Mid Cheshire Hospitals NHS Foundation Trust

AGENDA

Board of Directors
A meeting will be held in Public at
09.30am on Monday, 8 January 2018
in the Boardroom, Leighton Hospital

Action Key	
A	Approval
I	Information
D	Discussion

Item No	Title of Item	Action	Led By	Page No.
1.	**Welcome and Apologies** To welcome members of the public and attendees and to receive apologies for absence from Board Members. *(to note)*	I	Chairman **09.30**	-
2.	**Patient or Staff Story** *(verbal)*	I/D	Interim Director of Nursing & Quality **09.32**	-
3.	**Board Member's Interests** *(to note)* To **consider** any • Changes to Directors' interests since the last meeting • Conflicts of interest deriving from this agenda	I	Chairman **09.50**	-
4.	**Minutes of the Last Meeting** To **approve** the minutes of the Board of Directors meeting held in Public on Monday, 4 December 2017 *(attached)* *(to approve)*	A	Chairman **09.52**	-
5.	**Matters Arising and Action Log** *(verbal) (to note)*	A	Chairman **09.55**	-
6.	**Annual Work Programme 2017/18 v4** *(attached)* *(to approve)*	A/I	Chairman **09.57**	√
7.	**Chairman's Announcements** (*to note a verbal report*) **7.1 Meeting with Interim UHNM Chairman**	I	Chairman **10.00**	-
8.	**Governor's Items** (*to note a verbal report*) **8.1 Governor Agenda Setting – 15 December** **8.2 Nomination and Remuneration Committees 4 and 19 December** **8.3 NEDs and Governor Meeting – 18 December** *(to follow) (to note)*	I	Chairman **10.05**	-
9.	**Chief Executive's Report** *(to note a verbal report)* **9.1 System Update** **9.2 Cheshire East Health and Wellbeing Board**	I	Chief Executive **10.10**	-

Item No		Title of Item	Action	Led By	Page No.
10.	**CARING**				
	10.1	**Quality, Safety & Experience Report** *(attached) (for discussion)*	I/D	Interim Director of Nursing & Quality **10.20**	√
	10.2	**Quality Matters Assurance Framework and CQC Update** *(attached) (for discussion)*	I/D	Deputy Chief Executive/ Medical Director **10.30**	√
11.	**SAFE**				
	11.1	**Draft Quality Governance Committee notes from the meeting held on 18 December 2017** *(attached) (to note)*	I	Committee Chair **10.35**	-
	11.2	**Serious Untoward Incidents and RIDDOR Events** *(verbal)* (*to note*)	I/D	Deputy Chief Executive/ Medical Director **10.40**	-
12.	**RESPONSIVE**				
	12.1	**Performance Report** *(attached) (to note)*	I/D	Chief Operating Officer **10.43**	√
	12.2	**Legal Advice** *(verbal)* (*to note*)	I	Chief Executive **10.50**	-
	12.3	**Draft Performance & Finance Committee notes from the meeting held on 21 December 2017** *(attached) (to note)*	I	Committee Chair **10.55**	-
	12.4	**Car Park Business Cases** *(attached) (to approve)* - **4.1 Additional Spaces** - **4.2 Purchase of additional Land**	A/D	Chief Executive **11.00**	√ -
	12.5	**Anaesthetic Middle Grade Business Case** *(attached) (to approve)*	A/D	Chief Operating Officer **11.15**	-
13.	**WELL-LED**				
	13.1	**Visits of Accreditation, Inspection or Investigation** *(verbal)* (*to note*)	I	Chief Executive **11.25**	-
	13.2	**CCICP Partnership Board notes from the meeting held on 9 November** *(attached) (to note)*	I	Director of Strategic Partnerships **11.30**	√
	13.3	**Transformation and People Committee notes from the meeting held on 7 December 2017** *(attached) (to note)*	I	Committee Chair **11.35**	-
	13.4	**Corporate Governance Handbook** *(attached) (to approve)*	A/D	Chief Executive **11.40**	√

Item No	Title of Item	Action	Led By	Page No.
13.5	**Use of the Trust Seal** *(attached) (to approve)*	A/D	Chief Executive **11.45**	√
13.6	**Quarterly Organisational Risk Register Report 2017/18 - Quarters 1 & 2** *(attached) (to note)*	I/D	Deputy Chief Executive/ Medical Director **11.48**	√
14.	**EFFECTIVE**			
14.1	**Workforce Report** *(attached) (to note)*	I/D	Director of Workforce and OD **11.53**	√
14.2	**Consultant Appointments** *(verbal) (to note)*	I	Deputy Chief Executive/ Medical Director **12.00**	-
14.3	**Clinical System Outline Business Case** *(attached) (to approve)*	D/A	Deputy Chief Executive/ Medical Director **12.03**	-
15.	**Any Other Business** *(verbal)*	A/I/D	Chairman **12.40**	-
16.	**Time, Date and Place of Next Meeting**			
	To confirm that the next meeting of the Board of Directors will take place in public, in the Board Room at Leighton Hospital, at 9.30am on **Monday, 5 February 2018**	I	Chairman	

Board of Directors Workplan 2017 /18 Version: 4

Item	Board of Directors Meeting												Board Away Day				
	April	*May*	*June*	*July*	*August*	*Sept*	*Oct*	*Nov*	*Dec*	*Jan*	*Feb*	*March*	*Apr*	*Aug*	*Oct*	*Dec*	*Feb*
Patient/Staff Story	x	x	x	x	x	x	x	x	x	x	x	x					
Chief Executive Report	x	x	x	x	x	x	x	x	x	x	x	x					
Chairman's Report	x	x	x	x	x	x	x	x	x	x	x	x					
Governor Report	x	x	x	x	x	x	x	x	x	x	x	x					
Caring																	
Nursing and midwifery staffing comprehensive report							x										
Patient Survey Results (National)			x														
Patient Quality Safety and Experience Report	x	x	x	x	x	x	x	x	x	x	x	x					
Staff Survey		x															
Safe																	
Health & Safety Update to Board													x				
SUI & RIDDOR	x	x	x	x	x	x	x	x	x	x	x	x					
Quality Governance Committee	x	x	x	x	x	x	x	x	x	x	x	x					
Guardian of Safe Working Hours Report			x				x		x			x					
Effective																	
Consultant Appointments	x	x	x	x	x	x	x	x	x	x	x	x					
Medical Staffing Update (Part II)	x	x	x	x	x	x	x	x	x	x	x	x					
Responsive																	
Annual Budget/Planning/ Budget Pack	x											x					x
Quality Account	x																
Legal Advice	x	x	x	x	x	x	x	x	x	x	x	x					
Performance & Finance Committee	x	x	x	x	x	x	x	x	x	x	x	x					
Performance Report	x	x	x	x	x	x	x	x	x	x	x	x					
Report on Use of Trust Seal	x			x			x			x							
Corporate Trustee															x		x
Whistleblowing Report						x											
Well-Led																	
Annual Budget/Contract Discussions	x											x					
Annual Plan (Extraordinary BoD Meetings)	x	x										x					
Annual Report & Accounts		x															
Audit Committee		x	x				x		x		x						
Board Assurance Framework and Top 5 Risks		x						x			x						
Trust Strategy	x							x						x	x		x
Trust Strategy Update		x															
Visits of Accreditation, Inspection or Investigation	x	x	x	x	x	x	x	x	x	x	x	x					
Well-Led Governance Framework Self Assessment													x				
Corporate Goverance Handbook										x							
Transformation and People Committee	x	x	x	x	x	x	x	x	x	x	x	x					
Board Sub-Committee Annual Review			x														
Doctors Revalidation Report						x											
Board Actions	x	x	x	x	x	x	x	x	x	x	x	x					

We Care Because You Matter

NHS
Mid Cheshire Hospitals
NHS Foundation Trust

Board of Directors

Quality, Safety and Experience Report

January 2018

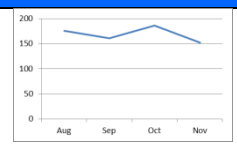
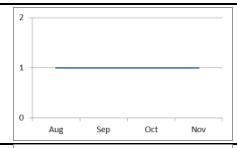
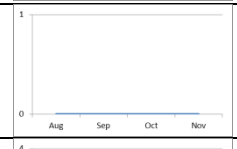
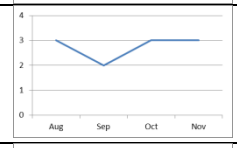
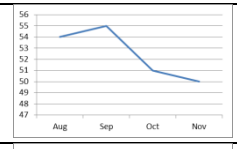
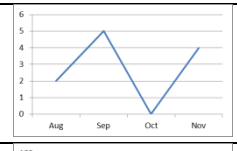
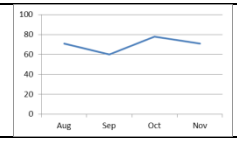
(November 2017 data)

Board Papers – Quality, Safety & Experience Section: January 2018

Contents

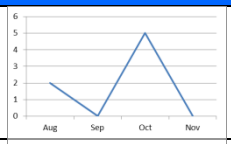
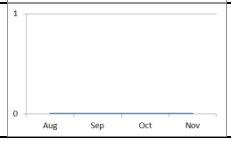
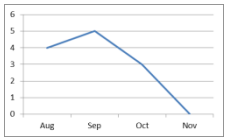
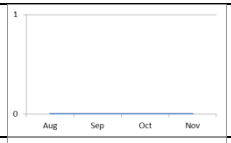
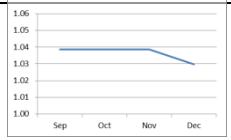
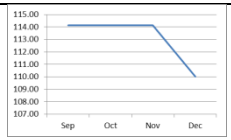
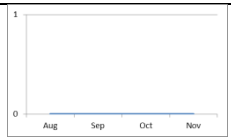
Contents (continued):

Board Papers – Quality, Safety & Experience Section: January 2018

Indicators	Position compared to previous month	Target	Last four months				Trajectory
			Aug -17	Sep-17	Oct-17	Nov-17	
Patient Safety Harm Incidents The aim is to reduce the number of harm incidents by the end of January 2018, measured by comparison to the previous financial year. In 2016/2017 2574 patient safety harm incidents were reported.	⬇	**<2574 at end of January 2018**	**176**	**161**	**186**	**152**	
Serious Incidents The aim is to have no serious incidents by the end of January 2018	⇔	**Zero at end of January 2018**	**1**	**1**	**1**	**1**	
Never Events Zero tolerance of Never Events	⇔	**Zero**	**0**	**0**	**0**	**0**	
Pressure Ulcers - Avoidable The aim is to reduce hospital acquired avoidable pressure ulcers by 5% quarter on quarter in 2017/2018	⇔	**5 at end of quarter 2**	**3**	**2**	**3**	**3**	
Inpatient Falls The aim is to reduce inpatient falls by 10% by January 2018	⬇	**733 at end of January 2018**	**54**	**55**	**51**	**50**	
Medication Incidents The aim is to reduce medication incidents resulting in harm by 10% in comparison to the previous financial year	⬆	**59 at end of 2017/2018**	**2**	**5**	**0**	**4**	
CCICP Patient Safety Harm Incidents The aim is to reduce the number of harm incidents. A target will be set in quarter 3 once a full year's data is available.	⬇		**71**	**60**	**78**	**71**	

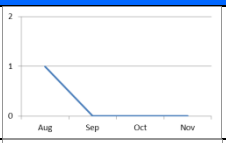
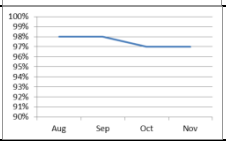
Key							
⬆ ⬇	**Position Declined since last month**	⬆ ⬇	**Position Improved since last month**	⇔	**On track to deliver**	⇔	**Work in place to recover position**

Board Papers – Quality, Safety & Experience Section: January 2018

Indicators	Position compared to previous month	Target	Last four months				Trajectory
			Aug -17	Sep-17	Oct-17	Nov-17	
CCICP Serious Incidents The aim is to have no serious incidents by the end of January 2018	⬇	**Zero at end of January 2018**	**2**	**0**	**5**	**0**	
CCICP Never Events Zero tolerance of Never Events by the end of January 2018	⇔	**Zero at end of January 2018**	**0**	**0**	**0**	**0**	
CCICP Pressure Ulcers - Avoidable The aim in quarter 1 is to develop a process to enable pressure ulcers to be classified as avoidable or unavoidable. A baseline for a 5% improvement will be agreed, which will then be measured quarterly.	⬇		**4**	**5**	**3**	**0**	
CCICP Medication The aim is to reduce harm medication incidents. A target will be set in quarter 3 once a full year's data is available.	**Process & measure to be agreed**		**0**	**0**	**0**	**0**	
SHMI The Trust's aim within the Sign Up To Safety Campaign is to have a SHMI at or below 1.0 from April 2016	**1.02** ⬇	**Below 1.0**	**1.03**			**1.02**	
HSMR The Trust's aim is to have an HSMR <100	**110.02** ⬇	**<100**	**114.12**			**110.02**	
MRSA The target for MRSA Bacteraemia is zero in 2017/18	⇔	**Zero at end of 2017/2018**	**0**	**0**	**0**	**0**	

Key							
⬆⬇	**Position Declined since last month**	⬆⬇	**Position Improved since last month**	⇔	**On track to deliver**	⇔	**Work in place to recover position**

Board Papers – Quality, Safety & Experience Section: January 2018

Indicators	Position compared to previous month	Target	Last four months				Trajectory
			Aug -17	Sep-17	Oct-17	Nov-17	
C-Diff Avoidable The target is less than 24 avoidable cases of Clostridium Difficile in 2017/18	⇔	**<24 at end of 2017/2018**	**1**	**0**	**0**	**0**	
Safety Thermometer The Trust aim is that >95% of patients receive harm free care as monitored by the Safety Thermometer.	⇔	**>95%**	**98%**	**98%**	**97%**	**97%**	

Key							
⇑ ⇓	**Position Declined since last month**	⇑ ⇓	**Position Improved since last month**	⇔	**On track to deliver**	⇔	**Work in place to recover position**

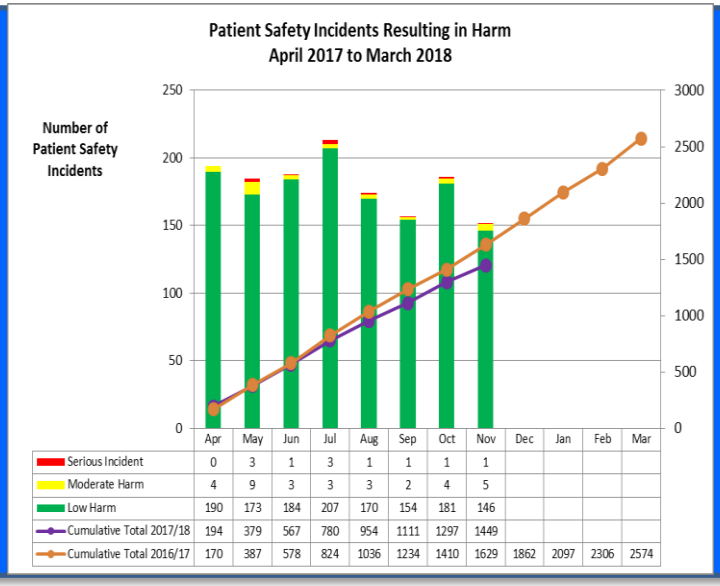
Quality & Safety Section:

Description	Aggregate Position	Trend	Performance against previous month

Patient Safety Incidents resulting in harm.

This chart demonstrates the total number of reported patient safety incidents which resulted in harm.

For November 2017, there were a total of 152 patient safety incidents:
96% (146 incidents) have resulted in low harm
3.3% (5 incidents) have resulted in moderate harm
0.7% (1 incident) has resulted in serious harm



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Serious Incident	0	3	1	3	1	1	1	1				
Moderate Harm	4	9	3	3	3	2	4	5				
Low Harm	190	173	184	207	170	154	181	146				
Cumulative Total 2017/18	194	379	567	780	954	1111	1297	1449				
Cumulative Total 2016/17	170	387	578	824	1036	1234	1410	1629	1862	2097	2306	2574

To reduce the number of patient safety harm incidents, a number of initiatives are being undertaken. These include:

- Bi-weekly Patient Safety Summit Meetings with Executive & Senior Teams
- Bi-weekly Patient Safety Matters newsletter that is delivered Trustwide

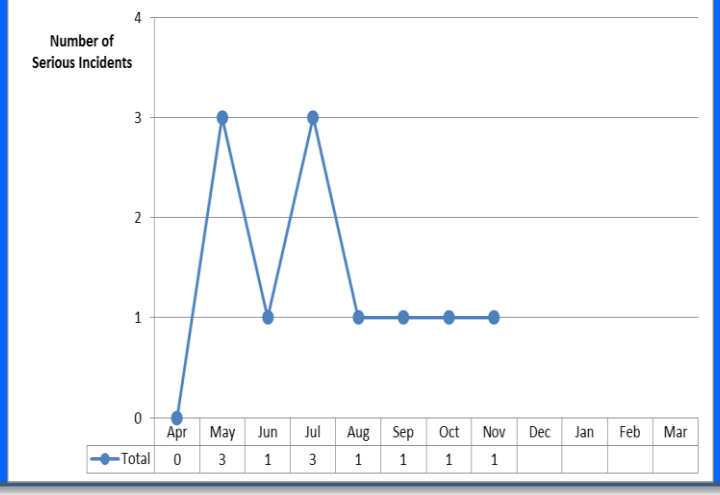
Serious Incidents.

This chart demonstrates the number of incidents that have resulted in serious harm.

For November 2017, there was a total of 1 serious incident reported.

- 1 x unexpected death

There have been no never events reported since November 2016.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total	0	3	1	3	1	1	1	1				

To reduce the number of serious incidents, the Trust has signed up to the Sign Up To Safety Campaign.

Board Papers – Quality, Safety & Experience Section: January 2018

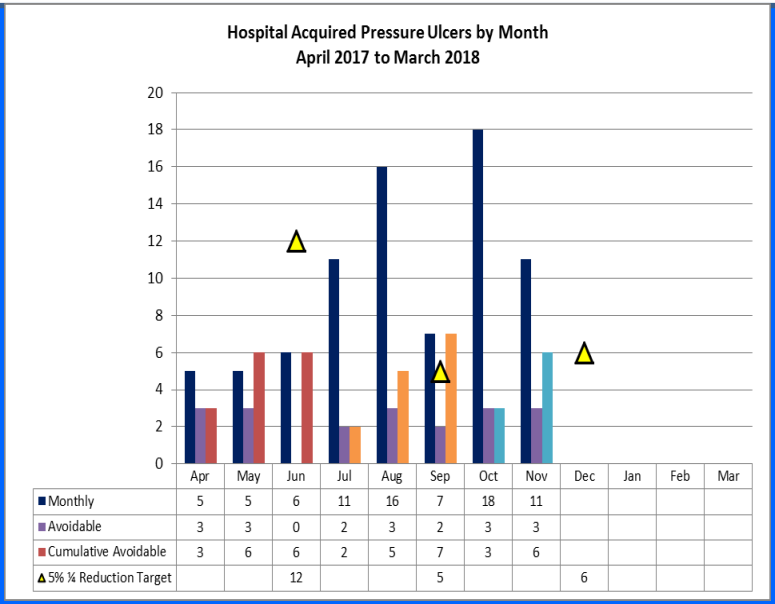
Description	Aggregate Position	Trend	Performance against previous month

Pressure Ulcer (PU) Incidents including both avoidable and unavoidable pressure ulcers based on EPUA Guidance

For November 2017, there were a total of 11 hospital acquired pressure ulcer incidents:

- 27.3% (3 PU's) have resulted in avoidable harm

The 5% reduction target (Quarter on quarter in 2017/18) to achieve by the end of quarter 3, the target is to have no more than 6 avoidable pressure ulcers reported. So far, there have been 6 avoidable pressure ulcers reported so far. Therefore no further avoidable pressure ulcers can be reported for December 2017, otherwise the target would not have been achieved.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Monthly	5	5	6	11	16	7	18	11				
Avoidable	3	3	0	2	3	2	3	3				
Cumulative Avoidable	3	6	6	2	5	7	3	6				
5% ¼ Reduction Target			12			5			6			

Improvement actions include:

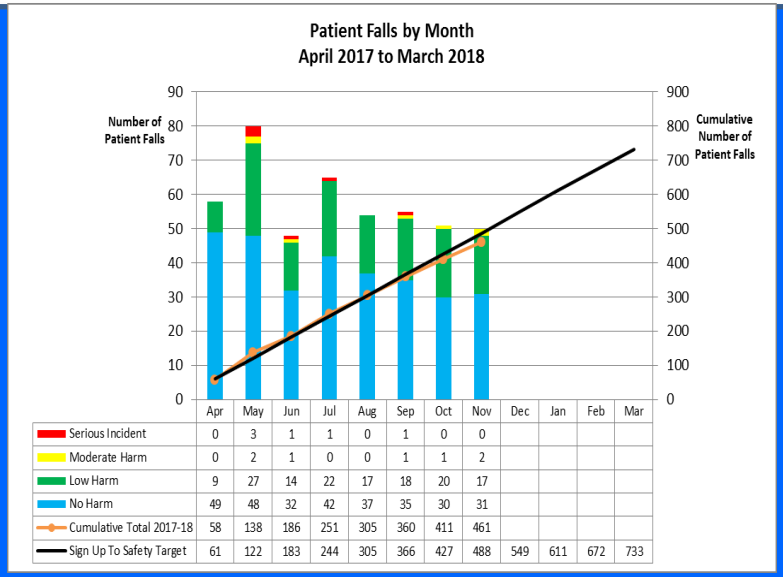
- As part of the Trustwide evaluation of pressure relieving mattresses trials of new mattresses will commence in January 2018.
- The SKIN bundle and repositioning chart have been reviewed and updated.
- Photographing pressure ulcers prior to discharge has been implemented.

Board Papers – Quality, Safety & Experience Section: January 2018

Description	Aggregate Position	Trend	Performance against previous month

Patient Falls Incidents.

- For November 2017, there were a total of 50 patient falls
- 62% (31 falls) have resulted in no harm
- 34% (17 falls) have resulted in low harm
- 4% (2 fall) has resulted in moderate harm
- 0% (0 falls) have resulted in serious harm



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Serious Incident	0	3	1	1	0	1	0	0				
Moderate Harm	0	2	1	0	0	1	1	2				
Low Harm	9	27	14	22	17	18	20	17				
No Harm	49	48	32	42	37	35	30	31				
Cumulative Total 2017-18	58	138	186	251	305	360	411	461				
Sign Up To Safety Target	61	122	183	244	305	366	427	488	549	611	672	733

Improvement actions include:

- Bespoke training where an increase in falls has been identified.
- Continued review of practice during senior nurse walkabout.
- Focus work through the cares programme.
- Development and approval of a post-falls chart.

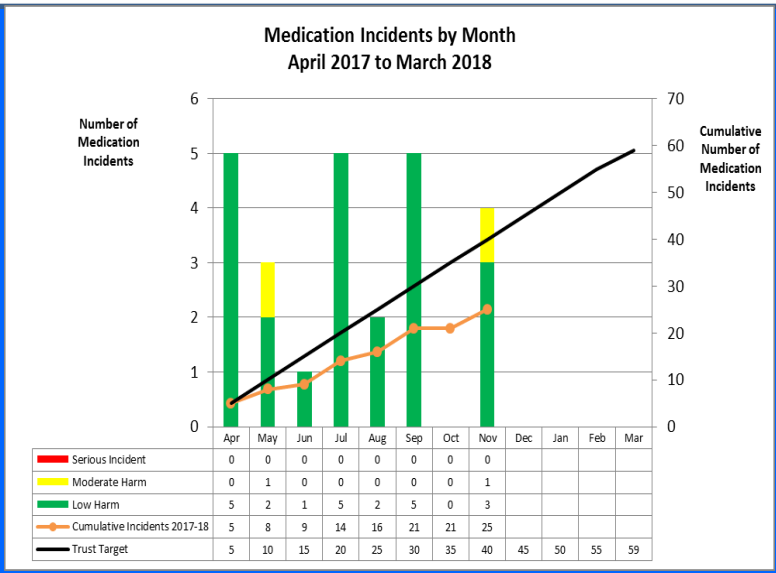
Board Papers – Quality, Safety & Experience Section: January 2018

Description	Aggregate Position	Trend	Performance against previous month

Medication Incidents.

For November 2017, there were a total of 4 medication incidents resulting in harm reported:

- 75% (3 medication incidents) have resulted in low harm
- 25% (1 medication incident) have resulted in moderate harm
- 0% (0 medication incidents) have resulted in serious harm



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Serious Incident	0	0	0	0	0	0	0	0				
Moderate Harm	0	1	0	0	0	0	0	1				
Low Harm	5	2	1	5	2	5	0	3				
Cumulative Incidents 2017-18	5	8	9	14	16	21	21	25				
Trust Target	5	10	15	20	25	30	35	40	45	50	55	59

Improvement actions include:

- Junior medical staff training
- E-learning package in place
- Zero tolerance to prescription anomalies at ward level

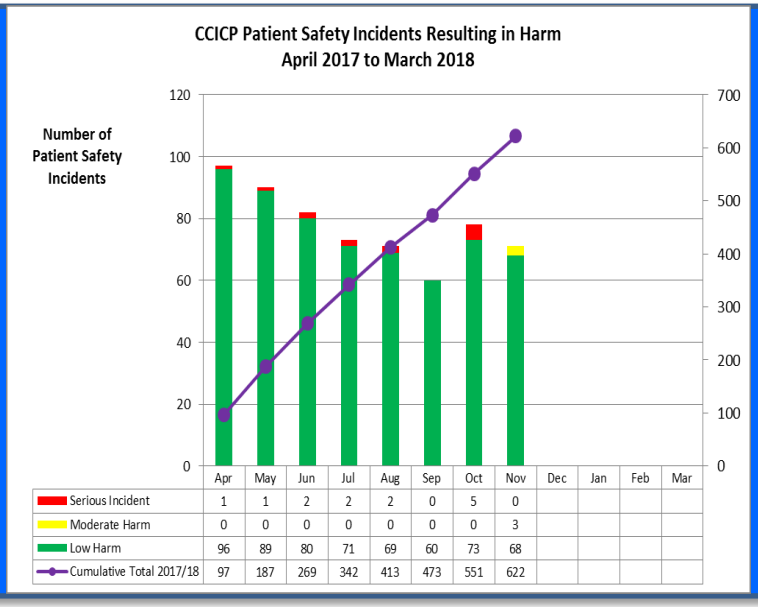
Board Papers – Quality, Safety & Experience Section: January 2018

Description	Aggregate Position	Trend	Performance against previous month

CCICP Patient Safety Incidents resulting in harm.

For November 2017, there were a total of 152 patient safety incidents:

- 95.8% (68 incidents) have resulted in low harm
- 4.2% (3 incidents) have resulted in moderate harm
- 0% (0 incidents) have resulted in serious harm



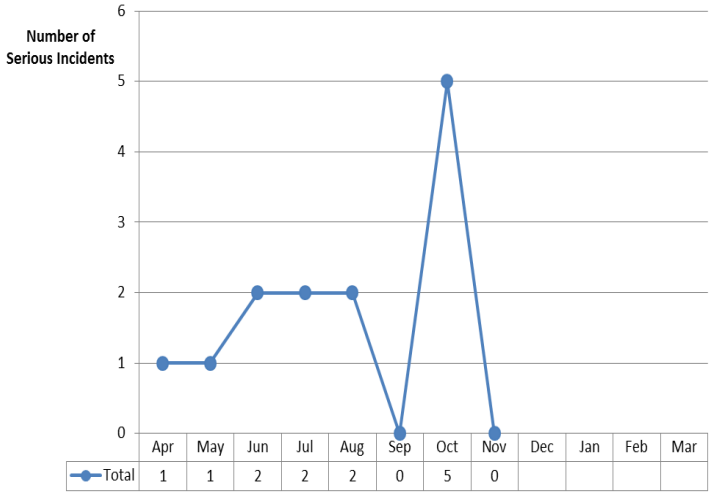
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Serious Incident	1	1	2	2	2	0	5	0				
Moderate Harm	0	0	0	0	0	0	0	3				
Low Harm	96	89	80	71	69	60	73	68				
Cumulative Total 2017/18	97	187	269	342	413	473	551	622				

To reduce the number of patient safety harm incidents, a number of initiatives are being undertaken. These include:

- Focused training and education to staff via team leader meetings.
- Development of a Quality role to support the Quality improvements in CCICP.

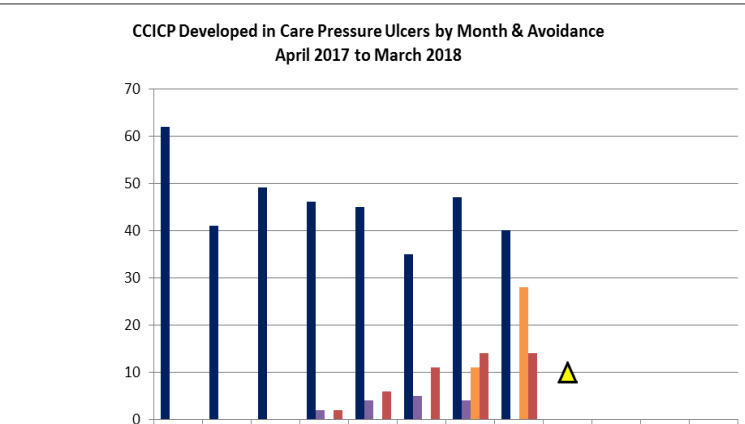
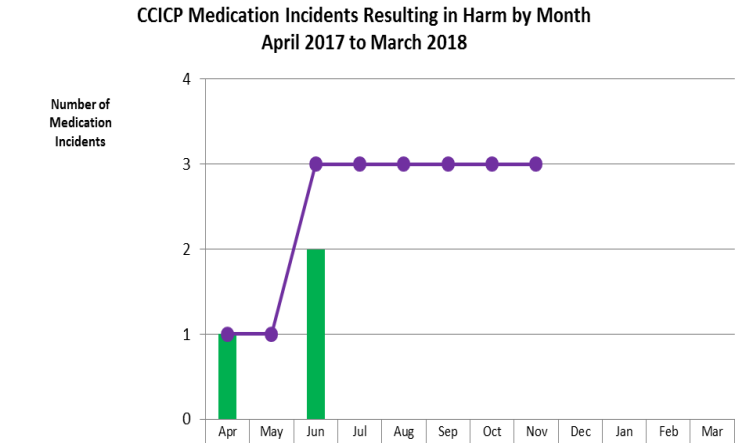
CCICP Serious Incidents.

For November 2017, no serious incidents were reported.

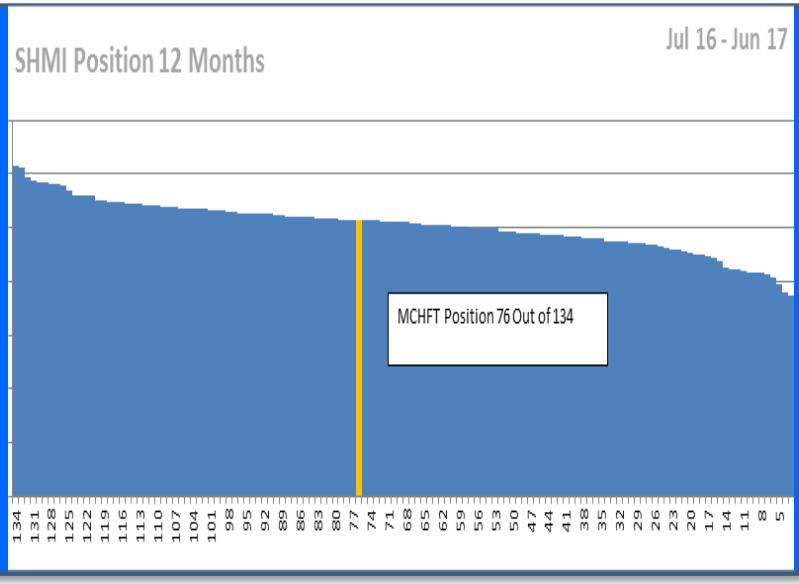
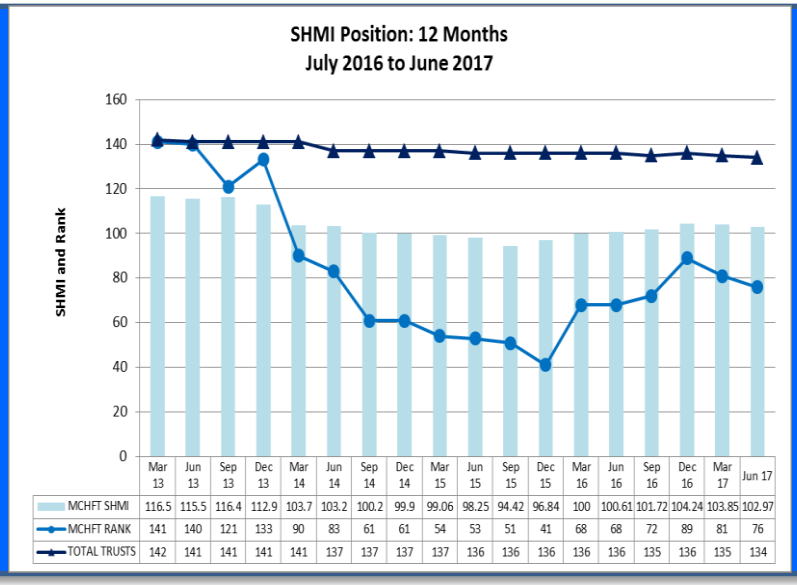


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total	1	1	2	2	2	0	5	0				

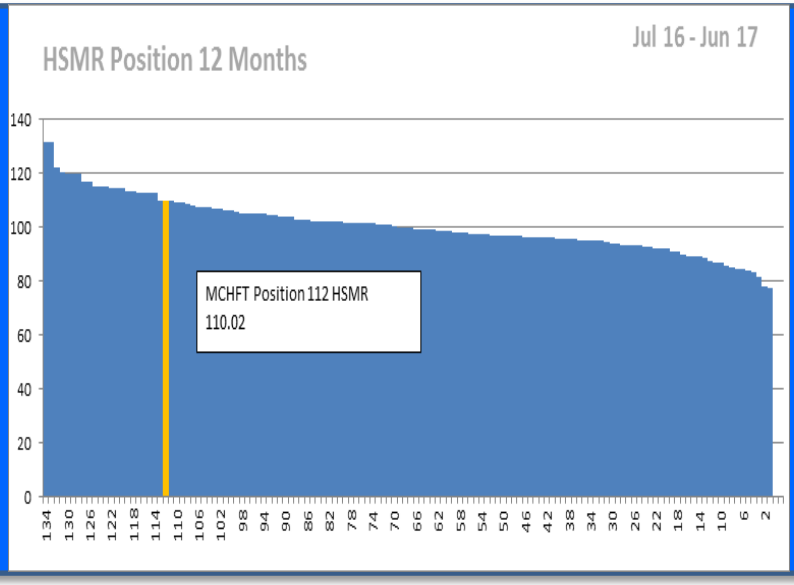
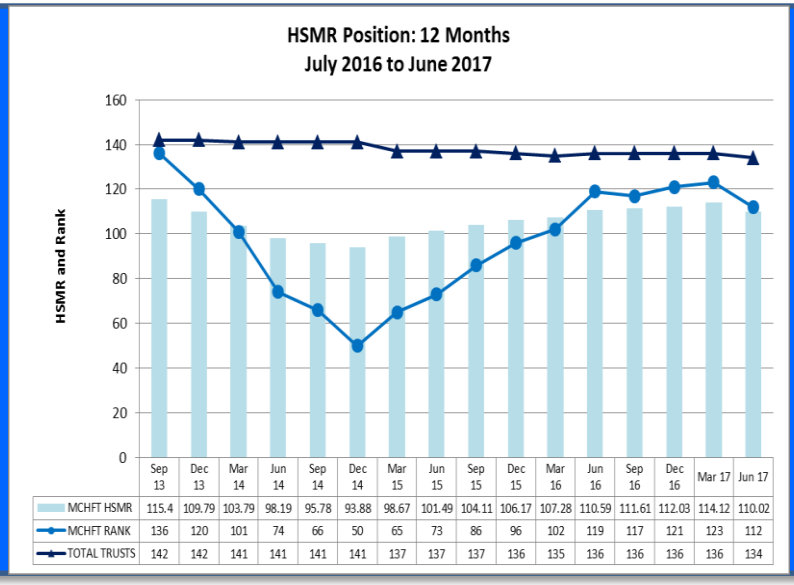
To reduce the number of serious incidents, the Trust has signed up to the Sign Up To Safety Campaign.

Description	Aggregate Position	Trend	Performance against previous month
CCICP Pressure Ulcer (PU) Incidents by Avoidance	For November 2017, there were a total of 40 developed in care pressure ulcers: • 0% (0 PU's) have resulted in avoidable harm. 28 of these incidents are currently unconfirmed.	 Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Monthly 62 41 49 46 45 35 47 40 Avoidable 2 4 5 4 0 Unconfirmed 0 0 0 11 28 Cumulative Avoidable 2 6 11 14 14 5% ¼ Reduction Target 10	• Membership at the Trust Skin Care Group has been expanded to include representatives from CCICP. • Design of an audit tool to assess if pressure ulcer is avoidable or unavoidable • Identification of a cohort of patients with established chronic wounds.
CCICP Medication Incidents.	For November 2017, no medical incidents resulted in harm: • 0% (0 medication incidents) have resulted in low harm • 0% (0 medication incidents) have resulted in moderate harm • 0% (0 medication incidents) have resulted in serious harm	 Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Serious Incident 0 0 0 0 0 0 0 0 Moderate Harm 0 0 0 0 0 0 0 0 Low Harm 1 0 2 0 0 0 0 0 Cumulative Incidents 2017-18 1 1 3 3 3 3 3 3	Membership at the Trust Safer Medicines Practice Group has been expanded to include representatives from CCICP. This is to ensure that learning is shared across both Organisations. Target will be set for achievement at Q3.

Board Papers – Quality, Safety & Experience Section: January 2018

Description	Aggregate Position	Trend	Performance against previous quarter
Summary Hospital-Level Mortality Indicator (SHMI) by Trust.	The chart benchmarks the Trust's latest SHMI against all NHS Trusts. MCHFT is shown as the yellow bar. The Trust's SHMI is 102.97 for the time period July 2016 to June 2017 and places the Trust 76 out of 134 Trusts.		The Trust's aim within the Sign Up To Safety Campaign is to have a SHMI at or below 1.0 from April 2016.
MCHFT 12 Month Rolling Position Summary Hospital-Level Mortality Indicator (SHMI) by Trust.	The chart shows the SHMI and rank of MCHFT for each of the 12 month rolling position submissions for the period July 2016 to June 2017.		The Trust's aim within the Sign Up To Safety Campaign is to have a SHMI at or below 1.0 from April 2016.

	Mar 13	Jun 13	Sep 13	Dec 13	Mar 14	Jun 14	Sep 14	Dec 14	Mar 15	Jun 15	Sep 15	Dec 15	Mar 16	Jun 16	Sep 16	Dec 16	Mar 17	Jun 17
MCHFT SHMI	116.5	115.5	116.4	112.9	103.7	103.2	100.2	99.9	99.06	98.25	94.42	96.84	100	100.61	101.72	104.24	103.85	102.97
MCHFT RANK	141	140	121	133	90	83	61	61	54	53	51	41	68	68	72	89	81	76
TOTAL TRUSTS	142	141	141	141	141	137	137	137	137	136	136	136	136	136	135	136	135	134

Description	Aggregate Position	Trend	Performance against previous quarter
Hospital Standardised Mortality Rate (HSMR) by Trust.	The chart benchmarks the Trust's HSMR against all NHS Trusts. MCHFT is shown by the amber bar. The Trust's HSMR is 110.02 (July 2016 to June 2017) and places the Trust 112 out of 134 Trusts.		The Trust's aim is to have an HSMR <100.
MCHFT 12 Month Rolling Position HSMR Position	The data in the chart shows the HSMR and rank of MCHFT for each of the 12 month rolling position submissions for the period July 2016 to June 2017.		The Trust's aim is to have an HSMR <100.

	Sep 13	Dec 13	Mar 14	Jun 14	Sep 14	Dec 14	Mar 15	Jun 15	Sep 15	Dec 15	Mar 16	Jun 16	Sep 16	Dec 16	Mar 17	Jun 17
MCHFT HSMR	115.4	109.79	103.79	98.19	95.78	93.88	98.67	101.49	104.11	106.17	107.28	110.59	111.61	112.03	114.12	110.02
MCHFT RANK	136	120	101	74	66	50	65	73	86	96	102	119	117	121	123	112
TOTAL TRUSTS	142	142	141	141	141	141	137	137	137	136	135	136	136	136	136	134

Board Papers – Quality, Safety & Experience Section: January 2018

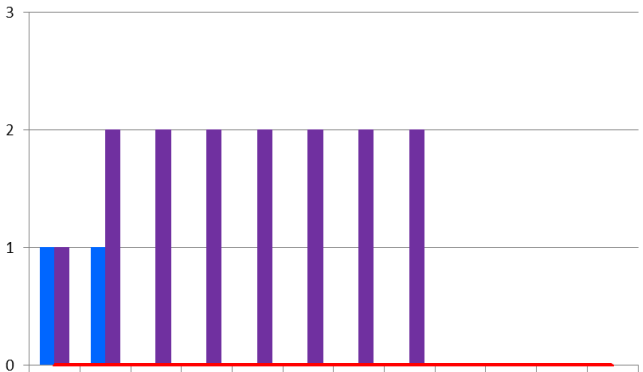
Description	Aggregate Position	Trend	Performance against previous month

MRSA Bacteraemia Cases.

In November 2017 no MRSA bacteraemia cases were reported in the Trust.

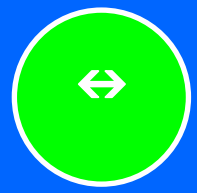
In this financial year there has been two confirmed MRSA bacteraemia cases reported.

MRSA Bacteraemia cases reported within the Trust
April 2017 to March 2018



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Monthly	1	1	0	0	0	0	0	0				
Cumulative	1	2	2	2	2	2	2	2				
Target	0	0	0	0	0	0	0	0	0	0	0	0

A recovery plan has been developed and is monitored through the Executive Infection Prevention Control Group

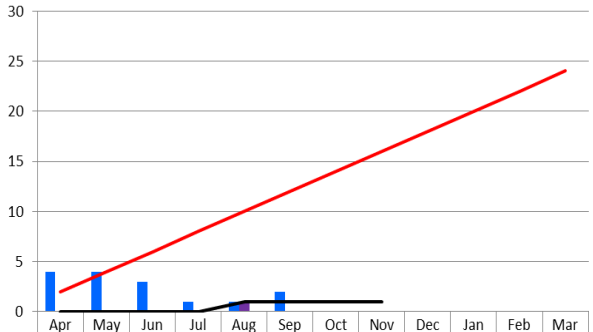


Clostridium Difficile toxin positive cases.

In November 2017, no avoidable cases were reported.

The total avoidable cases year to date is 1.

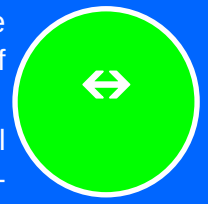
Clostridium Difficile toxin positive cases reported within the Trust
April 2017 to March 2018



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Unavoidable	4	4	3	1	1	2	0	0				
Avoidable	0	0	0	0	1	0	0	0				
Awaiting Confirmation	0	0	0	0	0	0	0	0				
Avoidable Total	0	0	0	0	1	1	1	1				
Avoidable Target	2	4	6	8	10	12	14	16	18	20	22	24

Improvement actions include:

- Bed side reviews are in place on the identification of infection
- Consultant level engagement in C-difficile root cause analysis



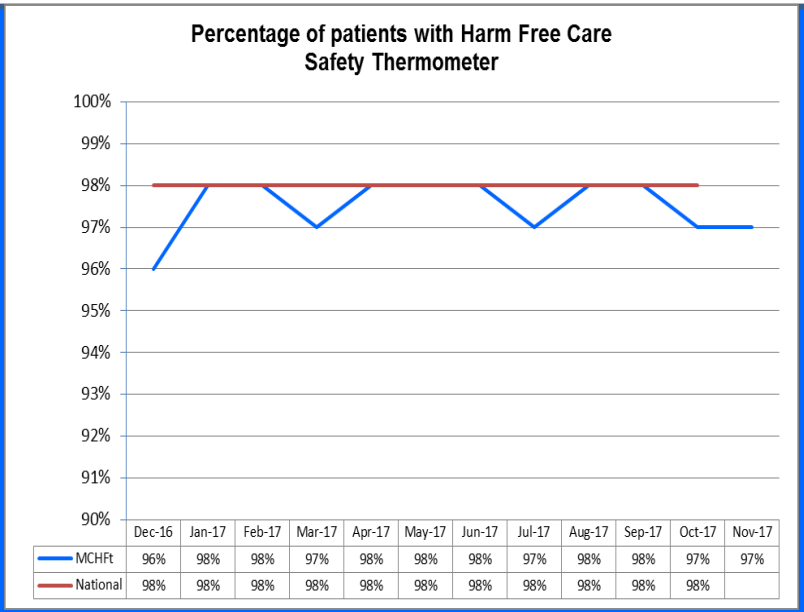
Board Papers – Quality, Safety & Experience Section: January 2018

CQUIN Indicator	Indicator Name	Milestone Achieved								
		Q1	Financial Incentive Achieved	Q2	Financial Incentive Achieved	Q3	Financial Incentive Achieved	Q4	Financial Incentive Achieved	Maximum Value
1a	**Health & Wellbeing** 5% point improvement in two of the three questions on H&W, MSK & Stress.	✓	No Payment in Q1	✓	No Payment in Q2	**Data will be available at the end of quarter 3**				**£144,109**
1b	**Health & Wellbeing** Maintain the four changes for improving healthy food for NHS staff, visitors and patients. Introduce three new changes to food and drink provision.	✓	No Payment in Q1	✓	No Payment in Q2					**£144,109**
1c	**Health & Wellbeing** Achieve an uptake of flu vaccinations of front line clinical staff of 70% by end of February 2018.	NOT REQUIRED	No Payment in Q1	NOT REQUIRED	No Payment in Q2					**£144,109**
2a	**Sepsis: Identification** Greater than 90% of eligible patients to have a timely identification of sepsis by the end of quarter four 2017/18.	✓ Partially	£13,510	✓ Partially	£13,510					**£108,082**
2b	**Sepsis: Treatment** Greater than 90% of eligible patients to have a timely treatment of sepsis by the end of quarter four 2017/18.	✗	Payment not achieved	✓ Partially	£13,510					**£108,082**
2c	**Sepsis: Antibiotic Review** An empiric review for at least 90% cases in the sample should be performed by the end of quarter four 2017/18.	✓	£27,020	✓	£27,020					**£108,082**
2d Part 1	**Reduction in antibiotic consumption** Achieve a reduction of x% or more in total antibiotic consumption per 1,000 admissions.	✗	No Payment in Q1	✗	No Payment in Q2					**£36,027**
2d Part 2	**Reduction in carbapenem consumption** Achieve a reduction of x% or more in total carbapenem consumption per 1,000 admissions.	✓	No Payment in Q1	✓	No Payment in Q2					**£36,027**
2d Part 3	**Reduction in piperacillin tazabactam consumption** Achieve a reduction of x% or more in total piperacillin tazabactam consumption per 1,000 admissions.	✓	No Payment in Q1	✓	No Payment in Q2					**£36,027**
4	**Mental Health in Emergency Department** Achieve a 20% reduction in attendances to the Emergency Department for people with Mental Health needs.	✓	£43,233	✓	£172,931					**£432,328**
6	**Offering advice and guidance** Providers to set up and operate advice and guidance services for non-urgent GP referrals, allowing GPs to access consultant advice prior to referring patients into secondary care.	✓	£108,082	✓	£108,082					**£432,328**
7	**NHS e-Referrals** Availability of services and appointments for e-Referral service.	✓	£108,082	✓ Partially	£64,849					**£432,328**
8a	**Supporting proactive and safe discharge** Acute providers.	✓	£64,849	✓	£172,931					**£432,328**

Board Papers – Quality, Safety & Experience Section: January 2018

CQUIN Indicator	Indicator Name	Milestone Achieved								Maximum Value
		Q1	Financial Incentive Achieved	Q2	Financial Incentive Achieved	Q3	Financial Incentive Achieved	Q4	Financial Incentive Achieved	
9	CQUIN 9 does not apply until year 2									
10	**Improving the assessment of wounds (Community Only)** The indicator aims to increase the number of wounds which have failed to heal after 4 weeks that receive a full wound assessment		No Payment in Q1	✓	£69,512	**Data will be available at the end of quarter 3**				**£139,025**
11	**Personalised Care and Support Planning (Community Only)** This CQUIN is to be delivered over two years with an aim of embedding personalised care and support planning for people with long -term conditions.		No Payment in Q1	✓	£34,756					**£139,025**
Public Health England CQUIN										
PH1	**Breast Screening Programme Clerical Staff Development (Health Promotion role)** Update and improve the clerical teams knowledge of health promotion to support clients who access The Breast Screening Unit and key partners involved in the Breast Screening Programme	✓	£3,401.50	✓	£3,401.50	**Data will be available at the end of quarter 3**				**£13,606**
PH2	**Cancer Screening Programme – reducing professional stress and building resilience** Holistic mapping review of health & wellbeing services and support available to staff within the bowel and breast screening programmes for the management of professional stress and building resilience	✓	£5,837.25	✓	£5,837.25					**£23,349**
Specialist Commissioning										
SC1	**Nationally Standardised Dose Banding for Adult Intravenous Systemic Anticancer Therapy (SACT) 38** A tool kit has been developed to support CQUIN. Targets will be set for each of the SACT drugs.	✓	£3,828.30	✓	£3,828.30	**Data will be available at the end of quarter 3**				**£38,283**
SC2	**Hospital Pharmacy Transformation and Medicines Optimisation**	✓		✓						**£57,424**

Board Papers – Quality, Safety & Experience Section: January 2018

Description	Aggregate Position	Trend	Performance against previous month
Safety Thermometer - Harm Free Care.	In November 2017, 97% of patients received harm free care as measured by the Safety Thermometer. The Safety Thermometer data is collected during the morning of the first Wednesday of each month and is collected by the nursing staff on duty on the ward assisted by the Divisional Senior Nursing Teams. National figures are not yet available for November 2017.		>95% of patients to receive harm free care as monitored by the Safety Thermometer.

	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17
MCHFt	96%	98%	98%	97%	98%	98%	98%	97%	98%	98%	97%	97%
National	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	

Description	Aggregate Position	Trend	Performance against previous month
Registered Nurses monthly expected hours by shift versus actual monthly hours per shift. Day time shifts only	93.3% of expected Registered Nurse hours were achieved for day shifts. Any registered nurse numbers that fall below 85% are required to have a divisional review and an update of actions provided to the Director of Nursing & Quality and the Deputy Director of Nursing & Quality.	Trend **November 2017 93.3%** October 2017 92.4% September 2017 91.4%	The lowest staffing levels during the day were on Ward 9 at 67.4%.
Registered Nurses monthly expected hours by shift versus actual monthly hours per shift. Night time shifts only	95.8% of expected Registered Nurse hours were achieved for night shifts.	Trend **November 2017 95.8%** October 2017 96.5% September 2017 96%	The lowest staffing levels during the night were on Ward 5 at 74.2%
Healthcare Assistant monthly expected hours by shift versus actual monthly hours per shift. Day time shifts only	100.8% of expected HCA hours were achieved for day shifts.	Trend **November 2017 100.8%** October 2017 100.7% September 2017 101.1%	The lowest staffing levels during the day were on Ward 9 at 60%
Healthcare Assistant monthly expected hours by shift versus actual monthly hours per shift. Night time shifts only	122.6% of expected HCA hours were achieved for night shifts. For areas with over 100% staffing levels for HCA's this is reviewed and is predominately due to wards requiring 1 to 1 specials for patients following a risk assessment or to increase staffing numbers when there are registered nursing gaps that are not filled.	Trend **November 2017 122.6%** October 2017 115.1% September 2017 113.9%	The lowest staffing levels during the night were on AMU at 98.3%

Board Papers – Quality, Safety & Experience Section: January 2018

Ward Name	Main Specialties	Day				Night				Day		Night		Care Hours Per Patient Day			
		Qualified		Unqualified		Qualified		Unqualified		Qualified	Unqualified	Qualified	Unqualified	Cumulative count over month of pts at 23:59 each day	Qualified	Unqualified	Overall
		Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Fill Rate	Fill Rate	Fill Rate	Fill Rate				
MCHFT		41581.7	38802.8	29190.5	29414.8	24743.2	23710.4	15407.3	18889.6	93.3%	100.8%	95.8%	122.6%	13358	4.7	3.6	8.3
AMU	GEN. MEDICINE	1950	1778.5	1470	1378	1837.5	1715	1470	1445.5	91.2%	93.7%	93.3%	98.3%	829	4.2	3.4	7.6
CAU (Winter)	PAEDIATRICS	2890	2890	1087.5	1087.5	1932	1932	586.5	586.5	100.0%	100.0%	100.0%	100.0%	81	59.5	20.7	80.2
Critical Care	GEN. SURGERY	3920	3920	576.5	576.5	2403.5	2403.5	0	0	100.0%	100.0%	100.0%	-	237	26.7	2.4	29.1
Elmhurst	REHABILITATION	847.5	847.5	2160	2130	750	750	1500	1850	100.0%	98.6%	100.0%	123.3%	877	1.8	4.5	6.4
Ward 1	GEN. MEDICINE	2125	2081.3	1125	1237.5	1470	1457.8	735	1188.3	97.9%	110.0%	99.2%	161.7%	817	4.3	3.0	7.3
Ward 10 SSW	GEN. SURGERY	1661	1557	960	1024	615	615	307.5	369	93.7%	106.7%	100.0%	120.0%	293	7.4	4.8	12.2
Ward 12	GEN. SURGERY	2171	1987	1920	1992	922.5	850.8	615	779	91.5%	103.8%	92.2%	126.7%	825	3.4	3.4	6.8
Ward 13	GEN. SURGERY	2216	1808	1920	1856	922.5	758.5	615	697	81.6%	96.7%	82.2%	113.3%	881	2.9	2.9	5.8
Ward 14	GEN. MEDICINE	1662	1620	1440	1416	720	720	1080	1164	97.5%	98.3%	100.0%	107.8%	933	2.5	2.8	5.3
Ward 15	TRAUMA & ORTHO	2178.5	1922.5	2640	2504	922.5	861	922.5	922.5	88.2%	94.8%	93.3%	100.0%	907	3.1	3.8	6.8
Ward 2	GEN. MEDICINE	1750	1687.5	1500	1406.3	735	992.3	1102.5	1188.3	96.4%	93.8%	135.0%	107.8%	930	2.9	2.8	5.7
Ward 21b	GEN. MEDICINE	1297.5	1154.5	1755	1768	750	737.5	750	862.5	89.0%	100.7%	98.3%	115.0%	716	2.6	3.7	6.3
Ward 23	OBSTETRICS	1200	1200	760	747.3	740	740	740	740	100.0%	98.3%	100.0%	100.0%	672	2.9	2.2	5.1
Ward 26	OBSTETRICS	3222.7	3222.7	684	684	2725.7	2725.7	382.3	382.3	100.0%	100.0%	100.0%	100.0%	163	36.5	6.5	43.0
Ward 4	GEN. MEDICINE	1572	1506	1800	1800	720	720	1440	1440	95.8%	100.0%	100.0%	100.0%	888	2.5	3.6	6.2
Ward 5	GEN. MEDICINE	2377.5	2152.5	1500	1431.3	1470	1090.3	735	1090.3	90.5%	95.4%	74.2%	148.3%	911	3.6	2.8	6.3
Ward 6	GEN. MEDICINE	1980	1842.5	1875	2093.8	1470	1372	735	1151.5	93.1%	111.7%	93.3%	156.7%	814	3.9	4.0	7.9
Ward 7	GEN. MEDICINE	1702.5	1615	1500	2343.8	735	735	1102.5	2168.3	94.9%	156.3%	100.0%	196.7%	938	2.5	4.8	7.3
Ward 9	TRAUMA & ORTHO	1646	1110	1440	864	615	615	307.5	358.8	67.4%	60.0%	100.0%	116.7%	309	5.6	4.0	9.5
NICU	PAEDIATRICS	1862.5	1595.3	177.5	159.8	1725	1357	0	0	85.7%	90.0%	78.7%	-	21	140.6	7.6	148.2
Ward 11 SAU	GEN. SURGERY	1350	1305	900	915	562	562	281	505.8	96.7%	101.7%	100.0%	180.0%	316	5.9	4.5	10.4

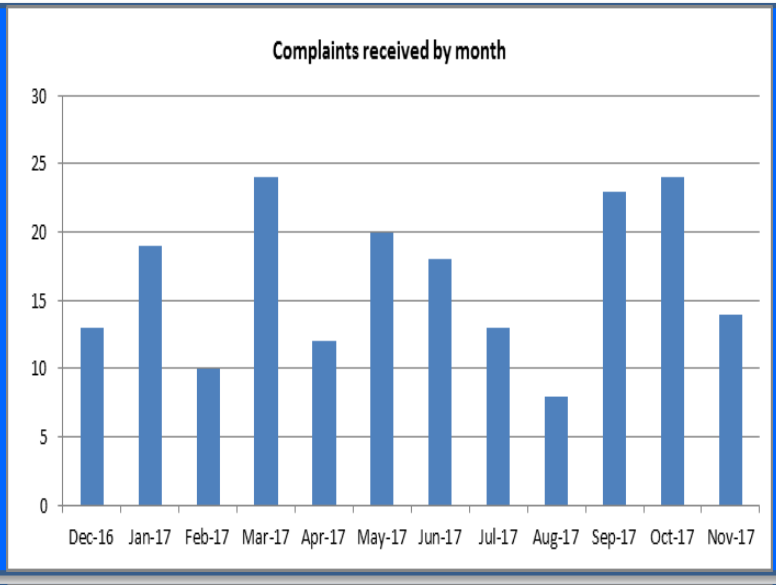
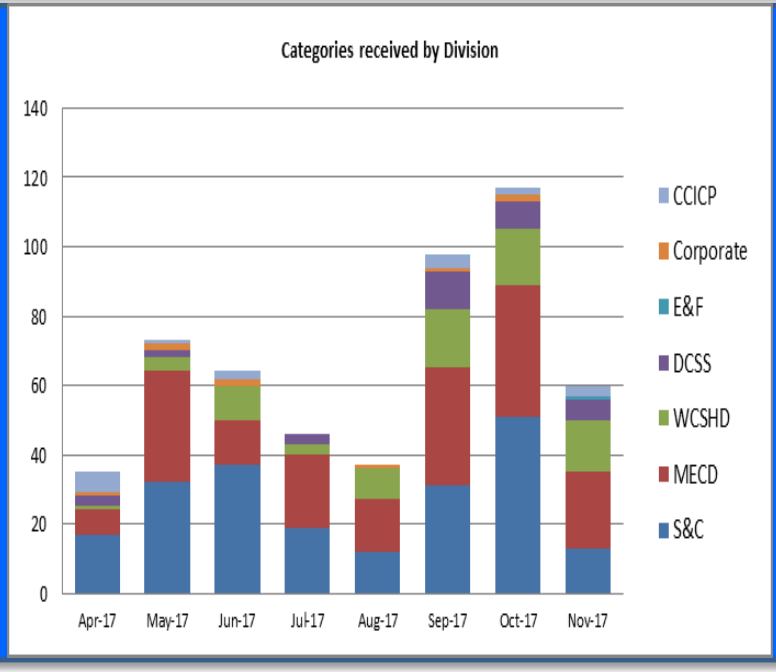
Board Papers – Quality, Safety & Experience Section: January 2018

Ward Name	Main Specialties	Safety Thermometer Results			
		Acquired Pressure Ulcers	Patient Falls resulting in harm	CAUTI	New VTE
MCHFT		**1.19% (10)**	**0.59% (5)**	**1.43% (12)**	**0.48% (4)**
AMU	Gen. Medicine	0% (0)	3.12(1)	0% (0)	0% (0)
CAU	Paediatrics	0% (0)	0% (0)	0% (0)	0% (0)
Critical Care	Gen. Medicine	0% (0)	0% (0)	0% (0)	0% (0)
Elmhurst	Rehab	0% (0)	0% (0)	0% (0)	0% (0)
Ward 1	Gen. Medicine	0% (0)	0% (0)	0% (0)	0% (0)
SAU	Gen. Surgery	0% (0)	0% (0)	0% (0)	0% (0)
Ward 10 SSW	Gen. Surgery & Urology	0% (0)	0% (0)	0% (0)	0% (0)
Ward 12	Gen. Surgery & Gynae	0% (0)	0% (0)	0% (0)	0% (0)
Ward 13	Gen. Surgery	3.12% (1)	3.12% (1)	0% (0)	3.12% (1)
Ward 14	Gen. Medicine	0% (0)	0% (0)	0% (0)	6.45% (2)
Ward 15	Trauma & Ortho	0% (0)	0% (0)	0% (0)	0% (0)
Ward 2	Gen. Medicine	3.12 (1)	0% (0)	12.5% (4)	0% (0)
Ward 21B	Rehab	8.33% (2)	4.17% (1)	4.17% (1)	0% (0)
Ward 23	Obstetrics	0% (0)	0% (0)	0% (0)	0% (0)
Ward 26	Obstetrics	0% (0)	0% (0)	0% (0)	0% (0)
Ward 4	Gen. Medicine	0% (0)	0% (0)	0% (0)	0% (0)
Ward 5	Gen. Medicine	0% (0)	0% (0)	9.38% (3)	3.12% (1)
Ward 6	Gen. Medicine	3.85% (1)	0% (0)	0% (0)	0% (0)
Ward 7	Gen. Medicine	3.12% (1)	3.12% (1)	3.12% (1)	0% (0)
Ward 9	Trauma & Ortho	0% (0)	0% (0)	0% (0)	0% (0)
NICU	Paediatrics	0% (0)	0% (0)	0% (0)	0% (0)
DN – Alsager	District Nursing	0% (0)	0% (0)	0% (0)	0% (0)
DN - Ashfields	District Nursing	0% (0)	0% (0)	0% (0)	0% (0)
DN – Dane bridge	District Nursing	0% (0)	0% (0)	0% (0)	0% (0)
DN – Eagle bridge	District Nursing	0% (0)	0% (0)	0% (0)	0% (0)
DN – Firdale	District Nursing	2.22% (1)	2.22% (1)	4.44% (2)	0% (0)
DN – Grosvenor & Hungerford	District Nursing	0% (0)	0% (0)	0% (0)	0% (0)
DN – Middlewich	District Nursing	0% (0)	0% (0)	0% (0)	0% (0)
DN – Rope Green	District Nursing	12.5% (1)	0% (0)	0% (0)	0% (0)
DN - Church View	District Nursing	0% (0)	0% (0)	2.22 % (1)	0% (0)
DN – Winsford	District Nursing	4.76% (2)	0% (0)	0% (0)	0% (0)
DN – Out of hours	District Nursing	0% (0)	0% (0)	0% (0)	0% (0)

Experience Section:

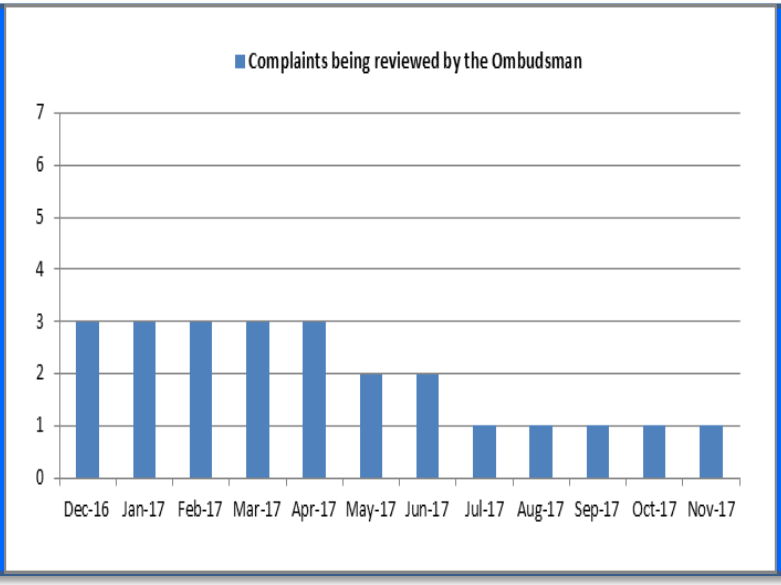
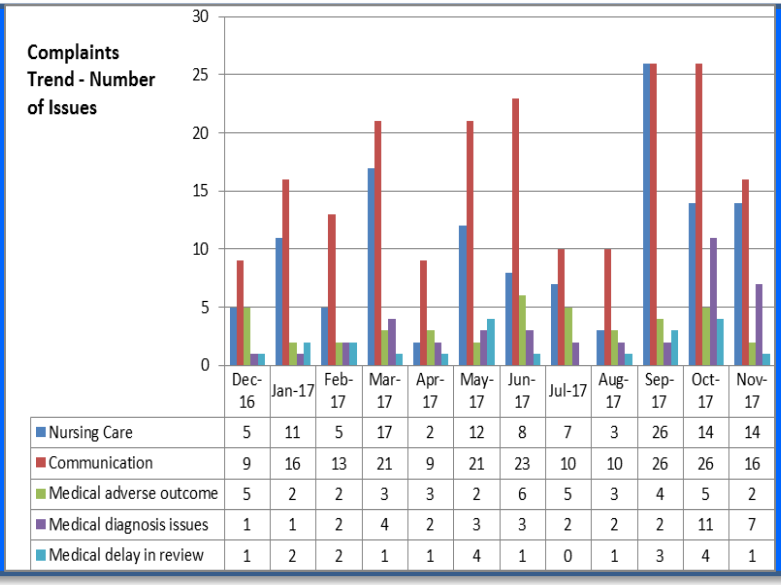
Indicators	Last four months			
	Aug-17	Sep-17	Oct-17	Nov-17
Complaints received by month	8	23	24	14
Complaints being reviewed by the Ombudsman	1	1	1	1
Closed complaints by month	21	12	9	22
Contacts raising informal concerns	89	79	92	95
Compliments received in month	158	139	212	186
Number of new claims received in month	5	3	2	6
Number of claims closed	0	1	5	3
Number of inquests concluded	0	0	0	0
NHS Choices - Star Ratings (Leighton)	4.5	4.5	4.5	4.5
NHS Choices - Star Ratings (VIN)	5	5	5	5
NHS Choices - Number of new postings	10	4	12	9
F&FT Response Rate ED, MIU, UCC and Assessment Areas*	5%	2%	3%	4%
Proportion of positive responses ED, MIU, UCC and Assessment Areas	89%	89%	93%	91%
F&FT Response Rate Inpatients and Daycases	18%	11%	21%	22%
Proportion of positive responses Inpatients and Daycases	99%	98%	98%	98%
F&FT Response Rate Outpatients	4%	7%	8%	7%
Proportion of positive responses Outpatients	96%	96%	96%	96%
F&FT Response Rate Maternity - Birth	7%	8%	10%	14%
Proportion of positive responses Maternity - Birth	95%	96%	100%	97%
F&FT Response Rate Community (CCICP)	17%	15%	19%	57%
Proportion of positive responses Community (CCICP)	83%	87%	88%	88%

*ED = Emergency Department; MIU = Minor Injuries Unit; UCC = Urgent Care Centre

Description	Aggregate Position/Description	Trend
Monthly Trust complaints received by the Trust	14 complaints were received in November 2017 which covered 60 categories. The highest categories were: • Communication • Medical – Diagnosis Problems • Nursing - Nutrition Highest 3 areas receiving complaints/issues were: • Ward 19: 2 complaints /7 issues • Ward 1: 1 complaint / 7 issues • Ward 5: 2 complaints /5 issues	
Number of formal complaints by Division	This graph shows the breakdown of issues by month for e ach division. S&C: 13 DCSS: 6 W&CD: 15 DMEC: 22 CCICP: 3 E&F:1 Corporate Services: 0	

Formal Complaints

Formal Complaints by Division

Description	Aggregate Position/Description	Trend	
Complaints being reviewed by the Public Health Service Ombudsman	In November 2017 1 complaint was active with the PHSO. This complaint is currently active as a further independent review is being carried out into the PHSO investigation. We await to hear further instruction.		Ombudsman
Complaint Trends and number of issues	The main trends in November 2017 were: • Communication: 9 complaints/16 issues • Medical - Diagnosis Problems: 3 Complaints/7 issues • Nursing – Nutrition: 3 complaints/ issues 3		Complaint Trends

Complaints Trend - Number of Issues

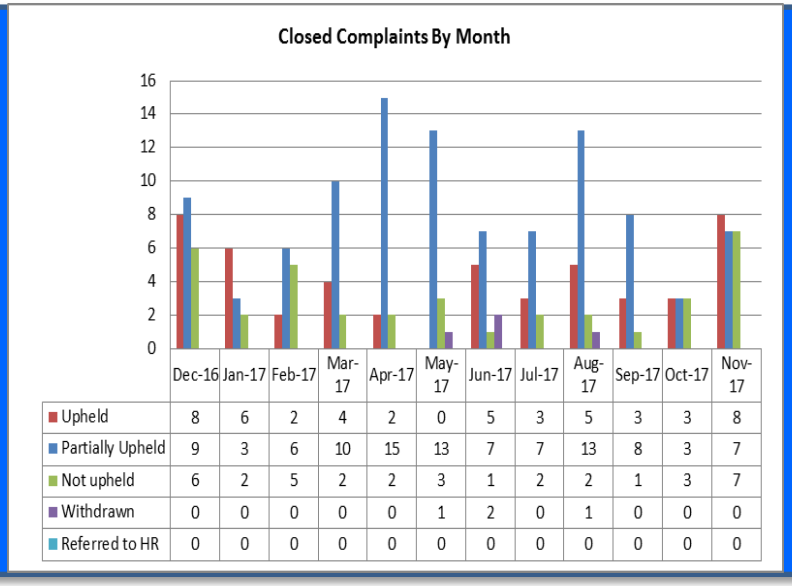
	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17
Nursing Care	5	11	5	17	2	12	8	7	3	26	14	14
Communication	9	16	13	21	9	21	23	10	10	26	26	16
Medical adverse outcome	5	2	2	3	3	2	6	5	3	4	5	2
Medical diagnosis issues	1	1	2	4	2	3	3	2	2	2	11	7
Medical delay in review	1	2	2	1	1	4	1	0	1	3	4	1

Board Papers – Quality, Safety & Experience Section: January 2018

Description | **Aggregate Position/Description** | **Trend**

Closed Complaints

22 complaints were closed in November 2017



	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17
Upheld	8	6	2	4	2	0	5	3	5	3	3	8
Partially Upheld	9	3	6	10	15	13	7	7	13	8	3	7
Not upheld	6	2	5	2	2	3	1	2	2	1	3	7
Withdrawn	0	0	0	0	0	1	2	0	1	0	0	0
Referred to HR	0	0	0	0	0	0	0	0	0	0	0	0

Closed Complaints

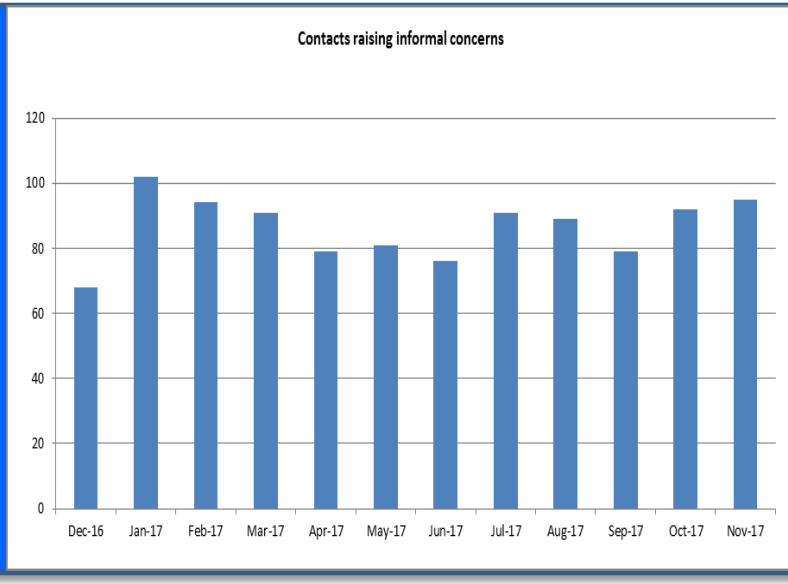
Closed Complaints by Division

The Table provides a breakdown of closed complaints by division, demonstrating those complaints which were upheld, not upheld or partially upheld.

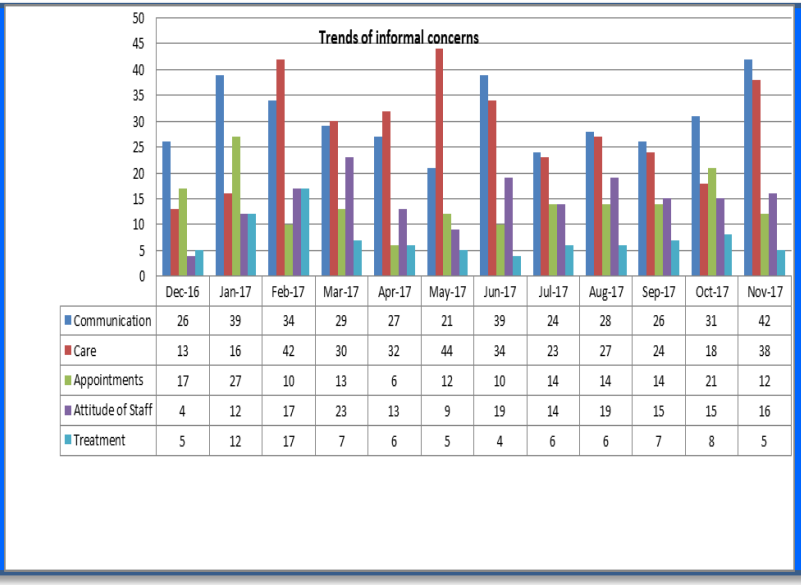
Division	Upheld	Partially Upheld	Not Upheld	Withdrawn	Ref HR	Sub-Total
Medicine and Emergency Care	3	4	2	0	0	9
Surgery and Cancer	2	1	2	0	0	5
Diagnostics & Clinical Support Services	2	2	1	0	0	5
Women's and Children's	1	0	1	0	0	2
CCICP	0	0	1	0	0	1
		Total closed				**22**

Complaints closed by Division

Complaints removed under Section 40 of the Freedom of Information Act

Description	Aggregate Position/Description	Trend
Informal Concerns Numbers	The number of contacts raising informal concerns for November 2017 was 95 which is an increase of 3 on the previous month. The Division of Medicine and Emergency Care has received the largest number of individual concerns raised at 65. Twenty seven of the 65 individual concerns raised belong to the emergency department.	

Informal Concerns Feedback

Informal Concerns Trends	Communication was the highest trend for informal concerns in November 2017, with 17 of the 42 issues raised belonging to the Surgery and Cancer Division. Five of the 17 issues were relating to general surgery. Of the 38 issues relating to care, 19 belong to the Division of Medicine and Emergency Care. Nine of these 19 issues relate to the emergency department, 8 being contributable to medical care.	

	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17
Communication	26	39	34	29	27	21	39	24	28	26	31	42
Care	13	16	42	30	32	44	34	23	27	24	18	38
Appointments	17	27	10	13	6	12	10	14	14	14	21	12
Attitude of Staff	4	12	17	23	13	9	19	14	19	15	15	16
Treatment	5	12	17	7	6	5	4	6	6	7	8	5

Informal Concerns Trends

Description	Aggregate Position/Description	Trend
New claims received.	Narrative and graph removed under Section 43 of the Freedom of Information Act.	
Claims closed with/without damages.	Narrative and graph removed under Section 43 of the Freedom of Information Act.	

Board Papers – Quality, Safety & Experience Section: January 2018

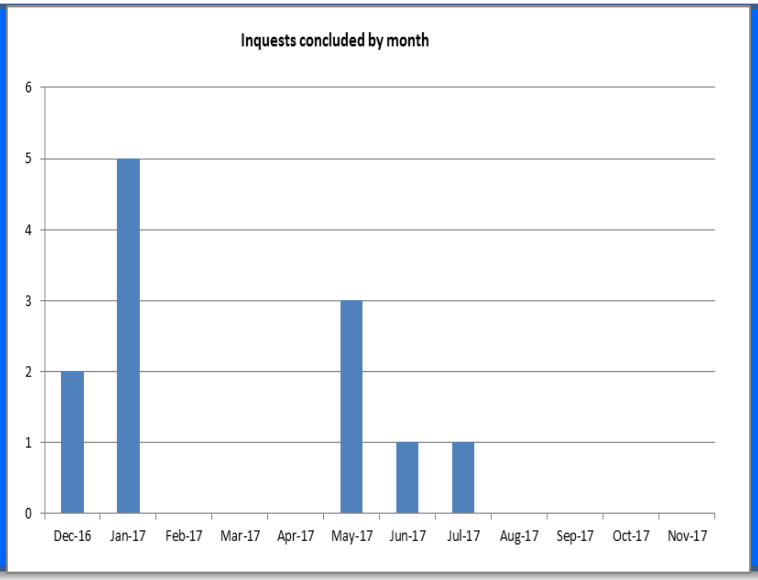
Description	Aggregate Position/Description	Trend
Value of claims closed by month	Narrative and graph removed under Section 43 of the Freedom of Information Act.	
Top five claims by Specialty	Narrative and graph removed under Section 43 of the Freedom of Information Act.	

Board Papers – Quality, Safety & Experience Section: January 2018

Description	Aggregate Position/Description	Trend

Number of Inquests concluded by month

No inquests were concluded in November 2017.

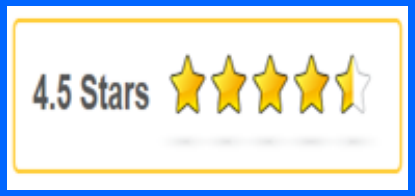


Inquests

NHS Choices Star Ratings

The ratings are based on 226 postings received to date.

Leighton Hospital is rated at 4.5 stars.



Victoria Infirmary, Northwich is rated at 5 stars.

NHS Choices – Star Ratings

Board Papers – Quality, Safety & Experience Section: January 2018

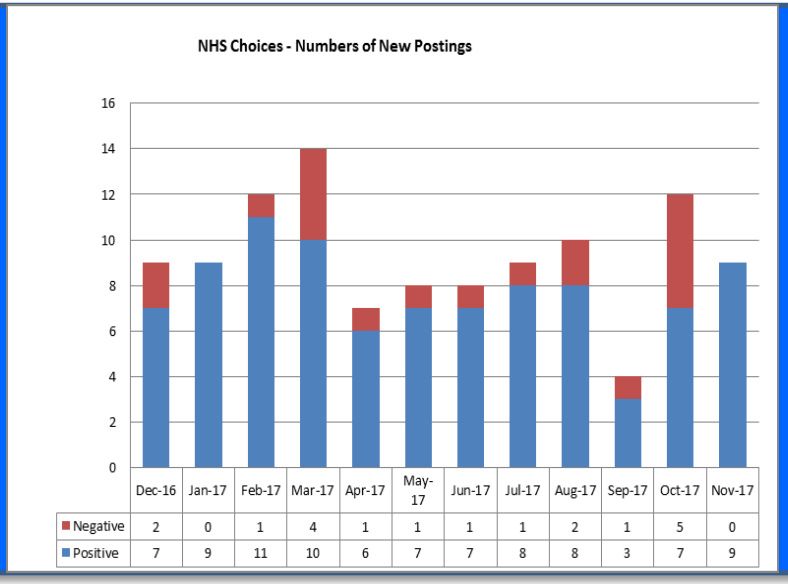
Description	Aggregate Position /description	Trend

NHS Choices postings

There were 9 postings on NHS Choices in November 2017 of which none were negative and 9 were positive. Examples of feedback included:

"Walked in 10.20 Monday morning checked in, assessed, x-rayed, treated, Physio arranged for next day and back home by 11.35. Brilliant service, very friendly professional staff, always my first choice for minor a&e issues for me and my family over the last 10 years. A credit to the NHS" Minor Injuries VIN

"I visited the treatment centre today for a procedure. I found all the staff to be friendly and courteous. The team who carried out the procedure were caring, efficient and professional. Feel lucky to have such a fantastic hospital close by" Treatment Centre



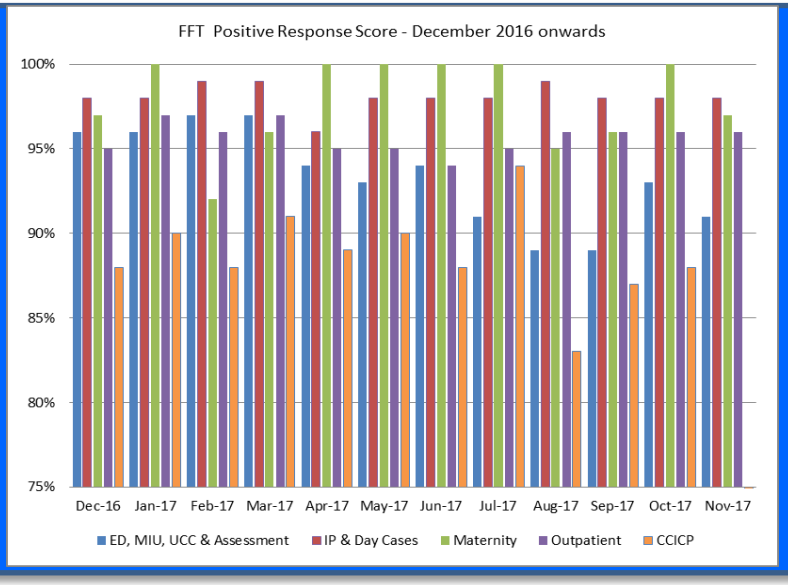
NHS Choices - Postings

The Family and Friends Test asks patients if this would recommend our hospital services to a friend or relative based on their treatment and experience

In November 2017 the Trust has scored the following positive response scores :

Inpatients and day cases	98%
Emergency care /Assessment areas	91%
Outpatients	96%
Maternity	97%
CCICP	88%

3072 responses were received and 95% of those patients would recommend our hospital services.



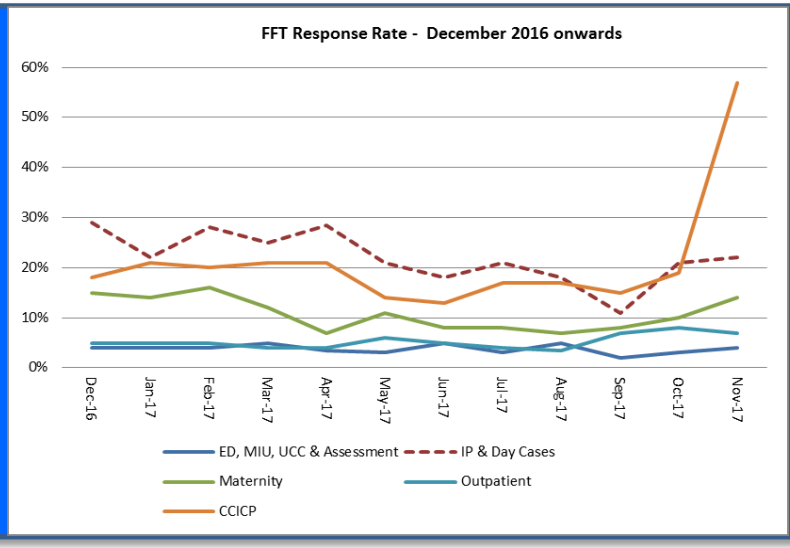
Family & Friends Test

Board Papers – Quality, Safety & Experience Section: January 2018

Description | **Aggregate Position** | **Trend**

Number of responses received for IP, Day Case, ED, maternity compared to eligible patients

November 2017 Ward/Dept	% Response	Total Responses received	How many would recommend
A&E , UCC & MIU	4%	189	172
Inpatients & Daycases	22%	908	889
Maternity	14%	38	37
Outpatients	7%	1498	1433
CCICP	57%	330	292



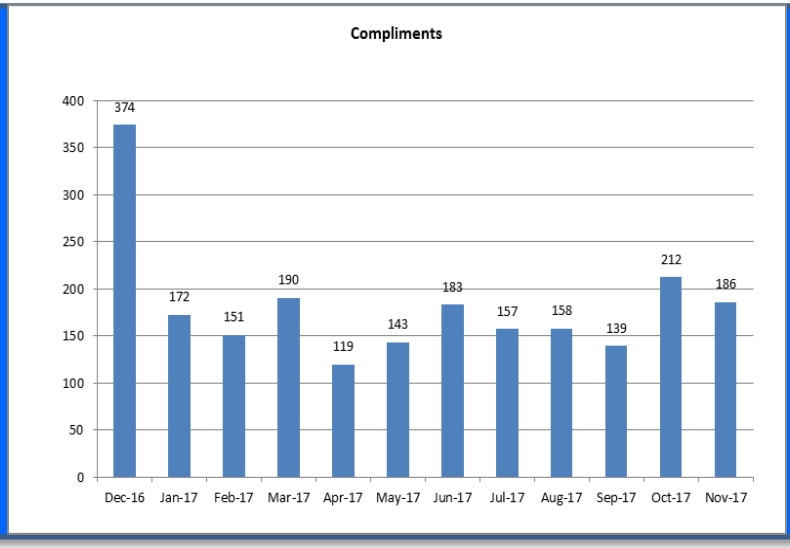
Family & Friends Test

Compliments received

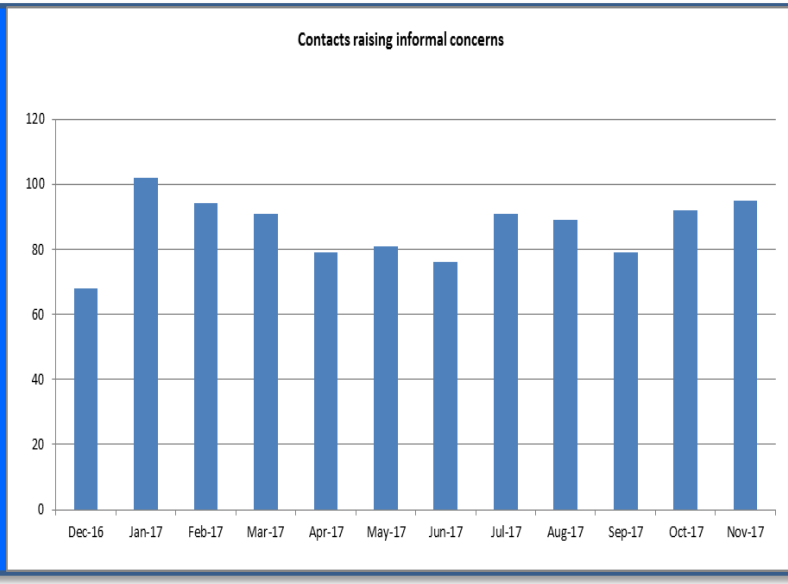
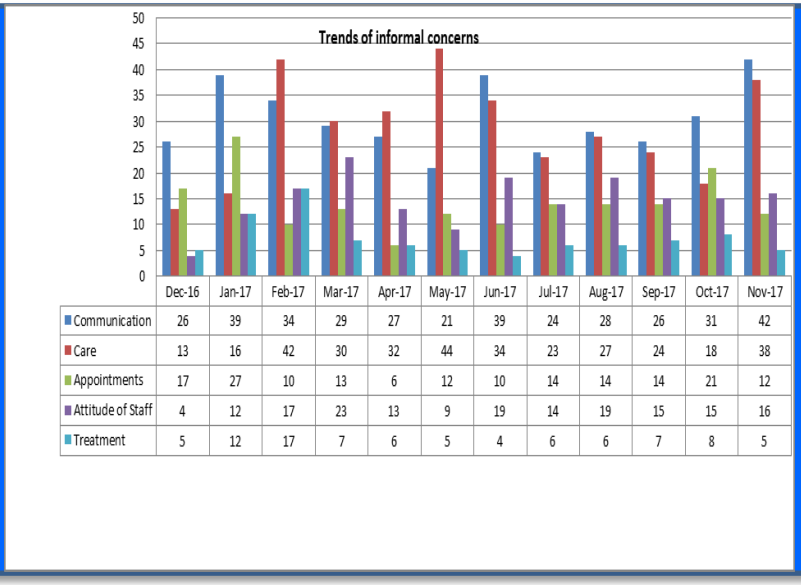
There were 186 compliments/thank-you's received for November 2017:

'I have recently being recovering from a shoulder injury and I just wanted to thank all the people involved in my speedy recovery including staff in the fracture clinic and, in particular, the physiotherapist, who has done an outstanding job.'

'I came to the emergency department after treading on a nail. I was processed, seen, advised and out within 15 minutes. Best service ever. Thank you very much!'



Compliments

Description	Aggregate Position/Description	Trend
Informal Concerns Numbers	The number of contacts raising informal concerns for November 2017 was 95 which is an increase of 3 on the previous month. The Division of Medicine and Emergency Care has received the largest number of individual concerns raised at 65. Twenty seven of the 65 individual concerns raised belong to the emergency department.	
Informal Concerns Trends	Communication was the highest trend for informal concerns in November 2017, with 17 of the 42 issues raised belonging to the Surgery and Cancer Division. Five of the 17 issues were relating to general surgery. Of the 38 issues relating to care, 19 belong to the Division of Medicine and Emergency Care. Nine of these 19 issues relate to the emergency department, 8 being contributable to medical care.	

Informal Concerns Feedback

	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17
Communication	26	39	34	29	27	21	39	24	28	26	31	42
Care	13	16	42	30	32	44	34	23	27	24	18	38
Appointments	17	27	10	13	6	12	10	14	14	14	21	12
Attitude of Staff	4	12	17	23	13	9	19	14	19	15	15	16
Treatment	5	12	17	7	6	5	4	6	6	7	8	5

Informal Concerns Trends

Board Papers – Quality, Safety & Experience Section: January 2018

Description	Aggregate Position/Description	Trend

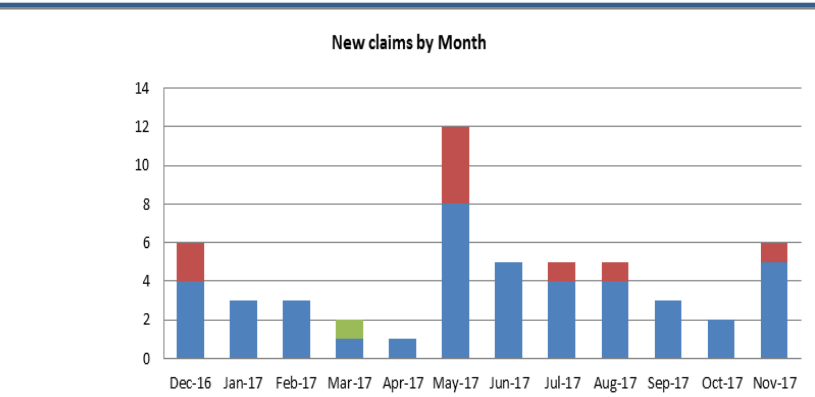
New claims received.

5 new clinical negligence claims were received in November 2017. These related to:

- General Surgery
- General Medicine
- Orthopaedics
- Radiology
- 1 was jointly against Orthopaedics and Emergency Department

1 new employer's liability claims was received. This related to General Medicine (Ward 1)

No new public liability claims were received.

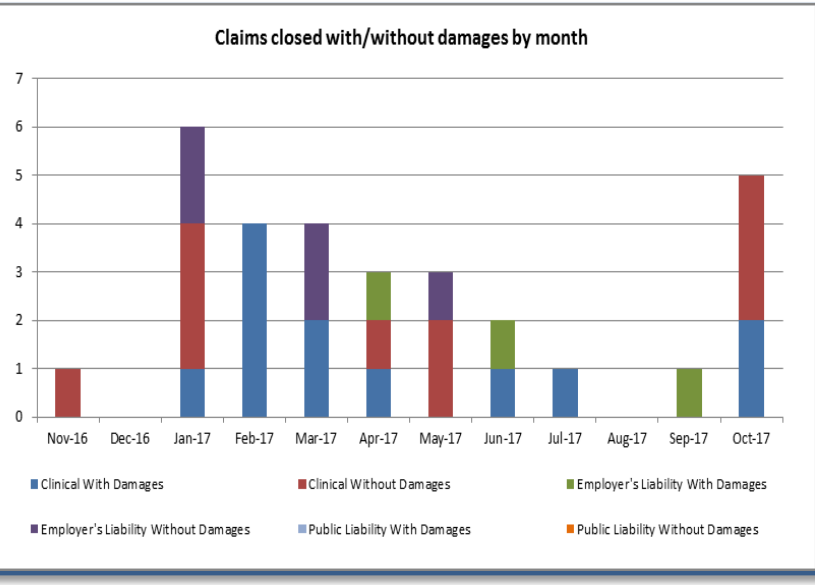


	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17
Public Liability	0	0	0	1	0	0	0	0	0	0	0	0
Employer's Liability	2	0	0	0	0	4	0	1	1	0	0	1
Clinical	4	3	3	1	1	8	5	4	4	3	2	5

Claims

Claims closed with/without damages.

5 clinical negligence claims were closed in October 2017 and 2 of these were upheld.



Closed Claims

Board Papers – Quality, Safety & Experience Section: January 2018

Description	Aggregate Position/Description	Trend

Value of claims closed by month

Damages of £28,500 were paid out on 2 clinical negligence claims in November.

Emergency Department (ED)

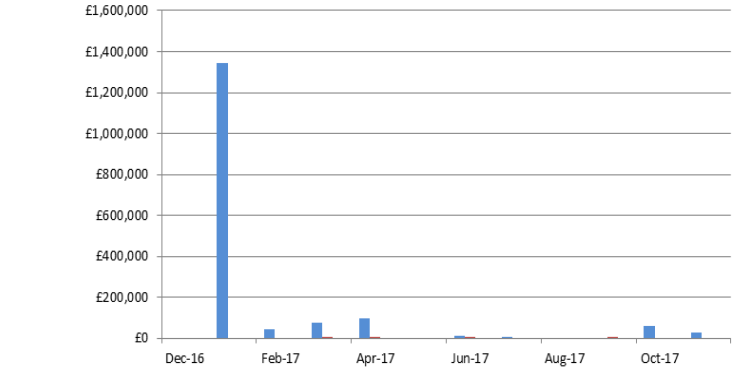
Alleged failure to diagnose and treat tendon damage to right little finger.

A Lessons Learnt flyer is being developed and will be shared with staff.

General Medicine (Ward 5)

Alleged negligent falls assessments and care resulting In claimant falling in the shower and sustaining a fracture to his right femur.

An episode of care poster was shared with ward staff regarding the need to update the patient's fall assessment on transfer from ED and to ensure that a patient information leaflet is given to the patient.



	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17
Clinical Damages Paid £	0	1,341,544	44,750	76,000	95,689	0	10,000	5,000	0	0	57,500	28,500
Employer's Liability Paid £	0	0	0	1	7,000	0	2,500	0	0	5,000	0	0
Public Liability Paid £	0	0	0	0	0	0	0	0	0	0	0	0

Value of Claims

Top five claims by Specialty

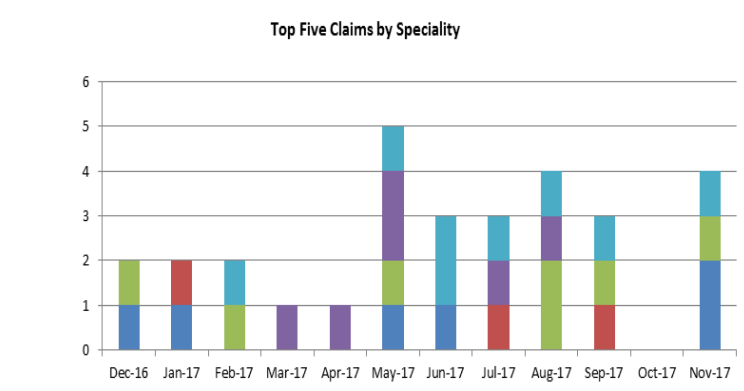
3 new claims were received which relate to the Trust's top five specialties for claims.

General Surgery: Alleged 12 month delay in diagnosing breast cancer.

Orthopaedics: On leaving theatre the claimant's hand was caught in the theatre doors causing a small laceration to her finger.

Orthopaedics and Emergency Department

Alleged negligent treatment of tibial spine fracture to left knee resulting in the need for additional sugery.



	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17
General Surgery	0	0	1	0	0	1	2	1	1	1	0	1
Obstetrics	0	0	0	1	1	2	0	1	1	0	0	0
Emergency Dept	1	0	1	0	0	1	0	0	2	1	0	1
Ophthalmology	0	1	0	0	0	0	0	1	0	1	0	0
Orthopaedics	1	1	0	0	0	1	1	0	0	0	0	2

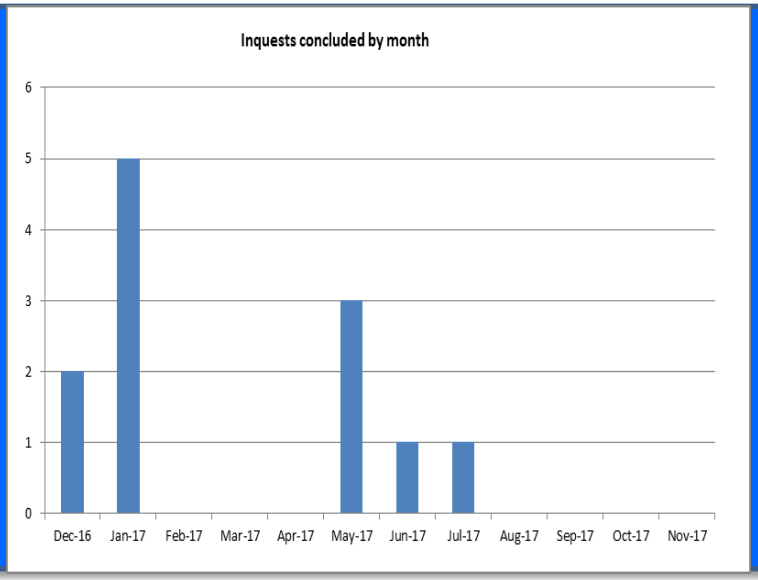
Top 5 Claims by Specialty

Board Papers – Quality, Safety & Experience Section: January 2018

Description	Aggregate Position/Description	Trend

Number of Inquests concluded by month

No inquests were concluded in November 2017.

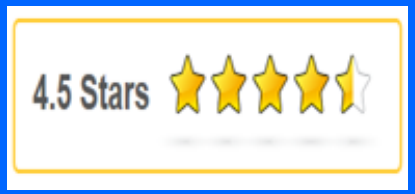


Inquests

NHS Choices Star Ratings

The ratings are based on 226 postings received to date.

Leighton Hospital is rated at 4.5 stars.



Victoria Infirmary, Northwich is rated at 5 stars.

NHS Choices – Star Ratings

Board Papers – Quality, Safety & Experience Section: January 2018

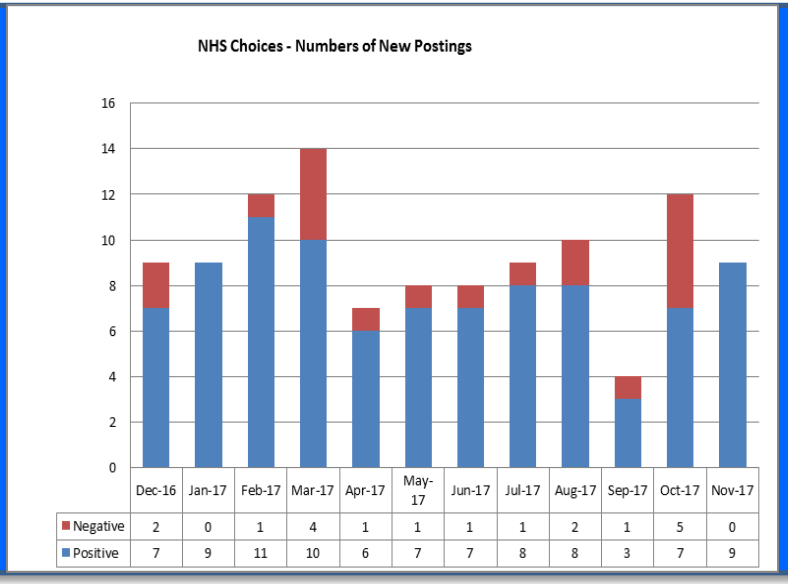
Description	Aggregate Position /description	Trend

NHS Choices postings

There were 9 postings on NHS Choices in November 2017 of which none were negative and 9 were positive. Examples of feedback included:

"Walked in 10.20 Monday morning checked in, assessed, x-rayed, treated, Physio arranged for next day and back home by 11.35. Brilliant service, very friendly professional staff, always my first choice for minor a&e issues for me and my family over the last 10 years. A credit to the NHS" Minor Injuries VIN

"I visited the treatment centre today for a procedure. I found all the staff to be friendly and courteous. The team who carried out the procedure were caring, efficient and professional. Feel lucky to have such a fantastic hospital close by" Treatment Centre



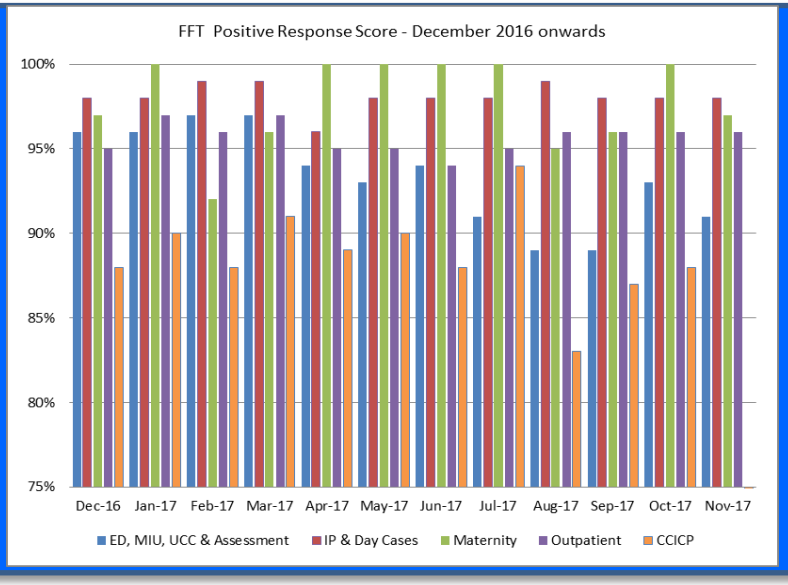
NHS Choices - Postings

The Family and Friends Test asks patients if this would recommend our hospital services to a friend or relative based on their treatment and experience

In November 2017 the Trust has scored the following positive response scores :

Inpatients and day cases	98%
Emergency care /Assessment areas	91%
Outpatients	96%
Maternity	97%
CCICP	88%

3072 responses were received and 95% of those patients would recommend our hospital services.

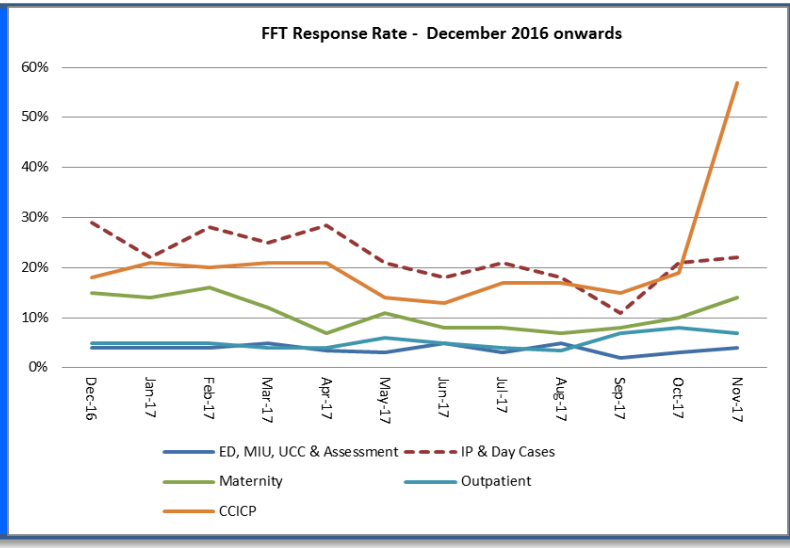


Family & Friends Test

Description | **Aggregate Position** | **Trend**

Number of responses received for IP, Day Case, ED, maternity compared to eligible patients

November 2017 Ward/Dept	% Response	Total Responses received	How many would recommend
A&E , UCC & MIU	4%	189	172
Inpatients & Daycases	22%	908	889
Maternity	14%	38	37
Outpatients	7%	1498	1433
CCICP	57%	330	292



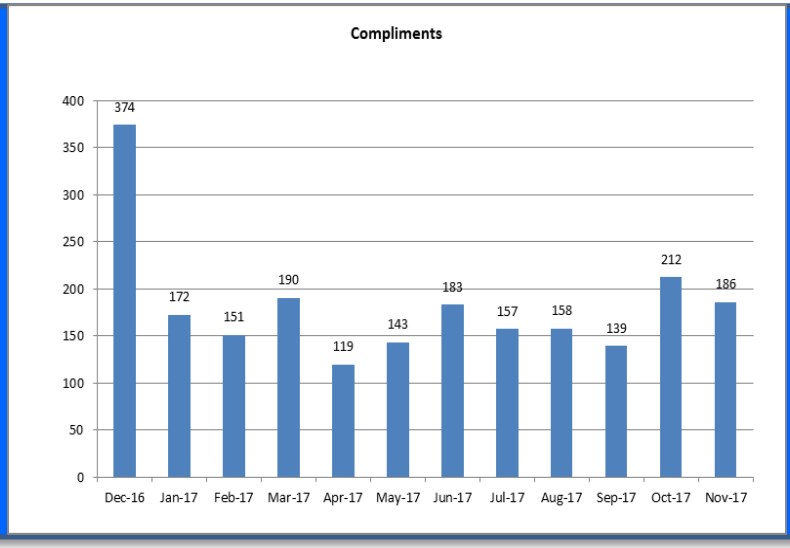
Family & Friends Test

Compliments received

There were 186 compliments/thank-you's received for November 2017:

'I have recently being recovering from a shoulder injury and I just wanted to thank all the people involved in my speedy recovery including staff in the fracture clinic and, in particular, the physiotherapist, who has done an outstanding job.'

'I came to the emergency department after treading on a nail. I was processed, seen, advised and out within 15 minutes. Best service ever. Thank you very much!'



Compliments

Title of Paper :	Quality Matters Assurance Framework and CQC Briefing Paper.	
Author:	Associate Director-Integrated Governance	
Executive Lead:	Medical Director	
Type of Report:	Concept Paper	
	Strategic Options Paper	
	Business Case	
	Information	
	Review/Benefits/Audit	✓

Link to Strategic Domains:		***Link to CQC Domain:***	
Delivering Outstanding Clinical Quality, Safety & Experience	✓	Safe	✓
Being a Leading partner in a Progressive Health Economy	✓	Effective	✓
Striving for Outstanding Organisational Effectiveness	✓	Caring	✓
Aspiring to Excellence in Practice Through Our Workforce	✓	Responsive	✓
Creating a 21st Century Infrastructure for Transformative Health and Social Care	✓	Well-Led	✓

Link to Board Responsibility:	Performance	✓
	Accountability	✓
	Strategy	✓
	Implementation	✓
Action Required:	Decide	
	Approve	
	Note	✓
	Recommend	
	Delegate	

Positive Benefit:	A Quality Matters Assurance Framework which links our systems and processes, forming the basis of the new Quality & Safety Improvement Strategy from April 2018. CQC briefing paper confirming approximate timings and overview of the inspection process.
Risk:	Lack of a succinct framework to develop the new Quality & Safety Improvement Strategy. Lack of Board oversight regarding the CQC inspection regime following receipt of the Provider Information Request (PIR).

To be published on Trust Website – complete version	***Yes***
If no, to be published on Trust Website – redacted	
If not to be published complete or redacted, please detail the reason why	
Presented at Board Meeting of:	8 January 2018

Quality Matters Assurance Framework & Care Quality Commission Update

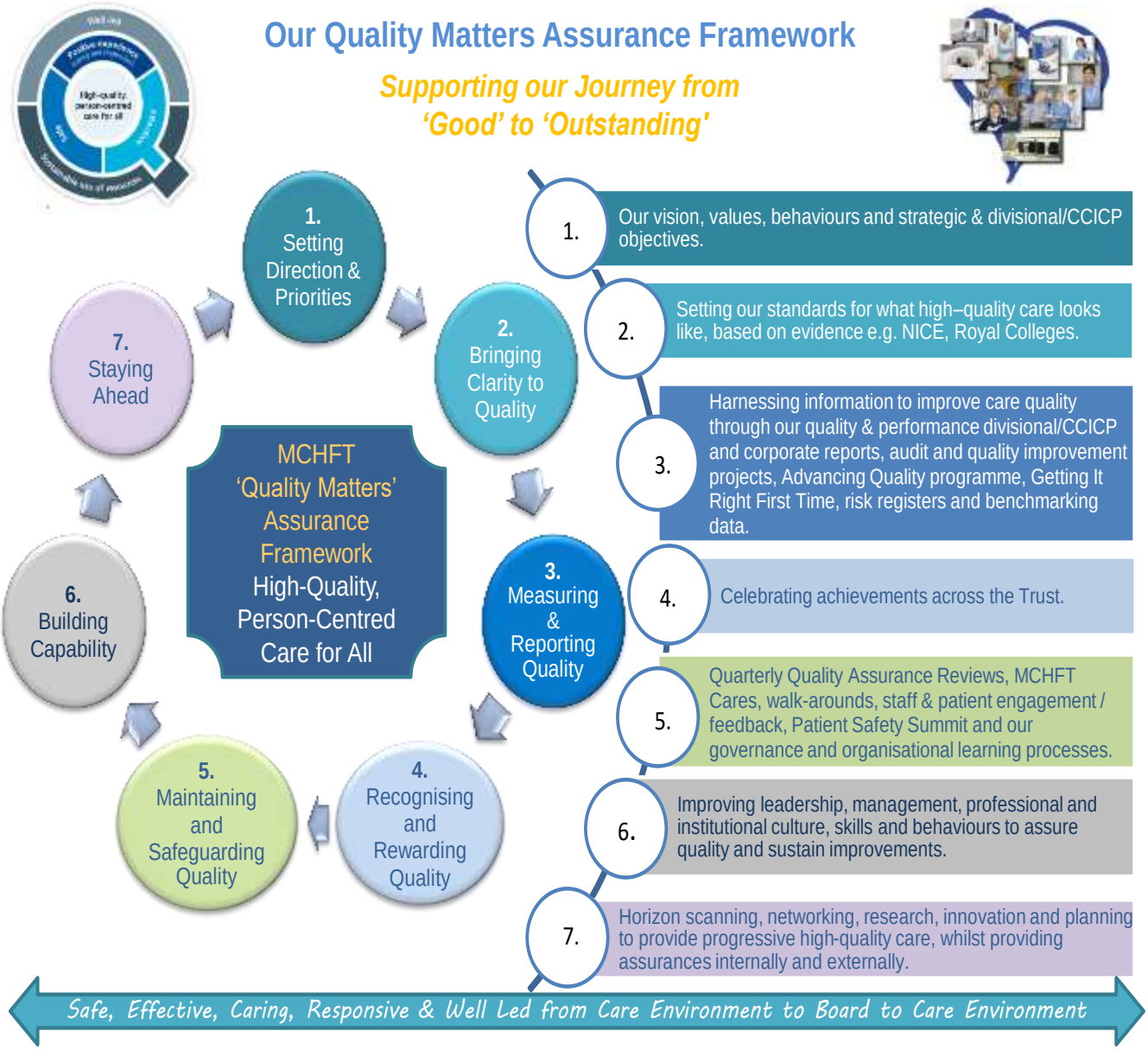
Briefing Paper

January 2018

'Delivering Excellence in Healthcare through Innovation and Collaboration'

1. Quality Matters Assurance Framework

The Trust's Quality and Safety Improvement Strategy 2016/18 is due for renewal by March 2018. Using the same approach as our key current strategy our quality priorities will be developed in collaboration with clinical teams, commissioners and wider stakeholders, drawing upon local data and information and national drivers. The diagram below provides an overview of a suggested Quality Matters Assurance Framework (QMAF), which following approval would form the basis of the new strategy and the subsequent development of an annual delivery plan. The revised strategy will support the delivery of the *Trust Strategy 2017/18 with 2020/21 Horizon* and will align with the Trust's other enabling strategies including workforce, organisational development, risk management and performance management. Additionally, the outputs and outcomes of the strategy will seek to provide assurances both internally through the governance structure and externally to commissioners and regulators.



2. Care Quality Commission (CQC) Update

On 20 November 2017 the Trust received a Provider Information Request (PIR) with the requirement to submit the completed document by 12 December 2017. The information requested included an extensive range of both quantitative and qualitative information spanning all of the CQC Domains (Safe, Effective, Caring, Responsive and Well-Led). The inspections going forward will be annual and will involve inspecting the five key questions in at least one core service, followed by an inspection of Well-Led. The number of core services inspected will vary for each organisation. Most core (and additional) service inspections will normally be unannounced to enable the CQC to observe routine activity. In some cases they may give a short notice period, for example when the service is delivered over a large geographical area.

The inspection of the Well-Led key question at trust level will follow the core service(s) inspection. This will be announced after the Regulatory Planning Meeting to give the CQC time to schedule the appropriate interviews. On-site activity will take approximately two days. This assessment focuses on Well-Led at trust level, and draws on wider knowledge of quality in the trust at all levels. Following the submission of the PIR the timeline for inspection is detailed below and therefore the Trust will undergo inspection by May 2018.

The Trust has a CQC relationship manager and the last meeting was held on 21 December 2017. Discussions included the logistics of the unannounced inspection of three or four core acute services and the approach if CCICP were inspected (48 hours' notice period is provided).

3. Next steps:

- Work is progressing as planned to revise the current divisional/CCICP and ward/departmental quality data and information, supporting the delivery of the new strategy with oversight at Quality Summit which next meets in January 2018;
- Implementation of the revised Executive Led quarterly quality matters assurance reviews by February 2018;
- Review of the PIR submission and lessons learnt to be discussed at Quality Summit in January 2018; and
- Consultation and development of the new Quality & Safety Improvement Strategy 2018/20, with a launch date of April 2018 with subsequent monitoring of improvement measures through the governance structure.

Mid Cheshire Hospitals NHS
NHS Foundation Trust

Board of Directors Performance Report

November 2017

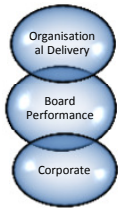
"To Deliver Excellence in Healthcare through Innovation & Collaboration"

Introduction

Performance Report

The MCHT Monthly Performance Report has been developed to integrate key domains of Quality and Safety, Performance and Corporate into one consistently presented report. It has been developed to provide an over arching view of performance against Trust priorities as set out in the NHS Improvement Compliance Framework, NHS Operating Framework, CCG CQuIN and Annual Plan.

The Monthly Performance Report will focus upon delivery of service improvements within 3 key domains:



The delivery of the service improvements within the 3 key domains are also reflected in the Board Assurance Framework which identifies where the organisation has insufficient assurance in delivering the strategic objectives of the organisation.
Within this Performance Report the indicators within each domain are presented on a summary page with the current month and year to date performance given. All indicators are measured against a NHS Improvement, national, peer or locally agreed target. A further analysis of all measures within each domain is then provided with supporting trend information and narrative. Performance against each indicator is rated as either red/green against the year to date or single month/quarter target as appropriate. Supporting narrative is provided on an exception basis.

This report is an evolving summary of overall Trust Performance, therefore measures, targets and reporting periods will be refined over time. A supporting and more detailed quality and safety report will be presented separately. This is also under further review.

Tracy Bullock
Chief Executive

Contents

Headline Measures

Organisational Delivery				
Indicator	**Standard**	**YTD**	**Nov-17**	
Cancer				
Rapid Access Referrals (%) *(seen in 2 wks)*	93.00%	97.50%	99.19%	
Total Patients Seen		*5,964*	*741*	
Patients seen >14 days		*149*	*6*	
62 day GP Classic (%)	85.00%	94.32%	94.39%	*
Accountable Patients Treated		*467*	*54*	
No. of Breached Pathways (adjusted)		*27*	*3*	
62 day Screening (%)	90.00%	95.72%	93.94%	*
Accountable Patients Treated		*94*	*17*	
No. of Breached Pathways (adjusted)		*4*	*1*	
Unplanned Activity				
A&E <4hrs Standard (%)	95.00%	92.04%	88.05%	
A&E Attendances (LH/MIU/UUC) (% to plan)		96.43%	92.90%	
A&E Attendances LH & MIU (Vol)		*58,917*	*7,120*	
Planned Activity				
Incomp Pathways <18wk (%)	92.00%	96.97%	96.53%	
>6wk Diagnostic Waits (%)	1.00%	0.30%	0.29%	
Total Patients Waiting for a First Outpatient Appointment			7,913	

** Provisional figures subject to change depending on further validation or treatment outcome*

Indicator	Standard	YTD
Workforce		
Sickness absence Rolling 12 Month		4.23%
Turnover Rolling 12 Month		10.93%

Corporate					
	YTD Rating		YE Rating	YE Metric	
Indicator	**Plan**	**Actual**	**Forecast**	**Plan**	**Forecast**
Finance					
Use of Resource Rating		3	3		
Capital Service Capacity	4	4	4	0.76	0.56
Liquidity	4	3	3	-23	-14
I&E Margin	2	2	2	0.38%	0.40%
Distance from Financial Plan	0	1	1	0.00%	0.02%
Agency Spend	1	1	1	-10.22%	-33.65%

	YTD Target	YTD Actual	YTD Variance	FY Target	FY Forecast	FY Variance
Cost Improvement Schemes Total (£000's)	3,298	2,641	-656	4,922	4,106	-817
Capped Expenditure Process Schemes (£'000)	2,880	2,315	-565	7,062	6,616	-446
Commission Contact Income SC & VR (£000's)	125,158	125,158	0			
Contract Income (£'000)	147,859	148,014	154			
Pay to Budget (£000's)	-110,048	-110,475	-427			
Non Pay to Budget (£000's)	-46,700	-46,525	175			
Agency Trajectory (£000's)	-3,871	-2,769	1,102			

Exec Summary

In November 2017, the Trust delivered four of the five NHS Improvement Single Oversight Framework performance indicators. The indicator not achieved was The 4 hour A&E waiting time target.

The 4-hour A&E standard in November achieved 88.05% against the 95% performance standard. This is a deterioration in performance compared to the same month in 2016 (93.33%). November's performance also falls below the required 90.52% STF performance trajectory for the month.
The Trust has achieved all three headline cancer access standards for November. Strong performance continues in terms of rapid access referrals and 62 day treatment pathways. Cancer 62 day Screening achieved 93.94% with one breach recorded in November.

The Trust continues to achieve the 92% standard for RTT 18 week incomplete pathways, with performance in November 2017 at 96.53%. The Trust is continuing to monitor this standard, with specific reference to managing the level of 'over performance' being delivered against 92%. The month also saw the Trust achieve the Non-Admitted and Admitted RTT elements.

Diagnostics waiting times continue to perform well, with just 0.29% of patients waiting longer than 6 weeks for their diagnostic test against a regulatory threshold of 1%.

The UoRR metric is 3, primarily a consequence of the override resulting from the impact of the Trust's ability to service DH loans from revenues and depreciation. The forecast position is to achieve the control total and deliver the £0.7M surplus although it is expected liquidity will reduce as loans become repayable.

The Trust's I&E position is a surplus of £1.0M which is £0.3M worse than plan as at Month 8.

The SC & VR commissioning contracts represent the revised contract value in line with the agreed Capped Expenditure Process (CEP).

CIP schemes are behind plan by £0.7M due to the no longer proceeding e-rostering scheme and infusion pump consumable savings not materialising. Income generation schemes have been removed in light of the CEP leading to fixed income for the Trust. In addition, CEP schemes are £0.6M worse than plan due to scheme slippage However, to date combined savings of £5.0M have been achieved.

The Trust is currently £1.1M better than its Agency spend trajectory which for the full year is £6.2M.

Single Oversight Framework

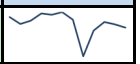
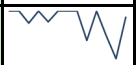
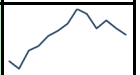
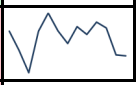
Triggers

Operational	For providers with Sustainability and Transformation Fund (STF) trajectories in any metric: failure to meet the trajectory for this metric for at least two consecutive months (quarterly for quarterly metrics), except where the provider is meeting the NHS Constitution standard.
Finance & Resource	Poor levels of overall financial performance (avg score of 3 or 4). Very poor performance (score of 4) in any individual metric. Potential value for money concerns.

The Trust's operational trigger rating continues as RED as a result of failure of a primary target during the year (A&E 95% 4-hour waiting time),despite the quarterly STF trajectory being achieved.

The Trust has a Use of Resource rating of 3 cumulative and is forecasting a rating of 3 for the full year. This results in a 'trigger' on the Finance & Resource theme. This is primarily driven by the loans required to support liquidity . The Trust is worse than plan for its I&E margin ytd but is expected to meet its control total plan by year end. The Agency trajectory target is currently better than plan.

Operational Performance

	Current YTD		Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Monthly Trend
	Target	Actual														
Maximum 6 week wait for Diagnostic procedures	1%	0.30%	0.13%	0.24%	0.18%	0.07%	0.09%	0.04%	0.17%	0.44%	0.76%	0.34%	0.21%	0.24%	0.29%	
All Cancers: 62 day GP Classic (%) *	85%	94.32%	92.00%	90.24%	90.43%	86.41%	96.46%	96.83%	92.81%	94.00%	93.04%	95.08%	91.67%	95.71%	94.39%	
All Cancers: 62 day Screening (%) *	90%	95.72%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	85.71%	100.00%	91.67%	83.33%	93.94%	
18 weeks from point of referral to treatment - patients on an incomplete pathway (%)	92%	96.97%	95.46%	95.16%	95.89%	96.07%	96.48%	96.69%	96.98%	97.57%	97.37%	96.78%	97.10%	96.79%	96.53%	
A&E - maximum waiting time of 4 hours from arrival to admission/transfer/discharge (%)	95%	92.04%	93.33%	89.25%	84.47%	93.33%	97.21%	93.37%	90.66%	94.24%	92.63%	95.26%	93.99%	88.28%	88.05%	
A&E STF Trajectory			0.00%	0.00%	0.00%	0.00%	0.00%	91.72%	91.72%	91.72%	91.34%	91.34%	91.34%	90.52%	90.52%	

** Provisional figures subject to change depending on further validation or treatment outcome*

Financial & Resource

		Unit	YE Plan	YE Forecast	YE Rating	YTD Plan	YTD Actual	YTD Rating
Financial Sustainability	Capital Service Capacity	0.0x	0.76	0.56	4	0.55	0.47	4
	Liquidity	days	-23	-14	3	-21	-8	3
Financial Efficiency	I&E Margin	%	0.38%	0.40%	2	0.03%	0.72%	2
Financial Controls	Distance from Financial Plan	%	0.00%	0.02%	1	0.00%	0.69%	1
	Agency Spend	%	-10.22%	-33.65%	1	-8.92%	-34.80%	1
Overall UOR Rating					3			3

Operational Delivery: *Cancer Pathway*

Headline Measures

	Current YTD		Rolling 13 months											
	Target	Actual	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Monthly Trend
Rapid Access Referrals (%) (seen in 2 wks)	93%	97.50%	98.79%	98.93%	97.66%	99.15%	98.10%	97.14%	97.84%	97.20%	97.51%	97.35%	96.82%	96.94%	99.19%	
Total Patients Seen		*5964*	*743*	*652*	*641*	*706*	*842*	*665*	*742*	*785*	*763*	*793*	*723*	*752*	*741*	
Patients seen >14 days		*149*	*9*	*7*	*15*	*6*	*16*	*19*	*16*	*22*	*19*	*21*	*23*	*23*	*6*	
% seen within 7 days		*52.2%*	*62.0%*	*51.1%*	*69.1%*	*54.3%*	*63.1%*	*55.6%*	*53.5%*	*48.7%*	*44.2%*	*46.2%*	*64.7%*	*54.8%*	*51.4%*	
62 day GP Classic (%) *	85%	94.32%	92.00%	90.24%	90.43%	86.41%	96.46%	96.83%	92.81%	94.00%	93.04%	95.08%	91.67%	95.71%	94.39%	

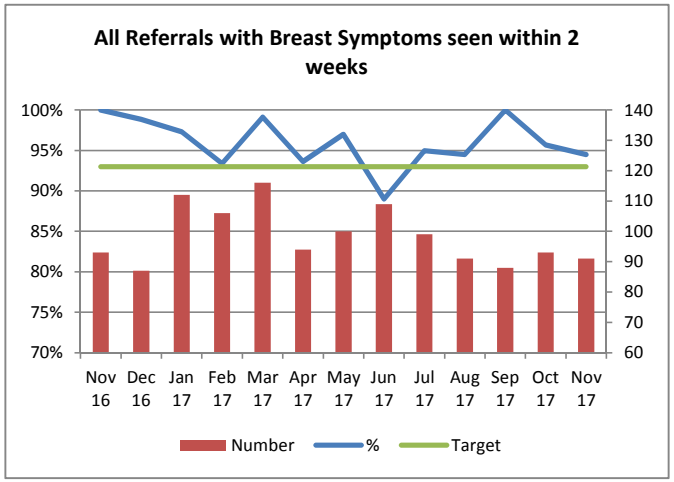
** Provisional figures subject to change depending*

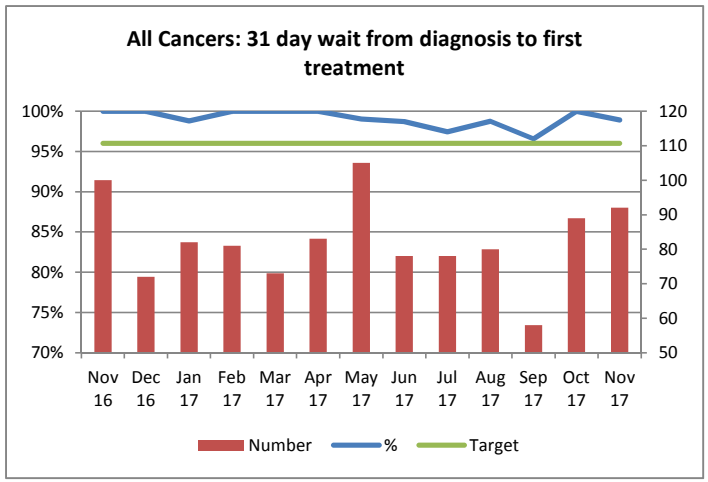
Commentary

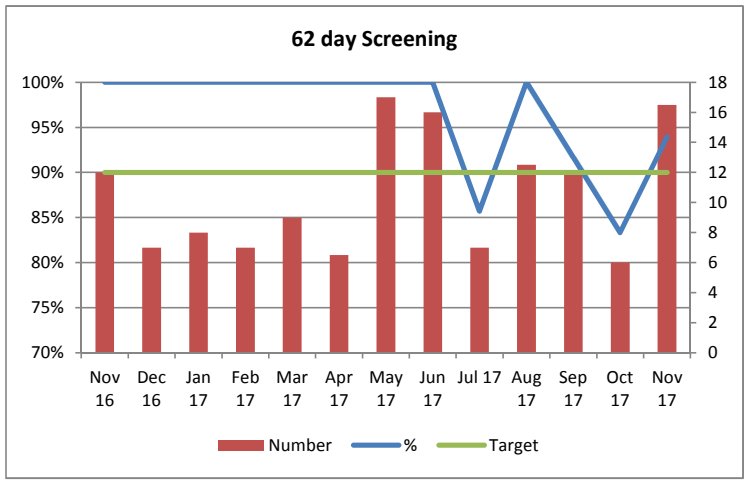
The Trust has achieved all three headline cancer standards during the month of November 2017. The figures presented in this paper reflect the Trust's regulatory performance measures (adjusted figures that take into account breach reallocation between providers).

The Trust has continued it's strong performance against the Rapid Access referrals standard, achieving 99.19% in November. In previous months the Trust had seen a 5% increase in patients seen compared to the previous year, however this month has seen no growth on November 2016.
The 2 week Breast Symptomatic standard has sustained its performance and continues to achieve above the 93% standard. The screening 62 day standard was not met in October but achieved in November with one breach. The standard continues to be met on a year to date basis.

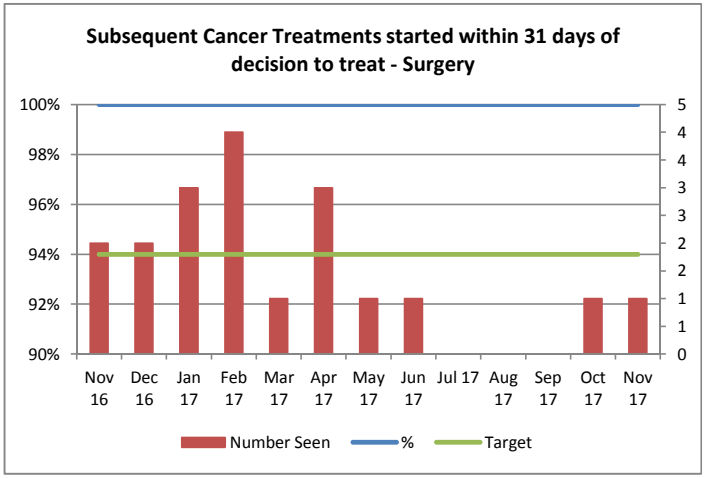
Primary Measures

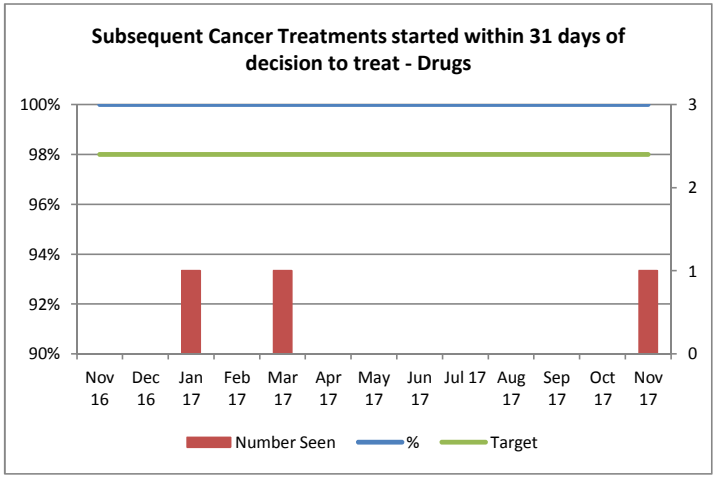


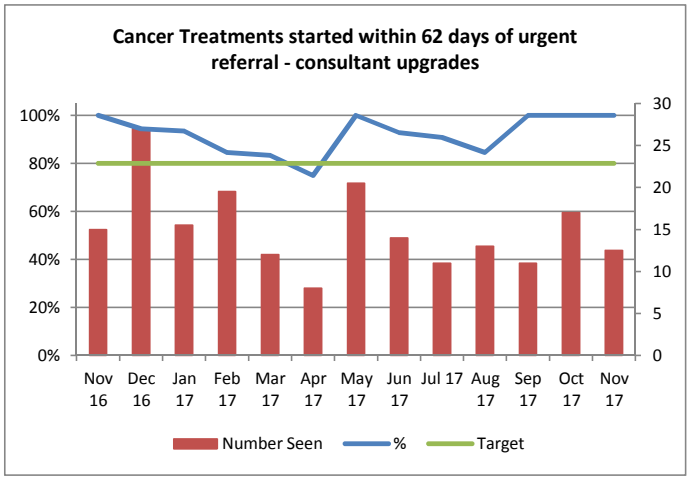




Operational Delivery: *Cancer Pathway*







Operational Delivery: *Unplanned Activity - A&E*

Headline Measures

	Current YTD		Rolling 13 months											
	Target	Actual	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Monthly Trend
A&E - >4 hr wait time from arrrival to admission/ transfer/ discharge (% to Target)	95%	92.04%	93.33%	89.25%	84.47%	93.33%	97.21%	93.37%	90.66%	94.24%	92.63%	95.26%	93.99%	88.28%	88.05%	
No. of 4hr breaches		*4,692*	*443*	*753*	*1,082*	*411*	*205*	*474*	*737*	*437*	*567*	*332*	*422*	*872*	*851*	

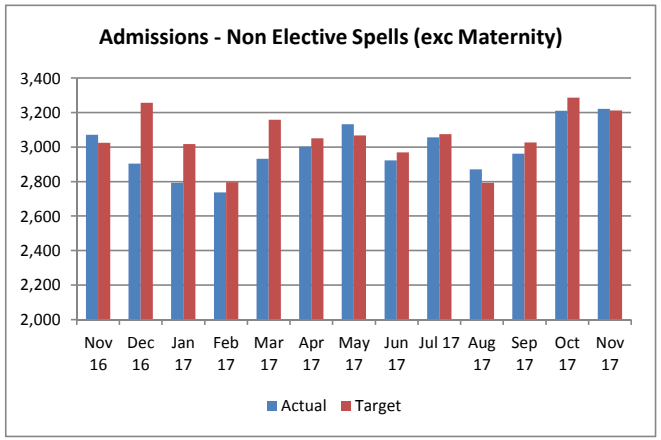
	Plan	Actual	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Monthly Trend
A&E Attendances (LH/MIU/UUC) (% to Plan)		*96.43%*	*97.2%*	*100.5%*	*103.7%*	*95.1%*	*98.5%*	*98.2%*	*101.8%*	*99.9%*	*96.3%*	*93.1%*	*97.1%*	*99.8%*	*92.9%*	
A&E Attendances (LH/MIU/UUC) (No.)	*59,845*	*58,917*	*6,643*	*7,005*	*6,965*	*6,166*	*7,357*	*7,144*	*7,890*	*7,593*	*7,697*	*7,011*	*7,023*	*7,439*	*7,120*	
A&E Attendance Case Mix — *Major*		*13,642*	*1,428*	*1,693*	*1,710*	*1,405*	*1,579*	*1,652*	*1,740*	*1,727*	*1,743*	*1,769*	*1,724*	*1,688*	*1,599*	
Minor		*25,580*	*3,107*	*3,137*	*3,116*	*2,678*	*3,167*	*3,141*	*3,442*	*3,421*	*3,345*	*3,152*	*2,939*	*3,198*	*2,942*	
Paediatrics		*12,044*	*1,332*	*1,218*	*1,223*	*1,183*	*1,631*	*1,433*	*1,674*	*1,568*	*1,626*	*1,182*	*1,416*	*1,588*	*1,557*	
Resus		*7,651*	*776*	*957*	*916*	*900*	*980*	*918*	*1,034*	*877*	*983*	*908*	*944*	*965*	*1,022*	

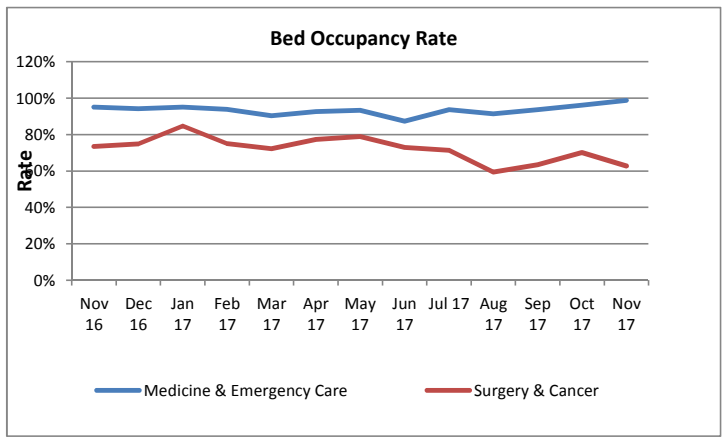
Commentary

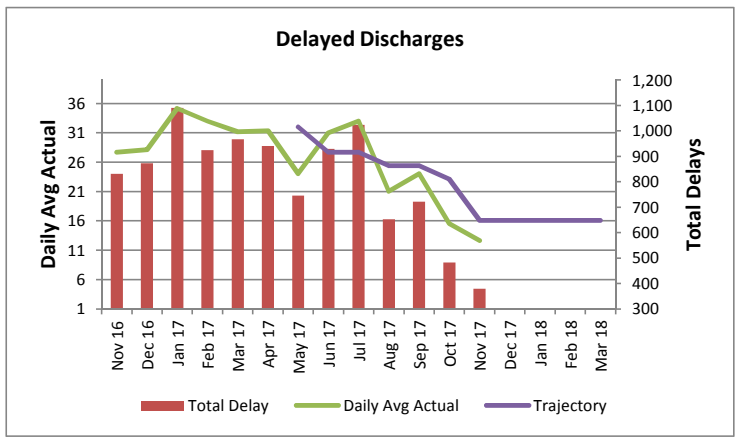
ED attendances in November saw a rise of 7% on the same period last year. The Trust achieved 88.05% against the 4-hour access standard in November and the STF trajectory of 90.52% for the month has therefore not been achieved . The Board are advised that the Trust delivered November 2017 performance with 25 fewer acute medical beds open than in November 2016, due to implementation of the efficiencies associated with the Trust's Access & Flow Transformation Programme. Poor performance was driven by an increase in ambulance arrivals at A&E and a higher acuity of patient.

Non elective admissions were above target in November and had a conversion rate from A&E at 39% (the highest seen this year). Bed occupancy rose in Medicine & Emergency Care leading to the number of medical patients on non medical wards in November reaching a high of 17. Delayed transfers of care decreased markedly since July and this trend has continued into November. The trajectory set to reduce to a daily average target of 16 reportable delays by November has been met.

Primary Drivers

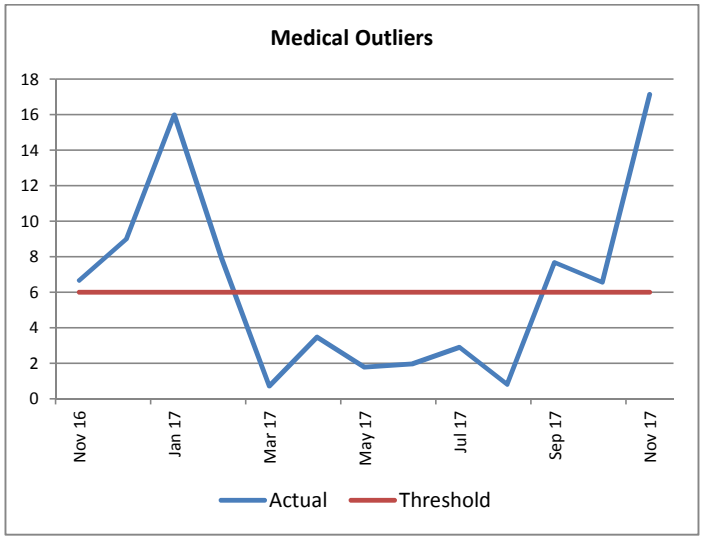


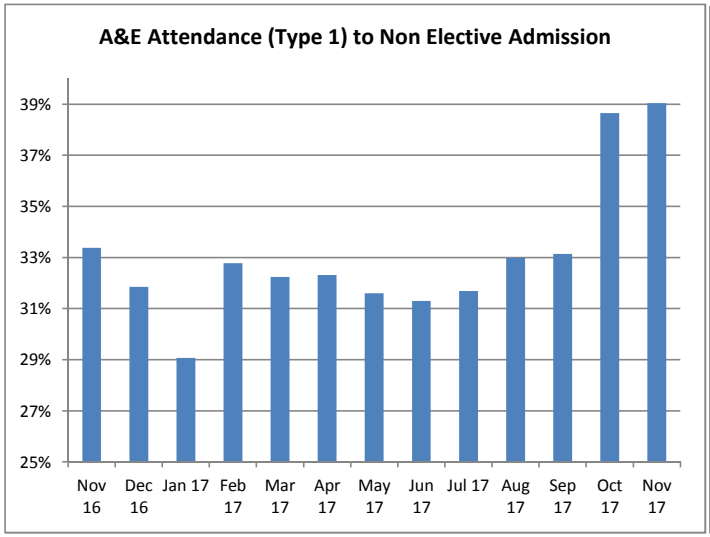


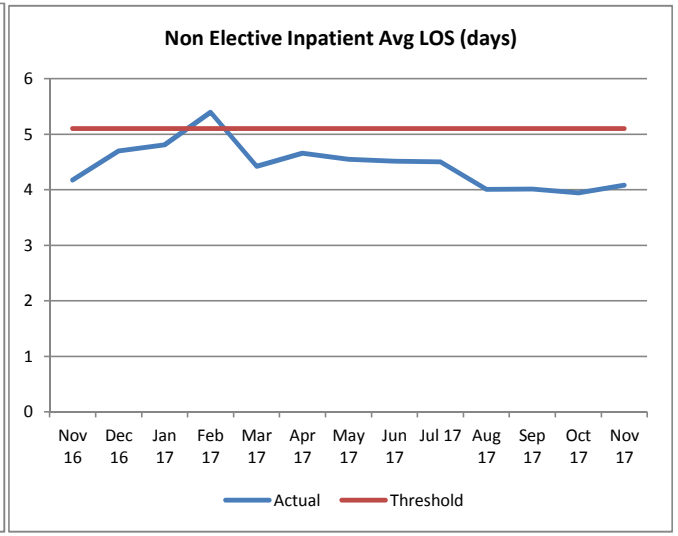


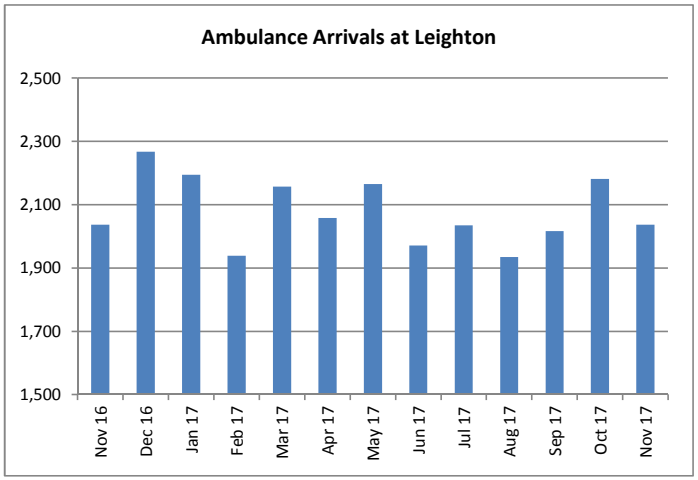
Operational Delivery: *Unplanned Activity A&E*

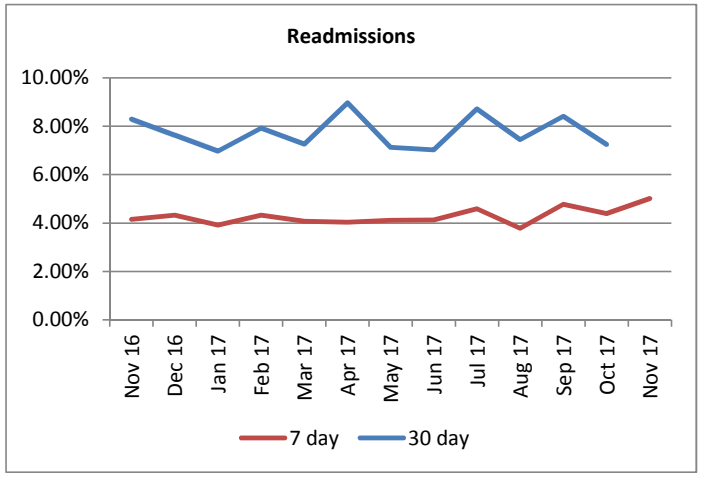
Secondary Drivers

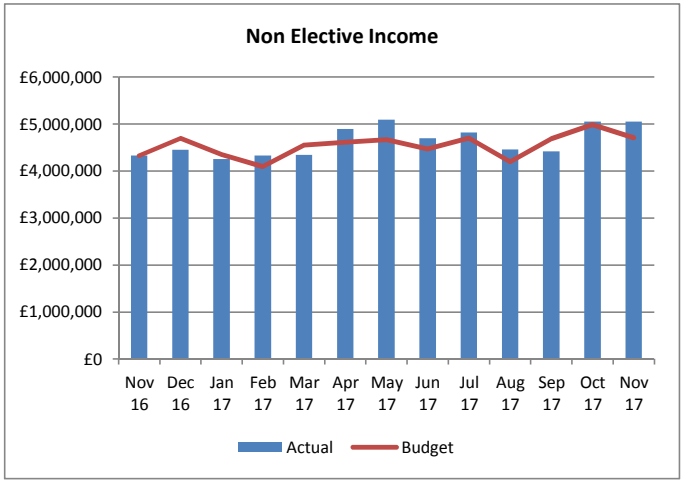












Operational Delivery: *Planned Activity*

Headline Measures

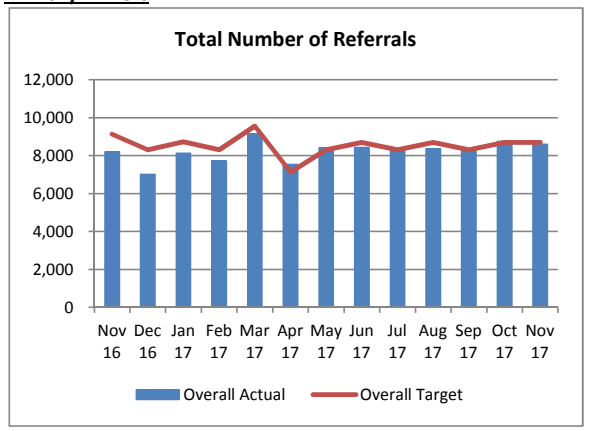
	Current YTD		Rolling 13 months											
	Target	Actual	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Monthly Trend
18 weeks from Referral to Treatment in Aggregate - Incomplete	92%	96.97%	95.46%	95.16%	95.89%	96.07%	96.48%	96.69%	96.98%	97.57%	97.37%	96.78%	97.10%	96.79%	96.53%	
Total 18 Weeks		*94,369*	*12,998*	*12,505*	*11,437*	*11,234*	*11,526*	*11,564*	*10,990*	*11,165*	*11,576*	*12,431*	*12,297*	*12,054*	*12,292*	
No. > 18 Weeks		*2,860*	*590*	*605*	*470*	*442*	*406*	*383*	*332*	*271*	*305*	*400*	*356*	*387*	*426*	
Diagnostic Waiting Time	1%	0.30%	0.13%	0.24%	0.18%	0.07%	0.09%	0.04%	0.17%	0.44%	0.76%	0.34%	0.21%	0.24%	0.29%	
Total Number of Waiters		*29,027*	*3,149*	*3,826*	*3,786*	*4,305*	*4,561*	*4,582*	*4,192*	*4,090*	*3,560*	*3,189*	*3,380*	*3,306*	*2,728*	
Waiters of 6 Weeks +		*88*	*4*	*9*	*7*	*3*	*4*	*2*	*7*	*18*	*27*	*11*	*7*	*8*	*8*	
Total Patients Waiting for a First Outpatient Appointment			8,359	7,842	7,205	7,812	7,057	7,223	7,172	7,352	7,643	8,029	7,808	7,731	7,913	
Longest Wait Time (weeks)												*40*	*42*	*42*	*37*	

Commentary

The Trust reported 96.53% against the 92% incomplete pathways standard for RTT. Community Paediatrics was failing the 92% target at the end of the month, with performance at 84.4%. The Division have a recovery plan in place which is monitored through PMG. General Surgery has achieved just under the 92% standard for November (91.85%). The Trust is now actively managing the level of over performance against this standard in light of the Capped Expenditure Programme with the aim of the over performance reducing over the coming months.

The Trust has delivered the diagnostic wait time consistently since July 2016. In November 2017, 0.29% of patients waited longer than 6 weeks for their diagnostic tests. All modalities delivered the standard, however significant outsourcing continued in medical imaging to support this position.
After a period of GP Referrals being consistently under target, the last three months have seen an increase with numbers meeting the target set. Comparatively GP referrals in November 2017 were 7.2% higher than November 2016.

Primary Drivers

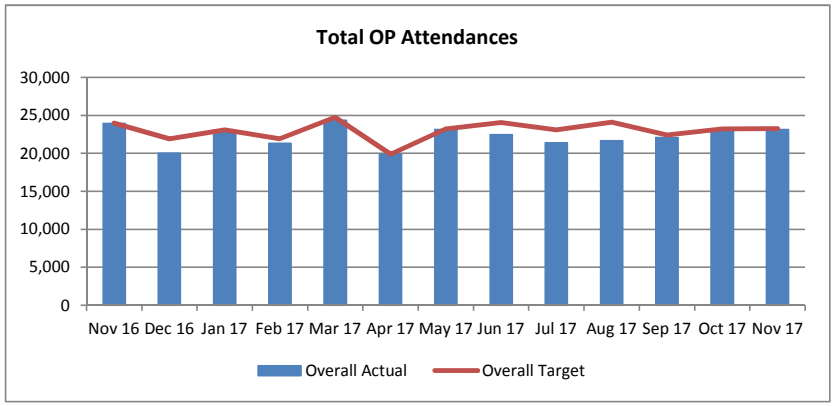


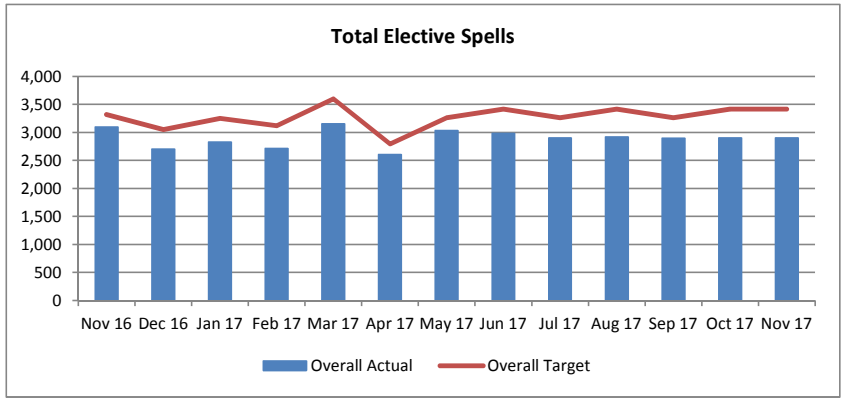
Referral Breakdown

	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Monthly Trend
GP Actual	5,061	4,192	4,930	4,592	5,534	4,427	4,779	5,248	5,115	5,211	5,277	5,506	5,424	
GP Target	5,767	5,243	5,505	5,243	6,029	4,507	5,259	5,509	5,259	5,509	5,259	5,509	5,509	
% to Target	87.8%	80.0%	89.6%	87.6%	91.8%	98.2%	90.9%	95.3%	97.3%	94.6%	100.3%	99.9%	98.5%	
Other Actual	3,135	2,821	3,200	3,126	3,621	3,100	3,632	3,179	3,191	3,156	2,969	3,251	3,166	
Other Target	3,376	3,069	3,222	3,069	3,529	2,614	3,050	3,195	3,050	3,195	3,050	3,195	3,195	
% to Target	92.9%	91.9%	99.3%	101.9%	102.6%	118.6%	119.1%	99.5%	104.6%	98.8%	97.4%	101.8%	99.1%	
Total Actual	8,196	7,013	8,130	7,718	9,155	7,527	8,411	8,427	8,306	8,367	8,246	8,757	8,590	
Total Target	9,143	8,312	8,728	8,312	9,559	7,121	8,308	8,704	8,308	8,704	8,308	8,704	8,704	
% to Target	89.6%	84.4%	93.2%	92.9%	95.8%	105.7%	101.2%	96.8%	100.0%	96.1%	99.3%	100.6%	98.7%	
GP % of Total	61.7%	59.8%	60.6%	59.5%	60.4%	58.8%	56.8%	62.3%	61.6%	62.3%	64.0%	62.9%	63.1%	

Operational Delivery: *Planned Activity*

Primary Drivers



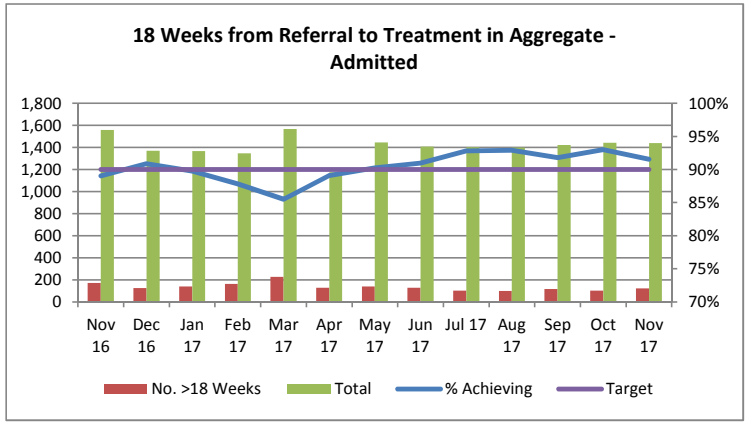


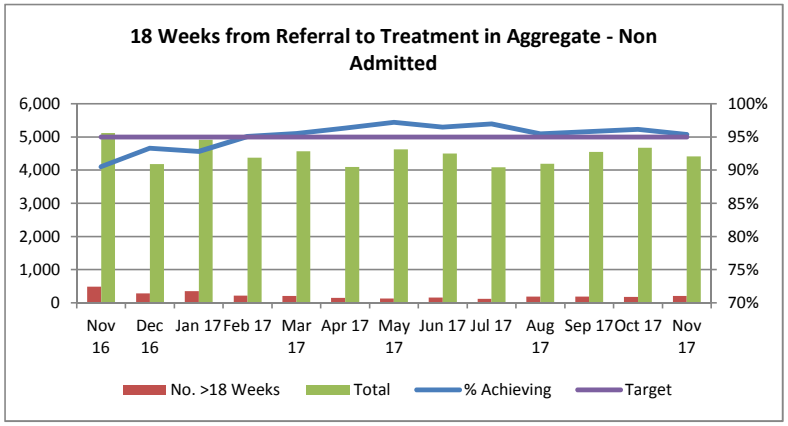
OP Attendance Breakdown	YTD	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Monthly Trend
New Actual	86,273	7,305	6,202	6,811	6,243	7,110	5,727	6,787	6,746	6,192	6,421	6,821	6,988	6,920	
New Target	92,452	7,408	6,747	7,138	6,791	7,764	6,098	7,113	7,423	7,098	7,427	6,941	7,250	7,253	
% to Target	93.3%	98.6%	91.9%	95.4%	91.9%	91.6%	93.9%	95.4%	90.9%	87.2%	86.5%	98.3%	96.4%	95.4%	
F U Actual	203,217	16,631	13,820	16,223	15,063	17,229	14,147	16,325	15,723	15,181	15,236	15,240	16,172	16,227	
F U Target	206,295	16,549	15,170	15,958	15,098	16,983	13,765	16,118	16,623	15,967	16,663	15,462	15,955	15,987	
% to Target	98.5%	100.5%	91.1%	101.7%	99.8%	101.4%	102.8%	101.3%	94.6%	95.1%	91.4%	98.6%	101.4%	101.5%	
Total Actual	289,490	23,936	20,022	23,034	21,306	24,339	19,874	23,112	22,469	21,373	21,657	22,061	23,160	23,147	
Total Target	298,748	23,957	21,917	23,096	21,889	24,747	19,862	23,231	24,046	23,065	24,090	22,403	23,205	23,240	
% to Target	96.9%	99.9%	91.4%	99.7%	97.3%	98.4%	100.1%	99.5%	93.4%	92.7%	89.9%	98.5%	99.8%	99.6%	
New % of Total	29.8%	30.5%	31.0%	29.6%	29.3%	29.2%	28.8%	29.4%	30.0%	29.0%	29.6%	30.9%	30.2%	29.9%	

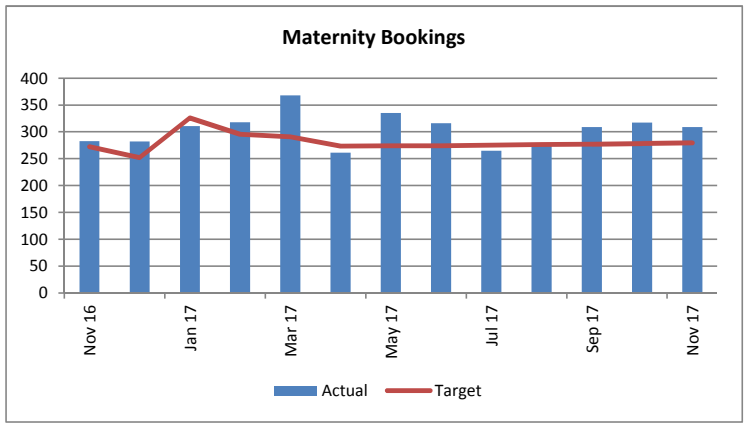
Elective Spells Breakdown	YTD	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Monthly Trend
I P Actual	3,752	324	258	210	304	342	260	307	294	266	298	279	299	311	
I P Target	4,451	369	335	359	342	393	281	330	346	330	346	330	346	346	
% to Target	84.3%	87.9%	77.0%	58.5%	88.8%	87.1%	92.4%	93.1%	85.1%	80.7%	86.2%	84.6%	86.5%	90.0%	
Daycase Actual	33,878	2,773	2,442	2,618	2,411	2,809	2,342	2,728	2,689	2,636	2,619	2,616	2,603	2,592	
Daycase Target	38,129	2,952	2,717	2,892	2,775	3,208	2,509	2,931	3,071	2,931	3,071	2,931	3,071	3,071	
% to Target	88.9%	93.9%	89.9%	90.5%	86.9%	87.6%	93.3%	93.1%	87.6%	89.9%	85.3%	89.3%	84.8%	84.4%	
Total Actual	37,630	3,097	2,700	2,828	2,715	3,151	2,602	3,035	2,983	2,902	2,917	2,895	2,902	2,903	
Total Target	42,580	3,321	3,052	3,252	3,117	3,601	2,791	3,260	3,417	3,260	3,417	3,260	3,417	3,417	
% to Target	88.4%	93.3%	88.5%	87.0%	87.1%	87.5%	93.2%	93.1%	87.3%	89.0%	85.4%	88.8%	84.9%	85.0%	
I P % of Total	10.0%	10.5%	9.6%	7.4%	11.2%	10.9%	10.0%	10.1%	9.9%	9.2%	10.2%	9.6%	10.3%	10.7%	

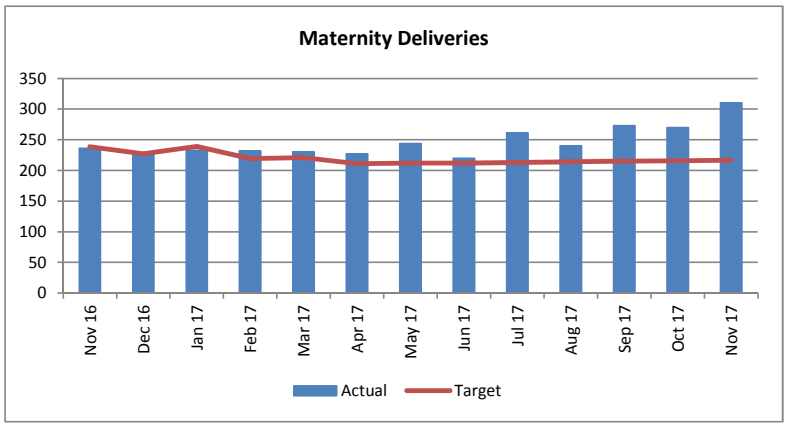
Operational Delivery: *Planned Activity*

Primary Drivers





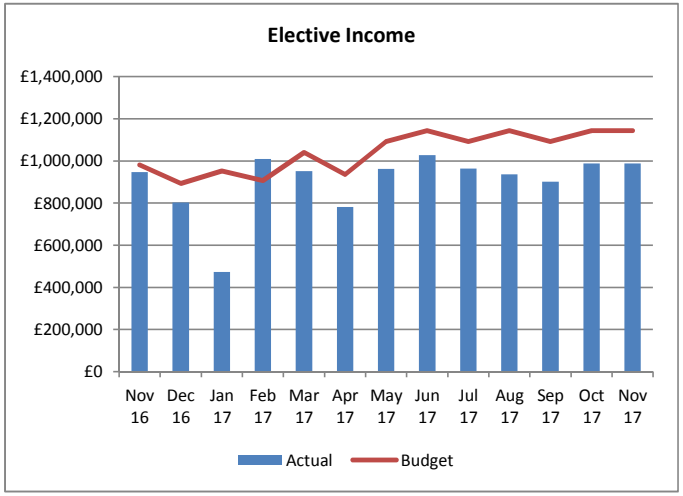


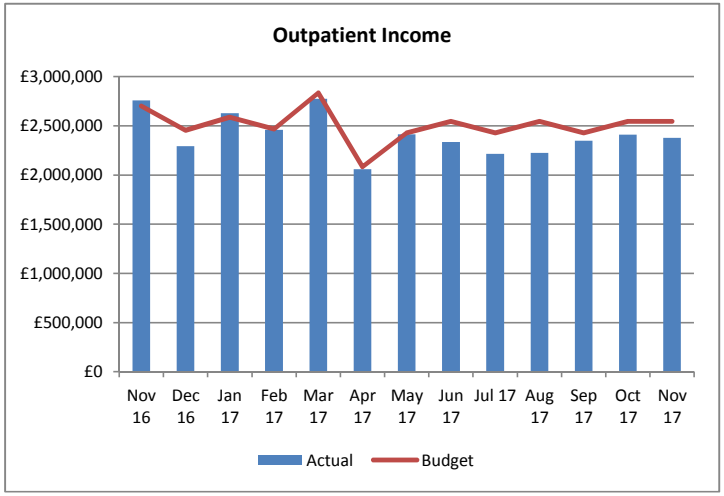


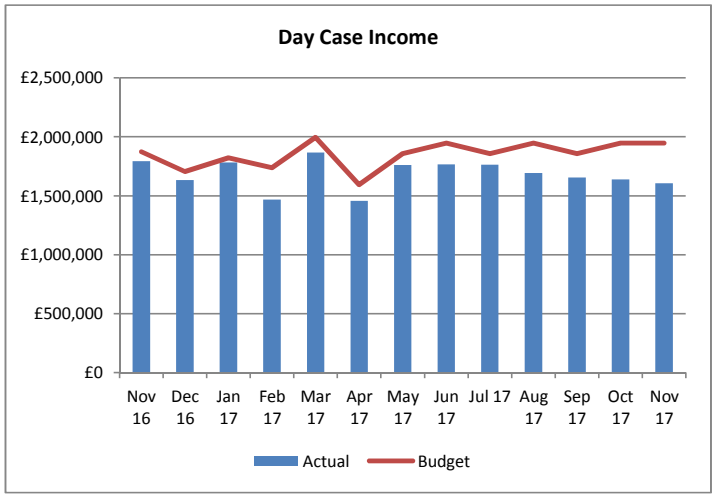
Operational Delivery: *Planned Activity*

Secondary Drivers

			Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Monthly Trend
Bed Occupancy Rate	Medicine & Emergency Care		95.2%	94.2%	95.2%	93.8%	90.3%	92.6%	93.3%	87.4%	93.7%	91.4%	93.8%	96.1%	98.8%	
	Surgery & Cancer		73.4%	74.9%	84.6%	75.1%	72.3%	77.3%	78.9%	72.9%	71.3%	59.3%	63.5%	70.1%	62.7%	
Elective Inpatient Avg LOS (Days)			2.3	3.3	2.1	2.8	2.4	3.4	2.9	3.1	3.7	2.5	2.3	2.4	2.7	
Delayed Transfers of Care (MFFD)		16.00	28	28	35	33	31	31	24	31	33	21	24	16	13	
Delayed Transfers of Care (% of Acute Beds)			5.7%	5.7%	6.9%	6.6%	6.3%	6.4%	4.9%	6.6%	7.1%	4.6%	5.2%	3.4%	2.7%	
Medical Outliers			7	9	16	8	1	3	2	2	3	1	8	7	17	
Readmission (Emergency Re-admissions after Planned Surgery)																
** reported from 16/17. One month delay*	30 Day Rate		3.14%	3.46%	3.27%	2.95%	0.27%	4.00%	3.05%	3.06%	2.76%	2.92%	3.12%	2.77%		
	7 Day Rate		1.37%	1.24%	1.75%	1.67%	1.40%	1.73%	1.56%	1.49%	1.05%	1.11%	1.44%	1.64%	1.23%	
Cancelled Operations - Non Clinical - Cancellation Rate			0.61%	2.12%	0.85%	1.25%	1.07%	1.30%	1.06%	0.80%	0.86%	0.40%	0.57%	1.31%	0.74%	
Theatre Efficiency																
	Main Theatres		75.7%	75.5%	71.4%	76.3%	76.2%	77.5%	79.5%	78.4%	77.9%	78.6%	80.5%	78.8%	77.0%	
	TC Theatres		73.9%	72.6%	72.1%	76.0%	75.3%	75.6%	79.6%	72.7%	75.0%	76.0%	71.5%	78.1%	75.5%	
DNA (OP Efficiency)			6.15%	6.28%	6.13%	5.44%	5.35%	5.86%	5.94%	6.63%	5.82%	5.82%	5.94%	5.62%	5.39%	
Hospital Cancellation Rate (OP Efficiency)			5.34%	5.56%	5.40%	5.73%	6.03%	6.57%	7.63%	7.51%	7.94%	7.58%	6.11%	6.27%	6.19%	







Financial Performance: Income & Expenditure Position - Aggregated

	Month			Year to Date			Forecast	Base Budget 17/18 £'000
	Plan Nov (£'000)	Actual Nov (£'000)	Variance Nov (£'000)	Plan Apr to Nov (£'000)	Actual Apr to Nov (£'000)	Variance Apr to Nov (£'000)	17/18 (£'000)	
Operating								
Operating Income								
NHS Acute Activity Income								
Elective	1,056	980	-77	8,102	7,549	-553	11,524	12,496
Non-Elective	4,619	4,952	332	36,258	38,494	2,236	57,741	57,367
Maternity	1,120	1,211	91	8,953	9,452	498	14,178	13,208
Day cases	1,921	1,600	-321	14,755	13,344	-1,412	20,216	22,066
Outpatients	2,473	2,392	-81	19,365	18,384	-982	28,247	29,033
A&E	736	791	55	6,286	6,581	295	9,872	9,309
Other NHS	6,308	6,327	18	50,842	51,276	434	73,385	70,720
Total NHS Clinical Revenue	**18,235**	**18,253**	**18**	**144,563**	**145,079**	**516**	**215,163**	**214,199**
Other Operating Income	1,911	1,969	58	15,251	14,970	-281	22,448	22,840
TOTAL OPERATING INCOME	**20,146**	**20,222**	**76**	**159,814**	**160,049**	**235**	**237,611**	**237,039**
Operating Expenses								
Employee Benefits Expenses (Pay)	-13,799	-13,827	-28	-110,048	-110,475	-427	-166,232	-165,061
Drugs	-1,376	-1,444	-68	-11,019	-10,593	426	-15,730	-16,526
Clinical Supplies	-1,792	-1,673	119	-13,111	-12,091	1,020	-18,067	-19,518
Non Clinical Supplies	-287	-330	-43	-2,238	-2,652	-414	-3,864	-3,338
Other operating expenses	-2,506	-2,907	-401	-20,332	-21,407	-1,075	-31,294	-30,178
TOTAL OPERATING EXPENSES	**-19,760**	**-20,181**	**-421**	**-156,748**	**-157,218**	**-470**	**-235,187**	**-234,621**
EBITDA	**386**	**41**	**-345**	**3,066**	**2,831**	**-235**	**2,424**	**2,418**
Non Operating								
Non Operating Income								
Interest & Asset disposal	3	3	0	24	14	-10	36	36
Non-Operating Expenses								
Depreciation & Finance Leases	-468	-461	7	-3,853	-3,516	337	-5,316	-5,850
PDC Dividend Expense	-159	-159	0	-1,268	-1,268	0	-1,900	-1,900
Net Surplus/(deficit) before STF/Exceptional Items	**-238**	**-576**	**-338**	**-2,031**	**-1,939**	**92**	**-4,756**	**-5,296**
STF	599	239	-360	3,298	2,936	-362	5,454	**5,994**
Net Surplus/(deficit) before Exceptional Items	**361**	**-337**	**-698**	**1,267**	**997**	**-270**	**698**	**698**
Prior Period Adjustment	0	0	0	0	0	0	0	0
Charitable Income	0	0	0	0	218	218	218	258
							0	**0**
Net Surplus/(deficit) after Exceptional Items	**361**	**-337**	**-698**	**1,267**	**1,215**	**-52**	**916**	**956**

The Trust delivered a £1.0M surplus (before charitable income) cumulative against a planned surplus of £1.3M.

Contract income is £0.2M better than plan cumulative. Key variances include planned income and drugs and the impact of the CEP.

Other income is 0.3M worse cumulative as a result of Training income, RTA income and nhs recharge variances.

Pay is £0.4M worse than plan cumulative, deteriorating slightly n month, this being a result of higher spend on nursing than plan , medical pay is now on plan and there remain underspends in community services from unfilled vacancies .

Non-Pay is on plan cumulative as a result of high cost drugs (income offset) , reduced spend on clinical supplies related to activity reduction. Also, non-clinical supplies is worse in community related to higher costs than planned and other operating expenses is worse than plan and includes costs of outsourcing to cover medical gaps.

The forecast is to acheive the agreed control total and deliver the cost savings under the CEP, recognising the reduced income flows from South Cheshire & Vale Royal CCGs.

* EBITDA Total excludes Charitable Income

Financial Performance: Income & Expenditure Position - MCHFT

	Month			Year to Date			Forecast	Base Budget
	Plan Nov (£'000)	Actual Nov (£'000)	Variance Nov (£'000)	Plan Apr to Nov (£'000)	Actual Apr to Nov (£'000)	Variance Apr to Nov (£'000)	17/18 (£'000)	2017/18 £'000
Operating								
Operating Income								
NHS Acute Activity Income								
Elective	1,056	980	-77	8,102	7,549	-553	11,524	12,496
Non-Elective	4,619	4,952	332	36,258	38,494	2,236	57,741	57,367
Maternity	1,120	1,211	91	8,953	9,452	498	14,178	13,208
Day cases	1,921	1,600	-321	14,755	13,344	-1,412	20,216	22,066
Outpatients	2,473	2,392	-81	19,365	18,384	-982	28,247	29,033
A&E	736	791	55	6,286	6,581	295	9,872	9,309
Other NHS	4,137	4,117	-21	33,427	33,545	118	46,811	44,645
Total NHS Clinical Revenue	**16,064**	**16,043**	**-21**	**127,148**	**127,348**	**200**	**188,589**	**188,124**
Other Operating Income	1,830	1,890	60	14,633	14,302	-332	21,434	21,941
Inter-Trust Income	48	48	0	333	495	162	743	571
TOTAL OPERATING INCOME	**17,942**	**17,980**	**39**	**142,115**	**142,145**	**30**	**210,766**	**210,636**
Operating Expenses								
Employee Benefits Expenses (Pay)	-12,048	-12,195	-147	-96,076	-97,256	-1,180	-146,343	-144,096
Drugs	-1,374	-1,442	-68	-11,001	-10,578	422	-15,707	-16,497
Clinical Supplies	-1,703	-1,610	93	-12,401	-11,368	1,033	-16,983	-18,455
Non Clinical Supplies	-219	-256	-37	-1,693	-1,853	-159	-2,756	-2,520
Other operating expenses	-2,138	-2,439	-301	-17,301	-18,169	-868	-26,195	-25,672
Inter-Trust Charges	-82	-82	0	-571	-653	-82	-979	-979
TOTAL OPERATING EXPENSES	**-17,564**	**-18,024**	**-460**	**-139,044**	**-139,877**	**-833**	**-208,963**	**-208,219**
EBITDA	**378**	**-43**	**-421**	**3,071**	**2,268**	**-803**	**1,803**	**2,417**
Non Operating								
Non Operating Income								
Interest & Asset disposal	3	3	0	24	14	-10	36	36
Non-Operating Expenses								
Depreciation & Finance Leases	-468	-461	7	-3,853	-3,516	337	-5,316	-5,850
PDC Dividend Expense	-159	-159	0	-1,268	-1,268	0	-1,900	-1,900
Net Surplus/(deficit) before STF/Exceptional Items	**-246**	**-660**	**-414**	**-2,026**	**-2,502**	**-476**	**-5,377**	**-5,296**
STF	599	239	-360	3,298	2,936	-362	5,454	5,994
Net Surplus/(deficit) before Exceptional Items	**353**	**-421**	**-774**	**1,272**	**434**	**-838**	**77**	**698**
Prior Period Adjustment	0	114	114	0	0	0	0	0
Charitable income	0	0	0	0	218	218	218	
Net Surplus/(deficit) after Exceptional Items	**353**	**-307**	**-660**	**1,272**	**652**	**-620**	**295**	**698**

The Trust excluding Community Services, delivered a £0.3M surplus cumulative against a planned £1.3M surplus..

Contract income is £0.2M worse than plan cumulative. Key variances include planned income and drugs. £111M of the £130M actual value is fixed in line with the CEP. The variance relates to services commissioned by NHSE, Public Health England and out of area commissioners.

Other income is £0.3M worse cumulative as a result of training income, RTA income and nhs recharge variances.

Pay is £1.2M worse than plan cumulative as a result of higher spend on Nursing and corporate vacancy targets.

Non-Pay is £0.3M better than plan cumulative as a result of better than plan for high cost drugs (income offset) and clinical supplies (activity related). Other Operating Expenses is £0.9M worse as a result of continuing outsourcing pressures in diagnostics from staffing gaps.

Financial Performance: Income & Expenditure Position - CCICP

	Month			Year to Date			Forecast	Base Budget
	Plan Nov (£'000)	Actual Nov (£'000)	Variance Nov (£'000)	Plan Apr to Nov (£'000)	Actual Apr to Nov (£'000)	Variance Apr to Nov (£'000)	17/18 (£'000)	2017/18 £'000
Operating								
Operating Income								
NHS Acute Activity Income								
Elective	0	0	0	0	0	0	0	
Non-Elective	0	0	0	0	0	0	0	
Maternity	0	0	0	0	0	0	0	
Day cases	0	0	0	0	0	0	0	
Outpatients	0	0	0	0	0	0	0	
A&E	0	0	0	0	0	0	0	
Other NHS	2,171	2,210	39	17,415	17,731	316	26,574	26,075
Total NHS Clinical Revenue	**2,171**	**2,210**	**39**	**17,415**	**17,731**	**316**	**26,574**	**26,075**
Other Operating Income	81	79	-2	618	668	51	1,014	899
Inter-Trust Income	82	82	0	571	653	82	979	979
TOTAL OPERATING INCOME	**2,334**	**2,371**	**37**	**18,604**	**19,052**	**448**	**28,567**	**27,953**
Operating Expenses								
Employee Benefits Expenses (Pay)	-1,751	-1,632	119	-13,972	-13,219	753	-19,889	-20,965
Drugs	-2	-2	0	-18	-15	4	-23	-29
Clinical Supplies	-89	-63	26	-709	-723	-13	-1,084	-1,063
Non Clinical Supplies	-68	-74	-6	-545	-799	-255	-1,108	-818
Other operating expenses	-368	-468	-100	-3,031	-3,238	-207	-5,099	-4,506
Inter-Trust Charges	-48	-48	0	-333	-495	-162	-743	-571
TOTAL OPERATING EXPENSES	**-2,326**	**-2,287**	**39**	**-18,609**	**-18,488**	**120**	**-27,946**	**-27,952**
EBITDA	**8**	**84**	**76**	**-5**	**563**	**568**	**621**	**0**
Non Operating								
Non Operating Income								
Interest & Asset disposal	0	0	0	0	0	0	0	0
Non-Operating Expenses								
Depreciation & Finance Leases	0	0	0	0	0	0	0	0
PDC Dividend Expense	0	0	0	0	0	0	0	0
Net Surplus/(deficit) before Exceptional Items	**8**	**84**	**76**	**-5**	**563**	**568**	**621**	**0**
STF	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Net Surplus/(deficit) before Exceptional Items	**8**	**84**	**76**	**-5**	**563**	**568**	**621**	**0**
Prior Period Adjustment	0	-114	-114	0	0	0	0	0
Net Surplus/(deficit) after Exceptional Items	**8**	**-30**	**-38**	**-5**	**563**	**568**	**621**	**0**

Community Services delivered a £0.6M surplus cumulative against a planned break even position.

Contract income is £0.3M better than plan cumulative as a result of property income accrued to offset costs..

Pay is £0.8M better than plan cumulative as a result of unfilled vacancies partly clinical and partly corporate.

Non-Pay is £0.6M worse than plan cumulative due to property costs and incontinence products back invoices being received late from suppliers. (prior year and above expectations)

The forecast is now expected to achieve better than the Budget break even position . This is after current under-spends in pay particularly being utilised non-recurrently to fund the non-recurrent costs of implementing the approved IT System investment (EMIS) that will result in additional pay and non-pay spend in Q4.

Financial Performance: Income & Expenditure Position

		Income			Expenditure				NET TOTAL	
		Contract	Variable	Better/ (Worse) than Budget	Pay	Better/ (Worse) than Budget	Non-Pay	Better/ (Worse) than Budget	Total	Better/ (Worse) than Budget
Surgical & Cancer Div Mgt	Divisional Management S&C	0	0	(79)	(596)	(549)	(30)	(20)	(626)	(648)
Endoscopy	Endoscopy	4,179	1	(712)	(1,587)	42	(782)	159	1,811	(510)
General Surgery Directorate	General Surgery	11,282	50	(570)	(5,771)	189	(1,168)	60	4,393	(321)
Head & Neck Directorate	Head & Neck	3,707	259	(114)	(1,680)	101	(515)	51	1,771	38
Macmillan Cancer Centre	Macmillan Cancer Centre	407	1,043	204	(587)	(12)	(895)	(51)	(32)	141
Ophthalmology	Ophthalmology	7,828	40	(400)	(2,659)	203	(2,220)	348	2,989	151
Orthopaedic Directorate	Orthopaedics	12,936	164	(761)	(4,171)	174	(2,383)	(85)	6,547	(672)
Theatres & TC	Theatres & TC	0	239	3	(4,863)	26	(1,759)	(10)	(6,384)	19
Urology Directorate	Urology	3,768	49	(180)	(1,798)	15	(348)	(119)	1,671	(284)
Surgical and Cancer Division	**Surgery & Cancer**	**44,107**	**1,846**	**(2,608)**	**(23,713)**	**190**	**(10,100)**	**333**	**12,140**	**(2,085)**

The Surgical Division is £2.1M worse than plan cumulative. Net of income as the CEP impact is reflected in Corporate, the Division is £0.5M better than plan, although variable income from PHE is behind plan by £0.4M. The key variancesin expenditure relate to medical staffing vacancies in Ophthalmology and Orthopaedics and Nursing vacancies in General Surgery. Non pay is better than plan in Ophthalmology as a result of lower than expected use of high cost drugs.

		Income			Expenditure				NET TOTAL	
		Contract	Variable	Better/ (Worse) than Budget	Pay	Better/ (Worse) than Budget	Non-Pay	Better/ (Worse) than Budget	Total	Better/ (Worse) than Budget
Emergency Care Divisional Mgmn	Divisional Mangement M&EC	0	113	113	(1,534)	(96)	(92)	(221)	(1,513)	(205)
Accident & Emergency Dir	Emergency Department	10,314	533	773	(3,827)	161	(457)	(66)	6,563	868
Anaesthetics & Critical Care	Anaesthetics & Critical Care	4,158	32	50	(5,355)	27	(738)	73	(1,902)	150
Medical Directorate	General Medicine	27,728	171	582	(14,794)	(587)	(2,970)	69	10,135	64
Urgent Care Centre	Urgent Care Centre	0	0	0	(457)	23	0	84	(457)	107
Emergency Services Division	**Medicine & Emergency Care**	**42,200**	**849**	**1,518**	**(25,966)**	**(472)**	**(4,257)**	**(61)**	**12,826**	**984**

The Medicine and Emergency Care Division are £1.0M better than plan. Net of income, the Division is £0.5M worse than plan. The key variances are Pay in the medical directorate as a result of higher nursing costs from use of bank HCA's over establishment for acuity pressures . Medical pay is slightly higher than plan. Non-pay is slightly worse than plan with non-deliverable infusion pump CIP in Divisional management.

		Income			Expenditure				NET TOTAL	
		Contract	Variable	Better/ (Worse) than Budget	Pay	Better/ (Worse) than Budget	Non-Pay	Better/ (Worse) than Budget	Total	Better/ (Worse) than Budget
Wom Chil & sexl hlth Div Magmn	Divisional Mangement W&C	0	49	43	(890)	(99)	(77)	12	(918)	(44)
Obstetric & Gynaecology Dir	Obstetrics & Gynaecology	12,489	71	391	(5,769)	(20)	(1,030)	(196)	5,761	175
Paediatric Directorate	Paediatrics	7,673	62	(74)	(5,136)	(50)	(741)	(20)	1,858	(144)
Women and Childrens Division	**Women and Children**	**20,161**	**181**	**360**	**(11,795)**	**(169)**	**(1,847)**	**(204)**	**6,701**	**(13)**

The Womens and Childrens Division is on plan cumulative. Net of income, the Division is £0.4M worse than plan. Pay pressures are a result of midwifery and medical over-establishment. Non-pay is £0.2M worse as a result of IVF recharges.

Financial Performance: Income & Expenditure Position

		Income			Expenditure				NET TOTAL	
		Contract	Variable	Better/ (Worse) than Budget	Pay	Better/ (Worse) than Budget	Non-Pay	Better/ (Worse) than Budget	Total	Better/ (Worse) than Budget
Diag & Clinc Spt Sv Div Mgmnt	Divisional Management D&S	0	0	0	(186)	27	(12)	(65)	(198)	(38)
Dermatology	Dermatology	1,150	18	(179)	(579)	94	(214)	14	375	(70)
ECG department	ECG	248	16	(28)	(640)	85	(48)	3	(424)	60
Elmhurst	Elmhurst	1,330	123	7	(1,019)	(30)	(118)	9	317	(14)
Integrated Discharge	Integrated Discharge	0	12	12	(200)	(20)	(3)	(1)	(192)	(9)
Medical Records Department	Medical Records Department	0	0	(1)	(1,161)	36	(149)	(4)	(1,310)	31
Outpatients	Outpatients	0	106	(6)	(367)	(1)	(37)	0	(298)	(8)
Pathology Directorate	Pathology	8,122	2,595	147	(6,580)	5	(5,874)	(146)	(1,736)	6
Pharmacy Departments	Pharmacy	2,080	160	224	(2,089)	42	(2,108)	(340)	(1,956)	(74)
Radiology Directorate	Radiology	2,200	478	(314)	(4,159)	16	(1,423)	(123)	(2,904)	(421)
Therapeutic Departments	Therapies	0	2	2	(1,297)	95	(36)	30	(1,331)	127
Victoria Infirmary Northwich	Victoria Infirmary Northwich	1,357	6	(92)	(1,132)	(43)	(199)	2	32	(132)
Diagnostics and Support Divisi	**Diagnostics and Support**	**16,487**	**3,517**	**(229)**	**(19,408)**	**307**	**(10,223)**	**(620)**	**(9,626)**	**(541)**

The Diagnostics Division is £0.5M worse than plan cumulative. Net of income, the Division is £0.3M worse than plan. The key variances include better than plan on pay from staffing gaps in Imaging, ECG and Dermatology. Non-pay is worse on drugs and outsourcing imaging and pathology.

		Income			Expenditure				NET TOTAL	
		Contract	Variable	Better/ (Worse) than Budget	Pay	Better/ (Worse) than Budget	Non-Pay	Better/ (Worse) than Budget	Total	Better/ (Worse) than Budget
Estates & Facilities Div Mgnt	Divisional Management E&F	0	0	0	(333)	9	(162)	(16)	(495)	(7)
Catering Directorate	Catering	0	929	62	(1,071)	(48)	(875)	(59)	(1,016)	(45)
Estates Departments	Estates Departments	0	307	(11)	(1,079)	(40)	(4,058)	256	(4,829)	205
Hotel Services	Domestics	0	0	0	(897)	(36)	(8)	(1)	(906)	(37)
Laundry Services Departments	Laundry	0	816	5	(735)	(69)	(546)	(30)	(466)	(95)
Security	Security	0	1,055	(34)	(471)	30	(429)	(50)	156	(54)
Site Services	Porters	0	0	0	(1,798)	47	(61)	(9)	(1,859)	38
Estates & Facilities Division	**Estates & Facilities Division**	**0**	**3,107**	**22**	**(6,384)**	**(108)**	**(6,138)**	**91**	**(9,415)**	**5**

The Estates and Facilities Division is on plan cumulative with no significant variances to report.

		Income			Expenditure				NET TOTAL	
		Contract	Variable	Better/ (Worse) than Budget	Pay	Better/ (Worse) than Budget	Non-Pay	Better/ (Worse) than Budget	Total	Better/ (Worse) than Budget
Executive Management	Executive Management	0	0	0	(967)	12	(431)	10	(1,398)	22
Computer Services	Computer Services	0	41	32	(931)	72	(1,450)	(78)	(2,339)	26
Finance & Information	Finance & Information	0	30	9	(2,085)	(73)	(503)	45	(2,558)	(20)
Human Resources	Human Resources	0	317	(2)	(1,570)	43	(291)	124	(1,543)	166
Risk Manangement & R&D	Risk Management & R&D	0	279	(81)	(970)	76	(32)	30	(722)	25
Quality Assurance Departments	Nurse Management	0	246	151	(1,843)	(217)	(6,126)	13	(7,724)	(53)
Trust Central Expenditure	Trust Central Expenditure	7,308	3,998	511	(1,439)	(831)	(371)	716	9,496	396
Other Departments	Other Departments	18	109	43	(185)	(9)	(199)	26	(258)	60
	Corporate	**7,326**	**5,019**	**662**	**(9,990)**	**(927)**	**(9,402)**	**887**	**(7,046)**	**623**

The Corporate Division is £0.6M better cumulative. Net of income, there is no variance. Pay is worse as a result of maternity pressures and vacancy control targets and non-pay is better as a result of slippage on investments.

Community Services	**17,736**	**669**	**364**	**(13,219)**	**753**	**(4,776)**	**(471)**	**410**	**647**
EBITDA	**148,018**	**15,188**	**89**	**(110,474)**	**(427)**	**(46,743)**	**(44)**	**5,989**	**(382)**

Financial Performance: Commissioner Income Analysis

Commissioner	FY Target (£'000)	YTD Target (£'000)	CEP Adjustmt	Final Actual (£'000)	Final Variance (£'000)
NHS Eastern Cheshire CCG	8,202	5,472	0	5,401	-72
NHS Eastern Cheshire CCG Community	412	273	0	273	0
NHS South Cheshire CCG Community	16,954	11,299	0	11,299	0
NHS South Cheshire CCG	99,576	69,511	1,408	69,511	0
NHS Vale Royal CCG	54,424	37,495	682	37,495	0
NHS Vale Royal CCG Community	10,284	6,853	0	6,853	0
NHS Warrington CCG	248	165	0	191	26
NHS West Cheshire CCG	3,342	2,225	0	2,380	155
NHS West Cheshire CCG Community	191	127	0	127	0
NHS North Staffordshire CCG	1,900	1,270	0	1,535	265
NHS Shropshire CCG	624	417	0	607	190
NHS Stoke on Trent CCG	1,407	942	0	1,053	111
Local Authority	0	0	0	0	0
NHS Commissioning Board	1,511	1,003	0	1,003	0
Specialist Commissioning Group	8,449	5,638	0	5,770	132
Non Contract Activity	1,932	1,287	0	1,541	254
Overseas Visitors Chargeable	0	0	0	0	0
Non-Commissioner Specific	10,757	3,882	-1,127	2,975	-907
TOTAL	**220,213**	**147,859**	**963**	**148,014**	**154**

The South Cheshire and Vale Royal contracts are in line with the agreed CEP value. Against PbR , the Trust is underperforming by £2.1M primarily associated with elective activity.

Non Commissioner Specific includes Public Health who commission the Bowel Scope programme and a target for Hep C very high cost drugs which will vary as associated with a small number of patients. (cost budget offset)

Other commissioners are showing positive variances related to elective activity in Ophthalmology and General Surgery.

Other Contract Income	FY Target (£'000)	YTD Target (£'000)	YTD Actual (£'000)	Final Variance (£'000)
Bed Based Services	5,951	3,967	3,971	4
Adult & Neonatal Critical Care	7,884	5,284	5,280	-3
Urgent Care Centre	0	0	0	0
Community Paediatrics	1,302	868	868	0
Direct Access Services	10,245	6,898	6,493	-405
Unbundled Radiology	3,613	2,408	2,363	-45
High Cost Drugs	9,953	6,636	6,442	-194
Screening Programmes	1,474	983	983	0
Audiology	1,057	705	788	84
IVF	321	214	185	-29
CQUIN	4,453	2,516	2,260	-256
STF	5,993	3,296	2,936	-360
Community Services	27,805	18,537	18,849	312
Other	14	1,829	2,792	963
TOTAL	**80,065**	**54,141**	**54,210**	**71**

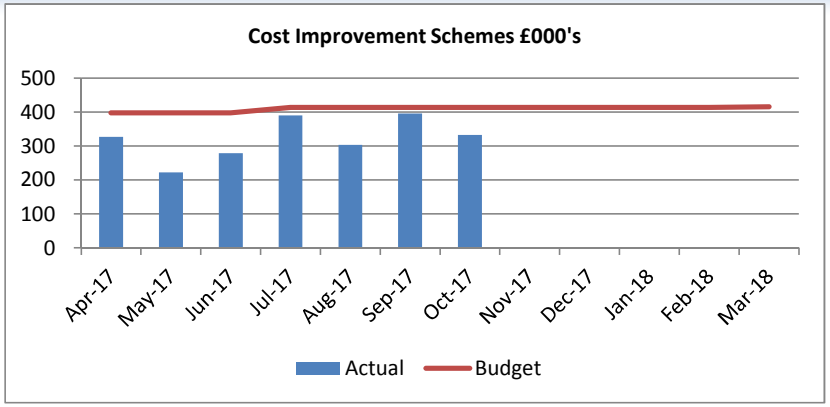
Other contract income is showing £0.1M better than plan.

An analysis of the key service lines identifies that this is primarily the result of High Cost Drugs which is showing growth in Healthcare at Home and Direct Access related to medical imaging coding changes.
A provision for non-perfromance of the A&E Q3 STF trajectory has been made in month.

Other includes the impact of the CEP (£1.0M favourable)

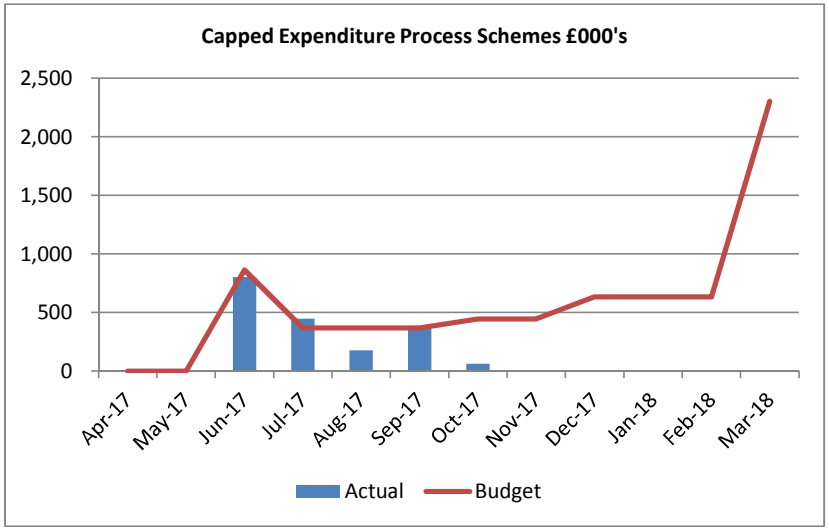
Financial Performance: Efficiencies

Cost Improvement Schemes (£'000's)						
Scheme Category	**YTD Target**	**YTD Actual**	**YTD**	**FY Target**	**FY Forecast**	**FY Variance**
Access & Flow	416	283	-133	600	600	0
Back Office	130	95	-35	195	150	-45
Commercial	93	108	15	140	145	5
Drugs	276	260	-17	414	375	-40
Medical Workforce	1,189	1,139	-50	1,783	1,716	-67
Non-Pay Efficiency	227	23	-203	340	37	-303
Nursing Workforce	200	0	-200	300	0	-300
Procurement	500	500	0	750	750	0
Service redesign	267	233	-33	400	333	-67
Total (£'000)	**3,298**	**2,641**	**-656**	**4,922**	**4,106**	**-817**



The Cost Improvement Programme is underperforming on Nursing (use of temporary staffing and e-rostering) and Non-pay efficiency (infusion pump consumables). Mitigation for the e-rostering scheme has been made in the CEP budget re-statement.

Capped Expenditure Schemes (£'000's)						
Scheme Category	**YTD Target**	**YTD Actual**	**YTD**	**FY Target**	**FY Forecast**	**FY Variance**
Acute CEP Diagnostic	60	30	-30	100	30	-70
Acute CEP ECT Rota	60	0	-60	100	0	-100
Acute CEP Elective*	906	701	-205	2,766	3,050	284
Acute CEP Diagnostic Capacity (	126	126	0	378	378	0
Acute CEP Diagnostic Capacity (	0	0	0	188	188	0
Acute CEP High Cost Drugs	400	288	-112	600	495	-105
Acute CEP Paeds	18	0	-18	30	0	-30
Acute CEP Pharmacy	30	0	-30	50	25	-25
Acute CEP PLCP	60	0	-60	100	0	-100
Acute CEP Tele-Derm	42	42	0	70	70	0
Acute CEP Winter	0	0	0	750	550	-200
Acute CEP Interest	50	0	-50	100	100	0
Acute CEP Maternity	0	0	0	100	0	-100
Community CEP (Pay)	312	312	0	479	479	0
Community CEP (Non-Pay)	816	816	0	1,251	1,251	0
Grand Total	**2,880**	**2,315**	**-565**	**7,062**	**6,616**	**-446**



Capped Expenditure Process schemes are £0.6M worse than plan cumulative as a result of not achieving the full target on elective efficiency as schemes commenced later in the year than planned and some elements are still in devleopment. In addition, PLCP will not impact in 2017/18 due to commitments to existing patients and the ECT partner schemes are still under discussion. Interest is set to deliver by the year end. There is a risk around the savings related to deferring winter investments.

Financial Performance: Capital Report

SCHEME	BOARD APPROVED	FUNDING SOURCE	FUNDING APPROVED	EXPENDITURE	2017/18 FY TARGET	2017/18 YTD TARGET	2017/18 CUMULATIVE ACTUAL	2017/18 BETTER/WORSE THAN BUDGET	2017/18 FORECAST	2018/19 + FORECAST	WHOLE PROJECT ACTUAL TO DATE	WHOLE PROJECT PROPOSED PLAN	TOTAL FORECAST
STRATEGIC INVESTMENTS (Requires individual signoff)													
ESTATES													
DR'S MESS INTO RMO'S	Yes	Internal	Yes		42	42	42	0	42	0	42	42	42
WARD 11 REFURBISHMENT	Yes	Internal	Yes	1500		0	-53	53	-53	0	1447	1,500	1,447
WARD 16 REFURBISHMENT	Yes	Internal	Yes	854	283	283	283	0	283	0	1137	1,137	1,137
CAR PARK BARRIERS	Yes	Internal	Yes		60	60	0	60	60	0	0	60	60
CENTRALISED POAC	Yes	Internal	Yes		122	122	170	-48	122	0	170	122	122
BISTRO & 2 OFFICES	Yes	Internal	Yes		178	178	0	178	208	0	0	178	208
OPHTHALMOLOGY OUTPATIENTS - PHASE 2	Yes	Internal	Yes	86	249	250	259	-9	259	0	345	335	345
UNDER / OVERS CAPITAL SCHEMES 16/17	Yes	Internal	Yes			0	-8	8	0	0	-8	0	0
WARD REFURBISHMENT	Yes	Loan	Not yet approved		4200	2200	5	2195	1400	8800	5	13,000	10,200
MRI SCANNER 3RD BUILD	Yes	Internal/Loan	Not yet approved	109	1540	1540	52	1488	770	770	161	2,419	1,649
WASTE COMPOUND AND SEGREGATION	No	Internal	Not yet approved		250	250	0	250	0	150	0	400	150
BARIATRIC SIDE ROOM	No	Internal	Not yet approved		100	0	0	0	0	100	0	200	100
3RD CT SCANNER BUILD	No	Loan	Not yet approved		850	850	0	850	0	850	0	1,700	850
TOTAL				**2549**	**7874**	**5775**	**751**	**5024**	**3091**	**10670**	**3300**	**21093**	**16310**
IT													
VOICE OVER IP	Yes	Internal	Yes	171	295	295	240	55	295	200	411	666	666
RADIOLOGY INFORMATION SYSTEM	Yes	Internal	Yes	96	132	132	-10	142	132	0	86	228	228
WIRELESS UPGRADE	Yes	Internal	Yes	6	24	24	1	23	24	0	7	30	30
PCTI	Yes	Internal	Yes	18	12	12	6	6	12	0	24	30	30
E-HANDOVER	No	Internal	Not yet approved		244	244	0	244	0	0	0	244	0
UNDER / OVERS CAPITAL SCHEMES 16/17	Yes	Internal	Yes			0	6	-6	6	0	6	0	6
PATIENT ADMIN SYS / CORE ELECTRONIC PATIENT RECORDS	No	Loan	Not yet approved		1500	0	0	0	0	4500	0	6,000	4,500
EDMS & E NOTES	No	Loan	Not yet approved		1956	1000	0	1000	0	0	0	1,956	0
UPS	Yes	Internal	Yes		150	150	0	150	150	0	0	150	150
CLINICAL PORTAL	No	Loan	Not yet approved		1260	660	0	660	0	0	0	1,260	0
Q PULSE	Yes	Internal	Yes		30	30	0	30	30	0	0	30	30
NET CALL / CALL CENTRE	Yes	Internal	Yes	12	13	13	4	9	13	0	16	25	25
HIGH IMPACT STAND ALONE IT SYSTEMS	Yes	Internal	Yes		100	80	48	32	100	400	48	500	500
PACS REPLACEMENT	Yes	Internal	Now Revenue		1590	0	0	0	0	0	0	1,590	0
E-PRESCRIBING	No	Loan	Not yet approved		900	900	0	900	0	460	0	1,360	460
VENDOR NEUTRAL ARCHIVE	No	Loan	Not yet approved		605	605	0	605	0	0	0	605	0
CREDITS FOR CLEANING SOFTWARE	Yes	Internal	Yes		11	11	0	11	11	0	0	11	11
REPLACEMENT BUSINESS INTELLIGANCE SYSTEM	No	Internal	Not yet approved		80	80	0	80	80	0	0	80	80
SINGLE CLINICAL SYSTEM	No	Loan	Not yet approved							6569	0		6,569
TOTAL				**303**	**8902**	**4236**	**295**	**3941**	**853**	**12129**	598	**14765**	**13,285**
TOTAL STRATEGIC INVESTMENTS				**2852**	**16776**	**10011**	**1045**	**8966**	**3944**	**22799**	**3897**	**35858**	**29595**

The Estates strategic investments capital spend is £5,021K less than the plan. This is mainly due to the build for the third MRI Scanner, the build for the third CT Scanner Waste Compound , Bistro and Offices and Ward 17 refurbishment. Originally the MRI and Ward 17 refurbishment projects are delayed due to the delay in the approval of loans from the DoH. However the Ward 17 refurbishment has now started. The request for the loan application has be submitted. This now includes an application of a contribution to the backlog maintenace programme. The business case for the third CT Scanner has still not been approved. The forecast has been amended due to the delay in the Ward 17, third MRI Scanner and the third CT Scanner, and Bariatric sideroom where some of the expenditure has been move to 2018/19.

The IT Strategic investments projects are £3,941K less than plan. This is mainly due to the Vendor Neutral Archive scheme, E-Handover, EDMS, E Prescribing.and Clinical Portal . The funding for these schemes along with Patient Admin System and some of the IBM Software scheme is proposed to use as one funding stream for a single clinical system. The forecast spend for these has been amended to the following financial year. A business case for this proposal is being prepared. In respect of the PACS this has now been approved as revenue and the forecast has been amended accordingly.

Financial Performance: Capital Report

SCHEME	BOARD APPROVED	FUNDING SOURCE	FUNDING APPROVED	EXPENDITURE	2017/18	2017/18	2017/18 CUMULATIVE ACTUAL	2017/18 BETTER/WORSE THAN BUDGET	2017/18 FORECAST	2018/19 + FORECAST	WHOLE PROJECT ACTUAL TO DATE	WHOLE PROJECT PROPOSED PLAN	TOTAL FORECAST
ROLLING ALLOCATIONS (Approved Delegated Budgets)													
ESTATES													
ASBESTOS REMOVAL	Yes	Internal	Yes		150	100	-6	106	150	600	-6	750	750
DESIGN TEAM	Yes	Internal	Yes		280	187	171	16	280	1120	171	1,400	1,400
CT / VT - HEATING INFRASTRUCTURE	Yes	Internal	Yes		175	95	41	54	175	525	41	700	700
BACKLOG GENERAL PROVISION	Yes	Internal/Loan	Yes		1604	1310	331	979	1,604	6750	331	8,354	8,354
TOTAL				**0**	**2,209**	**1,692**	**538**	**1154**	**2,209**	**8,995**	**538**	**11,204**	**11,204**
IT													
STORAGE - DATA ARCHIVING	Yes	Internal	Yes		27	27	56	-29	56		56	27	56
INTERSITE CONNECTIVITY	Yes	Internal	Yes		31	31	-3	34	31	25	-3	56	56
INTERFACING	Yes	Internal	Yes		85	60	9	51	85	110	9	195	195
IT APPLICATIONS	Yes	Internal	Yes		100	75	5	70	100	400	5	500	500
IBM HARDWARE	Yes	Internal	Yes		144	144	90	54	90	0	90	144	90
TOTAL				**0**	**387**	**337**	**157**	**180**	**362**	**535**	**157**	**922**	**897**
TOTAL ROLLING ALLOCATIONS				**0**	**2,596**	**2,029**	**695**	**1,334**	**2,571**	**9,530**	**695**	**12,126**	**12,101**
ADDITIONAL													
EQUIPMENT	Yes	Internal	Yes		0	0	46	-46	39	0	46	0	39
GP STREAMING ESTATES	Yes	Internal	Yes		0	0	5	-5	0	500	5	500	500
GP STREAMING IT	Yes	Internal	Yes		0	0	37	-37	247	0	37	0	247
COMMUNITY SERVICES	Yes	Internal	Yes		0	0	0	0	735	265	0	265	1,000
LEASING INVESTMENTS													
EQUIPMENT	Yes	Internal	Yes		648	236	236	0	648	0	236	648	648
3RD CT SCANNER	No	Internal	Not yet approved		480	0	0	0	0	480	0	960	480
REPLACEMENT CT SCANNER	No	Internal	Not yet approved		480	0	0	0	0	480	0	960	480
3RD MRI SCANNER	No	Internal	Not yet approved		640	0	0	0	0	640	0	1,280	640
ACCESS CONTROL	No	Internal	Not yet approved		100	0	0	0	100	0	0	100	100
LAUNDRY FINISHING	No	Internal	Not yet approved		56	0	0	0	56	0	0	56	56
OPHTHALMOLOGY EQUIPMENT	No	Internal	Not yet approved		150	0	0	0	150	0	0	150	150
CCTV	No	Internal	Not yet approved		157	0	0	0	157	0	0	157	157
CATERING TROLLIES	Yes	Internal	Yes		180	180	137	43	180	0	137	180	180
TOTAL LEASING INVESTMENTS				**0**	**2891**	**416**	**373**	**43**	**1291**	**1600**	373	**4491**	**2891**
TOTAL CAPITAL PROGRAMME (EXCLUDING LEASES)				**2,852**	**19,372**	**12,040**	**1,829**	**10,211**	**7,536**	**33,094**	**4,681**	**48,749**	**43,482**
TOTAL CAPTIAL PROGRAMME				**2,852**	**22,263**	**12,456**	**2,202**	**10,254**	**8,827**	**34,694**	**5,054**	**53,240**	**46,373**

In addition to the strategic capital schemes the rolling and additional schemes are £1,334K less than plan which is mainly due to Backlog Maintenace but the plan is to spend this by the end of the year . The forecast has been amended accordingly. The variance in the the NHSI return is less than above. This is due to the actual carry forwards from 2016/17 being higher than those submitted in the NHSI plan.

The Finance lease forecast has been amended for the third MRI Scanner and the Third CT Scanner and the replacment scanner to reflect the delay in the capital forecast and moved to 2018/19.

Financial Performance: Statement of Financial Position

	Plan Apr to Nov (£'000)	Actual Apr to Nov (£'000)	Variance (£'000)	Forecast 2016/17 (£'000)
Assets				
Assets, Non-Current	**88,661**	**80,763**	**-7,898**	**86,209**
Assets, Current				
Trade and other Receivables	3,779	6,493	2,714	7,841
Other Assets (including Inventories & Prepayments	5,357	4,852	-505	5,146
Cash and Cash Equivalents	3,778	8,184	4,406	1,888
Total Assets, Current	**12,914**	**19,529**	**6,615**	**14,875**
ASSETS, TOTAL	**101,575**	**100,292**	**-1,283**	**101,084**
Liabilities				
Liabilities, Current				
Finance Lease, Current	-487	-497	-10	-1,217
Loans Commercial Current	-67	-125	-59	-400
Trade and Other Payables, Current	-14,345	-12,560	1,784	-11,544
Provisions, Current	-175	-134	41	-194
Other Financial Liabilities	-8,466	-7,932	534	-7,072
Total Liabilities, Current	**-23,539**	**-21,249**	**2,290**	**-20,427**
Net Current Assets/(Liabilities)	**-10,625**	**-1,720**	**8,905**	**-5,552**
Liabilities, Non Current				
Finance Lease, Non Current	-4,064	-5,025	-961	-4,707
Loans Commercial Non-Current	-13,936	-9,796	4,140	-12,115
Provisions, Non-Current	-1,634	-1,668	-34	-1,582
Trade and Other Payables, Non-Current	0	0	0	**0**
Total Liabilities Non-Current	**-19,634**	**-16,489**	**3,145**	**-18,404**
TOTAL ASSETS EMPLOYED	**58,402**	**62,554**	**4,152**	**62,253**
Taxpayers' and Others' Equity				
Taxpayers Equity				
Public dividend capital	75,157	75,407	250	75,407
Retained Earnings	-26,975	-23,014	3,961	-23,316
Donated asset reserve	0	0	0	0
Revaluation Reserve	10,220	10,162	-58	10,162
TOTAL TAXPAYERS EQUITY	**58,402**	**62,554**	**4,152**	**62,253**
TOTAL FUNDS EMPLOYED	**58,402**	**62,554**	**4,152**	**62,253**

Non Current assets The main reason for the variance is that the plan is the capital programme expenditure submitted in the NHSI plan being £9,228K less than anticipated which is mainly due to a delay in Vendor Neutral Archive £605K and the Third MRI Scanner build £1,500K, Third CT Scanner build £850K, Backlog Maintenance £579K and Ward 17 Refurbishment £2,195K, E-Prescribing £900K, EDMS £1,000K, Clinical Portal £660K. All of these are reliant on capital loan funding which has not been secured. In addition there are delays in the UPS £150K, Waste Compound and Segregation £250K, E Handover £244k, however these are funded internally. This is offset by some additions in Finance Leases in particular the Endoscopy Lease where the capital cost was more than anticipated in the plan. In addition and underspend in depreciation by £364K.

NHS Trade Receivables are higher than anticipated as there are a number of other outstanding debts. These are East Cheshire NHS Trust £301K (£277K paid early December), Salford FT £92K, Property Services £137K, North Staffordshire CCG £188K, Christies Hospital £428K, North Midlands NHS Trust £116K, and NHS England £303K. In addition there is an outstanding debtor for the STF of £1,500K against the submitted plan.

Other receivables includes CLRN funding £100K, BMI Private Income £64K and University of Chester £37K

Other Assets mainly relates to the reduction in drug stocks and lower than anticipated prepayments.

Trade and Other Payables - This lower due to Trade creditors being paid more than expected than in the plan and accruals being slightly lower than anticipated due to the reduction in agency. In previous months this has been higher due to the payment profile of contract income this has now reduced due to the payments made are more in line with the original plan.

Finance Leases for both current and non current are higher due to the endoscopy lease being higher than anticipated in the plan.

Provisions mainly relates to the actual opening balance being lower than the plan due to a lower than anticipated increase in provision at the end of 2016/17.

Loans are due to capital loans not been taken out £6,914K. In the plan it was anticipated that £7,715K was paid off on the Interim Revolving Working Capital Loan. However only £1,551K has been paid off and £1,550K remains on a support loan. The payment made on the Interim Revolving Working Capital loan should have been allocated against the support loan which would have been paid off.

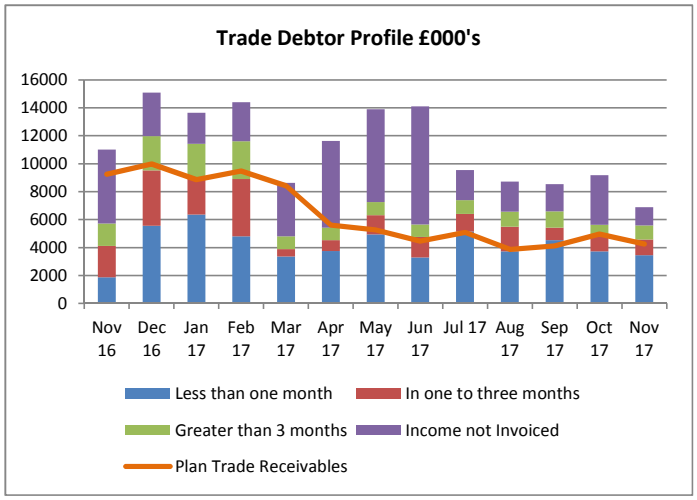
Public Dividend Capital is due to the A&E funding not anticipated in the plan.

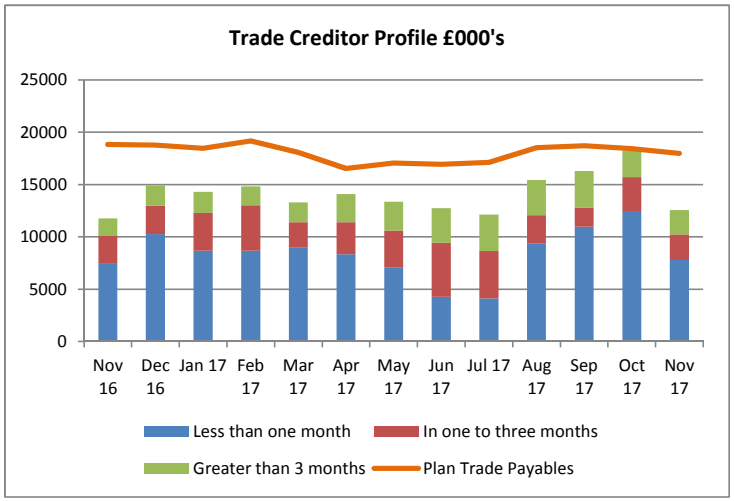
Financial Performance: Cash Position and Working Capital

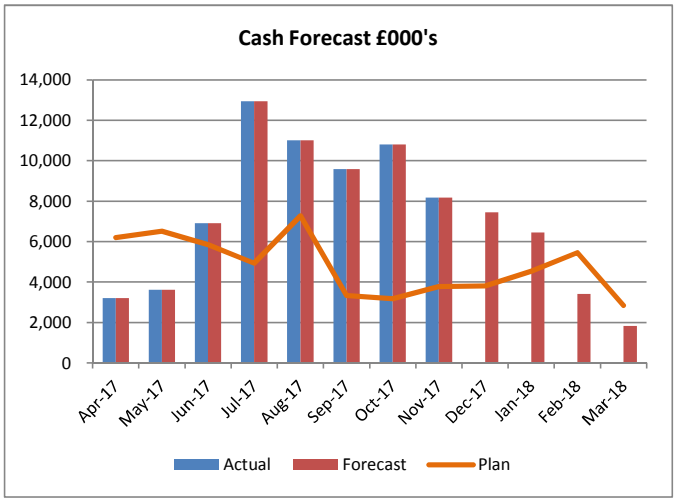
	Plan Apr to Nov (£'000)	Actual Apr to Nov (£'000)	Variance
Surplus/(deficit) after tax	**-114**	**1,215**	**1,329**
Non-cash flows in operating Surplus/(deficit) total	3,829	3,491	-338
Operating cash flows before movements in working capital	**3,715**	**4,706**	**991**
Increase/(Decrease) in working capital Total	4,811	5,084	273
Net cash inflow/(outflow) from operating activities	**8,526**	**9,790**	**1,264**
Net cash inflow/(outflow) from investing activities total	-10,458	-2,931	7,526
Net Cash inflow/(outflow) before financing	**-1,932**	**6,859**	**8,790**
Net cash inflow/(outflow) from financing activities Total	-141	-4,322	-4,181
Net increase/(decrease) in cash and cash equivalents	**-2,073**	**2,537**	**4,609**
Opening cash balance	**5,850**	**5,647**	**-203**
Closing cash balance	**3,777**	**8,184**	**4,406**

Cash is £4,406K better than anticipated. This is mainly due to the delay in repaying part of the Interim Revolving Working Capital loans and Support loans £3,573K. In addition the Operating Surplus is £1,363K better than planned but this is offset by depreciation being 364K less than plan.

The capital programme is £8,521K less than expected, this includes the movement in capital creditors. However this is offset by £7,715K capital loans which have not been approved to fund some of this capital programme. The cash position is improved due to the Trust receiving £250K PDC which was not in the plan.







Finance: *Staff Costs*

Headline Measures

	YTD £000's	Rolling 13 months £000's												
		Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Monthly Trend
Pay Budget	110,046	12,166	12,131	12,385	12,345	12,385	13,770	14,030	13,678	13,577	13,688	13,730	13,774	13,799	
Pay Actual	110,474	12,241	11,825	12,102	11,997	12,331	13,549	14,070	13,715	13,649	13,843	13,875	13,947	13,826	
Variance	-428	-75	306	283	348	55	221	-40	-37	-72	-155	-145	-173	-27	
% to Budget	*100.4%*	*100.6%*	*97.5%*	*97.7%*	*97.2%*	*99.6%*	*98.4%*	*100.3%*	*100.3%*	*100.5%*	*101.1%*	*101.1%*	*101.3%*	*100.2%*	
Nursing Staff % to Budget	101.2%	101.6%	98.4%	97.0%	100.5%	98.7%	101.8%	104.4%	99.8%	102.5%	97.5%	99.3%	101.6%	102.9%	
Medical Staff % to Budget	100.0%	94.9%	90.7%	94.4%	90.4%	99.5%	90.5%	101.9%	98.8%	98.0%	108.2%	103.5%	102.6%	97.4%	
Other Staff % to Budget	99.8%	104.2%	101.9%	101.2%	98.7%	109.3%	100.1%	95.1%	101.7%	100.1%	100.9%	101.4%	100.1%	99.1%	

Commentary

Figures exclude Community Services for 2016/17

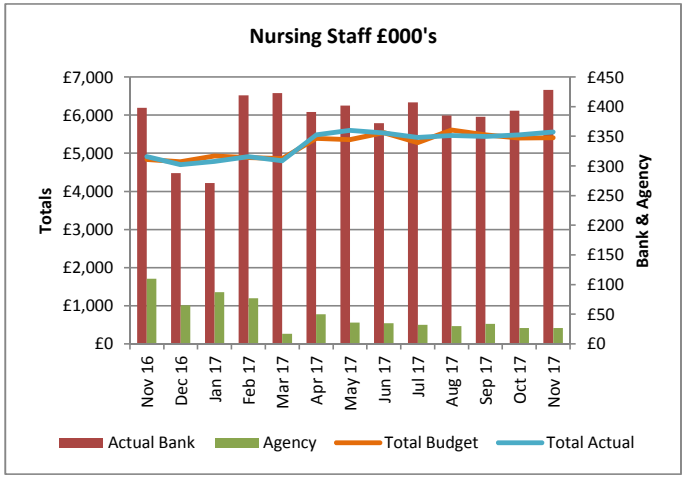
Pay is worse than budget by £0.4M as at Mth 8.

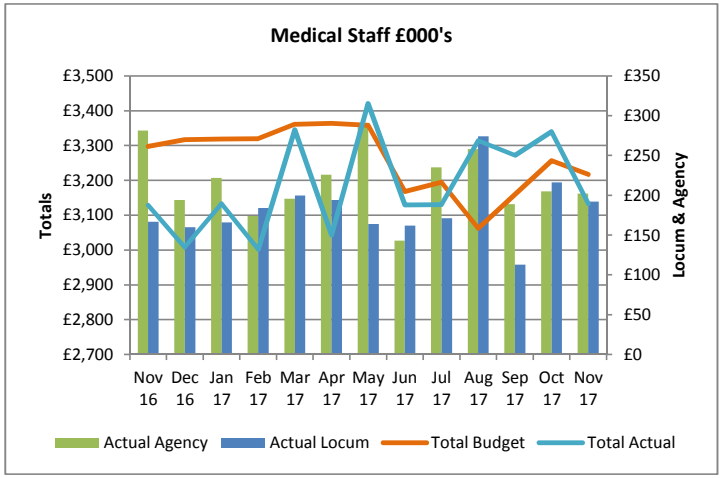
Nursing costs are higher than plan in Emergency Care as a result of Acuity. Nursing vacancies have started to rise in recent months although Nursing Agency spend continues to be controlled, however, bank use over establishment for HCAs continues to support one to one patient supervision and is a financial pressure.

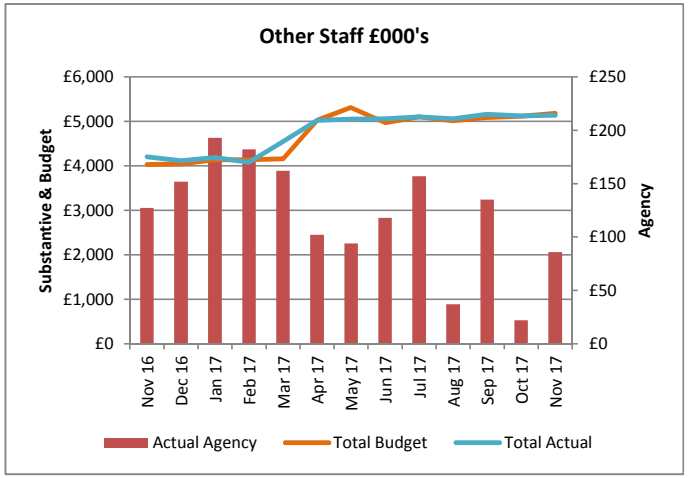
Medical pay is now in line with budget cumulative as a result of less vacancies and better than previous allocations of junior doctors. In month, an improved position is the result of less waiting list initiatives being run.

The Agency trajectory is better in month by £0.1M and cumulative by £1.1M mainly as a result of the reclassification of locum costs in 2017/18.

Primary Drivers

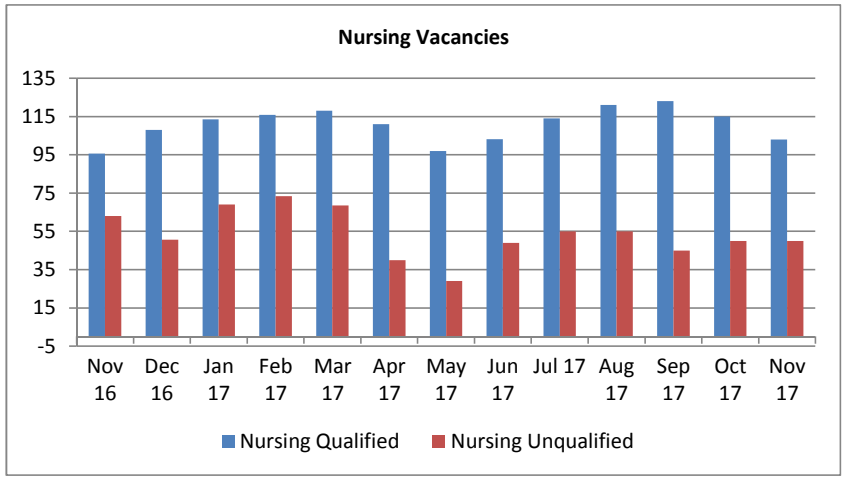


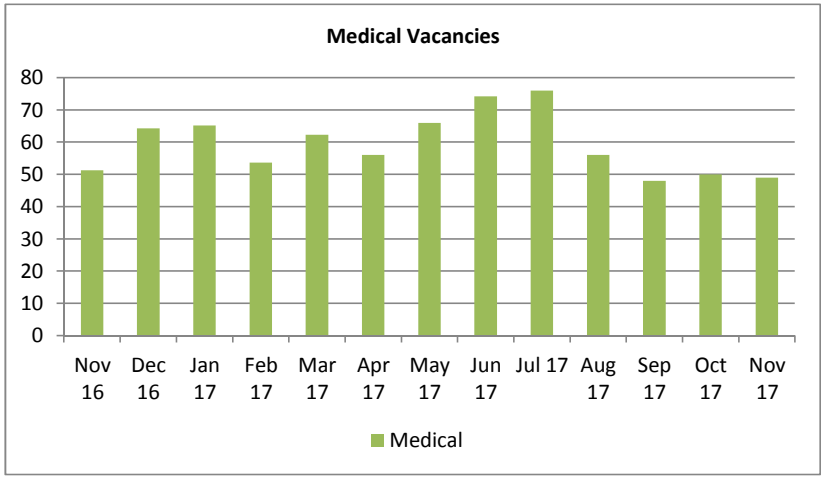




Finance: *Staff Costs*

Secondary Drivers





Agency Trajectory

	YTD	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Monthly Trend
Plan	-3,871	-477	-506	-495	-470	-484	-482	-518	-472	-579	-510	-451	-433	-426	
Actual	-2,769	-721	-572	-668	-618	-574	-378	-419	-296	-424	-325	-358	-254	-315	
Variance	1,102	-244	-66	-173	-148	-90	104	99	176	155	185	93	179	111	
CCICP Actual	0	-77	-152	-210	4	-77	0	0	0	0	0	0	0	0	

From 17/18, CCICP are included in the main figures above.

	Rolling 13 Months													
	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Monthly Trend
Sickness Rate (Rolling 12 mths)	3.81%	3.86%	3.94%	3.95%	3.92%	3.97%	3.99%	4.04%	4.07%	4.14%	4.20%	4.21%	4.23%	
Total Leavers	37	36	44	27	42	31	37	35	44	46	54	45	42	
Turnover (Rolling 12 mths)	9.10%	9.27%	9.17%	9.09%	9.27%	10.56%	10.75%	10.52%	10.12%	10.57%	11.10%	11.08%	10.93%	

NHS
Mid Cheshire Hospitals
NHS Foundation Trust

Title of Paper :	Additional Car Parking Spaces (from current footprint)	
Author:	Mike Babb	
Executive Lead:	Mark Oldham	
Type of Report:	Concept Paper	
	Strategic Options Paper	
	Business Case	✓
	Information	
	Review/Benefits/Audit	

Link to Strategic Domains:		***Link to Domain:***	
Delivering Outstanding Clinical Quality, Safety & Experience	✓	Safe	✓
Being a Leading partner in a Progressive Health Economy		Effective	✓
Striving for Outstanding Organisational Effectiveness	✓	Caring	
Aspiring to Excellence in Practice Through Our Workforce		Responsive	✓
Creating a 21st Century Infrastructure for Transformative Health and Social Care	✓	Well-Led	

Link to Board Responsibility:	Performance	✓
	Accountability	
	Strategy	
	Implementation	
Action Required:	Decide	
	Approve	✓
	Note	
	Recommend	
	Delegate	

Positive Benefit:	Deliver additional parking capacity from existing footprint
Risk:	Working on 'live' site adjacent to existing car park(s)

To be published on Trust Website – complete version	***Y***
If no, to be published on Trust Website – redacted	***N***
If not to be published complete or redacted, please detail the reason why	
Presented at Board Meeting of:	8 January 2018

REPORT TO: Executive Infrastructure Development Group

SUBJECT: Additional Car Parking spaces

REPORT FROM: Divisional Director – Estates and Facilities

PURPOSE: To recommend progressing with and providing some 90 additional car parking spaces at Leighton Hospital.

Introduction

The staff and visitor parking at Leighton is known to be insufficient at peak times on weekdays. MCHFT is attempting to purchase additional land to its north east border, however the land owners Agent is only seeking to sell land at above its agricultural market rate.
Therefore MCHFT needs to have a back-up plan in case the Agent cannot broker a deal.

Parking Spaces

The land at Leighton hospital is well utilised but there are several locations where it would be possible to create additional spaces from the existing footprint.

The site locations and the approximate number of spaces is shown on the table below.

Area on Plan	Description	No. of additional bays	Cost Estimate (Average)	Genuine Increase Y/N	Comments
D	ITIC Compound	20	£2,000	Y	Freed up by Area A (Requires Lining Only)
A (Phase 1)	Cardiac Rehab	21	£ 44,625	Y	39 total: 21 spaces phase 1 with cardiac rehab still in situ
E	MG Block	20	£ 25,000	Y	
C	MJ Block	23	£ 28,750	Y	
F	MC Block	2	£ 2,500	Y	
H	New Staff	2	£ 3,000	Y	Bike shelter to relocate
I	Med Records	3	£ 3,750	Y	
Sub Total		***91***	***£ 109,625***		
A (Phase 2)	Cardiac Rehab	18	£ 38,250	Y	Cardiac Rehab Building needs to be removed & service relocated at a cost
G	Computer Services	3	£ 3,750	N	Currently parking on grass
B	Sub Station & Gas House	14	£ 17,500	Y	Is this more cost effective as an Estates Store?
Grand Total		**126**	**£ 169,125**		

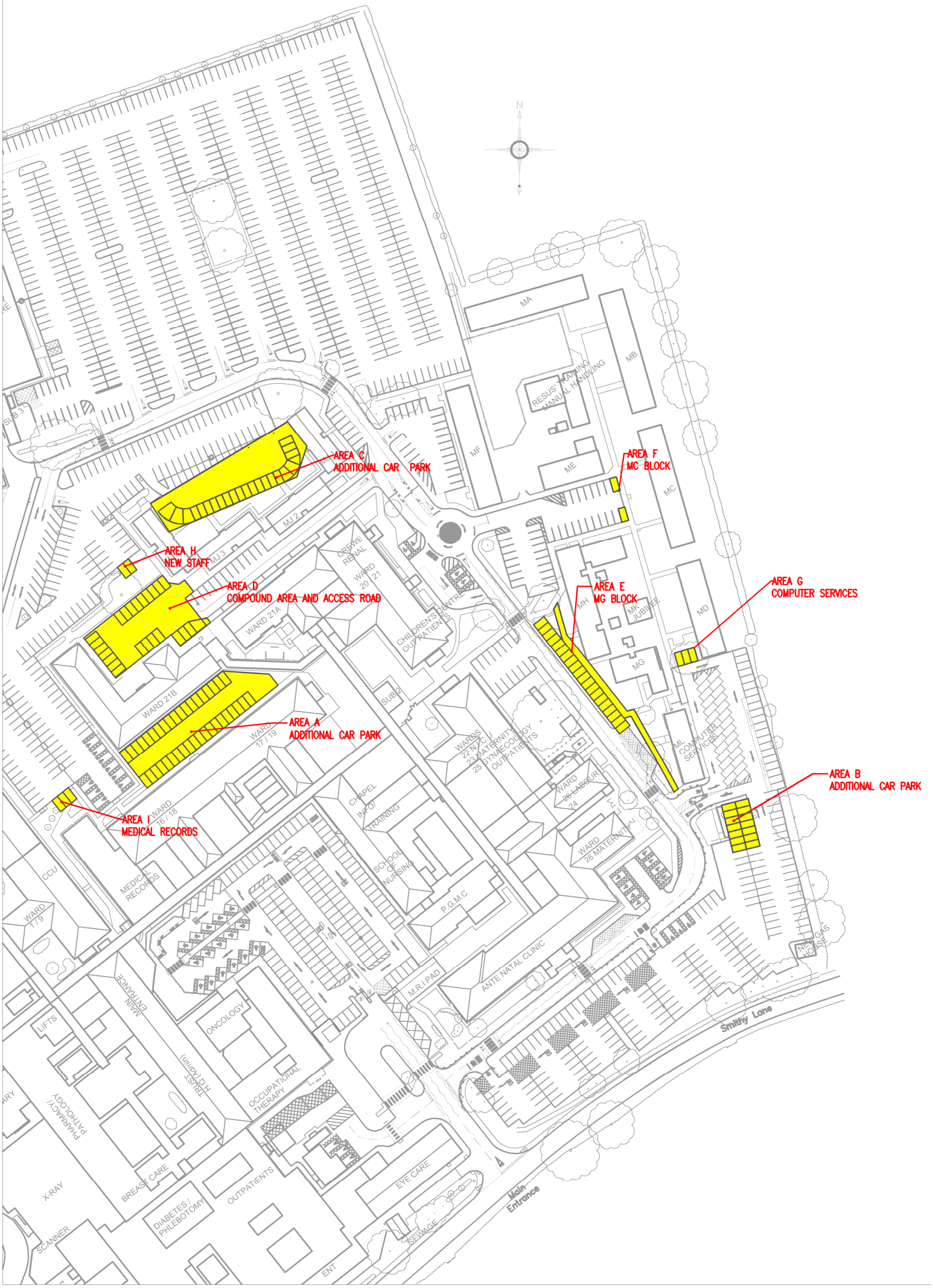
From the above table it can be seen that the first ninety spaces could be provided at a cost of around £110k and this works out to roughly £1,200 per space.

The last 35 spaces would cost a further £60k and the average cost of these spaces is higher at around £1,700 per space. There are also additional costs associated with these more difficult areas towards the bottom of the table.

The physical locations are detailed on the attached chart and it can also be seen that work could take place at various locations and it should not cause any major disruption to the provision of healthcare services.

Hence the Divisional Director of Estates and Facilities is recommending that the Trust build the 91 spaces at a cost of around £110k, VAT recoverable.

There is no 2017/18 specific budget allocation and so it is suggested that the cost is charged to Backlog with the Board noting the exception (as the financial outturn is likely to summarily, including VAT, exceed £100k).


AREA C
ADDITIONAL CAR PARK
AREA H
NEW STAFF
AREA D
COMPOUND AREA AND ACCESS ROAD
AREA A
ADDITIONAL CAR PARK
AREA I
MEDICAL RECORDS
AREA F
MC BLOCK
AREA E
MG BLOCK
AREA G
COMPUTER SERVICES
AREA B
ADDITIONAL CAR PARK
MA
MB
MC
MD
ME
MF
MG
MH
MJ 2
MJ 3
SUB 2
SUB 3
RESUS TRAINING MANUAL HANDLING
ORPHAN RENAL
WARD 20/21
WARD 21A
WARD 21B
CHILDREN'S OUTPATIENTS
WARD 17/19
WARD 16/18
WARDS 22 N.I.C.U 23 MATERNITY 25 GYNAECOLOGY OUTPATIENTS
WARD 26 LABOUR
WARD 26 MATERNITY
CHAPEL
INFO
TRAINING
SCHOOL OF NURSING
P.G.M.C
M.R.I PAD
ANTE NATAL CLINIC
COMPUTER SERVICES
MK JUBILEE
CCU
WARD 1/9
MEDICAL RECORDS
MAIN ENTRANCE
LIFTS
ONCOLOGY
TRUST H.Q (ADMIN)
OCCUPATIONAL THERAPY
PHARMACY/ PATHOLOGY
X-RAY
SCANNER
BREAST CARE
DIABETES / PHLEBOTOMY
OUTPATIENTS
ENT
EYE CARE
SEEMAGE
Main Entrance
Smithy Lane
N

CCICP Partnership Board

Date/time: Thursday 9th November 2017 at 9:00am

Venue: Boardroom, Ashfields PCC, Sandbach

Chair: Tim Welch, Director of Finance, CWP

Action Notes: Caron Corbin, Business and Project Support Officer, CCICP

Quorate (Y/N): Yes

No.	Item			
1	**Present**	Mr T Welch ***Chair***	**(TW)**	Director of Finance, CWP
		Mrs D Frodsham	**(DF)**	Director of Strategic Partnerships, MCHFT
		Dr J Price	**(JP)**	GP, Willow Wood surgery and Director SC/VR GP Alliance
		Dr Anushta Sivananthan	**(SV)**	Medical Director, CWP
		Mrs T Cookson	**(TC)**	Clinical Director (Nurse) SC/VR GP Alliance
		Dr N Paul	**(NP)**	GP, Ashfields Primary Care Centre and Director Howbeck Healthcare
		Dr P A Dodds	**(PAD)**	Medical Director & Deputy Chief Executive. MCHFT
	In attendance	Mrs Caron Corbin ***Notes***	**(CC)**	Business and Project Support Officer, CCICP
	Apologies	Mr M Oldham	**(MO)**	Director of Finance & Strategic Planning, MCHFT
		Mr A Styring	**(AS)**	Director of Operations, CWP
		Ms K Moore	**(KM)**	Operational Lead, CCICP
		Mrs S Hamman	**(SH)**	Head of Quality, Nursing and Professional Leadership, CCICP

Circulation: Mrs D Frodsham - Chief Operating Officer, MCHFT; Mr M Oldham – Director of Finance & Strategic Planning, MCHFT; Dr P A Dodds – Medical Director & Deputy Chief Executive. MCHFT; Dr N Paul – GP Alliance; Dr J Price – GP Alliance; Mrs T Cookson – GP Alliance; Ms K Moore - Operational Lead, CCICP; Mr T Welch – Director of Finance, CWP; Mr A Styring - Director of Operations, CWP; Dr Anushta Sivananthan – Medical Director, CWP

No.	Item	Discussion	Decision made	Action	Responsible	Due date
2.	**Board Members Interests**	Board Members confirmed that there were no changes to interests previously recorded, nor any specific interests relating to items on the agenda. JP declared in relation to agenda item 8, Community Beds review. Willow Wood Practice provide medical cover to one of the bases discussed in the paper.	Declaration of Interest noted.	Board Members Declarations of Interest to be re-submitted by next meeting	All	December
3.	**Minutes of previous meeting**	The minutes of the previous meeting, 12th October, were reviewed for accuracy.	The Board agreed the minutes presented were accurate and approved.			
4.	**Matters Arising/Action Tracker**					
4.1	**Action Log**	The Board reviewed and updated the action log. The following was noted: *Action 147:* QIA was circulated by KM to Board Members and no issues were raised. Action closed. *Action 167:* NS speaking to East Cheshire, the aim is to mirror arrangements already in place in West, placing a band 6 resource in each GP surgery.		Circulate Benefits Realisation Plan	NS	December
5.	**NHSI meeting Feedback**	The notes and action log of the third development session had been circulated to members. The group discussed the actions and noted the following progress: 1. Development of a job description for an independent Chair is in progress and will be circulated to Board Members for comment **TC** 2. MO working on Delegation of the Board but date of completion to be agreed 3. DF working on first draft of Vision and Strategy and will circulate to Board members for				

		comment w/c 13th November 4. Engagement events are being arranged through December/January. Clinical Leads are to be invited from each cluster. 5. OD – to be discussed within agenda 6. Clarification of commissioners – Dec 17 7. Collaboration of CCG - Dec 17 8. Model of Delivery to be completed by end January setting out the principles for Care Community Teams. Roles and Management Structure of the Board may be a product of the OD work, and will set out clear roles for Board members. 9. To be taken forward by the Independent Chair once appointed.				
6.	**Board Development Proposal**	TC had circulated to members of the Board the details of the offer of consultancy support for Board development arising from the Barratt survey. There would be no charge for the session, however the offer is time limited and needs to be taken up by the end of December. If availability allows, it is proposed that two sessions are arranged with the Consultant. Resource for OD is limited and a paper has been drafted which sets out the resource requirements for an OD practitioner, workshop facilitator and communications support. This will be included in the paper setting out the additional resource required for CCICP which is not currently factored into the budget. A bid has been submitted for Leadership funding, this may lead to funding to support requirements until the end of March 2018. A decision is due mid November.		Scope availability of members of the Board plus KM and SH to end December for development session	CC	ASAP

7.	**Finance Report**	DF presented the Finance report in the absence of MO. It was noted that: • IT non-recurrent costs will begin to impact the budget. A cost plan is being developed setting out when costs are expected to occur. This will form part of the operational plan • The prior period adjustment on the Income and Expenditure sheet relates to a refund of Estates costs. A reduction of £320k pa has been negotiated as part of the estates review workstream. As Estates costs were underwritten by the CCG to mitigate the risk to MCHFT, the recurrent saving of £320k will go to CCG. However iti s expected that the rebate from last year will remain in CCICP (£160k) • GPOOHs is now achieving almost break even. Nurses vacancies have been filled. DF reported that MO is reviewing how the budget information is presented and will provide more graphical information to the Board.				
8.	**CCG Community Beds Paper**	CCICP Partnership Board have been asked to note this paper in view of the fact that there is currently no CCICP representative on the A & E Delivery Board and the proposals impact on CCICP. The paper was developed as part of the Capped Expenditure Programme (CEP) proposals to reduce beds across the health economy. The proposals include: • Removing labels from beds to allow more flexibility • Reduce continuing healthcare beds and increase the number of discharge to assess community beds • Further development of a systems capacity Management system				

		• Commissioning an acute IV intervention in the community • Support the Home First model • Support recommissioning of domiciliary care and bed based care • Reduce number of acute beds from April 18 Partnership Board discussed the paper and the implications for CCICP services. JP and NS each raised concerns regarding the capacity of Winsford Grange to provide additional beds and effective care, particularly during the winter period. JP noted that her practice currently provides the medical cover for Winsford Grange and there had been no consultation with them regarding the proposals. It is understood that notice has been given to the GPs directly contracting with CCG to provide specific cover to CHC beds and that the intention is to re-commission medical cover through the CCICP contract. It was agreed that a formal response will be provided to the CCG via the Chair.		Board members to provide responses to TW. TW to draft a letter and circulate for agreement.	All TW	ASAP ASAP
9.	**Transformation Board Feedback**	It was noted that members of the last Transformation Board meeting were very positive regarding the progress now being made, however, the group were informed that the CCG were withdrawing their resource support and would no longer be joint working with the CCICP Transformation Team. This is creating a resource issue for the Team, however additional support is being provided by MCHFT transformation team.				
10.	**Transformation Programme**					
10.1	**Transformation Plan**	The final draft Transformation Plan now was accepted at the Transformation Board. However, noting that it now requires amending to match the				

		agreed priorities and themes: • Frail and elderly • Low level mental health • Long term conditions	Plan accepted noting that 2018/19 Transformation Plan, reflecting agreed priorities, is now required to be updated.			
10.2	**Staff alignment to Care Communities**	DF presented the paper detailing the proposed alignment of CCICP staff to Care Community Teams had been circulated. This was intended to provide Partnership Board with an understanding of the current position and was not intended to be shared outside of CCICP but a communication plan was necessary. The only staff not included in total within the paper and this exercise are those working in paediatric service areas and corporate staff. The principals were that Staff had been devolved according to where they currently worked and this had historically been done on patient need and referral activity. It was noted that a high level there appeared to be some differences in staff/patient ratios but noting this did not take account of weighted population or risk stratification. It was suggested that using weighted population to calculate the ratios may be useful. Partnership Board were asked to accept the paper and the recommendations as phase one of the devolvement process. The group discussed potential opportunities to focus resource, or consider how resource may be used more effectively. It is recognised that there is a historic inequality of Advanced Community Practitioner (formally Community Matron) provision in Northwich. This is included in the list of investment needs for 2018/19. however this role has proved to have significant positive impacts in other areas and the Board felt that in year provision should be made.	Partnership Board accepted the paper and all of the recommendations made therein. Board members suggested that weighted populations are used to calculate staff/population ratios. Partnership Board agreed that recruitment of a second ACP for Northwich should go ahead, increasing the vacancy management to fund therin.	DF to communicate to Transformation Team DF to request this is undertaken by transformation team DF to request this is progressed through operational group and communicated to Northwich cluster	Immediate Effect Dec 17 Immediate Effect	

10.3	**Workstream Highlight reports**	The Transformation Workstream Highlight Reports had been circulated for information. It was noted that: *GP Out of Hours:* There had been one Expression of Interest received for Clinical Lead for the service. The post will be interim in the first instance whilst a wider restructure across primary care streaming is considered. *MSK:* Contract variation for the MSK SPA has been signed. The group discussed how provision should be communicated to GPs and agreed that communications should come from the CCG as the commissioners for the service. *Estates:* Current location of all staff has been mapped and future provision is being considered. This will feed into the whole system estates review and IT workforce programme. *IT:* First task and finish group has met. Working with EMIS to sign contract. Mobile Device workshop has taken place and devices identified to trial. First IT engagement event has taken place. The training team will develop tools and resources that can also be used by GPs for their practices to ensure the whole team understands the new systems. Templates are all being reviewed. DF has seen an example of a combined referral form, common for all services and has asked for a copy to circulate for comment.				
11.	**Performance and Quality reports**	***Balanced Score Card:*** No incidents of serious concern. Friends and family score remains low in uptake and DF recognised this needs to be higher. but noting that a voicemail service is being introduced to try and encourage more patients to provide feedback. Sickness absence is generally good and long term sickness levels are reducing. Vacancies are to be micro-managed to try to improve vacancy rates. A recruitment open day is				

		being held in November for AHPs. ***Quality, Safety and Experience Report:*** No exceptions. There is now a more detailed report on medication incidents, supported by the Pharmacist for Community Services. Note that four complaints were received but 3 of these relate to one patient. ***Integrated Governance:*** No exceptions ***CQUIN Report:*** Circulated to Partnership Board for information. No issues to note.				
12.	**CCICP Risk register**	A review of the whole CCICP risk register had been carried out by Kevin Wynn, interim Risk Manager, and the format amended. A copy of the refreshed register had been circulated. Partnership Board are asked to approve the refreshed risk register. There are currently two red risks on the register, relating to staffing in the GP OOHs service, and provision of appropriate moving and handling training for community staff. Actions are already in progress to address each of these risks.	Revised risk register approved, noting the two red risks and mitigating actions.			
14.	**Operational Lead's Report**	The Operational Lead report had been circulated to Board Members. The Clinical Service Manager for GP OOHs remains on sick leave until January. An interim service manager from MCHFT has been sourced to provide support for the service and to develop more robust governance and sustainable rotas. Recruitment to support MSK SPA has begun. Local authorities are looking to pool budgets for Paediatric SALT services. Wheelchair Service tender presentations are to take place w/c 13th November. Management restructure is complete. Two external candidates have been recruited as well as one				

		internal promotion for the 3rd post. Interviewing takes place w/c 13th November for AD position. Three candidates have been shortlisted. AS has provided DF with a proposed transition plan to move KM back to CWP. The proposal is that KM works at CCICP for three days per week up to Christmas and two days per week after Christmas until the new person is in post. DF expressed concern that this leaves a resource gap for CCICP but also stretches KM's capacity. DF has responded to AS.				
10.	**Any other Business**	*ALG Concerns:* NS attended the Accountable Leadership Group (ALG) 8th November and reported that CWaC Cabinet had produced a position statement paper expressing concerns from an LA perspective, relating to geography of place based integrated care teams and unified commissioning and other recommendations of the Central and Cheshire Eastern Review (known as the Cheshire Review). *Heart Failure Service:* Contract variation is signed and pilot begins w/s 13th November. *Stoma:* CCG have approved a paper proposing to enhance the stoma team. Collectively manage 1300 patients. Next step will be to consider catheters. *MCHFT Celebration of Achievement:* Members of the Partnership Board are invited to attend the event at Crewe Hall 30th November. *CQC:* NP queried the CQC inspection process from a Board Member perspective. It was confirmed that Board Members would be tested under the "Well Led" theme, and these inspections are not unannounced. Mapping against CQC standards is in progress and SH will be reporting progress at December Board.				

	Next Meeting: **Date:** Thursday 14th December 2017 **Time:** 9am **Venue:** Board Room, Ashfields, Sandbach

Mid Cheshire Hospitals
NHS Foundation Trust

Title of Paper :	Corporate Governance Handbook	
Author:	Katharine Dowson, Trust Board Secretary	
Executive Lead:	Paul Dodds	
Type of Report:	Concept Paper	
	Strategic Options Paper	
	Business Case	
	Information	x
	Review/Benefits/Audit	x

Link to Strategic Domains:		***Link to Domain:***	
Delivering Outstanding Clinical Quality, Safety & Experience	x	Safe	x
Being a Leading partner in a Progressive Health Economy		Effective	x
Striving for Outstanding Organisational Effectiveness	x	Caring	
Aspiring to Excellence in Practice Through Our Workforce	x	Responsive	x
Creating a 21st Century Infrastructure for Transformative Health and Social Care		Well-Led	x

Link to Board Responsibility:	Performance	x
	Accountability	x
	Strategy	
	Implementation	x
Action Required:	Decide	
	Approve	x
	Note	
	Recommend	
	Delegate	

Positive Benefit:	Review of governance guidelines for staff
Risk:	none

To be published on Trust Website –complete version	***Y*** *(delete as appropriate)*
If no, to be published on Trust Website – redacted	***N*** *(delete as appropriate)*
If not to be published complete or redacted, please detail the reason why	
Presented at Board Meeting of:	8 January 2018

Corporate Governance Handbook

Next formal review date:	November 2018~~7~~
Lead Director:	Medical Director
Document owner:	Trust Board Secretary
Approved by: Governance Committee	~~Strategic Integrated Governance Committee~~Quality
Ratified by:	Board of Directors
Date:	~~February~~ January 2018~~7~~
Version:	7~~6~~

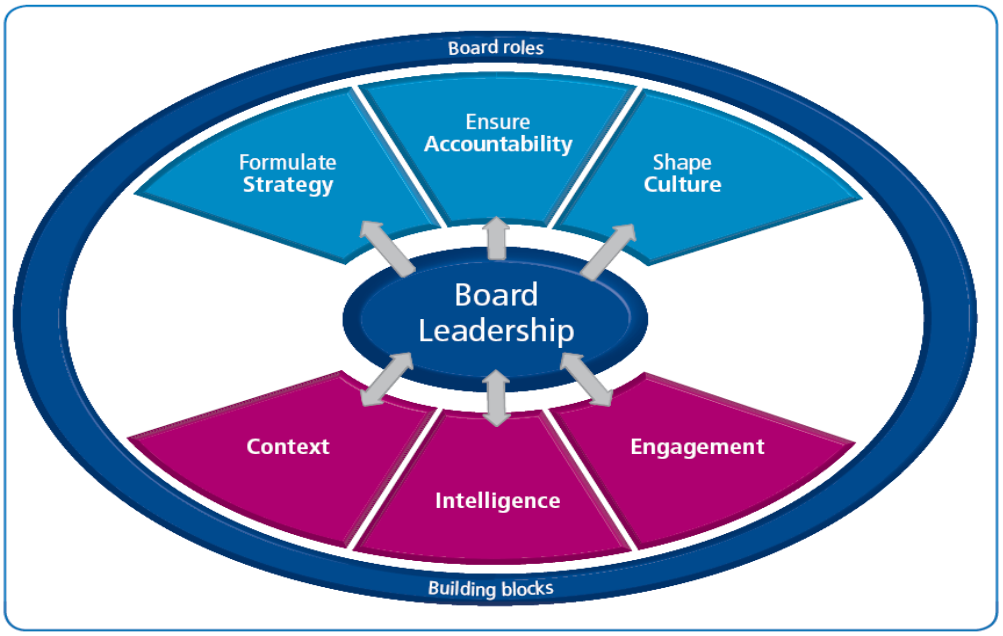
Contents Page for Key Sections

CORPORATE GOVERNANCE HANDBOOK

Overview

The strategic vision of Mid Cheshire Hospitals NHS Foundation Trust (The Trust) is clear and simple, to deliver excellence in healthcare through innovation and collaboration. Our mission is to be a District General Hospital that delivers high quality, safe, cost effective and sustainable healthcare services; provides a working environment that is underpinned by values and behaviours; is committed to patient-centred care and treats staff and patients with dignity and respect. To deliver these goals, the Board of Directors is collectively responsible for the performance of the Trust and it must ensure that an effective system is in place to enable the discharge of its duties.

Fig. 1 Key Roles of an Effective Board - The Healthy NHS Board (2013)



NHS foundation trusts were created as new legal entities by the Health and Social Care Act 2003. The legislation constituted NHS foundation trusts with a governance regime that is fundamentally different from NHS trusts. NHS foundation trusts have both local and external accountabilities. The framework of local accountability is to members through a Council of Governors.

Externally, while remaining part of the NHS, Foundation Trusts are authorised by, and accountable for the operation of their licence to, the independent regulator, Monitor, now part of NHS Improvement, rather than to the Secretary of State for Health. Foundation trusts are free to decide locally how to meet their obligations. They have specified powers to enter into contracts in their own name and to act as Corporate Trustees. In the latter role they are accountable to the Charity Commission for those funds deemed to be charitable.

The Trust is run by the Board of Directors, which is responsible for the quality of healthcare delivery and financial performance. The Board of Directors is accountable for the performance of the Trust, to NHS Improvement and locally to the Council of Governors. Additionally, the Trust is accountable to the Care Quality Commission for the quality of its services.

The Council of Governors links the Foundation Trust to its members and the community to ensure engagement and involvement of the public. The Council of Governors is chaired by the Chair of the Foundation Trust. One of the Non-executive Directors is appointed as the Senior Independent

Director to support relationships between the Board of Directors and the Council of Governors. It is the membership that elects the elected component of the Council of Governors. Any member of staff, patient or carer of the Trust, or member of the public who live in the local area can choose to become a member of the Trust.

Strong direction and leadership from the Board of Directors, Executive Management Team and Clinical Leaders is key to ensuring a positive impact on quality and safety across the organisation this is underpinned by 'good corporate governance' which is a fundamental cornerstone for the success of Mid Cheshire Hospitals NHS Foundation Trust.

Fig.2 NHS Leadership Academy Leadership Framework 2011

Associated Key Documents

- Trust Strategy 2017/18 with 2020/21 Vision
- *Risk Management Strategy and Assurance Frameworks* ~~*y*~~ (2014~~4~~7-2020~~17~~)
- *MCHFT Constitution (2016~~6~~7)*
- *Quality & Safety Improvement Strategy (2016~~4~~4-2016~~6~~8)*
- ~~*Procedure for the Establishment and Function of Committees or Groups (2014).*~~
- *Data Quality Policy* (2016-19)
- *Risk Assessment Procedure* (2016-19)
- *Incident Reporting Policy (including Serious Incident Management)*~~*, Management, Analysis and Improvement Policy*~~ (2014~~4~~7-20)
- *Freedom of Information Act & The Environmental Information Regulations Policy* (2016~~6~~7-18)
- *Major Incident Plan* (2013~~3~~6)
- ~~*Strategic*~~ *Corporate Continuity Plan* (2014~~4~~5)
- *Being Open Policy including the Duty of Candour (2016-19)*
- *Confidentiality and Data Protection (2015~~5~~7-18)*
- *Health & Safety Policy* (2016-19)

Glossary
Refer to page 194
References
Refer to page 197

Board of Directors Standing Orders

Board of Directors Standing Orders:

1 Introduction

~~Corporate g~~Governance is the means by which boards lead and direct their organisations so that decision-making is effective and the right outcomes are delivered in line with the guiding principles set out in the NHS Constitution. In the NHS this means delivering safe, effective services in a caring and compassionate environment in a way that is responsive to the changing needs of patients and service users. Robust governance structures should encourage proper engagement with stakeholders and strong local accountability.

1.1 Statutory Framework

Mid Cheshire Hospitals NHS Foundation Trust (the Trust) is a public benefit corporation. It was established, and it functions, in accordance with the provisions of the National Health Service Act 2006 (hereafter referred to as the 2006 Act). The primary duty of the Board of Directors is to promote the success of the organisation so as to maximise the benefits for the members of the Trust as a whole and for the public who will be treated by the Trust. Furthermore, the Monitor Foundation Trust Code of Governance (2013) states that every NHS Foundation Trust should be headed by an effective board of directors that is collectively responsible for the performance of the NHS FT.

The purpose of these standing orders is to ensure:

- the regulation of the Trust's Board of Directors' proceedings and business.
- that, along with the Council of Governors and the Trust overall, the Board achieves the highest standard of ~~corporate~~ governance and conduct.

1.2 Principal Purposes

The Board of Directors is a unitary Board that has overall responsibility for running the affairs of the Trust. Its role is to:

- ensure compliance with the Trust Constitution, the Provider Licence, statutory requirements and contractual obligations
- ensure the quality and safety of health care services, education and training
- ensure the Trust functions effectively, efficiently and economically
- set and communicate the Trust strategic direction and vision with due regard to the views of the Council of Governors
- define and demonstrate the culture and values of the organisation

- manage and minimise risk
- make well-informed and high-quality decisions based on intelligent information
- assess performance against agreed objectives and targets
- ensure that action is taken to eliminate or minimise, as appropriate, adverse deviations from objectives
- ensure and review that the highest standards of Corporate Governance are applied throughout the organisation. The Board shall at all times seek to comply with the NHS Foundation Trust Code of Governance which builds on the UK Corporate Governance Code
- have regard to the NHS Constitution in performing the Trust's NHS functions

1.3 NHS Codes

Directors ~~must~~ should behave in accordance with the seven Nolan principles of behaviour in Public Life:

Fig 3. The Nolan Principles, Public Standards Committee 1995

1.4 Documents Incorporated into Standing Orders

The Board shall approve, and from time to time revise Schedules to the standing orders of the Board of Directors, such as Committee Terms of Reference, which shall have effect as if incorporated into standing orders:

- The Standing Financial Instructions;
- The Standing Financial Instructions for Non-Financial Risk;
- The Reservation of Powers to the Board of Directors;
- The Delegation of Powers from the Board of Directors;

New or revised Financial Codes of Procedures shall have effect as if incorporated into standing orders by virtue of the Director of Finance & Strategic Planning issuing them and reporting their issue to the Board through the Audit Committee.

1.5 Powers

The Board of Directors shall exercise the powers of the Trust established under statute, in accordance with the terms of its NHS Provider Licence and its Constitution. The Board shall be required to retain full and effective control over the Trust. 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 Reservation of Powers to the Board and Delegation of Powers from the Board, and have effect as if incorporated into these standing orders.

As a statutory body, the Trust has specified powers to contract in its own name, and all business shall be conducted in the name of the Trust.

The Chairman and Non-executive directors are responsible for providing direction to and monitoring the performance of, the executive management of the Trust.

The Trust also has a common law duty as a Bailee for patients' property held by the Trust on behalf of patients. All such funds received in trust shall be held in the name of the Board as corporate trustee.

In relation to funds held on trust, powers exercised by the Board as corporate trustee shall be exercised separately and distinctly from those powers exercised as a NHS Trust. The Board of Directors shall be accountable to the Charity Commission.

1.6 Delegation of Powers

Save as set out in this Constitution and as otherwise permitted by law, the Board has powers to delegate, and to make arrangements for delegation. The standing orders set out the detail of these arrangements. Under standing order 5, the Board has powers to make arrangements for the exercise, on behalf of the Trust of any of their functions by a committee, sub-group or joint committee appointed by virtue of standing order 6 or by an officer of the Trust, in each case subject to such restrictions and conditions as the Trust thinks fit.

Save as stipulated in Constitution: 25 (Appointment of Non-Executive Directors) and as otherwise required by the Constitution and permitted by law, the Board shall from time to time agree the delegation of executive powers to be exercised by committees or sub-~~committees~~ groups that it has formally constituted. The Board shall approve the constitution and terms of reference of these committees, or sub-groups, and their specific executive powers.

Under Schedule 7 of the Health Service Act 2006 these powers may only be delegated to a committee of Directors. The Board shall approve, and shall annually review, Schedules concerning Reservation of Powers to the Board of Directors, and Delegation of Powers by the Board of Directors, which shall have effect as if incorporated into these standing orders

Those functions of the Trust which have not been retained as reserved by the Board, or delegated to one of its committees, shall be exercised on behalf of the Board by the Chief Executive. He shall determine which functions he will perform personally, and shall nominate officers to undertake remaining functions but still retain accountability for these to the Board.

1.7 Emergency Powers

The powers which the Board resolves to retain to itself may in emergency be exercised by the Chief Executive and the Chairman provided that they first consult at least two Non-executive directors, and subsequently report the exercise of such powers to the next formal meeting of the Board for ratification.

1.8 Derogation from Standing Orders

If, for any reason, these standing orders are not complied with, full details of the non-compliance, and any justification for non-compliance, and the circumstances around the non-compliance, shall be recorded in the minutes and reported to the next

meeting of the Board of Directors, (through its Audit Committee) for action or ratification.

All directors have a duty to disclose any non-compliance with these standing orders to the Chairman as soon as possible. Serious or deliberate non-compliance by staff will be dealt with through the Trust's disciplinary procedures.

1.9 Amendment of Standing Orders

The Audit Committee shall review standing orders at least every three years, and make any recommendations for change to the Board. This review shall include all documents having the effect as if incorporated in standing orders, including those reviewed annually. These standing orders shall only be amended in accordance with paragraph 43 of the Constitution.

2 Interpretation

2.1 Save as otherwise permitted by law, at any meeting the Chairman of the Trust shall be the final authority on the interpretation of standing orders, on which he should be advised by the Chief Executive, the Director of Finance & Strategic Planning, or the Trust Board Secretary.

2.2 Unless otherwise stated, words or expressions contained in this Constitution shall bear the same meaning as in the 2006 Act as amended by the 2012 Act.

3 The Board

3.1 Composition of the Board

See **Constitution:** 22

3.2 Appointment, Tenure and Resignation of the Non-Executive Chairman and Deputy Chairman, and Non-Executive Directors

The Chairman and Non-executive directors are appointed and removed by the Council of Governors. Any Non-executive director may at any time resign by giving notice in writing to the Chairman.

3.3 Eligibility and Appraisal of the Non-Executive Chairman and Non-Executive Directors

The Board shall approve a formal process to enable it to assess and declare (or otherwise) the independent status of each Non-executive director. The process shall apply to all proposed new appointees, and annually thereafter to those appointed. The Chief Executive and Chairman of the Audit Committee shall review the declarations and shall report the outcome to the Board. The Constitution requires the Chairman of the Audit Committee to be a Non-executive director, and his declaration shall be reviewed, and the outcome reported to the Board, by the Chairman and the Chief Executive. The Board shall then determine the status of each Non-executive director.

The Trust Constitution requires all Directors to declare that they are considered a fit or proper person, as set out in paragraph (3) of Regulation 5 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This declaration shall be made on appointment and annually thereafter.

The Board shall appoint one of the Non-executive directors, not being the Chairman, as the Senior Independent Director in consultation with the Council of Governors.

The Council of Governor's Appointments and Remuneration Committee shall meet to appraise the Chairman's performance at least annually, and on such other occasions as the Council deems to be appropriate, with or without the Chairman present, and led by the Senior Independent Director. The committee shall prepare a written appraisal and circulate it in confidence to all Non-executive directors including the Chairman, and to ~~g~~Governors. If appropriate, and with the approval of the majority of Non-executive directors, the Senior Independent Non-Executive Director shall make recommendations to the Chairman, or he shall appraise the Chief Executive of the committee's report and together they may make recommendations to the Chairman. Exceptionally the Senior Independent Director may, with the approval of the committee, disclose the committee's recommendations to the Council of Governors or the Board sitting in private session.

3.4 Appointment and Powers of Deputy Chairman

Where the Chairman of the Trust has died, or has ceased to hold office, or been unable to perform his duties as Chairman owing to illness or any other cause, the Deputy Chair shall act as Chairman until a new Chairman is appointed, or the existing Chairman resumes his duties, as the case may be; and references to the Chairman in these standing orders shall, as long as there is no Chairman able to perform his duties, be taken to include references to the Deputy Chair.

3.5 Appointment of Chief Executive

Collectively, the Chairman and Non-executive directors of the Trust shall comprise the Appointments and Remuneration Committee. In accordance with **Constitution: 27**, the Appointments and Remuneration Committee shall appoint the Chief Executive, subject to the approval of the Council of Governors, determine his remuneration and terms of employment, and if necessary terminate his employment. His appointment shall be subject to the approval of the Council of Governors. If the post of Chief Executive is unfilled for any reason, the Appointments and Remuneration Committee may make such appointments as it deems appropriate within its terms of reference.

3.6 Non-executive Directors may, at the Trust's expense, seek external advice, or appoint an external adviser, on any material matter of concern provided that the decision to do so is a collective one by the majority of Non-executive Directors. In doing so, they will normally seek the advice of the relevant Executive Director or the Trust Board Secretary.

3.7 Appointment of Executive Directors

The Board shall appoint an Appointments and Remuneration committee comprising of the Chairman, the Chief Executive and the Non-executive Directors to appoint or remove executive directors and to determine the remuneration and allowances and other terms and conditions of office of the executive Directors.

3.8 Jointly-Held Executive Director Appointments

Where more than one person is appointed jointly to a post, then those persons may, with the approval of the Board, be appointed as an executive director jointly, and shall count as one person.

3.9 Attendees at Board Meetings

The Board may resolve that certain officers, members, or elected or appointed governors of the Trust may be invited to attend all or some of the meetings of the

Board to assist the Board in its deliberations. Such invitees will not contribute to the numbers required for a quorum (as defined in standing order 4 below), and shall not vote on resolutions. Such invitees shall be required to undertake to comply with standing orders if they are not officers of the Trust.

3.10 Trust Board Secretary

The Board shall appoint a Trust Board Secretary who, under the direction of the Chairman and the Chief Executive, and reporting to the Chief Executive, shall ensure full and effective information flows within the Board of Directors, and between the Board of Directors and the Council of Governors, and their committees; between directors and governors, and between senior management and Non-executive Directors. The Trust Board Secretary shall also advise the Board and Council on all governance matters, and shall facilitate induction and professional development as required for members of the Board of Directors and Council of Governors.

3.11 Directors' Liability

On appointment, the Chairman, Non-executive Directors and Executive Directors shall be required to subscribe to the NHS Foundation Trust Code of Governance and Board Code of Conduct.

A director or officer of the Trust who has acted honestly and in good faith will not have to meet out of his own personal resources any personal civil liability which is incurred in the execution, or purported execution, of his function as a director save where the director has acted recklessly. On behalf of the directors, and as part of the Trust's overall insurance arrangements, the Board of Directors shall put in place appropriate insurance provision to cover such indemnity.

4 Board Meetings

Admission of Members, the Public and the Press

41 Board of Director Meetings shall be held in public. Members of the public may be excluded from a meeting for special reasons. A non-exhaustive list of such special reasons will be held by the Trust Board Secretary.

4.2 Nothing in these standing orders shall allow members of the public or representatives of the press to record proceedings in any manner whatsoever, other than writing, or to make any oral report of proceedings as they take place, without the prior agreement of the Board.

Calling Meetings

4.3 The Board of Directors will meet at a frequency, (but not less than quarterly) and at a time, date and place that it shall decide.

4.4 Notwithstanding the requirement in 4.6 below for notice, the Chairman may waive notice on written receipt of the agreement of at least two-thirds of directors (Non-executive and executive directors taken together) but to include a minimum of two executive directors and two Non-executive directors.

4.5 The Chairman may call a meeting of the Board at any time. If the Chairman refuses to call a meeting after a requisition for that purpose, signed by at least one-third of the whole number of directors, has been presented to him, or if, without so refusing, the Chairman does not call a meeting within seven days after such a requisition has been presented to him, at the Trust's head office, such one third or more directors

may forthwith call a meeting. In the case of a meeting called by directors in default of the Chairman, the notice shall be signed by those directors, and no business shall be transacted at the meeting other than that specified in the notice.

Notice of Meetings

4.6 Before each meeting of the Board, a notice of the meeting, specifying the business proposed to be transacted at it, and attaching relevant papers, shall be sent to each director seven consecutive calendar days before the meeting. In exceptional circumstances, the Chairman may agree to unavoidably late papers to be sent after this deadline.

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

4.8 Before each meeting takes place, notice of the meeting, including specification of the business proposed to be transacted at it will be made available to the Council of Governors and on request to any member of the public. Notice will also be given on the Trust's website.

Setting the Agenda

4.9 On an annual basis, the Board shall determine regular agenda items, and their frequency.

4.10 In considering the agenda, the Board and the Chairman shall balance:

- reporting and analysing past performance;
- examining the critical levers which will influence the future;
- operational issues, properly the function of the executive directors;
- strategic issues, deriving from the Board Assurance Framework and the Board's objectives, that will impact on performance;
- local interest, as represented by the Council of Governors;
- the interests of the wider population of NHS users.

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

4.12 A director desiring a matter to be included on an agenda shall make his request to the Chairman at least ten clear days before the meeting. Requests made less than ten days before a meeting may be included on the agenda at the discretion of the Chairman.

4.13 **Chairman of Meetings**

At any meeting of the Board, the Chairman, if present, shall preside. If the Chairman is absent from the meeting (including absence due to a declared conflict of interest), the Deputy Chair, if there is one and he is present, shall preside. If the Chairman and Deputy Chair are absent, a Non-executive Director chosen by those directors present, shall preside.

Notices of Motion

4.14 A director desiring to move or amend a motion shall send a written notice thereof at least ten clear days before the meeting to the Chairman, who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible

under the appropriate regulations. This paragraph shall not prevent any motion being moved during the meeting without notice on any business mentioned on the agenda.

4.15 Notice of a motion to amend or 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 directors who gives it and also the signature of four other directors. When any such motion has been disposed of by the Board, it shall not be competent for any director, other than the Chairman, to propose a motion to the same effect within six months; however, the Chairman may do so if he considers it appropriate.

4.16 **Withdrawal of Motion or Amendments**
A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chairman.

Motions

4.17 The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

4.18 When a motion is under discussion or immediately prior to discussion it shall be open to a director to move:

- an amendment to the motion;
- the adjournment of the discussion or the meeting;
- that the meeting proceed to the next business (*);
- the appointment of an ad hoc committee to deal with a specific item of business;
- that the motion be now put (*);

*In the case of sub-paragraphs denoted by (*) above, to ensure objectivity motions may only be put by a director who has not previously taken part in the debate and who is eligible to vote.

Such a motion, if seconded, shall be disposed of before the motion which was originally under discussion or about to be discussed.

4.19 No amendment to the motion shall be admitted if, in the opinion of the Chairman of the meeting, the amendment negates the substance of the motion.

4.20 **Conduct of the meeting and Chairman's Ruling**
The Chairman of the meeting will ensure that adequate time is afforded for the proper consideration of each item on the agenda. Contributions by directors, and other persons invited to attend, shall be relevant to the matter under discussion and the decision of the Chairman of the meeting on questions of order, relevancy and any other matter concerning the conduct of the m~~M~~eeting shall be final.

4.21 **Voting**
Each question at a meeting shall be determined by a majority of the votes cast on it by the Chairman of the meeting, and by other directors present. At his discretion, the Chairman of the meeting may determine such questions either by oral expression or by show of hands. A majority of directors present may require a vote to be taken by anonymous paper ballot.

4.22 If an equal number of votes are cast for and against the motion, the Chairman of the meeting shall have a second or casting vote.

4.23 If at least one-third of the directors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each director present voted or abstained.

4.24 If a director so requests, his vote shall be recorded by name upon any vote (other than by paper ballot).

4.25 In no circumstances may an absent director vote by proxy. Absence is defined as being absent at the time of the vote. Attendance may be permitted by telephone or video media link, if available, at the discretion of the Chairman.

4.26 An officer who has been appointed formally by the Board to act up for an executive director during a period of incapacity or temporarily to fill an executive director vacancy, shall be entitled to exercise the voting rights of the Executive director. An officer attending the Board to represent an Executive director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the executive director. An officer's status when attending a meeting shall be recorded in the minutes.

4.27 **Minutes**

The Chairman shall ensure that the minutes of the proceedings of a meeting are drawn up under the supervision of the Trust Board Secretary, and maintained as a permanent record. The minutes shall record all matters of significance, with details of any action to be taken, who will take the specified action and the dates for its completion where appropriate.

4.28 The Board Trust Secretary shall ensure that a draft of the minutes, endorsed by the Chairman, (or the person who presided at the meeting of which they are a record) are promptly circulated to directors, and submitted for agreement at the next ensuing meeting, where they will be signed by the person presiding. No discussion shall take place upon the minutes except upon their accuracy, or where the Chairman considers discussion appropriate. Any amendment to the minutes shall be recorded and agreed at the next meeting.

4.29 Minutes shall be circulated to each Governor as soon as is practicable after the meeting, and may be further circulated in accordance with directors' wishes. Where providing a record of a public meeting, the minutes shall be made available to the public.

4.30 **Joint Members**

Where the office of an executive director is shared jointly by more than one person:

- either or both of those persons may attend or take part in meetings of the Board;
- if both are present at a meeting, they should cast one vote if they agree;
- if they disagree, no vote should be cast;
- the presence of either or both of those persons should count as the presence of one person for the purposes of standing order 4.38.

4.31 **Suspension of Standing Orders**

Except where this would contravene any statutory provision, 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 Non-executive and one Executive director, and that a majority of those present vote in favour of suspension.

4.32 A decision to suspend standing orders shall be recorded in the minutes of the meeting.

4.33 A separate record of matters discussed during the suspension of standing orders shall be made and shall be available to the Chairman and directors.

4.34 No formal business may be transacted while standing orders are suspended.

4.35 The Audit Committee of the Trust shall review every decision to suspend standing orders.

4.36 **Variation and Amendment of Standing Orders**
These standing orders shall be amended only in accordance with the **Constitution 43**, and in consultation with the Council of Governors.

4.37 **Record of Attendance**
The names of the Chairman, directors, and any person invited by the Chairman to attend shall be recorded in the minutes by surname and initials, and by post, function or representative capacity.

4.38 **Quorum**
No business shall be transacted at a meeting unless at least one-third of the whole number of the Chairman and directors, including at least one Non-executive director and one executive director are present.

4.39 An officer in attendance for an executive director, but without formal acting up status approved by the Appointments and Remuneration Committee, may not count towards the quorum.

4.40 If the Chairman or a director 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 he shall no longer count towards the quorum.

4.41 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.

5 Arrangements for the Exercise of Functions by Delegation

5.1 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 these standing orders, or by a director or an officer of the Trust, in each case subject to such restrictions and conditions as the Board thinks fit.

5.2 In delegating a function to a third party, the Board will ensure effective governance procedures are in place e.g. committees, sub committees, or officers.

5.3 **Delegation to Committees**
Subject to the powers that the Board retains for itself, the Board may determine from time to time to delegate certain of its responsibilities to be exercised by a committee, sub-group, or joint-committee, which it has formally constituted. The constitution and terms of reference of these committees, or sub-groups, or joint committees, and their

specific powers (and, if necessary, those retained by the Board) shall be approved by the Board. These committees, sub-groups and joint committees must be formally constituted of Directors of the Board only.

5.4 **Delegation to Officers**
Those functions of the Trust which have not been retained as reserved by the Board or delegated to a committee or sub-committee or joint-committee shall be exercised on behalf of the Trust by the Chief Executive. The Chief Executive, subject to approval by the Board, shall determine which functions he will perform personally, and shall determine a management structure and nominate officers to undertake the remaining functions for which he will still retain accountability to the Board.

5.5 The Chief Executive shall prepare a Scheme of Delegation to Officers for consideration and approval by the Board. The Chief Executive may periodically propose amendments to the Scheme of Delegation for consideration and approval by the Board.

5.6 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of the Director of Finance & Strategic Planning to provide information and advise the Board in accordance with statutory requirements. Outside these statutory requirements, the Director of Finance & Strategic Planning shall be accountable to the Chief Executive for operational matters.

5.7 The arrangements made by the Board as set out in the Reservation of Powers to the Board and Delegation of Powers (to Officers) document shall have effect as if incorporated in these standing orders.

5.8 The Trust Board Secretary shall maintain a current management structure approved by the Board.

5.9 **Non-Compliance with Standing Orders**
If for any reason these standing orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be recorded in the minutes and:

- for standing orders 2, 3 and 4 above, reported to the next formal meeting of the Board for action or ratification, and
- for all other paragraphs of these standing orders to the next meeting of the Board committee responsible for audit, for its consideration and referral to the Board.

5.10 All members of the Board and staff have a duty to disclose any non-compliance with these standing orders to the Chief Executive as soon as possible. Serious or deliberate non-compliance by staff will be dealt with through the Trust's disciplinary procedures.

6 Committees and Convenors

6.1 **Appointment of Committees**
Subject to the provisions of the Constitution, these standing orders and any other legal requirements, the Board shall appoint committees of the Trust, consisting wholly or partly of directors of the Trust, or wholly of persons who are not directors of the Trust, and reporting to the Board through the committee chairman.

6.2 The Board shall approve the appointment of committee chairs, on the Chairman's recommendation.

6.3 Standing orders, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees or sub-group established by the Trust.

6.4 Each such committee shall have such terms of reference and powers and be subject to such conditions (including reporting back to the Board), as the Board shall decide and shall be in accordance with any legislation and regulation. After taking advice from each committee, the Board shall review the terms of reference of each committee annually, and those terms of reference, as reviewed and revised periodically, shall have effect as if incorporated into standing orders.

The Board may make, vary and revoke standing orders relating to the quorum, proceedings and place of meeting of a committee or sub-group but otherwise the committee or sub-group may determine these matters as it thinks fit.

The committee shall be empowered to establish the necessary infrastructure, to enable the committee to undertake their required responsibilities

6.5 Committees of the Board may establish sub-groups. In doing so, they:

- may not delegate executive powers to the sub-group - unless the Board has expressly authorised them to do so;
- must determine the membership and terms of reference of such sub-group;
- must require sight of the minutes of each sub-group meeting at their own meetings.

6.6 The Board may agree to the establishment of joint committees with the Council of Governors, and with other organisations, and appoint directors and staff as may be appropriate to such joint committees.

6.7 Committees, sub-groups and joint committees have no powers to commit expenditure by the Trust, except where budgets have been specifically delegated by the Board.

6.8 **Confidentiality**

If the Board or a committee resolves that a matter is confidential, a director or a member of the Board or that committee shall not disclose that matter, even if it has been reported to the Board, or otherwise dealt with by, or brought before, the committee, even if any associated action has been concluded, subject to any legal duties/requirements to disclose.

7 Incorporation of Standing Orders into Employment Contracts

7.1 The Chairman (for non-executive directors) and Chief Executive (for executive directors, managers, consultant medical staff and officers having delegated authority defined by the Delegation of Powers to Officers) shall ensure that these standing orders are incorporated into contracts of employment, and are brought to the attention of all such persons on appointment or when revised, and through the Trust's Intranet.

7.2 The Chief Executive shall ensure that appropriate training is put into place to reinforce these standing orders.

8. Declaration of Interests

Interests of Directors

8.1 In accordance with the Health and Social Care Act 2012 Directors will be open and transparent in the manner in which conflicts of interest are managed. Directors must declare to the Board their interests and the interests of their family which are relevant and material on appointment, or as soon as practical as such interests are acquired subsequent to appointment.

8.2 Interests which are regarded as "relevant and material" are:

- Directorships, including Non-executive directorships held in private companies or public limited companies (with the exception of those of dormant companies);
- Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS;
- Majority or controlling share-holdings in organisations likely or possibly seeking to do business with the NHS;
- Employment with any private company, business or consultancy.
- A position of trust in a charity or voluntary organisation in the field of health and social care;
- Any connection with a voluntary or other organisation contracting for NHS services.
- Any other commercial interest relating to any relevant decision to be taken by the Trust.

"Family" shall mean spouse, partner, children, grandchildren, other dependents, parents and grandparents. There is no requirement for the interests of directors' spouses or partners to be declared. However, the Membership and Procedure Regulations require that any interest in contracts of directors' spouses, if living together, should be declared.

8.3 Any changes in interests shall be declared at the next Board meeting following the change occurring. At the time that directors declare an interest, it will be recorded in the Board minutes.

8.4 Directors' directorships of companies likely or possibly seeking to do business with the NHS shall be published in the Board's Annual Report. The information shall be kept up to date for inclusion in succeeding annual reports and will be published on the Trust webpage.

8.5 During the course of a Board meeting, if a conflict of interest is established, the Chairman or a director concerned shall disclose the fact and withdraw from the meeting and play no part in the relevant discussion or decision.

8.6 If the Chairman or a director of the Trust has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter, and is present at a meeting of the Board of Directors 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. For the avoidance of doubt, the Board shall exclude the director from a meeting of the Board while any contract, proposed contract or other matter in which he has a pecuniary interest, is under consideration.

8.7 The Board of Directors, as it may think fit, may remove any disability imposed by this standing order in any case in which it appears to the Board that, in the interests of the National Health Service, the disability shall be removed. Such action shall have the

support of at least two-thirds of the directors (including two Executive and two Non-executive directors).

8.~~6~~8 Any remuneration, compensation or allowances payable to the director by virtue of the Act shall not be treated as a pecuniary interest for the purpose of this standing order.

8.9~~7~~ For the purpose of this standing order, and subject to other standing orders, the director shall be treated as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

- he, or a nominee, 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 or 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; or
- the interest is regarded as "relevant and material" in accordance with standing order 8.2 above.

The interests of the director shall include members of his family as defined in standing order 8.2

8.10~~8~~ The Chairman or a director shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

(a) of his membership of a company or other body, if he has no beneficial interest in any securities of that company or other body;

(b) of an interest in any company, body or person with which he is connected as mentioned above which is so remote or insignificant that it cannot reasonably be regarded as likely to influence the Chairman or a director in the consideration or discussion of, or in voting on, any question with respect to that contract or matter.

8.11~~9~~ Where the Chairman or a director:

(a) has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body, and

(b) the total nominal value of those securities does not exceed £10,000 or one-hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less, and

(c) if the share capital is of more than one class, the total nominal value of shares of any one class in which he has a beneficial interest does not exceed one-hundredth of the total issued share capital of that class, this standing order shall not prohibit him from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it without prejudice however to his duty to disclose his interest.

The above provisions apply to member of a committee, sub-group or joint committee as they apply to the Chairman and directors.

8.12~~1~~ Directors shall discuss any personal doubt about the relevance of an interest with the Chairman, who shall take account of current guidance. The Accounting Standards Board's *Financial Reporting Standard No 8* specifies that, in assessing the relevance of an interest, influence is more important than the immediacy of the relationship.

8.132 The Chief Executive will ensure that a register of interests is established, and maintained by the Trust Board Secretary to record formally declarations of interests of directors. In particular, the register will include details of all directorships and other relevant and material interests that have been declared by both Executive and Non-executive directors.

8.143 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.

8.14 The register shall be available to the public, and the Trust Board Secretary will take reasonable steps to bring to local public attention the existence of the register and arrangements for viewing it.

9 Custody of Seal and Sealing of Documents

9.1 **Custody of Seal**

The common seal of the Trust shall be kept by the Trust Board Secretary in a secure place and shall be secured by two separate locks.

Sealing of Documents

9.2 The Seal of the Trust shall not be fixed to any documents unless the sealing has been authorised by a resolution of the Board. In exceptional circumstances the Chairman and the Trust Board Secretary may affix the Seal to any document provided that all such instances are reported to the next meeting of the Board.

9.3 **Register of Sealing**

An entry of every sealing shall be made and numbered consecutively in a register provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. A report of all sealings shall be made to the Board at least quarterly, or 6 monthly if the seal has not been used. The report shall contain details of the seal number, the description of the document, date of sealing and date of Board approval.

10 Signature of Documents

10.1 Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the Director of Finance & Strategic Planning when the proceedings are to recover debts due to the Trust and by the Chief Executive in all other circumstances, 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.

10.2 All written contracts shall be signed by the Chief Executive and Director of Finance & Strategic Planning jointly subject to approvals contained in these standing orders.

Board of Directors

Standing Financial Instructions

FOREWORD

1. Each Board operates within a statutory framework within which it is required to adopt Standing Orders. The "Directions on Financial Management in England" issued under HSG(96)12 in 1996 states that each Board must adopt Standing Financial Instructions (SFI's) setting out the responsibilities of individuals. These Directions are mandatory for Health Authorities but not for NHS trusts. NHS trusts are asked to observe the Directions as far as they are relevant as a matter of good practice.

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

3. Once SFI's have been adopted by the Board they become mandatory on all directors and employees of the organisation.

CONTENTS

SCHEDULES

1 INTRODUCTION

1.1 General

1.1.1 The Code of Accountability requires that each NHS Trust shall give, and may vary or revoke, Standing Financial Instructions for the regulation of the conduct of its members and officers in relation to all financial matters with which they are concerned. These Standing Financial Instructions (SFIs) are issued in accordance with the Code. They shall have effect as if incorporated in the Standing Orders (SOs). There will be a training and communication programme administered by the Director of Finance & Strategic Planning to affect these SFIs.

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

1.1.3 These Standing Financial Instructions identify the financial responsibilities that apply to everyone working for the Trust and its constituent organisations including Trading Units. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial procedure notes. **All financial procedures must be approved by the Director of Finance & Strategic Planning.**

1.1.4 Should any difficulties arise regarding the interpretation or application of any of the Standing Financial Instructions then the advice of the Director of Finance & Strategic Planning MUST BE SOUGHT BEFORE ACTING. The user of these Standing Financial Instructions should also be familiar with and comply with the provisions of the Trust's Standing Orders.

1.1.5 Failure to comply with standing financial instructions and standing orders is a disciplinary matter that could result in dismissal**.**

1.1.6 **Overriding Standing Financial Instructions** – If for any reason these Standing Financial Instructions are not complied with full details of the non-compliance the justification and a description of all relevant circumstances shall be reported to the next formal meeting of the Audit Committee for referring action or ratification. All members of the Board and staff have a duty to disclose any non-compliance with these Standing Financial Instructions to the Director of Finance & Strategic Planning as soon as possible.

1.2 Terminology

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

1.2.2 Terms defined in the Glossary shall apply to this document.

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

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

1.3 Responsibilities and delegation

1.3.1 The Board exercises financial supervision and control by:

(a) formulating the financial strategy;
(b) requiring the submission and approval of budgets within approved allocations/overall income;
(c) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money);
(d) defining specific responsibilities placed on members of the Board and employees as indicated in the Scheme of Delegation document;
(e) ensuring that there is an adequately resourced, trained and competent finance function;
(f) reviewing, at least annually, the system of internal control for financial management.

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

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

1.3.4 Within the Standing Financial Instructions, it is acknowledged that the Chief Executive is ultimately accountable to the Board, and as Accountable Officer, through the Secretary of State for Health to Parliament, for ensuring that the Trust meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities; is responsible to the Chairman and the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

1.3.5 The Chief Executive shall ensure that there are clear lines of financial accountability throughout the organisation.

1.3.6 The Chief Executive and Director of Finance & Strategic Planning will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control.

1.3.7 It is a duty of the Chief Executive to ensure that existing members of the Board and Staff and all new appointees are notified of, and understand, their responsibilities within these Instructions.

1.3.8 The Director of Finance & Strategic Planning is responsible for:

(a) implementing the Trust's financial policies and for co-ordinating any corrective action necessary to further these policies;
(b) maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;
(c) ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time and the risks to financial duties.
(d) the provision of financial advice to other members of the Board and employees;
(e) the design, implementation and supervision of systems of internal financial control; and
(f) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

1.3.9 All Members of the Board and Staff, severally and collectively, are responsible for:

(a) the security of the property of the Trust;
(b) avoiding loss;
(c) exercising economy and efficiency in the use of resources; and
(d) conforming to the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation.

1.3.10 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.

1.3.11 For any and all Members of the Board and staff who carry out a financial function, the form in which financial records are kept and the manner in which Members of the Board and members of staff discharge their financial duties must be to the satisfaction of the Director of Finance & Strategic Planning.

1.3.12 The Director of Finance & Strategic Planning has a duty to investigate the manner in which Directors and Staff discharge their financial duties, to make recommendations to the Chief Executive and to report concerns to the Audit Committee or the Board at the earliest opportunity or in line with the Fraud and Corruption Policy as appropriate

2 AUDIT

2.1 Director of Finance & Strategic Planning

2.1.1 The Director of Finance & Strategic Planning is responsible for:

(a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective internal audit function;
(b) ensuring that the internal audit is adequate and meets the NHS mandatory audit standards;
(c) investigating and reporting to the Board on fraud and other offences (where malpractice is suspected the Director of Finance & Strategic Planning shall be notified immediately), and deciding at what stage to involve the police in cases of fraud, misappropriation, and other irregularities in line with the Trust's Fraud Response Plan;
(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 control in accordance with current controls assurance guidance issued by the Department of Health and Monitor 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 the annual audit plan,
    (v) strategic audit plan covering the coming three years,
    (vi) a detailed plan for the coming year.
(e) reviewing, appraising and reporting on :
    (i) the extent of compliance with, relevance and financial effect of established policies, plans and procedures;
    (ii) the extent to which the Trust's assets and interests are accounted for and safeguarded from losses of all kinds;
    (iii) the efficient use of resources;
    (iv) the suitability and reliability of financial and other related management data developed within the Trust;
    (v) the adequacy of follow-up action to his reports.

2.1.2 The Director of Finance & Strategic Planning 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 and premises of the Trust, members of the Board or employees of the Trust;
(c) the production of any cash, stores or other property of the Trust under a member of the Board and member of staff's control; and
(d) explanations concerning any matter under investigation.

2.2 Role of Internal Audit

2.2.1 Internal Audit will review, appraise and report upon:

(a) the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;
(b) the adequacy and application of financial and other related management controls;
(c) the suitability of financial and other related management data;
(d) the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:
  (i) fraud and other offences,
  (ii) waste, extravagance, inefficient administration,
  (iii) poor value for money or other causes.
(e) Internal Audit shall also independently verify the Annual Governance Statement in accordance with guidance from the Department of Health and Monitor.

2.2.2 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Director of Finance & Strategic Planning must be notified immediately.

2.2.3 The Head of Internal Audit will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chairman and Chief Executive of the Trust.

2.2.4 The Head of Internal Audit shall be accountable to the Director of Finance & Strategic Planning. The reporting system for internal audit shall be agreed between the Director of Finance & Strategic Planning, 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.

2.2.5 Where, in exceptional circumstances, the use of normal reporting channels could be seen as possible limitation of the objectivity of the audit, the Chief Internal Auditor shall seek the advice of the Chairman of the Audit Committee, other members of the Audit Committee or Chairman of the Board.

2.3 Fraud and Corruption

2.3.1 The NHS Counter Fraud & Corruption Manual shall be incorporated into the SFI's and Standing Orders so far as it applies to NHS trusts.

2.3.2 In line with their responsibilities, the Chief Executive and Director of Finance & Strategic Planning shall monitor and ensure compliance with Secretary of State Directions on fraud and corruption.

2.3.3 The Audit Committee shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist as specified by the Department of Health Fraud and Corruption Manual and guidance.

2.3.4 The Local Counter Fraud Specialist shall report to the Director of Finance & Strategic Planning and shall work with staff in the Directorate of Counter Fraud Services and the Counter Fraud Operational Service in accordance with the Department of Health Fraud and Corruption Manual.

2.4 External Audit

2.4.1 The External Auditor is appointed by the Council of Governors and paid for by the Trust. The Audit Committee must ensure a cost-efficient service. Should there appear to be a problem then this should be raised with the External Auditor and referred on to the Council of Governors if the issue cannot be resolved.

3 CASH CONTROLS

3.1 The Trust is required not to exceed its Working Capital Facilities. The Chief Executive has overall executive responsibility for the Trust's activities and is responsible to the Board for ensuring that it stays within its Working Capital Facilities. The Chief Executive must notify the Board when it is expected that such facilities will be used and there-after update the Board monthly as to the use of the facilities and action being taken to cease such use.

3.2 The definition of cash limits is set out in the Directions on Financial Management in England.

3.3 The Director of Finance & Strategic Planning will :

a) provide monthly reports in the form required by the Board or Monitor;
b) be responsible for ensuring that an adequate system of monitoring financial performance is in place to enable the Trust to fulfil its statutory responsibility and not to exceed its Working Capital Facilities.

4 ~~5 YEAR~~ STRATEGY, ANNUAL BUSINESS PLAN, BUDGETS, BUDGETARY CONTROL, AND MONITORING

4.1 Preparation and approval of business strategy

4.1.1 The Chief Executive shall compile and submit to the Board for its approval a ~~5 year~~ strategy at intervals as shall be decided by the Board.

4.2 Preparation and approval of business plans and budgets

4.2.1 The Chief Executive will compile and submit to the Board an annual business plan which takes into account financial and service targets and forecast income and available resources. The annual business plan will be produced in line with guidance published by NHS Improvement on Annual Plan production.

4.2.2 Prior to the start of the financial year the Director of Finance & Strategic Planning will, on behalf of the Chief Executive, prepare and submit budgets for income and expenditure, capital and cash flow for approval by the Board. Such budgets will:

(a) be in accordance with the aims and objectives set out in the Trust Strategy and Clinical Service Strategy;
(b) accord with demand and manpower plans;
(c) be produced following discussion with appropriate budget holders;
(d) be prepared within the limits of expected income;
(e) meet the Income & Expenditure surplus required by the Board; and
(f) identify potential risks and mitigation.

4.2.3 The Director of Finance & Strategic Planning shall also compile and submit to the Board such financial estimates and forecasts, on both capital and revenue account, as may be required from time to time.

4.2.4 The Director of Finance & Strategic Planning shall monitor financial performance against budget and the annual plan, periodically review them, and report to the Board in the format determined by the Board.

4.2.5 The Director of Finance & Strategic Planning will provide annual plans for Monitor in the format and timescale determined by NHS Improvement.

4.2.6 All budget holders must provide information as required by the Director of Finance & Strategic Planning to enable budgets to be compiled.

4.2.7 The Director of Finance & Strategic Planning has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage within budgets successfully.

4.2.8 The Chief Executive shall enter into effective dialogue with the stakeholders and local community on the Trust's strategy, annual plan and performance. The Chief Executive shall report back to the Board the needs and complaints expressed during such dialogue.

4.3 Budgetary Delegation

4.3.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities, including pooled budget arrangements under Section 31 of the Health Act 1999. 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, on the use of the budget and performance of the delegated functions

4.3.2 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board and non-recurring budgets should not be used to finance recurring expenditure without the specific resolution of the Board.

4.3.3 The Chief Executive may determine that any budgeted funds not required for their designated purpose(s) revert to his immediate control, subject to any authorised use of virement.

4.3.4 Expenditure for which no provision has been made in an approved budget and not subject to funding under the delegated powers of virement shall only be incurred after authorisation by the Chief Executive (within his overall budgetary limit) or the Board as appropriate.

4.4 Budgetary control and reporting

4.4.1 The Director of Finance & Strategic Planning will devise and maintain systems of budgetary control. These will include:

(a) the compilation of a monthly report containing financial and other information to be presented to the Board in a form approved by the Board. The Director of Finance & Strategic Planning shall be responsible for the accuracy of the financial reports. Other Directors have responsibility for the provision of the financial information contained in this report. The report shall be succinct and make clear recommendations.
(b) the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;
(c) investigation and reporting of variances from financial, workload and manpower budgets;
(d) monitoring of management action to correct variances; and
(e) arrangements for the authorisation of budget transfers.

4.4.2 Each Budget Holder is responsible for ensuring that:

(a) any likely overspending or reduction of income that cannot be met by virement is not incurred without the prior consent of the Board;
(b) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement; and
(c) no permanent employees are appointed without the approval of the Chief Executive other than those provided for within the available resources and manpower establishment as approved by the Board . The Director of Finance & Strategic Planning will monitor recruitment and appointment activity on behalf of the Board so as to facilitate this control. The Director of Finance & Strategic Planning will establish procedures for authorisation of recruitment within recruitment budgets. The Director of Finance & Strategic Planning will devise procedures for verifying that recruitment and appointments are against available resources and for reporting exceptions to the Board.

4.4.3 In carrying out their duties:

The Chief Executive shall not exceed the budgetary or virement limits set from time to time by the Board.

Budget holders shall not exceed the budgetary limits set out for them from time to time by the Chief Executive.

The Chief Executive may vary the budgetary limit of a budget holder within the Chief Executives own budgetary limit for the Trust as a whole.

4.4.4 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the annual plan and the approved budget.

4.4.5 The Director of Finance & Strategic Planning shall keep the Chief Executive and the Board informed of the financial consequences of changes in policy, pay awards, and other events and trends affecting budgets, and shall advise on the financial and other economic aspects of future plans and budgets.

4.5 Capital expenditure

4.5.1 The general rules applying to delegation and reporting shall also apply to capital expenditure. (The particular applications relating to capital are contained in SFI Section 12.)

4.6 Monitoring returns

4.6.1 The Director of Finance & Strategic Planning is responsible for ensuring that the appropriate monitoring forms are submitted to ~~Monitor~~ NHS Improvement on a timely basis, according with ~~Monitor's~~ NHS Improvement's timescales.

4.6.2 In respect of the Self Certification of financial risk rating and governance risks, the Director of Finance & Strategic Planning and Chief Operating Officer will provide Performance and Finance Committee (PAF) with appropriate forecasts to recommend a declaration to the Board.

4.6.3 Where timescales do not allow and PAF recommend a change in previously notified declaration, the Director of Finance & Strategic Planning will obtain Chief Executive and Chairman's approval prior to formal submission to Monitor.

5 ANNUAL ACCOUNTS AND REPORTS

5.1 The Director of Finance & Strategic Planning, on behalf of the Trust, will:

(a) prepare financial returns in accordance with the Trust's accounting policies, accounting standards and guidance given by the Department of Health, Treasury, or NHS Improvement~~Monitor~~;

(b) prepare annual financial reports for the Secretary of State or Monitor certified in accordance with current guidelines and to the timetable prescribed by the Department of Health or NHS Improvement~~Monitor~~.

As stated in the Code of Accountability under the Role of Chief Executive, the Chief Executive as Accountable Officer has a shared responsibility with the Director of Finance & Strategic Planning in this respect.

5.2 The Trust's annual accounts must be audited by an Auditor appointed by the Council of Governors. The Trust's audited annual accounts must be presented to a public meeting and made available to the public.

5.3 The Trust will publish an annual report, in accordance with guidelines on local accountability, and present it at a public meeting, (see Code of Accountability). The document will comply with the NHS Improvement~~Monitor~~'s FT Accounting Reporting Manual and been submitted to NHS Improvement~~Monitor~~ in line with prescribed deadlines.

6 BANK AND GBS ACCOUNTS

6.1 General

6.1.1 The Director of Finance & Strategic Planning is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account guidance/ Directions issued from time to time by the Department of Health or NHS Improvement ~~Monitor~~.

6.1.2 The Board shall approve the banking arrangements.

6.2 Bank and GBS accounts

6.2.1 The Director of Finance & Strategic Planning is responsible for:

(a) bank accounts and Government Banking Service (GBS) accounts;
(b) establishing separate bank accounts for the Trust's 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 all arrangements made with the Trust's bankers for accounts to be overdrawn.

6.3 Banking procedures

6.3.1 The Director of Finance & Strategic Planning will prepare detailed instructions on the operation of bank and GBS accounts that 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;
(c) those authorised to sign cheques or other orders drawn on the Trust's accounts.

All such instructions are to be approved by the Board before they come into effect.

6.3.2 The Director of Finance & Strategic Planning must advise the Trust's bankers in writing of the conditions under which each account will be operated (including changes and cancellations in those conditions) in accordance with the resolutions of the Board.

6.3.3 All funds shall be held in accounts in the name of the Trust. This shall include all funds from income generation, charitable or other sources connected with the Trust or its activities.

6.3.4 No Director, officer or other member of staff other than the Director of Finance & Strategic Planning shall open any bank account in the name of the Trust or for the purpose of depositing funds from income generation schemes, charitable or other sources connected with the Trust or its activities.

6.3.5 Where an agreement is entered into with another body for payments to be made on behalf of the Trust from bank accounts maintained in the name of the other body, or by electronic funds transfer (e.g. BACS), the Director of Finance & Strategic Planning shall ensure that satisfactory security regulations of the other body relating to bank accounts exist and are observed.

6.4 Review

6.4.1 The Director of Finance & Strategic Planning will review the banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money.

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

7.1 Income systems

7.1.1 The Director of Finance & Strategic Planning is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

7.1.2 The Director of Finance & Strategic Planning is also responsible for the prompt banking of all monies received.

7.2 Fees and charges

7.2.1 The Director of Finance & Strategic Planning is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the National Tariff. Independent professional advice on matters of valuation shall be taken as necessary. 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.

7.2.2 All employees must inform the Director of Finance & Strategic Planning promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings (involving Trust facilities or staff). Category 2 income (Medical and Dental Staff) and other transactions where such income is earned for work or transactions taking place on Trust premises or using Trust resources.

7.3 Debt recovery

7.3.1 The Director of Finance & Strategic Planning is responsible for the appropriate recovery action on all outstanding debts.

7.3.2 Income not received should be dealt with in accordance with losses procedures. (See section 14.)

7.3.3 Overpayments should be detected (or preferably prevented) and recovery initiated.

7.4 Security of cash, cheques and other negotiable instruments

7.4.1 The Director of Finance & Strategic Planning is responsible for:

(a) approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;
(b) ordering and securely controlling any such stationery;
(c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and
(d) prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

7.4.2 Trust money shall not under any circumstances be used for the encashment of private cheques, nor IOUs.

7.4.3 All cheques, postal orders, cash, and other financial instruments shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Director of Finance & Strategic Planning.

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

8 NHS SERVICE AGREEMENTS FOR PROVISION OF SERVICES

8.1 The Chief Executive is responsible for ensuring the Trust enters into suitable Service Agreements with Commissioners for the provision of NHS services. All Service Agreements shall aim to implement the agreed priorities contained within the NHS Operational Framework, locally agreed priorities and shall be in the format of the Model Contract for NHS Service provision. In discharging this responsibility, the Chief Executive shall take into account:

- the standards of service quality expected;
- the relevant national service framework (if any);
- the provision of reliable information on cost and volume of services;
- the annual plan and approved budget.

In carrying out these functions, the Chief Executive shall take into account the advice of the Director of Finance & Strategic Planning regarding:

(a) costing and pricing of all services;
(b) payment terms and conditions;
(c) amendments to contracts and extra-contractual arrangements;

(d) risks associated with fines and penalties and performance related payments (including CQUINS).
(e) Trust's capacity to deliver the activity levels.

8.2 Agreements should be so devised as to minimise risk whilst maximising the Trust's opportunity to generate income. Contract prices shall comply with "Costing for Contracting" guidelines and/or the National Tariff as appropriate.

8.3 All service changes planned for the year shall be included in the Budget and Annual Plan presented to the Board for approval in line with SFI 4.2.2

8.4 The Board shall authorise all subsequent changes to services where there is an estimated revenue income or expenditure of £100,000 or more. In such cases the Chief Executive shall present to the Board a detailed business case in the format agreed by the Board on the Director of Finance & Strategic Planning recommendation.

8.5 The Chief Executive shall report to the Board at the next meeting, all agreement where the estimated revenue income or expenditure is less than £100,000.

8.6 A good Service Agreement will result from a dialogue of clinicians, users, carers, public health professionals and managers. It will reflect knowledge of local needs and inequalities. This will require the Chief Executive to ensure that the Trust works with all partner agencies involved in both the delivery and the commissioning of the service required. The Service Agreement 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.

8.7 The Director of Finance & Strategic Planning shall ensure that regular reports are provided to the Board detailing actual and forecast income from the Service Agreement, against plan.

9 TERMS OF SERVICE, ALLOWANCES AND PAYMENT OF DIRECTORS AND EMPLOYEES

9.1 Remuneration and terms of service

9.1.1 The appointment and remuneration of Non-executive directors shall be determined by the Council of Governors.

9.1.2 The appointment and remuneration of Executive Directors shall be determined by the Remuneration Committee as set out in Standing Orders Section 3.7.

9.2 Funded establishment

9.2.1 The workforce plans incorporated within the annual budget will form the funded establishment.

9.2.2 The Trust's funded establishment may be varied only by

i) changes possible within the approved budget envelope for the budget manager,
ii) changes agreed through the virement process and within the Chief Executive's budget envelope,
iii) changes approved by the Board under SFI 8.4 or by the Chief Executive under SFI 8.5.

The Director of Finance & Strategic Planning shall issue procedures setting out how the funded establishment shall be changed.

9.3 Staff appointments

9.3.1 No Executive Director or member of staff 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 in the Scheme of Delegation; and

(b) within the limit of the Chief Executive's approved budget and funded establishment.

9.3.2 The Director of Finance & Strategic Planning shall devise such procedures so as to ensure that 9.3.1 is complied with and will report to the Chief Executive all instances when these procedures have not been complied with.

9.3.3 The Director responsible for Workforce shall devise procedures for the determination of commencing pay rates and conditions of service for employees.

9.4 Processing payroll

9.4.1 The Director Responsible for Workforce is responsible for:

(a) specifying timetables for submission of properly authorised time records and other notifications;
(b) the final determination of pay and allowances;
(c) making payment on agreed dates; and
(d) agreeing method of payment.

9.4.2 The Director responsible for Workforce 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) pay advances and their recovery;

The Director of Finance & Strategic Planning will issue instructions regarding

(h) methods of payment available to various categories of staff and officers;
(i) procedures for payment by cheque, bank credit, or cash to staff and officers;
(j) procedures for the recall of cheques and bank credits
(k) maintenance of regular and independent reconciliation of pay control accounts;
(l) separation of duties of preparing records and handling cash; and
(m) a system to ensure the recovery from leavers of sums of money and property due by them to the Trust.

9.4.3 Appropriately nominated managers have delegated responsibility for:

(a) submitting time records, and other notifications in accordance with agreed timetables;
(b) completing time records and other notifications in accordance with the Director responsible for Workforce's instructions and in the form prescribed by the Director responsible for Workforce; and
(c) submitting termination forms in the prescribed form immediately upon knowing the effective date of a member of staff or officer's resignation, termination or retirement. Where there are circumstances that suggest they have left without notice, the Director of Finance & Strategic Planning or his designated financial officer must be informed immediately.

9.4.4 Regardless of the arrangements for providing the payroll service, the Director responsible for Workforce shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

The Director of Finance & Strategic Planning will ensure that adequate internal controls and audit review procedures are in place.

9.5 Contracts of employment

9.5.1 The Chief Executive shall delegate responsibility to the Director responsible for Workforce who may then nominate a manager for:

(a) ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and
(b) dealing with variations to, or termination of, contracts of employment.

9.5.2 The Director responsible for Workforce shall ensure that there are procedures for agreeing staff objectives, carrying out staff appraisals, evaluation and identifying development needs.

9.5.3 The Director of responsible for Workforce shall prepare, for approval by the Board, appropriate Human Resource (HR) policies and documents, including the following:

(a) Terms and conditions of employment for all staff (except for those staff covered by the Appointments and Remuneration Committee)
(b) Disciplinary Policy
(c) Grievance Policy

10 NON-PAY EXPENDITURE

10.1 Delegation of authority

10.1.1 The Board will approve the level of non-pay expenditure on an annual basis and from time to time will determine the level of delegation to budget managers on advice from the Chief Executive and Director of Finance & Strategic Planning.

10.1.2 Within the overall framework established by the Board in Section 4 of The Delegation of Powers the Director of Finance & Strategic Planning will set out:

(a) the list of managers who are authorised to place requisitions for the supply of goods and services, and
(b) the maximum level of each requisition and the system for authorisation above that level.

10.1.3 The Director of Finance & Strategic Planning shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

10.2 Choice, requisitioning, ordering, receipt and payment for goods and services

10.2.1 The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's Supplies Manager shall be sought. Where this advice is not acceptable to the requisitioner, the Director of Finance & Strategic Planning (and/or the Chief Executive) shall be consulted.

10.2.2 The Director of Finance & Strategic Planning shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

10.2.3 The Director of Finance & Strategic Planning will:
(a) advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds will be incorporated in standing orders and regularly reviewed (incorporated as Section 4 of the Delegation of Powers);
(b) prepare procedural instructions, where not already provided in the Standing Orders/Standing Financial Instructions on the obtaining of goods, works and services incorporating the thresholds;
(c) be responsible for the prompt payment of all properly authorised accounts and claims;
(d) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

(i) A list of Directors/employees (including specimens of their signatures) authorised to certify invoices.

(ii) Certification that:

- goods have been duly received, examined and are in accordance with specification and the prices are correct;
- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;
- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
- the account is arithmetically correct;
- the account is in order for payment.

(iii) A timetable and system for submission to the Director of Finance & Strategic Planning 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).

The procedures approved by the Director of Finance & Strategic Planning will cover the use of electronic systems dealing with the above where they exist.

10.2.4 Prepayments are only permitted where exceptional circumstances apply. In such instances:

(a) Prepayments are only permitted where the financial advantages outweigh the disadvantages (i.e. cashflows must be discounted to NPV using the National Loans Fund (NLF) rate plus 2%).

(b) the appropriate Executive Director must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet his commitments;

(c) the Director of Finance & Strategic Planning will need to be satisfied with the proposal before contractual arrangements proceed (taking into account the EU public procurement rules where the contract is above a stipulated financial threshold); and

(d) the budget holder is responsible for ensuring that all items due under a prepayment contract are received and he must immediately inform the Director of Finance & Strategic Planning if problems are encountered.

10.2.5 Official Orders must:

(a) be consecutively numbered;
(b) be in a form approved by the Director of Finance & Strategic Planning;
(c) state the Trust's terms and conditions of trade; and
(d) only be issued to, and used by, those duly authorised by the Director of Finance & Strategic Planning

10.2.6 All directors, officers and employees of the Trust must ensure that they comply fully with the guidance and limits specified by the Director of Finance & Strategic Planning and that:

(a) the Director of Finance & Strategic Planning is directly informed of all money payable by the Trust arising from transactions which they initiate. The means of advice will normally be contained in the Financial Procedures Manual but, if in doubt, advice should be sought from the Director of Finance & Strategic Planning;
(b) 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 & Strategic Planning in advance of any commitment being made
(c) 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);
(d) where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Department of Health;
(e) 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;

    (see Standard of Business Conduct, Schedule C of Standing Orders)
(f) no requisition/order is placed for any item or items for which there is no budget provision. Budget Holders shall ensure that funds are vired to budget lines to meet the cost of such items. In the event that there is insufficient flexibility in the total department budget, the Budget Holder shall refer the matter to his manager and ultimately the Chief Executive for such necessary virement;
(g) all goods, services, or works are ordered on an official order (which may be an electronic form approved by the Director of Finance & Strategic Planning) except for works and services that are executed in accordance with a separate written contract, or purchases from petty cash;

(h) verbal orders must only be issued very exceptionally - by a member of staff designated by the Chief Executive (after advice from the Director of Finance & Strategic Planning) and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order";

(i) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

(j) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase. All loan equipment shall be acquired in accordance with procedures drawn up by the Director of Finance & Strategic Planning;

(k) changes to the list of directors/employees and officers authorised to certify invoices are approved by the Director of Finance & Strategic Planning;

(l) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Director of Finance & Strategic Planning; and

(m) petty cash records are maintained in a form as determined by the Director of Finance & Strategic Planning.

10.2.7 The Director of Finance & Strategic Planning shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the NHS Estates guidance including P21 where appropriate. The technical audit of these contracts shall be the responsibility of the relevant Director.

10.3 The Chief Executive shall delegate responsibility to clinical directorates to authorise the use of new pharmaceutical drugs up to an annual expenditure of £25,000, provided the expenditure is within the directorate's budget provision. Where a new drug is anticipated to cost more than £25,000 it must be referred to the Trust's Medicines Management Committee for approval and referral to the Executive Management Board (EMB) for information. All such expenditure must be contained within the budget limit for the division.

11 EXTERNAL BORROWING, PUBLIC DIVIDEND CAPITAL, AND INVESTMENTS

11.1 External Borrowing

11.1.1 The Director of Finance & Strategic Planning will advise the Board concerning the Trust's ability to pay interest and dividends on, and repay, the Public Dividend Capital, new capital and any proposed new borrowing, within the limits set by the Department of Health or Monitor. The Director of Finance & Strategic Planning is also responsible for reporting periodically to the Board concerning the Public Dividend Capital and all loans and overdrafts.

11.1.2 Any application for a loan or overdraft will only be made by the Director of Finance & Strategic Planning or by a member of staff so delegated by him.

11.1.3 The Director of Finance & Strategic Planning shall prepare detailed procedural instructions concerning applications for loans and overdrafts. These shall be detailed in the Financial Procedures Manual.

11.1.4 All short term borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position. Any short term borrowing requirement must be authorised by the Director of Finance & Strategic Planning.

11.1.5 All long term borrowing and additional Public Dividend Capital must be consistent with the plans outlined in the Annual Plan, be within the Trust's external borrowing limits as approved by Monitor, and approved by the Board.

11.2 Investments

11.2.1 The Board shall approve an Investment Strategy and Policy after advice from the Director of Finance & Strategic Planning.

11.2.2 Temporary cash surpluses must be held only in such public or private sector investments set out in the Investment Strategy and Policy.

11.2.3 The Director of Finance & Strategic Planning is responsible for advising the Board on investments and shall report periodically to the Board concerning the performance of investments held.

11.2.4 The Director of Finance & Strategic Planning will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

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

12.1 Capital investment

12.1.1 The Board shall approve, at least every three years, an Estates Strategy setting out the key capital investments on the estate, building, plant and equipment over the next five years.

12.1.2 The Chief Executive:

(a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon annual plans;
(b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost; and
(c) shall ensure that the capital investment is not undertaken without confirmation of commissioner support, where appropriate, and the availability of resources to finance all revenue consequences, including capital charges.

12.1.3 All "Capital Expenditure" must receive prior approval from the Board by way of the Capital Programme.

12.1.4 The Board may include in the Capital Programme a "Capital Contingency" intended to cover urgent needs arising during the year. Any commitments

against the capital contingency will be authorised in line with the Scheme of Delegation and reported retrospectively quarterly to the Board.

12.1.5 All bids for adhoc funds which have been identified after the Capital Programme has been approved, must be notified to the Board

i) prior to the bid being made, if possible;
ii) at the next meeting after the bid has been made

in order that the Board may consider the capital and revenue consequences in light of its annual priorities, and that the bids may be incorporated into the Capital Programme.

12.1.6 For every capital expenditure proposal the Chief Executive shall ensure:

(a) that for assets with a purchase cost of more than £100,000, 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;
(iii) the involvement of appropriate Trust personnel and external agencies;
(iv) list of all contractors and suppliers of materials and services with whom the Trust will have a contract or where the Trust specifies, in the contract, specific sub-contractors or suppliers; and

(b) that the Director of Finance & Strategic Planning has certified professionally to the costs and revenue consequences detailed in the business case.

All business cases shall be submitted to the Board for approval prior to any contractual or other commitment is made.

12.1.7 For Capital schemes under the limits in 12.1.6 and already included in the Capital Programme, there shall be no requirement for approval by the Board prior to commitment. Such commitment will be reported to the Board at its next meeting.

12.1.8 All purchase requisitions for “Capital” must be allocated a Capital Programme number (nominal code) by an officer, appointed by the Director of Finance & Strategic Planning, prior to authorisation.

12.1.9 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating NHS Estates recommended best practice.

12.1.10 The Director of Finance & Strategic Planning shall assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme in accordance with Inland Revenue guidance.

12.1.11 The Director of Finance & Strategic Planning shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

12.1.12 Section 4.3 of the Delegation of Powers shall set out those officers with authority to commit expenditure against capital schemes in the approved capital programme or against a capital contingency approved by the Board.

12.1.13 The Chief Executive shall give to the manager responsible for the scheme authority to proceed to tender and approval to accept a successful tender.

The Chief Executive will issue a scheme of delegation for the management of capital projects in accordance with "Estate code" guidance.

12.1.14 The Director of Finance & Strategic Planning shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes. These procedures shall fully take into account the delegated limits for capital schemes.

12.1.15 In the case of large capital schemes the Director of Estates & Facilities, subject to approval by the Chief Executive (on advice from the Director of Finance & Strategic Planning), shall establish a procedure for progressing the scheme and authorising various payments up to completion. The Board shall be kept informed of the progress of the scheme, including forecasts of expenditure compared to expenditure authorised.

12.2 Private finance

12.2.1 The Trust should normally test for PFI when considering a capital procurement. When the Trust proposes to use finance that is to be provided other than through its own internally generated resources or loan facilities, the following procedures shall apply:

(a) The Director of Finance & Strategic Planning shall demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.
(b) The proposal must be specifically agreed by the Board in line with paragraph 12.1 above.
(c) Where the sum involved exceeds delegated limits, the business case must be referred to NHS Improvement ~~Monito~~r.
(d) A full business case is produced in line with ~~M~~NHS Improvement~~onitor~~'s Risk Evaluation in investment decisions guidance

12.2.2 All PFI rentals (periods in excess of one month) and leases must be approved by the Director of Finance & Strategic Planning.

12.3 Asset registers

12.3.1 The Chief Executive shall delegate to the Director of Finance & Strategic Planning his responsibility for the maintenance of register of assets. The Director of Finance & Strategic Planning shall arrange for a physical check of assets against the asset register to be conducted once a year.

12.3.2 The Trust shall maintain an asset register recording fixed assets including those that are rented/leased. The minimum data set to be held within these registers shall be as specified in the *Capital Accounting Manual* as issued by the Department of Health or Monitor.

12.3.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

(a) properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;
(b) stores, requisitions and wages records for own materials and labour including appropriate overheads; and
(c) lease agreements in respect of assets held under a finance lease and capitalised.

12.3.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

12.3.5 The Director of Finance & Strategic Planning shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

12.3.6 The Director of Finance & Strategic Planning will arrange for interim and full asset valuations in line with the FT Annual Reporting Manual, using appropriate qualified valuers.

12.3.7 The value of each asset shall be depreciated using methods estimated lives as approved by the Director of Finance & Strategic Planning and in line with accepted accounting practice.

12.3.8 The Director of Finance & Strategic Planning shall calculate capital charges as specified in the FT Annual Reporting Manual issued by NHS Improvement ~~Monitor~~.

12.4 Security of assets

12.4.1 The overall control of fixed assets (including those that are rented/leased) is the responsibility of the Chief Executive.

12.4.2 Asset control procedures (including fixed assets, cash, cheques, negotiable instruments and donated assets) must be established by the Director of Finance & Strategic Planning. 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.
(h) negotiation for disposition of any asset at the end of the lease.

12.4.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Director of Finance & Strategic Planning.

12.4.4 Whilst all Staff have a responsibility for the security of property of the Trust, it is the responsibility of Board members and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with instructions.

12.4.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Directors and Staff in accordance with the procedure for reporting losses.

12.4.6 Wherever practical, the Supplies Manager shall ensure that assets are permanently marked as Trust property.

12.4.7 Staff wishing to use Trust property for their private use must obtain prior authorisation from the Director of Finance & Strategic Planning. An appropriate charge may be raised and the member of staff must :

a) sign an appropriate receipt form designed by the Director of Finance & Strategic Planning,
b) arrange for insurance as advised by the Director of Finance & Strategic Planning

12.4.8 The Director of Finance & Strategic Planning shall consult with the Trust's risk and insurance advisors so as to protect the Trust's assets. He will purchase adequate insurance against loss within Department of Health or Monitor rules.

13 STORES AND RECEIPT OF GOODS

13.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

(a) kept to a minimum;
(b) subjected to annual stock take;
(c) valued at the lower of cost and net realisable value.

13.2 Subject to the responsibility of the Director of Finance & Strategic Planning for the systems of control, overall responsibility for the control of stores shall be delegated to an officer by the Chief Executive. The day-to-day responsibility may be delegated by him to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Director of Finance & Strategic Planning. 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.

13.3 The Director of Finance & Strategic Planning shall authorise those Staff to have responsibility to requisition and receive stock from the Trust stores or through external suppliers.

13.4 The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager/Pharmaceutical Officer. Wherever practicable, stocks should be marked as NHS property.

13.5 The Director of Finance & Strategic Planning shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

13.6 Stocktaking arrangements shall be agreed with the Director of Finance & Strategic Planning and there shall be a physical check covering all items in store at least once a year.

13.7 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Director of Finance & Strategic Planning.

13.8 The designated Manager/Pharmaceutical Officer shall be responsible for a system approved by the Director of Finance & Strategic Planning 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 & Strategic Planning any evidence of significant overstocking and of any negligence or malpractice (see also SFI 14, Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

13.9 For goods supplied via the NHS Purchasing and Supplies Agency central warehouses or equivalent, 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 before forwarding this to the Director of Finance & Strategic Planning who shall satisfy himself that the goods have been received before accepting the cost.

14 DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

14.1 Disposals and Condemnations

14.1.1 The Director of Finance & Strategic Planning must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers.

14.1.2 The Director of Finance & Strategic Planning must nominate Condemning Officers, appropriate to the asset or goods.

14.1.3 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 & Strategic Planning of the estimated market value of the item, taking account of professional advice where appropriate.

14.1.4 All unserviceable articles shall be:

(a) condemned or otherwise disposed of by a member of staff authorised for that purpose by the Director of Finance & Strategic Planning;
(b) recorded by the Condemning Officer in a form approved by the Director of Finance & Strategic Planning that 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 member of staff authorised for the purpose by the Director of Finance & Strategic Planning.

14.1.5 The Trust's Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Director of Finance & Strategic Planning who will take the appropriate action.

14.1.6 The disposal of any land, building or other asset (where the net book value or proceeds of "other asset" is more than £50,000) shall be subject to prior approval by the Board.

14.1.7 Protected Assets will require Monitor approval prior to disposal/sale.

14.2 Losses and special payments

14.2.1 The Director of Finance & Strategic Planning must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments. (See Financial Procedures Manual)

14.2.2 Any members of Staff 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 & Strategic Planning (or an officer nominated by him) or inform an officer charged with responsibility for responding to concerns involving loss confidentially. (See Fraud Policy and Response Plan and/or the Trust's Whistle Blowing Policy). This officer will then appropriately inform the Director of Finance & Strategic Planning.

14.2.3 The Trust's "Fraud and Response Plan" shall form part of these SFI's. It sets out the actions to be taken by persons detecting a suspected fraud and those persons responsible for investigating it.

14.2.4 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Director of Finance & Strategic Planning or a nominated officer must notify as soon as possible :
(a) the Local Counter Fraud Specialist,
(b) the Audit Committee,
(c) the External Auditor,
(d) the Police in the cases of suspected theft or arson

14.2.5 Within limits delegated to it by the Department of Health (currently listed in Schedule II), the Board shall approve the writing-off of losses. The Board shall delegate its responsibility for the approval of write-off and authorisation of special payments to the Chief Executive and Director of Finance & Strategic Planning, acting jointly, for such categories and values as the Board shall determine and set out on Schedule II.

No payment exceeding these delegated limits may be made, even in an emergency, without the prior approval of the Chairman or in his absence, the Vice-Chairman.

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

14.2.7 For any loss, the Director of Finance & Strategic Planning should consider whether any insurance claim could be made.

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

14.2.9 No special payments exceeding delegated limits shall be made without the prior approval of the Treasury and notified to Monitor.

15 INFORMATION TECHNOLOGY

15.1 The Director of Finance & Strategic Planning, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:

(a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which he is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998;
(b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;
(c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;
(d) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as he may consider necessary are being carried out.

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

15.3 The Director of Finance & Strategic Planning shall ensure that contracts for computer services for financial applications with another health organisation or any other

agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

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

15.5 Where computer systems have an impact on corporate financial systems the Director of Finance & Strategic Planning shall satisfy himself that:

(a) systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy;
(b) data assembled for processing by financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;
(c) Director of Finance & Strategic Planning staff have access to such data; and
(d) such computer audit reviews are being carried out as are considered necessary.

16 PATIENTS' PROPERTY

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

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

- 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 Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

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

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

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

Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

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

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

17 FUNDS HELD ON TRUST

17.1 The Board of Directors Standing Orders (paragraph 1.5) state the Trust's responsibilities as a corporate trustee for the management of funds it holds on trust and define how those responsibilities are to be discharged. They explain that although the management processes may overlap with those of the organisation of the Trust, the trustee responsibilities must be discharged with full recognition of the accountabilities to the Charity Commission for charitable funds held on trust. The Trustee's Sub-Committee has authority to exercise many of the powers of the Board (see Schedule II to Standing Orders).

17.2 The reserved powers of the Board and the Scheme of Delegation and the Terms of Reference of the Trustees Sub-Committee make clear where decisions regarding the exercise of dispositive discretion are to be taken and by whom. Directors and officers must take account of that guidance before taking action. SFI's are intended to provide guidance to persons who have been delegated to act on behalf of the Corporate Trustee.

17.3 As management processes overlap most of the sections of these Standing Financial Instructions will apply to the management of funds held on trust. This section covers those instructions which are specific to the management of funds held on trust.

17.4 The over-riding principle is that the integrity of each trust must be maintained and statutory and trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

17.5 Non-charitable items such as payment for drug trials, shall not be held in Funds Held on Trust

17.6 The Director of Finance & Strategic Planning shall maintain such accounts and records as may be necessary to record and protect the funds, including an investment register.

17.7 The funds shall be invested by the Director of Finance & Strategic Planning in accordance with the Board's policies, subject to statutory requirements, and after seeking the advice of a professional body approved by the Board.

17.8 All share and stock certificates and property deeds shall be deposited either with the Trust's bankers or stock brokers, or in a safe or in a compartment of a safe, to which only the Director of Finance & Strategic Planning, or an officer delegated by him, will

have access. The Board (acting as Trustee) shall approve any organisation acting as Nominees to hold stocks and shares on behalf of the Trustee.

17.9 All gifts, donations, proceeds from fund-raising activities and other monies which are intended for the use of the Trust, patients or staff shall be handed immediately to the Director of Finance & Strategic Planning, to be banked in the funds' bank accounts. Under no circumstances may Directors, officers or staff maintain cash floats or separate bank accounts for money donated, gifted or earned through fund raising without the written authority of the Director of Finance & Strategic Planning.

17.10 All gifts accepted shall be received in the name of the fund to which they relate and administered in accordance with the Trust's procedures, subject to the terms of the specific trust.

17.11 Gifts may only be accepted for purposes relating to the National Health Service and, in cases of doubt, officers and staff should consult the Director of Finance & Strategic Planning before accepting such gifts. Further guidance is available in the Board of Directors and Staff Code of Conduct Section 2 of this document.

17.12 The Director of Finance & Strategic Planning shall be required to advise the Board on the financial implications of any proposal for fund-raising activities including those by outside bodies or organisations.

17.13 The Director of Finance & Strategic Planning shall be kept informed of all enquiries regarding legacies and shall keep an appropriate record. After the death of a testator, all correspondence concerning a legacy shall be dealt with on behalf of the Board by the Director of Finance & Strategic Planning who alone shall be empowered to give an executor a good discharge.

17.14 In the absence of an executor of a deceased person, the Director of Finance & Strategic Planning is authorised to make application for the grant of Probate in order to obtain a legacy due to the Trust under the terms of the deceased's Will.

18 RETENTION OF DOCUMENTS

18.1 The Chief Executive shall be responsible for maintaining archives for all financial and other documents required to be retained in accordance with Department of Health guidelines currently HSC 1999/053.

18.2 The documents held in archives shall be capable of retrieval by authorised persons.

18.3 Documents held in accordance with HSC 1999/053 shall only be destroyed in line with a Document Destruction Policy approved by the Board.

19 INSURANCE AGAINST RISK

19.1 Standing Instructions Relating for Non-Financial Risk set out the arrangements for identifying and managing risk.

19.2 The Director of Finance & Strategic Planning is responsible for advising the Board on insurance cover against risks and making the arrangements for this cover.

19.3 The Trust shall insure through the risk pooling schemes administered by the NHS Litigation Authority where this is appropriate but enhanced cover will be required from commercial underwriters where risk gaps exist or where cover is considered by the Board, after advice from the Director of Finance & Strategic Planning, to be inadequate.

In any case of doubt concerning a Trust's powers to enter into commercial insurance arrangements the Finance Director shall consult the NHS Litigation Authority and suitably qualified insurance brokers.

19.4 The Director of Finance & Strategic Planning shall ensure that the insurance arrangements entered into are appropriate and complementary to the risk management programme. The Director of Finance & Strategic Planning shall ensure that documented procedures cover these arrangements.

19.5 All the risk-pooling or insurance schemes require members to make some contribution to the settlement of claims (the 'deductible'). The Director of Finance & Strategic Planning should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

20 INVENTIONS AND INTELLECTUAL PROPERTY

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

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

20.3 In the case of collaborative research and evaluative exercises with manufacturers, the Trust shall see that it obtains a fair reward for the input they provide. If such an exercise involves additional work for a member of staff outside that paid for by the Trust under this or his contract of employment, arrangements should be made for some share of any rewards or benefits to be passed on to the member(s) of staff concerned from the collaborating parties. Care should, however, be taken that involvement in this type of arrangement with a manufacturer does not influence the purchase of other supplies.

21 COUNTERING FRAUD AND CORRUPTION

Definition

21.1 Fraud – any person who dishonestly makes a false representation to make a gain for himself or another or dishonestly fails to disclose to another person, information which he is under a legal duty to disclose, or commits fraud by abuse of position, including any offence as defined in the Fraud Act 2006.

21.2 Fraud by false representation – by dishonestly making a false representation intending by making the representation to make a gain for yourself or another, or to cause loss to another or expose another to risk of loss. A representation is false if it is untrue or misleading, and the person making it knows that it is, or might be, untrue or misleading. An example of this would be a member of staff submitting a false expense claim form for payment.

21.3 Fraud by failing to disclose information – by dishonestly failing to disclose to another person information which you are under a legal duty to disclose and intends, by failing to disclose the information, to make a gain for themselves or another, or to cause loss to another or expose another to the risk of loss. An example of this would be a member of staff failing to disclose a criminal conviction that would affect their working practices.

21.4 Fraud by abuse of position – by occupying a position in which you are expected to safeguard, or not to act against, the financial interests of another person, and dishonestly abusing that position, intending, by means of the abuse of that position, to make a gain for themselves or another, or to cause loss to another or to expose another to a risk of loss. An example of this would be a Finance Director diverting company monies from an employer's bank account into their own personal bank account.

21.5 The Secretary of State for Health, in exercise of powers confirmed by Section 17 and 126(4) of the National Health Service Act 1977, gave Directions to NHS trust regarding counter-fraud measures, in accordance with the NHS Protect's Standards for Providers 2013 and the General Conditions (GC6) of the NHS Standard Contract 2013/14..

21.6 The NHS Counter Fraud and Corruption Manual establishes the framework by which fraud will be minimised in the Trust.

21.7 The Trust shall prepare a Fraud and Corruption Policy and Procedures to guide staff. The Policy & Procedures shall be prepared in line with SFI 21 and SFI's shall have priority if in doubt.

21.8 The Chief Executive and Director of Finance & Strategic Planning shall monitor and ensure compliance with the NHS Counter Fraud and Corruption Manual including the Standards for Providers 2013 and General Conditions (GC6) on countering fraud and corruption against the NHS and other directions as may be notified by NHS Protect. The Trust shall ensure that action to counter fraud and corruption is taken in accordance with the NHS Counter Fraud and Corruption Manual and in accordance with the Standards for Providers 2013 and General Conditions (GC6) setting out the respective operational and liaison responsibilities of Trusts, and NHS Protect.

21.9 The Trust shall facilitate, and co-operate with, NHS Protect quality inspection work, giving prompt access to Trust staff, workplaces and relevant documentation. Nothing in this clause contravenes any right a member of staff may otherwise have to refuse to be interviewed. Nothing in this clause obliges or permits the Trust to supply information which is prohibited from disclosure by or under any enactment, rule of law or ruling of a court of competent jurisdiction or is protected by the common law.

21.10 The Trust shall, with other Trusts within its NHS Region, endeavour to agree a Service Level Statement with NHS Protect regarding the provision of support by NHS Protect in relation to countering fraud and corruption.

21.11 The Trust shall nominate a suitable officer to act as its Local Counter-Fraud Specialist (LCFS) and shall notify NHS Protect of that nomination within 7 days of that nomination. The Trust shall take account of guidance issued by NHS Protect when determining suitability. The Trust shall specify a job description for its LCFS which includes operational and liaison responsibilities specified by NHS Protect. The job descriptions shall include a requirement that the LCFS must adhere to the CFPAB Principles of Professional Conduct as set out in the NHS Counter Fraud and Corruption Manual. The Trust's LCFS must not undertake responsibility for or in any way engage in the management of security for the Trust. Where there is a need to replace a LCFS, NHS Protect shall be notified of a suitable replacement within three months of the need for the replacement becoming apparent. Where the Trust nominates a person whose services are provided to it by an outside organisation, it must:

a) comply with the requirements of NHS Protect as to the suitability of the organisation in question;
b) satisfy itself and NHS Protect that the terms on which those services are provided are such as to enable the LCFS to carry out his functions effectively and efficiently and in particular that he will be able to devote sufficient time to the Trust; and
c) give to NHS Protect a copy of the contract under which the services of the LCFS are supplied to it.

21.12 Once specialist training provided by NHS Protect has been completed by the nominee to the satisfaction of the DCFS, the nominee shall be accredited and shall assume the role of LCFS in the Trust.

21.13 The LCFS shall:

a) Report to the Trust's Director of Finance & Strategic Planning;
b) with the Director of Finance & Strategic Planning agree, at the beginning of each financial year a written work plan incorporating the seven generic areas of counter fraud activity set out in the NHS Counter Fraud & Corruption Manual;
c) provide a written report, at least annual, to the Audit Committee on counter fraud work within the Trust;
d) be entitled to attend any Audit Committee meetings and have a right of access to all Committee members and to the Chairman and Chief Executive of the Trust;
e) undertake, as specified by the Director of Finance & Strategic Planning or Chief Executive, proactive work to detect cases of fraud and corruption, particularly where systems weaknesses have been identified. This work shall

be carried out so as to complement the detection of potential fraud and corruption by auditors in the course of routine audits;

f) proactively seek and report to NHS Protect opportunities where details of counter fraud work (involving action on prevention, detection, investigation, sanctions or redress) can be used within presentation or publicity in order to deter fraud and corruption;
g) investigate cases of suspected fraud in accordance with the division of work specified in Schedule II as amended or replaced from time to time;
h) refer to the relevant NHS Protect Regional National Team all cases appropriate to them.
i) inform the appropriate NHS Protect team of all cases of suspected fraud investigated by the Trust.
j) contact details for the Counter Fraud team can be found on the Trust's Intranet Site under "Trust Info" – left-hand list "Counter Fraud Service" (7th line down)

21.14 The LCFS or relevant NHS Protect Regional National Team shall have access as soon as is reasonably practicable and in any event not later than 7 days from the date of the request to:

a) all premises, records or data owned or controlled by the Trust relevant to the detection and investigation of cases of fraud and corruption;
b) all staff who may have information to provide which is relevant to the detection and investigation of cases of fraud and corruption.

The Chief Executive and Director of Finance & Strategic Planning shall be responsible for ensuring that such access is given.

21.15 The Trust shall:

a) ensure that its LCFS has all necessary support including access to NHS Protect secure intranet site to enable him efficiently and effectively to carry out his responsibilities;
b) subject to any contractual or legal constraint, require all of its staff to co-operate with the LCFS and in particular that those responsible for human resources disclose information which arises in connection with any matters (including disciplinary matters) which may have implications in relation to the investigation, prevention or detection of fraud;
c) enable its LCFS to receive training recommended by NHS Protect;
d) require its LCFS, its other employees and any persons whose services are provided to the Trust in connection with fraud work to have regard to guidance and advice on medial handling of counter fraud matters which may be issued by NHS Protect;
e) enable its LCFS to participate in activities in which NHS Protect is engaged, including national anti-fraud measures, where he is requested to do so by NHS Protect;
f) enable its LCFS to work in conditions of sufficient security and privacy to protect the confidentiality of his work; and
g) enable its LCFS generally to perform his functions effectively, efficiently and promptly.

21.16 The LCFS shall send full reports of all cases where the Director of Finance & Strategic Planning believes fraud or corruption to be present to NHS Protect in accordance with HSC 1999/062, so that advice on the most appropriate sanction can be provided. The Director of Finance & Strategic Planning and LCFS shall consider further action in accordance with the NHS Counter Fraud and Corruption Manual. Reports shall also be sent to the Department of Health and to the External Auditor.

21.17 The Trust shall require the Chairman of the Audit Committee to undertake specific responsibility for the promotion of counter fraud measures. Where there is notice of a vacancy as Chairman of the Audit Committee, a new appointment must be made within 3 months of such notice. The Chairman of the Audit Committee shall receive appropriate training in connection with counter fraud measures. Such training shall be provided by NHS Protect.

21.18 The Director of Finance & Strategic Planning shall liaise and reach agreement with the relevant NHS Protect Regional National Team leader where the appropriate sanction is felt to be prosecution action before any further action is taken by either the Trust or NHS Protect.

21.19 The Director of Finance & Strategic Planning shall liaise and reach agreement with the relevant NHS Protect Regional National Team leader before any decision is reached on the referral of a case of fraud or corruption to the Police or any other body for investigative action.

21.20 Any information relevant to an investigation of suspected fraud or corruption shall not be disclosed except for the purposes of the investigation or subsequent proceedings. No information relating to the investigation shall be disclosed to any person who might possibly be implicated in the case of potential fraud or corruption.

21.21 The Director of Finance & Strategic Planning will inform any staff that they have been investigated for implication in potential fraud or corruption as soon as possible after the investigations are completed, whether or not the investigations result in disciplinary action or prosecution, subject to timing agreed with NHS Protect where prosecution may be pending.

21.22 Where there is a real possibility of the allegations becoming public knowledge (not including the limited number of public figures to whom the allegation may first have been made, or these limited number of individuals which are necessary to the investigations), the Director of Finance & Strategic Planning will consult with NHS Protect (and the Police as required) over the need to inform the staff that they are being investigated.

21.2~~2~~3 the LCFS shall report to internal auditors details of systems weaknesses identified as allowing proven fraud to take place. Internal and External auditors shall be asked to report to the LCFS systems weaknesses detected in the course of their work which may have allowed fraud to take place.

21.2~~3~~4 The LCFS shall ensure that all investigations of cases of suspected fraud take proper account of the need to obtain information relevant to the recovery of funds obtained through fraud and to the provision of this information so that redress can be sought. The Director of Finance & Strategic Planning is responsible for ensuring that the Trust seeks financial redress in respect of such losses.

Reporting Suspected Fraud or Corruption

21.25 Authority for investigating fraud has been delegated to the Director of Finance & Strategic Planning and, through him, to the LCFS. They shall also be responsible for informing third parties such as NHS Protect, external audit or the police when appropriate. The Director of Finance & Strategic Planning shall inform and consult the Chairman, Chief Executive, Chairman of the Audit Committee and Director of Risk Management in all cases.

21.26 The Director of Finance & Strategic Planning shall inform the LCFS at the first opportunity and delegate to the LCFS authority for leading any investigation whilst retaining overall responsibility himself.

21.27 The LCFS shall send full reports of all cases where the Director of Finance & Strategic Planning believes fraud or corruption to be present to NHS Protect in accordance with HSC 1999/062, so that advice on the most appropriate sanction can be provided. The Director of Finance & Strategic Planning and LCFS shall consider further action in accordance with the NHS Counter Fraud and Corruption Manual. Reports shall also be sent to NHS Protect and to the External Auditor.

21.28 The following individuals are authorised to receive inquiries of staff confidentially:-

- Chairman of the Audit Committee
- Chief Executive
- Director of Finance & Strategic Planning
- Local Counter Fraud Specialist
- Internal Audit Manager

Details of the current post-holders and points of contact are recorded in Annex A.

The Director of Finance & Strategic Planning will retain a secure log of all reported suspicions. Access to the log will be limited to the Director of Finance & Strategic Planning, LCFS, Chair of Audit Committee and Head of External Audit.

21.29 All staff have a duty to protect the assets of the Trust which include information and goodwill as well as property.

21.30 Staff shall normally discuss their suspicions confidentially with the head of department. They may instead discuss the matter confidentially with the nominated officer. The head of department or nominated officer will inform the Director of Finance & Strategic Planning directly of all suspicions raised. Where it is inappropriate to inform the Director of Finance & Strategic Planning, the head of department or nominated officer will inform the Chairman of the Audit Committee.

21.31 If staff suspect their department manager the member of staff should report the suspicions to someone more senior, or directly to the Director of Finance & Strategic Planning. If the suspicion involves an Executive Director the matter should be reported to the Chairman of the Audit Committee.

21.32 Staff are also able to contact NHS Protect confidentially to raise concerns externally from their employer through telephone number 0800 028 40 60, or via www.reportnhsfraud.nhs.uk .

Time may be of the utmost importance to prevent further loss to the Trust.

21.33 The log will contain details of all reported suspicions, including those dismissed as minor or otherwise not investigated. It will also contain details of action taken and conclusions reached. This log will be reviewed by the Audit Committee at least quarterly (ensuring that confidentiality is maintained [paragraph 21.20]), which will report any significant matters to the Board.

21.34 The Director of Finance & Strategic Planning, Chairman of the Audit Committee, Chief Executive or Internal Audit Manager shall advise the LCFS for the Trust as soon as practical after the suspicions have been brought to his attention. The LCFS will report all such cases to NHS Protect in accordance with the SFI 21.8 and the "NHS Counter Fraud & Corruption Manual" (Manual).

21.35 The Director of Finance & Strategic Planning shall inform and consult the Chief Executive and the Chairman at the first opportunity in all cases with a view to determining when the Board shall be informed. The Internal Audit Manager should normally be informed immediately in all but the most trivial cases.

21.36 The Director of Finance & Strategic Planning shall determine, in consultation with the LCFS and NHS Protect, at what point the police are to be informed in line with Standing Financial Instructions. In addition the requirements of FDL(95/27) and the Manual will determine whether the Department of Health, Monitor and External Auditors should be informed.

21.37 The Director of Finance & Strategic Planning shall, if significant, report suspected fraud or corruption to the External Auditors and the Strategic Health Authority or Monitor as appropriate.

Managing the Investigation

21.38 The person managing the investigation will be the LCFS or officers from NHS Protect (the latter shall act in cases of high value fraud and corruption or for specialist types of fraud – as determined by NHS Protect from time to time).

21.39 The investigation shall be managed in line with the Manual.

21.40 The Director of responsible for Workforce shall advise those involved in the investigation in matters of employment law and in other procedural matters, such as disciplinary procedures as requested.

21.41 The Director of Nursing and Quality shall advise those involved in the investigation on matters relating to NMC Guidelines for professional practice (Nursing and Midwifery) and the implication of these on any case of fraud. For medical staff the Medical Director shall advise the GMC. For other staff groups the professional heads shall advise the appropriate professional bodies

Recovering a Loss

21.42 Where recovering a loss is likely to require a civil action the Director of Finance & Strategic Planning shall seek legal advice. Where external legal advisors are used the Director of Finance & Strategic Planning and LCFS must ensure there is co-ordination between the various parties involved.

21.43 If the loss may be covered by insurance the Director of Finance & Strategic Planning shall inform the manager responsible for insurance matters. There may be time limits for making a claim and in certain cases claims may be invalidated if legal action has not been taken.

21.44 Guidance on losses and special payments is provided in FDL(95)27. For all fraud cases a copy of the fraud report as set out in Appendix 5 of the FDL must be sent to the NHS Executive.

21.45 The FDL sets out delegated limits for approving the writing off of losses and special payments.

Related Policy

21.46 The following documents are appropriate to cross reference:

- Disciplinary Policy;
- Whistleblowing Policy

both are available through the Trust Intranet under Policies.

STANDING FINANCIAL INSTRUCTIONS – SCHEDULE I

LOCAL COUNTER FRAUD SPECIALIST

Operational Responsibilities	Liaison Responsibilities
A. To routinely investigate all cases involving the LCFS's own Trust where 1. FHS fraud is not involved 2. It is clear that not more than £15,000 is involved 3. There is no evidence that the fraud extends beyond the Trust 4. There is no evidence of corruption involving a public official (ie someone either employed by or holding an official position on behalf of Health Authorities/Trusts) who is using their public influence for private gain B. To investigate cases outside these parameters with the agreement of the relevant NHS Protect Regional National Team Leader to do so and where the Trust Director of Finance & Strategic Planning is in agreement. C. To provide assistance involving cases under investigation by the relevant NHS Protect Regional National Team involving the LCFS's own Trust.	• To inform NHS Protect Regional Team of every case which is investigated. • To refer other FHS fraud cases to the relevant Health Authority LCDS. • To refer cases outside operational responsibilities defined in A1, A2, A3, A4 to NHS Protect Regional Team. • To ensure a full report is provided on each case to NHS Protect, Internal and External Auditors, NHS Protect including, where fraud is present, an assessment of the systems weakness that allowed the fraud to be perpetrated. • In conjunction with NHS Protect to identify suitable cases, or other key events, for proactive publicity.

STANDING FINANCIAL INSTRUCTIONS - SCHEDULE II

DELEGATED LIMITS

Category of loss/special payment			Delegated Limits per Case Chief Executive £
Losses (except in respect of family practitioner services)			
1.	**Losses of cash due to :**		
	a)	theft, fraud, etc	10,000
	b)	overpayments of salaries, wages, fees and allowances	10,000
	c)	other causes, including un-vouched or incompletely vouched payments, overpayments other than those included under 1(b); physical losses of cash and cash equivalents, eg stamps due to fire (other than arson), accident and similar causes.	10,000
2.	**Fruitless payments (including abandoned capital schemes)**		50,000
3.	**Bad debts and claims abandoned :**		
	a)	private patients (Sections 65 and 66 NHS Act 1977)	10,000
	b)	overseas visitors (Section 122 NHS Act 1977)	10,000
	c)	cases other than a-b	10,000
4.	**Damage to buildings, their fittings, furniture and equipment and loss of equipment and property in stores and in use to :**		
	a)	culpable causes eg theft, fraud, arson or sabotage whether proved or suspected, neglect of duty or gross carelessness	5,000
	b)	other causes	10,000
Special payments (except in respect of family practitioner services)			
5.	**Compensation payments made under legal obligation**		100,000
6.	**Extra contractual payments to contractors**		10,000
7.	**Ex gratia payments :**		
	a)	to patients, staff and visitors for loss of personal effects	10,000
	b)	for clinical negligence (negotiated settlements following legal advice) where the guidance relating to such payments has been applied.	100,000
	c)	for personal injury claims involving negligence where legal advice obtained and relevant guidance has been applied.	50,000
	d)	other clinical negligence cases and personal injury claims	10,000
	e)	other, except cases of maladministration where there was no financial loss by claimant	10,000
	f)	maladministration where there was no financial loss by claimant	NIL
8.	**Extra statutory and extra regulatory payments**		NIL
9.	**Payments to employees on termination of employment where the payment is not required under the member of staff's contract of employment**		NIL

The Board shall authorise all payments above the limits set for the Chief Executive. Wherever possible, the Chief Executive shall ensure that Board authorisation is "prior authorisation". For exceptional items where this is not possible, the Chief Executive will seek Chair's action (or nominated deputy) with reporting at the next available Board of Directors.

Payments under item 9 shall require prior approval by Monitor and HM Treasury.

Board of Directors

Standing Orders:
Delegation of Powers to Board Committees

Contents

Board Committees

1 The revised terms of reference are set out below for each of the following Board Committees:

- Appointments and Remuneration
- Audit
- Trustees Sub-Committee
- Performance and Finance
- Quality Governance Committee
- Transformation and People Committee

2 All Committees except the Audit Committee are executive committees of the Board and their delegated authority is outlined in the Terms of Reference.

3 The Committees will support the Board in fulfilling its responsibilities for corporate and clinical governance. The main organisational functions that have shaped the committee governance structure are:

- Systems and controls
- Effective operational management
- Measuring and adjusting performance
- Planning for the future

4 Board Committees shall

- schedule all meetings to allow relevant papers to be circulated to the full Board meeting that falls immediately after the Committee meeting concerned
- produce their minutes and agenda to a standard format for presentation to the committee Chairman by the committee Lead within one week after the meeting, and for approval and distribution within two weeks
- unless otherwise indicated, place a copy of the draft minutes on the Trust's intranet
- include routinely on their agenda, discussion of minutes received from any committee that reports to them
- maintain a list of senior staff who may receive copies of the papers, but are not full members of the committee or required to attend its meetings

5 Board Committees shall be chaired by a Non-executive Director as appointed by the Chairman. In his absence, the Committee may nominate another Non-Executive Director to chair the meeting concerned.

The chair is to ensure that key elements are monitored and audited, and decisions are made, particularly on all matters included on the Trust's Board Assurance Framework.

6 Except for the Audit Committee, members of committees who exceptionally cannot attend a meeting may, with the prior agreement of the Committee chairman, arrange for a deputy to attend in their absence.

7 Board Committees are authorised by the Board to:

- investigate any activity within their terms of reference. In doing so, they may request and review reports and positive assurances from directors and managers on the overall arrangements within their terms of reference. They may also

request relevant and specific reports from individual functions within the organisation (*e.g.* clinical audit)
- require the attendance, with due notice, of any director, clinician or other member of staff at one or more of its meetings in seeking to obtain any information that it requires. All employees are directed to co-operate with any request made by a committee
- obtain external independent professional or legal advice, and to secure the attendance of outsiders with relevant experience and expertise if they consider this necessary

8 Board Committees shall
- consider all relevant policy initiatives and changes prior to their presentation to the Board
- ensure that, if an issue to be considered is known to impact on another Committee, the Leads shall consider the optimum timing to allow transfer of business between committees, so that any necessary recommendations can reach the full Board meeting that falls immediately after the meeting of the Committee(s) concerned
- by 31 March each year, prepare for the Board an annual report on its work during the year beginning 1 April of the previous calendar year. This will include a report by internal audit or the Trust Board Secretary to validate the extent to which business plans and action plans have been followed, and to assist the committee in identifying skills gaps
- produce an annual plan by 31 March each year, for the subsequent year beginning 1 April. The business plans for all committees will be discussed at a meeting to be convened in March each year by the Chief Executive, chaired by the Chairman, and attended by all Non-Executive directors who attend the Board Committee, together with the Leads for each committee. The purpose of this meeting shall be to
  - ensure that committee plans are compatible with the Trust's Board Assurance Framework for the following year, or added to it
  - redistribute any work as necessary between committees
  - endorse a full programme of committee business plans for approval by the Board at its April meeting
- review their terms of reference annually, and those of any committees that report to them, for inclusion in the presentation to the Board each April of the business programme
- require each committee that reports to them to submit for approval an annual workplan
- consider only draft policies and procedures that are presented in a standard format, and sponsored by the committee Lead and after discussion by the Executive Team and (where necessary) a meeting of Non-executive directors

Subcommittees and Groups that report to Board Committees

The following groups currently report to Board Committees, but are subject to change by agreement of the Board Committees concerned:

Appointment and Remuneration (none)
Trustee Sub-Committee (none)

Quality Governance

- Executive Patient Experience Group (Patient Voice)
- ~~Executive~~ Executive Strategic Infection ~~Prevention and~~ Control Group
- Executive Quality Governance Group
- Executive Safeguarding Group

Performance and Finance

- Executive Infrastructure Development Group
- BIU Project Board
- Divisional Boards

Transformation and People (TAP)

- Executive Transformation Steering Group
- Joint Consultation and Negotiation Committee
- Executive Workforce Assurance Group

Terms of Reference

Appointments and Remuneration Committee

Purpose
The Committee is established by statute to appoint Executive and Associate Directors and to advise the Board on their employment packages and performance.

Accountable to
The Board

Membership
The Committee will comprise the Chairman, the Non-Executive Directors and the Chief Executive. The Chief Executive shall not be present at any meeting of the Committee where the Chief Executive's appointment or remuneration (including benefits package) is under discussion.

Frequency of meetings
As required, and not less than once every twelve months.

Quorum
Meetings of the Committee may be held with the Chairman of the Board and at least two Non-executive members in attendance. If the Chairman is not present there must be a minimum of three Non-executive Directors present.

Deputising arrangements
In the absence of the Chairman the Deputy Chair shall Chair the Committee. If neither the Chairman nor the Deputy Chair is present then a Chair may be elected from the Non-executive Director's present at the meeting.

Agenda and papers
An agenda for each meeting, together with relevant papers, will be forwarded to Committee members to arrive at least five working days before the meeting.

Minutes
The target for distribution of minutes will be ten working days following the meeting. Members of the Committee will confirm the minutes at their next meeting. The Committee chair will present the minutes (whether confirmed or unconfirmed) at the Trust Board meeting following the Committee meeting.

Terms of reference
1. The Committee is authorised:

1.1 to select and appoint the Executive Directors including the Chief Executive;

1.2 to advise the Board about appropriate remuneration and terms of service for the Chief Executive, other Executive Directors, and other senior employees including:
- 1.2.1 all aspects of salary (including any performance-related elements/bonuses)
- 1.2.2 provisions for other benefits, including pensions and cars
- 1.2.3 arrangements for termination of employment and other contractual terms

1.3 monitor and evaluate the performance of Executive; and

1.4 advise on and oversee appropriate contractual arrangements for Executive Directors including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

In this context "remuneration" is deemed to include salary (including any performance related elements thereof) and other benefits such as pension and cars, and "terms of service" shall include provisions relating to the termination of employment.

2. In carrying out its work, the Committee shall have regard to the following principles:

2.1 remuneration packages must be such as to enable people of appropriately high ability to be recruited, retained and motivated but at levels which the Trust can afford;

2.2 remuneration packages and terms of service must be publicly defensible;

2.3 remuneration packages should be linked to a clear statement of the individual's responsibilities with rewards linked to their measurable discharge;

2.4 remuneration packages and terms of service should take into account the state of the market for the kind of Executive Director or senior employee the Trust is seeking to recruit.

3 The Committee is authorised to seek independent advice on the state of the market and such other matters relating to its work as it may decide and to consult with other bodies within and outside the NHS on levels of remuneration and terms of service while bearing in mind the sensitivity of the subject matter.

4 The Committee shall establish appropriate contractual arrangements for the Chief Executive, the Executive Directors identified pursuant to paragraph 2 above including the proper calculation and scrutiny of any termination payments it is proposed should be made, taking into account such national guidance as is appropriate.

5 The Committee will meet at such times as it shall decide and will keep a written record of its proceedings.

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

7 To refer issues of mutual or common interest to other Committees accountable to the Board; and to consider the advice the Audit Committee of risks identified for, and reported on to, this Committee.

Date issued 2007
Date revised August 2017
Next review March 2018

AUDIT COMMITTEE TERMS OF REFERENCE

1. Formation of this Committee

The Board hereby resolves, under Standing Order 10, to establish a Committee of the Board to be known as the Audit Committee (The Committee). The Committee is a non-executive committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference.

2. Role

The Committee shall provide independent assurance to the Board that there are adequate controls in place to ensure that the Trust's key objectives and statutory obligations are being met.

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

3. Membership of the Committee

All Non-Executive Directors, except the Chairman, shall be the members of the Committee. One of these is the Committee chair, and another is her/his vice-chair, deputising in her/his absence.

Committee members may not have a deputy at Committee meetings.

It is expected that members will attend at least 75% of the Committee's meetings in any financial year and the Chair of the Committee will discuss with the Chair of the Board any breach of this guidance.

4. Chair of the Committee

The Chair and Vice-Chair of the Committee shall be appointed by the Board of Directors.

5. Quorum

The quorum for meetings of the Committee shall be three members.

6. Frequency of meetings

Meetings shall generally be held six times a year, but not less than four times.

7. Attendance at Meetings

The Director of Finance and Strategic Planning, the Associate Director - Integrated Governance, and appropriate Internal and External Audit representatives shall normally attend meetings. However at least once a year the Committee should meet privately with the External and Internal Auditors.

The Chief Executive and other executive directors may be invited to attend, but particularly when the Committee is discussing significant areas of risk or operation that are the responsibility of that director.

The Chief Executive should be invited to attend, at least annually, to discuss with the Audit Committee the process for assurance that supports the Annual Governance Statement.

8. Notice of Meetings

Meetings of the Committee shall be called at the request of the Chair. An agenda for each meeting, together with relevant papers, will be forwarded to Committee members to arrive at least five working days before the meeting. The PA to the Director of Finance and Strategic Planning will assist the Chair in drawing up the agenda and papers with input from the Director of Finance and the Director with responsibility for governance.

9. Minutes

The target for distribution of minutes will be ten working days following the meeting. Members of the Committee will confirm the minutes at their next meeting. The Committee chair will present the minutes (whether confirmed or unconfirmed) at the Trust Board meeting following the Committee meeting.

10. Reporting

The minutes of Audit Committee meetings shall be formally recorded by the PA to the Director of Finance and Strategic Planning and 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 Committee will report to the Board 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 Trust's performance against the Quality Governance Arrangements and compliance with CQC registration standards..

11. Responsibilities of the Committee

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 (both clinical and non-clinical), that supports the achievement of the organisation's objectives.

In particular, the Committee will review the adequacy of:

- all risk and control related disclosure statements (in particular the Annual Governance Statement and declarations of compliance with the CQC Domain Requirements), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board
- the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements
- the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements
- the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the Counter Fraud and Security Management Service
- The adequacy of systems to secure value for money.

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

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

Internal Audit

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

- consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal
- review and approval of the Internal Audit strategy, operational 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
- consideration of the major findings of internal audit work (and management's response), and ensure co-ordination between the Internal and External Auditors to optimise audit resources
- ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation
- annual review of the effectiveness of internal audit

External Audit

The Committee shall review the work and findings of the External Auditor appointed by the Governors and consider the implications and management's responses to their work. This will be achieved by:

- consideration of the appointment and performance of the External Auditor, as far as the Trust's Constitution rules permits
- discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensure coordination, as appropriate, with other External Auditors in the local health economy
- discussion with the External Auditors of their local evaluation of audit risks and assessment of the health economy/Trust/CCG and associated impact on the audit fee
- review all External Audit reports, including agreement of the annual audit letter before submission to the Board and any work carried outside the annual audit plan, together with the appropriateness of management responses

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 to the governance of the organisation.

These will include, but will not be limited to, any reviews by Department of Health Arms Length Bodies or Regulators/Inspectors (e.g. Care Quality Commission, NHS Litigation Authority, etc.), professional bodies with responsibility for the performance of staff or functions (e.g. 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. This will particularly include the Quality Governance Committee and the Performance and Finance Committee.

In reviewing the work of the Quality Governance Committee, and issues around clinical risk management, the Audit Committee will wish to satisfy themselves on the assurance that can be gained from the clinical audit function.

The Committee shall review the schedules of losses and compensation and make recommendations to the Board.

The Trust will undertake a review of the Corporate Governance Manual (comprising Standing Order, Standing Financial Instructions, Standing Instructions for Non-Financial Risk, Powers Reserved to the Board and Scheme of Delegation) at least every three years and the Committee will recommend changes for approval by the Board.

The Committee shall consider the circumstances when Standing Orders, Standing Financial Instructions or Standing Instructions for Non-Financial Risks have been waived or otherwise breached.

The Committee shall monitor the implementation of the Trust's policy on standards of business conduct for members of staff and will ensure that matters of propriety and regularity are referred to Internal or External Audit to investigate.

Management

The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

They may also request specific reports from individual functions within the organisation (e.g. clinical audit) as they may be appropriate to the overall arrangements.

The Committee shall prepare, by 31 March each year, a work plan for the Committee's next financial year.

The Committee shall review its effectiveness annually and will report its findings to the Board.

The Chair shall draw to the attention of the Board any issues that require disclosure to the full Board, or require executive action to manage risks with a significant impact on the Trust. The Committee shall report to the Board.

The Chair shall draw to the attention of the Board any issues that require disclosure to the full Board, or require executive action to manage risks with a significant impact on the Trust. The Committee shall report to the Board annually on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the risk assurance framework, the completeness and embeddedness of risk management in the organisation, the integration of governance arrangements and the appropriateness of the self-assessment against CQC Standards.

Financial Reporting

The Audit Committee shall review the Annual Report and Financial Statements before submission to the Board, focusing particularly on:

- the wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee
- changes in, and compliance with, accounting policies and practices
- unadjusted mis-statements in the financial statements
- major judgemental areas
- significant adjustments resulting from the audit

The Committee should also 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.

12. Authority

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any Director, officer or member of Staff who are directed to co-operate with any request made by the Committee.

The Committee is authorised to obtain independent professional or technical advice from Staff or externally as it requires.

The Committee may appoint sub-committees comprising Committee Members, officers and experts (both internal and external) to assist it in its work.

13. Relationships with other Committees

The Committee may refer matters to other Committees either to raise concerns or request assistance in investigating.

14. Administration

The Trust Secretary, or the Director of Finance and Strategic Planning if there is no Trust Secretary, shall ensure that secretarial support is provided to the Committee, the Chair and members. The Trust Secretary (or Director of Finance and Strategic Planning) will provide administrative support in drawing up the agenda and papers, and in taking the Minutes of meetings.

The Committee shall prepare a work plan for the following year by the end of March. This will be submitted to the Board for approval.

The Committee shall prepare an annual report for the Board by the end of April of each year.

Date issued: July 2011
Date revised: April 2017
Next review date: April 2018

Trustee Sub Committee
Terms of Reference

1. Formation of this Committee

The Corporate Trustee has established a Committee, known as the Trustee Sub Committee (the Committee) reporting to the Corporate Trustee

2. Role

The Committee is responsible for managing charitable funds on behalf of the Trustees subject to limitation of delegations. The role covers both major appeal and other on-going charitable activities

3. Membership of the Committee

The Committee shall be comprised of:

Four board members of the Corporate Trustee - two executive, (or nominated deputy) and two non-executive members.

To support the work of the four Board Members and contribute to the work of the Committee the following will be in attendance at Committee meetings:
Governor
Fundraising Manager
Representative of the major appeal
Finance Representative
Member of Clinical Staff
The committee may invite others to attend meetings at their discretion

It is expected that all members will attend at least 75% of meetings of the Committee. An annual attendance report will be submitted to the Committee for information and action as required.

4. Chair of the Committee

The chair of the Committee shall be a Non-Executive Director of the Corporate Trustee.

5. Quorum

The quorum shall be 2 board members of the Corporate Trustee – 1 Executive Director (or nominated Deputy) and 1 Non-Executive Director

6. Meetings

The Committee shall meet four times a year

7. Notice of meetings

Meetings of the Committee shall be called at the request of the chair. Notice of each meeting, including an agenda and supporting papers shall be forwarded to each member of the Committee not less than five working days before the date of the meeting.

8. Agenda and action points

The agenda and action points of all meetings of the Committee shall be produced and made available to all members of the Corporate Trustee.

9. Reporting arrangements

The proceedings of each meeting of the Committee shall be reported to the next meeting of the Corporate Trustee.

10. Responsibilities of the Committee

The Committee has responsibility for the ongoing management of the charity with the following exceptions which the Corporate Trustee reserves for its own decision or approval:

- Appointment of the members and chair to the Trustees Sub Committee
- Approval of annual budget
- Appointment of auditors
- Appointment of bankers
- Appointment of investment consultants
- Approval of reserves policy
- Selection of major appeal
- Approval of charitable expenditure over £25,000

The Committee will have responsibility the day to day ongoing management of the Charity, and in particular for:

- Treasury management of the charity
- Ensuring appropriate financial records are maintained
- Overall brand image and promotion of the charity
- Developing and ensuring that all internal policies procedures are in line with good practice and followed appropriately
- Operational management of the Major appeal and ongoing charitable activity
- Approval of charitable expenditure

11. Authority

The Committee is authorised by the Trustee to 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 co-operate with any request made by the Committee.

The Committee is authorised by the Trustee to obtain independent professional advice and to secure the attendance of outsiders with relevant experience or expertise, if it considers this to be necessary.

Date issued: April 2015
Date reviewed: April 2017
Review date: ~~March 2016~~April 2018

Quality Governance Committee

Terms of Reference

1. Formation of this Committee

The Mid Cheshire Hospitals NHS Foundation Trust Board of Directors (the Board) has established a Committee of the Board, known as the Quality Governance Committee (the Committee).

The Committee shall have Terms of Reference and powers and will ensure that the Board is able to act in accordance with legislation, compliance or direction requirements and to be fully appraised of the impact of quality governance on the delivery of the Trust's strategic objectives.

2. Role

The Committee is responsible for providing assurances to the Board that the Trust is safely managing all issues relating to quality governance including:

- The establishment and maintenance of effective systems of quality governance, risk management and internal control, particularly in relation to patient safety, clinical effectiveness, patient experience, and clinical & research governance.

The adequacy and effectiveness of:

- Assurances in relation to compliance with national statutory standards, legislative and regulatory compliance requirements and accreditation standards;
- Assurances on the systems of governance to monitor standards and outcomes of care, including benchmarking schemes;
- The underlying assurance processes that support achievement of the corporate objectives and the management of principal risks.

3. Membership of the Committee

Members of the Committee shall be appointed by the Board and at least two of whom shall be Non-Executive Directors. The members of the Committee shall be:

- 2 Non-Executive Directors (one designated Chair and one designated Deputy Chair)
- Chief Executive
- Medical Director
- Director of Nursing and Quality

4. Regular Attendees

- Associate Director of Integrated Governance

It is expected that all members and regular attendees will attend at least 75% of meetings of the Committee.

If members are unable to attend they must advise the Chair of the Committee and enquire whether a deputy is required, (if a deputy attends any meeting they must be able to fully participate but will have no voting rights).

The Board Chairman and the Chair of the Audit Committee shall not be a member of the Committee, but are authorised to observe any meetings of the Committee if they so wish.
The Committee may also require other senior officers of the Trust and other specialist advisors (internal or external) in addition to the regular attendees to present papers. Such attendees will hold no voting rights.

5. Chair of the Committee

The Board will assign a Non-Executive Director as Chair and a Non-Executive Director as Deputy Chair of the Committee.

In the absence of the Committee Chair or Deputy Chair, the remaining members present will elect another member to Chair the meeting.

6. Secretary

The Trust Board Secretary or their nominee shall act as the Secretary of the Committee.

7. Quorum

The quorum necessary for the transaction of business is three members (inclusive of one Non-executive Director). A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

8. Frequency of Meetings and Attendance Requirements

The Committee shall meet at least 11 times per annum. The Chair may at any time convene additional meetings of the Committee to consider business that requires urgent attention.

An annual attendance report will be submitted to the Committee for information and action as required and will be included within the Trust's Annual Report.

9. Notice of Meetings

Meetings shall be called at the request of the Chair of the Committee.

Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed, shall be forwarded to each member of the Committee, any other person required to attend, no later than five working days before the date of the meeting.

10. Minutes of the Committee

The Secretary, or nominated deputy, shall minute the proceedings of all meetings of the Committee, including recording the names of those present and in attendance.

Members and those present should state any conflicts of interest in relation to open agenda items to the Chair of the Committee prior to the meeting. Where there is a conflict of interest the Chair will notify the member whether they should withdraw from the meeting, the discussion and/or voting. The Secretary should minute any conflicts of interest accordingly.

Minutes of Committee meetings should be circulated to the Chair within five working days and promptly to all members of the Committee unless a conflict of interest exists.. The Committee chair will present the minutes (whether confirmed or unconfirmed) at the Trust Board meeting following the Committee meeting.

11. Reporting Arrangements

The Committee will report to the Board who will approve its Terms of Reference and membership.

The Committee Chair shall report formally to the Board and, where appropriate, the Council of Governors on its proceedings after each meeting on all matters within its duties and responsibilities.

The Committee shall make whatever recommendations to the Board it deems appropriate on any area within its remit where action or improvement is needed.

12. Responsibilities of the Committee

The Committee is responsible for providing information and assurances to the Board that the Trust is safely managing all issues in relation to quality governance and risk management including the financial elements where appropriate. In particular, the Committee's duties shall include:

- Ensure compliance with the requirements of Monitor's Provider Licence in relation to quality governance or promptly identify any risks that may prevent this and ensure that mitigations are in place and delivered;
- Ensure compliance with the Care Quality Commission's registration requirements or promptly identify any risks that may prevent this and ensure that mitigations are in place and delivered;
- Review the Board Assurance Framework quarterly and ensure that mitigations are appropriately actioned;
- Review the Corporate Risk Register, including the top organisational risks, quarterly and ensure that mitigations are appropriately actioned;
- Review and ensure implementation of the Trust's Risk Management Strategy and Quality & Safety Improvement Strategy;
- Review and approve the Trust's Annual Quality Account;
- Review and approve the Trust's Annual Governance Statement prior to submission to the Audit Committee;
- Review and approve the Trust's Corporate Governance Handbook;
- Review any relevant internal or external audits and ensure that all actions arising from such audits are delivered;
- Prepare an Annual Report for the Board by 30th April each year on the committee's work in discharging its duties against its Terms of Reference which covers the previous financial reporting period;
- Produce an Annual Work Plan by 1st March each year, for the subsequent year beginning 1st April;
- Identify any risks which may prevent the achievement of the Annual Work Plan and ensure that these are assessed and placed on the Trust's Risk Register;
- Review its Terms of Reference on at least an annual basis;
- Review and approve the Annual Report, Annual Work Plan and Terms of Reference of any Groups that have a direct report to the Committee;

- Address escalated issues and ensure that actions are appropriately reviewed and completed from the following Groups:

    1. Executive Strategic Infection Control Group
    2. Executive Quality Governance Group
    3. Executive Patient Experience Group
    4. Executive Safeguarding Group

13. Authority

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

The Committee is authorised by the Board to obtain legal or independent professional advice and to secure the attendance of partners with relevant experience or expertise, if it considers this to be necessary.

14. Relationships with other Committees

The Committee shall receive information and assurances from the:

- Executive Strategic Infection Control Group
- Executive Quality Governance Group
- Executive Patient Experience Group
- Executive Safeguarding Group

The relationship with other Committees or Groups will be a standing agenda item on the agenda to ensure the Committee routinely receives as a minimum appropriate action points.

The Committee may receive escalated matters of concern from other Board Committees in relation to quality governance for further investigation and may, if necessary, raise concerns or request further assistance in investigations from other Committees in order to meet its Terms of Reference.

15. Other Matters

The Committee should:

- Be provided with appropriate and timely training, both in the form of an induction programme for new members and on an on-going basis for all members;
- Give due consideration to laws and regulations;
- Abide by the Trust's Constitution, its values, its Code of Conduct and Nolan Principles of Conduct Underpinning Public Life;

16. Monitoring and Review

The Board will monitor the effectiveness of the Committee through receipt of the Committee's minutes and such written or verbal reports that the Chair of the Committee might provide.

At least once a year the Committee will review its own performance, constitution and Terms of Reference to ensure it is operating at maximum effectiveness and recommend any changes it considers necessary to the Board for approval.

The Secretary will monitor the frequency of the Committee meetings and the attendance records to ensure minimum attendance figures are complied with included within the Trust's Annual Report.

Terms of Reference approved by Committee: February 2017
Review Date: February 2018

Performance and Finance Committee
Terms of Reference

1. Formation of the Committee

The Mid Cheshire Hospitals NHS Foundation Trust Board of Directors (the Board) has established a Committee of the Board, to be known as the Performance and Finance Committee (the Committee).

The Committee shall have Terms of Reference and powers and will ensure that the Board is able to act in accordance with legislation, compliance or direction requirements and to be fully appraised on the impact of Performance and Finance on the delivery of the Trust's strategic objectives.

2. Role

The Committee is responsible for providing information and assurances to the Board that it is managing all issues in relation to performance and finance including:

- The establishment and maintenance of effective systems of performance and finance.

The adequacy and effectiveness of:

- Assurances in relation to compliance with national statutory standards, legislative and regulatory compliance requirements;
- Assurances on the systems in place to monitor performance and finance including benchmarking schemes.

3. Membership of the Committee

Members of the Committee shall be appointed by the Board and at least two of whom shall be Non-Executive Directors. The members of the Committee shall be:

- Two Non-Executive Directors (One designated Chair and one designated Deputy Chair)
- Director of Finance and Strategic Planning
- Chief Operating Officer

4. Regular Attendees:

- Head of Information

- Deputy Director of Finance – Business Intelligence
- Director of Operations

It is expected that all members and regular attendees will attend at least 75% of meetings of the Committee.

If members are unable to attend they must advise the Chair of the Committee and enquire whether a deputy is required (if a deputy attends any meeting they must be able to fully participate but will have no voting rights).

The Trust's Chairman shall not be a member of the Committee, but is authorised to observe any meetings of the Committee.

The Committee may also require other senior officers of the Trust and other specialist advisors (internal or external) in addition to the regular attendees to present papers. Such attendees will hold no voting rights.

5. Chair of the Committee

The Board will assign a Non-executive Chair and a Non-Executive Director Deputy Chair of the Committee.

In the absence of the Committee Chair or Deputy Chair, the remaining members present will elect another member to Chair the meeting.

6. Secretary

The Trust Secretary or their nominee shall act as the secretary of the Committee.

7. Quorum

The quorum necessary for the transaction of business is three members (inclusive of one Non-executive Director). A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

8. Frequency of Meetings and Attendance Requirements

The Committee shall meet at least 11 times per annum. The Chair may at any time convene additional meetings of the Committee to consider business that requires urgent attention.

An annual attendance report will be submitted to the Committee for information and action as required and will be included within the Trust's Annual Report.

9. Notice of meetings

Meetings shall be called at the request of the Chair of the Committee.

Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed, shall be forwarded to each member of the Committee, any other person required to attend, no later than five working days before the date of the meeting.

10. Minutes

The Secretary or nominated deputy, shall minute the proceedings of all meetings of the Committee, including recording the names of those present and in attendance.

Members and those present should state any conflicts of interest in relation to open agenda items to the Chair of the Committee prior to the meeting. Where there is a conflict of interest the Chair will notify the member whether they should withdraw from the meeting, the discussion and/or voting. The Secretary should minute any conflicts of interest accordingly.

Minutes of Committee meetings should be circulated promptly to all members of the Committee unless a conflict of interest exists and, once agreed, submitted to the public Board meeting for information.

11. Annual General Meeting

The Chair of the Committee will normally attend the Annual General Meeting prepared to respond to any questions on the Committee's activities.

12. Reporting Arrangements

The Committee Chair will report to the Board who will approve its Terms of Reference and membership.

The Committee Chair shall report formally to the Board and, where appropriate, the Council of Governors on its proceedings after each meeting on all matters within its duties and responsibilities.

The Committee shall make whatever recommendations to the Board it deems appropriate on any area within its remit where action or improvement is needed.

13. Responsibilities of the Committee

The Committee is responsible for providing information and assurances to the Board that it is managing all performance and finance issues effectively. In particular the Committee's duties shall include:

- Review the Trust's monthly contract income and activity performance, and alert the Board to issues of concern, real or potential;
- Review the Trust's cost performance in conjunction with the Trust's activity levels, to assure that revenue and costs are consistent;
- Approve key financial performance ratios, including but not limited to Monitor Performance requirements;
- Monitor divisional performance against plan, and when appropriate monitor sub-divisional levels requesting corrective action if appropriate;
- Approve the Monitor Quarterly returns prior to submission to the Board for ratification;
- Consider any new financial initiatives/formation of companies to assist with the business development of the Trust and, where appropriate, make recommendations to the Board;
- Review performance against the Trust's Investment Strategy;
- Review the Trust's Profit and Cost Improvement activities;
- Review the performance and implementation against the Capital programme and IM&T Strategy;
- Review the Corporate Risk Register/Board Assurance Framework quarterly and ensure that performance and finance mitigations are appropriately actioned;
- Monitor the effective alignment of Trust activity against strategic priorities in order to maintain focus;

- Monitor Divisional Boards' performance at Divisional Quarterly Performance Reviews as well as by receipt of minutes from the divisional meetings;
- Review escalated issues from the Infrastructure Development Group and ensure that actions are appropriately managed and delivered;
- Prepare an Annual Report for the Board 30th April each year on the Committee's work in discharging its duties against its Terms of Reference which covers the previous financial reporting period;
- Produce an Annual Work Plan by 1st March each year, for the subsequent year beginning 1st April;
- Identify any risks which may prevent the achievement of the Annual Work Plan and ensure that these are assessed and placed on the Trust's Risk Register/Board Assurance Framework;
- Review and approve the Annual Report, Annual Work Plan and Terms of Reference of any Groups that have a direct report to the Committee.

14. Authority

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

The Committee is authorised by the Board to obtain legal or independent professional advice and to secure the attendance of partners with relevant experience or expertise, if it considers this to be necessary.

15. Relationships with other Committees/Groups

The Committee shall receive information and assurances from the:

- Executive Infrastructure Development Group
- BIU Project Board
- Divisional Boards

The relationship with other Committees or Groups will be a standing agenda item on the agenda to ensure the Committee routinely receives as a minimum appropriate action points.

The Committee may receive escalated matters of concern from other Board Committees in relation to performance and finance issues for further investigation and may, if necessary raise concerns or request further assistance in investigations from other Committees in order to meet its Terms of Reference.

Whilst the Committee does not performance manage the Quality Report, it will receive key quality data and therefore may, from time to time, seek assurance from the Quality Governance Committee on the impact of operational issues.

16. Other Matters

The Committee should:

- Be provided with appropriate and timely training, both in the form of an induction programme for new members and on an on-going basis for all members;

- Give due consideration to laws and regulations;
- Abide by the Trust's Constitution, its values, its Code of Conduct and Nolan Principles of Conduct Underpinning Public Life.

17. Monitoring and Review

The Board will monitor the effectiveness of the Committee through receipt of the Committee's minutes and such written or verbal reports that the Chair of the Committee might provide.

At least once a year the Committee will review its own performance, constitution and Terms of Reference to ensure it is operating at maximum effectiveness and recommend any changes it considers necessary to the Board for approval.

The Secretary will monitor the frequency of the Committee meetings and the attendance records to ensure minimum attendance figures are complied with included within the Trust's Annual Report.

Terms of Reference approved by the Board:

Terms of Reference will be reviewed at least annually.

Transformation and People Committee
Terms of Reference

1. Formation of this Committee

The Mid Cheshire Hospitals NHS Foundation Trust Board of Directors (the Board) has established a Committee of the Board, to be known as the Transformation & People Committee (the Committee).

The Committee shall have Terms of Reference and powers and will ensure that the Board is able to act in accordance with legislation, compliance or direction requirements inclusive of workforce legislation and to be fully appraised of the strategic impact of the Transformation Programmes and People and Organisational Development Strategy on the delivery of the Trust's strategic objectives.

2. Role

The Committee is responsible for providing assurance to the Board that the Trust is effectively leading, developing and delivering the Trust's People and Organisational Development Strategy, together with ensuring the development of the Trust's approach to transformation and overseeing delivery of the major transformation programmes (internal and external).

3. Membership of the Committee

Members of the Committee shall be appointed by the Board and at least two of whom shall be Non-Executive Directors. The members of the Committee shall be:

- Two Non-Executive Director (One designated Chair and one designated Deputy Chair)
- Director of Workforce and Organisational Development
- Chief Operating Officer

4. Regular Attendees

- Director of Nursing and Quality (or deputy)
- Director of Strategy & Partnerships
- Director of Finance and Strategic Planning (or deputy)
- Assistant Director of Organisation Development & Education
- Deputy Medical Director (Clinical Lead for Transformation and Learning & Development)
- Guardian of Safe Working Hours
- Head of HR Management

- Head of Service Development

It is expected that all members will attend at least 75% of meetings of the Committee.

Regular attenders are expected to maintain a good standard of attendance and should attend meetings at least once per quarter.

If members are unable to attend they must advise the Chair of the Committee and enquire whether a deputy is required (if a deputy attends any meeting they must be able to fully participate but will have no voting rights).

Attendees who are deputising for members and/or regular attenders must be properly briefed by the person they are deputising for, on the content of the meeting and the item they are presenting.

The Trust's Chairman and the Trust's Chair of the Audit Committee shall not be a member of the Committee, but are authorised to observe any meetings of the Committee.

The Committee may also invite other senior officers of the Trust and other specialist advisors (internal or external) to present papers on an ad-hoc basis. Such attendees will hold no voting rights.

Governors may attend meetings of the Committee as an observer subject to approval by the Committee Chair. Any such requests should be made at least three days in advance of the meeting.

5. Chair of the Committee

The Board will assign a Non-executive Chair and a Non-Executive Director Deputy Chair of the Committee.

In the absence of the Committee Chair or Deputy Chair, the remaining members present will elect another member to Chair the meeting.

6. Secretary

The Trust Secretary or their nominee shall act as the Secretary of the Committee.

7. Quorum

The quorum necessary for the transaction of business is two members (inclusive of one Non-executive Director and one Executive Director) and at least two regular attendees. A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

8. Frequency of Meetings and Attendance Requirements

The Committee will meet at 11 times per annum (once per calendar month, with no meeting being held during August). The Chair may at any time convene additional meetings of the Committee to consider business that requires urgent attention.

An annual attendance report will be submitted to the Committee for information and action as required and will be included within the Trust's Annual Report.

In addition to meetings of the Committee there may be development sessions and Task & Finish Groups arranged as necessary to support the effectiveness of the Committee. These may be supported by external stakeholders and patient representatives.

9. Notice of Meetings

Meetings shall be called at the request of the Chair of the Committee and the annual plan for meeting dates will be circulated to members in November in preparation for the following year.

Unless otherwise agreed, notice of each meeting confirming the venue, date and time together with an agenda of items to be discussed, shall be forwarded to each member of the Committee, any other person required to attend, no later than five working days before the date of the meeting.

10. Minutes

The Secretary, or nominated deputy, shall minute the proceedings of all meetings of the Committee, including recording the names of those present and in attendance.

Members and those present should state any conflicts of interest in relation to open agenda items to the Chair of the Committee prior to the meeting. Where there is a conflict of interest the Chair will notify the member whether they should withdraw from the meeting, the discussion and/or voting. The Secretary should minute any conflicts of interest accordingly.

Minutes of Committee meetings should be circulated promptly to all members of the Committee unless a conflict of interest exists and, once agreed, submitted to the public Board meeting for information.

11. Annual General Meeting

The Chair of the Committee will normally attend the Annual General Meeting prepared to respond to any questions on the Committee's activities.

12. Reporting Arrangements

The Committee will report to the Board who will approve its Terms of Reference and membership.

The Committee Chair shall report formally to the Board and, where appropriate, the Council of Governors on its proceedings after each meeting on all matters within its duties and responsibilities.

The Committee shall make whatever recommendations to the Board it deems appropriate on any area within its remit where action or improvement is needed.

13. Responsibilities of the Committee

The Committee is responsible for ensuring that strategic transformation and people matters are considered and planned into Trust Strategy and service delivery and shall include the following duties:

Workforce and Organisational Development

- To ensure direction and priorities for the development of workforce strategies, including approval of:
  - Trust Workforce Strategy
  - Trust Education Strategy and
  - Trust Workforce plan
- To monitor the progress and effectiveness of workforce strategies against corporate strategy, organisational values and workforce experience;
- To approve new HR/OD projects and practices, paying particular attention to the impact on patient experience, quality, efficiency, equality and diversity and workforce;
- To receive assurance that workforce policies are regularly reviewed and updated as required;
- To monitor progress associated with Workforce recommendations arising from audits and the audit committee;
- To approve the development, implementation and evaluation of:
  - Leadership Development
  - Cross-Professional Leadership Development

- Talent Management & Succession Planning
- Management development across the Trust;

- To review and analyse the experiences of our staff and how we involve and engage with them to support successful and sustainable organisation and cultural change;
- To receive and consider the Quarterly Guardian of Safe Working Hours report on behalf of the Board of Directors;
- Through ensuring appropriate development and training, equip our staff and teams to deliver transformation as part of their service and as part of delivering corporate goals;
- To review and monitor the integrated workforce opportunities across the mid-Cheshire, Cheshire & Wirral and Cheshire & Merseyside areas;
- To review and approve mandated workforce reporting returns including Public Sector Equality Duties and the annual workforce plan returns;

Transformation

- To ensure direction and priorities for internal and external transformation align to the Trust's overall corporate strategy and its future development;
- To scrutinise strategic transformation performance indicators on behalf of the Board, reporting to the Board via the integrated performance report to highlight good practice and outline areas for improvement on an exception basis;
- To ensure transformation interdependencies and risks are properly accounted for as part of the Trust's overall transformation programme of work and to remove obstacles to successful delivery;
- To ensure key enablers are properly considered as part of the implementation of transformation programmes (e.g. Information Management & Technology and Organisational Development);
- To monitor progress associated with Transformation recommendations arising from audits and the audit committee;
- To receive assurance delivery reports of transformation schemes (inclusive of progress and delivery);
- To scrutinise, challenge and develop workforce and transformation performance indicators on behalf of the Board, reporting to the Board via the integrated performance report as required;

General Committee Duties

- To prepare an Annual Report for the Board by 30th April each year to review the Committee's work in discharging its duties against its Terms of Reference. The report will cover the previous financial reporting period;
- To ensure that the work of the committee liaises and consults with the divisions of the Trust in achieving the objectives of the Annual Work Plan and/or Strategy;
- To identify any risks which may prevent the achievement of the Annual Work Plan and ensure that these are assessed and placed on the Trust's Risk Register/Board Assurance Framework;
- To report any exceptions to the Annual Work Plan or Strategy to the Board;
- Review and approve the Annual Report, Annual Work Plan and Terms of Reference of any Groups that have a direct report to the Committee.

14. Authority

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

The Committee is authorised by the Board to obtain legal or independent professional advice and to secure the attendance of partners with relevant experience or expertise, if it considers this to be necessary.

15. Relationship with Other Committees/Groups

The Committee shall receive information and assurances from the:

- Executive Workforce Assurance Group
- Executive Transformation Steering Group
- JCNC

The relationship with other Committees or Groups will be a standing agenda item to ensure the Committee routinely receives as a minimum appropriate action points.

The Committee may receive escalated matters of concern from other Board Committees in relation to transformation and people issues for further investigation and may, if necessary raise concerns or request further assistance in investigations from other Committees in order to meet its Terms of Reference.

16. Other Matters

The Committee should:

- Be provided with appropriate and timely training, both in the form of an induction for new members and on an on-going basis for all members;
- Give due consideration to laws and regulations;
- Abide by the Trust's Constitution, its values, its Code of Conduct and Nolan Principles of Conduct Underpinning Public Life.

17. Annual Report

The committee will prepare an annual report at the end of each financial year, which will be reviewed and agreed at the April committee meeting and escalated by the Chair of the Committee as part of the annual committee review cycle.

18. Monitoring and Review

The Board will monitor the effectiveness of the Committee through receipt of the Committee's minutes and such written or verbal reports that the Chair of the Committee might provide.

At least once a year the Committee will review:

- The committee's own performance,
- The constitution of the committee and
- Terms of Reference

This will ensure it is operating at maximum effectiveness and recommend any changes it considers necessary to the Board for approval.

The Secretary will monitor the frequency of the Committee meetings and the attendance records to ensure minimum attendance figures are complied with included within the Trust's Annual Report.

Terms of Reference approved by the Board:

Date Issued: March 2014

Date Reviewed: March 2017

Review Date: March 2018

Board of Directors

Standing Orders:
Reservation and Delegation of Powers

Contents

A Introduction

Standing Orders: Delegation of Powers to Board Committees, provides that the Trust may make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee or sub-committee or by the Chairman or a Director or by an officer of the Trust., in each case subject to such restrictions and conditions as the Board thinks fit. The Code of Accountability also requires that there should be a formal schedule of matters specifically reserved to the Board of Directors, hereafter referred to as the Board.

This document sets out how those powers are to be reserved to the Board, while at the same time delegating to the appropriate level the detailed application of Trust policies and procedures. However, the Board remains accountable for all of its functions, even those delegated to the Chairman, individual directors or officers and would therefore expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

B Role of the Chief Executive

All powers of the Trust which have not been retained as reserved by the Board or delegated to an executive committee or sub-committee shall be exercised on behalf of the Board by the Chief Executive. The Chief Executive and Director of Finance & Strategic Planning shall jointly prepare a Scheme of Delegation, for approval by the Board, identifying which functions that the Chief Executive shall perform personally and which functions have been delegated to other directors and officers. The Scheme of Delegation approved by the Board on 7 January 2008 is set out in Sections 4-6 of this Schedule.

All powers delegated by the Chief Executive can be re-assumed by him should the need arise. As Accounting Officer the Chief Executive is accountable to Monitor and to Parliament for the funds entrusted to the Trust.

C Caution over the Use of Delegated Powers

Powers are delegated to directors and officers on the understanding that they will not exercise delegated powers in a manner which in their judgement was likely to be a cause for public concern.

D Directors' Ability to Delegate their own Delegated Powers

The Scheme of Delegation shows only the "top level" of delegation within the Trust. The Scheme is to be used in conjunction with the system of budgetary control and other established procedures within the Trust.

E Absence of Director or Officer to Whom Powers have been Delegated

In the absence of a director or officer to whom powers have been delegated those powers shall be exercised by that director or officer's line manager unless alternative arrangements have been approved by the Board. If the Chief Executive is absent powers delegated to him may be exercised by the Deputy Chief Executive as approved by the Board.

SECTION 1

RESERVATION OF POWERS TO THE BOARD OF DIRECTORS

1.1 The Code of Accountability which has been adopted by the Trust requires the Board to determine those matters on which decisions are reserved to itself. These reserved matters are set out in paragraphs 1.2 to 1.9 below:

1.2 **General Enabling Provision**

The Board may determine any matter it wishes in full session within its statutory powers.

1.3 **Timetable for consideration of those Powers Reserved to the Board**

It shall be the responsibility of the Chairman to, annually, prepare and present to the Board for approval a schedule and timetable of those matters reserved by the Board for discussion at future meetings.

1.4 **Regulation and Control**

1.4.1 Approval of Standing Orders (SOs), a Schedule of Matters Reserved to the Board, Standing Financial Instructions, Standing Instructions for Non-Financial Risk for the regulation of its proceedings and business, Codes of Conduct, Scheme of Delegation, Board Assurance Framework, Clinical Governance arrangements, Annual Audit Letter, and Annual Report and Statutory Accounts of the Trust.

1.4.2 Suspend Standing Orders

1.4.3 Vary or amend the Standing Orders.

1.4.4 Ratify in a Board meeting any urgent decisions taken by the Chairman and Chief Executive in accordance with SO.

1.4.5 Approve a scheme of delegation or powers from the Board to committees.

1.4.6 Approval of a scheme of delegation of powers from the Board to directors and officers.

1.4.7 Requiring and receiving the declaration of directors' and officers' interests which may conflict with those of the Trust and determining the extent to which that director or associate directors may remain involved with the matter under consideration.

1.4.8 Requiring and receiving the declaration of interests from officers which may conflict with those of the Trust.

1.4.9 Disciplining Directors who are in breach of statutory requirements, SOs, SFI's, or any other approved Policy or Procedure.

1.4.10 Adoption of the organisational structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications there to.

1.4.11 Establish committees of the Board including their terms of reference and reporting arrangements.

1.4.12 To receive reports from committees including those which the Trust is required by the Secretary of State or other regulation to establish and to take appropriate action thereon.

1.4.13 To consider and, if appropriate, approve the recommendations of those Trust committees that do not have executive powers or authority to commit additional expenditure.

1.4.14 Approval of arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust.

1.4.15 Approval of arrangements relating to the discharge of the Trust's responsibilities as a bailee for patients' property.

1.4.16 Authorise use of the seal.

1.4.17 Ratify or otherwise instances of failure to comply with Standing Orders brought to the Audit Committee's attention.

1.4.18 Compliance with the Trust's Monitor Provider Licence, its Constitution, and all statutory and regulatory obligations.

1.5 **Appointments/Dismissal**

1.5.1 Appointment of the Deputy Chairman of the Board, in consultation with the Council of Governors.

1.5.2 Appoint and dismiss committees (and individual members) that are directly accountable to the Board.

1.5.3 The appointment, appraisal, disciplining and dismissal by Non-Executive Directors of Executive Directors in accordance with the **Constitution**.

1.5.4 The appointment, appraisal, disciplining and dismissal of the Board Secretary.

1.5.5 Approve proposals of the Appointments and Remuneration Committee regarding Executive Directors.

1.6 **Strategy and Business Plans and Budgets**

1.6.1 In consultation with the Council of Governors, to define the strategic aims and objectives of the Trust.

1.6.2 In consultation with the Council of Governors, to determine key objectives to meet the needs of stakeholders.

1.6.3 Approve the Full Business Cases for Capital Investment to the limits set by the Board.

1.6.4 Approve budgets for revenue, capital and working capital.

1.6.5 Approve proposals for acquisition, disposal or change of use of land and/or buildings.

1.6.6 Approve PFI proposals.

1.6.7 Approve the opening of bank accounts.

1.6.8 Approve proposals on individual contracts (other than NHS contracts) of a capital or revenue nature amounting to, or likely to amount to over £100,000 over a 3 year period or the period of the contract if longer.

1.6.9 Approve proposals on individual contracts (other than NHS contracts for the provision of service) of a capital or revenue nature amounting to, or likely to amount to over £100,000 per annum, or greater than £500,000 over the life of the contract.

Where the following criteria is met the authority to sign such contracts is delegated to the Chief Executive and the Director of Finance & Strategic Planning:

1. The Board has approved a business case in relation to the expenditure / commitment and the contract is in line with the values approved
2. Replacement of existing lease arrangements which are affordable within approved budgets.

1.6.10 Review and approve the Trust's insurance against significant risks, including use of the NHS Litigation Authority's risk pooling schemes.

1.6.11 Approval annually of plans in respect of:-

- Health investment and purchasing intentions.
- The application of available financial resources.

1.6.12 Financial Forecasts and Plans.

1.6.13 Approval of strategic developments and associated Business Plans.

1,6.14 Approval of Working Capital Facility

1.7 **Risk Management**

1.7.1 Approval and monitoring of the Trust's strategy for the management of risk, specifically its Board Assurance Framework (BAF)

1.8 **Direct Operational Decisions**

1.8.1 The "substantive" introduction, increase or discontinuance of any significant activity or operation. An activity or operation shall be significant if it has a gross annual

income or expenditure (before any set off) in excess of £100,000. Interim investments to respond to increases in demand may be put in place on an interim basis with approval by the Chief Executive and Director of Finance & Strategic Planning up to a maximum of 6 months and a total commitment of no more than £250,000. The Board will be informed of such commitments through the Performance & Finance Committee.

Any extensions to the 6 months must receive prior Board approval.

1.8.2 Approval of the capital programme which shall comprise the purchase of items with a life of more than one year and

a) over the capital limit of £5,000, and
b) under the £5,000 limit but exceeding £250 each for grouped items.

Urgent items of "capital expenditure" against a contingency sum (previously approved by the Board) may be authorised by the Chief Executive and Director of Finance & Strategic Planning jointly and reported to the next Board meeting.

The Board may delegate to the Director of Finance & Strategic Planning a part of the capital in line with the contingency arrangements set out in Section 4.

1.8.3 To agree action on litigation against or on behalf of the Trust, except that the Director of Finance & Strategic Planning shall be authorised to take all necessary action to recover debts due to the Trust.

1.9 **Financial and Performance Reporting Arrangements**

1.9.1 Continuous appraisal of the affairs of the Trust by means of reports as it sees fit from directors, committees, associate directors and officers of the Trust. All monitoring returns required by Monitor and the Charity Commission shall be reported, at least in summary, to the Board.

1.9.2 Receive reports from Director of Finance & Strategic Planning on financial performance against budget and business plan.

1.9.3 Receipt and approval of NHS service contracts signed in accordance with arrangements approved by the Chief Executive.

1.9.4 Receive reports from the Chief Executive on actual and forecast income from service Commissioners.

1.9.5 Approval of the opening or closing of any bank or investment account and the approval of cheque signatories and any other bank mandates.

1.9.6 Consideration and approval of the Trust's Annual Report including the Annual Accounts and quality account

1.9.7 Receipt and approval of an annual report from the Audit Committee regarding internal control and requiring designated signatures.

1.9.8 Receipt of all minutes and annual reports of Board Committees, and receipt and approval of all annual work plans of all Board Committees.

1.9.9 Receipt and approval of the Directors' Statement on Compliance as may be required by the Secretary of State.

1.9.10 Appointment of Bankers.

1.9.11 Insurance Arrangements.

1.9.13 Approval of the Annual Governance Statement

1.10 **Audit Arrangements**

1.10.1 To approve audit arrangements and to receive reports of the Audit Committee meetings and take appropriate action.

1.10.2 The receipt of the annual management letter received from the External Auditor and consideration of any action recommended by the Audit Committee.

1.10.3 The receipt of the annual report received from the Internal Auditor and consideration of any recommendation made by the Board's Committee for audit.

SECTION 2

DELEGATION OF POWERS

2.1 **Delegation to Committees**

The Board *determines* that certain of its powers shall be exercised by Standing Committees. The composition and terms of reference of such committees shall be that determined by the Board from time to time taking into account where necessary the requirements of Monitor and/ or the Charity Commissioners (including the need to appoint an Audit Committee and an Appointments and Remuneration Committee). The Board shall determine the reporting requirements in respect of these committees. In accordance with SO, committees may not delegate executive powers to sub-committees unless expressly authorised by the Board.

SECTION 3

SCHEME OF DELEGATION TO OFFICERS

3.1 Standing Orders and Standing Financial Instructions set out in some detail the financial responsibilities of the Chief Executive (CE), the Director of Finance & Strategic Planning (DoF) and other directors. These responsibilities are summarised in Section 4.

Certain matters needing to be covered in the scheme of delegation are not covered by SFIs or SOs or they do not specify the responsible officer. These are:

The scheme of delegation in relation to the authorisation of expenditure is set out in Sections 4 & 5.

The scheme of delegation in relation to the authorisation of condemnations, losses and special payments is set out in SFI Schedule II.

3.2 Section 6 sets out the Detailed Scheme of Delegation implied by

- Standing Orders
- Standing Financial Instructions
- Standing Instructions for Non-Financial Risk

3.3 All matters which are not reserved for the Board or its Committees are delegated to the Chief Executive. In turn, the Chief Executive will delegate as he sees fit to each of the Executive Directors. Each of the Executive Directors has a functional responsibility determined by the Board or its Committees.

3.4 It should be noted (in accordance with the provisions of the Emergency Powers Section of Board Standing Order 10.2) that in an emergency the Board has retained to itself within these standing orders may be exercised by the Chief Executive and the Chairman after having consulted at least two Non-Executive Directors. The exercise of such powers by the Chief Executive and the Chairman shall be reported to the next formal meeting of the Board for ratification.

3.5 For the sake of clarity, certain significant matters are delegated to the Chief Executive, Executive Directors and line management.

SECTION 4

AUTHORISATION OF EXPENDITURE

4.1 General

4.1.1 All procurements shall be in line with the regulations set out in Section 14 of the Standing Orders, Sections 10, 12 and 13 of Standing Financial Instructions and shall be only permissible against budgets approved in line with Section 4 of the Standing Financial Instructions. They shall also be in line with the details in Financial Codes of Procedures.

4.1.2 The Trust's Supplies Manager and/or Director of Finance & Strategic Planning shall be responsible for advising the Chief Executive of all cases where procurement procedures have not been followed, prior to processing of orders. They shall be entitled to obtain all relevant information from managers and officers to assist in this respect.

4.1.3 "Principal requisitions" shall be those set up to form the main contract with a supplier. There may be a number of call-off requisitions (or orders) against a principal requisition.

4.1.4 Requisitions will be raised by responsible officers designated by the Director of Finance & Strategic Planning after discussion with the divisions. Requisitions will normally pass through the hierarchy for sign-off with final authorisation by the appropriate levels in Sections 4.2 and 4.3 below. The Director of Finance & Strategic Planning may authorise that certain levels of the hierarchy be missed out in the interests of economy.

4.1.5 NHS Standards on Internal Control require that there be adequate systems of internal check in the procurement process (eg different officers, not under undue

influence, are responsible for requisitioning, authorising, receiving and processing payment for goods and services). Each authorised officer is responsible for ensuring that there is adequate division of duties (internal check) and where there is doubt, passing the transaction upwards for authorisation. Internal Audit Department have a major role in giving the Board assurance that proper internal check is in place.

4.1.6 The Director of Finance & Strategic Planning shall draw up a list of managers and officers for each level shown in the following tables. Inclusion for each level shall be in accordance with budget responsibility and not professional grade or status. Authorised signatories may only authorise expenditure against budgets for which they are responsible.

4.1.7 Lower levels of authority are available for requisitions where the Trust's Procurement Procedures have not been complied with (e.g. single quote or single tender actions or where tendering has been dispensed with).

4.1.8 The Director of Finance & Strategic Planning shall satisfy himself that all managers and officers have a standard clause on budgetary and financial responsibility in their employment terms and conditions when determining the appropriate level.

4.1.9 The limits set out in this Section 4 shall be reviewed annually by the Director of Finance & Strategic Planning in line with the Retail Price Index (All items) and the Director of Finance & Strategic Planning shall recommend such changes to the Board for approval.

4.2. Authorisation of requisitions for Revenue Expenditure (inclusive of VAT)

Authorised Signatory	Cash Reimbursements	Authorisations up to £ (inclusive of VAT) Principal Purchase Requisitioner Using Procurement Processes	Not Using Procurement Processes	Call-off Requisitions	Virements
Joint CEO / Director of Finance			>£100,000*		
Chief Executive (solely) (Deputy CEO/Director of Finance & Strategic Planning deputies)	-	Unlimited	100,000		Unlimited
Director of Finance & Strategic Planning	200	50,000	50,000		100,000
Executive Director or Divisional Director	50	50,000	-		35,000
Divisional General Manager	50	25,000	-		20,000
Senior Divisional Nurse, Clinical Lead or Functional Head	50	10,000	-		10,000
Matron/Service Manager	50	5,000	-	Unlimited	5,000
Ward or Departmental Manager	50	2,500	-	10,000	-

Notes
1. Requisitions will progress up the authorisation tree, being checked at each stage.
2. Authorised signatories may only authorise expenditure against budgets that they are responsible for.

Exceptions
The following expenditure shall be authorised only when the requisition has been countersigned by the following or officers nominated by the following:

i)	Building or equipment works or maintenance	Divisional Director of Estates & Facilities
ii)	IT purchases (including hardware, software, or services) maintenance, consultancy or other services or works	Head of ICT
iii)	Consultancy Services	Chief Executive or Director of Finance & Strategic Planning
iv)	Telephones	Head of ICT

* whilst the requisition will physically be signed off by joint CEO and Director of Finance & Strategic Planning, the Board of Directors will be required to give formal approval for this, prior to sign off

4.3 Authorisation of Building Contracts or Requisitions for Capital Expenditure

"Capital Expenditure" shall be defined as items with

a) a life of more than one year,
b) over the capital limit of £5,000 for the item or the cost of a series of items which work together as a system,
c) a series of different items required to open a new ward or department where total cost is over £5,000,
d) a series of similar items that, although not necessarily located in one area, are under common management, are bought roughly at the same time and have similar expected lives, and where the total cost is over £5,000.

All values are inclusive of VAT.
The Director of Finance & Strategic Planning shall be consulted in all cases of doubt.

4.3.1 All proposals to lease assets must be approved by the Director of Finance & Strategic Planning.

4.3.2 All "Capital Expenditure" shall be authorised in line with the regulations set out in Standing Financial Instructions Section 12.

All "Capital Expenditure" must receive prior approval from the Trust Board by way of the Capital Programme.

4.3.3 All bids for ad hoc funds (identified after the Capital Programme has been approved) must be notified to the Board

i) prior to the bid being made, if possible
ii) at the next meeting after the bid has been made

in order that the Board may consider the capital and revenue consequences in light of its agreed priorities, and that the bids may be incorporated into the Capital Programme.

4.3.4 For Capital Schemes (excluding backlog maintenance and General Contingencies) where the Capital Cost is more than £100,000, a full business case shall be presented to the Board (in line with the guidance issued by the NHS in the Capital Manual) for approval prior to commitment. The business case shall list all contractors and suppliers of materials and services with whom the Trust will have a contract or where the Trust specifies in the contract specific sub-contractors or suppliers. All financial implications shall be agreed by the Director of Finance & Strategic Planning.

4.3.5 For Capital Schemes under the limits in C.6 above and already in the Capital Programme there shall be no need for prior approval by the Board to proceed. Such commitments shall be reported to the Board at its next meeting.

4.3.6 The Board may include in the Capital Programme a "Capital Contingency" and / or a provision for backlog maintenance intended to cover urgent needs arising during the year. Any commitments against the Capital Contingency will be authorised as below and reported in retrospect every other month to the Infrastructure Development Committee.

4.3.7 All requisitions for "Capital" must be allocated a Capital Programme number (nominal code) by an officer (appointed by the Director of Finance & Strategic Planning) prior to authorisation.

Authorised Signatories:

Authorised Signatory	Principal Purchase Requisitions Using Procurement Procedures £	Not Using Procurement Procedures £	Call-off reqns £
Buildings & Equipment			
Capital Manager	5,000 – 10,000	-	50,000
Divisional Director of Estates & Facilities	10,000 – 50,000	5,000	100,000
Director of Finance & Strategic Planning	50,000 – 100,000	50,000	Over 100,000
Chief Executive	Over 100,000	100,000	Over 100,000
Joint signatory CEO / Director of Finance & Strategic Planning	-	>100,000*	-
Information Technology			
Head of ICT	5,000 – 10,000	-	50,000
Medical Director	10,000 – 50,000	5,000	100,000
Director of Finance & Strategic Planning	50,000 – 100,000	50,000	Over 100,000
Chief Executive	Over 100,000	100,000	Over 100,000
Joint Signatory CEO / Director of Finance & Strategic Planning	-	>100,000	-

Requisitions will process up the authorisation tree, being checked at each stage.

* whilst the requisition will physically be signed off by joint CEO and Director of Finance & Strategic Planning, the Board of Directors will be required to give formal approval for this, prior to sign off

4.4. Authorisation of “Stock Items” by electronic “top up”

4.4.1 Stock items are requisitioned from NHS Logistics stores via an electronic “top up” system.

4.4.2 The Supplies Manager will draw up schedules of products required for each ward or department, together with the estimated top up levels, taking into account

a) advice from the ward or department manager
b) historical records of usage
c) seasonality or holiday factors.

4.4.3 The top up levels for each ward and department will be authorised jointly by the Supplies Manager and Ward/Department Manager. In the event of disagreement the matter shall be referred to the Director of Finance & Strategic Planning for authorisation.

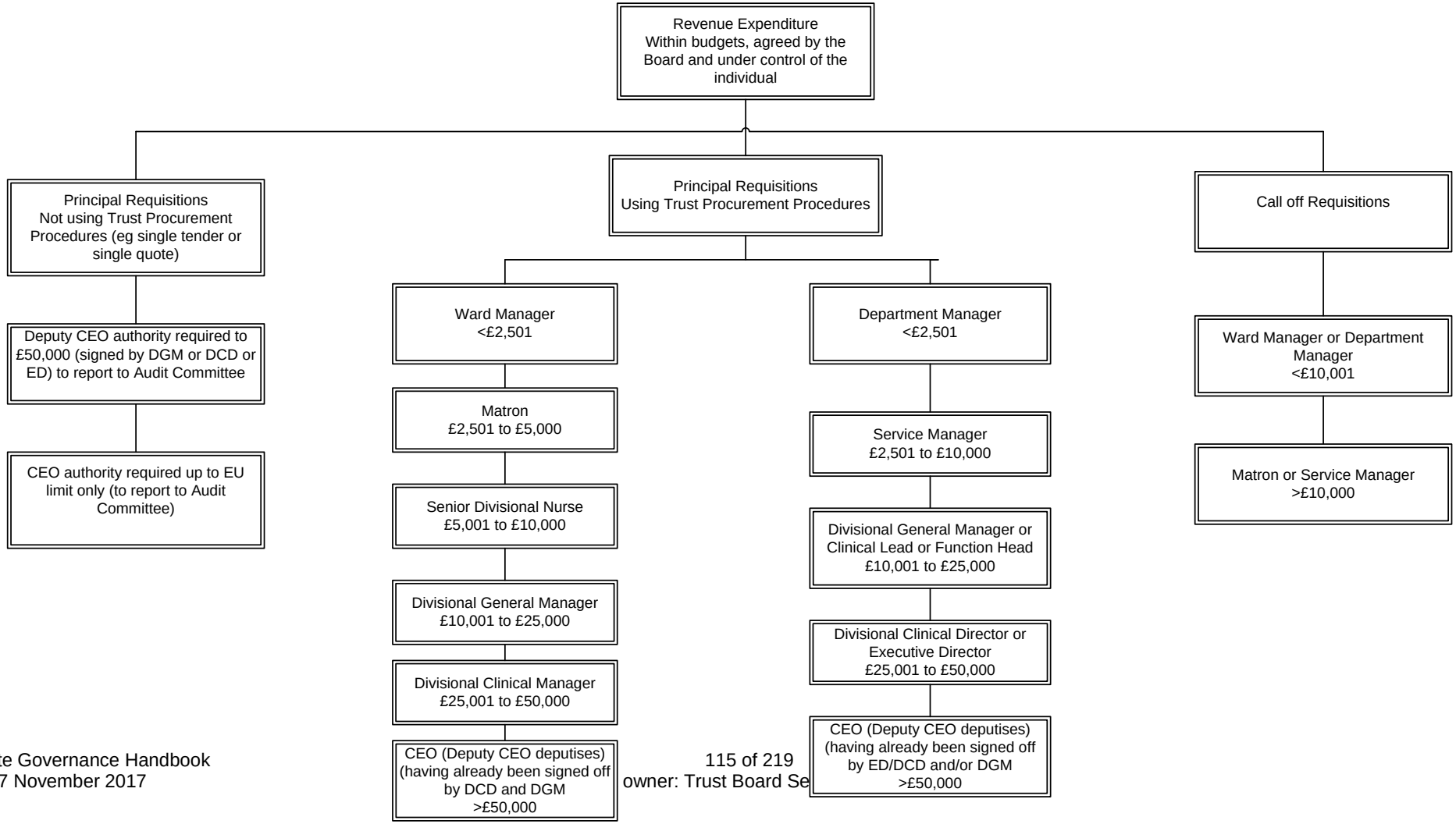
4.4.4 The Supplies Manager will arrange each week for electronic requisitioning to NHS Logistics in order to bring each Ward/Department’s stock levels up to the authorised top-up level.

AUTHORISATION LIMITS

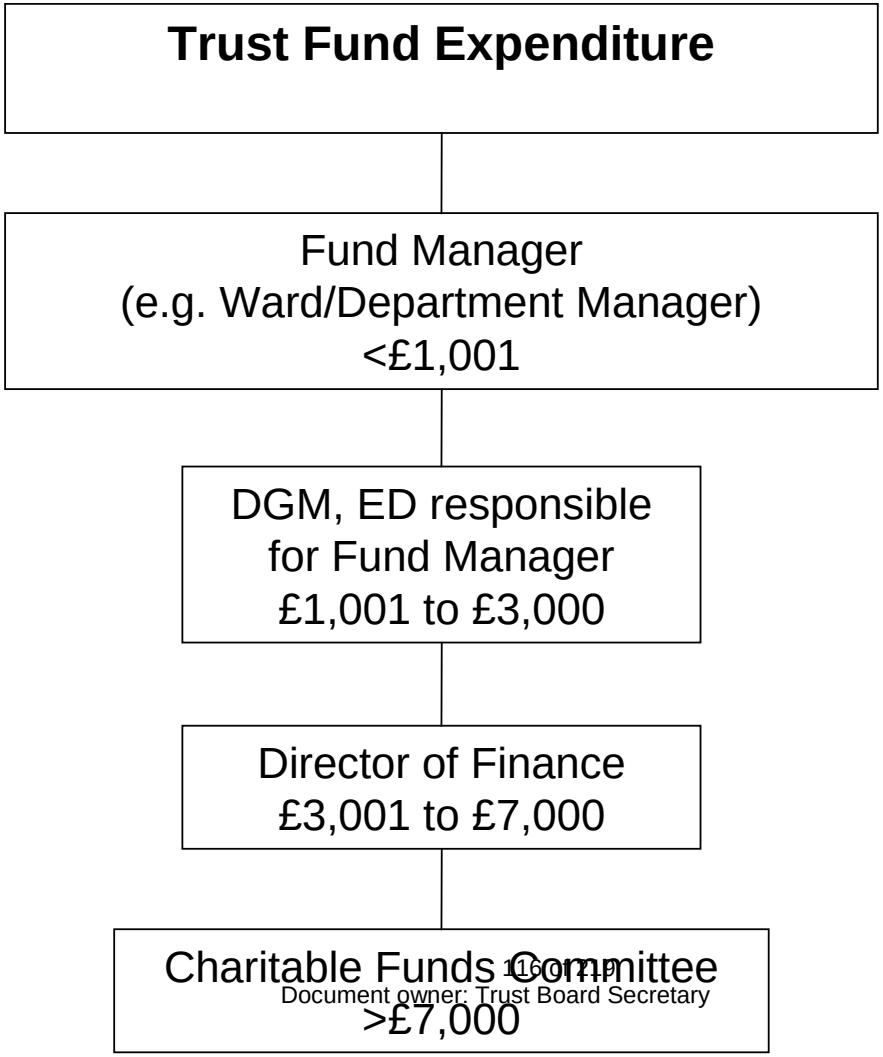
Non-pay and Capital Expenditure

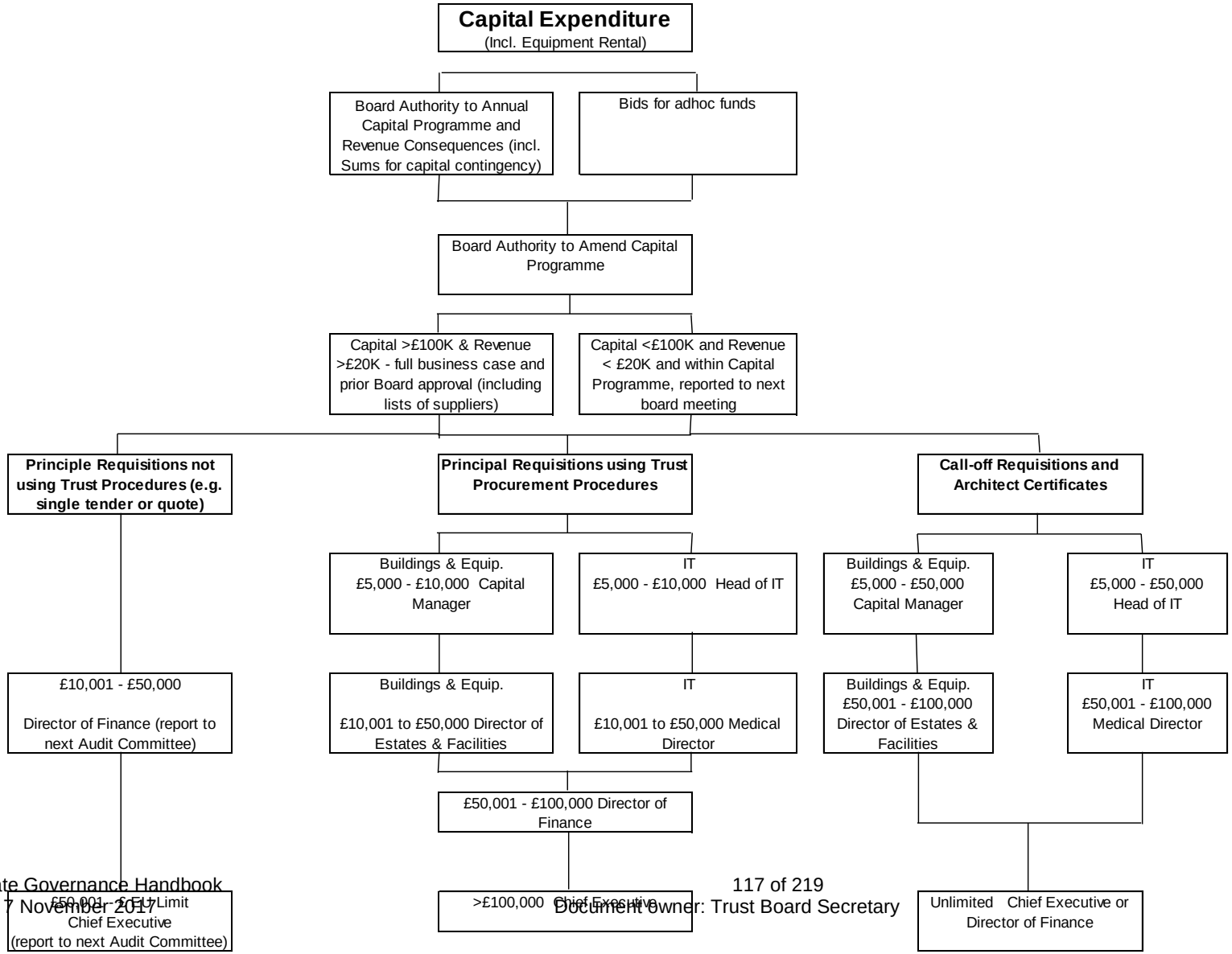
4.5 REVENUE EXPENDITURE

(EXCL TRUST FUNDS)



TRUST FUNDS


Trust Fund Expenditure
Fund Manager
(e.g. Ward/Department Manager)
<£1,001
DGM, ED responsible
for Fund Manager
£1,001 to £3,000
Director of Finance
£3,001 to £7,000
Charitable Funds Committee
>£7,000


Capital Expenditure
(Incl. Equipment Rental)
Board Authority to Annual Capital Programme and Revenue Consequences (incl. Sums for capital contingency)
Bids for adhoc funds
Board Authority to Amend Capital Programme
Capital >£100K & Revenue >£20K - full business case and prior Board approval (including lists of suppliers)
Capital <£100K and Revenue < £20K and within Capital Programme, reported to next board meeting
Principle Requisitions not using Trust Procedures (e.g. single tender or quote)
Principal Requisitions using Trust Procurement Procedures
Call-off Requisitions and Architect Certificates
Buildings & Equip. £5,000 - £10,000 Capital Manager
IT £5,000 - £10,000 Head of IT
Buildings & Equip. £5,000 - £50,000 Capital Manager
IT £5,000 - £50,000 Head of IT
£10,001 - £50,000
Director of Finance (report to next Audit Committee)
Buildings & Equip.
£10,001 to £50,000 Director of Estates & Facilities
IT
£10,001 to £50,000 Medical Director
Buildings & Equip. £50,001 - £100,000 Director of Estates & Facilities
IT £50,001 - £100,000 Medical Director
£50,001 - £100,000 Director of Finance
£50,001 - £[illegible] Limit
Chief Executive
(report to next Audit Committee)
>£100,000 Chief Executive
Unlimited Chief Executive or Director of Finance

SECTION 5 CHEQUES AND BACS SIGNATORIES (Effective by title of appointment June 2002)

AUTHORISED CHEQUE SIGNATORIES

A. Cheques with a value of up to £2,000

One of the following, solely:

T Bullock	Chief Executive
M Oldham	Director of Finance & Strategic Planning
K Edge	Deputy Director of Finance – Head of Business Intelligence
C Birch	Accounts Manager
D Goff	Deputy Director of Finance, Financial Services

B. Cheques with a value greater than £2,000 and up to £5,000

Any two of the above.

C. Cheques with a value greater than £5,000 and up to £100,000

Two of the above of which at least one must be as follows:

T Bullock	Chief Executive
M Oldham	Director of Finance & Strategic Planning
D Goff	Deputy Director of Finance, Financial Services

D. Cheques > £100,000

Any two of the following:

T Bullock	Chief Executive
M Oldham	Director of Finance & Strategic Planning
D Goff	Deputy Director of Finance, Financial Services

E. Authorisation for BACS payment lists

Any two of:

T Bullock	Chief Executive
M Oldham	Director of Finance & Strategic Planning
D Goff	Deputy Director of Finance, Financial Services
K Edge	Deputy Director of Finance, Head of Business Intelligence

F. Authorisation of Payroll Advances

T Bullock	Chief Executive
M Oldham	Director of Finance & Strategic Planning
D Goff	Deputy Director of Finance, Financial Services
K Edge	Deputy Director of Finance, Head of Business Intelligence
E Carmichael	Director of Service Transformation & Workforce
J Mitchell	Medical Staffing Manager

6. DETAILED SCHEME OF DELEGATION

Delegated matters in respect of decisions which may have a far reaching effect must be reported to the Chief Executive. **The delegation shown below is the lowest level to which authority is delegated.** Delegation to lower levels is only permitted with written approval of the Chief Executive who will, before authorising such delegation, consult with other Senior Officers as appropriate. All items concerning Finance must be carried out in accordance with Standing Financial Instructions and Standing Orders.

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
1. Affixing of sealings in accordance with Standing Orders	Chief Executive & Chairman	SOs Section 12
2. Agreements/Licences		
a) Preparation and signature of all tenancy agreements and licences for all staff subject to Trust Policy on accommodation for staff	Divisional Director of Estates and Facilities	
b) Extensions to existing staff leases and tenancy agreements	Residences Manager	
c) Letting of premises to outside organisations	Chief Executive Officer and Director of Finance & Strategic Planning	
d) Approval of rent based on professional assessment	Director of Finance & Strategic Planning	SFI Section 7
3. Audit		
a) Provide independent and objective view on internal control and probity	Audit Committee	SFI's Section 2
b) Provide adequate internal audit service	Director of Finance & Strategic Planning	

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
c) Review, evaluate and report on internal financial control d) Review, appraise and report in accordance with NHS Internal Audit Manual and best practice e) Ensure cost-effective external audit	Director of Finance & Strategic Planning	
4. Board & Meetings		
a) Final Authority in interpretation of SOs	Chairman	SO 8.20, 8.22, 2.1
b) Calling meetings	Board of Directors & Chairman	SO 8.5
c) Notice of Meetings	Chairman	SO 8.6
d) Chair all board meetings and associated responsibilities	Chairman	SO 8.12
e) Setting agenda for meetings and maintaining an agenda of agendas	Chairman	SO 8.9
e) Interpretation of SFI's	Trust Board Secretary	SFI 1
5. Budget Management		
i. Submit budgets to the Board.	Director of Finance & Strategic Planning	SFIs Section 4
ii. Monitor performance against budget, submit to Board financial estimates and forecasts.	Director of Finance & Strategic Planning	
iii. Delegate budget to budget holders and submit monitoring returns	Chief Executive	
iv. Responsibility of keeping expenditure within budgets (Pay, non-pay, income, recharges and capital charges)		
a) At individual ward & department level (Pay and Non Pay)	Ward and Departmental Manager	
b) At divisional level	Divisional General Manager	
c) For the totality of services provided by the Trust	Chief Executive	

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
6. Capital Schemes		
a) Compile and submit to the Board an Estates Strategy	Chief Executive	SFI 12.1.1
b) Compile and submit to the Board an Annual Capital Programme	Director of Finance & Strategic Planning	SFI 12.1.3
c) Submit bids for capital funds not in Capital Programme to the Board	Director of Finance & Strategic Planning	SFI 12.1.5
d) Submit business cases for capital expenditure >£100,000 and/or revenue consequences >£20,000	Chief Executive or nominated Executive Director	SFI 12.1.6
e) Monitoring Capital Programme	Director of Finance & Strategic Planning	SFI 12.1.2 & 12.1.14
f) Authority to commit capital expenditure	See Scheme of Delegation Section 4C	
g) Maintenance of asset registers	Director of Finance & Strategic Planning	SFI 12.3
h) Selection of architects, quantity surveyors, consultant engineer and other professional advisors within EU regulations & SFI's	Divisional Director of Estates & Facilities	
i) Approval of rentals & PFI finance	Director of Finance & Strategic Planning	SFI 12.2
7. Clinical Trials – Authorisation	Medical Director after taking advice from Director of Finance & Strategic Planning on costs and reimbursement	SO 13.44 – 13.45
8. Condemning & Disposal		

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
a) Condemning Officer i) Medical equipment ii) Computer equipment iii) Drugs iv) All other	 EBME Chief Medical Technical Officer IT Support Manager Director of Pharmacy & Medicines Management Divisional Director of Estates & Facilities	SFIs Section 14
b) Authorisation for disposal of Items that are obsolete, obsolescent, redundant, irreparable or cannot be repaired cost effectively i) with current/estimated purchase price of replacement <£5000 ii) with current purchase new price >£5000	 Supplies Manager Director of Finance & Strategic Planning	
9. Drugs (New) – Authorisation - Estimated total yearly cost up to £25,000 - Estimated total yearly cost above £25,000	 Clinical Lead Medicines Committee and referred to EMB for information	SFI's Section 10.3
10. Engagement of Trust's Solicitors	Trust Board Secretary	
11. Extended Role Activities Approval of Nurses to undertake duties / procedures which can properly be described as beyond the normal scope of Nursing Practice.	 Director of Nursing & Quality	Nurse/Midwives/ Health Visitors Act Midwives Rules / Code of Practice NMC Code of Professional Conduct

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
12. Facilities for staff not employed by the Trust to gain practical experience		
Professional Recognition, Honorary Contracts, & Insurance of Medical Staff.	Chief Executive , Clinical Tutor	
Work experience students	Voluntary Services Coordinator	
13. Financial Accountability		
a) Ensuring clear lines of accountability	Chief Executive	SFI 1.3.5
14. Financial Management		
a) Overall responsibility for Cash Control	Chief Executive	SFI 3.1
b) Ensuring compliance with Dept of Health or FT Monitor requirements, ensure money drawn from Dept of Health is for approved expenditure only at time of need, and ensuring adequate system of monitoring	Director of Finance & Strategic Planning	SFI 3.3
c) Annual Accounts– preparation	Director of Finance & Strategic Planning	SFI 5.1
d) Annual Reports preparation	Trust Board Secretary	
e) Banking arrangements	Director of Finance & Strategic Planning	SFI 6.1.1
f) Prompt payment of accounts	Director of Finance & Strategic Planning	SFI 12.2.2 & 12.2.3
g) Advise Board on borrowing and investment needs and prepare procedural instructions	Director of Finance & Strategic Planning	SFI 6.2
h) Capital investment programme and business cases	Chief Executive	SFI 12.1
i) Calculate and pay capital charges in accordance with NHS Executive requirements	Director of Finance & Strategic Planning	SFI 12.3.8
j) Responsible for accuracy and security of	Director of Finance & Strategic Planning	SFI 15

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
computerised financial data		
15. Financial Policies & Procedures & Records		
a) Responsible for: Implementing the Trust's financial policies and coordinating corrective action and ensuring detailed financial procedures and systems are prepared and documented. Provision of financial advice.	Director of Finance & Strategic Planning	SFI 1.3.8
b) Form and adequacy of financial records of all departments	Director of Finance & Strategic Planning	SFI 1.3.8
c) Review, evaluate and report on internal financial control	Director of Finance & Strategic Planning	SFI 2.1
d) Income systems and debt recovery	Director of Finance & Strategic Planning	SFI 7
e) Advise the Board on level of delegation of non-pay expenditure to budget managers	Director of Finance & Strategic Planning	SFI Introduction
f) Maintain lists of managers with authority levels	Director of Finance & Strategic Planning	SFI Section 4 A.6 SFI 10.1
g) Authorise who may use and be issued with official orders	Director of Finance & Strategic Planning	SFI 10.2.5
h) Maintenance of asset registers	Director of Finance & Strategic Planning	SFI 12.3
i) Calculate capital charges and pay dividends in accordance with DOH requirements	Director of Finance & Strategic Planning	SFI 12.3.8
j) Approval of asset control procedures	Director of Finance & Strategic Planning	SFI 12.3.5 & 12.4.2
k) Responsible for security of Trust assets including notifying discrepancies to DOF, and reporting losses in accordance with Trust procedure	All senior staff	SFI 12.4.3 to 12.4.5

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
l) Responsible for systems of control over stores & receipt of goods	Director of Finance & Strategic Planning	SFI 13.2 & 13.4
m) Responsibility for the control of stores in accordance with Director of Finance & Strategic Planning guidance	Departmental/Ward Managers	SFI 13.2
n) Identify persons authorised to requisition and accept goods from Supplies stores or PASA regional stores	Director of Finance & Strategic Planning	SFI 13.3
o) Retention of document procedures - clinical - other	Medical Director and Deputy Chief Executive Director of Finance & Strategic Planning	SFI 18.1
16. Fire Precautions – review	Associate Director - ~~Head of~~ Integrated Governance	
17. Fraud & Theft		
a) Investigate any suspected cases of fraud or other irregularity	LCFS and Director of Finance & Strategic Planning	SFI 21
b) Prepare procedures for recording and accounting for losses and special payments and informing DOH and NHS Fraud Service of all frauds and informing police in cases of suspected arson or theft	Director of Finance & Strategic Planning	
18. Hospitality – Authorisation	Director of Finance & Strategic Planning	SO13.21 – 13.22
19. Infectious Diseases & Notifiable Outbreaks	Senior Manager on call, or Control of Infection Doctor	

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
20. Insurance Policies	Director of Finance & Strategic Planning	SFI 19
21. Investment of Funds (including Charitable & Endowment Funds) a) Shall ensure each fund held on trust is managed appropriately (subject to the discretion and approval of the Trustees Sub-Committee). b)	Director of Finance & Strategic Planning	SFI 17.3
22. Losses, Write-off & Compensation a) For general condemnation, losses and special payments b) For clinical negligence and personal injury claims to public up to £100,000 (negotiated settlements) where cost to the Trust is <£20,000 c) For all other clinical negligence claims and personal injury claims from the public d) For personal injury claims to staff Up to £10,000 (including plaintiff's costs) e) For personal injury claims from staff above £10,000	See Sch II SFIs Director of Nursing & Quality Chief Executive Director of Workforce and Organisational Development Chief Executive	
23. Maintenance / Operation of Bank Accounts	Director of Finance & Strategic Planning	SFIs Section 6
24. Patients & Relatives Complaints a) Overall responsibility for ensuring that all	Director of Nursing & Quality	

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
complaints are dealt with effectively b) Responsibility for ensuring complaints relating to a directorate are investigated thoroughly. c) Legal Complaints Co-ordination of their management.	Divisional Clinical Lead Patient Experience Manager	
25. Patients Property		
a) Responsible for ensuring patients and guardians are informed about patients' money and property procedures on admission	Chief Executive	SFI 16.2
b) Prepare instructions for patient property	Director of Finance & Strategic Planning	SFI 16.3
26. Workforce, Employment Pay & Pensions		
a) Nominate officers to enter into contracts of employment, regrading staff, agency staff or consultancy service contracts	Director of Workforce and Organisational Development	SFI 9.3.1 (a)
b) To ensure all employees and Directors, present and future, are notified of and receive appropriate training on the Corporate Governance Manual	Director of Finance & Strategic Planning	SFI 9.5.1 (a)
c) To ensure there are procedures for agreeing objectives for all staff, carrying out staff appraisals, evaluating and identifying development needs	Director of Workforce and Organisational Development	SFI 9.5.2
d) Appointments & Remuneration Committee to be established	Board of Directors	SO Sch C
e) Proposals for setting of remunerations and conditions of service for all employees.	Director of Workforce and Organisational Development	SFI 9.5.3

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
f) Variation to funded establishment of any department and Trust as a whole within the overall Trust budget agreed by the Board	Director of Finance & Strategic Planning	SFI 9.2.2
g) Staff, including agency staff, appointments, contracts of employment.	Director of Workforce and Organisational Development	SFI 9.3.1 & 9.5.2
h) Staff objectives, appraisal and identification of staff development needs.	All managers and Supervisors	
i) Establish procedures for engaging, terminating or changing terms and conditions of staff within approved budgets	Director of Finance & Strategic Planning	SFI 9.3.2
j) Report in writing to the Board its advice and its bases about remuneration and terms of service of directors	Remuneration Committee	SO Sch C
k) Workforce, Employment, Pay and Pension policies	Director of Workforce and Organisational Development	SFI 9.5.3
l) Payroll processing and procedures	Director of Finance & Strategic Planning	SFI 9.4.1 & 9.4.2 & 9.4.3
m) <u>Engagement of Staff</u>		
i) authorisation of recruitment within directorate/department establishments (Establishment Control/Vacancy Request Forms)	Vacancy Control Group for each Division or Executive Director	SFI 9.3
ii) authorisation of recruitment not within directorate/department establishments but within overall Trust budget (Establishment Control/Vacancy Request Forms)	Director of Finance & Strategic Planning and Director of Workforce and Organisational Development	SFI 9.3.2

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
iii) booking of Bank or Nurse Agency Staff iv) Medical Locums and Medical Agency Staff	Nurse Bank Coordinator Head of Resourcing	
n) <u>Additional Increments</u> The granting of additional increments to staff within budget in line with existing terms & conditions	Director of Workforce and Organisational Development or nominated officer	
o) <u>Upgrading & Regrading</u> All requests for upgrading/regrading shall be dealt with in accordance with Trust Procedure	Ward/departmental manager, Matrons, Service Managers, Senior Divisional Nurses, Divisional General Managers, Divisional Clinical Leads, Executive Directors Subject to procedure 15(l) above	
p) <u>Pay</u> i) Authority to action standing data forms effecting pay, new starters, variations and leavers within establishments and against approved Establishment Control	Director of Workforce and Organisational Development or Nominated Deputy	
ii) Authority to complete and authorise time sheets and pay variation forms	Ward/departmental manager, Matrons, Service Managers, Divisional Heads of Nursing, Divisional General Managers, Divisional Clinical Leads, Executive Directors Subject to procedure 15(l) above	
iii) Authority to authorise overtime within Establishment/Budgets	Ward/departmental manager, Matrons, Service Managers, Divisional Heads of	

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
	Nursing, Divisional General Managers, Divisional Clinical Leads, Executive Directors Subject to procedure 15(l) above	
iv) Authority to authorise travel & subsistence expenses in line with Trust policy and procedures. Medical Staff - other than own - clinical leads - Divisional Clinical Leads All other staff	Ward/departmental manager, Matrons, Service Managers, Senior Divisional Nurses, Divisional General Managers, Divisional Clinical Leads, Executive Directors Subject to procedure 15(l) above Line Manager	
q) <u>Leave</u> i) Approval of annual leave Medical staff - other than own - clinical leads - Divisional Directors All other staff	 Clinical Leads Divisional Director Line Manager	
ii) Annual leave - approval of carry forward (max 5 days)	Chief Executive or Director of Workforce and Organisational Development	
iii) Payment in lieu of annual leave (non-pensionable)	Divisional or Executive Director after discussion with Director of Workforce and Organisational Development	

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
iv) Compassionate Leave in accordance with Trust Policy (up to 3 days)	Line Manager	
v) Compassionate Leave more than 3 days	Executive Director, Divisional Clinical Lead, Divisional General Manager	
vi) Special leave arrangements - paternity leave - carers leave - up to 3 days - over 3 days	Line Manager Line Manager Executive Director, Divisional Clinical Lead	
vii) Leave without pay in line with Trust policies	Divisional Clinical Lead, Executive Director	
viii) Medical Staff Leave of Absence	Medical Director and Chief Executive jointly	
ix) Medical Staff Study Leave	Medical Director after checking by Divisional Clinical Lead	
x) Time off in lieu	Line Manager	
xi) Maternity or Adoption Leave - paid and unpaid	Line Manager	
r) <u>Study Leave</u>		
i) Study leave outside the UK	Executive Director	
ii) Study leave for non-medical staff	Line Manager	

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
s) <u>Removal Expenses, Excess Rent and House Purchases</u> Authorisation of payment of removal expenses incurred by officers taking up new appointments (providing consideration was promised at interview)	Director of Finance & Strategic Planning & Director of Workforce and Organisational Development jointly	
t) <u>Grievance Procedure</u> All grievance cases must be dealt with strictly in accordance with the Grievance Procedure.	Line Manager	Trust Grievance Procedure
u) <u>Authorised Car Users</u> Requests for new posts to be authorised as car users	Director of Finance & Strategic Planning	
v) <u>Redundancy</u>	Chief Executive on the advice of the Director of Finance & Strategic Planning and Director of Workforce and Organisational Development	
w) <u>Ill Health & Industrial Injury Retirement</u> Decision to pursue retirement on the grounds of ill-health	Director of Finance & Strategic Planning in respect of the financial impact and affordability, and Director of Workforce and Organisational Development in respect of compliance with HR policies, recommendations made by an OH Consultant and risk management	

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
x) <u>Dismissal</u>	Executive Director	Disciplinary Procedures
y) <u>Fit and Proper Person Requirements</u> i) Procedure for completing FPPR on appointment ii) Annual assurance that Board members remain compliant and meet the requirements of the FPPR procedure	Director of Workforce and Organisational Development Director of Workforce and Organisational Development	
z) <u>Injury Benefit</u> i) Temporary Injury Allowance	Divisional Heads of Nursing, Divisional General Managers, Divisional Clinical Leads	
ii) TIA Appeal	Executive Director	
iii) Permanent Injury Allowance	Divisional Heads of Nursing, Divisional General Managers, Divisional Clinical Leads	
iv) PIA Appeal	Executive Director	
27. Property		
a) Responsible for security of the Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming to Standing Orders, Financial Instructions and financial procedures	All Directors and Staff	SFI 12.4.4
b) Overall responsibility for fixed assets	Chief Executive Officer	SFI 12.4.1
c) Responsibility for security of Trust assets including notifying discrepancies to DOF, and reporting losses in accordance with Trust procedure	All Managers & Staff	SFI 12.4.3

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
d) Insurances	Director of Finance & Strategic Planning	SFI 12.4.8
28. Provisions of Services		
a) Negotiating Service Agreements after taking advice from …….	Chief Executive Officer Director of Finance & Strategic Planning	SFIs Section 8
b) Submission of Service Agreements to Board	Chief Executive	SFIs Section 8 & 9
c) Reporting of changes to Service Agreements >£100,000 to the Board	Chief Executive	
d) Reporting of changes to Service Agreements <£100,000 to the Board	Chief Executive	
e) Monitoring Reports to the Board on Service Agreements	Director of Finance & Strategic Planning	
- Financial	Director of Finance & Strategic Planning	
- other		
f) Arrangements for payment of NHS contracts and Out of Area Treatments (OATs)	Director of Finance & Strategic Planning	
g) Varying prices from the national tariff	Director of Finance & Strategic Planning	
h) Variation of operating and clinic sessions within existing numbers		
- Outpatients	Divisional Clinical Lead	
- Theatres	Divisional Clinical Lead	
- Other	Divisional Clinical Lead	
NB Income or cost changes will require a business		

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
case to be considered by the Board i) All proposed changes in bed allocation and use - Temporary Change - Permanent Change **NB An executive director must be informed before such changes take effect.** j) Private Patient, Overseas Visitors, Income Generation and other patient related services k) Price of NHS Contracts Calculation of charges for all NHS Contracts, be they block, cost per case, cost and volume, spare capacity.	Chief Operating Officer and Divisional Clinical Lead Director of Finance & Strategic Planning or Nominated Deputy Director of Finance & Strategic Planning	
29. Quotation, Tendering & Contract Procedures a) Best value for money is demonstrated for all services provided under contract or in-house b) Demonstrate that the use of private finance represents best value for money c) Nominate an officer to oversee and manage the contract on behalf of the Trust d) Officer responsible for procuring goods and services • Capital Building Contracts (major jobs) • Adhoc Building Contracts (small jobs)	Chief Executive Director of Finance & Strategic Planning Chief Executive Estates Manager Estates Capital Manager	Standing Orders Section 14 and Sch J; SFIs Sections 10. Standing Orders Section 14 and Sch J; SFIs Sections 10.

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
• Medicines	Director of Pharmacy & Medicines Management	
• All other goods and services	Supplies Manager	
e) Officer responsible for ensuring all procurement is in line with Standing Orders and EU regulations	Director of Finance & Strategic Planning	
f) Approve and sign all building, engineering, property or capital documents	Chief Executive & Director of Finance & Strategic Planning	
g) Officer responsible for receipt and custody of tenders before opening	Trust Board Secretary	
h) Open tenders	Two of a panel made up of Executive Directors and/or Trust Board Secretary	
i) Decide whether any late tenders should be considered	Director of Finance & Strategic Planning	
j) Keep lists of approved firms for tenders	Director of Finance & Strategic Planning	
k) Advise the Board, level of delegation of non-pay expenditure to budget managers	Director of Finance & Strategic Planning	
l) Advise on best value for money	Supplies Manager	
m) Authorise who may use and be issued with official orders	Director of Finance & Strategic Planning	
n) Waiving of tendering or quotation procedures	Chief Executive	
• Expenditure <£50,000	Director of Finance & Strategic Planning	
• Framework agreements	Chief Executive	
All other > £50,000		
o) Obtaining **2 minimum verbal quotations** for goods/services up to £6,000	Ward or Departmental Manager, Matrons, Service Managers, Clinical Leads, Divisional General Managers, Divisional Clinical Leads	
p) Obtaining **3 written quotations** for goods/services	Procurement Manager	

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
from £10,000 to £30,000, q) Approving expenditure >tender price up to 10% or £15k whichever is the higher r) Approving expenditure >tender price > 10% > or £15k up to a maximum of £25k.	 Director of Finance & Strategic Planning Chief Executive	
30. Relationships with Press		
a) Non-Emergency General Enquiries - Within Hours - Outside Hours b) Emergency - Within Hours - Outside Hours	Communications Manager Senior Manager on call, or Executive Director on call Chief Executive Senior Manager on call, or Executive Director on call.	
31. Reporting of Incidents to the Police		
a) Where a criminal offence is suspected i) criminal offence of a violent nature ii) other b) Where a fraud is involved	Senior Departmental manager on duty Or Security Manager Senior Departmental manager on duty Or Security Manager Director of Finance & Strategic Planning or LCFS	 SFI 21
32. Research Projects, not clinical trials - Authorisation	Executive Directors within allocated budgets	
33. Retention of Records	Chief Executive	SFIs Section 18

DELEGATED MATTER		AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
34.	**Review the Trust's compliance with the Access to Records Act and Freedom of Information Act**	Medical Director	
35.	**Review of Trust's compliance with the Data Protection Act**	Medical Director	
36.	**Review of the Trust's compliance code of Practice for handling confidential information in the contracting environment and the compliance with "safe haven" per EL 92/60**	Medical Director (Caldicott Guardian)	
37.	**Risk Management**		
	a) Accountability for internal control	Board of Directors	
	b) Maintaining sound system of internal control	Chief Executive	
	c) Implementing systems of risk management and prepare procedures	Medical Director	
	d) Maintaining systems of risk management	Medical Director	
	e) Ensuring that all staff have risk management responsibilities in employment contracts, job descriptions and objectives	Director of Workforce and Organisational Development	
	f) Complaints & claims	Director of Nursing & Quality	
	g) Systems of accountability with definitions of responsibilities and relationships	Chief Executive	
	h) Employment of competent persons	Chief Executive	
	i) Oversight of risk management through scrutiny and review	Quality Governance Committee	
	j) Objective view on internal control independent of executive and line management	Audit Committee.	
	k) Recommend Risk Management Strategy & Framework~~Policy~~	Medical Director	

DELEGATED MATTER		AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
l)	Prioritising risk and recommendation to Board for resources	Medical Director	
m)	Annual Review of Risk Management Strategy & Framework~~Policy~~	Medical Director	
n)	Annual Risk Management Plan to prepare and to include staff information, instruction and training	Medical Director	
o)	Verification that internal control exists	Internal Audit Department	
p)	Recommend Complaints Policy to Board	Director of Nursing & Quality	
q)	Reporting complaints and claims regularly to the Board	Director of Nursing & Quality	
r)	Recommend Patient/User Involvement Policy to the Board	Director of Nursing & Quality	
s)	Annual Review of Patient/User Involvement Policy	Director of Nursing & Quality	
t)	Patient Surveys – review and evaluate data	Director of Nursing & Quality	
38.	**Sponsorship deals – Authorisation**	Director of Finance & Strategic Planning	CC 2.14 – 2.16
39.	**Strategy and Business Plans (LDP)**		
a)	Compile and submit to the Board a Business Strategy and Annual Business Plan (LDP)	Chief Executive	SFI 4.1.1
40.	**The keeping of Registers.**		
a)	Register(s) of Director's interest	Trust Board Secretary	SO 13.16
b)	Register of staff interests	Director of Finance & Strategic Planning	CC 2.2 & 2.7
c)	Register of offers of hospitality or gifts	Director of Finance & Strategic Planning	CC 2.5, 2.6 & 2.8

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
d) Register of commercial sponsorship	Director of Finance & Strategic Planning	CC 2.14 – 2.16
e) Register of Outside Employment (including Private Practice	Director of Finance & Strategic Planning	CC 2.11 & 2.12
f) Register of Patents and Intellectual Property	Director of Finance & Strategic Planning	CC 2.16
g) Register of Donations	Director of Finance & Strategic Planning	CC 2.13
41. The keeping of a register of Sealings		SOs Section 9
a) Keep seal in safe place and maintain a register of sealing	Chief Executive	
b) Approve and sign all building, engineering, property or capital documents not requiring seal	Chief Executive and Director of Finance & Strategic Planning	
c) Approve and sign all documents which will be necessary in legal proceedings except proceedings to recover debts due to the Trust	Chief Executive and Director of Finance & Strategic Planning	
d) Sign on behalf of the Trust any agreement or document not requested to be executed as a deed	Chief Executive and Director of Finance & Strategic Planning	
42. Detention under the Mental Health Act To be responsible for ensuring that a named officer is available at all times to receive and scrutinise admission documents relating to patients who are detailed for assessment or treatment under the Mental Health Act.	Director of Nursing and Quality	

Board of Directors

Standing Orders:

Board Reports

Financial and Performance Reports to the Board

Patient Safety

- Serious incidents
- All patient safety incidents resulting in harm
- Learning & changes in practice from incidents
- Learning from Deaths
- Frequently occurring incidents including falls, pressure ulcers & medication incidents
- Safety Thermometer
- Risk Adjusted Mortality ~~and Crude Mortality~~ indices or equivalent
- MRSA and Clostridium Difficile cases
- ~~Stroke performance~~
- National CQUINs
- Patient safety objectives
- Inquests concluded
- CCICP patient safety harm incidents, serious incidents, pressure ulcers and medication incidents

Patient Focus

- Complaints and Informal Complaints received, complaint trends and complaints closed in month
- Number of complaints sent to CQC and Ombudsman
- Claims received and closed
- Compliments, NHS Choices Star Ratings and Family and Friends Test

Workforce Focus

- Nursing and HCA staffing levels
- Care hours per patient day
- Workforce absence
- Staff Turnover
- Agency Spend
- ~~Commissioner Income Analysis~~

Financial Focus

- Statement of financial position
- Income and expenditure
- Elective, outpatient and day case income
- Non-elective income
- Cost improvement schemes
- Commissioner Income Analysis
- Capital service capacity
- Liquidity, cash position and working capital
- Distance from financial plan
- Staff costs

Systems Delivery Focus

Local Delivery Plan targets and existing national standards:

- Elective inpatients and length of stay
- Outpatient waiting times and DNAs
- 18 weeks elapse from referral to treatment
- 4 hours transit time target
- 14, 31 and 62 days cancer waits
- 6 week diagnostic waits
- Non-elective admissions, readmissions and length of stay
- A&E attendance and ambulance arrivals
- GP Referrals
- Theatre efficiency
- Bed occupancy and medical outliers
- Delayed discharges
- Cancelled operations seen within 28 days, and year to date
- Maternity bookings and deliveries

~~Central Cheshire Integrated Care Partnership results have been incorporated into the Performance and Quality, Safety and Experience Report since December 2016 and will continue until their own dashboards are developed.~~

Board of Directors

Standing Orders:

Private Practice

Contents

Code of Conduct for Private Practice: Recommended Standards of Practice for NHS Consultants

A Introduction

1 Scope of Code

1.1 This Schedule (Department of Health 2004, amended 2009) sets out recommended standards of best practice for NHS Consultants in England about their conduct in relation to private practice. The standards are designed to apply equally to honorary contract holders in respect of their work for the NHS. The Code covers all private work, whether undertaken in non-NHS or NHS facilities.

1.2 Adherence to the standards in the Code will form part of the eligibility criteria for clinical excellence awards.

1.3 This Code should be used at the annual job plan review as the basis for reviewing the relationship between NHS duties and any private practice.

1.1 The Code is based on the following key principles:

- NHS Consultants and NHS employing organisations should work on a partnership basis to prevent any conflict of interest between private practice and NHS work. It is also important that NHS Consultants and NHS organisations minimise the risk of any perceived conflicts of interest; although no Consultant should suffer any penalty (under the code) simply because of a perception
- the provision of services for private patients should not prejudice the interest of NHS patients or disrupt NHS services
- with the exception of the need to provide emergency care, agreed NHS commitments should take precedence over private work; and
- NHS facilities, staff and services may only be used for private practice with the prior agreement of the NHS employer

1.5 The expression “private practice” in this Code of Conduct includes:

- the diagnosis or treatment of patients by private arrangement (including such diagnosis or treatment under section 65(2) of the National Health Service Act 1977), excluding fee paying services as described in Schedule 10 of the Terms and Conditions
- work in the general medical, dental or ophthalmic services under Part II of the National Health Service Act 1977 (except in respect of patients for whom a hospital medical officer is allowed a limited “list”, e.g. members of the hospital staff)

B STANDARDS OF BEST PRACTICE

2 Disclosure of Information about Private Practice

2.1 In line with the code and refreshed guidance for the management of Conflicts of Interest in the NHS issued by NHS England in 2017, Consultants should declare any private practice, which may give rise to any actual or perceived conflict of interest, or which is otherwise relevant to the practitioner's proper performance of his contractual duties. As part of the annual job planning process, Consultants should disclose details of regular private practice commitments, including the timing, location and broad type of activity, to facilitate effective planning of NHS work and out of hours cover.

2.2 Under the appraisal guidelines agreed in 2001, NHS Consultants should be appraised on all aspects of their medical practice, including private practice. In line with the requirements of revalidation, Consultants should submit evidence of private practice to their appraiser.

Scheduling of Work and On-Call Duties

2.3 In circumstances where there is, or could be, a conflict of interest, programmed NHS commitments should take precedence over private work. Consultants should ensure that, except in emergencies, private commitments do not conflict with NHS activities included in their NHS job plan.

2.4 Consultants should ensure in particular that:

- private commitments, including on-call duties, are not scheduled during times at which they are scheduled to be working for the NHS (subject to paragraph 2.8 below)
- there are clear arrangements to prevent any significant risk of private commitments disrupting NHS commitments, eg by causing NHS activities to begin late or to be cancelled
- private commitments are rearranged where there is regular disruption of this kind to NHS work; and
- private commitments do not prevent them from being able to attend an NHS emergency while they are on call for the NHS, including any emergency cover that they agree to provide for NHS colleagues. In particular, private commitments that prevent an immediate response should not be undertaken at these times

2.5 Effective job planning should minimise the potential for conflicts of interests between different commitments. Regular private commitments should be noted in a Consultant's job plan, to ensure that planning is as effective as possible.

2.6 There will be circumstances in which Consultants may reasonably provide emergency treatment for private patients during time when they are scheduled to be working or are on call for the NHS. Consultants should make alternative arrangements to provide cover where emergency work of this kind regularly impacts on NHS commitments.

2.7 Where there is a proposed change to a job plan which impacts the scheduling of NHS work, the employer will allow three months from formal sign off for

Consultants to implement the plan and rearrange any private sessions, taking into account any binding commitments entered into (e.g. leases).

Provision of Private Services Alongside NHS Duties

2.8 The job planning policy for the Trust states that a Consultant will not undertake private practice or fee paying services when on call for the NHS with unless:

- The Consultant's rota frequency is 1 in 4 or more frequent, his or her on-call duties have been assessed as falling within the category B described in Schedule 16, and the employing organisation has given prior approval for undertaking specified Private Professional Services or Fee Paying Services or;
- The Consultant has to provide emergency treatment or essential continuing treatment for a private patient. If the Consultant finds that such work regularly impacts on his or her NHS commitments, he or she will make alternative arrangements to provide emergency cover for private patients.
- In these circumstances, the Consultants should ensure that any private services are provided with the explicit knowledge and agreement of the employer and that there is no detriment to the quality or timeliness of service for NHS patients.

Information for NHS Patients about Private Treatment

2.9 In the course of their NHS duties and responsibilities Consultants should not initiate discussions about providing private services for NHS patients, nor should they ask other NHS staff to initiate such discussions on their behalf.

2.10 Where an NHS patient seeks information about the availability of, or waiting times for, NHS and/or private services, Consultants should ensure that any information provided by them, is accurate and up-to-date and conforms with any local guidelines.

2.11 Except where immediate care is justified on clinical grounds, Consultants should not, in the course of their NHS duties and responsibilities, make arrangements to provide private services, nor should they ask any other NHS staff to make such arrangements on their behalf unless the patient is to be treated as a private patient of the NHS facility concerned.

Referral of Private Patients to NHS Lists

2.12 Patients who choose to be treated privately are entitled to NHS services on exactly the same basis of clinical need as any other patient.

2.13 Where a patient wishes to change from private to NHS status, Consultants should help ensure that the following principles apply:

- any patient seen privately is entitled to subsequently change his status and seek treatment as an NHS patient
- any patient changing their status after having been provided with private services should not be treated on a different basis to other NHS patients as a result of having previously held private status

- patients referred for an NHS service following a private consultation or private treatment should join any NHS waiting list at the same point as if the consultation or treatment were an NHS service. Their priority on the waiting list should be determined by the same criteria applied to other NHS patients; and
- should a patient be admitted to an NHS hospital as a private inpatient, but subsequently decide to change to NHS status before having received treatment, there should be an assessment to determine the patient's priority for NHS care

Promoting Improved Patient access to NHS Care and Increasing NHS Capacity

2.14 Subject to clinical considerations, Consultants should be expected to contribute as far as possible to maintaining a high quality service to patients, including maintaining and reducing waiting times, and improving access and choice for NHS patients. This should include co-operating to make sure that patients are given the opportunity to be treated by other NHS colleagues or by other providers where this will maintain or improve their quality of care, such as by reducing their waiting time. Consultants should make all reasonable efforts to support initiatives to increase NHS capacity, including appointment of additional medical staff.

C MANAGING PRIVATE PATIENTS IN NHS FACILITIES

3.1 Consultants may only see patients privately within NHS facilities with the explicit agreement of the responsible NHS organisation. It is for NHS organisations to decide to what extent, if any, their facilities, staff and equipment may be used for private patient services and to ensure that any such services do not interfere with the organisation's obligations to NHS patients.

3.2 Consultants who practise privately within NHS facilities must comply with the responsible NHS organisation's policies and procedures for private practice. The NHS organisation should consult with all Consultants or their representatives, when adopting or reviewing such policies.

Use of NHS Facilities

3.3 NHS Consultants may not use NHS facilities for the provision of private services without the agreement of their NHS employer. This applies whether private services are carried out in their own time, in annual or unpaid leave, or – subject to the criteria in paragraph 2.8 – alongside NHS duties.

3.4 Where the employer has agreed that a consultant may use NHS facilities for the provision of private services:

- the employer will determine and make such charges for the use of its services, accommodation or facilities as it considers reasonable
- any charge will be collected by the employer, either from the patient or a relevant third party; and

- a charge will take full account of any diagnostic procedures used, the cost of any laboratory staff that have been involved and the cost of any NHS equipment that might have been used
- Except in emergencies, Consultants should not initiate private patient services that involve the use of NHS staff or facilities unless an undertaking to pay for those facilities has been obtained from (or on behalf of) the patient, in accordance with the NHS body's procedures

3.5 In line with the standards in (B), private patient services should take place at times that do not impact on normal services for NHS patients. Private patients should normally be seen separately from scheduled NHS patients. Only in unforeseen and clinically justified circumstances should an NHS patient's treatment be cancelled as a consequence of, or to enable, the treatment of a private patient.

Use of NHS Staff

3.6 NHS Consultants may not use NHS staff for the provision of private services without the agreement of their NHS employer.

3.7 The Consultant responsible for admitting a private patient to NHS facilities must ensure, in accordance with local procedures, that the responsible manager and any other staff assisting in providing services are aware of the patient's private status.

Board of Directors

Standing Orders:

Stakeholders

Schedule of External Stakeholders

A list of the Trust's external stakeholders is maintained electronically by the Trust Board Secretary. This list is based on the following groups of stakeholders:

- Members including Governors
- All County, District or Unitary local authorities in which the classes of the Trust's Public Constituency are located
- Its patients and their carers
- The local population
- All staff
- All Clinical Commissioning Groups with which the Trust has a contract for the provision of services
- All local primary care providers including local GP Alliances
- All NHS Trusts that operate clinical services from any premises maintained by the Trust
- All NHS trusts with which the Trust has a formal partnership agreement.
- Members of Parliament for those geographical areas in which the classes of the Trust's Public Constituency are located
- National Health Service Litigation Authority, and the associated Clinical Negligence Scheme for Trusts and Risk Pooling Scheme for Trusts
- Care Quality Commission
- NHS Improvement
- Central Cheshire Integrated Care Partnership (CCICP)
- Health & Safety Executive
- All places of further and higher education with which the Trust co-operates or works in any way
- Those organisations that exist to promote diversity in the geographical areas in which the classes of the Trust's Public Constituency are located
- Voluntary organisations working in the field of health and/or social care relevant to the work of the Trust
- External organisations operating from premises owned, leased, or operated by the Trust
- External contractors undertaking work on behalf of the Trust

Board of Directors:

Standing Instructions For Non-Financial Risk

Contents

1. Integrated Governance Structure

The Governance Structure (Appendix A) is intended to support and assist the organisation in achieving its corporate objectives including quality improvement, achieving compliance with requirements from regulatory bodies, meeting national and local targets and delivering contracts with commissioners with the outcome of positively moving forward along the integrated governance maturity pathway. Integrated Governance is a process that spans the various functional governance processes, enabling these functions to be coordinated to ensure a process of learning and continual improvement, and which moves beyond the handling of issues in governance silos which:

- Is underpinned by intelligent information and public/patient engagement
- Is intended to move organisations towards 'good governance'
- Moves governance out of individual silos into a coherent and complementary set of challenges
- Requires Boards to focus on strategic objectives, but also to know when to drill down to critical areas of delivery
- Requires the development of robust assurance and reporting of delegated clinical and operational decision making in line with well-developed controls
- Is supported by the Board Assurance Framework which provides Board members with a series of prompts with which to challenge their objectives and focus

Integrated Governance is the means by which we pull together all the competing pressures on Boards (Fig. 1) and their supports (staff, advisors, systems and processes). It is a transitional position to good governance, but moves beyond the handling of issues in governance silos. It is clear that all healthcare organisations need to demonstrate that they have strengthened and streamlined their own governance arrangements and, over time, develop further integration between health and social care organisations in their health community.

The purpose of the governance structure is to ensure that the Trust Board receives the correct information in a timely fashion relating to key issues including exception reporting and assurances, in order that it can make the right decisions and discharge its duties effectively.

Clinical issues must be at the heart of the way that the Trust delivers healthcare. Integrated governance is the process that links clinical issues with finance, workforce, health & safety, performance, and non-clinical risk. By pulling together all these competing pressures it will empower the Board of Directors to lead and direct the Trust more effectively.

Fig. 3 Challenges to NHS Boards: The Healthy NHS Board Principles for Good Governance (2010)

2.0 Specific Roles and Responsibilities

2.1 The intention is to embed integrated governance arrangements into all services and to devolve effective management to the divisions and corporate departments within a supportive common framework.

2.2 The Board of Directors

The Board of Directors is ultimately responsible for risk and governance and ensuring the governance structure is fit for purpose. Board members have a corporate responsibility for the management of risk and each member must be aware of the obligations to promote this and protect the public from risk in the normal course of events within local NHS provision. The Board of Directors will review its corporate objectives through the Board Assurance Framework on a minimum of a quarterly basis. Additionally the Medical Director/Deputy Chief Executive will provide information and assurances on any high level risks and incidents on a monthly basis to the Board of Directors. The Board of Directors is accountable for ensuring a system of internal control which supports the achievement of the organisation's objectives is in place. The system of internal control ensures that:

- The Trust's principal objectives are agreed
- Principal risks to those objectives are identified
- Controls which eliminate or reduce these risks are implemented
- The effectiveness of these controls is independently assured
- Reports on unacceptable or serious risks and the effectiveness of control mechanisms are received from the Executive Directors and independent assurors

- Action plans are agreed to improve control over serious or unacceptable risks
- Policies are in place to determine what level of risks should be retained.

2.3 Chief Executive Officer

The Chief Executive Officer, as Accountable Officer, has, on behalf of the Trust Board, responsibility for maintaining a sound system of internal control. This requires the organisation to have in place the necessary controls to manage its risk exposure. Non-financial risk is delegated via the Medical Director/Deputy Chief Executive to the Integrated Governance Department, divisional general managers, managers and ultimately to all staff members.

2.4 Executive Leads

Within these arrangements the Executive Leads have delegated responsibility for their respective functions from the Chief Executive. However, responsibility for the day to day management of risk and governance is devolved to the divisions and corporate departments.

2.5 Non-Executive Leads

Non-Executive Directors have a duty to ensure that the Trust has sufficient control measures in place to be able to effectively manage risk and ensure the governance structure is fit for purpose. The Audit Committee which is a Non-Executive Director committee has the delegated responsibility from the Board for ensuring an effective system of integrated governance, risk management and internal controls is in place. Non-Executive Directors are members of and Chair the Quality Governance Committee which is a Board sub-committee with overarching responsibility for organisational and clinical risk and the Performance and Finance Committee which is the Board sub-committee with overarching responsibility for financial risk.

2.6 Integrated Governance Department

This department is accountable and responsible to the Medical Director/Deputy Chief Executive and is led by the Associate Director of Integrated Governance who will monitor the implementation of the Risk Management Strategy & Framework through the governance group/committee structure and scheduled reports. Additionally the team will provide advice and support to directors and managers accordingly.

The Integrated Governance Department will monitor the corporate risk profile of the Trust including the maintenance of the risk register and dealing with escalated risks. It will highlight any risk management issues that it considers should be brought to the attention of Board Committees and provide assurance to the Medical Director/Deputy Chief Executive (as the executive

director responsible for risk management), that these are adequately managed. The department will prepare regular reports for the Board of Directors and its groups/committees on areas of significant risk and identify any internal audit and other assurance requirements.

2.7 Patient Experience Department

The Patient Experience Department leads on PALS, complaints, claims and inquests and works closely with the Integrated Governance Department to identify significant issues and trends Trust wide in order to implement changes in practice.

2.8 Corporate Services / Divisional Risk Management

Whilst the Chief Executive has overall accountability for risk management across the Trust, the Executive Directors together with the Corporate Leads, Divisional General Managers and their divisional and departmental management teams are tasked with the responsibility to lead the co-ordination, integration, oversight and support of the risk management agenda.

The Divisional General Managers and Professional Leads will provide assurances to the Divisional Boards and the Board of Directors Committees that all significant risks are adequately managed and the risk management principles are embedded across the divisions (Appendix B & C).

All Executive Directors, Corporate Leads, Divisional General Managers and other members of the Divisional Boards and all those staff (including contractors) with managerial and supervisory responsibility, will have risk management responsibilities defined in their objectives. This will include the identification, assessment and analysis of risks and the development and monitoring of action plans to control known risks.

Each of the five Divisional Boards has a senior manager named as the Governance Lead who is a member of the Executive Quality Governance Group. Additionally there is a Risk and Governance Manager in post in each of these divisions, reporting to the Associate Director – Integrated Governance ~~and they are a member of the Risk and Governance Group~~, thus providing a direct escalation route from the divisions through the governance structure.

All managers across the Trust have a responsibility to encourage staff to identify risks and ensure that they are familiar with the latest risk management guidance and controls. The risk register will capture formally the assessment and management of each risk identified and the risks will be reviewed dependent on the risk rating assigned.

2.9 Responsibility of All Trust Employees & Volunteers

The management of risk is the responsibility of all managers, staff and volunteers throughout the organisation and they have a responsibility to be risk aware at all times. Every effort should be made to maintain a safe environment and safe systems of work thereby reducing the potential to cause harm to patients, staff and others and negatively affect the reputation and assets of the organisation. The Trust aims to achieve this within a progressive, honest and open environment, where risks, incidents, accidents, mistakes and “near misses” are identified quickly and acted upon in a positive and constructive way which either eliminates the risk or reduces the likelihood of future occurrence or impact. Staff will be provided with education, training and support to enable them to meet this responsibility through mandatory training programmes.

All employees and volunteers have a personal responsibility to as appropriate:

- Comply with policies and procedures
- Be aware of risks at all times and take reasonable action to identify, eliminate where possible, or control them
- Notify line managers of risks they have identified which cannot be adequately managed
- Participate in risk management education and training

2.10 Divisional Reporting Mechanisms

As a minimum the following will be discussed and minuted at Divisional Boards on a monthly basis, this maybe in the form of exception reporting:

- Significant risks including those rated 20 & above
- Serious incidents & approval & monitoring of actions
- Complaints
- Claims
- Response to Safety Alert Broadcasts
- Risk adjusted mortality index for specialties & sub specialties
- External agency visits, inspections and accreditations involving the Division.
- National guidance relevant to the Division

The divisional exception information is included in the Integrated Governance Monthly ~~Exception~~ Report which is presented and discussed at the Operational Safety and Effectiveness Group and the Executive Quality Governance Group~~Committee~~, with escalation to the Quality Governance Committee and Trust Board as appropriate.

3.0 The Committees of the Board of Directors

3.1 The committees/groups within the governance structure (Appendix A) have standardised terms of reference, action points, and an annual work plan and ~~will~~ produce an annual report. Actions to be undertaken by the workstream groups will be managed and monitored through the Quality Governance Committee, Performance and Finance Committee or Transformation and People Committee as appropriate.

3.2 The purpose of the governance structure is to ensure key issues are escalated to the Board of Directors in a timely manner. The Trust Board will then delegate any subsequent actions to Trust Board sub-committees or workstream groups as appropriate. Senior committees in the governance structure (Appendix 1) include:

3.2.1 Audit Committee

The Audit Committee monitors and concludes upon the adequacy and

effective operation of the organisation's overall internal control system and is chaired by a Non-Executive Director. In performing that role the committee's work will predominantly focus upon the framework of risks, controls and related assurances that underpin the delivery of the organisation's objectives.

3.2.2 Quality Governance Committee

The Quality Governance Committee is a sub-committee of the Board of Directors with overarching responsibility for organisational and clinical risk management and governance. It is responsible for providing information and assurances to the Board of Directors that the organisation is safely managing the quality of patient care, effectiveness of quality interventions and investments, and patient safety. Quality Governance Committee is chaired by a Non-Executive Director.

3.2.3 Performance and Finance Committee

The Performance and Finance Committee is a sub-committee of the Board of Directors with overarching responsibility for financial risk and performance and is chaired by a Non-Executive Director.

3.2.4 Transformation and People Committee

Transformation and People is responsible for providing assurance to the Board that the Trust is effectively leading, developing and delivering the Trust's People and Organisational Development Strategy, together with ensuring the development of the Trust's approach to transformation and overseeing delivery of the major transformation programmes (internal and external).

And the lower workstream groups:

3.2.6 Work stream Groups

The work stream groups (Appendix 1) are specialist groups with responsibility for ensuring the Trust is meeting the appropriate internal & external requirements and standards and escalating any key issues to the next Quality Governance Committee, Performance and Finance Committee or Transformation and Performance Committee as appropriate.

3.2.7 Rapid Escalation of Issues to the Executive Team / Board of Directors

Where an issue is deemed urgent senior managers and directors have immediate direct access to the Executive team ensuring matters are dealt with in a timely manner, this includes out of hours.

3.2.8 Council of Governors

The ~~c~~Council of ~~g~~Governors consists of elected Mid Cheshire Hospitals NHS Foundation Trust members and appointed individuals or representatives from other key stakeholders. As required in statute, the Chair of the Board of Directors is also the Chair of the Council of Governors. Additionally a Senior Independent Director has been appointed by the Board of Directors and acts as a point of contact if ~~g~~Governors have concerns which contact through normal channels has failed to resolve. **A Lead Governor is elected by the Council and is the point of contact used by NHS Improvement if required.**

4.0 Risk Management Approach

Effective and mature risk management systems and processes are crucial so that priority is given, at the appropriate level within the organisation, to identifying and managing risks to the quality of care (Healthy NHS Board, 2013). The Board of Directors need to be assured that there is a clear assurance and escalation framework in place to enable staff to escalate issues and risks. In order to do this the Board of Directors will foster a culture of transparency, openness and continual learning with patients firmly at its heart underpinned by the Trusts values and behaviours (Berwick 2013).

Risk maturity can be assessed on the basis of:

- The commitment to risk management by senior levels of management
- The presence of working risk registers (with prioritised risks; assigned actions. assurances feeding back into the process) and an aggregated shortlist of highest risks reported to the Board
- The extent to which risk management is embedded throughout the organisation
- Co-ordination with strategic partners; and evidence that risks and opportunities are considered to inform decision making

~~*Fig. 4*~~

5.0 Risk Management Objectives

5.1 The risk management objectives are inherently linked to the strategic objectives contained within the Board Assurance Framework. The Board Assurance Framework and the Risk Register will continually be developed and monitored:

- For the Trust as a whole; and
- For each Division

5.2 To continue the pro-active use of the Risk Register to:

- Link risk assessments with the Board Assurance Framework, Care Quality Commission registration process, Health & Safety Executive and other relevant national standards and reports
- Ensure the Risk Register is populated with risks from a wide range of sources both internally & externally
- Establishing real ownership of risks at the appropriate level and the assignment of appropriate action plans to reduce risks to reasonable and acceptable levels
- Facilitate and monitor the review of risks on a risk based basis and identify when residual risk is acceptable
- Ensure a holistic approach to the management of risk by identifying and closely monitoring both high scoring risks e.g. 15 and above and those identified as a potentially catastrophic outcome but on scoring may only score 5 as the likelihood of occurrence is rare
- Provide to Board committees appropriate information to assist with their assurance functions and to highlight inadequately controlled risks and monitor shift in risk ratings therefore demonstrating implementation of effective action plans

5.3 To continue to promote a pro-active & reactive incident reporting culture and learning and sharing lessons through:

- The encouragement of near miss and incident reporting organisation wide maintaining the organisation's high reporting status nationally. Induction, mandatory training and staff development programmes
- The promotion of the organisation's just culture through induction, training and interaction with staff
- Undertaking investigations of near miss events and incidents appropriate to the severity and learning opportunities
- Identifying staff training requirements through the incident analysis process and sharing with Learning & Development to inform the Trust's training needs analysis
- Sharing lessons to learn and changes in practice both internally and with the wider health community

5.4 To achieve:

- Care Quality Commission (CQC) unconditional registration each financial year.

5.5 To maintain and monitor robust risk management/governance arrangements in each division.

5.6 To develop an appropriate risk management education and training programme for staff at all levels in the Trust including root cause analysis which is linked to the corporate training needs analysis

5.7 To monitor and review key integrated governance policies and procedures to ensure that all risks are effectively managed by the Trust Executive Team and the divisions on behalf of the Board of Directors.

5.8 To ensure that programmes of audit are in place to review the control mechanisms in place for key risks.

5.9 To continue to develop and monitor emergency preparedness policies including:

- Major Incident Plan
- Divisional and Corporate Business continuity plans
- Influenza pandemic
- Heatwave Plan

6.0 Strategic & Operational Risk Management System

The primary purpose of the risk management system is to:

- Improve the quality of care and treatment
- Promote success and innovation by managing opportunities
- Protect patients, staff and visitors from avoidable harm
- Eliminate or reduce unnecessary costs
- To develop the risk maturity of the organisation
- Provides the mechanism through which the Chief Executive can assure all stakeholders that the Trust's internal controls are effective

Risk Management is a proactive approach that addresses every element of the organisation's activities and comprises a cycle of:

- Risk identification
- Risk analysis
- Risk control
- Risk funding
- Risk review & monitoring

7.1 Risk Identification

Risks will be identified, analysed, prioritised and documented at all levels in the organisation.
These risks can arise from any aspect of the organisation including:

- Clinical practice
- The environment
- Buildings and equipment
- Chemical or hazardous substances
- People employed by the Trust or by visitors, patients or contractors
- Procedures, systems or practices

- Financial activities
- Communication and information
- Legislation
- Business plans

Risk identification involves examining all the sources of risk from the perspective of all stakeholders at all levels in the organisation. The following are a list of methods among many others which may be used to identify risks:

- Healthcare communication - Adverse incidents, complaints and claims reporting, internal audits and inspections
- Patient and staff satisfaction surveys
- Customer Care Team National reports
- Media coverage
- High level enquiries
- External agency visits, inspections and accreditations
- HM Coroner inquests
- Parliamentary and Health Service Commissioner (Ombudsman) reports

A gap analysis is to be undertaken for all relevant national / external reports and this is coordinated through the Integrated Governance Department. All identified risks are recorded on the Trust's Risk Register. At divisional level managers and lead clinicians will ensure that risks are included on the Risk Register. At corporate level the Medical Director/Deputy Chief Executive and Associate Director of Integrated Governance will ensure that all risks rated 15~~20~~ & above are analysed through the Governance Structure and identify those risks which may impact on the corporate objectives.

7.2 Risk Analysis

Risks identified are analysed using the Trust's Risk Assessment Procedure and are given a score for the consequences and the likelihood of the risk becoming an event as detailed in the Trust's risk matrix contained in the *Risk Management Policy.*

7.3 Risk Control

The risk control objective of the Trust is to reduce risks to a reasonable level consistent with its mission to provide highest quality patient care and treatment. Risk control is the means by which the risk's severity, or frequency, or both are reduced, transferred or retained.
Controls include:

- Systems & processes
- Training
- Contingency plans and strategies
- Policies, Procedures, Guidelines, & Protocols
- Design of equipment, buildings and materials
- Insurance

Risk control measures must be included in the action plan of those risks deemed unacceptable and monitored as per Figure 5.

7.4 Risk Financing

The funding of risk control measures is primarily through the budgets agreed annually with managers across the Trust. Financial planning and business planning should therefore include the management of identified risks.

As the financial year progresses decisions may need to be taken as to the most appropriate use of funds to manage unexpected risk control requirements and this is determined by the Trust Board via the governance structure.

Shared executive attendance at the Quality Governance Committee and Performance and Finance Committee provides the link between identified high level risks and finance.

Even when the Trust has taken reasonable measures to eliminate or reduce risks, some risks will always remain and these risks will be reviewed in line with the risk rating.

7.5 Risk Review & Monitoring

Risks will be monitored in line with the framework in Figure 5. As part of the~~is~~ Risk Management Strategy & Framework ~~Strategy~~ the Trust will be reviewing the assurance process to determine if positive progress is being made in relation to the action plans developed to mitigate & control risks at all levels.

7.6 Acceptable Risk / Risk Appetite

The Trust recognises that it is impossible and not always appropriate to eliminate all risks. Systems of controls must be balanced in order that innovation and the imaginative use of limited resources are supported when it is to achieve increased health benefits for the local population, for example a new method of service delivery. Additionally the Trust may be willing to accept a certain level of risk when the cost of mitigating the risk is high in comparison to the potential severity of the risk or the likelihood of it occurring.

> *At its simplest, risk appetite can be defined as the amount of risk, on a broad level, that an organisation is willing to take on in pursuit of value. Or, in other words, the total impact of risk an organisation is prepared to accept in the pursuit of its strategic objectives.*
>
> (KPMG 2010)

As a general principle the Trust will seek to eliminate or control risks which have the potential to:

- Harm patients, staff, volunteers, visitors, contractors and other stakeholders
- Harm the reputation of the organisation
- Have severe financial consequences which would prevent the Trust from carrying out its functions

The assessed level (rating) of the risk will determine what action is to be taken, who is authorised to manage the risk and the subsequent review dates detailed in Figure 5 overleaf.

Risk Rating	Priority	Level of Action	Authority to Manage Risk	Timescales for Initial Actions & Development of Action Plans as Required	Minimum Review Requirements by Designated Lead
Green Low (1 to 3)	Low	No further action or records required. Manage via routine procedures.	All staff undertaking assessments	None	Annually
Yellow Moderate (4 to 6)	Low / Medium	Departmental / ward management action required to reduce risk as low as reasonably practicable	Ward / Department Manager	6 Months	Annually
Amber High (8 to 12)	Medium / High	Departmental /Divisional management action required to reduce risk as low as reasonably practicable. Monitored by Divisional Board / Subcommittee as appropriate	Divisional General Manager / Directors	3 months	Annually
Red Extreme (15 to 16)	High	Divisional management action required to reduce risk as low as reasonably practicable and review & monitored by Divisional Board / Subcommittee. Monitoring through Operational Integrated Governance and Strategic Integrated Governance Committee reports and escalate to the Board of Directors as required.	Divisional General Manager / Directors	Immediate	6 months
Red Extreme (20 and above)	High	Divisional management action required to reduce risk as low as reasonably practicable and review & monitored by Divisional Board / Subcommittee. Monitoring through Operational Integrated Governance and Strategic Integrated Governance Committee reports and escalate to the Board of Directors as required.	Divisional General Manager / Directors	Immediate	3 months

Fig. 5

Risk Rating	Priority	Level of Action	Authority to Manage Risk	Minimum Review Requirements by Designated Lead
Green Very Low (1 to 3)	Very Low	• No further action or records required. Manage via routine procedures.	All staff undertaking assessments	-
Yellow Low (4 to 6)	Low	• Departmental / ward management action required to reduce risk as low as reasonably practicable.	Ward / Department Manager	Annually
Amber Moderate* (8 to 12)	Medium	• Departmental / Divisional management action required to reduce risk as low as reasonably practicable. • Monitored by Divisional Board / Subcommittee as appropriate. *Note: Some risks may require escalation at this level	Divisional General Manager / Directors	6 monthly
Red High (15 to 16)	High	• Divisional management action required to reduce risk as low as reasonably practicable. • Approval of rating by the Divisional Board. • Quarterly Risk Report to Divisional Board. • Risks rated 15 & above approved at Executive Quality Governance Group (EQGG) ahead of inclusion to the Organisational Risk Register. • Monitoring through EQGG quarterly reports, with assurances to the Quality Governance Committee and onward escalation to the Trust Board as required.	Divisional General Manager / Directors	Quarterly
Purple Extreme (20 and above)	Very High	• Divisional management action required to reduce risk as low as reasonably practicable. • Approval of rating by the Divisional Board. • Monthly review at Divisional Board. • Quarterly Risk Report to Divisional Board. • Risks rated 20 & above approved at Executive Quality Governance Group (EQGG) ahead of inclusion to the Organisational Risk Register. • Monitoring through EQGG quarterly reports, with assurances to the Quality Governance Committee and onward escalation to the Trust Board as required.	Divisional General Manager / Directors	Monthly

Fig. 4

The Trust is committed to risk management. It recognises that there are risks involved in becoming a more effective Trust. However, it will only tolerate that level of risk required by its commitment to achieving its strategic aims. Staff completing risk assessments must indicate if the risk is acceptable prior to inclusion onto the risk register. If the risk is not acceptable then a detailed action plan must be developed and monitored in line with Fig. 4 above.

7.7 Risk Register

A Risk Register is:
"*A log of all risks of all kinds that threaten an organization's success in achieving it's declared aims and objectives. It is a dynamic document, which is populated through the organisation's risk assessment and evaluation process.*

This enables risk to be quantified and ranked, and information about risks to be collated and analysed. It therefore provides a structured approach to decision-making about whether or how risks should be treated."

Each division will be responsible for maintaining its own Risk Register on the central risk management information system. This will be used by their management team to inform priorities for the local implementation and monitoring of agreed controls. Each risk will be allocated a risk owner(s) who will be responsible for taking appropriate action to minimise its impact and develop actions plans with timescales and responsibilities accordingly. Review of the Risk Register will be undertaken by the designated divisional committee/group and this process will help inform planning management decisions and priorities. Divisional Boards and all management teams will be expected to regularly review and update their risk registers in line with ~~Table 1~~Fig.4 above.

Each Division has a nominated Governance Lead on the Divisional Board and a Risk and Governance Manager working within the division and their remit includes the following:

- Overseeing risk assessments
- Investigating incidents, claims and complaints
- Training divisional staff in risk management
- Reviewing national alerts and guidance

The Integrated Governance Department is responsible for maintaining an electronic risk register continually and will record and report on action being taken to manage the risks facing the Trust. The risks included on the risk register will be informed by the escalation procedures noted below, as well the collective input of the Integrated Governance Department and the Board of Directors.

If high or extreme level risks have been identified that are deemed impossible or impractical to manage at a Divisional or Executive Director level, then they will be submitted by the Integrated Governance Department for consideration by the appropriate Executive Group ~~Board Committee~~. Primary responsibility for the management of risks remains with the nominated owner and the Divisional Board.

All risks on the risk register will:

- Be allocated an owner
- Be allocated a responsible division
- Have an action plan if the risk is deemed unacceptable
- Be mapped to the relevant source
- Undergo a quality check by the Integrated Governance Department prior to inclusion on the risk register if rated 15 or above
- Undergo review as detailed in Table 1

Additionally all risks graded 20 or above will be cross referenced to the Board Assurance Framework (BAF) to identify high level risks which may impact on the strategic objectives.

Risks identified for closure must be signed off using the risk closure form and submitted to Integrated Governance Department.

7.8 Board Assurance Framework

The Board of Directors require assurances that risk control measures are effective and this is provided by the Board Assurance Framework. The Board Assurance Framework is a simple but comprehensive method for:

- The management of the principal risks to meeting the organisation's objectives
- Providing evidence for the Annual Governance Statement.

And which:

- Covers all of the organisation's main activities
- Identifies which objectives and targets the organisation is striving to achieve
- Identifies the risks to the achievement of objectives and targets
- Identifies and examines the system of internal control in place to manage the risks
- Identifies and examines the review and assurance mechanisms which relate to the effectiveness of the system of internal control
- Records the actions taken by the Trust Board to address control and assurance gaps

The Board Assurance Framework is the primary mechanism by which the Trust determines the priorities for audit of controls in place and includes both internal management audits and external independent audits. Through a process of audit and monitoring the Trust will undertake a review of the effectiveness of the risk control measures and progress against action plans on at least a six monthly basis at Trust Board. Fig. 6 & Fig. 7 demonstrate the links between the risk management process and the Board Assurance Framework overleaf.

The strategic domains are:

- **Delivering Outstanding Clinical Quality, Safety & Experience**
- **Being a Leading Partners in a ~~Strong~~ Progressive Health Economy ~~Foundation Trust~~**
- **Striving for Outstanding Organisational Effectiveness ~~Delivery~~**
- **Aspiring to Excellence in Practice through our Workforce ~~Development & Effectiveness~~**
- **Creating a 21st Century ~~Fit for Purpose~~ Infrastructure for Transformative Health and Social Care**

Fig. 6 NHS Risk Based Board Assurance Approach

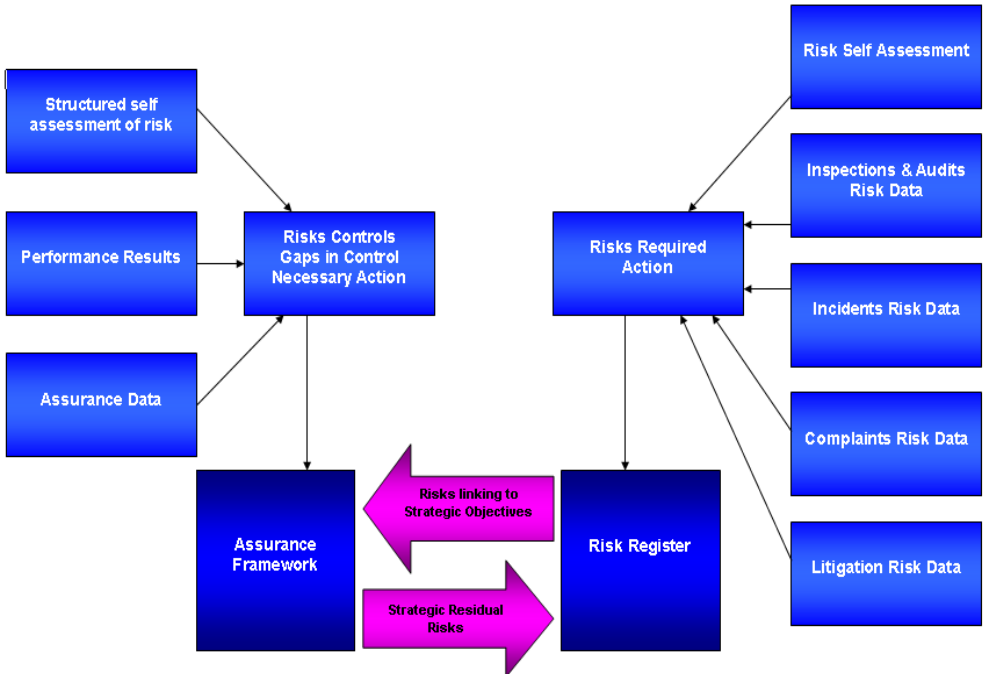


Fig.~~7~~6 Integration of the Board Assurance Framework and Organisational ~~Strategic~~ Risk Register

8 Emergency Preparedness

8.1 The Trust Emergency Planning Officer co-ordinates the development of all necessary emergency contingency plans to ensure preparedness for an effective response to any major incident or emergency and to ensure that the organisation fully recovers to normal services as quickly as possible.

The Trust has a detailed Major Incident Plan (MIP), which is tested and reviewed at least on an annual basis. These plans include national and local policies and procedures to manage major adverse incidents and disasters impacting on NHS services. The plans address effective communications with patients, relatives, carers, management, emergency, services, specialist advisors, Inspectorates, press, media and the public. An Emergency Preparedness Group assists the Operational Safety and Effectiveness Group and the Executive Quality Governance Group with this work.

9 Arrangements for Working with Partner Organisations / Governance Between Organisations

9.1 As the Trust develops in accordance with national and local initiatives, the risks emerging from joint working between NHS care, other care providers/partners and independent contractors will require joint solutions. The Trust is committed to minimise any risk by ensuring:

- All departments manage risk in partnership with partner agencies and contractors
- An adequate risk management and governance framework is incorporated as part of the arrangements for joint management and partnership agreements monitored through contractual arrangements
- Common objectives are agreed with partner agencies, contractors and the voluntary sector

10 Training

10.1 Effective risk management depends on all staff having a clear understanding of the subject and the contribution they can make to risk control. As an integral part of the Trust's mandatory training schedule, appropriate and targeted risk management training will ensure that staff are sufficiently aware and competent to identify hazards and assess and manage risk within their working environment. This training will be in line with the corporate training needs analysis.

10.2 Managers will be responsible for ensuring that their staffs are able to access and attend training appropriate to their needs including statutory and mandatory training and reference must be made to the organisations training needs analysis (TNA). Individual members of staff also have a responsibility, through their Personal Development Plans, to identify and participate in risk management training. New staff will receive information on risk management as part of the organisations' general induction arrangements.

10.3 Training & development for Board of Directors members will be orchestrated through the Quality Governance Committee on an annual basis. This training is deemed mandatory. All Board of Directors are to attend the Trust's mandatory training programme.

10.4 Divisional General Managers receive risk management training as part of their participation on the Executive On Call Rota and are also provided with supporting information this is a mandatory requirement.

10.5 Senior manager risk & governance training will also be provided through the 'Becoming a MCHFT Manager' and the 'Managers Moving On' course which will be run on an annual basis. Selection is through a nomination and interview process. This training is deemed as essential further training not mandatory training.

11 Information Governance

11.1 Openness and public responsibilities

The Trust understands that there is a need for a culture of openness and accountability across the public sector. Information about the Trust, its activities and decisions should be made available through the Trust's

Publication Scheme. The Trust is also committed to responding to any requests for information in accordance with the Freedom of Information Act 2000 and any other relevant legislation pertaining to information rights. For further information, refer to the Trust's Policy on *Freedom of Information Act & The Environmental Information Regulations.*

12 Data Quality

12.1 The Trust maintains clinical databases about patients and the care delivered to them; data may then be sent to other authorised and mandated users of the data. The Trust recognises its responsibility in ensuring that this data is complete, accurate and fit for purpose as defined by the Data Protection Act.

12.2 The Data Quality Group, which reports to the Information Governance Group, provides a standardised approach to the management and audit of data quality across the Trust to ensure compliance with NHS standards and guidance.

13. Information Technology (ICT)

13.1 The ICT Department is responsible for all Information technology / telecommunications infrastructure / security used within the Trust.

The ICT Department in collaboration with the Trust developed ~~a 5 year~~ Technology Ss~~s~~trategy based on 5 key principles these being:

1) ICT is a Key enabler to the modernisation of health care services
2) ICT must enable the Trust to be adaptable, flexible and agile
3) ICT is embedded within the overall change management strategy of the Trust
4) ICT investment must solve real business problems
5) ICT has a responsibility for the provision of high quality information systems

From these 5 principles was developed a strategy designed to support and be supported by the other strategic initiatives within the Trust, to ensure the strategy and the principles remain valid, a structure of assurance had been implemented, with oversight of the strategy, its progress and development being undertaken by the Executive Infrastructure Development Group & Information Governance Groups.

14. Monitoring and Assurances

The monitoring of the implementation of the risk management systems will be undertaken via a wide range of mechanisms but as a *minimum* will include monitoring via the Integrated Governance Committee Structure through the following:

1) The Integrated Governance Monthly ~~Exception~~ Report presented to ~~Operational Safety and Effectiveness Group and~~ the Executive Quality G~~overnance Committee~~roup on a monthly basis, with escalation to the Quality Governance Committee as required~~.~~
2) Review of the Board Assurance Framework and assurances in relation to progress against action plans by the Quality Governance Committee on a quarterly ~~monthly basis~~ and review at least six monthly ~~quarterly~~ by the Board of Directors.
3) The Quarterly Organisational ~~Significant~~ Risk Register Report (including risks 15~~20~~ and above) by ~~the Operational Safety and Effectiveness group and~~ the Executive Quality Governance Group and Quality Governance Committee and escalation to Board of Directors as required.
~~4) The Operational Safety and Effectiveness Group annual report.~~
4) The Executive Quality Governance Group ~~Committee~~ annual report.
5) The Quality Governance Committee annual report
6) Board of Directors minutes demonstrating review and discussion of significant incidents & risks.
7) Audits undertaken as part of the internal audit work programme.
8) Mandatory training reports.
9) Annual Governance S~~s~~tatement.

15. Potential Assurances

Potential assurances will be obtained via a number of sources including the:

- Trust's internal audit programme
- Action points and annual reports from committees/groups within the governance structure
- Integrated Governance monthly and annual reports
- Organisational Quarterly ~~Strategic~~ Risk Register quarterly report (including risks rated 15~~20~~ & above)
- External audit programme
- Board Assurance Framework quarterly report
- The use of external assessment reports from bodies such as NHS Improvement, NHS England ~~Monitor~~, ~~the~~ NHS Resolution ~~Litigation Authority~~, Care Quality Commission and Health & Safety Executive
- External audit reports and surveys e.g. Royal Colleges, staff surveys and patient surveys
- National benchmarking data e.g. NHS Improvement ~~National Patient Safety Agency reporting data~~reporting data

16. Positive Assurances

Positive assurances will be obtained via a number of sources including:

- The use of external assessment reports from bodies such as NHS Improvement , NHS England, ~~Monitor~~, the NHS Resolution ~~Litigation Authority~~, Care Quality Commission and Health & Safety Executive
- External audit reports and surveys e.g. Royal Colleges, staff surveys and patient surveys
- National benchmarking data e.g. NHS Improvement ~~National Patient Safety Agency~~ reporting data
- External & Internal Audit

Board of Directors

Code of Accountability

Contents

1 Accountabilities and Responsibilities

1.1 The Board shall be required to retain full and effective control over the Trust. Non-executive and executive directors shall share corporate responsibility for all decisions of the Board.

1.2 The Board shall commit to being open, transparent and candid including ensuring the proactive provision of information about performance, facilitating appropriate scrutiny of performance and actions and appropriately volunteering information wherever possible.

1.3 The Chairman and Non-executive directors are responsible for monitoring the performance of the executive management of the Trust. The separate functions and responsibilities of the Chairman and of the Chief Executive are set out below to demonstrate a clear division of responsibility between them.

1.4 The Board is accountable for key functions within the governance framework, and shall:

- meet its statutory financial duties, and ensure effective financial stewardship through value for money, financial control, financial planning and strategy, and compliance by directors individually and collectively with Standing Financial Instructions prepared by the Finance Director and approved by the Board for the guidance of all staff employed by the Trust;
- meet its statutory duty of quality by putting and keeping in place arrangements for maintaining, monitoring and improving the quality of health care which the Trust provides to individuals;
- establish a system of risk management throughout the Trust in accordance with the law and Government policy, in order to
    - minimise the risk to the Trust's patients, assets, its employees, visitors and business
    - comply with its contractual commitments with commissioning bodies and others for the volume and quality of its services, within its statutory responsibilities, financial and otherwise
    - identify, prioritise and treat risks, including those deriving from the Care Quality Commission, through an effective Board Assurance Framework
- determine the Trust's scope of activities within the statutory framework, and the Trust's values
- ensure that the Trust Board Secretary maintains a current schedule of stakeholders
- that the needs of its stakeholders are regularly and systematically identified; and to determine a set of key objectives and outcomes for meeting these needs within the financial resources available
- in consultation with the Council of Governors, set the strategic direction of the Trust within the overall policies and priorities of the NHS; to define its annual and longer term objectives; and to agree plans to achieve them
- enter into, and fulfil, contracts with commissioning bodies, after advice from the Chief Executive and Director of Finance & Strategic Planning

- exercise leadership, enterprise, integrity and judgment in directing the Trust
- ensure that high standards of corporate governance and personal behaviour are maintained in the conduct of the business of the whole Trust
- establish a committee comprising the Chairman, Chief Executive and the Non-executive directors to appoint or remove the executive directors
- establish a committee of Non-executive directors to decide the remuneration and allowances, and the other terms and conditions of office, of the executive directors
- ensure the provision of structured plans for the appraisal of, and succession planning for, executive directors
- on the advice of appointments committees that it constitutes, appoint consultant medical staff
- ensure that the Trust has clear lines of accountability, reinforced by corporate and personal objectives, and that there are proper processes in place to meet the Trust's objectives and secure delivery of outcomes
- oversee the delivery of planned results by monitoring performance against objectives, and ensure that relevant corrective action is taken
- develop effective dialogue with the Council of Governors so that there can be effective communication with members and the local community on the Trust's plans and performance, and that these plans and this performance are responsive to the community's needs
- maintain relationships with patients, commissioners and partnership organisations
- ensure that the Trust complies with all laws and regulations
- approve a formal Letter of Understanding between the Chairman and Chief Executive setting out, as clearly as possible, a division of their responsibilities. The Letter shall be reviewed and modified as the Board shall, from time to time, decide

1.5 In fulfilling these functions, the Board shall:

- ensure that the Trust complies with the terms of its Provider Licence
- take systematic account of the views of members, expressed through the Council of Governors
- set a strategic direction
- set organisational and operational targets
- minimise risk
- assess achievement against the above objectives
- ensure that action is taken to eliminate or minimise, as appropriate, adverse deviations from objectives
- ensure that the highest standards of Corporate Governance are applied throughout the organisation
- conduct its business as efficiently and effectively as possible
- act within statutory financial and other constraints
- through the development and systematic review of the Board Assurance Framework, ensure that there is clarity about the risks faced by the Trust in meeting its objectives and how the Trust will treat/manage these risks

- be clear what decisions and information are appropriate to the Board and draw up standing orders, a schedule of Decisions Reserved to the Board, and Standing Financial Instructions to reflect these
- ensure that management arrangements are in place to enable responsibility to be clearly delegated to directors and managers for the main programmes of action and for performance against programmes to be monitored, and directors and managers held to account
- ensure that the appropriate human, physical, financial and leadership resources are in place to ensure capability of meeting objectives
- establish performance and quality targets that ensure that resources are used effectively, and provide value for money
- ensure that the Trust learns and improves its performance through regular and systematic monitoring and review of the systems and processes in place for meeting its objectives and delivery of appropriate outcomes
- specify its requirements for financial and other information succinctly to ensure the Board can fully undertake its responsibilities
- ensure that value for money is a primary consideration for the Board
- ensure proper stewardship of public money
- establish committees, including those listed below, with formally agreed terms of reference that set out the committee's membership, powers, and arrangements for reporting back to the Board
- ensure that there are proper and independent assurances given on the soundness and effectiveness of systems and processes in place for meeting its objectives and delivering appropriate outcomes
- demonstrate that it is doing its reasonable best to achieve its objectives and outcomes
- ensure that the Annual Report and Accounts, and all spoken and written public statements and reports issued by the Board, are clear, comprehensive, balanced and fully represent the facts
- ensure that annual and other key reports are issued in good time to all members, partners and stakeholders with a legitimate interest in health issues
- in consultation with the Council of Governors, consult with and involve the public on the planning and delivery of local health services
- notify Monitor and the Council of Governors of any major changes in the circumstances of the Trust which have made or could lead to a substantial change to its financial wellbeing, healthcare delivery performance, or reputation and standing or which might otherwise affect the Trust's compliance with the terms of its Provider Licence.

1.6 The disputes resolution procedure recognises the different roles of the Council of Governors and the Board of Directors

1.7 The Chairman (or Deputy Chairman if the dispute involves the Chairman) shall first endeavour through discussion with governors and directors, to achieve the earliest possible conclusion, appropriate representatives from among them, to resolve the matter to the reasonable satisfaction of both parties.

1.8 Failing resolution under 1.7 above, the Council of Governors or the Board of Directors, as appropriate, shall, at its next formal meeting, approve the precise wording of a disputes statement setting out clearly and concisely the issue or issues giving rise to the dispute.

1.9 The Chairman shall ensure that the Disputes Statement, without amendment or abbreviation in any way, shall be an agenda item and agenda paper at the next formal meeting of the Council of Governors or Board of Directors as appropriate. That meeting shall agree the precise wording of a Response to Disputes Statement.

1.10 The Chairman, or Deputy Chairman if the dispute involves the Chairman, shall immediately, or as soon as is practical, communicate the outcome to the other party and deliver the Response to Disputes Statement. If the matter remains unresolved, or only partially resolved, the procedure outlined in 1.7 to 1.9 above shall be repeated.

1.11 If, in the opinion of the Chairman, or Deputy Chairman if the dispute involves the Chairman, and following the further discussions prescribed in 1.9, there is no further prospect of a full resolution or, if at any stage in the whole process, in the opinion of the Chairman or Deputy Chairman, as the case may be, there is no prospect of a resolution (partial or otherwise) then he shall advise the Council of Governors or Board of Directors accordingly.

1.12 On the satisfactory completion of this disputes process, the Board of Directors shall implement agreed changes.

1.13 On the unsatisfactory completion of this disputes process, the view of the Board of Directors shall prevail.

1.14 Nothing in this procedure shall prevent the Council of Governors, if it so desires, from informing NHS Improvement that, in the Council of Governor's opinion, the Board of Directors has not responded constructively to concerns of the Council of Governors that the Trust is not meeting the terms of its Provider Licence.

2 Role of Chairman

2.1 The Chairman is accountable to the Council of Governors for chairing and leading the Council of Governors and the Board of Directors. In respect of the Board of Directors, he is responsible for ensuring that it successfully discharges its overall responsibility for the Trust as a whole. He is not responsible for executive matters regarding the Trust's business, except where required to do so by the Constitution; a resolution of the Board of Directors; or as a responsibility conferred on him as Chairman of the Trust. Other than the Chief Executive, no executive reports to the Chairman, other than through the Board of Directors. His job description will be reviewed as

part of the appraisal process, and take account of current guidance and good practice.

2.2 The Chairman will:

- provide leadership to the Board, ensuring its effectiveness in all aspects of its role
- ensure that the highest standards of probity and clinical and corporate governance are maintained
- ensure that the Trust promotes equality for all its patients, staff and stakeholders;
- leads the Council of Governors and Board of Directors in playing a full and constructive part in the development and setting of the Trust's strategy, objectives. values and standards
- set the agenda of the Council of Governors and Board of Directors, ensuring that they take account of the important issues facing the Trust and the concerns of the governors and directors and that sufficient time is given for discussion with an emphasis on strategic, rather than operational, issues
- set the tone and style of meetings of the Council of Governors and Board of Directors in order to facilitate constructive discussion and challenge and an open and honest culture of debate
- lead the Non-executive directors in supporting and, where appropriate, challenging, the executive directors, to ensure that the Board of Directors makes appropriate decisions and conforms to the highest standards of clinical and corporate governance
- ensure that the Trust complies with its terms of its Provider Licence, its Constitution, and any other applicable legislation and regulations
- enable all ~~g~~Governors or ~~d~~Directors to make a full contribution to the affairs of the Council or the Board, and to the development of the Trust
- ensure that the Board acts as a team
- arrange informal meetings of some or all of the directors to ensure that sufficient time and consideration is given to complex, contentious or sensitive issues. Such meetings have no executive authority
- facilitate the effective contribution of Non-executive Directors and encourage constructive relations between Executive and Non-executive Directors ensure the Board determines the nature, and extent of the significant risks the organisation is willing to embrace in the implementation of its strategy
- ensure that the Board has local plans and strategies which reflect the priorities of the Council of Governors and of national policy for the NHS, and the requirements of commissioners
- develop and maintain a working relationship between the Trust and NHS Improvement
- acts as an ambassador for the Trust
- ensure the Council of Governors and Board of Directors have adequate support, and are provided efficiently with full, accurate, clear and timely information on which to base informed decisions, and monitor its strategies and policies, relating to the Trust's performance, to issues,

challenges and opportunities facing the Trust; and matters reserved to the Council of Governors or the Board of Directors for discussion and/or decision

- ensure that, in reaching decisions, the Board of Directors takes into account, as appropriate, the views of the Council of Governors
- ensure effective communications between the Council of Governors and Board of Directors; between Non-executive and Executive Directors, and with staff, patients, commissioners, other stakeholders and the public
- Chair, and be a member of, the Nominations and Remuneration Committee for Non-executive Directors.
- chair and lead the Appointments and Remuneration Committee of the Board of Directors and in doing so initiate change and succession planning in Executive Director appointments to retain and build an effective and complementary Board of Directors, and to facilitate the appointment of effective and suitable members of Board committees
- provide support to the Chief Executive in his personal development
- recommend the appointment of Non-executive directors as Chairs and members of the respective Board committees
- ensure the regular evaluation of the performance of the Board, its committees and individual directors
- develop, in the best interests of the Trust, a constructive and open relationship with the Chief Executive, through regular communication
- provide support to the Chief Executive in their personal development
- ensure provision of an induction and development programme for governors and directors
- ensure that the performance of the Council of Governors and the Board of Directors, and their respective committees, is evaluated annually
- with the assistance of the Trust Board Secretary, lead, at least annually, a performance assessment process for the Board. This process should act as the basis for determining individual and collective professional development programs for directors

3 Role of Non-Executive Directors

3.1 The Council of Governors appoints Non-executive Directors and determines their remuneration. Their job descriptions will be reviewed as part of the appraisal process, and take account of current guidance and good practice.

3.2 The Non-executive Directors are appointed to bring independent judgment and critical detachment to bear on issues of strategy, performance, key appointments, and accountability to the local community. They are responsible for ensuring that the Board acts in accordance with the terms of its Provider Licence, and their duties do not extend into operational matters. They are appointed to assist the Board in governance, rather than to act in a representative capacity.

3.3 Non-executive Directors shall have the following key functions, some of which are common to all directors:

- to bring independent judgement and experience based on commercial, financial, legal or governance expertise from outside the Trust, and apply this to the benefit of the Trust, its stakeholders, and its wider community
- to provide independent judgement, appropriate oversight and advice on issues of strategy, vision, performance, resources and standards of conduct, and to constructively challenge, influence and help the executive directors to develop related proposals
- to participate actively in the decision-making process of the Board
- to scrutinise and monitor the reporting and performance of management in meeting agreed goals and objectives
- to ensure there is an effective management team in place
- to satisfy themselves that financial information is accurate and that effective financial controls and systems of risk management are robust and defensible
- to jointly comprise (with the Chairman, and with the Chief Executive as defined in the committee's terms of reference) the Board's Appointments and Remuneration Committee, undertaking a key role in appointing and removing Executive Directors from office, agreeing Executive remuneration and in succession planning
- to jointly comprise (without the Chairman) the Board's Audit Committee, with an over-arching responsibility for giving assurance to the Board that risk management and internal control processes are in place and functioning
- to ensure that the Board and the Trust develop useful and productive relations with other organisations relating to the Trust's activities as appropriate
- to be a member or Chair of one or more Board committees or *ad hoc* working groups or panels of enquiry, with a responsibility for giving assurance to the Board on risks in line with the terms of reference of the committee, group or panel concerned
- to undertake specific functions agreed by the Board, but these should not detract from the key functions above, or compensate for any related skill gaps among executive directors

4 Role of Chief Executive

4.1 The Chief Executive will be allowed full scope for action, within clearly defined delegated powers, in fulfilling the decisions of the Board. The Chief Executive is responsible for the executive management of the Trust and all Executive Directors report to the Chief Executive. The Chief Executive job description will be reviewed as part of the appraisal process, and take account of current guidance and good practice.

4.2 The Chief Executive is accountable to both the Chairman (acting on behalf of the Board of Directors), and directly to the Board of Directors for:
- the executive management of the Trust's operations
- ensuring that the Trust's financial and operating goals and objectives are achieved

- ensuring that its decisions, and those of its formally constituted committees, are implemented
- ensuring that the Trust works effectively, in accordance with local and NHS policy, and with public service values
- ensuring that proper financial stewardship is maintained of the resources available to the Trust, avoiding waste and extravagance in the Trust's
- ensuring that recommendations affecting good practice as set out on reports from such bodies as the Audit Commission and the National Audit Office are fully considered, reported on, and implemented
- developing and recommending to the Board a vision, strategy and objectives for the Trust
- developing and recommending to the Board annual business plans and budgets;
- ensuring that the Trust meets its statutory duty of quality
- ensuring that sufficient information is provided to the Board to enable it to effectively monitor progress against its strategy and goals

4.3 As Accounting Officer, the Chief Executive is responsible to Parliament for the following as set out in the FT Accounting Officer Memorandum:

- ensuring there are effective management systems in place to safeguard public funds and assets and assisting in the implementation of corporate governance
- ensuring value for money is achieved from the resources available to the Trust and financial systems and procedures support this
- ensuring financial considerations are fully taken into account in decision on policy proposals
- ensuring the expenditure and income of the Trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them
- ensuring sound and effective financial management systems are in place
- Performance Management, succession planning and recruitment of the executive team

4.4 Together with the Director of Finance & Strategic Planning, the Chief Executive as Accounting Officer is responsible for:

- ensuring that the Accounts of the Trust that are presented to the Council of Governors for approval are prepared under principles, and in a format directed by the Secretary of State, with the approval of HM Treasury as set out in the NHS Finance Manual; and disclose a true and fair view of the Trust's income and expenditure, cash flows, gains and losses, and of its state of affairs
- signing the Statement of Financial Position and Annual Report, the foreword to the accounts, the Annual Governance Statement and the Remuneration report on behalf of the Board In addition, the Chief Executive will sign a statement in the Annual Accounts that describes his responsibilities as Accounting Officer

4.5 The Chief Executive shall ensure that the Trust has in place effective management systems that safeguard public funds. The Chief Executive will assist the Chairman in implementing the requirements of corporate governance exemplified in the NHS Foundation Trust Code of Governance, and will ensure that managers at all levels:

- have a clear view of their objectives, and the means of assessing achievement of them
- are assigned well-defined responsibilities for making the best use of resources
- have the information, training and access to the expert advice they need to exercise their responsibilities effectively
- are appraised of, and held to account for, the responsibilities above that are assigned to them

4.6 The Chief Executive shall provide such information as the National Audit Office requests, and shall:

- co-operate with external auditors in any enquiries into the use that the Trust has made of public funds
- make arrangements for internal audit that comply with those described in the NHS Internal Audit Manual
- ensure prompt action is taken in response to concerns raised by both external and internal audit

4.7 Effective and sound financial management and information are of fundamental importance. Whilst this is the operational responsibility of the Director of Finance & Strategic Planning, the Chief Executive as the Accounting Officer has a primary duty to see that these functions are properly discharged. The Chief Executive is required to ensure the continuing financial viability of the Trust, in particular to ensure that expenditure is contained within available levels of income, and to achieve any other financial objectives set by NHS Improvement with the consent of the Treasury, as appropriate. The Chief Executive shall also ensure that the assets of the Trust are properly safeguarded.

4.8 The Chief Executive has a particular responsibility for ensuring that expenditure by the Trust complies with Parliamentary requirements, and seeking any necessary approvals prior to expenditure by the Trust, observing the basic principle that funds are applied only to the extent and for the purpose authorised by Parliament. The Chief Executive must:

- draw the attention of Parliament to losses or special payments by appropriate notation of the statutory accounts
- ensure that all items of expenditure, including payments to staff, fall within the legal powers of the Trust, are exercised responsibly and with due regard to probity and value for money

4.9 As the Accounting Officer the Chief Executive has a responsibility to ensure that appropriate advice is tendered to the Board on all matters of financial probity and regularity, and more broadly on all considerations of prudent and

economical administration, efficiency and effectiveness. The Director of Finance & Strategic Planning has a special responsibility to support the Chief Executive in this role. The Chief Executive, together with the Appointments and Remuneration Committee, shall ensure that the Director of Finance & Strategic Planning is fully aware of this obligation and has the requisite skills and experience.

4.10 If the Board or the Chairman is contemplating a course of action that the Chief Executive considers would infringe the requirements of propriety and regularity, he shall:

- set out in writing to the Chairman and the Board his objection to the proposal and the reasons for it
- if the Board decides nonetheless to proceed, the Chief Executive shall seek a written instruction from the Board to take the action in question. The Chief Executive should ensure that the Audit Committee, which has specific terms of reference and delegated powers to enquire into matters of propriety and regularity, receives copies of the documents that describe his objections
- also inform the Council of Governors, if possible before the Board takes its decision, or in any event before the decision is implemented, so that the Council can, if necessary, intervene with the Board

4.11 If the Board is contemplating a course of action that raises an issue, not of formal propriety or irregularity, but which affects the Chief Executive's responsibility for obtaining value for money from the Trust's resources, it is his duty to draw the relevant factors to the attention of the Board. If the outcome is that he is overruled, it is normally sufficient to ensure that his advice and the overruling of it are clearly apparent from the papers submitted to the Board for consideration and/or with minutes of Board meetings. If, exceptionally, the Chief Executive has given clear advice that the course proposed could not reasonably be held to represent good value for money and the Board seems likely to overrule him, he shall inform the Council of Governors, so that it can intervene if necessary. In such cases, the Accounting Officer should as a member of the Board vote against the course of action rather than merely abstain from voting.

4.12 The Chief Executive shall have other responsibilities to:

- ensure continuous improvement in the quality and value of services that the Trust provides
- formulate and oversee implementation of policy
- serve as chief spokesperson for the Trust
- maintain a positive and ethical work climate that is conducive to attracting and retaining top-quality employees at all levels
- foster a corporate culture that promotes ethical practices, encourages individual integrity and fulfils social objectives and imperatives
- ensuring that the Trust culture, values and behaviours are communicated to the organisation and demonstrated by the executive team

- support the Chairman to ensure that appropriate standards of governance permeate through all parts of the organisation

4.13 The Chief Executive is responsible for ensuring that ~~e~~Executive D~~d~~irectors provide accurate, timely and clear reports to the Council of Governors and the Board of Directors.

4.14 The Chief Executive is required to sign on behalf of the Board of Directors service contracts to deliver health services to agreed specifications.

4.15 The Chief Executive is responsible for ensuring that the Chairman is alerted to forthcoming complex, contentious or sensitive issues affecting the Trust, of which he might not otherwise be aware.

4.16 The Chief Executive is responsible for managing the Trust's risk profile, including all clinical, non-clinical, and business risks.

4.17 The Chief Executive is responsible for providing the Chairman, the Appointments and Remuneration Committee, and other members of the Board of Directors with information and advice on succession planning within the Executive Management Team.

4.18 The Chief Executive supports induction programmes for new directors and governors, by ensuring that appropriate management time is made available for the process.

4.19 The Chief Executive is responsible for ensuring that the development needs of the executive directors reporting to him are identified and met. He ensures that performance reviews are carried out at least annually for each member of the Team.

4.20 The Chief Executive may arrange regular or *ad hoc* meetings of executive directors and/or senior managers, to ensure that sufficient time and consideration is given to complex, contentious or sensitive issues. Such meetings have no formal status or authority.

4.21 The Chief Executive assists the Chairman in promoting effective communications between Non-executive and executive directors, and between the Council of Governors and the Board of Directors.

4.22 The Chief Executive maintains, in the best interests of the Trust, a constructive and open relationship with the Chairman through regular communication and dialogue with him regarding the important issues facing the Trust, and proposes to him related agenda for consideration by the Council of Governors or the Board of Directors.

Board of Directors and Staff

Code of Conduct

Contents

1. Codes of Conduct for the Board and for Officers

1.1 Three crucial public service values shall underpin the work of the Trust:

- **Accountability**
  Everything done by those who work in the Trust must be able to stand the test of parliamentary scrutiny, public judgments on propriety and professional codes of conduct
- **Probity**
  There shall be an absolute standard of honesty in dealing with the assets of the Trust; integrity shall be the hallmark of all personal conduct in decisions affecting patients, staff and suppliers, and in the use of information acquired in the course of Trust duties
- **Openness**
  There shall be sufficient transparency about the Trust's activities to promote confidence between the Trust and its staff, patients and the public

1.2 In conducting the Trust's business in accordance with the public service values of accountability, probity and openness, directors and managers will seek to apply both the letter and the spirit of this Code, and the Trust's policies and procedures correctly, reasonably and consistently in regard to their own conduct and the conduct of staff. The NHS Foundation Trust Code of Governance shall apply to all directors and staff of the Trust.

1.3 In particular directors and managers will:

- respect and treat with fairness the public, patients, relatives, carers, staff and partners in other agencies by seeking to ensure that no-one is unlawfully discriminated against because of their religion, beliefs, race, colour, gender, marital status, disability, sexual orientation, age, social and economic status or national origin
- make the care and safety of patients their first concern and act to protect them from risk
- involve patients, and with their consent, their relatives and carers, in their care and treatment
- be open and honest when something goes wrong with patient care or treatment in line with the duty of candour
- protect patient confidentiality
- help staff members to realise their potential by improving their knowledge and skills while maintaining a reasonable balance between their personal and working lives
- strive to provide a safe working environment for staff and others and to protect staff from harassment and bullying
- involve staff in the management of the Trust by keeping them informed of the Trust's progress and performance, encouraging staff to raise questions and to make suggestions and by responding to promptly
- seek to ensure that the public is kept informed of the Trust's activities and to evolve methods of gathering the views of members of the public so that

these can be taken into account in developing the health services to be provided by the Trust
- seek to involve and co-operate with other agencies in improving the delivery of health services generally

1.4 Directors and managers will:
- welcome the involvement of staff representatives in the affairs of the Trust
- respect the confidentiality of discussions with staff, particularly in relation to disciplinary or confidentiality issues, grievances, health and family matters
- respond to staff personal problems in a sympathetic way and try to assist if reasonably practicable
- offer an explanation to a member of staff where it is not possible to agree to a member of staff's request for assistance
- not deal with staff in a way which could reasonably be considered to be demeaning, abusive or threatening. When correcting a member of staff, attention shall be paid to maintaining the person's dignity and self-esteem, and the emphasis usually placed on learning and development in preference to allocating blame or punishing
- create an open and learning organisation in which concerns about people failing to comply with standing orders, policies and procedures can be raised without fear

1.5 Directors and managers will act with integrity and probity at all times. They shall not make, permit or knowingly allow to be made, any untrue or misleading statement relating to their own duties or the functions of the Trust.

1.6 Directors and managers will seek to ensure that:
- the best interest 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

1.7 Directors and managers shall accept responsibility for their own work and the proper performance of the people they manage. They will seek to ensure that those they manage acknowledge that they are ultimately responsible 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

1.8 Directors and managers will support and assist the Accounting Officer of the Trust in his responsibility to answer to Parliament and NHS Improvement in terms of fully and faithfully declaring and explaining the use of resources and the performance of the Trust in putting national policy into practice and delivering targets.

1.9 There shall be nothing in this Code which requires or authorises a director or manager 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 duties and obligations to his employer, save as permitted by law

In any conflict, this sub-clause of 1.9 shall prevail over other requirements of 1.

1.10 Directors and managers will show their 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 Trust plays its full part in community development

1.11 Directors and managers will take responsibility for their own learning and development, and will seek to:

- take full advantage of the opportunities provided
- keep up to date with best practice; and
- share their learning and development with others

1.12 Directors and managers will follow the codes of conduct and ethics of their own profession as well as this Code of Conduct.

1.13 Through the Chief Executive, the Board will ensure the provision of reasonable learning and development opportunities for directors and managers, and shall seek to establish and maintain an organisational culture that values the role of managers.

1.14 Directors, managers and staff will 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

1.15 The Chief Executive will ensure that all staff are appropriately made aware of these Codes of Conduct.

2 Standards of Business Conduct and Declaration of Interest

Bribery and The Bribery Act 2011

2.1 Bribery

Giving (or offering) or receiving (or requesting) 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 (Bribery Act 2010)

The Bribery Act 2010 repealed previous corruption legislation and has introduced the offences of offering and / or receiving a bribe. It also places specific responsibility on Trusts to have in place sufficient and adequate procedures to prevent bribery and corruption taking place. Bribery is defined as "Inducement for an action which is illegal, unethical or a breach of trust. Inducements can take the form of gifts, loans, fees, rewards and other privileges". Corruption is broadly defined as the offering or the acceptance of inducements, gifts or favours, payments or benefit in kind which may influence the improper action of any person; corruption does not always result in a loss. The corrupt person may not benefit directly from their deeds; however, they may be unreasonably using their position to give some advantage to another.

Facilitation payments are small payments made to secure or expedite the performance of a routine action, typically by a government official or agency (e.g. issuing licenses or permits, installation of a telephone line, processing goods through customs, etc.) to which the payer (or the company) has legal or other entitlement. Facilitation payments are prohibited under the Bribery Act like any other form of bribe. They shall not be given by the Trust or by the Trust's employees in the UK or any other country.

Principles of Conduct

The Chief Executive and Director of Finance & Strategic Planning shall ensure that this is brought to the attention of all staff through:

- incorporation into Contracts of Employment
- induction training for new staff
- training courses generally
- 'flyers' and other communications

2.2 Managing Conflicts of Interest in the NHS

Guidance has been issued by NHS England that came~~omes~~ into place on 1 June 2017 to introduce consistent principles and rules for managing conflicts of interest. All staff defined as 'decision making staff' should declare any material interests at the earliest opportunity (and in any event within 28 days) via a positive declaration to their organisation. Therefore, declarations should be made:

- On appointment with an organisation

- When a person moves to a new role or their responsibilities change significantly
- At the beginning of a new project/piece of work
- As soon as circumstances change and new interests arise
- Annually to update their declarations of interest, or make a nil return.

Decision making staff are defined as those groups of staff that have a material influence on how taxpayers' money is spent. They should include but not be limited to:

- Executive and Non-executive Directors who have decision making roles which involve the spending of taxpayers' money
- Those at Agenda for Change band 8d and above
- Administrative and clinical staff who have the power to enter into contracts on behalf of their organisation
- Administrative and clinical staff involved in decision making concerning the commissioning of services, purchasing of goods, medicines, medical devices or equipment, and formulary decisions
- Those who undertake fundraising activities on behalf of the organisation's registered charity
- Members of advisory groups which contribute to direct or delegated decision making on the commissioning or provision of taxpayer funded services such as:
    - Entering into, or renewing large scale contracts
    - Awarding grants
    - Making procurement decisions
    - Selection of medicines, equipment, and devices

Governors, directors, all staff will:

- refuse gifts, benefits, hospitality or sponsorship of any kind which might reasonably be seen to compromise their personal judgment or integrity, and to seek to exert influence to obtain preferential consideration. All such gifts should be returned and hospitality refused
- accept only hospitality where there is a legitimate business reason and it is proportionate to the nature and purpose of the event
- declare and register the offer of gifts, benefits, hospitality or sponsorship ~~of any kind~~
- declare and record any financial or personal interest (eg company shares, research grant) in any organisation with which they have to deal or might be reasonably expected to deal with, and be prepared to withdraw from those dealings if required, thereby ensuring that their professional judgment is not influenced by such considerations
- make it a matter of policy that offers of sponsorship that breach standing orders be reported to the Board and that all staff involved with arranging sponsored research, posts or events for their organisation should declare this
- not misuse their official position or information acquired in the course of their official duties to further their private interests or those of others

- ensure professional registration (if applicable) and/or status are not used in the promotion of commercial products or services
- beware of bias generated through sponsorship where this might impinge on professional judgment and impartiality
- neither agree to practice under any conditions which compromise professional independence or judgment, nor impose such conditions on other professionals
- make all purchasing decisions, including prescribing and those involving pharmaceuticals and appliances, based on best clinical practice and value for money. Such decisions shall take into account their impact on other parts of the healthcare system, for instance, products dispensed in hospital which are likely to be required by patients regularly at home.

Governors, directors, decision making staff and staff who are members of any key strategic decision making groups will:

- declare patents and other intellectual property rights they hold or are in application (either individually or by virtue of their association with a commercial or other organisation) which might reasonably expected to be related to items to be procured or used by their organisation
- declare any loyalty interests 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.
- declare any role on advisory groups or other paid or unpaid decision making forums that can influence how their organisation spends taxpayers money.
- declare where they could be involved in the recruitment or management of close family members, relatives, close friends, associates or business partners.
- declare any interest whereby ~~an~~ the Trust does business with an organisation that has close family members, relatives, close friends business partners or associates who have decision making responsibilities.

2.3 Interests of Directors

Provisions in relation to the Interests of Directors are included in the Directors Standing Orders of the Mid Cheshire Hospitals NHS Foundation Trust Constitution.

2.4 NHS Hospitality and Other Expenditure

Board members shall set an example to the Trust in the use of public funds, and the need for good value in incurring public expenditure. The use of NHS monies for hospitality and entertainment, including hospitality at conferences or seminars, shall be carefully considered. All expenditure on these items should be justifiable as reasonable in the light of general practice in the public sector.

2.5 Casual Gifts

Casual gifts offered by contractors or suppliers to directors, managers and staff, *e.g.* at Christmas time, may not be in any way connected with the performance of duties so as to constitute an offence under the Bribery Act 2010. Such offers of gifts should nevertheless be advised to the Director of Finance & Strategic Planning for entry into the register of gifts and hospitality and politely but firmly declined. Articles of low intrinsic value, (lower than £6), such as diaries or calendars, or small tokens of gratitude from patients or their relatives, need not necessarily be refused. Gifts from suppliers or contractors doing business (or likely to do business) with an organisation should be declined, whatever their value. Staff should be mindful that even gifts of a small value may give rise to perceptions of impropriety and might influence behaviour if not handled in an appropriate way. In cases of doubt staff should either consult their line manager or politely decline acceptance.

2.6 Hospitality Offered to Staff

Modest hospitality to directors, managers and staff provided it is normal and reasonable in the circumstances, e.g. lunches in the course of working visits or meetings may be acceptable. Any such hospitality should be:

- similar to the scale of hospitality which the NHS as an employer would be likely to offer
- secondary to the purpose of the visit or meeting
- appropriate and not out of proportion to the occasion
- not extended beyond those whose role makes it appropriate for them to attend the meeting

NHS England guidance recommends the following guidance for the acceptance of meals and refreshment:

- 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 approval is given by the Director of Finance & Strategic Planning or the Chief Executive.

Staff should use a common sense approach to make a reasonable estimate to the value of any hospitality

Staff shall advise the Director of Finance & Strategic Planning of all other offers of gifts, hospitality or entertainment and shall politely but firmly decline. If in doubt, they should seek advice from the Director of Finance & Strategic Planning.

~~This Code applies to a committee or group of the Board as it applies to the Board, and applies to any member of any such committee or group (whether or not he is also a director) as it applies to a director of the Trust~~.

2.7 Declaration of Interests by Staff

The Trust requires interests, employment or relationships declared, to be entered in a register of interests of staff. All interests should remain on this register until 6 months after the interest has expired and a historic record should be maintained for a minimum of six years after the interest has expired. This register will be maintained by the Director of Finance and Strategy in line with the Trust policy, reviewed at least annually and made available on the Trust website. As a minimum the interests of all decision-making staff, should be published annually. In exceptional circumstances staff may make representations that their interests should not be published where there is a real risk of harm or is prohibited by law.

The Director of Finance & Strategic Planning shall establish systems to communicate this requirement to staff and inform the Chief Executive if there are any interests.

The Director of Finance & Strategic Planning shall introduce whatever measures he considers necessary to ensure that the Trust's interests and those of patients are adequately safeguarded.

The Chief Executive shall ensure that contracts of employment require all staff to declare such interests and shall develop a local policy, in consultation with staff and local staff interests. This may include the disciplinary action including reporting regulated professions to their regulator if a member of staff fails to declare a relevant interest, or is found to have abused his official position, or knowledge, for the purposes of self-benefit, or that of family or friends.

If it comes to the knowledge of an officer of the Trust that a contract in which he has any pecuniary interest not being a contract to which he is himself a party, has been, or is proposed to be, entered into by the Trust he shall, at once, give notice in writing to the Director of Finance & Strategic Planning of the fact that he is interested therein. In the case of married persons or persons living together as partners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner.

This Code applies to a committee or group of the Board as it applies to the Board, and applies to any member of any such committee or group (whether or not he is also a director) as it applies to a director of the Trust.

2.8 Bequests and Gifts to Staff, Volunteers, Governors and Non-Executive Directors from Patients

Payments and/or gifts should not be solicited from patients or patients' relatives in any circumstances. If such goods are received, any gifts of money

from patients or patients' relatives (whether direct or indirect should be declared to the member of staff's manager or the Chairman as appropriate, and paid into the Trust's charitable funds. Small value goods (e.g. box of chocolates) should be shared among the staff and patients. Larger value goods, over £25, will be considered on a case by case basis by the Director of Finance & Strategic Planning.

Proposed bequests in the wills of patients or patients' relatives should be politely declined. If any such bequests are made, the individual(s) concerned should promptly notify their line manager or the Chairman as appropriate and pay any monies into the Trust's charitable funds. Bequests of other property (non-monetary) will be considered on a case-by-case basis but the Trust may require the member of staff to give up the bequest if it is not appropriate.

Any doubts about appropriate responses to a gift/bequest must be referred to the Director of Finance & Strategic Planning.

Any concerns about bequests will be investigated by the Trust and any breach of the above may lead to a disciplinary action.

If you have any suspicions regarding Money Laundering please refer to the Money Laundering Policy or contact the Trust Fraud Officer.

2.9 Preferential Treatment in Private Transactions

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

2.10 Contracts

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

2.11 Outside Employment

NHS employees must not seek to engage in outside employment which may conflict with their NHS work, be detrimental to it, or cause a breach of the European Working Time Directive. Any outside employment should be declared by staff on appointment and when any new employment arises. For the purpose of this guidance this can include directorships, Non-executive roles, self-employment, consultancy work, charitable trustee roles, political roles and roles within not-for-profit organisations, paid advisory position and

paid honorariums which relate to bodies likely to do business with an organisation. Where a risk of conflict of interest is identified staff must tell their manager. The manager and/or the Director for Workforce and Organisational Development and/or the Chief Executive will be responsible for judging whether the interests of the Trust or patients could be harmed.

2.12 Private Practice and Fees

Consultants employed under the Terms and Conditions of Service of Hospital Medical and Dental Staff are permitted to carry out private practice subject to the conditions outlined in the current code of conduct governing private practice for hospital medical and dental staff which require a declaration of any private practice, (see Standing Orders for Private Practice P.138)

Prior agreement for the use of NHS facilities, staff and services shall be applied for by written request to the Chief Executive, a copy being sent to the Director of Finance & Strategic Planning.

Other medical staff may undertake private practice or work for outside agencies, providing they do not do so within the time they are contracted to the NHS, and they observe the conditions in the Code. Hospital doctors are entitled to receive additional fees depending upon their contract of employment. Doctors should obtain advice from the Head of Resourcing on their entitlements. Other medical staff must obtain prior agreement from the Chief Executive, with a copy sent to the Director of Finance & Strategic Planning, where they wish to use NHS facilities, staff or services.

Consultants may engage in “Fee Paying Services” subject to the conditions set out in current terms and conditions for consultant medical staff and where permissions are required, such permissions shall be sought from the Chief Executive in writing.

2.13 Political and Charitable Contributions

The Trust does not make any contributions to politicians, political parties or election campaigns.

As a responsible member of society, the Trust may make charitable donations. However, these payments shall not be provided to any organisation upon suggestion of any person of the public or private sector in order to induce that person to perform improperly the function or activities which he is expected to perform in good faith, impartially or in a position of trust or to reward that person for the improper performance of such function or activities. Any donations and contributions must be ethical and transparent. The recipient’s identity and planned use of the donation must be clear, and the reason and purpose for the donation must be justifiable and documented. All charitable donations will be publicly disclosed.

2.14 Commercial Sponsorship

Subject to 2.12.1 below, acceptance by staff of Commercial Sponsorship is acceptable, but only

- where the staff member seeks permission in advance from the Director of Finance & Strategic Planning
- where the event or meeting will result in a clear benefit for the organisation and the NHS
- the Director of Finance & Strategic Planning is satisfied that acceptance will not compromise purchasing decisions in any way; and
- the offer and decision is entered into a register of sponsorship maintained by the Director of Finance & Strategic Planning, and which is available for inspection by the general public during normal working hours

Sufficient detail of the itinerary, detailed costs and subject relevance shall be provided by the member of staff to the Director of Finance & Strategic Planning. If an element of hospitality is included then this shall be declared.

Under the Medicines (Advertising) Regulations 1994 and the exceptions below subject to where relevant medicinal products are being promoted to persons qualified to prescribe or supply relevant medicinal products, no person shall supply, offer or promise to such persons any gift, pecuniary advantage or benefit in kind, unless it is inexpensive and relevant to the practice of medicine or pharmacy. This shall not prevent any person offering hospitality (including the payment of travelling or accommodation expenses) at events for purely professional or scientific purposes to persons qualified to prescribe or supply relevant medicinal products, provided that:

- such hospitality is at a reasonable level
- it is subordinate to the main scientific objective of the meeting; and
- it is offered only to health professionals

For avoidance of doubt, under this Code, no person qualified to prescribe or supply relevant medicinal products shall solicit or accept any gift, pecuniary advantage, benefit in kind, hospitality or sponsorship prohibited by this regulation.

Whatever type of agreement is entered into, clinician's judgment should always be based on clinical evidence that the product is best for their patients. No information should be supplied to the sponsor from which they could gain a commercial advantage, and information which is not in the public domain should not normally be supplied. During dealings with sponsors there must be no breach of patient or individual confidentiality or data protection rules and legislation.

Where meetings are sponsored by external sources, the fact must be disclosed in the papers relating to the meeting and any published proceedings. The sponsor or their representatives may attend any event or

meeting at the organisation's discretion but must not have a dominant influence over the content or the main purpose of the event.

On occasions when the Trust considers it necessary for staff advising on the purchase of equipment to inspect such equipment in operation in other parts of the country (or exceptionally, overseas), the Trust shall consider meeting the cost, so as to avoid putting in jeopardy the integrity of subsequent purchasing decisions.

2.15 Commercial Sponsorship of Posts: Linked Deals

Pharmaceutical companies, for example, may offer to sponsor, wholly or partially, a post for the Trust. Any such offers shall be advised immediately to the Director of Finance & Strategic Planning who will decide on the issue. The Trust shall not enter into such arrangements, unless it has been made abundantly clear in writing to the company concerned that the sponsorship will have no effect on purchasing decisions. Where such sponsorship is accepted, monitoring arrangements shall be established by the Director of Finance & Strategic Planning to ensure that purchasing decisions are not, in fact, being influenced by the sponsorship agreement. Rolling sponsorship of posts should be avoided unless appropriate checkpoints are put in place to review and confirm the appropriateness of arrangements continuing.

Under no circumstances shall the Trust agree to "linked deals" whereby sponsorship is linked to the purchase of particular products, or to supply from particular sources, unless the linked deal is openly tendered. Sponsors should have no undue influence over the duties of the post. Staff should declare any other interests arising as a result of their association with the sponsor, in line with general guidance on the declaration of interests.

The Director of Finance & Strategic Planning shall maintain a register for this purpose.

2.16 Research and Development

Where research and development is sponsored, whether or not linked to the purchase of particular products or a supply from particular sources the following shall apply:

- a trial shall not commence until an indemnity agreement is in place, signed by the Medical Director
- approval for the trial has been agreed in writing by the Medical Director which specifies the written protocol and written contract between staff, the organisation 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 Trust must be able to recover the full cost of the trial from the commercial company on whose behalf the trial is carried out
- funding shall be transparent

- there shall be no incentive to prescribe, supply, administer, recommend, buy or sell more of any particular treatment or product other than in accordance with the peer reviewed and mutually agreed protocol for the specific research intended
- full consideration has been given to the continuing cost of any pharmaceutical or other treatment initiated during the research and how this will be managed once the study has ended. The Director of Finance & Strategic Planning shall agree such estimates and management plans prior to the study being approved
- Staff shall declare any involvement in sponsored research and the Director of Finance & Strategic Planning shall keep a register of such declarations

The Chief Executive shall ensure that the Trust benefits from commercial exploitation of intellectual property derived from research and development that the Trust has funded (or the NHS has funded through the Trust), even where the intellectual property itself is owned by people outside the NHS. The Chief Executive shall ensure that an agreement to this effect is included in contracts concerning research and development, including contracts with members of staff engaging in research and development whilst employed by the Trust.

2.16.1 Commercial in-Confidence

Staff shall be particularly careful of using, or making public, internal information of a *commercial in-confidence* nature, particularly if its disclosure would prejudice the principle of a purchasing system based on fair competition. This principle applies whether private competitors or other NHS providers are concerned, and whether or not disclosure is prompted by the expectation of personal gain.

However, the Trust should be careful about adopting a too restrictive view on this matter. It should not be a cause of excessive secrecy on matters which are not strictly commercial per se. For example, the term "commercial in-confidence" should not be taken to include information about service delivery and activity levels, which should be publicly available. Nor should it inhibit the free exchange of data for medical audit purposes, for example, subject to the normal rules governing patient confidentiality and data protection. In all circumstances the overriding consideration must be the best interests of patients.

2.17 Patents and Intellectual Property

The development and holding of patents and other intellectual property rights allows staff to protect something that they create. However, conflicts of interest can arise when staff who hold patents and other intellectual property rights are involved in decision making and procurement. Where product development involves use of time, equipment or resources from their organisation this too can create risks of conflicts of interest. In these cases it

is important that the Trust is aware of this so that it can be managed appropriately.

- 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 and which may reasonably be expected to relate to items to be procured or used by the Trust
- Staff should seek prior permission from the Trust to before entering into any agreement with bodies regarding product development, research, work on pathways etc where this impacts on the organisations 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 handbook should be considered and applied to mitigate any risks.

2.18 Canvassing of, and Recommendations by, Chairman and Directors in Relation to Appointments

Canvassing the Chairman, directors or members of any committee, directly or indirectly, on behalf of a candidate for any appointment by the Trust shall disqualify the candidate for such appointment, unless the approach made clearly relates to the content of the post. The contents of this paragraph shall be included in application forms or otherwise brought to the attention of candidates.

The Chairman or director shall not solicit for any person any appointment to the Trust or recommend any person for such appointment: but this paragraph shall not preclude a member from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

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

2.19 Relatives of Members or Officers

Candidates for any staff appointment under the Trust shall, when making application, disclose in writing to the Trust whether they are related to any member of staff or the holder of any office under the Trust. Failure to disclose such a relationship shall cause the candidate to be liable to disqualification if appointed, and render him liable to instant dismissal.

The Chairman, directors and officers of the Trust shall disclose to the Chief Executive any relationship between himself and a candidate of whose candidature that director or officer is aware. It shall be the duty of the Chief Executive to report to the Board any such disclosure made.

Non-executive directors on appointment, and executive director before accepting an appointment, shall disclose to the Board whether they are related to any other director or officer of the Trust.

Where the relationship to the Chairman or director of the Trust is disclosed, this shall be treated as an Interest of the director for the purpose of this Code, and recorded as such.

Where such relationships are established between the Chairman and Directors during the course of employment / term of office these should be declared in the same manner.

2.20 Staff Awareness and Breach of these Standards and Declaration of Interest

The Chief Executive shall ensure that all staff are made aware of the provision of this Code of Conduct. Staff should speak up about actual or suspected breaches of compliance in line with the Trust's Whistleblowing policy.

The Chairman and Directors shall be responsible for taking firm, prompt and fair disciplinary action against any Executive Director or staff in breach of this section of the Code. Any breach will be investigated and judged on its own merits and those involved will have the opportunity to explain and clarity any relevant circumstances. Anonymised information on this breach may be published on the Trust website to aid transparency.

Breaches by the Chairman, Governors or Non-executive Directors shall be brought to the attention of the Council of Governors.

2.21 Audit

The Director of Finance & Strategic Planning shall set up systems to monitor the requirements of 2 – Standards of Business Conduct and Declaration of Interest, and will include its review in the annual audit plan for Internal Audit.

Board of Directors

Standing Orders:

Glossary

Glossary of Terms

Accounting Officer means the **Chief Executive** of the **Trust**, who is responsible for ensuring the proper stewardship of public funds and assets.

Act means the National Health Service Act 2006.

Board or **Board of Directors** means the collective body formally constituted in accordance with the Constitution and comprising the Non-Executive **Chairman,** the **Non-Executive Directors,** and the **Executive Directors**.

Budget means a resource, expressed in financial terms, proposed by the **Board** for the purpose of carrying out, for a specific period, any or all of the functions of the **Trust**.

Budget Holder means the **Director** or a member of staff with delegated authority to manage finances (income and expenditure) for a specific area of the Trust.

Chairman means the person appointed by the **Council of Governors** to lead the Council and the **Board of Directors**, and to ensure that the Board successfully discharges its overall responsibility for the **Trust** as a whole. The **Deputy Chairman** shall be deemed to include the Non-Executive Director appointed by the Council of Governors to take on the Chairman's duties if the Chairman is absent from the meeting or is otherwise unavailable.

Chief Executive means the chief executive officer of the **Trust**, whose appointment is made by the **Non-executive Directors** and approved by the **Council of Governors**.

Class means a subdivision of a **Constituency**.

Commercial Sponsorship means **Trust** funding from an external source, including funding of all or part of the costs of a member of staff, NHS research, staff training, pharmaceuticals, equipment, meeting rooms, costs associated with meetings, meals, gifts, hospitality, hotel and transport costs (including trips abroad), provision of free services (including speakers), buildings or premises.

Commissioning means the process for determining the need for, and for obtaining the supply of, healthcare and related services by the **Trust** within available resources.

Committee of the Board of Directors means a committee appointed by the **Board of Directors** with specific terms of reference, chairman, and membership approved by the Board.

Committee of the Council of Governors means a committee appointed by the **Council of Governors** with specific terms of reference, chairman, and membership approved by the Council.

Committee members means persons formally appointed to sit on, or to chair specific committees; or persons co-opted as members of any specific committee.

Constituency means either one of the Public constituencies, the Staff and Volunteers constituency or Patients and Carers constituency as the context requires and "constituencies" means two or more of them together.

Contracting and procuring means the systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets.

Council of Governors means the body formally constituted in accordance with the Constitution, meeting in public (other than exceptionally) and presided over by the **Chairman**.

Deputy Chairman means the **Non-executive Director** appointed by the **Council of Governors** to take on the Chairman's duties if the **Chairman** is absent for any reason.

Director means the **Chairman**, a **Non-executive Director** or an **Executive Director** appointed in accordance with the Constitution.

Director of Finance & Strategic Planning means the chief financial officer of the **Trust**.

Effective Date means the date on which these **Standing Orders** came into effect.

Emergency shall comprise those events that put the **Trust**, its staff or patients at significant risk and their immediate actions shall be required to effectively control that risk without delay until the next scheduled **Board** meeting.

Executive Director means a member of the Board who is appointed by the **Non-executive Directors** and the **Chief Executive** (other than for the appointment of a Chief Executive) as an **officer** of the Trust.

EU means the European Union.

Family means the spouse, partner, children, grandchildren, other dependants, parents or grandparents of any **Governor**, **Director**, or **Officer** of the **Trust**.

Funds Held on Trust means those funds which the Trust held on the date of incorporation, **r**eceived on distribution by statutory instrument or which it has chosen subsequently to accept under powers defined by legislation. Such funds may or may not be charitable.

Governor means a person elected or appointed to the **Council of Governors** in accordance with the Constitution.

Legal Adviser means a properly qualified person appointed by the **Trust** to provide legal **a**dvice.

Manager means any member of staff of the Trust, or other person on contract to the Trust, who shall exercise management control and/or direction over other staff either on a continuous basis or for a period of time (for instance, during a clinical procedure). This includes staff at all levels and disciplines who supervise other clinical staff.

Member means a person registered as a member of a Constituency of the **Trust** in accordance with the Constitution.

Monitor is the regulator for Foundation Trusts that was absorbed into NHS Improvement in April 2016.

Motion means a formal proposition to be discussed and voted on during the course of a meeting.

NAO means National Audit Office.

NHS Improvement is the body corporate formerly known as Monitor, as provided by Section 61 of the 2012 Act

Nominated Officer means an officer charged with the responsibility for discharging specific tasks within **Standing Orders** and Standing Financial Instructions.

Non-executive Director means a person appointed to the **Board of Directors** by the **Council of Governors**, who is not an officer of the **Trust** and is not to be treated as an officer.

Officer means a member of staff of the Trust or any other person holding a paid appointment or **o**ffice with the **Trust**.

SFI means **Standing Financial Instructions**.

Staff shall include those persons employed by the Trust and those on contract from third party organisations whose duties and responsibilities require them to act as if they were staff. For avoidance of doubt, it does not include persons employed by a contractor where the contractor supervises the persons on a day to day basis.

Standing Orders means the document regulating the proceedings of the Trust's **Board of Directors** or its **Council of Governors.**

Trust means Mid Cheshire Hospitals NHS Foundation Trust.

Trust Board Secretary means a person who may be appointed by the **Board** to provide advice on **c**orporate governance issues to the **Board** and the **Chairman** and monitor the Trust's compliance with **Standing Orders**, legislation, and related guidance.

Please note words importing the masculine gender only shall include the feminine gender; words importing the singular shall import the plural and vice-versa.

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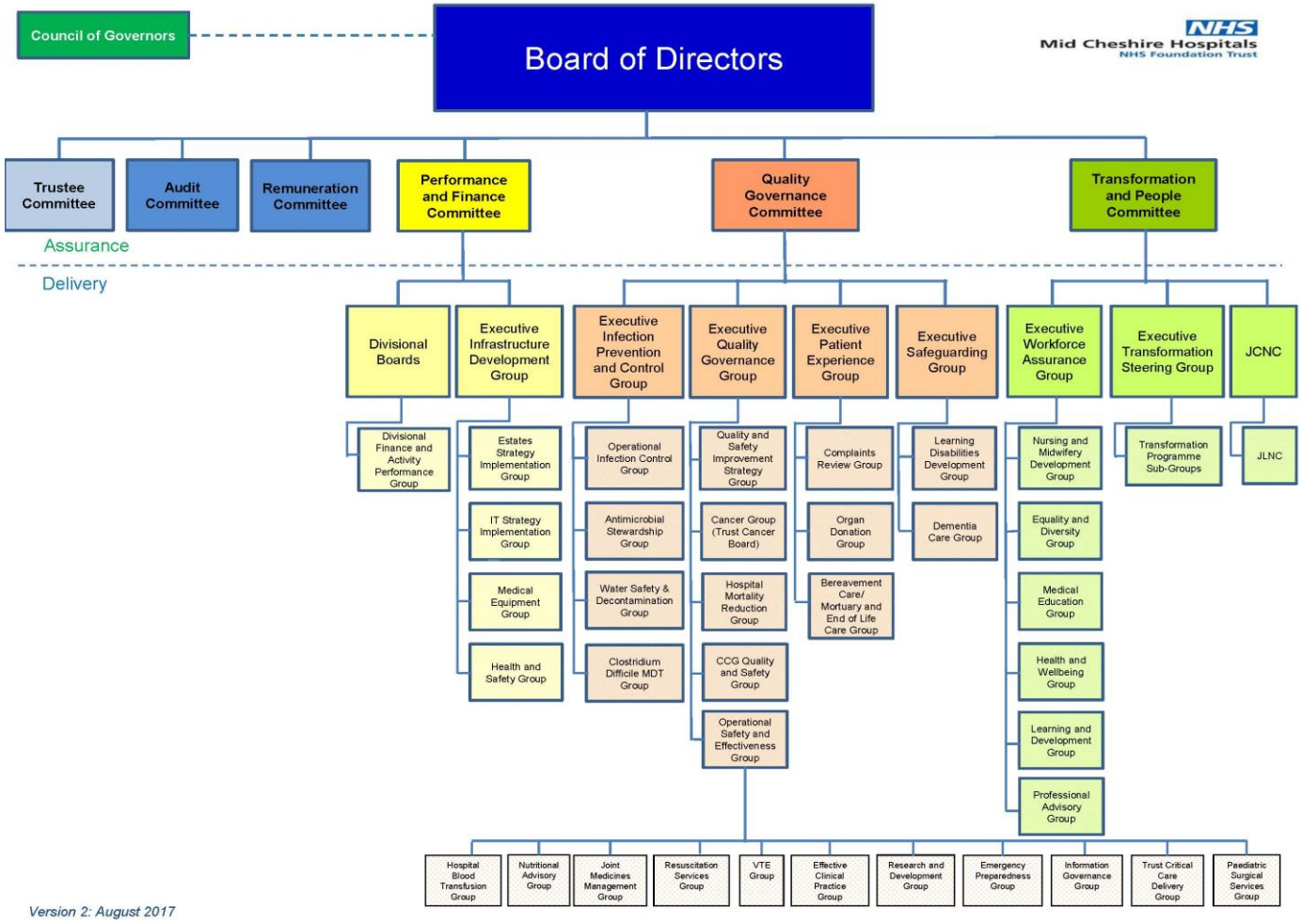
Appendix A


Council of Governors
Board of Directors
NHS
Mid Cheshire Hospitals
NHS Foundation Trust
Trustee Committee
Audit Committee
Remuneration Committee
Performance and Finance Committee
Quality Governance Committee
Transformation and People Committee
Assurance
Delivery
Divisional Boards
Executive Infrastructure Development Group
Executive Infection Prevention and Control Group
Executive Quality Governance Group
Executive Patient Experience Group
Executive Safeguarding Group
Executive Workforce Assurance Group
Executive Transformation Steering Group
JCNC
Divisional Finance and Activity Performance Group
Estates Strategy Implementation Group
IT Strategy Implementation Group
Medical Equipment Group
Health and Safety Group
Operational Infection Control Group
Antimicrobial Stewardship Group
Water Safety & Decontamination Group
Clostridium Difficile MDT Group
Quality and Safety Improvement Strategy Group
Cancer Group (Trust Cancer Board)
Hospital Mortality Reduction Group
CCG Quality and Safety Group
Operational Safety and Effectiveness Group
Complaints Review Group
Organ Donation Group
Bereavement Care/ Mortuary and End of Life Care Group
Learning Disabilities Development Group
Dementia Care Group
Nursing and Midwifery Development Group
Equality and Diversity Group
Medical Education Group
Health and Wellbeing Group
Learning and Development Group
Professional Advisory Group
Transformation Programme Sub-Groups
JLNC
Hospital Blood Transfusion Group
Nutritional Advisory Group
Joint Medicines Management Group
Resuscitation Services Group
VTE Group
Effective Clinical Practice Group
Research and Development Group
Emergency Preparedness Group
Information Governance Group
Trust Critical Care Delivery Group
Paediatric Surgical Services Group
Version 2: August 2017

Mid Cheshire Hospitals
NHS Foundation Trust

Title of Paper :	Request to Affix Trust Seal	
Author:	Katharine Dowson	
Executive Lead:	Tracy Bullock	
Type of Report:	Concept Paper	
	Strategic Options Paper	
	Business Case	
	Information	X
	Review/Benefits/Audit	

Link to Strategic Domains:		***Link to Domain:***	
Delivering Outstanding Clinical Quality, Safety & Experience		Safe	
Being a Leading partner in a Progressive Health Economy		Effective	
Striving for Outstanding Organisational Effectiveness	X	Caring	
Aspiring to Excellence in Practice Through Our Workforce		Responsive	
Creating a 21st Century Infrastructure for Transformative Health and Social Care		Well-Led	X

Link to Board Responsibility:	Performance	
	Accountability	X
	Strategy	
	Implementation	
Action Required:	Decide	
	Approve	X
	Note	
	Recommend	
	Delegate	

Positive Benefit:	Board approval given to affix Trust Seal to a lease
Risk:	Lease cannot be completed without Board approval

To be published on Trust Website –complete version	***Y*** *(delete as appropriate)*
If no, to be published on Trust Website – redacted	***N*** *(delete as appropriate)*
If not to be published complete or redacted, please detail the reason why	
Presented at Board Meeting of:	8 January 2018

Mid Cheshire Hospitals NHS
NHS Foundation Trust

Estates & Facilities Division

Capital Procedures

Form CF31 – Request to affix Trust Seal
(Version 1.0 – February 2013)

In line with the provisions Trust Standing Order Section 17 (Sealing of Documents), we request approval to affix the Trust Seal to the following document –

Type of Documents – Property Lease Renewal

Title of Document – Lease Renewal between Mid Cheshire Hospitals Foundation Trust and Cheshire and The British Red Cross Society relating to premises at Leighton Hospital

Reason for Trust Seal – Engrossment of a lease renewal to an area located within the MD Block at Leighton Hospital. The accommodation has a GIA of 13.5sqm

Please note - this document is a request to affix the Trust Seal, the content of the Lease has been agreed and authorised

Number of copies to be sealed – Two copies of Lease Renewal

The seal is to be applied to – Plan between page 9 & 10 Plus Page 34

Parties to Agreement - The parties are Mid Cheshire Hospitals NHS Foundation Trust and The British Red Cross Society

Value – Rental income of £Nil (Concession agreed at EIDG)

Mike Babb
Divisional Director of Estates & Facilities

Date: 12th December 2017

To be completed by Trust Secretary

Approval minuted at Board meeting of *(date)*_____

Seal Applied *(date)*_____

Seal Number _____

HILL DICKINSON

Dated 2017

LEASE

between

(1) Mid Cheshire Hospitals NHS Foundation Trust

and

(2) The British Red Cross Society

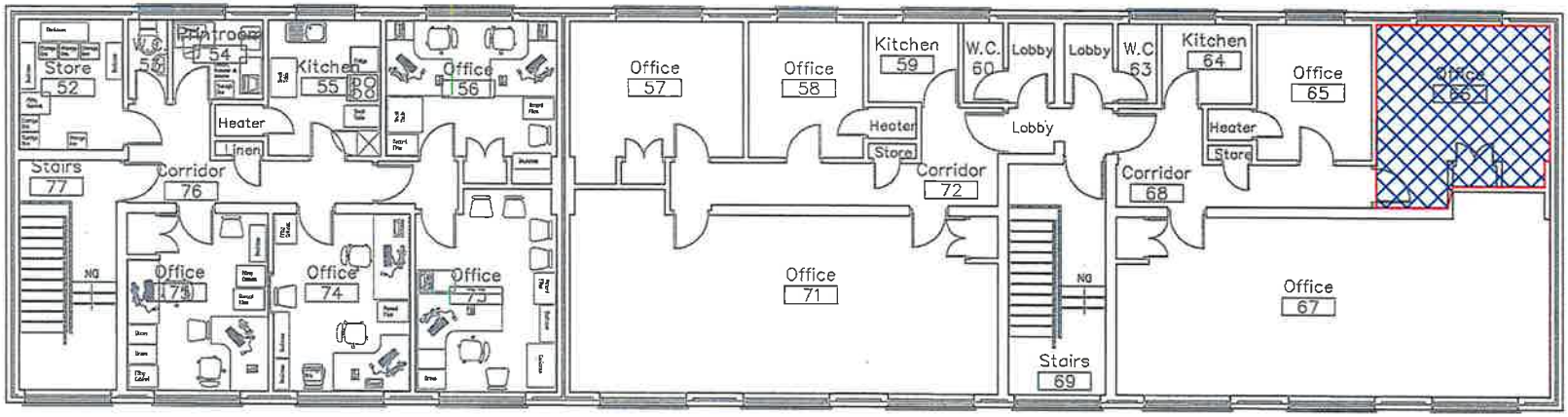
Relating to
Second Floor Premises at
Leighton Hospital
Middlewich Road
Leighton
Crewe
Cheshire
CW1 4QJ

Hill Dickinson LLP
Manchester
Ref: LPM/ RRLB/DF/99944.252

Rev.	Revision note	Date	Drawn

MD BLOCK

RED CROSS SF
BLOCK MD 13.5 m2



LEASED OUT

AS FITTED

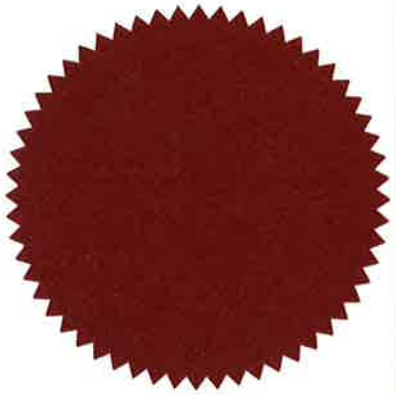
Mid Cheshire Hospitals NHS
NHS Foundation Trust

Estates and Facilities Division
Leighton Hospital, Middlewich Road,
Crewe, Cheshire, CW1 4QJ.
Tel. (01270) 612391 Fax. (01270) 211456

Location: LEIGHTON HOSPITAL MIDDLEWICH ROAD, CREWE, CHESHIRE	
Job Title: LEASED OUT DETAIL	
Drawing Title: MD BLOCK BUILDING LAYOUT (SECOND FLOOR)	
Drawn By: A.J.W	Drawing Number: 04/MO/40C
Scale: N.T.S @ A3	Revision: -
CAD Details by: -	Date: 04-01-10

DO NOT SCALE DIMENSIONS FROM THIS DRAWING

EXECUTED AS A DEED by affixing the common seal of **MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST** in the presence of:)
)
)
)



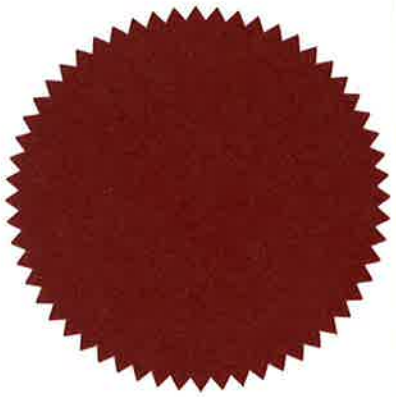
_____ Authorised signatory

_____

_____ Authorised signatory

_____

EXECUTED AS A DEED by **THE BRITISH RED CROSS SOCIETY** by the affixing of its Common Seal in the presence of:)
)
)



_____ Director:

_____

_____ Director:

_____

Mid Cheshire Hospitals NHS
NHS Foundation Trust

Title of Paper :	Organisational Risk Register Report Q1 & Q2 2017/18	
Author:	Associate Director - Integrated Governance	
Executive Lead:	Medical Director	
Type of Report:	Concept Paper	
	Strategic Options Paper	
	Business Case	
	Information	
	Review/Benefits/Audit	✓

Link to Strategic Domains:		***Link to CQC Domain:***	
Delivering Outstanding Clinical Quality, Safety & Experience	✓	Safe	✓
Being a Leading partner in a Progressive Health Economy	✓	Effective	✓
Striving for Outstanding Organisational Effectiveness	✓	Caring	
Aspiring to Excellence in Practice Through Our Workforce	✓	Responsive	✓
Creating a 21st Century Infrastructure for Transformative Health and Social Care	✓	Well-Led	✓

Link to Board Responsibility:	Performance	✓
	Accountability	✓
	Strategy	✓
	Implementation	✓
Action Required:	Decide	
	Approve	
	Note	✓
	Recommend	
	Delegate	

Positive Benefit:	A revised organisational risk register report, including risks rated 15 and above following the approval of the new Risk Management Strategy & Framework 2017/20. Further work is progressing with the development of divisional board and CCICP quarterly reports.
Risk:	Lack of oversight of key risks to achieving the Strategic Objectives.

To be published on Trust Website – complete version	***Yes***
If no, to be published on Trust Website – redacted	
If not to be published complete or redacted, please detail the reason why	
Presented at Board Meeting of:	8 January 2018

Quarterly Organisational Risk Register Report 2017/18

Quarter 1 & 2

'Delivering Excellence in Healthcare through Innovation and Collaboration'

Contents

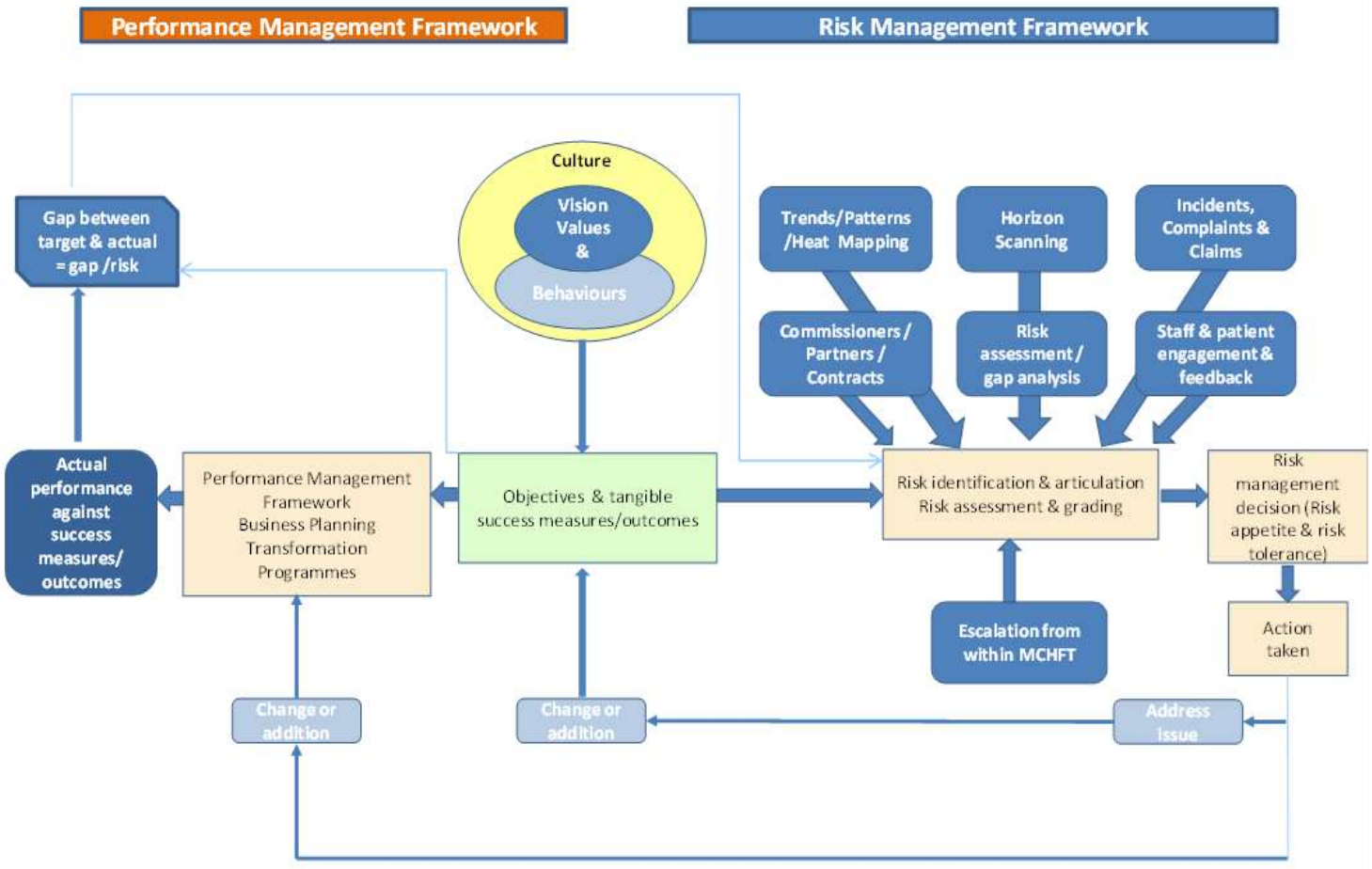
1. Purpose

The new *Risk Management Strategy & Framework 2017/20* was approved in August 2017 and forms part of the Trust's wider internal control and governance arrangements. Work on the Trust's risk management processes will be iterative over the lifetime of the strategy & framework. This report provides an overview of organisational risks rated 15 and above and a summary of progress, with detailed risks rated 20 and above included in Appendix A. Appendix B provides a progress update against the six key priorities detailed in the *Risk Management Strategy & Framework 2017/20* and Appendix C provides the summary risk matrices.

2. Current position & next steps

This is the first version of the revised quarterly organisational risk register report. In parallel divisional/CCICP level reports are being developed and presented at Divisional/CCICP Boards as first iterations for discussion and feedback during November/December 2017. Work on revising the current approach to defining risk statements to a *"There is a risk that <risk event> as a result of <cause> which may lead to <effect/impact>"* is progressing with a focus on risks rated 15 and above. With the introduction of the web based risk system and supportive education and training the aim is that all risks will be revised as they are due for review.

From quarter 3 2017/18 the organisational report will be collated following approval of the divisional / CCICP level reports. The diagram below details the relationship between the performance and planning and risk management frameworks and the linkages across. Future versions of the divisional/CCICP reports will map the risks to the local objectives (*Trust Strategy 2017 with 2020 Horizon*: Plans on a page).



3. Top five organisational risks

The top five organisational risks mapped to the Board Assurance Framework are detailed below.

Risk Title	Mitigated (With controls) Risk Rating	Shift					Key links to BAF 2017/18
		Q4 – 16/17	Q1-17/18	Q2-17/18	Q3-17/18	Q4-17/18	
Operational Sustainability of MCHFT	4(C)x4(L)=16	⇔	⇔	⇔			Q1,Q2 E1,E2 P1.P2
Sustainability of Vulnerable Clinical Services due to Lack of Resource (People & finance)	5(C)x4(L)=20	⇔	⇔	⇔			Q1,Q2 P1,P2 E2,W2
Delivering High Quality Clinical Services 7 Days per Week	5(C)x4(L)=20	⇔	⇔	⇔			Q1,Q2 P1.P2 E2,W2,T1 T2a, T2b
Long Term Financial Sustainability of MCHFT	5(C)x4(L)=20	⇔	⇔	⇔			E1,E2 P1,P2 T1 T2a, T2b
Delivering the Information Technology Strategy	4(C)x5(L)=20	⇔	⇔	⇔			Q1,Q2 E1,E2 T2a,T2b

4. New risks in the quarters 1 & 2 rated 15 & above

- EC0388 – The Risks Associated with the Loss of the Cardiac Monitoring System
- EC0396 - Lack of Service Provision within the Heart Failure Service
- EC0397 - Risks Associated with Inadequate Staffing Levels on Ward 5
- EC0399 – Ward 5 Patient Dependency (Non-Invasive Ventilation and Tracheostomy Patients)

5. Risks past the review date rated 15 & above

- None

6. Closed / de-escalated risks previously rated 15 & above

* In development

Ref	Lead	Divisional Objective*	Title	Date of Initial Assessment	Rating with existing control measures (CxL)						Rationale De-escalation / Closure	Date
					Controls Assurance Rating*	Q4 16/17	Q1	Q2	Q3	Q4	Target Rating	
DC0735	**Deputy DGM** Lee Bloomfield		Condition of Health Records	19/04/2012		4x4 ⇔ 16	4x4 ⇔ 16	4x4 ⇔ 16			4x1 = 4	*Risk closed as covered in DC0564 (Rated 12, therefore included in the Divisional level report)*	24/08/2017
73	**Service Manager** David Stokes		Staff Stress within the Breast Screening Service	27/04/2017			4x5 = 20				4x1 = 4	*Risk closed as covered by Risk 72 (Rated 16 – included in this report)*	13/06/2017
74	**Service Manager** David Stokes		Potential Financial Loss >£1m	27/04/2017			5x4 = 20				5x1 = 5	*Risk closed as covered by Risk 72 (Rated 16 – included in this report)*	13/06/2017
EC0380	**Matron** Rachel Wilkinson		Staffing levels - Ward 18	07/11/2016		4x5 ⇔ 20	4x5 ⇔ 20				4x2 = 8	*Risk closed due to ward closure.*	13/06/2017
EC0383	**Matron** Sian Axon		Nurse Staffing levels - Winter Ward	22/12/2016		4x5 ⇔ 20	4x5 ⇔ 20				4x2 = 8	*Risk closed due to ward closure*	20/04/2017
DC1006	**CCICP Manager** Philippa Wise		The Delivery of Videofluoroscopy During Upgrading of Radiology Facilities	04/08/2016		5x3 ⇔ 15	5x3 ⇔ 15				5x2 = 10	*Risk closed as room back to normal use*	31/05/2017

7. Potential new risks awaiting assessment / horizon scanning

7.1 Medicine & Emergency Care

- Escalation beds
- Out-patient appointments – Delays across multiple specialities

7.2 Surgery & Cancer

- Capped expenditure programme and potential associated impacts on quality of care and operational performance metrics (NHSI Single Oversight Framework)
- Individual assessments for staffing levels on in-patient locations currently in progress with ward managers/matrons
- Review of governance between organisations with network partners
- Potential risks associated with outputs from reviews of NICE guidance and quality standards

7.3 Diagnostics & Clinical Support Services

- Haematology Services at Macclesfield site – Staffing issues/rota coverage

7.4 Women & Children's

- Royal College of Anaesthetists recommendation – Immediate Life Support (ILS) trained staff in recovery
- Home Care Team – Manual Handling

7.5 CCICP

- Work is in progress to review and identify risk across all service lines in CCICP, with an initial report planned to go to CCICP Board in quarter 3. Initial assessments indicate higher risk areas include manual handling and staffing levels in the Urgent Care (Out of Hours) unit.

7.6 Estates & Facilities

- No high level risks identified through horizon scanning / audit processes

7.7 Corporate Services

- Risks identified through CEP / planning processes for 2018/19
- General Data Protection Regulations – April 2018

8. Organisational Risk Register - Summary on a page

The total number of risks on the risk register currently is **492**. The scores of the mitigated assessed risks are depicted in the total column on the matrix below. Detailed risks rated 20 and above are presented in Appendix A. As work on the risk register progresses to apply a more consistent approach to both the articulation of the risk, the grading and centralisation of improvement actions, it is expected a shift will be seen in the overall risk profile of the organisation.

Total number of risks – Organisational															**492**
Risk Matrix	**Likelihood**														
Impact	**1**			**2**			**3**			**4**			**5**		
	Rare			**Unlikely**			**Possible**			**Likely**			**Almost certain**		
	Score	**Total**	**%**	**Score**	**Total**	**%**	**Score**	**Total**	**%**	**Score**	**Total**	**%**	**Score**	**Total**	**%**
5 Catastrophic	**5**	**27**	**5.5%**	**10**	**102**	**20.7%**	**15**	**19**	**3.9%**	**20**	**7**	**1.4%**	**25**	**-**	**-**
4 Major	**4**	**10**	**2%**	**8**	**82**	**16.7%**	**12**	**84**	**17.1%**	**16**	**12**	**2.4%**	**20**	**7**	**1.4%**
3 Moderate	**3**	**9**	**1.8%**	**6**	**53**	**10.8%**	**9**	**33**	**6.7%**	**12**	**11**	**2.2%**	**15**	**8**	**1.6%**
2 Minor	**2**	**1**	**0.2%**	**4**	**2**	**0.4%**	**6**	**8**	**1.6%**	**8**	**5**	**1%**	**10**	**3**	**0.6%**
1 Negligible	**1**	**-**	**-**	**2**	**4**	**0.8%**	**3**	**3**	**0.6%**	**4**	**2**	**0.4%**	**5**	**1**	**0.2%**

9. Risks by Division by mitigated risk score

Division	Risks rated 20 & above	Risks rated 16	Risks rated 15	Risks rated 12	Risks rated 10 & below	Total
Medicine & Emergency Care	**8**	**4**	**7**	**14**	**26**	**59**
Surgery & Cancer	**0**	**3**	**2**	**16**	**17**	**39**
Diagnostics & Clinical Support Services	**0**	**1**	**1**	**21**	**17**	**40**
Women & Children's	**0**	**0**	**4**	**12**	**57**	**73**
CCICP	**0**	**0**	**0**	**4**	**43**	**47**
Estates & Facilities	**0**	**3**	**7**	**18**	**138**	**166**
Corporate Services	**6**	**1**	**6**	**10**	**46**	**69**
Total	**14**	**12**	**27**	**95**	**344**	**492**

10. Summary of the Organisational Risk Register by mitigated risk score (Rated 15 & above)

* In development

Reference	Lead	Divisional Objective*	Risk Title	Date of Initial Assessment	Rating with existing control measures (CxL)							Position Statement
					Controls Assurance Rating*	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Target Rating	
CS0275	**Medical Director** Dr Paul Dodds		Delivering High Quality Clinical Services 7 days per Week	29/05/ 2012		5x4 ⇔ 20	5x4 ⇔ 20	5x4 ⇔ 20			5x1 = 5	*The 7 Day Services Working Group focuses on the delivery of the national four clinical priority standards and the national bi-annual return. The next national 7 Day Audit will focus on consultant reviews within 14 hours, for all patients admitted as an emergency.*
CS0302	**Head of Information Governance** Cora Suckley		Information Governance Overarching Risk Assessment	08/08/ 2014		5x4 ⇔ 20	5x4 ⇔ 20	5x4 ⇔ 20			5x2 = 10	*Population of the Information Governance Toolkit has commenced for the March 2018 return, with oversight by the Information Governance Group.*
CS0326	**Medical Director** Dr Paul Dodds		Delivering the Information Technology Strategy	07/09/ 2015		4x5 ⇔ 20	4x5 ⇔ 20	4x5 ⇔ 20			4x2 = 8	*Retaining a risk score of 20 based upon that the business case process is still progressing.*
CS0327	**Director of Finance** Mark Oldham		Long Term Financial Sustainability of MCHFT	02/09/ 2015		5x5 ⇔ 25	5x5 ⇔ 25	5x4 ⇩ 20			5x2 = 10	*2017/18 position reduced in quarter 2 from 20 to 8 to reflect the reduced risk to the Trust following the participation in the system wide Capped Expenditure Programme (CEP), with NHS Improvement and / NHS England joint meetings in place. Long term plans- risk remains high.*

Reference	Lead	Divisional Objective*	Risk Title	Date of Initial Assessment	Rating with existing control measures (CxL)						Position Statement
					Controls Assurance Rating*	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Target Rating	
CS0328	**Medical Director** Dr Paul Dodds		Sustainability of Vulnerable Clinical Services due to Lack of Resource (People & Finance)	24/09/ 2015		5x4 ⇔ 20	5x4 ⇔ 20	5x4 ⇔ 20			5x2 = 10	*Ability to recruit to senior leadership posts remains a challenge. Reduction in risk will occur when there is a shift from locum cover to filling posts substantively.*
EC0287	**AMD** Doug Robertson		Insufficient Numbers of Junior Doctors Across the ECD Division	01/03/ 2013		5x4 ⇔ 20	5x4 ⇔ 20	5x4 ⇔ 20			5x2 = 10	*The risk is likely to reduce in quarter 3 to 15, as there has been a shift in the vacancies across the division from 8 WTE to 4 WTE.*
EC0331	**AMD** Doug Robertson		Vacancies in a Number of Difficult to Recruit Consultant Posts within the Division	03/06/ 2015		4x5 ⇔ 20	4x5 ⇔ 20	4x5 ⇔ 20			4x2 = 8	*Risk is to be closed in quarter 3 as speciality specific risk assessments are being developed which will cover this risk.*
EC0379	**Matron** Ali Barnes		Risks Associated with Inadequate Staffing Levels - Ward 2	10/11/ 2016		4x5 ⇔ 20	4x5 ⇔ 20	4x5 ⇔ 20			4x2 = 8	*Three registered nurses currently on long term sick leave and there has been a high incidence of short term sickness. The off duty is currently being reviewed regarding RN night shift cover.*

Reference	Lead	Divisional Objective*	Risk Title	Date of Initial Assessment	Rating with existing control measures (CxL)							Position Statement
					Controls Assurance Rating*	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Target Rating	
EC0384	**DGM** Tony Mayer		Lack of Service Provision Within Cardiology	29/11/ 2016		4x5 ⇔ 20	4x5 ⇔ 20	4x5 ⇔ 20			4x2 = 8	*Dr Duckett to undertake weekly session covering Dobutamine (stress) echocardiogram session. Substantive recruitment in August unsuccessful. SLA to be agreed with UHNM for weekly sessions for ward cover, OPD clinics and imaging sessions. However this is reliant on UHNM recruiting 2 WTE Consultants so will not reduce the risk in the short term for clinics as these are cancelled to prioritise consultant of the week.*
EC0386	**DGM** Tony Mayer		Lack of Service Provision Within Diabetes /Endocrinology	23/03/ 2017		4x5 ⇔ 20	4x5 ⇔ 20	4x5 ⇔ 20			4x2 = 8	*Risk assessments to be reviewed and split into separate services in quarter 3. Likely to see a risk reduction in the risks across both services.*
EC0387	**DGM** Tony Mayer		Lack of Service Provision Within Respiratory	23/03/ 2017		4x5 ⇔ 20	4x5 ⇔ 20	4x5 ⇔ 20			4x2 = 8	*There is on-going recruitment for the Respiratory Consultant vacancy. Consultant Locum positions are being sourced therefore quarter should see a shift in position. The ANP business case is being presented at October 2017 Divisional Board Meeting.*
EC0396	**DGM** Tony Mayer		Lack of Service Provision Within the Heart Failure Service	19/06/ 2017			4x5 = 20	4x5 ⇔ 20			4x2 = 8	*Progressing and anticipating shift in position next quarter. Long term sick vacancy returned, but on reduced hours. Vacancy recruited into but requires additional support.*

Reference	Lead	Divisional Objective*	Risk Title	Date of Initial Assessment	Rating with existing control measures (CxL)							Position Statement
					Controls Assurance Rating*	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Target Rating	
EC0397	**Matron** Ali Barnes		Risks associated with inadequate Staffing levels on Ward 5	19/06/ 2017			4x5 = 20	4x5 ⇔ 20			4x2 = 8	*Nurse recruitment and review of alternative roles continues as part of the Trust workforce plans, vacancy remains at 5.83wte.*
SC0591	**Clinical Services Manager** Del Owen		Increase in Haematology SACT Activity	30/06/ 2017			5x4 = 20	5x4 ⇔ 20			5x2 = 10	*The business case has been approved by the Executive Management and the nursing positions have been recruited to awaiting start dates. Pharmacy positions – recruitment in progress. Following recruitment the risk will be reduced.*
CS0325	**Chief Operating Officer** Chris Oliver		Operational Sustainability of MCHFT	09/09/ 2015		4x4 ⇔ 16	4x4 ⇔ 16	4x4 ⇔ 16			4x2 = 8	*Strong record of compliance against the Single Oversight Framework with the exception of the A&E 4 hour standard, although performance over the last twelve months has seen performance against this standard increase. There are however, significant external factors outside of the Trust's direct control which can directly impact on the Trust's ability to maintain compliance.*
DC0887	**AMD** David Butterworth		Consultant Histopathologist Capacity	24/03/ 2015		4x4 ⇔ 16	4x4 ⇔ 16	4x4 ⇔ 16			4x2 = 8	*Significant substantive consultant vacancies supported by a non-consultant workforce.*

Reference	Lead	Divisional Objective*	Risk Title	Date of Initial Assessment	Rating with existing control measures (CxL)							Position Statement
					Controls Assurance Rating*	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Target Rating	
EC0327	**Consultant Anaesthetist** Michelle Green		Lack of Secondary Anaesthetic On-Call Cover	31/07/ 2010		4x4 ⇔ 16	4x4 ⇔ 16	4x4 ⇔ 16			4x2 = 8	*The business case is awaiting discussion with the commissioners to facilitate the commissioning of the additional service. A business case has been developed and is awaiting approval for Critical Care ANPs. There is an on-going review of the emergency theatre list. There is a consultation period regarding the possibility of the flexibility for the Middle Grade Doctors to utilise some PA time to cover.*
EC0329	**Service Manager** Verity Lockett		Delivery of the 4 Hour Standard	03/06/ 2015		4x4 ⇔ 16	4x4 ⇔ 16	4x4 ⇔ 16			4x3 = 12	*Nationally the majority of Trusts are challenged with the four hour target. Over the period we have fluctuated against the standard. Work is progressing to improve the timely flow of our non –elective activity.*
EC0367	**Matron** Betty Lodge		Bedding Patients within Majors not in a Designated Cubicle	12/05/ 2016		4x4 ⇔ 16	4x4 ⇔ 16	4x4 ⇔ 16			4x2 = 8	*Review in quarter 3 anticipating closure based on incident data.*
EC0399	**Matron** Ali Barnes		Ward 5 Patient Dependency (Non-invasive ventilation and tracheostomy patients)	12/09/ 2017				4x4 = 16			4x2 = 8	*Links to risk EC0397. Recruitment continues vacancy remains at 5.83wte.*

Reference	Lead	Divisional Objective*	Risk Title	Date of Initial Assessment	Rating with existing control measures (CxL)							Position Statement
					Controls Assurance Rating*	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Target Rating	
EF0258	**Head of Facilities** Miriam Hickman		Work Place Risk Assessment, External Waste Hold	03/03/ 2010		4x4 ⇔ 16	4x4 ⇔ 16	4x4 ⇔ 16			4x2 = 8	*No change - Awaiting funding for new Waste compound.*
EF0260	**Director of E&F** Mike Babb		Loss of Mechanical Infrastructure and Associated Resources: Leighton Hospital	25/05/ 2010		4x4 ⇔ 16	4x4 ⇔ 16	4x4 ⇔ 16			4x1 = 4	*No change – Awaiting Asbestos removal.*
EF0404	**Head of Facilities** Miriam Hickman		Potential Claims relating to Reportable Occupational Disease - including Mesothelioma & Noise induced Hearing Loss	13/11/ 2014		4x4 ⇔ 16	4x4 ⇔ 16	4x4 ⇔ 16			4x2 = 8	*No change. No claims during Q1 & Q2 received.*
SC0568	**DGM** Daniel Moore		Reduced Numbers Of Middle - Junior Grade Medical Staff	08/09/2017		4x3 ⇔ 12	4x3 ⇔ 12	4x4 ⇧ 16			4x2 = 8	*Workforce planning reviews include the development of alternative roles e.g. advanced nurse practitioners and associates.*
SC0579	**Clinical Service Manager** Maureen Brown		Endoscopy Capacity and Bowel Cancer Screening 2016 and Beyond	13/09/ 2017		4x4 ⇔ 16	4x4 ⇔ 16	4x4 ⇔ 16			4x3 = 12	*Following discussion with the SMT this risk has been split to cover endoscopy and bowel screening capacity separately and this will be reflected in the Q3 report.*
SC0583	**Clinical Services Manager** Del Owen		Maintenance of Lift within the Macmillan Cancer Unit	13/09/ 2017		4x4 ⇔ 16	4x4 ⇔ 16	4x4 ⇔ 16			4x2 = 8	*Estates plans underway for resolution by April 2018.*

Reference	Lead	Divisional Objective*	Risk Title	Date of Initial Assessment	Rating with existing control measures (CxL)							Position Statement
					Controls Assurance Rating*	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Target Rating	
CS0023	**Director of Operations** Jonathan O'Brien		Influenza Type Disease Pandemic Causing Disruption to Services	26/01/ 2007		5x3 ⇔ 15	5x3 ⇔ 15	5x3 ⇔ 15			5x2 = 10	*Plan in place and reviewed on an annual basis. No recent new national guidance published.*
CS0233	**Patient Safety Manager** Sheila Townsend		Medical Devices Training	02/02/ 2011		5x3 ⇔ 15	5x3 ⇔ 15	5x3 ⇔ 15			5x1 = 5	*Self-assessment of medical equipment has been developed and rolled out following a successful pilot in the Critical Care Unit. The use of this SOP is not yet fully embedded into practice therefore the risk remains 15.*
CS0268	**Communications** Deborah Walton		Loss/Unavailability Of Switchboard Telecommunications Equipment	24/01/ 2012		5x3 ⇔ 15	5x3 ⇔ 15	5x3 ⇔ 15			5x2 = 10	*New telephony equipment is due to be in place in the next 12 months.*
CS0284	**Director of Nursing & Quality** Anne Cleary		Nursing Vacancies Across MCHFT	02/01/ 2013		5x3 ⇔ 15	5x3 ⇔ 15	5x3 ⇔ 15			5x2 = 10	*Workforce Matters Strategy in development, workforce planning programmes including international recruitment and return to nursing schemes.*
CS0294	**H&S Lead** Wendy Astle-Rowe		Sharp Instruments	21/11/ 2013		5x2 ⇔ 10	5x2 ⇔ 10	5x3 ⇧ 15			5x1 = 5	*Relates to ensuring the provision of safer sharps, training in the use and risk assessments where non-safe options are required on clinical grounds. Task & Finish Group work should bring this down to 10 for Q3.*

Reference	Lead	Divisional Objective*	Risk Title	Date of Initial Assessment	Rating with existing control measures (CxL)							Position Statement
					Controls Assurance Rating*	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Target Rating	
CS0314	**H&S Lead** Wendy Astle-Rowe		Trust Wide Fire Risk Assessment	28/04/ 2015		5x2 ⇔ 10	5x2 ⇔ 10	5x3 ⇔ 15			5x2 = 10	*This relates to the over-arching rating for the Trust relating to infrastructure and fire safety provisions. This is rated as a 15 mainly due to the infrastructure status in non-refurbished wards.*
72	**Service Manager** David Stokes		Lack of Breast Cancer Capacity due to Lack of Consultants	27/04/ 2017			4x4 = 16	4x4 ⇔ 16			4x1 = 4	*Fragmented service dependent on 2 key individuals. In house training for consultant in place.*
EC0213	**HoN** Linda Ormson		The Management of Patients who are Voicing Suicidal Thoughts	18/06/ 2010		5x3 ⇔ 15	5x3 ⇔ 15	5x3 ⇔ 15			5x2 = 10	*Risk assessment reviewed and score likely to reduce to 10 in Q3 as no reported incidents.*
EC0317	**Clinical Service Manager** Sian Axon		Delayed Discharge from Critical Care	01/02/ 2010		3x5 ⇔ 15	3x5 ⇔ 15	3x5 ⇔ 15			3x3 = 9	*Reductions in delays seen this is reviewed on a weekly basis – anticipating reduction in Q3 to reduce to 12.*

Reference	Lead	Divisional Objective*	Risk Title	Date of Initial Assessment	Rating with existing control measures (CxL)							Position Statement
					Controls Assurance Rating*	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Target Rating	
EC0369	**HoN** Linda Ormson		The Risks Associated with the Gastroenterology Ward Being Located On The 1st Floor	14/07/ 2016		5x3 ⇔ 15	5x3 ⇔ 15	5x3 ⇔ 15			5x2 = 10	*Structural work completed in Q2 and training & education embedded in practice. Anticipated to close Q3.*
EC0375	**Resuscitation Officer** Susan Barber		Automated External Defibrillator (AED)	18/11/ 2016		5x3 ⇔ 15	5x3 ⇔ 15	5x3 ⇔ 15			5x2 = 10	*Risk assessment undergoing review – anticipated to reduce following training programmes and no incident data.*
EC0378	**Theatre Manager** Emma Reay		Use of Gravity Fluid Administration Sets	15/11/ 2016		5x3 ⇔ 15	5x3 ⇔ 15	5x3 ⇔ 15			5x2 = 10	*Training now embedded. Risk likely to reduce to 10 following review of incident data in Q3.*
EC0381	**Matron** Ali Barnes		Insufficient Advanced Life Support (ALS) Covered Registered Nurses in the Coronary Care Unit (CCU)	21/11/ 2016		5x3 ⇔ 15	5x3 ⇔ 15	5x3 ⇔ 15			5x2 = 10	*The currently vacancies on Ward 1 & CCU are as follows:* *1.92 WTE Band 5 vacancy currently being appointed into.* *0.425 over establishment on HCA's* *0.96 Band 6 secondment until February 2018* *0.53 WTE band 6 being seconded to an ANP role* *Training programme in place – CCU competency programme with ALS mentor.*
EC0388	**Matron** Ali Barnes		Cardiac Monitoring System	13/06/ 2017			5x3 = 15	5x3 ⇔ 15			5x2 = 10	*During quarter 2 Philips undertook the required work on the system, incident data to be monitored and review Q3. Issues reported to the MHRA.*

Reference	Lead	Divisional Objective	Risk Title	Date of Initial Assessment	Rating with existing control measures (CxL)							Position Statement
					Controls Assurance Rating	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Target Rating	
EF0101	**Head of Estates** Paul Dyche		Legionella- Water Distribution / Temperature at Leighton Hospital	09/12/ 2010		**5x3 ⇔ 15**	**5x3 ⇔ 15**	**5x3 ⇔ 15**			**5x1 = 5**	*No change - Work continuing as part of ward /street/dept. refurbishment programme.*
EF0291	**Head of Estates** Paul Dyche		Estates Maintenance Staff - Lone Worker	24/02/ 2011		**5x3 ⇔ 15**	**5x3 ⇔ 15**	**5x3 ⇔ 15**			**5x2 = 10**	*Actions completed and risk score to reduce (10) in next quarter.*
EF0321	**Head of Facilities** Miriam Hickman		Packaging, Storage, Transportation and Disposal of Infectious Waste (burn)	13/04/ 2012		**5x3 ⇔ 15**	**5x3 ⇔ 15**	**5x3 ⇔ 15**			**5x2 = 10**	*Actions completed and risk score to reduce (10) in next quarter.*
EF0393	**Head of Estates** Paul Dyche		Continuity of MCHFT Critical Functions Identified by the Estates and Facilities Division	11/04/ 2014		**5x3 ⇔ 15**	**5x3 ⇔ 15**	**5x3 ⇔ 15**			**5x1 = 5**	*No change – Awaiting direction, funding from IDG.*
EF0411	**Head of Facilities** Miriam Hickman		Injury to Pedestrians from the Treatment Centre Pay on Foot Car Park Barriers	05/11/ 2014		**5x3 ⇔ 15**	**5x3 ⇔ 15**	**5x3 ⇔ 15**			**5x2 = 10**	*No change currently but likely to reduce in next 6 months upon installation of new barrier equipment.*

Reference	Lead	Divisional Objective*	Risk Title	Date of Initial Assessment	Rating with existing control measures (CxL)							Position Statement
					Controls Assurance Rating*	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Target Rating	
EF0415	**Head of Estates** Paul Dyche		Risk Master	15/12/ 2014		5x3 ⇔ 15	5x3 ⇔ 15	5x3 ⇔ 15			5x2 = 10	*No change – Awaiting Asbestos removal. Back log maintenance.*
EF0418	**Engineering Manager**		Infusion Pump Availability	09/01/ 2015		5x3 ⇔ 15	5x3 ⇔ 15	5x3 ⇔ 15			5x2 = 10	*No change – dependant on better system (Medical Equipment Library) being introduced.*
SC0443	**Matron** Sue Sarson		Insufficient staffing within Inpatient Locations: Ward 15	01/09/ 2011		5x3 ⇔ 15	5x3 ⇔ 15	5x3 ⇔ 15			5x2 = 10	*Trust wide nurse recruitment programme in place. Minimum staffing levels agreed within division for inpatient locations. Back fill of nursing shifts with bank and agency staff. Escalation of staffing issues to designated divisional co-ordinator.*
SC0569	**HoN** Sally Mann		Insufficient staffing within Inpatient Locations (S&C)	15/10/ 2015		4x3 ⇔ 12	5x3 ⇧ 15	5x3 ⇔ 15			5x2 = 10	*Individual inpatient location risk assessments are being progressed and will be included in the Q3 report.*
MS0153	**DGM** Mark Wilde		Fetal Anomaly Scanning	29/06/2016		3x5 ⇔ 15	3x5 ⇔ 15	3x5 ⇔ 15			3x1 = 3	*The Trust is an outlier nationally. Mitigations in place include regular training and local audit of fetal abnormalities and detection rates. No history of associated incidents reported to date. Locum sonographer route explored but recruitment unsuccessful. Plan is to advertise for a substantive post.*

Reference	Lead	Divisional Objective*	Risk Title	Date of Initial Assessment	Rating with existing control measures							Position Statement
					Controls Assurance Rating*	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Target Rating	
MS0155	**Home Birth & MLU Lead** Sarah Wedgewood		Drugs and Gases Intended for Use at Homebirth	21/09/ 2016		3x5 ⇔ 15	3x5 ⇔ 15	3x5 ⇔ 15			3x1 = 3	*Planned mitigated actions have been completed and following review it is likely the target rating will be reached in Q3.*
PG0057	**Paediatric Clinical Lead** Sarah Pyper		Inadequate Availability of Medical Staff within Paediatrics	22/04/ 2009		5x3 ⇔ 15	5x3 ⇔ 15	5x3 ⇔ 15			5x1 = 5	*Monthly review at paediatric governance group. Current rating maintained – workforce plans in place exploring alternative roles including ANNPs, ANPs and AMPs.*
PG0272	**Clinical Lead** Karen McIntyre		Inadequate Availability of Medical Staff to Cover Rotas – Obstetrics And Gynaecology	08/06/ 2016		4x3 ⇔ 12	5x3 ⇧ 15	5x3 ⇔ 15			5x2 = 10	*Monthly review at maternity governance group. Current rating maintained – workforce plans in place exploring alternative roles including ANNPs, ANPs and AMPs.*

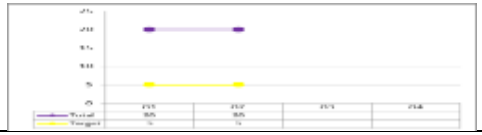
11. Risks with partner organisations (Governance / partnerships between organisations)

As part of the Risk Management Strategy & Framework 2017/20 work across partner organisations will be undertaken to understand shared risks which may impact on the quality / performance of services provided at the Trust these include:

- University Hospitals of North Midlands NHS Trust
- CCICP Partners
- East Cheshire NHS Trust
- Local Authorities
- 'One to One' Midwifery

Appendix A: Detailed Risks Rated 20 & above (*In development)

CS0275 – Delivering High Quality Clinical Services 7 Days per Week	Very Low Risk			Low Risk			Moderate Risk			High Risk		Extreme Risk	
	1	2	3	4	5	6	8	10	12	15	16	20	25
					T (5x1)							C (5x4)	I (5x5)

Potential Risk "There is a risk that <risk event> as a result of <cause> which may lead to <effect/impact>"	Lead	Control Measures	Controls Assurance Rating*	Position Statement	Original Date
Risk: Risk of harm to patient's including increased mortality rates or a delay in treatment and diagnosis **Cause:** Reduced weekend, bank holidays and out of hours services **Effect/Impact:** • Reduced bed capacity and patient flow • Poor patient experience • Poor patient outcomes • Increase in staff sickness and absence • Non delivery of NHSI Single Oversight Performance Standards • Increased length of stay	**Medical Director** Dr Paul Dodds	1. Trust Escalation Policy 2. Clinical pathways 3. 7 days/week for emergency and critically ill patients 4. 7 Day Services Working Group 5. Access to diagnostics out of hours 6. On call pharmacist. 7. Level 2 and Level 3 critical care beds 8. Consultants rotas provide 7 days/week on call 9. Exec / SMOC 7 days/week on call cover 10. Critical care outreach service 7 days/week 11. Night Nurse Practitioner service 12. Clinical Site Managers. 13. 7 days/week medical and nursing cover. 14. Increasing shop floor time for ED Consultants "out of hours". 15. Doubling up of Consultant Physicians for part of weekend. 16. Separating of Consultant Anaesthetist rotas to establish specific Critical Care on call rota. 17. Command and control structure to communicate with the wider healthcare community regarding capacity issues. 18. Urgent Care Centre 19. Daily Bed Management 20. Dedicated discharge liaison team		*The 7 Day Services Working Group focuses on the delivery of the national four clinical priority standards and the national bi-annual return. The next national 7 Day Audit will focus on consultant reviews within 14 hours, for all patients admitted as an emergency.* **Shift Position** 	29/05/2012 **Review Frequency** Monthly **Monitoring Group** Executive Quality Governance Group **Risk Source** Risk Assessment **Version** 4 **BAF Links** Q1, Q2, E1, E2, W1, W2, W3 **Shift** **2016-17** Q1 20 ► Q2 20 ► Q3 20 ► Q4 20 ► **2017-18** Q1 20 ► Q2 20 ► Q3 Q4

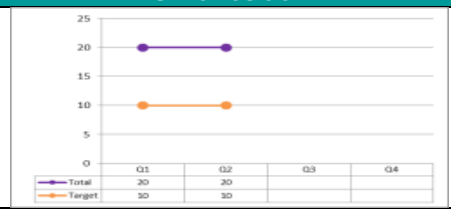
Key:

I = Initial Risk Rating
▲ = Risk rating has increased since previous quarter

C = Current Risk Rating
► = No change from previous quarter

T = Target Risk Rating
▼ = Risk rating has decreased since previous quarter

Summary: CS0302 – Information Governance Overarching Risk Assessment	Very Low Risk			Low Risk			Moderate Risk			High Risk		Extreme Risk	
	1	2	3	4	5	6	8	10	12	15	16	20	25
								T (5x2)				C (5x4)	I (5x5)

Potential Risk "There is a risk that <risk event> as a result of <cause> which may lead to <effect/impact>"	Lead	Control Measures	Controls Assurance Rating	Position Statement	Original Date
Risk: Risk of a breach of the obligation to process information fairly and lawfully in line with the principles of the Data Protection Act 1998 and other associated regulations. **Cause:** Failure to adequately protect data/information in line with regulations. **Effect/Impact:** • Unsatisfactory Information Governance Toolkit rating • Reporting required to Information Commissioners Office • Financial penalties • Reputational risks	**Head of Information Governance** Cora Suckley	1. Privacy Impact Assessment Procedure 2. Information Governance Training 3. Confidentiality and Data Protection Policy 4. Information Governance Handbook 5. Information Governance and Clinical Audit Guidance leaflet for staff 6. Bedside Folder (containing relevant paragraphs) relating to the management of personal information 7. Information sharing agreements signed off by Caldecott Guardian for all sharing of information. 8. Health Records Management Policy 9. Corporate Records Management Policy 10. Access to Health Records Policy 11. Confidentiality and Data Protection Policy 12. ICT Policies 13. Audits can be run on Patient Administration System if concerns are raised. 14. Websense software implemented 15. Review of IG Toolkit. Toolkit Action Plan drawn up and leads identified. Toolkit progress is monitored at Information Governance Group.		*Population of the Information Governance Toolkit has commenced for the March 2018 return, with oversight by the Information Governance Group.*	08/08/2014 **Review Frequency** Monthly **Monitoring Group** Executive Quality Governance Group **Risk Source** Risk Assessment **Version** 2 **BAF Links** T2 a & b **Shift** **2016-17** Q1 15 ► Q2 20 ▲ Q3 20 ► Q4 20 ► **2017-18** Q1 20 ► Q2 20 ► Q3 Q4 **Shift Position** 

Key:

I = Initial Risk Rating
▲ = Risk rating has increased since previous quarter

C = Current Risk Rating
► = No change from previous quarter

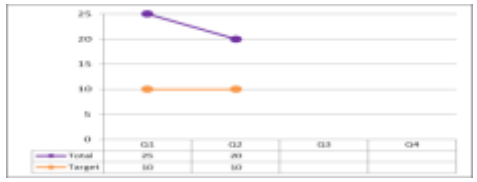
T = Target Risk Rating
▼ = Risk rating has decreased since previous quarter

CS0326 – Delivering the Information Technology Strategy	Very Low Risk			Low Risk			Moderate Risk			High Risk		Extreme Risk	
	1	2	3	4	5	6	8	10	12	15	16	20	25
							T (4x2)					I & C (4x5)	

Potential Risk "There is a risk that <risk event> as a result of <cause> which may lead to <effect/impact>"	Lead	Control Measures	Controls Assurance Rating	Position Statement	Original Date
Risk: Failure to improve the quality of care and patient safety due to not being able to share information quickly and effectively, there is a potential to inadvertently incorrectly treat a patient. **Cause:** Continuing to rely on the use of paper records. **Effect/Impact:** • Poor quality of care • Poor patient experience • Inability to transform and modernise services • Delays in completing horizontal and vertical integration • Continued lack of access to the medical records from home leading to delays • Reputational risks • We will not be seen as 'progressive' and could possibly miss out on other external funding streams. • Difficulty in recruiting clinical staff who expect EPR system to be in place.	**Medical Director** Dr Paul Dodds	1. GP patient record electronically via Docman. 2. Case notes are tracked using the Trust's Patient Administration System 3. Major investments in IT infrastructure. These include Trust-Wide Wi-Fi, new core network and virtualised server infrastructure which has increased our disaster recovery capabilities 4. Policies & procedures for Health Records		*Retaining a risk score of 20 based upon that the business case process is still progressing.*	07/09/2015 **Review Frequency** Monthly **Monitoring Group** Executive Quality Governance Group **Risk Source** Risk Assessment **Version** 1 **BAF Links** T2a, T2b & E2 **Shift**

Shift		
2016-17		
Q1	20	►
Q2	20	►
Q3	20	►
Q4	20	►
2017-18		
Q1	20	►
Q2	20	►
Q3		
Q4		

Shift Position



Key: I = Initial Risk Rating ▲ = Risk rating has increased since previous quarter

C = Current Risk Rating ► = No change from previous quarter

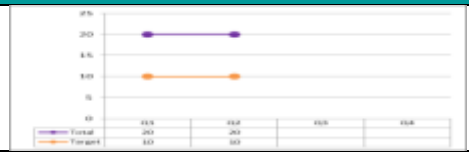
T = Target Risk Rating ▼ = Risk rating has decreased since previous quarter

CS0327 – Long Term Financial Sustainability of MCHFT	Very Low Risk			Low Risk			Moderate Risk			High Risk		Extreme Risk	
	1	2	3	4	5	6	8	10	12	15	16	20	25
								T (5x2)				C (5x4)	I (5x5)

Potential Risk "There is a risk that <risk event> as a result of <cause> which may lead to <effect/impact>"	Lead	Control Measures	Controls Assurance Rating	Position Statement	Original Date
Risk: The Trust becomes financially unsustainable **Cause:** • Non Delivery of CIP targets • Underperformance on Elective Activity • Increasing premium costs of staff to cover gaps • Non Electivity Demand outstripping bed capacity • Loss of contracts due to competition • Increasing efficiency requirements in the National Tariff **Effect/Impact:** • Cash flow implications of deteriorating trading position • Quality & performance of services	**Director of Finance** Mark Oldham	1. Monthly CIP performance meetings 2. Quality Impact Assessment of CIP schemes 3. Theatre Productivity Group plans 4. Cash flow monitoring and debt collection processes 5. Budget meetings on monthly basis 6. Recruitment initiatives (foreign and domestic) and Premia incentives 7. Tendering for services (new and existing) 8. Stronger Together Programme 9. Weekly performance meetings re: activity delivery 10. Annual Plan 11. Trust Strategy & local plans 12. Borrowings in place for key schemes		*2017/18 position reduced in quarter 2 from 20 to 8 to reflect the reduced risk to the Trust following the participation in the system wide Capped Expenditure Programme (CEP), with NHS Improvement and / NHS England joint meetings in place. Long term plans- risk remains high.*	29/05/2012 **Review Frequency** Monthly **Monitoring Group** Executive Quality Governance Group **Risk Source** Risk Assessment **Version** 2 **BAF Links** Q1, Q2, P1, P2, E1, E2, W1, T1, T2a, T2b

Shift		
2016-17		
Q1	25	►
Q2	25	►
Q3	25	►
Q4	25	►
2017-18		
Q1	25	►
Q2	20	▼
Q3		
Q4		

Shift Position



Key: I = Initial Risk Rating; C = Current Risk Rating; T = Target Risk Rating

▲ = Risk rating has increased since previous quarter

► = No change from previous quarter

▼ = Risk rating has decreased since previous quarter

CS0328 – Sustainability of Vulnerable Clinical Services due to Lack of Resource (People & finance)	Very Low Risk			Low Risk			Moderate Risk			High Risk		Extreme Risk	
	1	2	3	4	5	6	8	10	12	15	16	20	25
								T (5x2)				C (5x4)	I (5x5)

Potential Risk "There is a risk that <risk event> as a result of <cause> which may lead to <effect/impact>"	Lead	Control Measures	Controls Assurance Rating	Position Statement	Original Date
Risk: Failure to maintain essential clinical services **Cause:** Vulnerability of key clinical specialities – difficult to recruit posts (e.g. Gastroenterology; Histopathology and Radiology) **Effect/Impact:** • Poor quality of care and lack of services • Significant financial impact to the Trust due to the vulnerability of the identified clinical services	**Medical Director** Dr Paul Dodds	1. Stronger Together Programme. 2. Annual Plan. 3. Trust Strategy. 4. Recruitment initiatives (foreign and domestic) and Premia incentives. 5. Workforce planning – alternative roles 6. Partnership working		*Ability to recruit to senior leadership posts remains a challenge. Reduction in risk will occur when there is a shift from locum cover to filling posts substantively.*	24/09/2015 **Review Frequency** Monthly **Monitoring Group** Executive Quality Governance Group **Risk Source** Risk Assessment **Version** 2 **BAF Links** Q1, Q2, P1, P2, E1, E2, W1, W2, W3

Shift		
2016-17		
Q1	20	►
Q2	20	►
Q3	20	►
Q4	20	►
2017-18		
Q1	20	►
Q2	20	►
Q3		
Q4		

Shift Position

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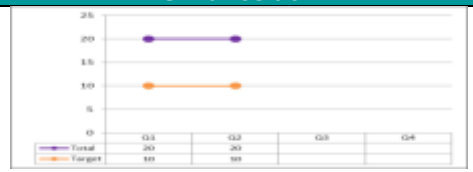
T = Target Risk Rating ▼ = Risk rating has decreased since previous quarter

EC0287 – Risks associated with Insufficient Numbers of Junior Doctors Across the Medicine and Emergency Care Division	Very Low Risk			Low Risk			Moderate Risk			High Risk		Extreme Risk	
	1	2	3	4	5	6	8	10	12	15	16	20	25
								T (5x2)				C (5x4)	I (5x5)

Potential Risk "There is a risk that <risk event> as a result of <cause> which may lead to <effect/impact>"	Lead	Control Measures	Controls Assurance Rating	Position Statement	Original Date
Risk: Insufficient numbers of junior Doctors across the Division. **Cause:** Lack of sufficient medical workforce due to vacancies. **Effect/impact:** • Potential patient safety harm due to delays in medical review/treatment • Non-compliance with National Guidance and Best Practice Standards for patient care. • Reduced quality of care. • Reduction in access and flow targets. • Potential breaches within European Working Time directives. • Potential breaches with RTT. • Potential lack of on call cover. • Potential impact on service provision, quality of care and patient experience. • Financial implications due to increased use of locum agency.	**AMD** Doug Robertson	1. Use of locum agencies 2. On-going recruitment 3. On-going job planning within the Division 4. Forward planning of on call rota 5. Consultant to cover when no Medical Registrar available 6. Access and flow meetings and length of stay monitored 7. RTT monitored within the Division 8. Monitoring of the 4 hour target.		*The risk is likely to reduce in quarter 3 to 15, as there has been a shift in the vacancies across the division from 8 WTE to 4 WTE.*	01/03/2013 **Review Frequency** Monthly **Monitoring Group** Executive Quality Governance Group **Risk Source** Risk Assessment **Version** 8 **BAF Links** Q1, Q2, E2, W1, W2, W3

Shift		
2016-17		
Q1	20	►
Q2	20	►
Q3	20	►
Q4	20	►
2017-18		
Q1	20	►
Q2	20	►
Q3		
Q4		

Shift Position



Key: I = Initial Risk Rating ▲ = Risk rating has increased since previous quarter

C = Current Risk Rating ► = No change from previous quarter

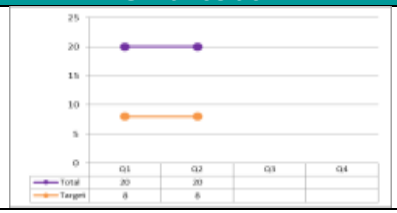
T = Target Risk Rating ▼ = Risk rating has decreased since previous quarter

EC0331 - Vacancies in a Number of Difficult to Recruit Consultant Posts within the Medicine and Emergency Care Division	Very Low Risk			Low Risk			Moderate Risk			High Risk		Extreme Risk	
	1	2	3	4	5	6	8	10	12	15	16	20	25
							T (4x2)					I&C (4x5)	

Potential Risk "There is a risk that <risk event> as a result of <cause> which may lead to <effect/impact>"	Lead	Control Measures	Controls Assurance Rating	Position Statement	Original Date
Risk: Insufficient numbers of Consultants across some specialities within the Division. **Cause:** Inability to recruit into the Consultant vacancies. **Effect/impact:** • Potential patient safety harm due to delays in medical review/treatment • Non-compliance with National Guidance and Best Practice Standards for patient care. • Reduced quality of care. • Inability to comply with 7 day working. • Reduction in access and flow targets. • Potential breaches within European Working Time directives. • Potential breaches with RTT. • Potential lack of on call cover. • Potential impact on service provision, quality of care and patient experience. • Financial implications due to increased use of locum agency. • Increase in work related stress. • Potential reduction in deanery allocation.	**AMD** Doug Robertson	1. On-going recruitment. 2. Use of locum agencies. 3. On-going job planning within the Division. 4. Forward planning of on call rota. 5. Consultant to cover when no Medical Registrar available. 6. Access and flow meetings and length of stay monitored. 7. RTT monitored within the Division. 8. Monitoring of the 4 hour target.		*Risk is to be closed in quarter 3 as speciality specific risk assessments developed.*	03/06/2015 **Review Frequency** Monthly **Monitoring Group** Executive Quality Governance Group **Risk Source** Risk Assessment **Version** 6 **BAF Links** Q1, Q2, E2, W1, W2, W3

Shift		
2016-17		
Q1	20	►
Q2	20	►
Q3	20	►
Q4	20	►
2017-18		
Q1	20	►
Q2	20	►
Q3		
Q4		

Shift Position



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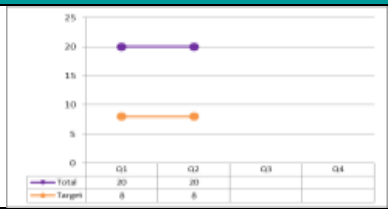
T = Target Risk Rating ▼ = Risk rating has decreased since previous quarter

EC0379 – Risks Associated with Inadequate Staffing Levels – Ward 2 in the Medicine and Emergency Care Division	Very Low Risk			Low Risk			Moderate Risk			High Risk		Extreme Risk	
	1	2	3	4	5	6	8	10	12	15	16	20	25
							T (4x2)					I&C (4x5)	

Potential Risk "There is a risk that <risk event> as a result of <cause> which may lead to <effect/impact>"	Lead	Control Measures	Controls Assurance Rating	Position Statement	Original Date
Risk: Inadequate staffing ratio on Ward 2. **Cause:** Due to the impact of long/short term sick leave. **Effect/impact:** • Potential impact on service provision, quality of care and patient experience. • Potential patient safety harm due to delays in nursing review/intervention • Reduced quality of care • Increased work related stress • Higher incident reporting • Increased length of stay • Financial implications with increased use of agency staff • Potential delays in the completion of training and staff appraisals • Potential for inappropriate skill mix	**Matron** Ali Barnes	1. Daily staffing review undertaken by the Matrons within the Division. 2. Ward escalation to Matrons when gaps present in rota. 3. Ward Managers within the Division review off duty to review the skill mix. 4. Ward 2 co-ordinator/Band 6 will attend AMU to review patients prior to transfer to assess the suitability. 5. Use of Nurse Bank and Agency staff. 6. Pharmacy technician utilised on Ward 2. 7. Ward Manager can refer staff to Occupational Health following episodes of sickness. 8. Return to work interviews completed. 9. Safety huddles.		*Three registered nurses currently on long term sick leave and there has been a high incidence of short term sickness. The off duty is currently being reviewed regarding RN night shift cover.*	10/11/2016 **Review Frequency** Monthly **Monitoring Group** Executive Quality Governance Group **Risk Source** Risk Assessment **Version** 2 **BAF Links** Q1, Q2, W1,W2.W3 **Shift** **2016-17** Q1 — Q2 — Q3 20 ► Q4 20 ► **2017-18** Q1 20 ► Q2 20 ► Q3 Q4 **Shift Position** 

Key:

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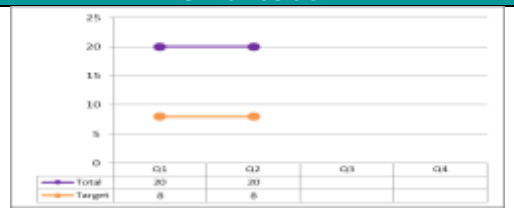
T = Target Risk Rating
▼ = Risk rating has decreased since previous quarter

EC0384 – Lack of Service Provision within Cardiology in the Medicine and Emergency Care Division	Very Low Risk			Low Risk			Moderate Risk			High Risk		Extreme Risk	
	1	2	3	4	5	6	8	10	12	15	16	20	25
							T (4x2)					I&C (4x5)	

Potential Risk "There is a risk that <risk event> as a result of <cause> which may lead to <effect/impact>"	Lead	Control Measures	Controls Assurance Rating	Position Statement	Original Date
Risk: Insufficient numbers of Consultant Cardiologists within the Division. **Cause:** Inability to recruit Consultant Cardiologists. **Effect/impact:** • Potential patient safety harm due to delays in medical review/treatment • Non-compliance with National Guidance and Best Practice Standards for patient care • Reduced quality of care • Inability to deliver 7 day services • Reduction in access and flow targets • Potential breaches within European Working Time directives • Potential breaches with RTT • Potential lack of on call cover • Potential impact on service provision, quality of care and patient experience • Financial implications due to increased use of locum agency • Increase in work related stress • Reduction in deanery allocation • Failure to comply with the 6 week diagnostic wait time for DSE & TOE • Unable to provide emergency inpatient TOE service • Reduction within the service provision for heart failure	**DGM** Tony Mayer	1. On-going recruitment. 2. Use of Locum Consultants. 3. Partnership agreements with UHNM. 4. On-going job planning within the Division. 5. Forward planning of on call rota. 6. Access and flow meetings and length of stay monitored. 7. RTT monitored within the Division. 8. Weekly DSE sessions being delivered.		*Dr Duckett to undertake weekly session covering Dobutamine (stress) echocardiogram session. Substantive recruitment in August unsuccessful. SLA to be agreed with UHNM for weekly sessions for ward cover, OPD clinics and imaging sessions. However this is reliant on UHNM recruiting 2 WTE Consultants so will not reduce the risk in the short term for clinics as these are cancelled to prioritise consultant of the week.*	29/11/2016 **Review Frequency** Monthly **Monitoring Group** Executive Quality Governance Group **Risk Source** Risk Assessment **Version** 2 **BAF Links** Q1, Q2, E2, W1, W2

Shift		
2016-17		
Q1		
Q2		
Q3	20	►
Q4	20	►
2017-18		
Q1	20	►
Q2	20	►
Q3		
Q4		

Shift Position



Key: I = Initial Risk Rating; C = Current Risk Rating; T = Target Risk Rating

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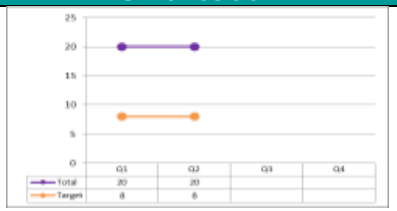
► = No change from previous quarter

▼ = Risk rating has decreased since previous quarter

EC0386 – Lack of Service Provision within Diabetes/Endocrinology in the Medicine and Emergency Care Division	Very Low Risk			Low Risk			Moderate Risk			High Risk		Extreme Risk	
	1	2	3	4	5	6	8	10	12	15	16	20	25
							T (4x2)					I&C (4x5)	

Potential Risk "There is a risk that <risk event> as a result of <cause> which may lead to <effect/impact>"	Lead	Control Measures	Controls Assurance Rating	Position Statement	Original Date
Risk: Insufficient numbers of Consultant Diabetologists/Endocrinologists within the Division. **Cause:** Inability to recruit Consultant Diabetologists/Endocrinologists. **Effect/impact:** • Potential patient safety harm due to delays in medical review/treatment • Non-compliance with National Guidance and Best Practice Standards for patient care • Reduced quality of care • Inability to comply with 7 services. • Reduction in access and flow targets • Potential breaches within European Working Time directives • Potential breaches with RTT • Potential impact on service provision, quality of care and patient experience. • Financial implications due to increased use of locum agency • Increase in work related stress • Potential reduction in deanery allocation • Potential failure to meet Antenatal National and Trust recommendations for Diabetology review in clinic	**DGM** Tony Mayer	**Diabetology:** • Secure locum position • Explore partnership working with external Trust- sessional and joint posts • Explore ways of delivering the service e.g implementation of additional ANPs/clinical nurse specialist • Task and finish group established to explore ways to develop the service and the substantive recruitment process. • Management of patients within the community by Diabetes Specialist Nurses. • To gain support from the Divisional AMD and the Clinical Lead for Internal Medicine who have Diabetes as their specialism. • Access and flow meetings and length of stay monitored. • RTT monitored within the Division. • On-going job planning within the Division. • Review of Antenatal SLA. **Endocrinology:** • To gain support from the Divisional AMD who has Endocrinology as their specialism. • Access and flow meetings and length of stay monitored. • RTT monitored within the Division. • On-going job planning within the Division. • Virtual clinics.		*Risk assessments to be reviewed and split into separate services in quarter 3. Likely to see a risk reduction in the risks across both services.*	23/03/2017 **Review Frequency** Monthly **Monitoring Group** Executive Quality Governance Group **Risk Source** Risk Assessment **Version** 1 **BAF Links** Q1, Q2, E2, W1, W2 **Shift** **2016-17** Q1 Q2 Q3 Q4 20 ► **2017-18** Q1 20 ► Q2 20 ► Q3 Q4 **Shift Position** 

Key:

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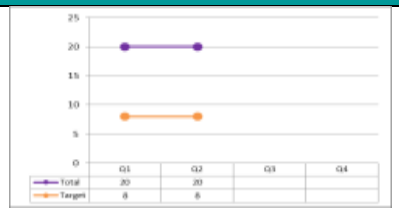
C = Current Risk Rating
► = No change from previous quarter

T = Target Risk Rating
▼ = Risk rating has decreased since previous quarter

EC0387 - Lack of Service Provision within Respiratory in the Medicine and Emergency Care Division	Very Low Risk			Low Risk			Moderate Risk			High Risk		Extreme Risk	
	1	2	3	4	5	6	8	10	12	15	16	20	25
							T (4x2)					I&C (4x5)	

Potential Risk "There is a risk that <risk event> as a result of <cause> which may lead to <effect/impact>"	Lead	Control Measures	Controls Assurance Rating	Position Statement	Original Date
Risk: Insufficient numbers of Consultant Respiratory Physicians within the Division. **Cause:** Inability to recruit Consultant Respiratory Physicians. **Effect/impact:** • Potential patient safety harm due to delays in medical review/treatment • Non-compliance with National Guidance and Best Practice Standards for patient care. • Reduced quality of care. • Inability to deliver 7 day services • Reduction in access and flow targets. • Potential breaches within European Working Time directives. • Potential breaches with RTT. • Potential impact on service provision, quality of care and patient experience. • Financial implications due to increased use of locum agency. • Increase in work related stress. • Potential reduction in deanery allocation. • Failure to achieve cancer targets. • Implementation of EBUS locally • Implementation of the sleep service • Implementation of medical thoracoscopy • Delivery of the pleural service	**DGM** Tony Mayer	1. On-going recruitment. 2. Use of Locum Consultants. 3. To explore Partnership agreements with external Trusts. 4. On-going job planning within the Division. 5. Forward planning of on call rota. 6. Access and flow meetings and length of stay monitored. 7. RTT monitored within the Division. 8. Task & finish group initiated. 9. ANP business case approved at Divisional Board.		*There is on-going recruitment for the Respiratory Consultant vacancy. Consultant Locum positions are being sourced therefore quarter should see a shift in position. The ANP business case is being presented at October 2017 Divisional Board Meeting.*	23/03/2017 **Review Frequency** Monthly **Monitoring Group** Executive Quality Governance Group **Risk Source** Risk Assessment **Version** 1 **BAF Links** Q1, Q2, E2, W1, W2 **Shift** **2016-17** Q1 — Q2 — Q3 — Q4 20 ► **2017-18** Q1 20 ► Q2 20 ► Q3 Q4 **Shift Position** 

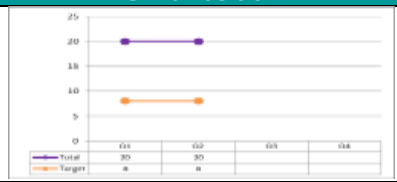
Key:

I = Initial Risk Rating
▲ = Risk rating has increased since previous quarter

C = Current Risk Rating
► = No change from previous quarter

T = Target Risk Rating
▼ = Risk rating has decreased since previous quarter

EC0396 - Lack of Service Provision within the Heart Failure Service in the Medicine and Emergency Care Division	Very Low Risk			Low Risk			Moderate Risk			High Risk		Extreme Risk	
	1	2	3	4	5	6	8	10	12	15	16	20	25
							T (4x2)					I&C (4x5)	

Potential Risk "There is a risk that <risk event> as a result of <cause> which may lead to <effect/impact>"	Lead	Control Measures	Controls Assurance Rating	Position Statement	Original Date
Risk: Failure to deliver the heart failure service. **Cause:** Due to the impact of long term sick leave and vacancy post. **Effect/impact:** • Potential patient safety harm due to delays in nursing review/treatment • Non-compliance with National Guidance and Best Practice Standards for patient care. • Reduced quality of care. • Reduction in access and flow targets. • Potential breaches within European Working Time directives. • Potential breaches with RTT. • Potential impact on service provision, quality of care and patient experience. • Increase in work related stress. • Reduction within the service provision for heart failure. • Increased administration work.	**DGM** Tony Mayer	1. Advanced Nurse Practitioners to be utilised within the Heart Failure service 2. Partnership agreement. 3. Recruitment into vacancy position 4. Occupational Health supporting return to work 5. Access and flow meetings and length of stay monitored 6. RTT monitored within the Division		*Progressing and anticipating shift in position next quarter. Long term sick vacancy returned, but on reduced hours. Vacancy recruited into but requires additional support.*	19/06/2017 **Review Frequency** Monthly **Monitoring Group** Executive Quality Governance Group **Risk Source** Risk Assessment **Version** 1 **BAF Links** Q1, Q2, E2, W1, W2, W3 **Shift** **2016-17** Q1 Q2 Q3 Q4 **2017-18** Q1 20 ► Q2 20 ► Q3 Q4 **Shift Position** 

Key: I = Initial Risk Rating ▲ = Risk rating has increased since previous quarter

C = Current Risk Rating ► = No change from previous quarter

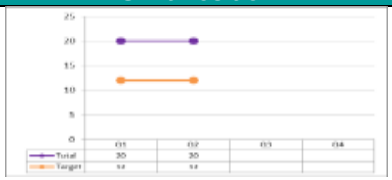
T = Target Risk Rating ▼ = Risk rating has decreased since previous quarter

EC0397 – Inadequate Staffing Levels on Ward 5 in the Medicine and Emergency Care Division	Very Low Risk			Low Risk			Moderate Risk			High Risk		Extreme Risk	
	1	2	3	4	5	6	8	10	12	15	16	20	25
							T (4x2)					I&C (4x5)	

Potential Risk "There is a risk that <risk event> as a result of <cause> which may lead to <effect/impact>"	Lead	Control Measures	Controls Assurance Rating	Position Statement	Original Date
Risk: Inadequate staffing ratio on ward 5. **Cause:** Due to the budgeted establishment not being achieved. **Effect/impact:** • Potential impact on service provision, quality of care and patient experience • Potential patient safety harm due to delays in nursing review/intervention • Reduced quality of care • Increased work related stress • Higher incident reporting • Increased length of stay • Financial implications with increased use of agency staff • Potential delays in the completion of training and staff appraisals • Potential for inappropriate skill mix • Unable to facilitate NIV treatment	**Matron** Ali Barnes	1. On-going recruitment 2. Daily staffing review undertaken by the Matrons within the Division 3. Ward escalation to Matrons when gaps present in rota 4. Ward Managers within the Division review off duty to review the skill mix. 5. Use of Nurse Bank and Agency staff. 6. Planned implementation for a Pharmacy technician to be utilised on Ward 5 7. Safety huddles 8. Involvement of Critical Care to facilitate NIV where appropriate 9. ANP business case approval		*Nurse recruitment and review of alternative roles continues as part of the Trust workforce plans, vacancy remains at 5.83 WTE.*	19/06/2017 **Review Frequency** Monthly **Monitoring Group** Executive Quality Governance Group **Risk Source** Risk Assessment **Version** 1 **BAF Links** Q1, Q2, E2, W1, W2, W3

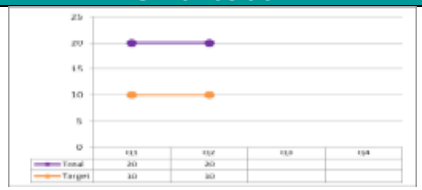
Shift		
2016-17		
Q1		
Q2		
Q3		
Q4		
2017-18		
Q1	20	►
Q2	20	►
Q3		
Q4		

Shift Position



Key: I = Initial Risk Rating ▲ = Risk rating has increased since previous quarter | C = Current Risk Rating ► = No change from previous quarter | T = Target Risk Rating ▼ = Risk rating has decreased since previous quarter

SC0591 – Increase in Haematology SACT Activity in the Surgery & Cancer Division	Very Low Risk			Low Risk			Moderate Risk			High Risk		Extreme Risk	
	1	2	3	4	5	6	8	10	12	15	16	20	25
								T (5x2)				C (5x4)	I (5x5)

Potential Risk "There is a risk that <risk event> as a result of <cause> which may lead to <effect/impact>"	Lead	Control Measures	Controls Assurance Rating	Position Statement	Original Date
Risk Potential risk that patient's requiring SACT for haematological experience delays within the cancer pathway **Cause** Insufficient capacity to meet demand **Effect/Impact** • Timeliness of the care the patient's receive • Failure to achieve the 31-day cancer target • Patient's travelling to other centres to receive care • Temporary loss of acute oncology nurse led service • Breach of SLA arrangements with specialist centres • Increase of staff stress due to workload • Non-compliance with NHS England Quality Surveillance Programme	**DGM** Dan Moore S&C **DGM** Julie Weir DCSS	1. Utilisation of Acute Oncology Nurse Specialist Team for SACT administration. Utilisation of designated non-clinical management time for the Lead Chemotherapy Nurse and Chemotherapy Sister. 2. Utilisation of staffing allocated and funded to deliver SACT solid tumour activity under SLA for The Christie. 3. Utilisation of designated non-clinical management time for the Lead Chemotherapy Nurse and Chemotherapy Sister. 4. Limited support from Oncology Pharmacist due to vacancy and Maternity Leave within Pharmacy Dept.		*The business case has been approved by the Executive Management and the nursing positions have been recruited to awaiting start dates. Pharmacy positions – recruitment in progress. Following recruitment the risk will be reduced.*	30/06/2017 **Review Frequency** Monthly **Monitoring Group** Executive Quality Governance Group **Risk Source** Risk Assessment **Version** 1 **BAF Links** Q1,Q2,E1, E2, W1,W2.W3 **Shift** **2016-17** Q1 Q2 Q3 Q4 **2017-18** Q1 20 ▶ Q2 20 ▶ Q3 Q4 **Shift Position** 

Key:

I = Initial Risk Rating
▲ = Risk rating has increased since previous quarter

C = Current Risk Rating
► = No change from previous quarter

T = Target Risk Rating
▼ = Risk rating has decreased since previous quarter

Table 1

Table 1: Improvement plans – Classification of progress		
Colour	Narrative	Description
B	Blue 'Complete/BAU'	Completed: Improvement / action delivered. Business as usual with sustainability, monitoring and assurances in place.
G	Green 'On track'	Improvement on track/trajectory either: a) On track - not yet completed. b) On track – not yet started.
A	Amber 'Problematic'	Delivery remains feasible issues / risks require additional intervention to deliver the required improvement. E.g. Milestones breached.
R	Red 'Delayed'	Off track/trajectory – milestone / timescales breached. Recovery plan required.

Appendix B - Progress against the Risk Management Strategy & Framework (2017/20) priorities

Progress against the key priorities for 2017/18 is detailed below, with the classification of progress included in Table 1 above.

Priority	Key areas 2017/19	Position	Commentary
1. New Risk Management Strategy & Framework 2017/20	• Categorisation matrix review (Part of the Incident Report & Management Policy)	On track: Not yet completed	• Executive Quality Governance Group (EQGG) December 2017
	• Revise Risk Assessment Procedure	On track: Not yet started	• Planned February 2018
	• Start to review governance between organisations	On track: Not yet completed	• In progress
	• Revise organisational quarterly risk register report	On track: Not yet completed	• First iteration to EQGG November 2017 • Quality Governance Committee (QGC)December 2017
	• Implement quarterly divisional / CCICP risk register reports	On track: Not yet completed	• First iterations to Boards in November / December 2017
	• Implement risk approval process for risk rated 15 & above	Completed	• Standing agenda item on EQGG. Gate keeper system in place for approval at Divisional Boards/CCICP
	• Develop training needs analysis and risk based approach	On track: Not yet completed	• Roll out with online risk assessment process by March 2018
	• Review the Risk Management Early Warning System	On track: Not yet started	• Planned May 2018
2. New Board Assurance Framework (BAF)	• Development of a new dynamic BAF aligned to the 'Three Lines of Defence' model and mapping process	On track: Not yet completed	• First iteration to Board of Directors – November 2017 • Sub-committee review in detail • Summary version to Board of Directors from Q3 2017/18 • Quarterly assurance mapping process commenced • Web based version planned March 2017
3. Review of Risk Registers	• Apply new approach to risk descriptors: "There is a risk that <risk event> as a result of <cause> which may lead to <effect/impact>"	On track: Not yet completed	• Risks rated 15 & above prioritised and all new risks described as per strategy & framework. All risks to be re written through review process
	• Link to organisational or divisional objectives	On track: Not yet completed	• Risk rated 12 & above prioritised
	• Initial review of divisional risk registers	Completed	• Initial reviews undertaken with plans in place
	• Review process for high impact risks with low likelihood	On track: Not yet started	• Planned May 2018
	• Develop a register of risk registers	On track: Not yet started	• Planned January 2018
	• Develop a risk profiling process	On track: Not yet started	• Planned June 2018
	• Triangulate risk information in quality reports / mortality reports	On track: Not yet started	• Initial reports to be developed for February 2018 Quality Assurance reviews

Appendix B - Progress against the Risk Management Strategy & Framework (2017/20) priorities

Priority	Key areas 2017/19	Position	Commentary
3. Review of Risk Registers	• Develop sources on web based system	On track: Not yet started	• Planned from March 2018
	• Undertake TNA for risk management	On track: Not yet started	• Training to dovetail with web based system from March 2018
4. Governance Structure Group Reporting	• Review the information flows and functions of the groups reporting into the Executive Quality Governance Group.	On track: Not yet started	• To include as part of the Well –Led Developmental Review in February 2018 with Board oversight in April 2018
	• Review annually	On track: Not yet started	• Review March 2019
5. Safety Culture Assessment	• Undertake initial assessment	On track: Not yet started	• Initial assessments as part of the Well –Led Developmental Review in February 2018 with Board oversight in April 2018. • Trust rolling programme from July 2018
6. Ulysses – Web Based Solution for risk management and improvement planning	• Review of all fields to include controls assurance rating, cost benefit analysis, risk proximity and risk profiling • Education & training programme • Cleansing of all grades of risks • Quality improvement, audit and national guidance gap analysis system to be developed	Delivery remains feasible but potential risk to delivery within original timescales	• Potential delays due to resourcing issues • Delay in Ulysses provision of improvement / action module • CCICP services will need reconfiguring on the system post change to care groups • Dependency on recruitment process to new Quality Governance Team (Quality Governance Analyst) – launch February 2018 • This action is included in the risk management internal audit report for completion by March 2018

Appendix C – Risk Matrices

Consequence / Likelihood	1	2	3	4	5
1	1	2	3	4	5
2	2	4	6	8	10
3	3	6	9	12	15
4	4	8	12	16	20
5	5	10	15	20	25

Likelihood	Definition	Estimated Probability	Lessons Learned
Almost certain	This event may be imminent or there are strong indications it will occur in the future. Not confident risk can be managed at this level and contingency is required	More than 80% chance of occurring	A regular occurrence. Circumstances found frequently
Likely	This event is likely to occur in most circumstances. Requires additional mitigation/contingency. Little confidence risk can be managed at this level.	51% to 80% chance of occurring	Has occurred from time to time and may do so again in the future
Possible	This event is likely to occur at some time even if controls operate normally. Confident risk can be managed at this level	21% to 50% chance of occurring	Has occurred previously but not often, and may have been in a limited way
Unlikely	Not expected, this event has a small chance of occurring at some time	6% to 20% chance of occurring	Has not happened, or happened in a very limited way
Rare	Highly unlikely, will occur only in very exceptional circumstances. Very confident risk can be managed at this level. Controls operate normally	Less than a 5% chance of occurring	Has rarely happened

Performance Report Workforce Chapter
Month: Nov-17

Measure	Target	Performance	Description	Narrative	Rolling Trend
Sickness Absence	3.60%	**4.23%**	Rolling 12m average Sickness Absence described as a Percentage	Unfortunately we have experienced an increase in both the 12-month rolling average sickness absence rate and the in-month absence (4.4%) during November 2017. Whilst this is disappointing, it is to be expected at this time of year and it is also important to recognise that significant work has taken place to support staff who are absent for extended period to return to work more quickly. As at 30th November, only 4 staff had been absent for 6 months or more.	
Appraisal Rate	90.00%	**88.31%**	Percentage of Staff who have received an appraisal in the last 12 months. Excludes New Staff with less than 12m service and Bank Staff	An increase of a further 4% for the Trust in month. This increase has is attributed to the significant increase in appraisal rates for the following divisions who are now ABOVE target: - Womens & Childrens - 91.04% (inc of 6%) and - Estates & Facilities - 91.64% (inc of 5%). Medicine & EC should also be highlighted as the most improved division in month with a 10% increase in appraisals.	
Mandatory Training	90.00%	**83.00%**	Mandatory Training Monthly Rate Excludes Bank Staff, Staff on long term sick & mat. leave.	A further increase in the compliance rate with Mandatory training during November. The main reason for this is that all 4 clinical divisions and corporate services have increased their Mandatory training compliance to above 80%, with Diagnostics & Clinical Support and Estates & Facilities now achieving over 90%. Regrettably, CCICP Madatory training is currently below 70% and a recovery plan has been put into place to address this by the end of the financial year.	
Staff Turnover	10.00%	**10.93%**	Number of Leavers expressed as a percentage of the workforce over a 12m rolling period. Exclude Junior Doctors, Temporary and Fixed term.	Our retention rate has improved during November and it is useful to note that: a. We benchmark in the top performing quartile of NHS Trusts in England and b. We continue to perform well in comparison to our local NHS Trists where the mean average turnover rate is over 14%.	

Measure	Target	Performance	Description	Narrative	Rolling Trend
Agency Spend	(426)	**(315)**	In month and cumulative total spend for the Trust.	In correlation with the Trust's activity and acuity levels, as well as the increase in sickness absence during November, our agency useage has increased, however it continues to be below both our Trust plan and the NHSI agency cap trajectory. The main area of agency spend continues to be Medical and Dental staff and particularly in the following areas: - A&E; - GP Out of Hours and - Diagnostic specialties.	
NHSI Ceiling	less than 100%	**73.94%**	Trust Agency Spend as a percentage of the Ceiling Set by NHS Improvement		
Over Cap Rates	No National Benchmark	**48.51%**	Number of Agency shifts filled by agency staff that are over the nationally determined capped rates	A total of 163/336 shifts were filled during November by agency staff who were paid above NHSI capped rates. In all cases the decision has been approved by Executive Directors to ensure we continue to maintain a safe and good quality service for our patients.