These were defined by the Committee for Standards of Public Life chaired by Lord Nolan. These principles were published in its first report in 1995. The seven (7) principles are: Selflessness, Integrity, Objectivity, Accountability, Openness, Honesty and Leadership
Bankruptcy / Insolvency Register	Registers of individuals who have been declared bankrupt or insolvent. These registers are available for public viewing.
Sequestration	The seizure of property for creditors or the state
Regulated activity	Activities which involve working with or coming in contact with vulnerable people like children, elderly or those requiring personal care.

Flowchart for Fit & Proper Persons' Policy



INTRODUCTION

Regulation 5 of the Fit and Proper Persons' Regulations has been introduced as a direct response to the failings at Winterbourne View Hospital *and the Francis Inquiry Report into Mid Staffordshire NHS Foundation Trust,* out of which it was recommended that a statutory fit and

proper person's requirement be imposed on health service bodies. This policy outlines the application of this test for new board and senior managers' appointments and existing post holders.

In addition, where the Trust engages an interim at a senior level equivalent to the posts above, the process for *Fit and Proper Persons' Requirements (FPPR)* will apply if they are employed or registered as an external worker. Where an interim is sourced by an agency the recruitment agency will be made aware of the FPPR procedure and must confirm that they have undertaken the necessary checks. Executive search companies will also be required to confirm compliance with the FPPR and provide relevant evidence for inspection by the Trust.

It is ultimately the Chair's responsibility to discharge the requirement placed on the Trust to ensure that all Directors meet the *Fit and Proper Persons' Requirements* and do not meet any of the unfit criteria.

In NHS Trusts NHS Improvement (NHSI) is responsible for the recruitment of Non-Executive Directors (NEDs), therefore, NHSI conducts the initial FPPR checks upon the appointment of Non-Executive Directors and retain this information centrally. The Trust conducts checks for Executive Directors and will ensure that both NEDs and Executive Directors remain fit and proper.

PURPOSE

This policy sets out how the Trust will comply with its regulatory requirements to ensure that all Directors are fit and proper persons to carry out their roles as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

SCOPE

This policy and procedure applies to all board appointments i.e. executive and non-executive directors and those senior managers which are formally recognised as part of the Trust's Executive Team and Senior Management Team. This includes permanent, interim and associate positions. This will also apply to direct reports who act up for a director for an extensive period.

LINKS TO OTHER KEY POLICIES AND PROCEDURES

This policy and procedure should be read in conjunction with the following Trust's policies:

- Standards of Business Conduct and Managing Conflicts of Interest
- Anti-Fraud, Bribery & Corruption
- Code of Conduct for Board Members

Meeting the REQUIREMENTS OF THE REGULATIONS

The introduction of the *Fit and Proper Person's Requirements (FPPR)* places the ultimate responsibility of the Chair to discharge the requirement placed on the Trust, to ensure that all relevant post holders meet the fitness test and do not meet any of the 'unfit' criteria. Further detail is provided in the *Care Quality Commission (CQC) Guidance for NHS Bodies: Fit and Proper Persons: Directors, November, 2014*.
http://www.cqc.org.uk/sites/default/files/20141120_doc_fppf_final_nhs_provider_guidance_v1-0.pdf

The Trust will make every reasonable effort to assure itself about existing post holders and new applicants and to make specified information about board directors available to CQC on request. Individuals who fall into the categories above must satisfy the Chair they:

- Are of good character
- Hold the required qualifications and have the competence, skills and experience required for the relevant office for which they're employed
- Are able, by reason of their physical and mental health after any required reasonable adjustments if required, capable of properly performing their work.
- Can supply relevant information as required by *Schedule 3 of the Act,* i.e. documentation to support the FPPR.
- Not have been responsible for or privy to, contributed to, or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on regulated activity (or providing a service elsewhere which if provided in England would be a regulated activity)

In accordance with *Schedule 4 part 1* of the act a person is deemed "unfit" if:

- The person is an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged.
- The person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland.
- The person is a person to whom a moratorium period under a debt relief order applies under Part v11A (debt relief orders) of the *Insolvency Act 1986.*
- The person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it.
- The person is included in the children's barred list or the adults' barred list maintained under section 2 of the *Safeguarding Vulnerable Groups Act 2006,* or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland.
- The person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment.
- In accordance with part 2 of the Act a person will fail the good character test if they;
- Has been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom would constitute an offence.
- Has been erased, removed, struck off a register of professionals maintained by a regulator of health care of social work professionals

IMPLEMENTATION OF FPPR FOR EXISTING STAFF AND ON-GOING FITNESS

Implementation

All post holders identified above are obliged to complete a FPPR declaration (**Appendix 1**).

This declaration will be retained on the individual's personal file by the Associate Director of Human Resources & Organisational Development for executive appointments and those senior managers which are formally recognised as part of the Trust Executive Group or the Chairman for non-executive appointments.

The process for assurance includes a check of personal files to ensure there is a complete employment history and where there are any gaps or omissions the post holder will be asked to provide a written explanation for this. Where the Trust has no record of mandatory qualifications or mandatory professional registration the individual will be asked to produce the original for inspection and verification.

The Chairman will be notified of any issues of non–compliance and is the responsible officer for making an informed decision regarding the course of action to be followed. Current post holders that cannot satisfy the declaration questions will not necessarily be barred from continuation of employment/office as it will depend on the relevance of the information provided in respect of the nature of the position, and the particular circumstances. The Trust will address this in the most appropriate, relevant and proportionate way on a case by case basis.

On-going fitness

The annual appraisal process will provide an opportunity to discuss continued "fitness", competence and how the post holder role displays the Trust values and behaviour standard including the leadership behaviour expected. The CEO will be responsible for appraising the Executive Directors, whilst the Chairman will be responsible for appraising the Non-Executive Directors. The CEO will be appraised by the Chairman. The Chairman will be appraised by NHSI. A new self-declaration will be completed at each appraisal.

Every April there will be a requirement for post holders to complete a further form of declaration confirming that they continue to be a fit and proper person. Confirmation of compliance will be published in the Trust's Annual Report.

Individuals will be required to make the Trust aware as soon as practicable of any incident or circumstances which may mean they are no longer to be regarded as a fit and proper person, and provide details of the issue, so that this can be considered by the Trust using the Fit and Proper Persons Requirement Disclosure Form Existing post holders (Appendix 1).

Concerns about an individual's continued FPPR compliance status.

Where matters are raised that cause concerns relating to an individual being fit and proper to carry out their role the Chairman will address this in the most appropriate, relevant and proportionate way on a case by case basis. Where it is necessary to investigate or take action the Trust's current processes will apply using the Trust's capability process (managing performance or sickness absence), Disciplinary procedure or afforded a similar process to this if the potential discontinuation could be due to 'some other substantial reason'. There may be occasions where the Trust would contact NHS Improvement for advice or to discuss a case directly.

The Trust reserves the right to suspend a Director or restrict them from duties on full pay / emoluments (as applicable) to allow the Trust to investigate the matters of concern. Suspension

or restriction from duties will be for no longer than necessary to protect the interests of patients of the Trust and/or where there is a risk that the Director's presence would impede the gathering of evidence in the investigation.

Should there be sufficient evidence to support the allegation(s), then the Trust may terminate the appointment of the Director with immediate effect, in line with the Trust's Disciplinary policy. Where an individual who is registered with a professional regulator (GMC, NMC etc.) no longer meets the fit and proper person's requirement the Trust will inform the regulator, and also take action to ensure the position is held by a person meeting the requirements. Directors may personally be accused and found guilty by a court of serious misconduct in respect of a range of already prescribed behaviours set out in legislation. Professional regulators may remove an individual from a register for breaches of codes of conduct.

PROCESS FOR NEW APPOINTMENTS

The Trust's comprehensive pre-employment checking processes for both executive and non-executive appointments and are determined by the NHS employment standards and include the following. Although the NHSI undertakes some of the following checks for non-executive directors, the Trust will undertake all the checks as required under Regulation 5 of the Fit and Proper Persons' Regulations for both executive and non-executive appointments:

1. Proof of identity
2. DBS check where relevant to the post (the Trust considers all Executive/Non-Executive Directors and those Senior Managers which are formally recognised as part of the Trust Executive Group.
3. Occupational Health Clearance as relevant to the role
4. Evidence of the right to work in the UK
5. A check of employment history and two references one of whom must be the most recent employer. Specifically, this includes validating a minimum of three years continuous employment including details of any gaps in service. The number of references may differ for each applicant, depending on how many episodes of employment they may have had in the last three years prior to making their application.
6. Qualifications/registration applicable to role

In addition the following registers will be checked:

- *Disqualified directors*
- *Bankruptcy and insolvency*
- *Removed Charity Trustees*
- *A web search of the individual*

The FPPR requirements introduce the requirement to complete a FPPR Declaration form for new employees, (**Appendix 3).** This forms and summary guidance (**Appendix 4**) will be included with the application pack and form part of the application process for the position.

While the Trust will have regard to information on when convictions, bankruptcies or similar matters are considered 'spent' there is no time limit for considering serious misconduct or responsibility for failure in a previous role.

The Chair of the appointments panel will be responsible for ensuring compliance supported by the relevant recruitment support. A detailed checklist will be completed and will be retained on the post holder's personal file for the purposes of audit.

NHSI is responsible for the appointment and removal of the Chairman and the Non-Executive Directors, drawing on the recommendations of the Board of Directors' Remuneration & Nominations Committee and the Chair respectively. In respect of Executive Directors, this responsibility will be discharged by the Board of Directors' Remuneration & Nominations Committee which is responsible for the appointment and removal of the Executive Directors.

Any executive or non-executive appointment will take into account the Trust's obligations under the Regulations. Where the Trust makes a decision on the suitability of an individual, the reasons will be recorded by the Trust's Director of HR or equivalent.

Where the Trust deems that the individual who is to be appointed is suitable, despite not meeting the characteristics outlined in *Schedule 4, Part 2 of the Regulations (Good Character),* the reasons will be recorded by the Trust's Company Secretary in the minutes of the relevant meeting: i.e. the Board of Directors' Remuneration and Nominations Committee (in the case of Executive Directors) or NHS Improvement (in the case of the NEDs) (the 'Relevant Meeting') and the information about the decision will be made available. The appointment process will include an evaluation against the Trust's values and any relevant external guidance. External advice will be sought as necessary.

Where specific qualifications are deemed by the Trust as necessary for a role, the Trust will make this clear and will only appoint those individuals that meet the required specification; including any requirements to be registered with a professional Regulator.

The Trust will carry out employment checks (so far as reasonably practicable) on a candidate's qualifications and employment records. The recruitment process will necessarily include a qualitative assessment and values based assessment.

Where the Trust considers that an individual can be appointed to a role based on their qualification, skills and experience with the expectation that they will develop specific competence to undertake the role within a specified timescale any such discussions or recommendations will be recorded by the Company Secretary in the minutes of the Relevant Meeting. Any discussion, recommendation or decision must also be recorded in the minutes.

If the Director has a physical or mental health disability wherever possible, reasonable adjustments will be made to enable the individual to carry out the role that they have been appointed to. Any prospective candidate will need to complete the '*Fit and Proper Person' Declaration*. In the event the prospective candidate identifies any physical or mental health concerns (and subject to further information being obtained from the candidate, if necessary) their appointment will be subject to clearance by Occupational Health as part of the pre-appointment process. Any discussion or decision as to whether a candidate is appointable on grounds of health will be recorded by the Trust's Company Secretary in the minutes of the Relevant Meeting.

BOARD ASSURANCE

The Board of Director's Remuneration and Nominations Committee will receive a report to confirm implementation of the FPPR for existing post holders. The Trust's statutory and

assurance committees will also receive reports regarding new appointments and the annual FPPR checking process. The Chairman is the responsible officer for ensuring compliance for new starters. A summary of compliance will appear in the Trust's *Annual Report*.

REFERENCES

The following documents are helpful in providing a greater understanding of the policy

- Committee for Standards of Public Life (Nolan Principles)
- The Insolvency Act
- The Bankruptcy Act
- The NHS and Social Care Act 2006 (as amended 2012)
- The Data Protection Act 1998
- The Freedom of Information Act 2000

Roles and Responsibilities for this Policy

Title	Role	Responsibilities
Trust Chairman		Overall responsibility to ensure that there is compliance with the policy including appointment of the Chief Executive and other Executive Directors. NHSI is responsible for pre-employment checks for Non-Executive Directors (NEDs). Ongoing checks for fitness for NEDs and Executive Directors will be undertaken by the Trust
Chief Executive		To ensure that the policy is applied with regards to executive directors
Associate Director of Human Resources		To support the Chairman by ensuring all the Regulation 5 checks are undertaken prior to appointees commencing their role
Company Secretary		To support the Chairman by undertaking searches of relevant registers to ascertain a potential board member's fit and proper status and to ensure that all directors (NEDs and Executives) are annually declared fit and proper
Executive Directors		To support the Chairman by ensuring that direct reports engaging in regulated activities are fit and proper by undertaking the relevant checks

Training

Which aspect(s) of this policy will require staff training?	Which staff groups require this training?	Is this training covered in the Trust's Mandatory and Risk Management Training Needs Analysis document?	If no, how will the training be delivered?	Who will deliver the training?	How often will staff require training	Who will ensure NHS Improvement that staff have had this training
Checks and searches	Human Resources	No	On a face to face session	By the Company Secretary	Annually	The Company Secretary

EQUALITY ANALYSIS ASSESSMENT

Southport & Ormskirk Hospital NHS Trust is committed to ensuring that the way we provide services and the way we recruit and treat staff reflects individual needs, promotes equality and does not discriminate unfairly against any particular individual or group. The Equality Impact Assessment for this policy has been completed and is readily available on the Intranet. If you require this policy in a different format e.g. larger print, Braille, different languages or audio tape, please contact the Corporate Governance Team.

DATA PROTECTION AND FREEDOM OF INFORMATION

This statement reflects legal requirements incorporated within the Data Protection Act and Freedom of Information Act that apply to staff who work within the public sector. All staff members have a responsibility to ensure that they do not disclose information about the Trust's activities in respect of service users in its care to unauthorised individuals. This responsibility applies whether you are currently employed or after your employment ends and in certain aspects of your personal life e.g. use of social networking sites etc. The Trust seeks to ensure a high level of transparency in all its business activities but reserves the right not to disclose information where relevant legislation applies.

MONITORING HOW this policy is working in practice

Monitoring this policy is working in practice? (measurable policy objectives)	Ensure process for new appointments are robustly undertaken	Undertake checks of existing staff	Ensure that relevant staff maintain on-going fitness and proper persons' requirements
Where described in the policy?	Section 7	Section 6	Section 6
How will they be monitored? (method & sample size)	Undertake random checks of personal files	Undertake checks of all personal files for relevant staff	Undertake checks of all personal files for relevant Fit & Proper Persons' Declaration Form to be completed and signed along with Directors' Code of Conduct
Who will monitor?	Internal Audit and Company Secretary	Company Secretary	Company Secretary
How Frequently?	Annually	Annually	Annually or more frequently if required
Group/Committee that will receive and review results	Audit Committee/Board	Audit Committee/Board	Audit Committee/Board
Group/Committee to ensure actions are completed	Audit Committee/ Board	Audit Committee/ Board	Audit Committee/ Board
Evidence this has happened	Report of findings in personal files of designated staff: * identity *DBS check *Occupational Health clearance *Evidence of right to work in UK *Employment history *Qualification & Registration checks	As above	Completed and signed FPPT Form Completed Code of Conduct Form

	*Disqualified directors check *Bankruptcy and insolvency check *Removed Charity Trustee Check *Web search of individual		

APPENDICES

Appendices for the Fit and Proper Persons Policy and Procedure	
Appendix 1	Fit and Proper Persons Requirement Personal Disclosure Form for an Existing Post Holder (Implementation, Annual Review or Ad-hoc Declaration).
Appendix 2	Recruitment and Selection Processes to meet Fit and Proper Persons Regulations (FPPR) for a New Appointment.
Appendix 3	Fit and Proper Persons Requirement Personal Disclosure Form for Applicants.
Appendix 4	Fit and Proper Persons Requirement, Important information for Applicants.
Appendix 5	Fit and Proper Persons Requirement, New Applicants' Employment Checklist.
Appendix 6	Supplementary information to support reference request, Fit and Proper Persons Requirement.

Appendix 1 Fit and Proper Persons Requirement Personal Disclosure Form for an Existing Post Holder

Southport and Ormskirk Hospital NHS Trust

Fit and Proper Persons Requirement Personal Disclosure Form
For an Existing Post Holder
(Implementation, Annual Review or Ad-hoc Declaration)

STRICTLY CONFIDENTIAL

First Names	
Surname	
If you are known under any other name please state	

Position Held	

Please respond to the following questions. You can type your responses and the box will expand if necessary. You can add an 'X' in the relevant answer box or delete the one that does not apply. If you choose to complete by hand please continue on a separate sheet if there is insufficient space detailing the number of the relevant question/s. A hard copy of the signed form will be required.

1. Are you currently or have you been the subject of action by the police? Action includes, but is not restricted to: investigation, summons, arrest, bound over, caution, reprimand, warning, driving offences, charge conviction or imprisonment which are not deemed 'protected' under the amendment to the Exceptions order 1975*, issued by a Court or Court-Martial in the United Kingdom or in any other country?

NO ☐
YES ☐

If **YES**, please include here details of the order binding you over and/or the nature of the office, the penalty, sentence of order of the Court, and the date and place of the Court hearing: You are not required to tell us about parking offences or spent driving offences

Please note that you do not need to tell us about convictions, cautions, warnings or reprimands which are deemed 'protected' under the Rehabilitation of Offenders Act 1974 (Exceptions) Order 1975 as amended by the Rehabilitation of Offenders Act 1974 (Exceptions) Order 1975 (Amendment) (England and Wales) Order 2013. You can read guidance and the criteria for the filtering of these convictions and cautions from the Disclosure and Barring Service website at:

https://www.gov.uk/government/organisations/disclosure-and-barring-service

2. Have you been charged with any offence in the United Kingdom or in any other country that has not yet been disposed of?

NO ☐
YES ☐

If **YES**, please include here details of the nature of the offence with which you are charged, date on which you were charged, and details of any on-going proceedings by a prosecuting body:

You are reminded that you have a continued responsibility to inform us immediately if you are charged with any new offence, criminal conviction or fitness to practise proceedings in the United Kingdom or in any other country.

You do not need to tell us if you are charged with a parking offence.

3. Are you aware of any current NHS Counter Fraud and Security Management Service (CFSMS) investigation following allegations made against you?

NO ☐
YES ☐

If **YES**, please include details of the nature of the allegations made against you, and if known to you, any action to be taken against you by the NHS CFSMS.

4. Have you been investigated by the Police, NHS CFSMS or any other Investigatory Body resulting in a current or past conviction or dismissal from your employment or volunteering position?

NO ☐
YES ☐

If **YES**, please include details of the nature of the allegations made against you, and if known to you, any action to be taken against you by the Investigatory Body:

Investigatory bodies include: Local Authorities, Customs and Excise, Immigration, Passport Agency, Inland Revenue, Department of Trade and Industry, Department of Work and Pensions, Security Agencies, Financial Service Authority. This list is not exhaustive and you must declare any investigation conducted by an Investigatory Body.

5. Have you ever been dismissed by reason of misconduct from any employment, volunteering, office or other position previously held by you?

NO ☐
YES ☐

If **YES**, please include details of the employment, office or position held, the date that you were dismissed and the nature of allegations of misconduct made against you:

6. Have you ever been disqualified from the practice of a profession, or required to practice subject to specified limitations following fitness to practice proceedings, by a regulatory or licensing body in the United Kingdom or in any other country?

NO ☐
YES ☐

If **YES**, please include details of the nature of the disqualification, limitation or restriction, the date, and the name and address of the licensing or regulatory body concerned:

7. Are you currently or have you ever been the subject of any investigation or fitness to practice proceedings by any licensing or regulatory body in the United Kingdom or in any other country?

NO ☐
YES ☐

If **YES**, please include details of the reason given for the investigation and/or proceedings undertaken, the date, details of any limitation or restriction to which you are currently subject, and the name and address of the licensing or regulatory body concerned:

8. Are you subject to any other prohibition, limitation, or restriction?

NO ☐
YES ☐

If **YES**, please include details:

9. Have you been responsible for, been privy to, or contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity?

NO ☐
YES ☐

If **YES**, please include details:

10. Do you consider that there is any reason why you are not able to carry out your role by reason of health (physical or mental health)? (See note below).

NO ☐
YES ☐

Note: It is important to stress that the FPPR requirements regarding ability to properly perform tasks intrinsic to the office or post does not mean that people who have a long-term condition, a disability or mental illness cannot be in such a position. It would be required of the Trust to, wherever possible, make reasonable adjustments to enable an individual to carry out the role. If you wish to discuss any aspect of your response, in confidence with an Occupational Health Physician, we can make arrangements for you to do so.

If **YES**, please include details:

11. Are there any other matters that may be relevant to your position which might cause your reliability or suitability to be called into question?

NO ☐
YES ☐

If **YES**, please include details:

Declaration
Important: The Data Protection Act 1998 requires us to advise you that we will be processing your personal data. Processing includes: holding, obtaining, recording, using, sharing and deleting information. The Data Protection Act 1998 defines 'sensitive personal data' as racial or ethnic origin, political opinions, religious or other beliefs, trade union membership, physical or mental health, sexual life, criminal offences, criminal convictions, criminal proceedings, disposal or sentence.

The information that you provide in this Declaration Form will be processed in accordance with the Data Protection Act 1998. It will be used for the purpose of determining your suitability for the senior position you hold. It will also be used for purposes of enquiries in relation to the prevention and detection of fraud.

This declaration will be kept securely and in confidence. Access to this information will be restricted to designated persons within the Trust who are authorised to view it as a necessary part of their work.

In signing the declaration on this form, you are explicitly consenting for the data you provide to be processed in the manner described above.

I consent to the information provided in this declaration form being used by the Trust for the purpose of checking that I satisfy the requirements of the FPPR for the position I hold.

I confirm that the information I have provided in this declaration form is correct and complete. In addition to completing an annual FPPR questionnaire I also understand that it is a requirement that I make the Trust aware as soon as practicable of any incident or circumstances which may impact on my position and provide details of the issue to the Chair or Associate Director of Human Resources so that this can be considered by the Trust.

I understand and accept that if I knowingly withhold information, or provide false or misleading information, this may result in an investigation in accordance with relevant Trust processes and could lead to the termination of the appointment.

Signature	
Full Name	
Date	

PLEASE COMPLETE, SIGN AND FORWARD A HARD COPY OF THE DECLARATION FORM IN AN ENVELOPE MARKED 'CONFIDENTIAL' FOR THE ATTENTION OF THE CHAIRMAN OR COMPANY SECRETARY.

Appendix 2 Recruitment and Selection Processes to meet Fit and Proper Persons Regulations (FPPR) for a New Appointment

Recruitment and Selection Processes to meet Fit and Proper Persons Regulations (FPPR) for a New Appointment

The aim of the FPPR is to ensure that all board level appointments of NHS institutions carrying on a regulated activity are responsible for the overall quality and safety of that care and for making sure that care meets the existing regulations and effective requirement of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014. FPPR Regulation 5 is about ensuring that those individuals in senior appointments are fit and proper to carry out this important role.

FPPR Declaration requirements

The Trust will ensure that full compliance with the FPPR. Candidates will be required to complete a FPPR Declaration form along with a supporting up to date CV for the position. A copy of the guidance notes for candidates and the Declaration form is attached at Appendix (to be amended as relevant for each process).

If an agency or executive search organisation is supporting the Trust with the appointment, the agency/executive search company will be required to ensure that the Declaration form is completed by all candidates.

If the shortlisting panel considers a candidate that has declared a matter that appears to be in breach of the FPPR is a strong candidate worthy of further consideration it will be responsibility of the Chair of the shortlisting panel to discuss with the Chairman and the Director of Human Resources and Organisational Development before making a final shortlist decision. The Chairman and Director of Human Resources & Organisational Development will consider the matter and there may be occasions where it is considered necessary to consult with Monitor before deciding to exclude or include a candidate to the next stage of the process.

FPPR pre-appointment processes

The following checks are undertaken for all appointments to the Trust:

- Identity check.
- Right to work in the UK.
- Qualification checks (where essential/mandatory).
- Comprehensive employment history with any gaps in employment explained in writing.
- Reference checks to include confirmation of period of employment with the referee organisation, reasons for leaving their post.
- DBS checks (standard or enhanced appropriate to role).

- Occupational Health Declaration form.

Additionally for posts that require the FPPR test the following must be in place:

- Fit & Proper Person's Declaration form assessed as meeting the requirements.
- Checks on the 'barred' list, by using the register of disqualified directors, the bankruptcy/ insolvency register and the register of removed charities trustees' sites.
- The Trust will also carry out a web search of the individual.

Appendix 3 Fit and Proper Persons Requirement Personal Disclosure Form
For Applicants

Southport and Ormskirk Hospital NHS Trust

Fit and Proper Persons Requirement Personal Disclosure Form
For Applicants
(This form will form part of the application process for all posts that are considered to meet the FPPR)

STRICTLY CONFIDENTIAL

First Names	
Surname	
If you are known under any other name please state	

Position Applied for	

Please respond to the following questions. You can type your responses and the box will expand if necessary. You can add an 'X' in the relevant answer box or delete the one that does not apply. If you choose to complete by hand please continue on a separate sheet if there is insufficient space detailing the number of the relevant question/s. A hard copy of the signed form will be required.

1. Are you currently or have you been the subject of action by the police?? Action includes, but is not restricted to: investigation, summons, arrest, bound over, caution, reprimand, warning, driving offences, charge conviction or imprisonment which are not deemed 'protected' under the amendment to the Exceptions order 1975*, issued by a Court or Court-Martial in the United Kingdom or in any other country?

NO ☐
YES ☐

If **YES**, please include here details of the order binding you over and/or the nature of the office, the penalty, sentence of order of the Court, and the date and place of the Court hearing:

You are not required to tell us about parking offences or spent driving offences.

*Please note that you do not need to tell us about convictions, cautions, warnings or reprimands which are deemed 'protected' under the Rehabilitation of Offenders Act 1974 (Exceptions) Order 1975 as amended by the Rehabilitation of Offenders Act 1974 (Exceptions) Order 1975 (Amendment) (England and Wales) Order 2013. You can read guidance and the criteria for the filtering of these convictions and cautions from the Disclosure and Barring Service website at: https://www.gov.uk/government/organisations/disclosure-and-barring-service

2. Have you been charged with any offence in the United Kingdom or in any other country that has not yet been disposed of?

NO ☐
YES ☐

If **YES**, please include here details of the nature of the offence with which you are charged, date on which you were charged, and details of any on-going proceedings by a prosecuting body: You are reminded that you have a continued responsibility to inform us immediately if you are charged with any new offence, criminal conviction or fitness to practise proceedings in the United Kingdom or in any other country.

You do not need to tell us if you are charged with a parking offence.

3. Are you aware of any current NHS Counter Fraud and Security Management Service (CFSMS) investigation following allegations made against you?

NO ☐
YES ☐

If **YES**, please include details of the nature of the allegations made against you, and if known to you, any action to be taken against you by the NHS CFSMS.

4. Have you been investigated by the Police, NHS CFSMS or any other Investigatory Body resulting in a current or past conviction or dismissal from your employment or volunteering position?

NO ☐
YES ☐

If **YES**, please include details of the nature of the allegations made against you, and if known to you, any action to be taken against you by the Investigatory Body:

Investigatory bodies include: Local Authorities, Customs and Excise, Immigration, Passport Agency, Inland Revenue, Department of Trade and Industry, Department of Work and Pensions, Security Agencies, Financial Service Authority. This list is not exhaustive and you must declare any investigation conducted by an Investigatory Body.

5. Have you ever been dismissed by reason of misconduct from any employment, volunteering, office or other position previously held by you?

NO ☐
YES ☐

If **YES**, please include details of the employment, office or position held, the date that you were dismissed and the nature of allegations of misconduct made against you:

6. Have you ever been disqualified from the practice of a profession, or required to practice subject to specified limitations following fitness to practice proceedings, by a regulatory or licensing body in the United Kingdom or in any other country?

NO ☐
YES ☐

If **YES**, please include details of the nature of the disqualification, limitation or restriction, the date, and the name and address of the licensing or regulatory body concerned:

7. Are you currently or have you ever been the subject of any investigation or fitness to practice proceedings by any licensing or regulatory body in the United Kingdom or in any other country?

NO ☐
YES ☐

If **YES**, please include details of the reason given for the investigation and/or proceedings undertaken, the date, details of any limitation or restriction to which you are currently subject, and the name and address of the licensing or regulatory body concerned:

8. Are you subject to any other prohibition, limitation, or restriction?

NO ☐
YES ☐

If **YES**, please include details:

9. Have you been responsible for, been privy to, or contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity?

NO ☐
YES ☐

If **YES**, please include details:

10. Are there any other matters that may be relevant to your position which might cause your reliability or suitability to be called into question?
NO ☐
YES ☐

If **YES**, please include details:

Declaration

Important: The Data Protection Act 1998 requires us to advise you that we will be processing your personal data. Processing includes: holding, obtaining, recording, using, sharing and deleting information. The Data Protection Act 1998 defines 'sensitive personal data' as racial or ethnic origin, political opinions, religious or other beliefs, trade union membership, physical or mental health, sexual life, criminal offences, criminal convictions, criminal proceedings, disposal or sentence.

The information that you provide in this Declaration Form will be processed in accordance with the Data Protection Act 1998. It will be used for the purpose of determining your suitability for the senior position you hold. It will also be used for purposes of enquiries in relation to the prevention and detection of fraud.

This declaration will be kept securely and in confidence. Access to this information will be restricted to designated persons within the Trust who are authorised to view it as a necessary part of their work.

In signing the declaration on this form, you are explicitly consenting for the data you provide to be processed in the manner described above.

I consent to the information provided in this declaration form being used by the Trust for the purpose of checking that I satisfy the requirements of the FPPR for the position applied for.

I understand and accept that if I knowingly withhold information, or provide false or misleading information, this may result in an investigation in accordance with relevant Trust processes and could lead to the termination of the appointment.

Signature	
Full Name	
Date	

Appendix 4 Fit and Proper Persons Requirement Important information for Applicants

Fit and Proper Persons Requirement Important information for Applicants

1. Background to Regulation 5: Fit and Proper Persons, Directors

The aim of this regulation is to ensure that all board level appointments of NHS foundation trusts and special health authorities carrying on a regulated activity are responsible for the overall quality and safety of that care, and for making sure that care meets the existing regulations and effective requirement of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 5 is about ensuring that those individuals in senior appointments are fit and proper to carry out this important role

The regulation was introduced as a direct response to the failings at Winterbourne View Hospital and the Francis Inquiry report into Mid Staffordshire NHS Foundation Trust, which recommended that a statutory fit and proper person's requirement be imposed on health service bodies.

2. Applying the FPPR

Where the Trust engages an interim at a senior level equivalent to the posts above the same process will apply where they are employed or registered as associates with the Trust's Bank. Where an interim is sourced by an agency the recruiting agency will be made aware of the FPPR process and must confirm that they have undertaken the necessary checks.

3. Applicants Requirement to Complete a FPPR Declaration Form

The position for which you are applying is considered as a post that requires the FPPR test to be applied. At the application stage applicants are required to complete the Fit and Proper Persons Requirement (FPPR) Procedure (new applicants) self-declaration form and attach this to their application for the position.

This is required to ensure the Trust is able to properly discharge its requirement that all those in post holders detailed in paragraph 2 above meet the fitness test and that a post holder does not meet the 'unfit' criteria as outlined below:

The regulations require that post holders must:

- Be of good character.
- Have the qualifications, competence, skills, and experience necessary for the relevant office for the position of work for which they are employed be able by reason of their health, after reasonable adjustments are made, of properly.
- Be able to perform tasks which are intrinsic to the office or position to which they are appointed or to the work for which they are employed.
- Not be prohibited from holding office (e.g. directors' disqualification order).
- Not have 'been responsible for or privy to, contributed to or facilitated any serious.

- Misconduct or mismanagement (whether unlawful or not) in the course of carrying on regulated activity (or providing a service elsewhere which if provided in England would be a regulated activity).

A person is deemed unfit to hold senior office if they:

- Are an un-discharged bankrupt.
- Are subject to bankruptcy restrictions.
- Are prohibited from holding an office or position under relevant legislation (for example the Companies Act or Charities Act).

In assessing character the matters to be considered include whether the person:

- Has been convicted of any offence.
- Has been erased, removed, struck off a register of professionals maintained by a regulator of health care or social work professionals.
- Is on any 'barred' list, by using the register of disqualified directors, the bankruptcy /insolvency register and the register of removed charities trustees.

More detailed information about the fitness requirements to help you respond to the questions can be found on CQC Guidance for NHS Bodies (Nov. 14).
http://www.cqc.org.uk/sites/default/files/20141120_doc_fppf_final_nhs_provider_guidance_v1-0.pdf

4. Trust pre-appointment processes

The following checks are undertaken for all appointments to the Trust:

- Identity check.
- Right to work in the UK.
- Qualification checks (where essential/mandatory).
- Comprehensive employment history with any gaps in employment explained in writing.
- Reference checks to include confirmation of period of employment with the referee organisation, reasons for leaving their post.
- DBS checks (standard or enhanced appropriate to role).

Additionally for posts that require the FPPR test the following must be in place:

- Occupational health clearance.
- Fit & Proper Person's Declaration form assessed as meeting the requirements.
- Checks against the register of disqualified directors, the bankruptcy /insolvency register and the register of removed charities trustees.
- A web search of the individual.

An appointment cannot commence until full compliance with the checks detailed above, and is conditional upon the same.

Appendix 5 Fit and Proper Persons Requirement New Applicants' Employment Checklist

Fit and Proper Persons Requirement New Applicants' Employment Checklist
(This checklist must be completed for all applicants for the positions included in the Trust's FPPR Policy and Procedure)

If an executive search company is engaged, it is standard practice to accept CVs at the initial stages. Where the Trust engages an interim at a senior level (equivalent to ED or Director status) the Trust, or if relevant, the agency recruiting the interim must be made aware of the requirement and standards that have to be met and will need to provide documentary evidence of compliance.

Name ……..

Position ……..

Date..……..

Identification Checks	**Yes**	**No**	**Comments**
Verification of ID as per the right to work checklist NHS employment standards Confirmation of any restrictions on right to work in UK – if applicable Verification of Identification and Right to Work Checklist Confirm documents seen and that copies have been taken and verified			
Employment History			
Confirmation of a full employment history			
Any gaps in employment or study have been clearly documented and written explanations provided			

Detail any further information below			
Qualification Checks			
Original certificates verified for mandatory qualifications Confirm copies taken and verified			
Criminal Record Checks			
Standard DBS Disclosure received prior to employee commencing work Confirm e-DBS undertaken and date received			
Enhanced DBS in place for those staff working in a 'regulated activity' with children or vulnerable adults. This will also include the children and adults barred list Confirm e-DBS undertaken and date received			
Professional Registration			
Evidence of Professional registration checked at initial appointment *(e.g. nursing midwifery, medical)* State the professional body and details of registration			
References			
Reference from current employer and a further relevant reference.			
Occupational Health Checks			
Completed Health Declaration Form received			
OH referral completed if appropriate			
Immunisation/Infection Screening Questionnaire in			

place for all those in clinical roles			
Fit and Proper Persons Checks			
Declaration form received and confirmation of no cause for concern. If there is any cause for concern confirm outcome after discussion with the Chairman and/or the Director of Human Resources & Organisational Development. Confirm check against the 'barred' list by using the register of disqualified directors, the bankruptcy / insolvency register and the register of removed charities trustees: o Disqualified directors http://wck2.companieshouse.gov.uk//dirsec o Bankruptcy and insolvency https://www.insolvencydirect.bis.gov.uk/eiir/ o Removed Charity Trustees http://apps.charitycommission.gov.uk Confirm any relevant web search results			
	Date	Tick to Confirm	Name and Signature
Recruitment Adviser confirmation all the above is in place **Final Approval by Chair of Panel** **All pre-employment checks completed and proceed to final offer of employment** **Chairman's Report to the appropriate Remuneration & Nominations Committee**			

Chairman's Signature	

Full Name	
Date	

Appendix 6 Supplementary Information to Support Reference Requests for the Fit and Proper Persons Requirement

Supplementary Information to Support Reference Requests for the Fit and Proper Persons Requirement

The *Health and Social Care Act 2008* (Regulated Activities), Regulations 14, sets out fundamental standards of care. Regulation 5 introduces specific criteria against which the applicant for this post must be assessed.

- Is of good character.
- Hold the required qualifications and have the competence, skills and experience required for the relevant office for which they're employed.
- Is able, by reason of their physical and mental health, after any required reasonable adjustments if required, capable of properly performing their work.
- Can supply relevant information as required by schedule 3 of the Act.
- Not have been responsible for or privy to, contributed to, or facilitated any serious
- Misconduct or mismanagement (whether unlawful or not) in the course of carrying on regulated activity (or providing a service elsewhere which if provided in England would be a regulated activity).

In accordance with schedule 4 part 1 of the act a person is deemed "unfit" if:

- The person is an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged.
- The person is the subject of a bankruptcy restrictions order or an interim bankruptcy.
- Restrictions order or an order to like effect made in Scotland or Northern Ireland.
- The person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986.
- The person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it.
- The person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland.
- The person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment.

In accordance with part 2 of the Act a person will fail the good character test if they;

- Have been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom would constitute an offence.
- Have been erased, removed or struck off a register of professionals maintained by a regulator of health care of social work professionals.

Considering the above requirements do you have any concerns relating to individuals suitability for Employment.

YES/NO

Based on your knowledge of the individual do you believe that they are compliant with the Fit and Proper Person Requirements as outlined above.

YES/NO

If you have answered yes to either question please specify detail.

Signature	
Full Name	
Date	

Policy Implementation Plan

Policy Title	Fit and Proper Persons' Regulation Policy
Is this New or revision of an existing policy	New
Name and role of Policy Lead	Audley Charles, Interim Company Secretary
Give a Brief Overview of the Policy	
The policy sets out the requirements needed to ensure that relevant staff undergo the relevant checks as set out in *Regulation 5* of the Fit and Proper Persons' Regulation. It sets out the process for checks for new appointments, checks for existing staff and activities to ensure continued fitness. The policy also sets out the training and monitoring process.	
What are the main changes in practice that should be seen from the policy?	
More robust checks of *Regulation 5 r*equirements and reporting of same during the year	
Who is affected directly or indirectly by this policy?	
The Board of Directors, the Trust's senior management Team and all staff involved in regulated activities.	
Implications	
Will staff require specific training to implement this policy and if yes, which staff groups will need training?	
Explain the issues? Human Resources staff and Board of Directors	**Explain how this has been resolved** Annual training by the Company Secretary
Are other resources required to enable the implementation of the policy e.g. increased staffing, new documentation?	

Explain the issues?	**Explain how this has been resolved**
NO	N/A
Have the financial impacts of any changes been established?	
Explain the issues?	**Explain how this has been resolved**
N/A	N/A
Any other considerations	
Explain the issues?	**Explain how this has been resolved**
NO	N/A

Approval of Implementation Plan
Enter Name and Title of Policy Lead whose portfolio this policy will come under: **Signature: Audley Charles** **Date Approved 10 January 2018**.

Title of Policy	Fit and Proper Persons' Regulation
Unique Identifier for this policy is	CORP 118
State if policy is **New** or **Revised**	New
Previous Policy Title where applicable	N/A
Policy Category Clinical, HR, H&S, Infection Control, Finance etc.	Corporate
Executive Director	Company Secretary
Policy Lead/Author	Company Secretary
Committee/Group responsible for the approval of this policy	Board of Directors
Month/year consultation process completed	December 2017
Month/year policy approved	January 2018
Month/year policy ratified and issued	January 2018
Next review date	January 2020
Implementation Plan completed	Yes
Equality Impact Assessment completed	Yes
Previous version(s) archived	Yes 04.05.18
Disclosure status	Full
Key words for this policy	Fit and Proper Persons, Disclosure Baring Service, Regulated activities

For more information on the consultation process, implementation plan, equality impact assessment, or archiving arrangements, please contact Corporate Integrated Governance.

Review and Amendment History

Version	Date	Details of Change
1.0.0	December 2017	Policy made more robust by adding more details of Regulation 5 requirements, added sections of requirements for new appointments, on-going fitness and annual checks and declarations. The policy has been strengthened by adding a number of templates in the appendices for good practice. Training of key staff and monitoring of the policy has also been added. A flow diagram illustrating the process has also been added
1.1.0	May 2018	Minor amendment as requested by the CQC
1.2.0	May 2019	Minor amendment in Implementation section Removed regulation 3 and add regulation 5

STANDARDS OF BUSINESS CONDUCT
AND
MANAGING CONFLICTS OF INTEREST POLICY
Corporate 121

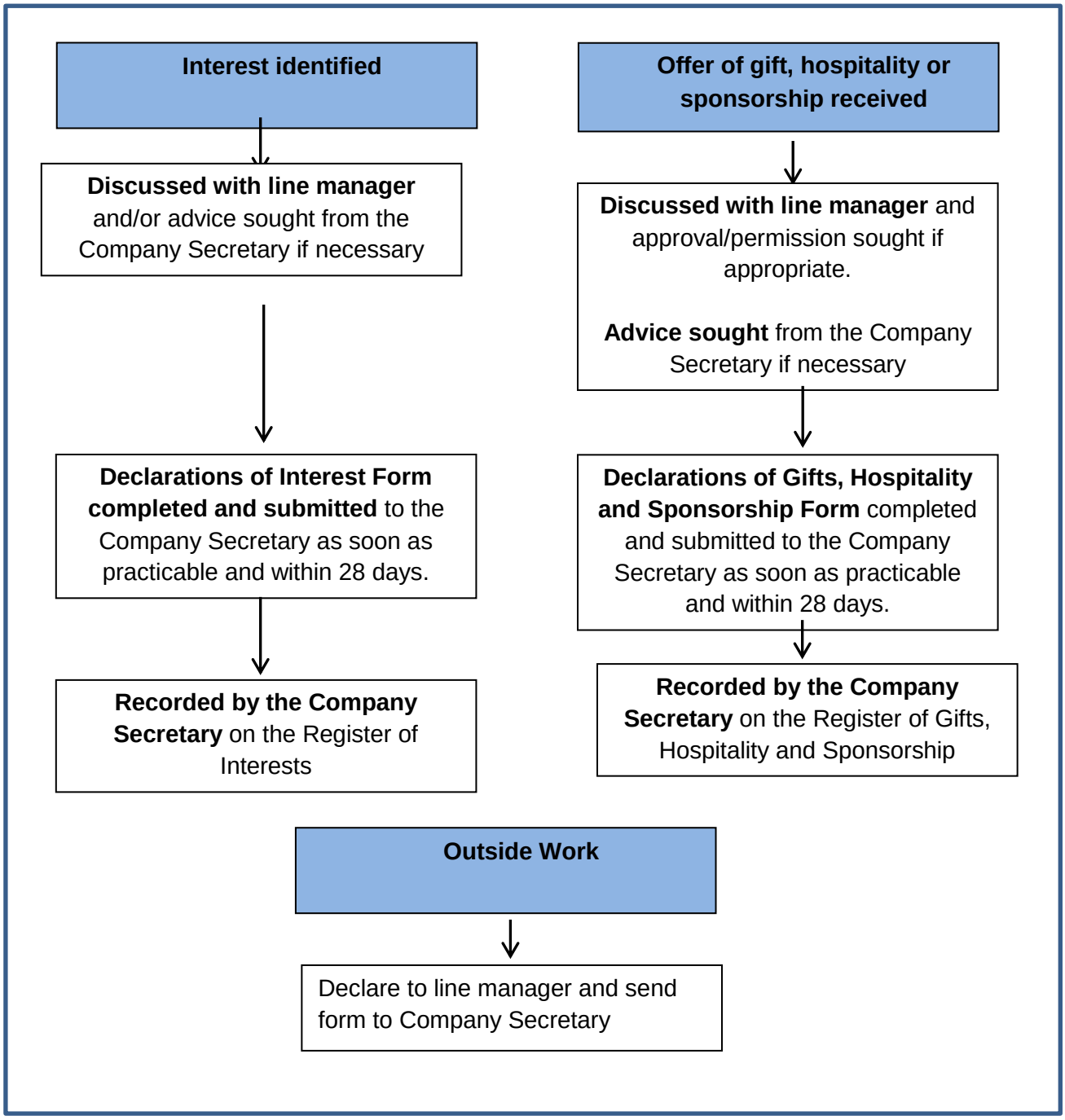
Target Audience				
Who should read this policy:	**Planned Care CBU**	**Urgent Care CBU**	**Specialist Services CBU**	**Corporate**
all employees of Southport and Ormskirk Hospital NHS	x	x	x	x

CONTENTS (CTRL + CLICK ON HYPERLINK TO RELEVANT SECTION)

Explanation of terms used in this policy

A set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold.'

Flowchart for the Creation and Review of Procedural Documents



1. INTRODUCTION

As a public sector organisation Southport and Ormskirk Hospital NHS Trust ('the 'Trust') has a duty to ensure its resources are utilised effectively and money is spent well, free from undue influence.

Providing best value for taxpayers and ensuring that decisions are taken transparently and clearly, are both key principles in the NHS Constitution. We are committed to maximising our resources for the benefit of the whole community. As an organisation and as individuals, we have a duty to ensure that all our dealings are conducted to the highest standards of integrity and that NHS monies are used wisely so that we are using our finite resources in the best interests of patients.

The Trust, and the people who work with and for us, collaborate closely with other organisations, delivering high quality care for our patients. These partnerships have many benefits and should help ensure that public money is spent efficiently and wisely. But there is a risk that conflicts of interest may arise.

All declared interests that are material will be promptly transferred to the appropriate register and maintained by the Company Secretary and such Registers would normally be published on the Trust's website

PURPOSE

Adhering to this policy will help to ensure that we use NHS money wisely, providing best value for taxpayers and accountability to our patients for the decisions. It does so by helping our staff manage risks related to conflicts of interest effectively by:

- Introducing consistent principles and rules;
- Providing simple advice about what to do in common situations; and
- Supporting good judgement about how to approach and manage interests.

This policy should be used in conjunction with the Trust's organisational policies:

- Corporate Governance Handbook (which incorporates the Standing Financial Instructions, Standing Orders, Scheme of Reservation and Delegation and Terms of Reference of all statutory and assurance committees)
- Raising Concerns (Whistleblowing) Policy
- Anti-Fraud, Bribery and Corruption Policy

OBJECTIVES

The objectives of this policy are to:

- Ensure that no member of staff abuses their position to further their own interests or the interests of close associates;
- Ensure that no member of staff is influenced, or gives the impression of being influenced, by outside interests; and
- Ensure that outside interests do not influence decisions any member of staff makes when using taxpayers money.

INTERESTS

A **conflict of interest** is 'a set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold.'

A conflict of interest may be:

- **Actual** – there is a material conflict between one or more interests
- **Potentia**l – there is the possibility of a material conflict between one or more interests in the future.

Staff may hold interests for which they cannot see potential conflict. However, caution is always advisable because others may see it differently and perceived conflicts of interest can be damaging. The golden rule should be: **If in doubt declare it.** All interests should be declared where there is a risk of perceived improper conduct.

Interests can fall into the following categories:

- **Financial interests** – where an individual may get direct financial benefit from the consequences of a decision they are involved in making.
- **Non-financial professional interests** – where an individual may obtain a non-professional benefit from the consequences of a decision they are involved in making, such as increasing their professional reputation or promoting their professional career.
- **Non-financial personal interests** – where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career.
- **Indirect interests** – where an individual has a close association with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest and could stand to benefit from a decision they are involved in making.

Staff

The Trust uses the skills of many different people, all of whom are vital to our work. This includes people on differing employment terms, who for the purposes of this policy we refer to as 'staff' and are listed below:

- All salaried employees;
- All prospective employees – who are partway through recruitment;
- Contractors and sub-contractors;
- Agency staff; and
- Committee, sub-committee and advisory group members (who may not be directly employed or engaged by the organisation)

Decision Makers

Some staff are more likely than others to have a decision making influence on the use of taxpayers' money, because of the requirements of their role. For the purposes of this guidance these people are referred to as 'decision making staff'.

Decision makers in this organisation are:

- Executive and Non-Executive Directors
- Members of committees and advisory groups which contribute to direct or delegated decision making on the commissioning or provision of taxpayer funded services.
- Agenda for Change 8a and above.
- Administrative and clinical staff who have the power to enter into contracts on behalf of the Trust.
- Administrative and clinical staff involved in decision making concerning the commissioning of services, purchasing of goods, medicines, medical devices or equipment, and formulary decisions.

PROCESS FOR THE IDENTIFICATION, DECLARATION AND REVIEW OF INTERESTS

Identification and declaration of interests (including gifts and hospitality)

All staff should identify and declare material interests at the earliest opportunity (and in any event within 28 days). If staff members are in any doubt as to whether an interest is material they should declare it, so that it can be considered. Declarations should be made:

- On appointment with the Trust;
- When staff move to a new role or their responsibilities change significantly;
- At the beginning of a new project/piece of work;
- At the outset of meetings and
- As soon as circumstances change and new interests arise (for instance, in a meeting when interests staff hold are relevant to the matters in discussion).

The Company Secretary is responsible for implementing the guidance, including:

- Reviewing current policies and bringing them in line with the national guidance 'Managing Conflicts of Interest in the NHS' February 2017;
- Providing advice, training and support for staff on how interests should be managed;
- Maintaining the registers of interests; gifts and hospitality and commercial sponsorships
- Auditing policy, process and procedures relating to this guidance at least every three years.

Declarations must be made to the Company Secretary. A declaration of interest(s) Form is available at **Appendix A** or from the Company Secretary.

After expiry, an interest will remain on register(s) for a minimum of 6 months and a private record of historic interests will be retained for a minimum of 6 years.

Proactive review of interests

We will prompt decision making staff annually to review declarations they have made and, as appropriate, update them or make a nil return.

RECORDS AND PUBLICATION

Maintenance

The Trust will maintain the following registers which will be updated to reflect changes in staff circumstances:

- Register of Interests for Board of Directors-Non-Executive and Executive Directors
- Register of Interests for Decision Making Staff-example procurement staff
- Register of Interests for Staff above Agenda for Change Band 8a
- Register of Outside Work including Private Practice by Clinicians
- Register of Loyalty Declarations
- Register of Gifts and Hospitality and Commercial Sponsorship

All declared interests that are material will be promptly transferred to the Registers by the Company Secretary.

Publication

We will:

- Publish the interests declared by decision making staff in the Register of Interests and Register of Gifts, Hospitality and Sponsorship;
- Refresh this information annually; and
- Make this information available on the Trust's website.

If decision making staff have substantial grounds for believing that publication of their interests should not take place then they should contact the Company Secretary to explain why. In exceptional circumstances, for instance where publication of information might put a member of staff at risk of harm, information may be withheld or redacted on public registers. However, this would be the exception and information will not be withheld or redacted merely because of a professional preference.

Wider transparency initiatives

The Trust fully supports wider transparency initiatives in healthcare, and we encourage staff to engage actively with these.

Relevant staff members must disclose payments they receive from the pharmaceutical industry to be disclosed as part of the Association for British

Pharmaceutical Industry (ABPI) Disclose UK Initiative. This policy takes precedence over the APBI Initiative. These 'transfers of value' include payments relating to:

- Speaking at and chairing meetings;
- Training services;
- Advisory board meetings;
- Fees and expenses paid to healthcare professionals;
- Sponsorship of attendance at meetings, which includes registration fees and the costs of accommodation and travel, both inside and outside the UK; and
- Donations, grants and benefits in kind provided to healthcare organisations.

Further information about the scheme can be found on the ABPI website:

http://www.abpi.org.uk/our-work

Management of interests – general

If an interest is declared but there is no risk of a conflict arising then no action is warranted. However, if a material interest is declared then the general management actions that could be applied include:

- Restricting staff involvement in associated discussions and excluding them from decision making;
- Removing staff from the whole decision making process;
- Removing staff responsibility for an entire area of work; or
- Removing staff from their role altogether if they are unable to operate effectively in it because the conflict is so significant.

Each case will be different and context-specific, and the Trust will always clarify the circumstances and issues with the individuals involved. Staff should maintain a written audit trail of information considered, action taken and the reasons for it.

Staff members, who declare material interests, should make their line manager or the person(s) they are working to aware of their existence.

The Company Secretary will advise on possible disputes about the most appropriate management action.

MANAGEMENT OF INTERESTS – COMMON SITUATIONS

This section sets out the principles and rules to be adopted by staff in common situations, and what information should be declared.

Gifts

Staff should not accept gifts that may affect, or be seen to affect, their professional judgement.

Gifts from suppliers or contractors:

- Gifts from suppliers or contractors doing business (or likely to do business) with the organisation should be declined, whatever their value.
- Low cost branded promotional aids such as pens or post-it notes may, however, be accepted where they are under the value of £6 in total, and need not be declared.

Gifts from other sources (e.g. patients, families, service users):

- Gifts of cash and vouchers to individuals should always be declined.
- Gifts such as alcohol and cartons of cigarettes must not be accepted.
- Staff should not ask for any gifts.
- Gifts valued at over £25 should be treated with caution and only accepted on behalf of the Trust's Charitable Funds and not in a personal capacity. These should be declared by staff.
- Modest gifts accepted under a value of £25 do not need to be declared.
- A common sense approach should be applied to the valuing of gifts (using an actual amount, if known, or an estimate that a reasonable person would make as to its value).
- Multiple gifts from the same source over a 12 month period should be treated in the same way as single gifts over £25 where the cumulative value exceeds £25. These should be declared.

What should be declared?

- Staff name and role within the Trust.
- A description of the nature and value of the gift, including its source.
- Date of receipt.
- Any other relevant information (e.g. circumstances surrounding the gift, action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

Hospitality

- Staff should not ask for or accept hospitality that may affect, or be seen to affect, their professional judgement.
- Hospitality must only be accepted when there is a legitimate business reason and it is proportionate to the nature and purpose of the event.
- Particular caution should be exercised when hospitality is offered by actual or potential suppliers or contractors. This can be accepted if modest and reasonable (not exceeding £100) but must be declared. Senior approval must be obtained.

Meals and refreshments:

- Under a value of £25 – may be accepted and need not be declared.
- Of a value between £25 and £75 - may be accepted and must be declared.
- Over a value of £75 – should be refused unless (in exceptional circumstances) senior approval is given in advance. A clear reason should be

recorded on the Trust's register of gifts and hospitality as to why it was permissible to accept.

- A common sense approach should be applied to the valuing of meals and refreshments (using an actual amount, if known, or a reasonable estimate).

Travel and accommodation:

- Modest offers to pay some or all of the travel and accommodation costs related to attendance at events may be accepted and must be declared.
- Offers which go beyond modest, or are of a type that the Trust itself might not usually offer, need approval by senior staff (preferably in advance), should only be accepted in exceptional circumstances, and must be declared. A clear reason should be permissible to accept travel and accommodation of this type. A non-exhaustive list of examples includes:
  - Offers of business class or first class travel and accommodation (including domestic travel)
  - Offers of foreign travel and accommodation.

What should be declared?

- Staff name and their role within the Trust.
- The nature and value of the hospitality including the circumstances, the purpose of the business activity to which the hospitality relates and also the name of the organisation (and contact) that is paying for that hospitality..
- Date of receipt.
- Any other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

Outside Employment including Private Practice by Clinicians

- Staff should declare any existing outside employment on appointment and any new outside employment when it arises.
- Where a risk of conflict of interest arises, the general management actions outlined in this policy should be considered and applied to mitigate risks.
- Where contracts of employment or terms and conditions of engagement permit, staff may be required to seek prior approval from the organisation to engage in outside employment.

The organisation may also have legitimate reasons within employment law for knowing about outside employment of staff, even when this does not give rise to risk of a conflict. Further advice can be sought from the Associate Director of Human Resources.

Clinical private practice

Clinical staff should declare all private practice on appointment, and/or any new private practice when it arises including:

- Where they practice (name of private facility).
- What they practice (specialty, major procedures).
- When they practice (identified sessions/time commitment).

Clinical staff should (unless existing contractual provisions require otherwise or unless emergency treatment for private patients is needed):

- Seek prior approval of the Trust before taking up private practice.
- Ensure that, where there would otherwise be a conflict or potential conflict of interest, NHS commitments take precedence over private work.
- Not accept direct or indirect financial incentives from private providers other than those allowed by Competition and Markets Authority guidelines: Assets: how they work - Assets | GOV.UK Developer Documentation

Hospital Consultants should not initiate discussions about providing their Private Professional Services for NHS patients, nor should they ask other staff to initiate such discussions on their behalf.

What should be declared?

- Staff name and their role in the Trust.
- The nature of the outside employment (e.g. who it is with, a description of duties, time commitment).
- Relevant duties.
- Other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

SHAREHOLDINGS AND OTHER OWNERSHIP ISSUES

- Staff should declare, as a minimum, any shareholdings and other ownership interests in any publicly listed, private or not-for-profit company, business, partnership or consultancy which is doing, or might be reasonably expected to do, business with the Trust.
- Where shareholdings or other ownership interests are declared and give rise to risk of conflicts of interest then the general management actions outlined in this policy should be considered and applied to mitigate risks.
- There is no need to declare shares or securities held in collective investment or pension funds or units of authorised unit trusts.

What should be declared?

- Staff name and their role in the Trust.
- Nature of the shareholdings/other ownership interest.
- Relevant dates.
- Other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

Patents and Intellectual Property Rights

- Staff should declare patents and other intellectual property rights they hold (either individually, or by virtue of their association with a commercial or other organisation), including where applications to protect have started or are

ongoing, which are, or might be reasonably expected to be, related to items to be procured or used by the Trust.

- Staff should seek prior permission from the Trust before entering into any agreement with bodies regarding product development, research, work on pathways etc., where this impacts on the Trust's own time, or uses its equipment, resources or intellectual property.
- Where holding of patents and other intellectual property rights give rise to a conflict of interest then the general management actions outlined in this policy should be considered and applied to mitigate risks.
- Intellectual property or copyright created by employees in the course of their employment belongs to the Trust and cannot be used for financial gain. (Please refer to the Standing Operating Procedures for Research: Intellectual Property arising from Research Activity) and The DoH Framework and Guidance on the Management of Intellectual Property in the NHS.
- Where an invention that is a patentable object, device, process or procedure capable of commercial exploitation, is produced by a Trust employee, the invention is the property of the Trust to the extent that it was produced by the employee in the course of Trust employment, or arises by virtue of the employee's conditions of employment or from the opportunities afforded by Trust employment.
- In the event of an employee coming to believe that an invention may arise or has arisen from their endeavour, there is an absolute and immediate requirement for complete secrecy. This is to ensure that the patent rights that may apply to the Trust or employee are not jeopardised by inadvertent creation of prior art. The employee must immediately report the invention to the Company Secretary, who will provide further guidance, and to no-one else.
- Where an invention is commercially exploited, the Trust regards the employee as having the right to a fair, proportionate and negotiated share of any profit.
- Any work commissioned from third parties or work carried out by employees in the course of their Trust employment, belongs to the Trust, including any rewards or benefits (such as royalties). Where this involves publishing a book or article of which s/he is the author or a contributor, or delivering a lecture or speech or making a broadcast, all employees will be expected to consult with their manager first. Appropriate specifications and provisions will be included in contract arrangements before work is commissioned or begins.
- Should an employee be rewarded for work carried out as part of Trust business (for example, giving certain presentations), or to outside parties but wholly within Trust time, then the sum involved shall be registered and paid into the Trust's accounts. The employee concerned shall be reimbursed an appropriate proportion of the fee if some of her/his own time was spent on the task.
- Appropriate arrangements will be agreed regarding the receipt of rewards for Trust related collaborative work with manufacturers and for any rewards to be shared with employees, where their participation involved additional work outside that paid for by the Trust under normal contractual arrangements. These arrangements must be agreed with the Trust before the work involved is undertaken.

What should be declared

- Staff name and their role in the Trust.
- A description of the patent.
- Relevant dates.
- Other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

LOYALTY INTERESTS

Loyalty interests can be defined as a director or officer reneging on his responsibility to avoid possible conflicts of interest, thereby precluding him from self-dealing or taking advantage of a corporate opportunity for personal gain or the gain of someone with whom he has a close relationship. Loyalty interests should be declared by staff involved in decision making where they:

- Hold a position of authority in another NHS organisation or commercial, charity, voluntary, professional, statutory or other body which could be seen to influence decisions they take in their NHS role.
- Sit on advisory groups or other paid or unpaid decision making forums that can influence how an organisation spends taxpayers' money.
- Are, or could be, involved in the recruitment or management of close family members and relatives, close friends and associates, and business partners.
- Are aware that the Trust does business with an organisation in which close family members and relatives, close friends and associates, and business partners have decision making responsibilities.

What should be declared?

- Staff name and their role in the Trust.
- Nature of the loyalty interest.
- Relevant dates.
- Other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

Donations

- Donations made by suppliers or bodies seeking to do business with the Trust should be treated with caution and not routinely accepted. In exceptional circumstances they may be accepted but should always be declared. A clear reason should be recorded as to why it was deemed acceptable, alongside the actual or estimated value.
- Staff should not actively solicit charitable donations unless this is a prescribed or expected part of their duties for the Trust, or is being pursued on behalf of the Trust's own registered charity or other charitable body and is not for their own personal gain.
- Staff must obtain permission from the Trust if in their professional role they intend to undertake fundraising activities on behalf of a pre-approved charitable campaign for a charity other than the Trust's own charitable fund.

- Donations, when received, should be made to the Trust's charitable fund (never to an individual) and a receipt should be issued.
- Staff wishing to make a donation to a charitable fund in lieu of receiving a professional fee may do so, subject to ensuring that they take personal responsibility for ensuring that any tax liabilities related to such donations are properly discharged and accounted for.

What should be declared?

- The Trust will maintain records in line with the above principles and rules and relevant obligations under charity law.

SPONSORED EVENTS

- Sponsorship of events by appropriate external bodies will only be approved if a reasonable person would conclude that the event will result in clear benefit to the Trust and the NHS.
- During dealings with sponsors there must be no breach of patient or individual confidentiality or data protection rules and legislation.
- No information should be supplied to the sponsor from whom they could gain a commercial advantage, and information which is not in the public domain should not normally be supplied.
- At the Trust's discretion, sponsors or their representatives may attend or take part in the event but they should not have a dominant influence over the content or main purpose of the event.
- The involvement of a sponsor in an event should always be clearly identified.
- Staff within the Trust involved in securing sponsorship of events should make it clear that sponsorship does not equate to endorsement of a company or its products and this should be made visibly clear on any promotional or other materials relating to the event.
- Staff arranging sponsorship events must declare this to the Trust.

What should be declared?

- The Trust will maintain records regarding sponsored events in line with the above principles and rules.

Sponsored research

Funding sources for research purposes must be transparent.

- Any proposed research must go through the relevant health research authority or other approvals process.
- There must be a written protocol and written contract between staff, the Trust and/or institutes at which the study will take place and the sponsoring organisation, which specifies the nature of the services to be provided and the payment for those services.
- The study must not constitute an inducement to prescribe, supply, administer, recommend, buy or sell any medicine, medical device, equipment or service.
- Staff should declare involvement with sponsored research to the Trust.

What should be declared?

The Trust will retain written records of sponsorship of research, in line with the above principles and rules.

Staff should declare:

- Their name and role in the Trust
- Nature of their involvement in the sponsored research.
- Relevant dates.
- Nature of the sponsored research
- Other relevant information (e.g. what, if any, benefit the sponsor derives from the sponsorship, action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

Sponsored posts

- External sponsorship of a post requires prior approval from the Trust.
- Rolling sponsorship of posts should be avoided unless appropriate checkpoints are put in place to review and withdraw if appropriate.
- Sponsorship of a post should only happen where there is written confirmation that the arrangements will have no effect on purchasing decisions or prescribing and dispensing habits. This should be audited for the duration of the sponsorship. Written agreements should detail the circumstances under which organisations have the ability to exit sponsorship arrangements if conflicts of interest which cannot be managed arise.
- Sponsored post holders must not promote or favour the sponsor's products, and information about alternative products and suppliers should be provided.
- Sponsors should not have any undue influence over the duties of the post or have any preferential access to services, materials or intellectual property relating to or developed in connection with the sponsored posts.

What should be declared?

- The Trust will retain written records of sponsorship of posts, in line with the above principles and rules.
- Staff should declare any other interests arising as a result of their association with the sponsor, in line with the content of the rest of this policy.

MANAGEMENT OF INTERESTS – ADVICE IN SPECIFIC CONTEXTS

Strategic decision making groups

In common with other NHS bodies the Trust uses a variety of different groups to make key strategic decisions about things such as:

- Entering into (or renewing) large scale contracts.
- Awarding grants.
- Making procurement decisions.
- Selection of medicines, equipment and devices.

The interests of those who are involved in these groups should be well known so that they can be managed effectively. For this Trust these groups include but are not limited to the:

- Board of Directors
- Board Committees
- Drugs and Therapeutics Committee

These groups should adopt the following principles:

- The Board, Committees and Groups should have a list of declared interests of all members. These must be updated as soon as a change of circumstances arises.
- Chairs should consider any known interests of members in advance, and begin each meeting by asking for declaration of relevant material interests.
- Members should take personal responsibility for declaring material interests at the beginning of each meeting and as they arise.
- Any new interests identified should be added to the Trust's Register of Interests.
- The vice chair (or other non-conflicted member) should chair all or part of the meeting if the chair has an interest that may prejudice their judgement.

If a member has an actual or potential interest the chair should consider the following approaches and ensure that the reason for the chosen action is documented in the minutes or records:

- Requiring the member to not attend the meeting.
- Excluding the member from receiving meeting papers relating to their interest.
- Excluding the member from all or part of the relevant discussion and decision.
- Noting the nature and extent of the interest, but judging it appropriate to allow the member to remain and participate.
- Removing the member from the group or process altogether.

The default response should not always be to exclude members with interests, as this may have a detrimental effect on the quality of the decision being made. Good judgement is required to ensure proportionate management of risk.

Procurement

Procurement should be managed in an open and transparent manner, compliant with procurement and other relevant law, to ensure there is no discrimination against or in favour of any provider. Procurement processes should be conducted in a manner that does not constitute anti-competitive behaviour – which is against the interest of patients and the public.

Those involved in procurement exercises for and on behalf of the Trust should keep records that show a clear audit trail of how conflicts of interest have been identified and managed as part of procurement processes. At every stage of procurement

steps should be taken to identify and manage conflicts of interest to ensure and to protect the integrity of the process.

Further advice can be sort from the Procurement and Commercial Services Manager (or equivalent) or Company Secretary.

Bribery Act 2010

There are circumstances when a conflict of interest has the potential to also be a possible offence under the Bribery Act. Under the Bribery Act 2010 any money, gift or hospitality received by an employee from a person or company seeking a contract within the Trust may be deemed to have been received as a bribe.

Reference should be made to the Trust's Anti-Fraud, Bribery and Corruption Policy for clarification and, as a consequence, if any employee feels that they have been offered an incentive or bribe in the course of their professional duties, this should also be declared in writing and immediately notified to the Local Counter Fraud Specialist. For further information refer to the Trust's Anti-Fraud, Bribery and Corruption Policy.

Dealing with breaches

There will be situations when interests will not be identified, declared or managed appropriately and effectively. This may happen innocently, accidentally, or because of the deliberate actions of staff or other organisations. For the purposes of this policy these situations are referred to as 'breaches'.

Identifying and reporting breaches

Staff who are aware about actual breaches of this policy, or who are concerned that there has been, or may be, a breach should report these concerns to the Company Secretary, Director of Finance, Speak Up Guardian or the local Counter Fraud Specialist who can be contacted at:

Company Secretary: Audley Charles: a.charles1@nhs.net
Tel: 01704 704 769 x 4679
M: 07741 293 757

Director of Finance: Steve Shanahan:steve.shanahan@nhs.net
Tel:01704 704 825 x 4825
M: 07813 695 775

Speak Up Guardian: Rev Martin Abrams:martin.abrams@nhs.net
Tel: 01704 704 639 x 4639
M: 07467 374 824 OR 07917 658 722

Local Counter Fraud: Paul Bell: paul.bell@miaa.nhs.uk

Specialist Tel: 0151 285 4523
M: 07837 747 333

To ensure that interests are effectively managed staff members are encouraged to speak up about actual or suspected breaches. Every individual has a responsibility to do this. For further information about how concerns should be raised refer to the Trust's Whistleblowing Policy or Anti-Fraud, Bribery and Corruption Policy.

The Trust will investigate each reported breach according to its own specific facts and merits, and give relevant parties the opportunity to explain and clarity any relevant circumstances.

Following investigation the Trust will:

- Decide if there has been or is potential for a breach and if so the severity of the breach.
- Assess whether further action is required in response – this is likely to involve the member of staff involved and their line manager as a minimum.
- Consider who else inside and outside of the Trust should be made aware.
- Take appropriate action as set out in the next section.

Taking action in response to breaches

Action taken in response to breaches of this policy will be as follows:

- A brief fact finding investigation to determine the circumstances and reasons in accordance with the disciplinary procedures of the Trust and could involve Trust leads for Human Resources, Fraud and members of the management and executive team and Trust's auditors.

Breaches could require action in one or more of the following ways:

- Clarification or strengthening of existing policy, process and procedures.
- Consideration as to whether HR/employment law/contractual action should be taken.
- Consideration being given to escalation to external parties. This might include referral of matters to external auditors, NHS Protect, the Police, statutory health bodies (such as NHS England, NHS Improvement of the CQC), and/or health professional regulatory bodies.

Inappropriate or ineffective management of interests can have serious implications for the Trust and staff. There will be occasions where it is necessary to consider the imposition of sanctions for breaches.

Sanctions should not be considered until the circumstances surrounding breaches, have been properly investigated. However, if such investigations establish wrong-doing or fault then the Trust can and will consider the range of possible

sanctions that are available, in a manner which is proportionate to the breach. This includes:

- Employment law action against staff, which might include:

- Informal action (such as reprimand, or signposting to training and/or guidance).
- Formal disciplinary action (such as formal warning, the requirement for additional training, re-arrangement of duties, re-deployment, demotion or dismissal).

- Reporting incidents to the external parties described above for them to consider what further investigations or sanctions might be.
- Contractual and civil legal actions, such as exercise of remedies or sanctions against the body or staff which caused the breach.
- Criminal legal action, including but not limited to legislation relating to offences including fraud and bribery; such as investigation and prosecution under fraud, bribery and corruption legislation.

Learning and transparency concerning breaches

Anonymised reports on breaches, the impact of these, and action taken will be considered by the Audit Committee at least annually.

To ensure that lessons are learnt and management of interests can continually improve, anonymised information on breaches, the impact of these, and action taken will be prepared and published on the Trust website as appropriate or made available for inspection by the public upon request.

LINKS TO RELEVANT LEGISLATION

This policy is underpinned by the following relevant legislation:

- Freedom of Information Act 2000
- Bribery Act 2010-see PB's comments
- The Fraud Act 2006
- The Data Protection Act 1998
- The Public Interest Disclosure Act 1998

Links to Relevant National Standards

This policy is underpinned by the following national guidance:

- ABPI: The Code of Practice for the Pharmaceutical Industry (2014)
- ABHI Code of Business Practice
- NHS Code of Conduct and Accountability (2004)
- NHS England Managing Conflicts of Interest in the NHS (2017)
- NHS Code of Conduct for Managers
- Code of Practice on Openness in the NHS

Links to other key policies

This policy links to the following Trust policies:

- Freedom to Speak Up (Whistleblowing) Policy
- Anti-Fraud, Bribery and Corruption Policy

- Corporate Governance Manual (incorporating the Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation)
- Disciplinary Policy

References

This policy has been aligned to NHS England's Managing Conflicts of Interest in the NHS – model policy content for organisations.

ROLES AND RESPONSIBILITIES FOR THIS POLICY

Title	Role	Responsibilities
All Staff	To comply with the policy	Have a responsibility to: • Use common sense and judgement to consider whether the interests held could affect the way taxpayers' money is spent • Regularly consider interests held and declare these as they arise. • Not misuse their position to further their own interests or those of close associations • Not be influenced, or give the impression of being influenced by outside interests • Not allow outside interests to inappropriately affect the decisions being made using taxpayers' money
Company Secretary	Policy Lead	Responsible for: The review of the policy every 3 years or as and when required to reflect any change in relevant legislation or guidance. The dissemination of the policy and provision of advice, training and support for staff on how interests should be managed. Maintaining the register of interests and register of gifts, hospitality and sponsorship. Auditing this policy and its associated processes and procedures at least once every three years.
Chief Executive	Executive Lead	Overall Responsibility for: Ensuring that the Trust conducts its business in accordance with standards of good business and employment law and practice, and for ensuring compliance with the Trust's Standing Orders.

TRAINING

What aspect(s) of this policy will require staff training?	Which staff groups require this training?	Is this training covered in the Trust's Mandatory and Risk Management Training Needs Analysis document?	If no, how will the training be delivered?	Who will deliver the training?	How often will staff require training	Who will ensure and monitor that staff have this training
Sections 7, 9, 10 &11	All staff	No	Policy will be available on the Intranet. New Starters are provided with the Code of Conduct for all staff. Regular electronic prompts to remind all staff to declare interests, acceptance of gifts, hospitality and sponsorship. Electronic reminders to decision making staff	The Company Secretary, the Speak Up Guardian and the Local Counter Fraud Specialist	Annually	The Company Secretary

EQUALITY ANALYSIS ASSESSMENT

Southport & Ormskirk Hospital NHS Trust is committed to ensuring that the way we provide services and the way we recruit and treat staff reflects individual needs, promotes equality and does not discriminate unfairly against any particular individual or group. The Equality Impact Assessment for this policy has been completed and is readily available on the Intranet. If you require this policy in a different format e.g. larger print, Braille, different languages or audio tape, please contact the Corporate Governance Team.

DATA PROTECTION AND FREEDOM OF INFORMATION

All staff have a responsibility to ensure that they do not disclose information about the Trust's activities in respect of service users in its care to unauthorised individuals. This responsibility applies whether you are currently employed or after your employment ends and in certain aspects of your personal life e.g. use of social networking sites etc. The Trust seeks to ensure a high level of transparency in all its business activities but reserves the right not to disclose information where relevant legislation applies.

PRIVACY IMPACT ASSESSMENT

No Impact

MONITORING THIS POLICY IS WORKING IN PRACTICE

Using the table below identify how the Trust will ensure that the policy is working effectively in practice

Monitoring this policy is working in practice **What key elements will be monitored? (measurable policy objectives)**	**Where described in the policy?**	**How will they be monitored? (method + sample size)**	**Who will undertake this monitoring?**	**How Frequently?**	**Group/Committee that will receive and review results**	**Group/Committee to ensure actions are completed**	**Evidence this has happened**
All decision making staff (8a and above) must complete an annual Declaration of Interests, (DOI) Fit and Proper Persons' Test and Code of Conduct	Sections 6 and 7	Review of Register of Interests	The Company Secretary	Annually	Board and Audit Committee	Board and Audit Committee	Minutes of Board and Audit Committee DOI FORM Completed FPPT and Code of Conduct
All relevant	Sections 6	Quarterly	The	As and	Board and Audit	Board and Audit	Minutes of

gifts, hospitality and sponsorships must be declared	and 7	Report on Corporate Registers to Audit Committee/ Annual Fit & Proper Persons Requirement and Code of Conduct	Company Secretary	when required	Committee	Committee	Board and Audit Committee Register
All new Staff including NEDs	Sections 6 and 7	Item on Corporate Induction Agenda and Declaration of Interest Form Filled in and Signed at Induction	The Company Secretary	Commencement of Employment	Board and Audit Committee and Workforce and OD Committee	Board and Audit Committee and Workforce and OD Committee	Induction Agenda and Programme

APPENDIX

APPENDIX 1 Declaration of Gifts, Hospitality and Sponsorship Form
APPENDIX 2 Declaration of Outside Work Including Private Practice by Clinicians
APPENDIX 3Declaration of Interests Form

APPENDIX 1 Declaration of Gifts, Hospitality and Sponsorship Form

Name	Role	Description of Gift, Hospitality or Sponsorship (including organisation and value)	Relevant Dates		Comments
			From	To	

Please see below information on how to populate the above boxes.

The information submitted will be held by Southport & Ormskirk Hospitals NHS Trust to comply with the Trust's policies. This information may be held in both manual and electronic format in accordance with the Data Protection Act 1998. Information may be disclosed to third parties in accordance with the Freedom of Information Act 2000 and published in registers that the Trust holds.

I confirm that the information provided above is complete and correct. I acknowledge that any changes in these declarations must be notified to Southport & Ormskirk Hospitals NHS Trust as soon as practicable and no later than 28 days after the offer of gift, hospitality and sponsorship arises. I am aware that if I do not make full, accurate and timely declarations then civil, criminal, internal disciplinary, or professional regulatory action may result.

I **do / do not** (delete as appropriate) give my consent for this information to be published on the Trust's register of gifts, hospitality and sponsorship.

Signed: _____
Date: _____

If consent is not given then please state the reason here:

_____

_____

Please return to the Company Secretary, Corporate Management Office, Southport Hospital as soon as possible or within 28 days of the gift, hospitality and sponsorship being offered.

Guidance notes for completing the Declaration of Gifts, Hospitality and Sponsorship form.

Name and Role Insert your name and job title in relation to the Trust.

Description Provide a brief description of the gift, hospitality or sponsorship being declared including the value if known or estimate of the value. This should contain enough information to be meaningful (e.g. detailing the supplier of any gifts, hospitality, sponsorship, etc.). That is, the information provided should enable a reasonable person with no prior knowledge to read this and understand the nature of the offer.

This would include but is not limited to:

- gifts
- hospitality in the form of meals and refreshments, travel and accommodation
- sponsored events
- sponsored research
- sponsored posts

Relevant Dates Detail here when the offer was made arose and, if relevant, when it ceased.

Comments This field should describe the approval or permission sought to accept the gift, hospitality or sponsorship (including who gave such approval/permission and when).

APPENDIX 2 Declaration of Outside Work Including Private Practice by Clinicians

Should you undertake any outside work during your employment with SOHT, you must declare the details to your line manager and complete this form, a copy of which must be sent to the Company Secretary. *You do not need to declare as outside work part-time hours accrued across more than one NHS organisation provided that the aggregate hours do not exceed the maximum number of hours (48) per week you are allowed to work.*

Section 1	
In addition to your work with SOHT, do you undertake any work outside of the Trust? (for example private, paid or voluntary work)	Yes No
Details of Outside Work	
Name	
Job Title	
Band	
Service / Department	
Contact Telephone Number	
Normal Working Hours Per Week at SDGH	
Other Employer's Name	
Nature of Business	
Outline of work pattern in other employment (e.g. days worked / shift patterns)	
No. of hours worked per week in other employment	
Will you be working more than 48 hours per week in total or more than 12 hours in any one 24 hour period as a result of your combined employment?	Yes No
Any other relevant information that you wish to disclose	
Section 2 – Declaration and Authorisation	
To be completed by the Employee	
Name:	
Signature:	
Date:	

To be completed by the Line Manager	
Do you envisage a conflict of interest between the above 'outside work and the employee's employment with SOHT?	
Name:	
Signature:	
Date:	
Please return the completed Form to: The Trust Company Secretary, Trust Corporate Office, Southport & Ormskirk Hospital	

APPENDIX 3 Declaration of Interests Form

Name:		
Position / Role:		
Signature:		
Date:		
Directorship, including non-executive directorship held in private companies or Public Limited Companies (PLCs) (with the exception of those dormant companies) *[PLCs are companies floated on the stock exchange]*		
Ownership, or part ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS *[These include companies limited by guarantee or shares. If you work through and are paid via these means you must declare such information]*		
Majority holding or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS [*Where you hold more than 50% of the shares in this organisation]*		
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 [*This may be a Charity or independent organisation like Social Housing]*		
Other *[Any other interest that falls outside of the other categories, for example: Governor of a local school]*		

Related to anybody that works for the Trust *[This could be a partner or relative]*		
Loyalty *[Conflict can arise when decision-making is influenced subjectively through association with colleagues or organisations out of loyalty to the relationship you may have, rather than through an objective process. The scope of loyalty is potentially huge so use your judgement in making declarations]*		
Date of entry on register or amendment		

Policy Implementation Plan

An Implementation template document for policy leads to use is available in a Word document on the intranet

Policy Title	Policy for Managing Conflicts of Interest
Is this New or revision of an existing policy	Revision of existing policies Corp 05 and Corp78
Name and role of Policy Lead	Company Secretary

Give a Brief Overview of the Policy

The policy sets out the Trust's arrangements for business conduct and managing conflicts of interest, including outside work, private practice, acceptance of gifts, hospitality and sponsorship.

What are the main changes in practice that should be seen from the policy?

The policy has been updated to align to the latest national guidance issued in 7 February 2017 and in effect from 1 June 2017. The policy should provide further clarification on the declarations staff need to make in relation to interests, gifts, hospitality and sponsorship

Who is affected directly or indirectly by this policy?

The policy applies to all staff including Non-Executive Directors**.**

Implications	
Will staff require specific training to implement this policy and if yes, which staff groups will need training?	
Explain the issues?	**Explain how this has been resolved**
Decision making staff (defined within the policy) will need to be made aware of the updates made to this policy. This can be done via face-to-face or in some cases, via email.	N/A
Are other resources required to enable the implementation of the policy e.g. increased staffing, new documentation?	
Explain the issues?	**Explain how this has been resolved**
The declarations of interest and gifts and hospitality forms on the intranet will need to be updated	N/A

Implications cont'd/…	
Have the financial impacts of any changes been established? There are no financial impacts.	
Explain the issues? N/A	**Explain how this has been resolved** N/A
Any other considerations	
Explain the issues? N/A	**Explain how this has been resolved** N/A

Approval of Implementation Plan
Enter Name and Title of Policy Lead whose portfolio this policy will come under Audley Charles, Interim Company Secretary **Signature** **Date Approved** January 2018

Policy Details

Southport and Formby District General Hospital
Ormskirk and District General Hospital
North West Regional Spinal Injuries Unit

NHS
Southport and Ormskirk Hospital
NHS Trust

Title of Policy	**Policy for Standards of Business Conduct and Managing Conflicts of Interest**
Unique Identifier for this policy is	SOHNHST-Corp-POL-1.0.0
State if policy is **New** or **Revised**	Revised and Updated
Previous Policy Title where applicable	Declarations of Interest Policy Policy for the Acceptance of Gifts and Hospitality
Policy Category Clinical, HR, H&S, 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
Consultation with	Executive Team, Leadership Executive Team and Counter Fraud Specialist at Internal Audit
Privacy Impact Assessment	November 2017
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 2020
Implementation Plan completed	YES
Equality Impact Assessment completed	yes
Previous version(s) archived	N/A
Disclosure status	Fully
Key words for this policy	Business Conduct/Conflicts of Interests/ Gifts and Hospitality/ Sponsorships/ Bribery and Corruption

For more information on the consultation process, implementation plan, equality impact assessment, or archiving arrangements, please contact Corporate Integrated Governance.

Review and Amendment History

Version	Date	Details of Change
1.0.0	February 2018	New policy

Anti-Fraud, Bribery & Corruption Policy

CORP 66

Target Audience				
Who should read this policy:	**Planned Care CBU**	**Urgent Care CBU**	**Specialist Services CBU**	**Corporate**
all employees of Southport and Ormskirk Hospital NHS	x	x	x	x

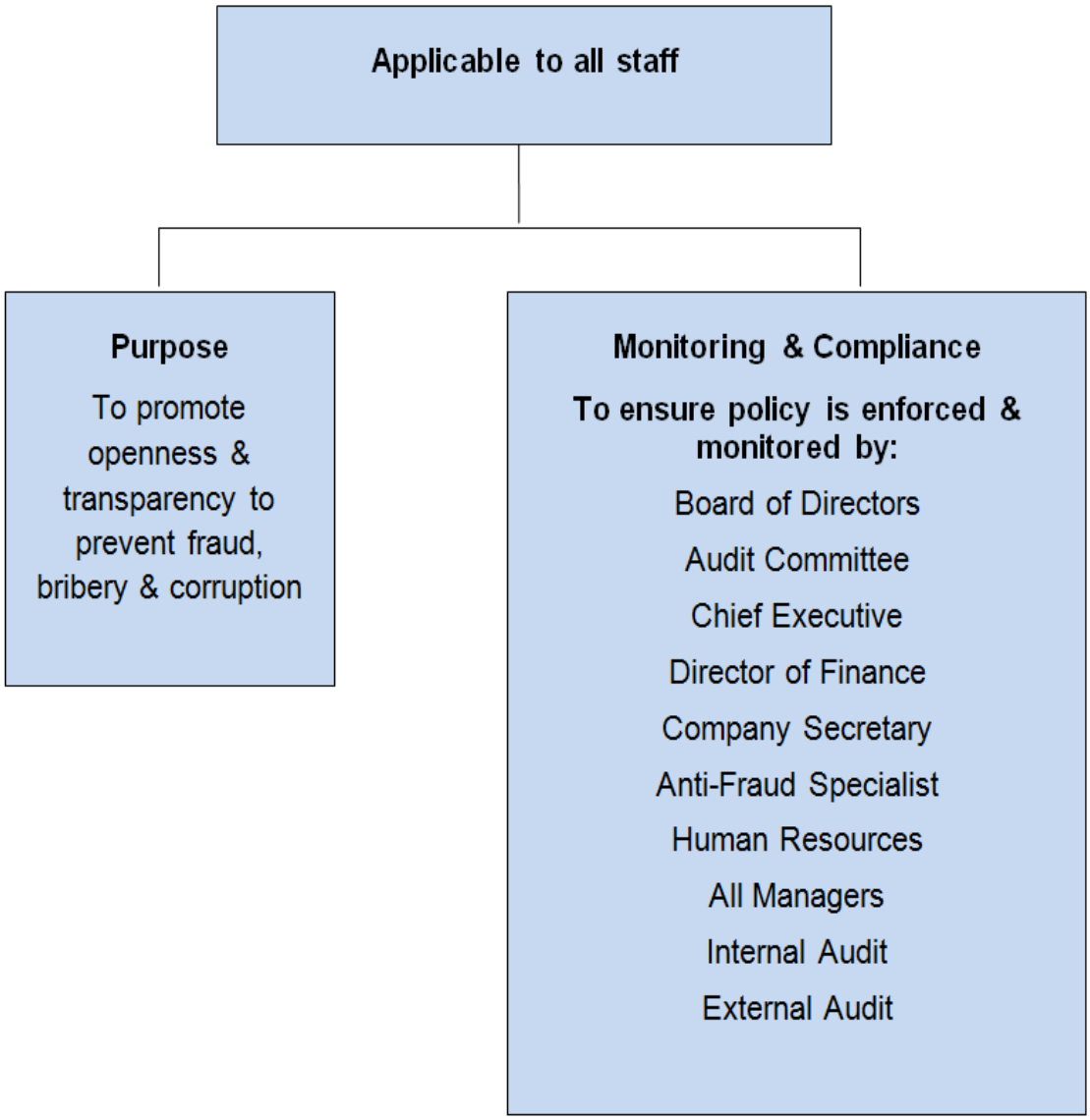

OUR VALUES
Supportive
Caring
Open and honest
Professional
Efficient

CONTENTS (CTRL + CLICK ON HYPERLINK TO RELEVANT SECTION)

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 Counter-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).

FLOWCHART FOR ANTI-FRAUD, BRIBERY AND CORRUPTION POLICY



2. 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.

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

OBJECTIVES

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.

FRAUD, BRIBERY AND CORRUPTION

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.

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.]

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.

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.

PROCEDURES CONNECTED TO THIS POLICY

None

LINKS TO RELEVANT LEGISLATION

Fraud Act 2006

Prevention of Corruption Acts 1906 and 1916

Bribery Act 2010

Links to relevant standards

Codes of Conduct for Trust Board and NHS Managers

NHS Standards of Business Conduct and Managing Conflicts of Interest

Links to other key policy/ies

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

References

none

ROLES AND RESPONSIBILITIES FOR THIS POLICY

Title	Role	Responsibilities
Employees	Use	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.
Managers	Implement	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.
Head of Information Security	escalation	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.
Human Resources (HR)	Investigate	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.
Internal & External Audit	escalation	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.
NHS Protect Area Anti-Fraud Lead (AAFL)	Prosecution	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.
Anti-Fraud Specialist (AFS)	Accountable officer	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.
Company Secretary	Support	The Company Secretary will support the Director of Finance by liaising with the AFS and receive reports from referrers if the Chief Executive and/or Director of Finance are involved.
Director of Finance	Monitoring	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.
Responsibility of Trust Board	Responsible olfficer	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.

TRAINING

None Required

EQUALITY ANALYSIS ASSESSMENT

Southport & Ormskirk Hospital NHS Trust is committed to ensuring that the way we provide services and the way we recruit and treat staff reflects individual needs, promotes equality and does not discriminate unfairly against any particular individual or group. The Equality Impact Assessment for this policy has been completed and is readily available on the Intranet. If you require this policy in a different format e.g. larger print, Braille, different languages or audio tape, please contact the Corporate Governance Team.

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

DATA PROTECTION AND FREEDOM OF INFORMATION

All staff have a responsibility to ensure that they do not disclose information about the Trust's activities in respect of service users in its care to unauthorised individuals. This responsibility applies whether you are currently employed or after your employment ends and in certain aspects of your personal life e.g. use of social networking sites etc. The Trust seeks to ensure a high level of transparency in all its business activities but reserves the right not to disclose information where relevant legislation applies.

PRIVACY IMPACT ASSESSMENT

N/A

MONITORING THIS POLICY IS WORKING IN PRACTICE

Using the table below identify how the Trust will ensure that the policy is working effectively in practice

Monitoring this policy is working in practice **What key elements will be monitored? (measurable policy objectives)**	**Where described in the policy?**	**How will they be monitored? (method + sample size)**	**Who will undertake this monitoring?**	**How Frequently?**	**Group/Committee that will receive and review results**	**Group/Committee to ensure actions are completed**	**Evidence this has happened**
Fraud Awareness	Throughout	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	Throughout	Annual Staff Fraud Survey	AFS	Annually	Audit Committee via the Anti-Fraud Annual Report	Audit Committee	

Fraud Awareness	Throughout	Increased reports demonstrating increased awareness and policy compliance	AFS	Ongoing	Audit Committee via the Anti-Fraud Annual Report	Audit Committee	

APPENDIX

APPENDIX 1 A Desktop Guide to Reporting NHS Fraud, Bribery and Corruption

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 Implementation Plan

An Implementation template document for policy leads to use is available in a Word document on the intranet

Policy Title	Anti-Fraud, Bribery & Corruption Policy
Is this New or revision of an existing policy	Revision
Name and role of Policy Lead	A Charles Company Secretary

Give a Brief Overview of the Policy

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.

What are the main changes in practice that should be seen from the policy?

Updated to reflect current practice

Who is affected directly or indirectly by this policy?

All trust staff and Volunteers

Implications	
Will staff require specific training to implement this policy and if yes, which staff groups will need training? None	
Explain the issues? **N/A**	**Explain how this has been resolved**
Are other resources required to enable the implementation of the policy e.g. increased staffing, new documentation? **N/A**	
Explain the issues? **N/A**	**Explain how this has been resolved**
Implications cont'd/…	

Have the financial impacts of any changes been established? None	
Explain the issues? **N/A**	**Explain how this has been resolved**
Any other considerations	
Explain the issues? **None**	**Explain how this has been resolved**

Approval of Implementation Plan
Enter Name and Title of Policy Lead whose portfolio this policy will come under **Signature** **Date Approved** March 2018

Policy Details

Title of Policy	Anti-Fraud, Bribery & Corruption Policy
Unique Identifier for this policy is	SOHNHST-Corp66-POL-2.0.0
State if policy is **New** or **Revised**	Revised
Previous Policy Title where applicable	No Change
Policy Category Clinical, HR, H&S, Infection Control, Finance etc.	Corporate
Executive Director *whose portfolio this policy comes under*	Chief Operating Officer
Policy Lead/Author *Job titles only*	Company Secretary
Committee/Group responsible for the approval of this policy	Trust Board
Consultation with	Director of Finance, Executive Team and Leadership Executive Group (LEG) and AFS
Privacy Impact Assessment	Not Required
Month/year consultation process completed	April 2018
Month/year policy approved	March 2018
Month/year policy ratified and issued	April 2018
Next review date	April 2021
Implementation Plan completed	Yes
Equality Impact Assessment completed	Yes
Previous version(s) archived	
Disclosure status	Fully
Key words for this policy	Anti-Fraud, Bribery & Corruption

Review and Amendment History

Version	Date	Details of Change
1.0.0	March 2014	New policy
2.0.0	April 2018	Updated

Development and Management of Procedural Documents

Corporate 68

.

Target Audience				
Who should read this policy:	**Planned Care CBU**	**Urgent Care CBU**	**Specialist Services CBU**	**Corporate Staff**
Policy Leads/Authors	✓	✓	✓	✓

Appendices

Explanation of terms used in this policy

Procedural Documents - the collective term for policies, procedures or guidelines.

Policy - sets out the aims and principles under which services, groups, or units will operate. A policy outlines roles and responsibilities, defines the scope of the subject covered, and provides a high level description of the controls that must be in place to ensure compliance.

Standard Operating Procedure - a prescribed and established procedure detailing all relevant steps and activities to be followed in carrying out a given process, operation, or in a given situation. They are specific, factual and to the point and tell you how it must be done.

Guideline - is a description of a 'best practice' way to work based on the best available evidence when no applicable standard is in place; it is not usually a requirement but is strongly recommended and tells you how it may be done.

Ratification - the process by which a policy or procedure is officially accepted as the approved document for the organisation following appropriate consultation and approval.

Approval - formal confirmation by the organisation's designated group or committee that the document meets the required standards and may go forward for ratification.

Consultation - seeking the views, opinions and advice from people or Groups who are directly involved with the policy area or will be affected by the content of the policy. Consultation is designed to improve transparency and decision-making and to ensure the arrangements set out are workable and practical to implement.

Draft - a preliminary version in the development of a procedural document, which will be subject to consultation, changes and amendments before final approval is granted.

Stakeholders - those individuals that are involved or affected by the policy who can usefully contribute, comment and agree to the content of the document. Stakeholders may be internal or external to the Trust for example, directors, managers, governors, employees, trade union representatives, service users, commissioners, carers, service user groups and others representing the local community.

Archiving - the collating and recording of obsolete policies, strategies and procedures for retrieval when required.

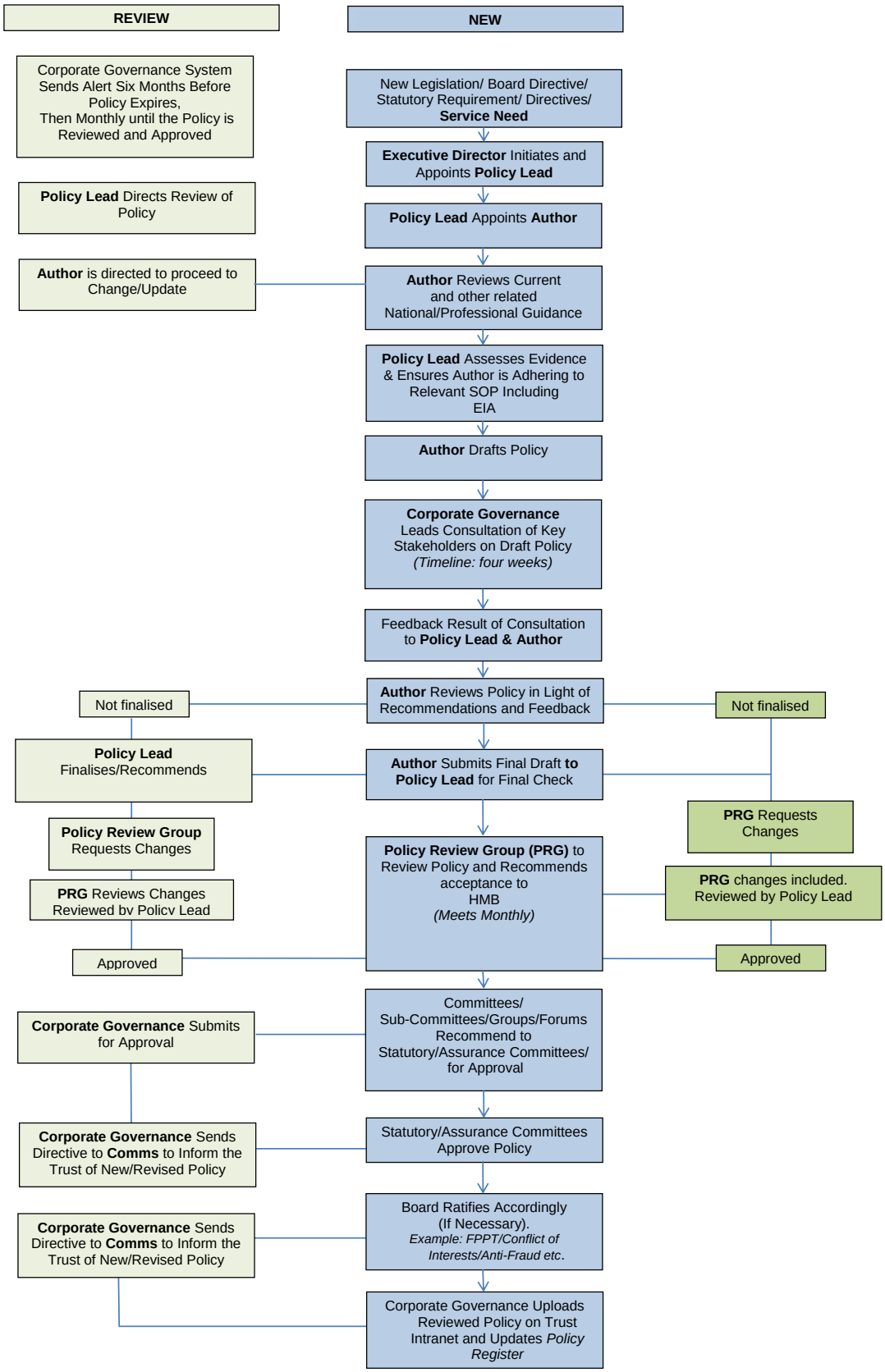
Policy Review Group – a forum established to review all policies and procedures to ensure compliance with guidance and format as set out in the SOP.

LocSIPPS- One of the recommendations of the Surgical Never Events Taskforce report was to develop a set of high-level national standards of operating department practice that will support all providers of NHS-funded care to develop and maintain their own more detailed standardised local procedures.

The National Safety Standards for Invasive Procedures (NatSSIPs) were published in September 2015 to support NHS organisations in providing safer care and to reduce the number of patient safety incidents related to invasive procedures in which surgical Never Events can occur. The NatSSIPs cover all invasive procedures including those performed outside of the operating department.

The principle behind the NatSSIPs is that organisations will review their current local processes for invasive procedures and ensure that they are compliant with the new national standards. This will be done by organisations working in collaboration with staff to develop their own set of ‘Local Safety Standards for Invasive Procedures’ (LocSSIPs).

PROCESS FOR THE DEVELOPMENT, DISSEMINATION & MANAGEMENT OF TRUST POLICY DOCUMENTS



Document name:	*Policy for the Development, Approval, Management, Dissemination and Monitoring of policy and procedural documents (Policy on Policies)*
Document type:	Policy
What does this policy replace?	Update of previous policy (Policy for the Creation and Review of Procedural Documents)
Staff group to whom it applies:	All staff within the Trust
Distribution:	The whole of the Trust
How to access:	Intranet
Issue date:	Date & Versions here (V2) List revisions done and dates The Policy has been updated and improvements made in the following ways: • Changes to the approval and ratification process • The creation of a Policy Review Group to replace the Virtual Groups hitherto in place • A provision in the Policy for emergency powers to be evoked in the event of expediting the approval of a Policy • Strengthening the reporting and monitoring process
Next review:	August 2020
Approved by:	Board of Directors
Developed by:	Company Secretary
Executive Lead:	Company Secretary
Contact for advice:	Trust Secretariat

INTRODUCTION

Policies and procedural documents are designed to provide a framework against which the Trust adheres to legal and regulatory requirements and good practice. They also support staff in discharging their duties, ensuring consistent behaviour across the Trust.

PURPOSE

The aim of this policy is to ensure a well governed, structured and systematic approach to the development, review, ratification, implementation and archiving of all procedural documentation in use throughout Southport and Ormskirk Hospital NHS Trust.

OBJECTIVES

The objectives of the policy are to set out the processes to achieve the following:-

- To set out the approach to development and approval of policies and procedural documents;
- To provide a standard template for policy documents;
- To ensure that there are arrangements for dissemination so that staff are aware of their responsibilities in relation to the policy or procedure;
- To describe arrangements for ensuring such documents are regularly reviewed to reflect current guidance;
- To describe the process for version control to ensure people have access to – and are operating to - the most current version;
- To describe how the Trust and the Board can receive assurance that the Trust's policies are effectively managed.
- To ensure arrangements are in place for archiving documents in line with non-clinical records management requirements.

PROCESS

Development of a new Procedural document

The Trust will identify the need to develop new procedural documents in line with the priorities of the organisation e.g. national guidance, legislation, organisational changes, service requirements and evidence-based practice whether in the form of the latest research, audit findings, national inquiries or serious investigation reports.

The relevant director will initiate the process to develop a new policy/procedure in line with service priorities and appoint a policy development lead. A Policy Register is maintained by the Trust Secretariat/Corporate Governance to prevent part or whole duplication of another approved policy or procedure in operation. The policy development lead will liaise with Trust Secretariat/Corporate Governance, which will check the register to ensure that the proposed policy does not duplicate any other policy work. Where a potentially similar policy is already in operation, the policy development lead will discuss with their director whether it is more prudent to develop this policy further rather than develop a new policy.

If it is clear that no similar policy exists the Trust Secretariat/Corporate Governance will allocate the proposed policy/procedure to be developed a unique reference identifier.

Trust Secretariat/Corporate Governance will liaise with the Trust Librarian to undertake a review of all relevant national and professional guidance related to the policy on behalf of the policy development lead. On receipt of this information, the policy lead will focus on completing the 'process' section of the policy/procedure i.e. the main body of the document. The policy lead may wish to consider whether this task would benefit from establishing a 'task and finish' group of key operational staff from across the trust, to ensure that the policy is workable and practical to implement.

The policy lead, in conjunction with the Trust Secretariat/Corporate Governance and a task and finish group should also consider if an overarching trust-wide policy could be developed with several standard operating procedures to support and supplement the policy. This alternative option will ensure the total number of trust policies are kept to a manageable number.

Another important aspect of this task will be to complete an implementation plan **Appendix 1** to fully consider all of the issues associated with policy implementation e.g. the need for additional resources and in particular, what training will be required, liaising with the Head of Training as necessary. This will ensure that implementation is always considered at the very beginning of policy development and whether it is achievable within the resources available. On completion of the plan, the policy lead will approve it.

Trust Secretariat/Corporate Governance will complete the other supporting sections of the policy and be responsible for the draft and final production of the document on behalf of the policy development lead.

Review of Procedural Documents

The policy available on the Trust's Intranet is the current version and the one by which the Trust stands even if the review date has passed. An expired date does not automatically indicate that the policy/procedure has been superseded.

All procedural documents are subject to review within approved time scales. Most policy/procedure reviews should take place **within 3 years** dependent on the policy area. However, a review may take place earlier if new evidence becomes available that renders this necessary e.g. changes in legislation, or to reflect changes to working practices.

Trust Secretariat/Corporate Governance will maintain a Policy Register to ensure all procedural documents are current, in date and relevant. They will also ensure the policy review takes place within the stated timeframe by notifying the policy lead/author in good time that a review is required.

The detail of the review will vary depending on the policy topic but it should take account of the most up-to-date evidence-based practice available. The Trust Secretariat/Corporate Governance will liaise with the Trust Librarian to undertake a

review of all relevant national and professional guidance related to the policy on behalf of the policy development lead.

If the review indicates that only minor amendments are required, which will not alter current practice and as such involve no significant change to the document, there is no requirement to consult on the revised policy. This may include 'Appendices,' which can be reviewed, revised and replaced by the policy lead without the need to follow the consultation process. The updated policy will go forward for approval to the relevant approving group/committee.

If the review indicates significant changes in current practice and major amendments to the document will be required, the procedures outlined in 4.1 above, for development, consultation, approval and ratification apply and must be followed.

If a policy lead is unclear whether the proposed changes to a policy constitute a significant change to current practice or not, they should consult with the Corporate Governance, who will provide advice on this matter.

Where significant changes to current practice are proposed, the policy lead must ensure they also undertake a review of the likely equality impact assessment and complete a new implementation plan. Policy details listed on the back page of the policy will be updated by the Trust Secretariat/Corporate Governance.

Style and Format of Procedural Documents

Standard templates have been developed for the formation of policies Appendix 2, standard operating procedures/LocSIPs Appendix 3 and guidelines Appendix 4. The Trust Secretariat/Corporate Governance will be responsible for ensuring these procedural documents are produced in a standardised corporate style and format, which is concise and clear, using unambiguous terms and language.

Equality Impact Assessment Process

All public bodies have a statutory duty under The Equality Act 2010 (Statutory Duties) Regulations 2011 to provide the "evidence of analysis it undertook to establish whether its policies and practices would further, or had furthered, the aims set out in section 149(1) of the (Equality Act 2010)"; in effect to undertake equality analysis assessments on all policy documents.

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.

This policy provides a system for administering the management, identification and authorisation of organisational wide procedural documents, ensuring that they are produced and managed in a consistent way. An equality analysis of this policy has been completed and shows no evidence of impact against any protected groups.

Privacy Impact Assessment (PIA)

The Trust has an obligation under the Data Protection Act 1998 and its own information policy to ensure that all information is processed fairly, lawfully and in line with expectations. To this end, the Trust has an implemented process of Privacy Impact Assessments (PIAs). A Privacy Impact Assessment of this policy has been completed and shows no evidence of impact against any Information Governance risks

Consultation

In order to obtain approval for a policy, submission to the relevant group/committee must be accompanied by evidence of robust consultation. The policy lead and task and finish group, will identify those stakeholders directly or indirectly involved and engaged with the policy area, who should take part in the consultation process and advise the Trust Secretariat/Corporate Governance accordingly. The consultation process will be managed by the Trust Secretariat/Corporate Governance on behalf of the policy lead.

To allow a reasonable time for responses, an ideal consultation period of four weeks for comments is to be set with the exact period confirmed with each circulation.

All comments received will be recorded by Trust Secretariat/Corporate Governance for the policy lead to consider and for the document to be amended accordingly. Where this results in a substantial change to the consultation document, a revised draft document will be sent out again to stakeholders for further consultation and comment.

Only when the policy lead is fully satisfied that the consultation process has been completed and comments and amendments have been included or reasons stated for suggestions not being used, the final draft will be forwarded to the appropriate group/ committee for approval.

Review

All policy/procedural documents together with a completed Equality Impact Assessment Tool and Implementation Plan will be submitted to the Policy Review Group (PRG). The PRG will make recommendations to the relevant Committee or the Board for approval.

Members of the PRG will consist of:

- Company Secretary (Chair)
- Information Governance Manager (Deputy Chair)
- Deputy Medical Director, or nominated representative
- Head of Risk
- Assistant Director of Nursing (Safer Staffing)
- Assistant Director of Operations – rotational or nominated representative
- Assistant Director of Human Resources Governance
- Estates & Facilities Lead
- Assistant Director of Finance

Approval

The final draft of a new or revised policy/procedure should be approved by the appropriate committee or group. The approving committee/group will be responsible for the subject matter, or area of practice within the trust so its members have the collective specialist knowledge and experience needed to give formal approval. Where unusually, there is no appropriate group, policies should be submitted to the Director responsible for the policy area for approval.

Ratification

Although some policies may have been approved by an assurance committee, they may need to be ratified by the Board of Directors.

Dissemination

All policies and procedures can be accessed electronically via the Trust's Intranet. For a limited time, all newly uploaded policies and procedures are highlighted in a prominent position, to alert and direct staff who access the Intranet, to their publication and availability.

Departmental managers, team leaders and professional leads are responsible for having a system in place within their sphere of responsibility that ensures their staff are aware of, and have read and understood relevant new and revised policies. Additionally, it is strongly recommended that relevant new policies are read within team/department meetings, to consider the relevance to that service/department.

Every month, the PRG will develop a Report, which includes a section giving details of all new policies and procedures that have been ratified and uploaded on to the Trust's intranet. Each Group is required to confirm that all relevant policies and procedures have been disseminated to their staff. This report is submitted to the Finance, Performance & Investment Committee providing assurance of compliance for each policy. This process is designed to provide assurance and accountability that effective dissemination of policies and procedures is taking place throughout the organisation.

Policies and procedures of relevance to corporate-based staff are forwarded separately by the Trust Secretariat/Corporate Governance to all corporate heads of departments every month for dissemination to their staff via the Trust Bulletins. A feedback form will be provided to ensure compliance with each policy and procedure.

Every month a list of procedural documents that have been uploaded to the intranet in the previous month are also distributed to all Trust staff via the Trust Bulletins.

Implementation

All policies need to identify arrangements for training, support and implementation as necessary. All Directors, Assistant Directors, service managers, heads of departments, team leaders and professional leads, are responsible for ensuring policies are effectively implemented and their staff receive any training that is required.

Document Control including Archiving Arrangements

The Trust Secretariat/Corporate Governance is responsible for maintaining the Policy Register of all current, active policies and procedures and for overseeing the recording, storing, archiving and controlling of policies.

To enable effective tracking and retrieval of procedural documents, each document is allocated a unique reference identifier. Each identifier is made up of the following components:-

- Trust initials i.e. SOHNHST
- Followed by an abbreviation of the policy category e.g. Corp = Corporate
- Followed by the initials of the type of procedural document e.g. POL = Policy
- Finally, an originator number is then allocated to the identifier e.g. 01
- Example = SOHNHST-CORP-POL-01 (current version control is more specific)

SOPs and guidelines will follow a similar numbering pattern but include a component to the overarching policy they link to e.g. SOHNHST-CORP-SOP-01-1

In this example, Health and Safety is the policy category, SOP is an abbreviation of standard operating procedure, '01' is the health and safety policy it links to and 1 is the number of the standard operating procedure.

Thereafter, all versions of policies will keep the same unique reference identifier, with a different version number being used for each review. If the review involves significant changes to the document, a new version number will be allocated e.g. 1.0, 2.0, 3.0. However, if the review only generates minor amendments, the version number will be changed to read, 1.1, 1.2 and so on. Details of the review and the new version number will be made in the Review and Amendment History at the end of each document.

When the review is complete and the new version of the policy has been approved and/or ratified as appropriate, the Trust Secretariat/Corporate Governance will upload the new or updated policy on to the Trust's Intranet, removing the replaced version where there is one.

The Trust Secretariat/Corporate Governance maintains a Register of all Archived Policies. Master copies of all archived policies, in both PDF and Microsoft word versions, are stored electronically and where only paper versions exist these are also stored centrally by the Trust Secretariat/Corporate Governance.

The Trust Secretariat/Corporate Governance is responsible for archiving the older versions of all policies using the tracking and retrieval system described above and controls access to all archived policy information. Copies of archived policies/procedures documents can be obtained on request. Policy leads are encouraged to keep copies of archived versions of their policy for their own future reference purposes.

Archived policies are retained for 25 years from the year of replacement, primarily for litigation purposes.

PROCEDURES CONNECTED TO THIS POLICY

SOP 1 – Writing an Operational Policy/Local Safety Standard for Invasive Procedures. **This is an example to follow when writing a policy.**

LINKS TO RELEVANT LEGISLATION

The Equality Act 2010

The Equality Act came into force on 1st October 2010 and brought together over 116 separate pieces of legislation into one single Act to provide a legal framework to protect the rights of individuals and advance equality of opportunity for all. The Act simplifies, strengthens and harmonizes the current legislation to provide a new discrimination law which protects individuals from unfair treatment and promotes a fair and more equal society.

The Freedom of Information Act 2000

This Act provides public access to information held by public authorities. It does this in two ways, public authorities are obliged to publish certain information about their activities and members of the public are entitled to request information from public authorities.

The main principle behind freedom of information legislation is that people have a right to know about the activities of public authorities, unless there is a good reason for them not to. This is sometimes described as a presumption or assumption in favour of disclosure.

The Act does not give people access to their own personal data (information about themselves) such as their health records. If a member of the public wants to see information that a public authority holds about them, they should make a subject access request under the Data Protection Act 1998.

The Data Protection Act 2018

The Data Protection Act came into force in May 2018, replacing the 1998 Act, to control the way information is handled and to give legal rights to people who have information stored about them. It sets out strict rules for people who use or store data about living people and gives rights to those people whose data has been collected. The law applies to data held on computers or any sort of storage system, including paper records. On 25 May 2018, the Information Commissioner's Office was given new powers to issue monetary penalties requiring organisations to pay for serious breaches of the Data Protection Act 2018.

Links to Relevant National Standards

NHS Resolution Risk Management Standards

In 2013, NHS Resolution carried out a review of the risk management standards and assessments process and decided that the time was right to end the current process. However, the standards reflect good risk management practice and continue to provide a useful reference point when developing organisational procedural documents.

Links to other key policy/s

- CORP 92 Corporate Records
- CORP 111 Privacy Impact Assessment
- Standard Operational Procedure for Meeting

References

NHS Litigation Authority, 2013. NHS Litigation Authority Risk Management Standards 2013-14 [Online]. [Accessed 20 September 2017] Available from http://www.nhsla.com/Safety/Documents/NHS%20LA%20Risk%20Management%20Standards%202013-14.pdf

The Plain English Campaign. How to write in plain English. [Online]. [Accessed 20 September 2017] Available from www.plainenglish.co.uk

The Equality Act 2010. (c15). London: The Stationery Office. [Online]. [Accessed 20 September 2017] Available from https://www.legislation.gov.uk/ukpga/2010/15/contents

The Equality and Human Rights Commission website provides further guidance, updates and resources in relation to equality impact assessments and the effect of the Equality Act 2010: www.equalityhumanrights.com

The Equality and Human Rights Commission website provides further guidance, updates and resources in relation to equality impact assessments and the effect of the Human Rights Act 1998: www.equalityhumanrights.com

The Freedom of Information Act 2000 (c 36). London: The Stationery Office. [Online]. [Accessed 20 September 2017] Available from https://www.legislation.gov.uk/ukpga/2000/36/contents

The Data Protection Act 1998 (c 29). London: The Stationery Office. [Online]. [Accessed 20 September 2017] Available from https://www.legislation.gov.uk/ukpga/1998/29/contents

DUTIES

Title	Role	Responsibilities
All Employees and Other Workers	Adherence	Have a duty to read, adhere to and maintain up-to-date awareness of policies and procedures as laid down in job descriptions and contracts of employment; to know where policies are stored and how to gain access to them. • Attend training as required, to familiarise themselves and enable compliance with, policies relevant to their role and responsibilities • To co-operate and contribute to the development of policies and procedures relevant to their duties • To inform their line manager if they identify any part of a policy/procedure that is no longer relevant
Ward Managers/ Team Leaders/ Senior Nurses	Implementation	Responsible for the practical day-to-day implementation of the policy ensuring that:- • All staff are aware of their role under the policy • Staff have received sufficient training and/or are competent to implement the policy • Records are kept as specified • Ensuring that all incidents/issues relating to this policy and area of practice are reported
Business Unit Governance Committees	Monitor	Monitor and review all incidents, complaints and claims relating to this area of practice and policy within their Business Unit. • Receive the results and recommendations of all related completed audits and be responsible for monitoring action plans to Implement changes to current practice until completion

Business Unit Leads (ADOs, AMDs and HoN)	Leads	Lead discussions around this topic area and policy at Business Unit Governance Committee meetings • Oversee the completion of audits in respect of the topic area and policy. • Provide updates on this area of practice and policy within their Group to the Business Unit Governance Committee. • Provide support and guidance regarding resources to enable this policy to be implemented • Systems are put in place to enable this policy to be implemented within their service areas • All managers are aware of the policy and promote good practice
Trust Secretariat/Corporate Governance	Administration and support	Co-ordination, administration and management of all trust procedural documents • Supporting document authors through the development, consultation, approval and ratification process • Document Control including Archiving Arrangements
Policy Leads/Authors	Review Lead	Completing the 'process' section of the policy/procedure i.e. the main body of the document for new and revised polices • Establishing a 'task and finish' group of key operational staff from across the trust as necessary, to ensure the policy is workable and practical to implement
Policy Review Group	Review	Ratification of all approved trust policies and procedures
Approving Groups/Committees/Board	Approval	Approving all policies and procedures that relate to their subject matter or area of practice
Executive Directors	Executive Lead	Identify and agree which policies are required relevant to their individual portfolio to ensure every policy has a designated named Executive Director • Appoint a Policy Lead for each policy within their individual portfolios

TRAINING

What aspect(s) of this policy will require staff training?	Which staff groups require this training?	Is this training covered in the Trust's Mandatory and Risk Management Training Needs Analysis document?	If no, how will the training be delivered?	Who will deliver the training?	How often will staff require training	Who will ensure and monitor that staff have this training?
Writing procedural documentation to a high standard	Members of the Trust Secretariat to support policy leads	No	Training will be delivered internally	Trust Secretariat/Corporate Governance	Training will continue until a team member is competent to undertake this task	Trust Secretariat/Corporate Governance

EQUALITY IMPACT ASSESSMENT

Southport & Ormskirk Hospital NHS Trust is committed to ensuring that the way we provide services and the way we recruit and treat staff reflects individual needs, promotes equality and does not discriminate unfairly against any particular individual or group. The Equality Impact Assessment for this policy is readily available from the policy coordinator. If you require this policy in a different format e.g. larger print, Braille, different languages or audio tape, please contact the Trust Secretariat/Corporate Governance.

DATA PROTECTION AND FREEDOM OF INFORMATION

This statement reflects legal requirements incorporated within the Data Protection Act and Freedom of Information Act that apply to staff who work within the public sector. All staff have a responsibility to ensure that they do not disclose information about the Trust's activities in respect of service users in its care to unauthorised individuals. This responsibility applies whether you are currently employed or after your employment ends and in certain aspects of your personal life e.g. use of social networking sites etc. The Trust seeks to ensure a high level of transparency in all its business activities but reserves the right not to disclose information where relevant legislation applies.

MONITORING COMPLIANCE WITH THIS DOCUMENT

All policies and procedure must identify the arrangements that are in place for ensuring and monitoring compliance. This should include ensuring compliance with all external requirements, such as legal requirements, Care Quality Commission standards, NHS Resolution Risk Management Standards and Monitor Compliance.

Methods may include:

- monitoring and analysis of incidents, performance reports and training records;
- reports to assurance committees and the Board

- audit;
- checklists;
- monitoring of delivery of actions plans through CBUs and departments.

Monitoring this policy is working in practice What key elements will be monitored? (measurable policy objectives)	**Where described in the policy?**	**How will they be monitored? (method + sample size)**	**Who will undertake this monitoring by Audit?**	**How Frequently?**	**Group/Committee that will receive and review results**	**Group/Committee to ensure actions are completed**	**Evidence this has happened**
Review and Revision arrangements	Section	An audit of 10% of all documents. A random sample representing 10% of all procedural documents will be selected from the Corporate Governance Policy Register	Audit Team	Annual	Finance, Performance & Investment Committee	Finance, Performance & Investment Committee	Completed action plan signed off / minutes of meeting
Procedural documents are produced in a standardised format	Sections	An audit of 10% of all documents. A random sample representing 10% of all	Audit Team	Annual	Policy Review Group	Policy Review Group	Completed action plan signed off / minutes of meeting

		procedural documents will be selected from the Corporate Policy Register					
Consultation Process	Section	An audit of 10% of all Corporate Governance policy folders for evidence this has been followed correctly	Audit Team	Annual	Finance, Performance & Investment Committee	Finance, Performance & Investment Committee	Completed action plan signed off / minutes of meeting
Document approval process	Section	An audit of 10% of all Corporate Governance policy folders for evidence of	Audit Team	Annual	Finance, Performance & Investment Committee	Audit Committee	Completed action plan signed off / minutes of meeting

		the minutes of approving groups' meetings confirming approval					
Review process	Section	An audit of 10% of all Corporate Governance policy folders for evidence of ratification by members	Audit Team	Annual	Policy Review Group	Finance, Performance & Investment Committee	Completed action plan signed off / minutes of meeting
Dissemination and Implementation of procedural documents	Sections	A random sample representing 10% of all procedural documents will be selected from the Register of each Group	Audit Team	Annual	Finance, Performance & Investment Committee	Audit Committee	Completed action plan signed off / minutes of meeting
Document Control including archiving	Section	Archived Policies	Audit Team	Annual	Finance, Performance & Investment Committee	Audit Committee	Completed action plan signed off / minutes of meeting

Policy Template

Title of Policy

Target Audience (Amend to reflect who should view the policy)				
Who should read this policy:	**Planned Care CBU**	**Urgent Care CBU**	**Specialist Services CBU**	**Corporate**

The blue comments in each section are a guide for you; please delete them as you complete each section Red text are (below) sections to be completed by policy author

Appendices

Delete table where a policy has no additional appendices

Explanation of terms used in this policy

Please provide the definitions/explanations of any unfamiliar or unusual words used in this policy

Flowchart of process to be included

Insert flow chart here

1.0 Introduction

Provide a summary description of the background to this policy and why the policy is needed.

2.0 Purpose

Explain the main aim of this policy

3.0 Objectives

Identify and list the key objectives this policy is intended to achieve

NB: The first three sections of the policy will be limited to one page.

4.0 Process

This section forms the main focal point and body of the document. Describe the process or procedure and course of action required to implement and comply with the policy. Be explicit. The process/procedure needs to be clear and concise. Where it will help the reader consider including flow charts or diagrams to support the process outlined in the policy.

Some policies may require more than the number 4.0 section, in which case adjust the numbering for all other subsequent headings and amend the contents page accordingly.

5.0 Procedures connected to this Policy

Please list any standard operating procedures that relate to this policy

6.0 Links to Relevant Legislation

Please provide a summary of the key legislation this policy relates to, to help the reader develop a greater understanding of the importance of this policy.

6.1 Links to Relevant National Standards

Please provide a summary of the key national standard(s) this policy relates to, to help the reader develop a greater understanding of the importance of this policy.

6.2 Links to other key policy/s

Please include a summary of any other key policy that would help the reader develop a greater understanding of how this policy links to it.

6.3 References

Please list only the references that were key to the development of this policy, which would signpost the reader to a greater understanding of this subject, or area of practice.

7.0 Roles and Responsibilities for this Policy

Using the table below, this section is to identify those Trust staff/groups/individuals with responsibility for implementing the policy

Title	Role	Responsibilities

8.0 Training

Using the table below, this section should describe the training which staff require to enable implementation of this policy. Any training needs identified in the table below should be more than just making staff aware of the policy. Please ensure you discuss the above with the Head of Learning and Development as part of the consultation process.

What aspect(s) of this policy will require staff training?	Which staff groups require this training?	Is this training covered in the Trust's Mandatory and Risk Management Training Needs Analysis document?	If no, how will the training be delivered?	Who will deliver the training?	How often will staff require training	Who will ensure and monitor that staff have this training
		If yes, please refer to it for details on training requirements, and update frequencies				

9.0 Equality Impact Assessment The following statement should always be included

Southport and Ormskirk Hospital NHS Trust is committed to ensuring that the way we provide services and the way we recruit and treat staff reflects individual needs, promotes equality and does not discriminate unfairly against any particular individual or group. The Equality Impact Assessment for this policy is readily available from the policy coordinator. If you require this policy in a different format e.g. larger print, Braille, different languages or audio tape, please contact the Corporate Integrated Governance Team.

10.0 Data Protection and Freedom of Information The following statement should always be included

This statement reflects legal requirements incorporated within the Data Protection Act and Freedom of Information Act that apply to staff who work within the public sector. All staff have a responsibility to ensure that they do not disclose information about the Trust's activities in respect of service users in its care to unauthorised individuals. This responsibility applies whether you are currently employed or after your employment ends and in certain aspects of your personal life e.g. use of social networking sites etc. The Trust seeks to ensure a high level of transparency in all its business activities but reserves the right not to disclose information where relevant legislation applies.

11.0 Monitoring this policy is working in practice

Using the table below identify how the Trust will ensure that the policy is working effectively in practice

What key elements will be monitored? (measurable policy objectives)	Where described in policy?	How will they be monitored? (method + sample size)	Who will undertake this monitoring?	How Frequently ?	Group/ Committee that will receive and review results	Group/ Committee to ensure actions are completed	Evidence this has happened

POLICY IMPLEMENTATION PLAN

An Implementation template document for policy leads to use is available in a Word document on the intranet

Policy Title	
Is this New or revision of an existing policy	
Name and role of Policy Lead	
Give a Brief Overview of the Policy	
What are the main changes in practice that should be seen from the policy?	
Who is affected directly or indirectly by this policy?	

Implications

Implications	
Will staff require specific training to implement this policy and if yes, which staff groups will need training?	
Explain the issues?	**Explain how this has been resolved**
Are other resources required to enable the implementation of the policy e.g. increased staffing, new documentation?	
Explain the issues?	**Explain how this has been resolved**

Implications cont'd/…	
Have the financial impacts of any changes been established?	
Explain the issues?	**Explain how this has been resolved**
Any other considerations	
Explain the issues?	**Explain how this has been resolved**

Approval of Implementation Plan
Enter Name and Title of Policy Lead whose portfolio this policy will come under **Signature** …… **Date Approved** ……..

Policy Details

The table below is designed to ensure there is proper document control for the continued development and application of this policy – **Corporate Integrated Governance only**

Title of Policy	
Unique Identifier for this policy is	
State if policy is **New** or **Revised**	
Previous Policy Title where applicable	
Policy Category Clinical, HR, Corporate, Infection Control, Finance etc.	
Executive Director *whose portfolio this policy comes under*	
Policy Lead/Author *Job titles only*	
Committee/Group responsible for the approval of this policy	
Consultation with	
Month/year consultation process completed	
Month/year policy approved	
Month/year policy ratified and issued	
Next review date	
Implementation Plan completed	
Equality Impact Assessment completed	
Previous version(s) archived	
Disclosure status	
Key words for this policy	

For more information on the consultation process, implementation plan, equality impact assessment, or archiving arrangements, please contact Corporate Integrated Governance.

Review and Amendment History

Version	Date	Details of Change

Southport and Formby District General Hospital
Ormskirk and District General Hospital
North West Regional Spinal Injuries Unit

Southport and Ormskirk Hospital NHS Trust

Standard Operational Procedure (SOP) / Local Safety Standard for Invasive Procedures (LocSIP) Template

Title of Procedure/ LocSIP

Target Audience (Amend to reflect who should view the procedure/ LocSIP)				
Who should read this SOP:	**Planned Care CBU**	**Urgent Care CBU**	**Specialist Services CBU**	**Corporate**

The blue comments under each heading are a guide for you; please delete them as you complete each section
Explination of terms

A flowchart can be ideal to cover all of the below

Why we have a procedure? (Background)

Briefly set out the background to the procedure, making reference to any legislation, legal requirements and national or international guidance. Consider the driving forces or why the procedure is necessary e.g. to ensure patient safety, compliance standards are met, best practice etc.) and what adherence will achieve

What overarching policy the procedure links to?
Every standard operating procedure should link to an overarching policy

Which services of the trust does this apply to?

Where is it in operation? Complete the table below with a for the appropriate areas, and identify who should read this SOP

Who does the procedure apply to?

- **Competencies required**

When should the procedure be applied? (Context)

- **State In what circumstances/situations this procedure should be applied**

How to carry out this procedure (step step-by-step information)

- **Methodology and procedures.** The meat of the issue -- list all the steps with necessary details, including what equipment needed. Cover sequential procedures and decision factors.
- **Clarification of terminology**. Identify acronyms, abbreviations, and all phrases and provide an explanation of terms used
- **Additional Information/ Associated Documents** Use this section to list any documentation associated with the described procedure to ensure that the user can identify the appropriate document(s) to use.
- **Any safety warnings** To be listed alongside the steps where it is an issue.
- **Equipment and supplies.** Complete list of what is needed and when, where to find equipment, standards of equipment, etc.
- **Cautions and interferences**. Basically, a troubleshooting section. Cover what could go wrong, what to look out for, and what may interfere with the final, ideal product.

Where do I go for further advice or information?
Roles and responsibilities of key staff in relation to this procedure

8.0 Training

Using the table below, this section should describe the training which staff require to enable implementation of this SOP. Any training needs identified in the table below should be more than just making staff aware of the policy. Please ensure you discuss the above with the Head of Learning and Development as part of the consultation process.

What aspect(s)	Which staff	Is this training	If no, how will the	Who will deliver the	How often will staff	Who will ensure and monitor that

of this SOP will require staff training?	groups require this training?	covered in the Trust's Mandatory and Risk Management Training Needs Analysis document?	training be delivered?	training?	require training	staff have this training
		If yes, please refer to it for details on training requirements , and update frequencies				

9.0 Equality Impact Assessment The following statement should always be included

Southport and Ormskirk Hospital NHS Trust is committed to ensuring that the way we provide services and the way we recruit and treat staff reflects individual needs, promotes equality and does not discriminate unfairly against any particular individual or group. The Equality Impact Assessment for this SOP is readily available from the policy coordinator from the overarching policy. If you require this SOP in a different format e.g. larger print, Braille, different languages or audio tape, please contact the Corporate Integrated Governance Team.

10.0 Data Protection and Freedom of Information The following statement should always be included

This statement reflects legal requirements incorporated within the Data Protection Act and Freedom of Information Act that apply to staff who work within the public sector. All staff have a responsibility to ensure that they do not disclose information about the Trust's activities in respect of service users in its care to unauthorised individuals. This responsibility applies whether you are currently employed or after your employment ends and in certain aspects of your personal life e.g. use of social networking sites etc. The Trust seeks to ensure a high level of transparency in all its business activities but reserves the right not to disclose information where relevant legislation applies.

11.0 Monitoring this SOP is working in practice

Using the table below identify how the Trust will ensure that the policy is working effectively in practice

What key elements will be monitored? (measurable	Where described in SOP?	How will they be monitored? (method + sample	Who will undertake this monitoring ?	How Frequently ?	Group/ Committee that will receive and review	Group/ Committee to ensure actions are completed	Evidence this has happened

objectives)		size)			results		

Appendix

SOP Implementation Plan

An Implementation template document for policy leads to use is available in a Word document on the intranet

SOP Title	
Is this New or revision of an existing policy	
Name and role of SOP Lead	
Give a Brief Overview of the SOP	
What are the main changes in practice that should be seen from the SOP?	
Who is affected directly or indirectly by this SOP?	

Implications	
Will staff require specific training to implement this SOP and if yes, which staff groups will need training?	
Explain the issues?	**Explain how this has been resolved**
Are other resources required to enable the implementation of the SOP e.g. increased staffing, new documentation?	
Any other considerations	
Explain the issues?	**Explain how this has been resolved**

Approval of Implementation Plan
Enter Name and Title of SOP Lead whose portfolio this policy will come under **Signature** …… **Date Approved** ……..

Standard Operating Procedure/ Local Safety Standard for Invasive Procedures Details

Unique Identifier for this SOP is	
State if SOP is **New** or **Revised**	
Policies Category	
Executive Director *whose portfolio this SOP comes under*	
Lead/Author *Job titles only*	
Committee/Group Responsible for Approval of this SOP	
Month/year consultation process completed	
Consultation with	
Month/year SOP was approved	
Next review due	
Disclosure Status	
Key words relating to this SOP	

Appendix 3 Guideline

Southport and Formby District General Hospital
Ormskirk and District General Hospital
North West Regional Spinal Injuries Unit

Southport and Ormskirk Hospital NHS Trust

Trust Guideline

Title

Target Audience (Amend to reflect who should view the Guideline)				
Who should read this Guideline:	**Planned Care CBU**	**Urgent Care CBU**	**Specialist Services CBU**	**Corporate**

The blue comments below each heading are a guide for you; please delete them as you complete each section

A flowchart can be ideal to cover all of the below

Rationale /Background
Why is this guideline needed? A guideline is a description of a 'best practice' way to work, based on the best available evidence **when no applicable standard is in place**.

Purpose of the Guideline
State the key objectives for having this guideline

Explanation of Terms used in this guideline
Please provide the definitions/explanations of any unfamiliar or unusual words used in this guideline

Best Available Evidence
What the best available evidence recommends
Presentation of the evidence required to inform key decisions in a simple, accessible format
Review of the relevant, valid evidence on the benefits, risks, and costs of alternative decisions

Who does this Guideline apply to?
Who should read this guideline?
Competencies required

When should the Guideline be applied?
Context - state in what circumstances/situations this guideline should be followed

Putting the Guideline into Practice
This may include:-
General Principles to be followed
Flowchart / Algorithm where this would be helpful to the reader
A description of a 'best practice' way to work
Identification of the key decisions and their consequences
Key Points of learning

Where do I go for further advice or information?
Roles and responsibilities of key staff in relation to this guideline

What overarching policy the guideline links to?
Every guideline should link to an overarching policy. Policy for the Development and Management of Procedural Documents

References
Please give accurate details of all references quoted as this is integral to the overall validity of the guideline

8.0 Training

Staff may receive training in relation to this guideline, where it is identified in their appraisal as part of the specific development needs for their role and responsibilities.

Please refer to the Trust's Mandatory & Risk Management Training Needs Analysis for further details on training requirements, target audiences and update frequencies

What aspect(s) of this policy will require staff training?	Which staff groups require this training?	Is this training covered in the Trust's Mandatory and Risk Management Training Needs Analysis document?	If no, how will the training be delivered?	Who will deliver the training?	How often will staff require training	Who will ensure and monitor that staff have this training
		If yes, please refer to it for details on training requirements, and update frequencies				

9.0 Equality Impact Assessment

Please refer to overarching policy

Data Protection Act and Freedom of Information Act

Please refer to overarching policy

11.0 Monitoring this policy is working in practice

In the event of new evidence or a planned change in the process(es) described within this document or an incident involving the described process(es) within the review cycle, this guideline will be reviewed and revised as necessary to maintain its accuracy and effectiveness.

What key elements will be monitored? (measurable Guideline objectives)	Where described in Guideline?	How will they be monitored? (method + sample size)	Who will undertake this monitoring?	How Frequently ?	Group/ Committee that will receive and review results	Group/ Committee to ensure actions are completed	Evidence this has happened

Guideline Title	
Is this New or revision of an existing Guideline	
Name and role of Guideline Lead	
Give a Brief Overview of the Guideline	
What are the main changes in practice that should be seen from the Guideline ?	
Who is affected directly or indirectly by this Guideline ?	

Implications

Implications	
Will staff require specific training to implement this Guideline and if yes, which staff groups will need training?	
Explain the issues?	**Explain how this has been resolved**
Are other resources required to enable the implementation of the Guideline e.g. increased staffing, new documentation?	
Explain the issues?	**Explain how this has been resolved**

Implications cont'd/…	
Have the financial impacts of any changes been established?	
Explain the issues?	**Explain how this has been resolved**
Any other considerations	
Explain the issues?	**Explain how this has been resolved**

Approval of Implementation Plan
Enter Name and Title of Guideline Lead whose portfolio this policy will come under **Signature** …… **Date Approved** ……..

Guideline Details

Unique Identifier for this Guideline is

State if Guideline is **New** or **Revised**	
Policies Category	
Executive Director *whose portfolio this Guideline comes under*	
Lead/Author *Job titles only*	
Committee/Group Responsible for Approval of this Guideline	
Month/year consultation process completed	
Consultation with	
Month/year Guideline was approved	
Next review due	
Disclosure Status	
Key words relating to this Guideline	

Review and Amendment History Version	Date	Description of Change
1.0		New Guideline

Policy Implementation Plan

An Implementation template document for policy leads to use is available in a Word document on the intranet

Policy Title	Corp 68 Development and Management Procedural Documents
Is this New or revision of an existing policy	Revision
Name and role of Policy Lead	A Charles, Company Secretary

Give a Brief Overview of the Policy

The aim of this policy is to ensure a well governed, structured and systematic approach to the development, review, approval, ratification, implementation and archiving of all procedural documentation in use throughout Southport and Ormskirk Hospital NHS Trust.

What are the main changes in practice that should be seen from the policy?

The Policy has been updated and improvements made in the following ways:

- Changes to the approval and ratification process
- The creation of a Policy Review Group to replace the Virtual Groups hitherto in place
- A provision in the Policy for emergency powers to be evoked in the event of expediting the approval of a Policy
- Strengthening the reporting and monitoring process
- Monitoring by Policy Review Group, Finance, Performance & Improvement and Audit Committee
- Audit to be undertaken by the Audit Team

Who is affected directly or indirectly by this policy?

All Trust Staff and visitors

Implications

Implications	
Will staff require specific training to implement this policy and if yes, which staff groups will need training? **No**	
Explain the issues? **N/A**	**Explain how this has been resolved** N/A
Are other resources required to enable the implementation of the policy e.g. increased staffing, new documentation? No	
Explain the issues?	**Explain how this has been resolved**

Implications cont'd/…	
Have the financial impacts of any changes been established? **N/A**	
Explain the issues?	**Explain how this has been resolved**
Any other considerations	
Explain the issues?	**Explain how this has been resolved**

Approval of Implementation Plan
Enter Name and Title of Policy Lead whose portfolio this policy will come under **Signature** …… **Date Approved** ……..

Policy Details

Title of Policy	Development and Management of Procedural Documents
Unique Identifier for this policy is	SOHNHST-CORP- Pol 05.1.0
State if policy is **New** or **Revised**	Revised
Previous Policy Title where applicable	Development and Management Procedural Documents
Policy Category Clinical, HR, Health & Safety, Finance etc.	Corporate 68
Executive Director whose portfolio this policy comes under	Director of Nursing, Midwifery, AHP's, Quality and Governance
Policy Lead/Author Job titles only	Assistant Director of Integrated Governance
Committee/Group responsible for the approval of this policy	Quality and Safety Group
Month/year consultation process completed *	July 2017
Month/year policy approved	June 2017
Month/year policy ratified and issued	July 2017
Month/year policy reviewed	August 2018
Reviewed by the Board	TBC
Next review date	July 2020
Implementation Plan completed	Yes
Equality Impact Assessment completed	Yes
Previous version(s) archived	Yes
Disclosure status	Can be disclosed to patients and the public
Key words for this policy	'procedural,' 'policy for policies,' 'procedure,' 'standard operating procedure,' 'SOP

Revision History

Version	Date	Author	Status	Comment
1.0.0	Sept 2009	SL	Superseded	Archived
2.0.0	March 2012	DL	Superseded	Archived
3.0.0	Feb 14	DL/IG	Superseded	Archived
4.0.0	Feb 2016	DL	Superseded	Archived
5.0.0	July 2017	Assistant Director Integrated Governance	Superseded	Archived
5.1.0	September 17	Assistant Director Integrated	Superseded	Archived

		Governance		
6.0.0	August 18	Company Secretary	Current	Intranet

Date of Assessment: _August 2018_____

	Equality Impact Assessment Questions:		Evidence based Answers & Actions:
	Name of the document that you are Equality Impact Assessing		POLICY FOR THE DEVELOPMENT, APPROVAL AND DISSEMINATION AND MONITORING OF POLICY AND PROCEDURAL DOCUMENTS
	Describe the overall aim of your document and context? **Who will benefit from this policy/procedure/strategy?**		The overall aim of the policy is to describe the Trust's approach to the development and approval of policies and procedural documents. All staff
	Who is the overall Lead for this assessment?		Company Secretary and Data Protection Officer
	Who else was involved in conducting this assessment?		None
	Have you involved and consulted patients and staff in developing this policy/procedure/strategy? **What did you find out and how have you used this information?**		The Executive Management Team was consulted on the original development of the policy. Feedback from the NHS LARMS assessment has also been considered in developing the policy. N/A
	What equality data have you used to inform this equality impact assessment?		N/A
	What does this data say?		N/A
	Taking into account the information gathered above, could this policy /procedure/strategy affect any of the following equality group unfavourably:		**Evidence based Answers & Actions. Where Negative impact has been identified please explain what action you will take to remove or mitigate this impact.**
	Race		N/A

	Equality Impact Assessment Questions:		Evidence based Answers & Actions:
	Disability		N/A
	Gender		N/A
	Age		N/A
	Sexual Orientation		N/A
	Religion or Belief		N/A
	Transgender		N/A
	Maternity & Pregnancy		N/A

	Equality Impact Assessment Questions:		Evidence based Answers & Actions:
	Marriage & Civil partnerships		N/A
	What monitoring arrangements are you implementing or already have in place to ensure that this policy/procedure/strategy:-		This policy aims to standardise the approach to policy development, approval and dissemination and requires adoption of the Equality Impact Assessment throughout the organisation.
	Promotes equality of opportunity for people who share the above protected characteristics;		
	Eliminates discrimination, harassment and bullying for people who share the above protected characteristics;		
	Promotes good relations between different equality groups;		
	Public Sector Equality Duty – "Due Regard"		
	Have you developed an Action Plan arising from this assessment?		No
	Assessment/Action Plan approved by:		**Signed: Date:** **Title:** Company Secretary
	Once approved, you must forward a copy of this Assessment/Action Plan to the Equality and Diversity Lead: **Please note that the EIA is a public document and will be published on the website. Failing to complete an EIA could expose the Trust to future legal challenge.**		

If you have identified a potential discriminatory impact of this policy, please refer it to the Associate Director of Human Resources together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact the Associate Director of Human Resources

NHS
Southport and
Ormskirk Hospital
NHS Trust

Risk Management Strategy 2018-2021

VERSION CONTROL	DATE	BY
Policy Author	**TBC**	Assistant Director, Integrated Governance
Version 6.0		
Reviewed by	**28th March 2018**	Interim Company Secretary
Date Approved	**11th April 2018**	Board of Directors
Version 6.1		
Reviewed by	**14 June 2019**	Company Secretary
Date Approved	**TBC**	Board of Directors
Mandatory Review date	**March 2021**	

VERSION 6.1 Amendments	• Replaced *Board to Ward Escalation* Diagram with the Risk Management, *Escalation and Assurance schematic* as shown in the Terms of Reference of the Risk and Compliance Group • Removed *objectives* from Section 3 heading • Inserted Integrated Governance Structure after Section 5 with introductory statement • Added the role of the Hospital Management Board's role in risk management/monitoring • Inserted Risk Appetite Statement and moved section from the end of the document relating to Risk Appetite, to link with this. • Insert current risk scoring matrix and update the Consequence scoring matrix to correspond with the scoring matrix

CONTENTS

1. Introduction

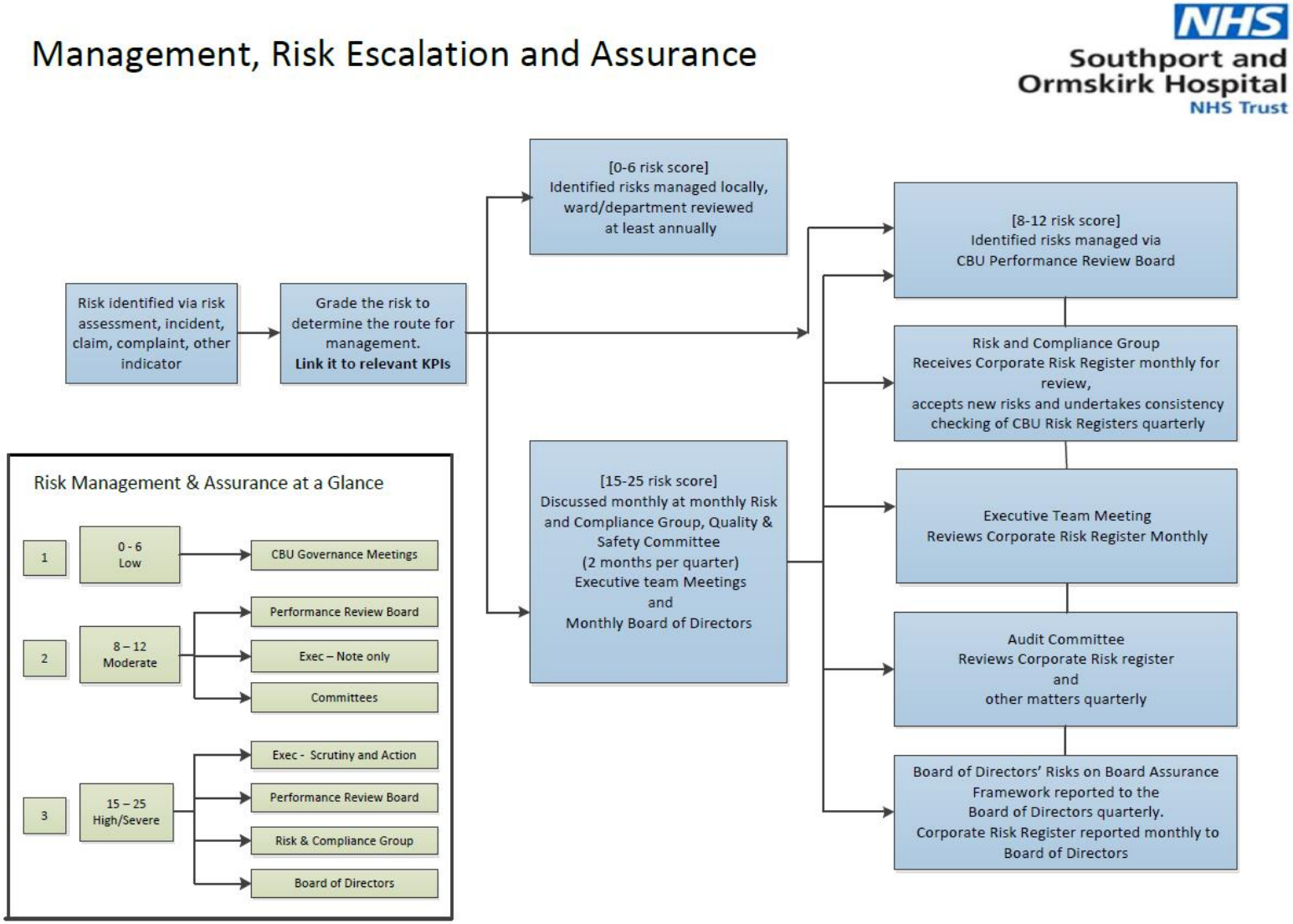
Risk Management is an integral part of Southport and Ormskirk Hospital NHS Trust management activity and is a fundamental pillar in delivering the Trust vision of ***providing safe, high quality services*** for the people of Southport and Ormskirk. As a complex organisation delivering a range of services 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 Risk and Compliance Group's Terms of Reference 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


Management, Risk Escalation and Assurance
NHS
Southport and Ormskirk Hospital
NHS Trust
Risk identified via risk assessment, incident, claim, complaint, other indicator
Grade the risk to determine the route for management.
Link it to relevant KPIs
[0-6 risk score]
Identified risks managed locally, ward/department reviewed at least annually
[8-12 risk score]
Identified risks managed via CBU Performance Review Board
[15-25 risk score]
Discussed monthly at monthly Risk and Compliance Group, Quality & Safety Committee
(2 months per quarter)
Executive team Meetings
and
Monthly Board of Directors
Risk and Compliance Group
Receives Corporate Risk Register monthly for review,
accepts new risks and undertakes consistency checking of CBU Risk Registers quarterly
Executive Team Meeting
Reviews Corporate Risk Register Monthly
Audit Committee
Reviews Corporate Risk register
and
other matters quarterly
Board of Directors' Risks on Board Assurance Framework reported to the Board of Directors quarterly.
Corporate Risk Register reported monthly to Board of Directors
Risk Management & Assurance at a Glance
1
0 - 6
Low
CBU Governance Meetings
2
8 – 12
Moderate
Performance Review Board
Exec – Note only
Committees
3
15 – 25
High/Severe
Exec - Scrutiny and Action
Performance Review Board
Risk & Compliance Group
Board of Directors

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:

- **Improve clinical outcomes and patient safety to ensure we deliver high quality services**
- **Deliver services that meet NHS constitutional and regulatory standards**
- **Efficiently and productively provide are within agreed financial limits**
- **Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated**
- **Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values**
- **Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire**

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."

1. 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	These relate to risks which would impact on: • 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

2. Strategic Aims 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.

3. Scope

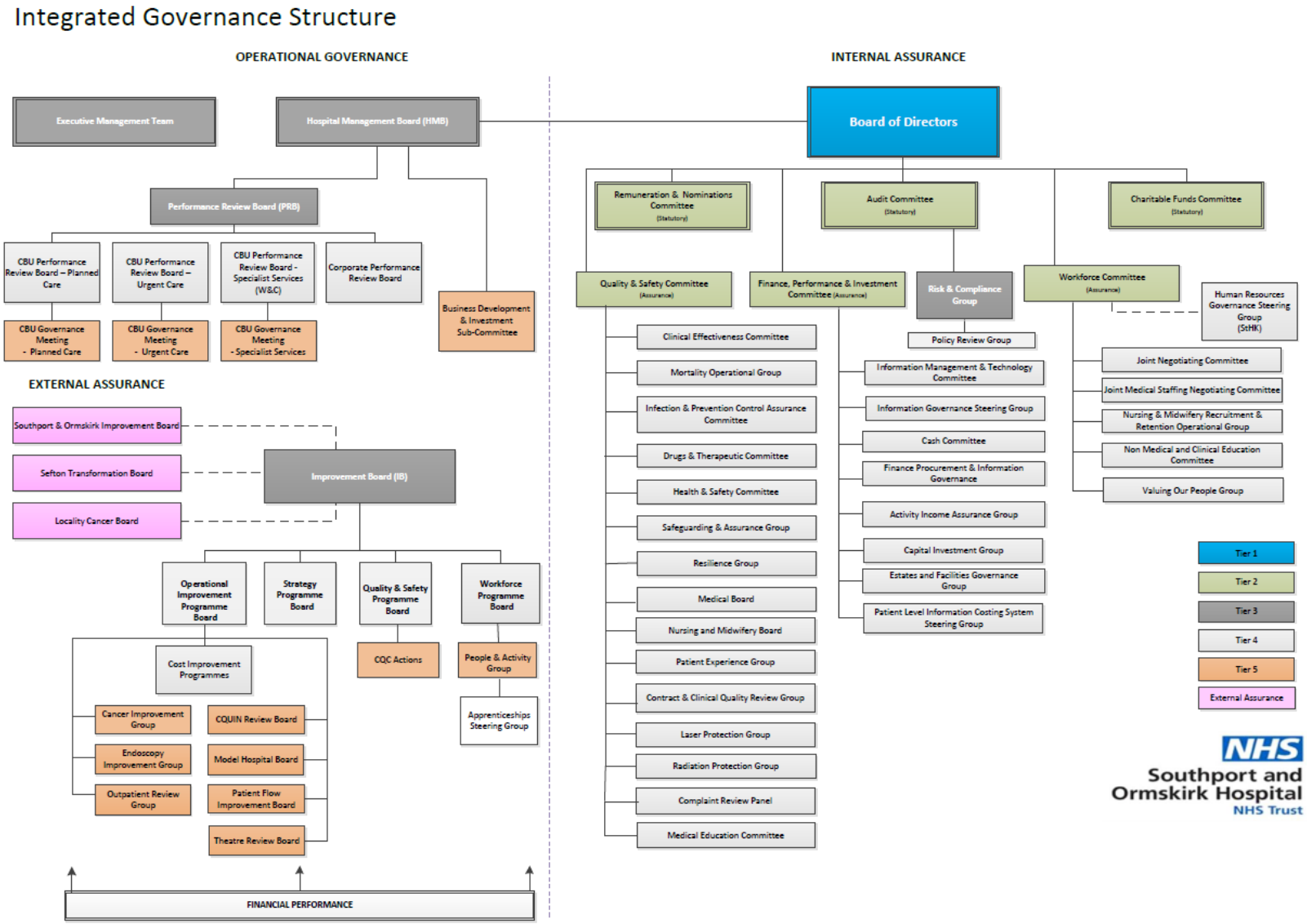
The objective of the *Risk Management Strategy* is to promote an integrated and consistent approach across all parts of the organisation to managing risk.

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.

Our Integrated Governance Structure sets out our approach to governance and escalation and informs the role of senior officers, committees and the Board in risk management. **See Figure 2**

Figure 2


Integrated Governance Structure
OPERATIONAL GOVERNANCE
INTERNAL ASSURANCE
Executive Management Team
Hospital Management Board (HMB)
Board of Directors
Performance Review Board (PRB)
Remuneration & Nominations Committee (Statutory)
Audit Committee (Statutory)
Charitable Funds Committee (Statutory)
CBU Performance Review Board – Planned Care
CBU Performance Review Board – Urgent Care
CBU Performance Review Board - Specialist Services (W&C)
Corporate Performance Review Board
Business Development & Investment Sub-Committee
CBU Governance Meeting - Planned Care
CBU Governance Meeting - Urgent Care
CBU Governance Meeting - Specialist Services
Quality & Safety Committee (Assurance)
Finance, Performance & Investment Committee (Assurance)
Risk & Compliance Group
Workforce Committee (Assurance)
Human Resources Governance Steering Group (StHK)
Clinical Effectiveness Committee
Mortality Operational Group
Infection & Prevention Control Assurance Committee
Drugs & Therapeutic Committee
Health & Safety Committee
Safeguarding & Assurance Group
Resilience Group
Medical Board
Nursing and Midwifery Board
Patient Experience Group
Contract & Clinical Quality Review Group
Laser Protection Group
Radiation Protection Group
Complaint Review Panel
Medical Education Committee
Policy Review Group
Information Management & Technology Committee
Information Governance Steering Group
Cash Committee
Finance Procurement & Information Governance
Activity Income Assurance Group
Capital Investment Group
Estates and Facilities Governance Group
Patient Level Information Costing System Steering Group
Joint Negotiating Committee
Joint Medical Staffing Negotiating Committee
Nursing & Midwifery Recruitment & Retention Operational Group
Non Medical and Clinical Education Committee
Valuing Our People Group
EXTERNAL ASSURANCE
Southport & Ormskirk Improvement Board
Sefton Transformation Board
Locality Cancer Board
Improvement Board (IB)
Operational Improvement Programme Board
Strategy Programme Board
Quality & Safety Programme Board
Workforce Programme Board
Cost Improvement Programmes
CQC Actions
People & Activity Group
Apprenticeships Steering Group
Cancer Improvement Group
Endoscopy Improvement Group
Outpatient Review Group
CQUIN Review Board
Model Hospital Board
Patient Flow Improvement Board
Theatre Review Board
FINANCIAL PERFORMANCE
Tier 1
Tier 2
Tier 3
Tier 4
Tier 5
External Assurance
NHS
Southport and Ormskirk Hospital
NHS Trust

4. Organisational Risk Management Approach and Responsibilities

All staff members 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 or equivalent 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 or equivalent 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 or equivalent	The Company Secretary or equivalent is responsible for development, monitoring and maintenance of the Board Assurance Framework (BAF) document and the management of corporate risks. The Company Secretary or equivalent will also undertake the role of Data Protection Officer (DPO) which is one of several nationally recognised controls to strengthen data handling and ensure accountability of information risk.
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.

5. 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 (FP&I) 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 Hospital Management Board (HMB) monitors risks as they impact on the operations of the Clinical Business Units and their link with corporate risks and the Board Assurance Framework (BAF).

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.

6. 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.

7. Compliance and Assurance

NHS Improvement (NHSI) has 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 *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 has introduced a Risk and Compliance Group designed to ensure there is an effective and comprehensive system in place for pro-actively managing compliance Trust-wide and

within each Corporate Business Unit through compliance and regulation registers. This includes developing and maintaining systems for the regular evaluation and monitoring of compliance and regulation against any relevant internal and external audit recommendations, external assessments (e.g. Care Quality Commission (CQC)), accreditations, service reviews, standards and criteria; as directed by the Board of Directors. Compliance registers will be reviewed at every other meeting of the Group, Policy Management, compliance with Provider Licence and Annual Governance Statement. The Escalation Schematic above illustrates the Groups approach to monitoring risks.

The Trust has agreed a risk appetite statement and each risk owner has assigned risk appetites to areas of risks under their areas of responsibility. 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 will 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. See **Figure 3** below:

Figure 3 - Risk Appetite Statement

	OBJECTIVES	RISK APPETITE CATEGORY	AREA OF RISK	RISK APPETITE	STRATEGIC BLUEPRINT	PRINCIPAL RISKS
Quality	Improve clinical outcomes and patient safety to ensure we deliver high quality services	CAUTIOUS	Recognition management of the deteriorating patient	Cautious	We will protect people from harm, provide effective care and make sure that they have a good experience of care. We will collect appropriate information on quality and share this information quickly with the people who are best placed to improve care. We will empower our people to get things done and will be constantly vigilant in keeping quality standards high. We will take every opportunity to compare ourselves with other providers so that we continue to strive for excellence. We will put patient experience at the heart of what we do and report consistently high quality experiences.	If quality is not maintained in line with regulatory standards this will impede clinical outcomes and patient safety.
			Care of the older person	Cautious		
			Infection prevention and control	Cautious		
			Medicines management	Cautious		
Operations	Deliver services that meet NHS constitutional and regulatory standards	OPEN	Achievement of quality targets for ED	Moderate	Our service users and carers will tell us that our services are of high quality. Our local GP colleagues will recommend us to family and friends. We will be respected by our commissioners and other providers as a co-producing partner in shaping new service models that deliver our aligned strategies. We will have achieved a national reputation for excellence and will build a multi-region secure services business.	If the Trust cannot achieve its key performance targets it may lead to loss of services.
			Achievement of quality targets for RTT	Open		
			Achievement of quality targets for cancer	Moderate		
			Achievement of quality targets for diagnostics	Moderate		
Finance	Efficiently and productively provide care within agreed financial limits	OPEN	Deliver our control total	Open	We will operate at, at least our current scale. We will provide services that offer excellent value for money without compromising financial stability. Local accountability and decision-making will enable services to sustain margins to fund investment. We will be outwards looking and actively seeking business opportunities to expand and serve new geographies, whilst concentrating on things that add value for our customers and for local people. We will succeed by competing on quality.	If the Trust cannot meet its financial regulatory standards and operate within agreed financial resources the sustainability of services will be in question
			Maximize capacity using transformative efficiency and productivity tools within the specified timeline as set out in the BAF	Open		
Workforce	a. Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated b. Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values	OPEN	Culture – organisational development	Hungry	We will have effective and appreciative leadership throughout the organisation, creating a high performance environment. Out people will be clear about what is expected on them, receive regular feedback and understand that poor performance will be addressed. Our employees will be engaged, supported to reach their potential and embrace change. People will want to work here.	a. If the Trust does not attract, develop, and retain a resilient and adaptable workforce with the right capabilities and capacity there will be an impact on clinical outcomes and patient experience. b. If the Trust does not have leadership at all levels patient and staff satisfaction will be impacted
			Staff Recruitment & Retention	Open		
			Employer of Choice	Open		
			Staff Engagement	Hungry		
			Workforce Transformation	Open		
Strategy	Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire	HUNGRY	Engage with partners to develop opportunities for joint working	Hungry	We will deliver integrated mental and physical health care services. We will reduce waiting times across all services and localities. We will deliver increased volume to meet demand and increase productivity. We will focus our efforts on key services and initiatives and change services that do not deliver agreed outcomes. We will ensure patients are cared for in appropriate environments and services and will pilot innovative services earlier in patient pathways.	There is a risk due to the system not having an agreed acute services strategy leading to non-alignment of partner organisations plans resulting in the inability to develop and deliver sustainable services
			Develop an affordable, sustainable acute services model	Hungry		

Averse	Prepared to accept only the very lowest levels of risk, with the preference being for ultra-safe delivery options, while recognising that these will have little or no potential for reward/return.	Cautious	Willing to accept some low risks while maintaining an overall preference for safe delivery options despite the probability of these having mostly restricted potential for reward/return.	Moderate	Tending always towards exposure to only modest levels of risk in order to achieve acceptable, but possibly unambitious outcomes.	Open	Prepared to consider all delivery options and select those with the highest probability of productive outcomes, even when there are elevated levels of associated risks.	Hungry	Eager to seek original/creative/ pioneering delivery options and to accept the associated substantial risk levels in order to secure successful outcomes and meaningful reward/return.

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 Effectiveness 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.

8. 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.

9. 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 4 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*

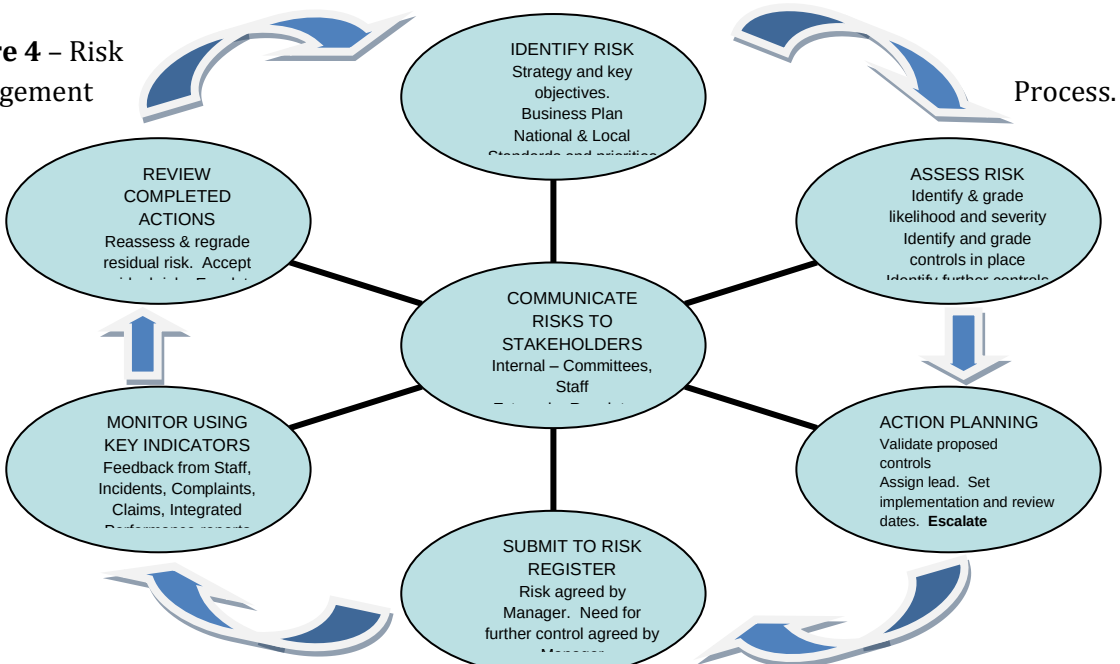


Figure 4 – Risk Management Process.

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.

10. 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.

11. 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. The method for calculating these can be found at Figures 4, 5 and 6.

Trend shows the movement compared to the previous review – rising, stable, or reducing, and will be represented by an appropriate arrow.

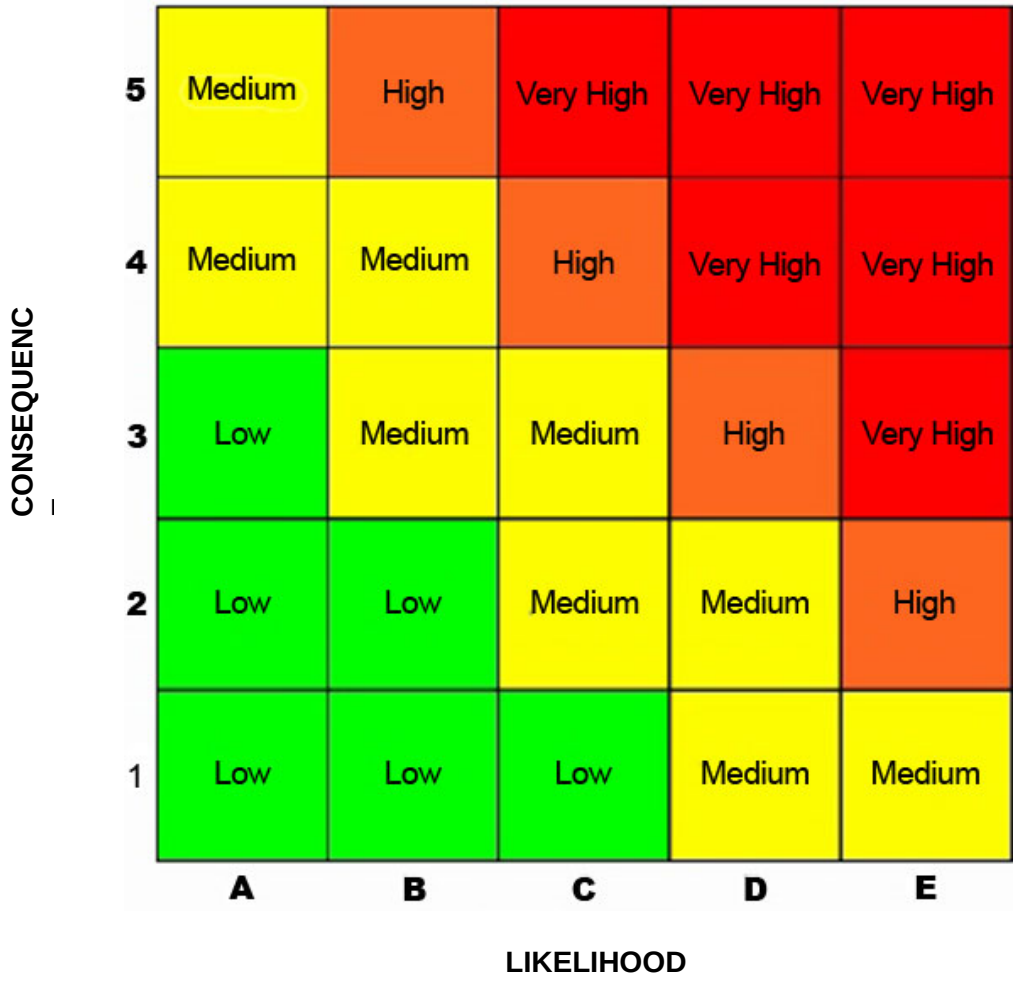
Review Date should be used to indicate when this risk was reviewed, i.e. the date of the latest information including rating and key controls.

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.

Figure 4 – Risk Matrix



The risk scoring system is set out below at Figures 5 and 6:

Figure 5 - 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.

Figure 6 - Consequence (C) 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	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on

Domains	1	2	3	4	5
	Insignificant	Minor	Moderate	Major	Catastrophic
	complaint/inquiry	Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	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	Low performance rating Critical report	Inquest/ombudsman inquiry Gross failure to meet national standards
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	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

Domains	1	2	3	4	5
	Insignificant	Minor	Moderate	Major	Catastrophic
				training	
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 expectation not being met	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. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 % 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	Incident leading >25 per cent over project budget Schedule slippage

Domains	1	2	3	4	5
	Insignificant	Minor	Moderate	Major	Catastrophic
				Schedule slippage Key objectives not met	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

12. 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.

13. 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.

14. 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.

15. 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.

16. 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 or equivalent (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	Director of Nursing / Company Secretary or equivalent
Governance structure - TORs for the statutory and 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	CoSec	Terms of Reference of Board Committees are reviewed at least annually Annual reports for each committee reporting to EMC	Annually Annually	Board EMT	Company Secretary or equivalent

• 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)		demonstrate -ing compliance with terms of reference, reporting and attendance.			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

17. 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.

18. Dissemination

This Strategy will be circulated to all staff and uploaded onto the staff and public website.

19. 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

20. Review

In order that this Strategy remains current, any appendices attached 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 and Risk Register
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

16. Procedure for Amending the Corporate Governance Manual

This document will be updated annually or more frequently in line with legislation, directives from the regulator or as required internally to reflect change of practice