Mid Cheshire Hospitals NHS Foundation Trust

Board of Directors

Thursday 29 April 2021, 9.30am
Virtual – via Microsoft Teams

AGENDA

No	BAF Risk	Item
PRELIMINARY BUSINESS		
1 9:30		**Apologies (v)** Chair
2 9:32		**Declarations of Interest (v)** Chair To receive declarations of interest in agenda items and / or any changes to the register of directors' declarations of interest pursuant to Section 8 of Standing Orders
3 9:35		**Patient Story (p)** Director of Nursing & Quality To note
4 9:50		**Draft Minutes of the Last Meeting – 25 March 2021 (d)** Chair To approve the draft minutes of the last meeting of the Board of Directors, discuss any matters arising and review the action log • **Board Workplan 2021/22 (d)** To approve
5 09.53		**Chair's Opening Remarks (v)** • Governor Items
CONTEXT / OVERVIEW		
6 10:00	**BAF13**	**Chief Executive's Report (d)** • **Hospital Redevelopment Programme Board – 15 April 2021 (d)** To note
7 10.15	**BAF19**	**Board Assurance Framework (BAF) (d)** Chief Executive • **BAF 2020/21** • **Strategic Objectives & Principal Risks 2021/22** To approve

No	BAF Risk	Item
8 10.30		**Integrated Performance Report (Month 12 – March 2021) (d)** Chief Executive To note
QUALITY - Patient Safety, Clinical Effectiveness & Patient Experience		
9 10:30		**Quality & Safety Committee Chair's Assurance Report 21 April 2021 (d)** Committee Chair To note
10 10:35	**BAF 8**	**Serious Incidents (d)** Medical Director To note
PERFORMANCE		
11 10:40		**Performance & Finance Committee Chair's Assurance Report 22 April 2021 (d)** Committee Chair To note
	BAF 7	• **Restoration Plan (d)** Chief Operating Officer To note
WELL LED		
12 10:55		**Workforce & Digital Transformation Chair's Assurance Report 19 April 2021 (d)** Committee Chair To note
	BAF10	• **Health and Wellbeing Assessment (d)** Director of Workforce and OD To approve
13 11:05	**BAF12**	**Freedom to Speak up Guardian Q4 2020-21 Report (d)** Freedom to Speak up Guardian To note
GOVERNANCE		
14 11:15		**Audit Committee Chair's Assurance Report - 15 April 2021 (d)** Committee Chair To note
	BAF19	• **Corporate Governance Framework Manual (d)** Company Secretary To approve

No	BAF Risk	Item
15 11:25	**BAF19**	**Evaluation of Board Committees Effectiveness (d)** Company Secretary To note

CONSENT AGENDA (all items '*to note'* unless otherwise stated)

These items have been read by Board members and the minutes will reflect recommendations, unless an item has been requested to come off the consent agenda for debate; in this instance, these items will be identified at the start of the meeting

➢	**BAF19**	**Trust Constitution** Company Secretary To approve
➢	**BAF12**	**Guardian of Safe Working Hours Q4 2020-21 Report** Director of Workforce and OD
➢	**BAF19**	**Use of the Trust Seal Report 2020-21** Company Secretary

CONCLUDING BUSINESS

16
11:35

Any Other Business
Chair
To consider any other matters of business

17
11:40

Items for the Risk Register/Changes to the Board Assurance Framework (BAF) (v)
Chair
To identify any additional items for the Risk Register or changes to the BAF arising from discussions at this meeting

18
11:42

Key Messages from the Board (v)
Chair
To agree

Resolution

The Board is asked to resolve that in accordance with Section 1(2) of the Public Bodies (Admission to Meetings) Act 1960, representatives of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity of which would be prejudiced to the public interest.

Action Log Board of Directors 29 April 2021

Agenda item		Assigned to	Deadline	Status
Board of Directors 25/03/2021 5 Board Workplan 2021/22 (d)				
439.	Board Workplan	• Dowson, Katharine • Keating, Caroline	22/04/2021	Agenda Item 4.2
	Explanation action item Final version of Board workplan for 2021/22 to be approved at April Board meeting			
	Explanation Dowson, Katharine On agenda for 29 April.			

Board Workplan 2021/22

				2021														2022	
				Board Dev. Day			Board Strategic Session	Board Dev. Day		Board Strategic Session		Board Dev. Day			Board Strategic Session	Board Dev. Day		Board Strategic Session	
Meeting Date	**Part I/II**	**Lead Dir**	**Frequency**	01-Apr	29-Apr	27-May	24-Jun	09-Jul	29-Jul	26-Aug	30-Sep	08-Oct	28-Oct	25-Nov	17-Dec	07-Jan	27-Jan	24-Feb	31-Mar
Patient Story	I	JT	M		✓	✓			✓		✓		✓	✓			✓		✓
Preliminary Business																			
Board Action Log	I	CK	M		✓	✓			✓		✓		✓	✓			✓		✓
Board Workplan 2020/21	I	CK	Q		✓				✓				✓				✓		
Chair's Report	I	DD	M		✓	✓			✓		✓		✓	✓			✓		✓
* Council of Governors Key Issues Report (tbc)		CK	Q																
Context																			
BAF Report	I	JS	Q		✓				✓				✓				✓		
BAF Heat Map (when BAF report not submitted)	I	JS				✓					✓			✓					✓
Integrated Performance Report	I	JS	M		✓	✓			✓		✓		✓	✓			✓		✓
CEO Report	I & II	JS	M		✓	✓			✓		✓		✓	✓			✓		✓
* Hospital Redevelopment Programme Board					✓	✓			✓				✓				✓		
* Digital Clinical System Programme Board						✓			✓		✓			✓			✓		✓
* Consultant appointments		JS	ad hoc		✓														
STRATEGY																			
Trust Strategy	I	JS	A			✓							✓						
Quality & Safety Improvement Strategic Plan (tbc)	I	JT	A																
Risk Management Strategic Plan	I	JS/CK	A						✓										
* Risk Appetite Statement	I	CK	A			✓													
Workforce Strategic Plan	I	HB	A											✓					
Estates Strategic Plan	I	RF	A			✓													
Digital Strategic Plan	I	AF	A							✓	✓								
QUALITY																			
Q&S Chair's Assurance Report	I	LM	M		✓	✓			✓		✓		✓	✓			✓		✓
Safeguarding Adults & Children Annual Report	I	JT	A						✓										
Health & Safety Report	I	RF	A								✓								
Nursing & Midwifery Staffing Report	I	JT	A										✓						
Serious Incidents	I	ML	M		✓	✓			✓		✓		✓	✓			✓		✓
Medical Revalidation Annual Report	I	ML	A								✓								
Clinical Negligence Scheme for Trusts	I	JT	A			✓													
Guardian of Safe Working Hours	I	HB	Q		✓				✓				✓				✓		
Learning from Deaths	I	ML	Q			✓													
Quality Account (date tbc)	I	JT	A																
National Inpatient Survey Results	I	JT	A								✓								
PERFORMANCE & FINANCE																			
PAF Chair's Assurance Report	I	TB	M		✓	✓			✓		✓		✓	✓			✓		✓
Financial Plan	I	RF	A			✓													
Operational Plan	I	OB	6M			✓							✓						
Capital Programme	I	RF	A			✓													
Winter Plan	I	OB	A										✓						
Emergency Planning																			
* Annual Report	I	OB	A											✓					

				Board Dev. Day			Board Strategic Session	Board Dev. Day		Board Strategic Session		Board Dev. Day			Board Strategic Session	Board Dev. Day		Board Strategic Session	
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* EPRR Assurances	I	OB	A											✓					
PEOPLE																			
WDT Committee Assurance Report	I	LB	M		✓	✓			✓		✓		✓	✓			✓		✓
WRES Data	I	HB	A											✓					
WDES Report	I	HB	A											✓					
Equality Delivery System	I	HB	A																✓
Equality, Diversity and Inclusion Annual Report	I	HB	A						✓										
Clinical Excellence Awards	I	ML	A																✓
HEE Self Assessment Report	I	HB	A								✓								
People Recovery Plan	I	HB	A			✓													
Medical Staffing Update	Part II	ML	ad hoc																
GOVERNANCE/WELL-LED																			
CQC Report & Action Plan	I	JT	6M						✓										
Annual Report & Accounts	I	RF/CK	A			✓													
Remuneration Committee Assurance Report	I	DD	Ad hoc		✓														
Corporate Governance																			
Audit Committee Assurance Report	I	LP	Q		✓	✓			✓		✓		✓	✓			✓		✓
NHS Provider Licence - Annual Self-Certification:	I	JS	A																
* General Condition 6/ Continuity of Services Condition 7						✓													
* Corporate Governance Statement						✓													
CQC:	I																		
* Registration Compliance	I	JT	A			✓													
Board Self-Certification	I	RF/CK	A			✓													
Corporate Governance Framework Manual (SOs, SFIs, SoD)	I	CK/RF	A		✓														✓
Use of Trust Seal Annual Report	I	CK	A		✓														
Well-Led																			
National Staff Survey (Results & Improvement Plan)	I	HB	A																✓
Board of Directors' Self-Assessment/Evaluation	I	DD/CK	A	✓															
Evaluation of Board Committees Effectiveness/ToR	I	CK/NED Chairs	A		✓														
Board Development Plan	I	CK/HB	A			✓													
Fit & Proper Person's Review	I	CK	A											✓					
Modern Slavery Strategy Statement	I	CK	A			✓													
Freedom to Speak Up Guardian	I	JS	Q		✓				✓				✓				✓		
Gender Pay Gap	I	HB	A														✓		
ITEMS IDENTIFIED IN YEAR																			
Heallth and Wellbeing Assessment	I	HB	A		✓														
Restoration Plan	I	OB	A		✓														
Other Items (Ad Hoc in Year)																			
Well Led Governance Feedback Review	I	CK	A								✓								
Trust Responsible Roles	I	CK	A			✓													

				Board Dev. Day			Board Strategic Session	Board Dev. Day		Board Strategic Session		Board Dev. Day			Board Strategic Session	Board Dev. Day		Board Strategic Session	
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EVENTS / OTHER MEETINGS																			
Annual Members' Meeting													✓						
Board to Boards																			
Board Development																			
Principal Risks				✓															
Risk Appetite Statement				✓															
Board Effectiveness Survey Results				✓															

Mid Cheshire Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

Agenda Item	**6**	Date of Meeting: 29/04/2021
Report Title	**Chief Executive's Report April 2021**	
Executive Lead	James Sumner, Chief Executive	
Lead Officer	Caroline Keating, Company Secretary	
Action Required	To note	

☐ **Acceptable assurance** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐ **Partial assurance** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Low assurance** Evidence indicates poor effectiveness of controls

Key Messages of this Report *(2/3 headlines only)*

-

Next Steps (*actions to be taken following agreement of recommendation/s by Board/Committee)*

N/A

Strategic Objective(s) *(indication of which objective/s the report aligns to)*

• Manage Covid response and recovery	☐	• Provide safe and sustainable services	☐
• Provide outstanding care/patient experience	☐	• Provide strong system leadership by working together	☐
• Deliver most effective care to achieve best possible outcomes	☐	• Be well governed and clinically led	✓
• Be the best place to work	☐		

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

• Quality	✓	• Compliance	✓
• Finance	✓	• Legal	☐
• Workforce	✓	• Risk/BAF Click here to select relevant risk	
• Equality	☐		

Equality Impact Assessment (*must accompany the following submissions)*

Strategy ☐ Policy ☐ Service Change ☐

REPORT DEVELOPMENT

Committee/ Group Name	Date	Report Title	Lead	Brief summary of key issues raised and actions agreed
Board of Directors	Monthly	CEO Report	Chief Executive	Noted

Chief Executive's Report
Board Meeting – 29 April 2021

Key Highlights

National / Regional Update

1. The new White Paper outlining the future of Integrated Care Systems is a significant focus for the region and locally in Cheshire and Merseyside (C&M). Over the last month there have been several working groups with ICPs and Health and Wellbeing Boards across Cheshire East and Cheshire West PLACEs. The Trust's developing new strategy potentially aligns well to the future direction and discussions are maturing as to what the future may look like; however, there is still some way to go before this is fully clear. The Board will have further opportunity to discuss this at upcoming development and strategy sessions.

Trust Update

2. The Trust has been shortlisted as finalists for an HSJ Award under the 'Best Acute Sector Partnership with the NHS' for our workforce transformation work with Attain. As part of the rapid three-month transformation, MCHFT & Attain undertook extensive engagement, workforce modelling and developed a strategy for the alternative medical workforce at MCHFT. The outputs shifted the Trust to becoming a leading employer of choice for Physician Associates (PA) and leading employer for the size of organisation comparative to the number of PAs employed in the UK.

Senior Appointments

- John Awad – Consultant Ophthalmologist (starting August 2021)

Covid-19

3. As at 20 April, there were five confirmed positive Covid-19 patients in the hospital compared to 35 reported at last month's Board and 209 at the peak of the third wave. There are also no Covid patients in Critical Care. The ward reconfiguration roadmap has been successfully implemented and there is now only the South Cheshire Unit earmarked for the ongoing management of Covid patients in the hospital, down from nine wards at the peak. In line with national guidance, local visitor restrictions at the Trust started to be relaxed from 19 April and the roadmap is to be fully lifted for most restrictions by June 2021.

4. Clinically Extremely Vulnerable staff were advised by the Government that the requirement for shielding would end from 1 April 2021. The HR team has been supporting these members of staff to return to work and ensuring managers are contacting their staff and reviewing risk assessments.

Vaccination Programme

5. The Vaccination Centre has now vaccinated over 36,000 people and including over 90 per cent of staff and the provision of second dose injections is well underway.

Covid-19 Restoration

6. The Trust is making good progress with the resumption and restoration of all clinical services and activity. However, the backlog of patients waiting for care is significant and the challenge ahead cannot be underestimated. In line with recently published NHS planning guidance and Trust priorities, patients are being seen and treated in order of clinical need, followed by those that have been waiting the longest. For week ending 11 April, the Trust has restored 71% of daycase, 88% of ordinary electives, 84% of first outpatient and 108% of follow-up outpatient activity. The Chief Operating Officer is presenting a detailed paper later in the agenda that sets out the Trust's restoration and recovery plan for the first half of 2021/22.

Maternity Services

7. The Trust is compliant with both national guidelines for adult and women attending maternity appointments. For adults, the Trust led the work on a NW visiting map (good practice guide) that sits alongside current guidance and provides consistency for patients and families across the North West. Visiting was re-commenced on 19 April 2021 with four wards (4, 7, 10, 21b) and Elmhurst.

8. For maternity appointments, all partners are able to attend, supported with PPE, social distancing and all required safety measures.

Trust 'Business as Usual'

Finance

Month 12 (March) 2020/21 - Final Year End position

9. At the end of the financial year, the Trust has reported a cumulative deficit of £4.4m (excluding technical adjustments and subject to Audit) to NHSI. The position includes provisions of £2.4m for 2020/21 untaken annual leave and £0.4m for the Flowers case ruling (i.e. staff are entitled to have both non-guaranteed and voluntary overtime taken into account for the purposes of calculating their statutory and contractual holiday pay). This position is above the £3.9m previously forecast position due to the increase in the Flowers case and other provisions but appears to have been accepted by NHSI.

10. The Capital programme spend in 2020/21 was £24.3m, an underspend against the original plan of £9m, due to slippage on the new A&E scheme (£4.5m), Digital Clinical System project (£2m) and general maintenance & refurbishment schemes (£2m). The Capital system for 2021/22 has changed to a system approach with a Capital Resource Limit being set at a Cheshire & Merseyside Health & Care Partnership (HCP) level with the HCP then setting resource limits at organisational levels. The Trust's demand for Capital schemes will outstrip the funding available and the Capital limit set; the programme, therefore, will need to be carefully managed and prioritised in 2021/22, with further negotiations taking place with the HCP.

Financial Plan 2021/22

11. The Trust submitted its first cut of the 2021/22 financial plan covering April to September on 23 April (final submission is 4 May 2021). Last month I reported on the interim budgets set internally before Income had been notified and any investment or efficiencies had been built

into the plan, based upon expenditure run rates. Block Income for the Trust has now been notified by the Centre directly to the Trust and, in addition, C&M HCP has received some system funding (including C&M share of the £1bn Elective Recovery Fund (ERF)). At this stage, it is difficult to assess the Trust's financial position as not all the system resource has been finalised but, based upon the notified direct income from NHSI and assuming HCP allocations match expenditure locally, this would leave the Trust with a £6.6m deficit. At this stage, this seems to have been accepted by the HCP as a control total. Costs associated with elective recovery (above set thresholds based upon 19/20 activity) will be in addition to this position and anticipated will be reimbursed to organisations via the ERF; however, the reimbursements will be linked to the overall system performance. Once this draft financial plan has been reviewed, if there is an overall system deficit at the HCP level, there is potential for an efficiency ask from all organisations.

12. Whilst the financial regime for April to September is now clearer, beyond that is unknown but, as I said last month, it is clear that we will be faced with an unique and challenging operating environment and it is, therefore essential, that we maintain strong financial governance and control.

Urgent and Emergency Care Pressures

13. The Cheshire and Mersey HCP is experiencing significant pressures on its urgent and emergency care services and the Trust is no exception with rising attendances (the highest A&E attendances in March for six years), increasing admissions and sicker patients residing in hospital. There are also increasing concerns with overcrowding in A&E as demand rises. The Trust has processes in place to keep patients safe when experiencing surges in demand and overcrowding and these are being audited and quality assured regularly. Because of the increase in pressure, there is a renewed focus in the Trust, and indeed regionally, on urgent and emergency care and how we keep patients in our Emergency Department as safe as possible.

Workforce

The People Recovery Plan

14. A six-phase stakeholder engagement process has been undertaken across the organisation to create and develop the Trust's People Recovery ('Forward Together') Plan. The initial phases of the project have now been completed with valuable information gained on what staff want and need to support their recovery. A two-week pilot rollout commenced on 19 April 2021 with individual conversations and team interventions trialed within Critical Care and Ward 5. Feedback will be sought and further roll out will follow. To shape and personalise recovery support, it is anticipated all members of staff will be afforded the opportunity to have an individual conversation tailored to their own experiences and support requirements as a result of working in the Covid-19 pandemic. The Plan is intended to ensure our staff are given an opportunity to reflect and compute the experiences that they have lived through over the last 12 months to enable them to recover and rebalance their lives. This will include restorative and development opportunities. Both qualitative and quantitative data, including existing Trust metrics, will be used to monitor the impact of the Plan.

Cheshire International Recruitment Collaboration

15. Good progress is being made and as the project moves into the busier summer phases. 67% of offers (325/482) have now been made and the project has taken a total of 170 (35% of total) new International nurses to date. The remaining arrivals are planned throughout the year to ensure that the Practice Education Facilitators can support the nurses and maintain the excellent pass rates for the Objective Structured Clinical Exams that the project has been achieving - the last cohort achieved a 100% first attempt pass rate, with the overall pass rate to date at 83% on the first attempt and 100% with the second).

16. The project has been adapting to the challenges posed by the rapidly altering COVID restrictions on international travel, quarantine requirements and allowances, and the continuous evolution of the associated guidelines. The project is working closely with PHE and NHSE to ensure that the nurses have the best experience possible despite these challenges and to minimise disruption to their study wherever possible. The project is working to minimise and mitigate any extra costs that changes in restrictions and/or guidelines impose.

Appraisals

17. The transition to the new Motiv8 process has been impacted by COVID-related work pressures, resulting in appraisal compliance levels remaining below acceptable levels. The HR team is working closely with Divisions to develop realistic plans and trajectories for completion of Motiv8 sessions and an improvement in compliance.

Talent Review Process

18. The past year presented unprecedented challenges and change for all our staff. Many colleagues had the opportunity to gain new skills and work on different things or in new roles, whereas some placed personal aspirations on hold to focus on the requirements arising from Covid.

19. To ensure we are nurturing our talent and to provide a formal space to discuss talent development, we will be rolling out talent review panels in early June 2021. The Divisional HR teams are working with managers to put panels in place and support local level data capture. To support this process, a career conversation tool has been developed.

(Leighton) Hospital Redevelopment Programme Board (HRPB)

20. The HRPB met in April 2021 to consider the draft Strategic Outline Case. The Chair's Assurance Report is appended to my report (Appendix I).

Digital Clinical System

21. The complexity of the procurement evaluations has required a 'Chairs' Action' to delay the publication of the 'Best and Final Offer' by six weeks. The target contract award date, however, remains unchanged as 28 October 2021. The Programme Director is meeting with all groups of evaluators to ensure their engagement.

James Sumner, Chief Executive
April 2021

Leighton Hospital Redevelopment Programme Board (HRPB)
Chair's Assurance Report
April 2021

Report to	Board of Directors – 29 April 2021
Date	15 April 2021
Report from	James Sumner, Chief Executive
Report prepared by	Katharine Dowson, Head of Corporate Governance
Executives	Russell Favager, Deputy Chief Executive/Director of Finance Murray Luckas, Medical Director Caroline Keating, Company Secretary
Committee meeting quoracy	Yes ☒ No ☐

KEY AREAS OF ASSURANCE

Strategic Outline Case (SOC) – final review prior to Board submission - overall positive case in line with national priorities. Performance and Finance (PAF) Committee to review financial aspects on 21 April
Stakeholder Engagement – process has started with positive reception from Cheshire East Council Health and Scrutiny Overview Committee building on work with Cheshire and Wirral Partnership NHS Foundation Trust and others
Terms of Reference reviewed and agreed to September 2021; Associate Director of Communications to be added as a regular member
Business Case for RAAC Emergency Capital Fund – reviewed initial plans for capital funding of £22m to be spent by 31 March 2022. To be aligned to redevelopment plans and reduce capital ask of main development.
Corporate Project Risk Register reviewed
Planning for NHS Estates Visit strategy agreed in preparation for visit from NHSI Director of Estates and National Estates Operational Lead on 22 April

KEY CONCERNS/RISKS

None

Priority Areas: DECISIONS MADE

To submit SOC to PAF and Board in April.

RECOMMENDATION

To note

NHS
Mid Cheshire Hospitals
NHS Foundation Trust

BOARD OF DIRECTORS

Agenda Item	**7.1**	Date of Meeting: 29/04/2021
Report Title	**Board Assurance Framework Year-End 2020/21**	
Executive Lead	James Sumner, Chief Executive	
Lead Officer	Caroline Keating, Company Secretary	
Action Required	To note	

☐ **Acceptable assurance** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐ **Partial assurance** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Low assurance** Evidence indicates poor effectiveness of controls

Key Messages of this Report *(2/3 headlines only)*

- The latest information relating to the Trust's principal risks is presented in this report alongside a summary of the key operational risks mapped to the current Strategic Objectives.
- Proposal to reduce BAF3 risk score from 12 to 8; BAF13 score increased from 15 to 20.
- Relevant detail from the 2020/21 BAF will be mapped to the refreshed BAF for 2021/22.

Next Steps (*actions to be taken following agreement of recommendation/s by Board/Committee)*

- Executive Risk Leads to act on recommendations agreed during meeting

Strategic Objective(s) *(indication of which objective/s the report aligns to)*

• Manage Covid response and recovery	☐	• Provide safe and sustainable services	☐
• Provide outstanding care/patient experience	☐	• Provide strong system leadership by working together	☐
• Deliver most effective care to achieve best possible outcomes	☐	• Be well governed and clinically led	✓
• Be the best place to work	☐		

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

• Quality	☐	• Compliance	☐
• Finance	☐	• Legal	☐
• Workforce	☐	• Risk/BAF Click here to select relevant risk	
• Equality	☐		

Equality Impact Assessment (*must accompany the following submissions)*

Strategy ☐ Policy ☐ Service Change ☐

REPORT DEVELOPMENT

Committee/ Group Name	Date	Report Title	Lead	Brief summary of key issues raised and actions agreed
Workforce & Digital Transformation Committee	19 April 2021	Board Assurance Framework – Committee Report	Heather Bennett / Amy Freeman	Latest position noted.
Quality & Safety Committee	21 April 2021	Board Assurance Framework – Committee Report	Julie Tunney / Murray Luckas	Latest position noted. BAF3 reduced rating approved.
Performance & Finance Committee	22 April 2021	Board Assurance Framework – Committee Report	Russ Favager / Oliver Bennett	Latest position noted.

Board Assurance Framework Year-End 2020/21

Introduction

1. The Board Assurance Framework (BAF) is an important component of the Trust's corporate governance and risk management framework. It is a monitoring tool used by the Board to assess the organisation's capacity to achieve its strategic objectives, and to ensure it has appropriate oversight of the Trust's risk profile and risk management arrangements. A properly used BAF will also drive the forward work plan and agendas for the Board and its Committees.

2. The Trust's principal risks aligned with the strategic objectives were agreed with the Board of Directors in Q1 2020/21. Each principal risk has been assigned either to the Board or a Board Committee for oversight. The Board receives a quarterly report of the full BAF.

3. This report presents the status of the BAF at the end of the 2020/21 financial year. It consists of:
    - a Board Assurance Framework heatmap showing the current risk scores for the Trust's principal risks and the direction of travel compared with the initial position recorded in Q1 2020/21 (Appendix 1),
    - a set of integrated risk dashboards showing the high scoring operational risks (15+) mapped to the principal risks and strategic objectives (Appendix 2),
    - a more detailed BAF report of the controls, assurances and actions mapped to the principal risks (Annex 1).

4. The proposed principal risks for 2021/22, which relate to the delivery of the Trust's new strategy, are presented in a separate paper for approval by the Board. Relevant controls and actions from the current BAF will be taken forward into the next year's iteration.

Changes of note in Q4

5. BAF3 has been reassessed in light of evidence that initiatives to close the nurse staffing vacancy gap have been successful. Projections to the end of December 2023 indicate that the risk has reduced to the target level. The Quality & Safety Committee 21 April 2021 agreed to recommend to the Board of Directors the proposal to reduce the risk score from 12 (4x3) to 8 (4x2).

6. As agreed by the Board 25 March 2021 following a recommendation from the Performance & Finance Committee, the risk score for BAF13 has been increased from 15 (5x3) to 20 (5x4) in light of the number of linked high priority operational risks.

Recommendations

7. To note the current status of principal risks and associated operational risk profiles. Executive Risk Leads will answer any questions relating to individual risks within their portfolios.

Author: Gilly Conway, Risk and Governance Consultant
Date: 21 April 2021

Addendum: notes relating to appendices – BAF heatmap and risk dashboards

1. The following appendices consist of a one-page summary of the current score for the Trust's principal risks included in the Board Assurance Framework, followed by a series of risk dashboards aligned to the Trust's strategic objectives.

2. The heatmap shows the year-end risk scores for all principal risks. Symbols show the direction of travel compared with the initial position at the start of the year (= no change, ⇑ increase **/** ⇓ decrease).

3. The dashboards provide a summary view of the key risks that would hinder achievement of strategic objectives by linking the principal risks from the BAF to the highest priority operational risks (rated 15+). There is one dashboard for each strategic objective. Each page shows the Trust's principal risks in the table on the left and the associated operational risks in the table on the right. Any changes in risk scores compared with the Q3 report are indicated using arrows (⇑ increase **/** ⇓ decrease). Operational risks that have been reduced from high to medium priority during the period are not highlighted to the Board in this report but have been reviewed by the relevant Executive Groups, the Executive Risk and Assurance Group, and reported to the relevant Board Committees.

4. Risks are prioritised in accordance with the Risk Management Process Guide as follows:

Impact / **Likelihood**	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
1 Rare	**1**	**2**	**3**	**4**	**5**
2 Unlikely	**2**	**4**	**6**	**8**	**10**
3 Possible	**3**	**6**	**9**	**12**	**15**
4 Likely	**4**	**8**	**12**	**16**	**20**
5 Almost certain	**5**	**10**	**15**	**20**	**25**

Appendix 1: BAF heatmap showing current scores (Impact x Likelihood) and direction of travel during the financial year 2020-21

SO1 Manage the impact of the Covid-19 pandemic and ensure safe recovery	SO2 Deliver outstanding care and patient experience	SO3 Deliver the most effective care to achieve best possible outcomes	SO4 Ensure MCHFT is the best place to work	SO5 Provide safe and sustainable healthcare to our population	SO6 Provide strong system leadership by working together	SO7 Be well governed and clinically led
BAF1 Inadequate arrangements for safe management of pandemic against national guidance = **4 x 2 = 8**	**BAF3** Inability to close the nurse staffing vacancy gap ⇩ **4 x 2 = 8**	**BAF7** Inability to provide sufficient capacity to meet demand and achieve operational standards = **4 x 5 = 20**	**BAF10** Failure to attract, retain and support a high performing workforce = **4 x 3 = 12**	**BAF13** Failure to provide modern, efficient, sustainable estate, infrastructure and equipment ⇧ **5 x 4 = 20**	**BAF16** Failure to enable a successful Integrated Care Partnership and carry out the Trust's hosting responsibility = **3 x 3 = 9**	**BAF19** Ineffective governance systems to foster a risk assurance culture ⇩ **3 x 3 = 9**
BAF2 Failure to manage risks to business continuity identified during Covid **Closed**	**BAF4** The Trust's environments are not adequately safe and secure for staff, patients and visitors = **4 x 3 = 12**	**BAF8** Insufficiently robust processes for clinical audit and quality improvement, learning and implementation of new practice = **3 x 3 = 9**	**BAF11** Failure to harness the benefits of technology to integrate, streamline and improve systems of working = **4 x 3 = 12**	**BAF14** Failure to adequately plan future workforce requirement = **4 x 3 = 12**	**BAF17** Ineffective capacity across the Health and Social Care system = **4 x 3 = 12**	**BAF20** Failure to establish appropriate governance and risk mitigation around existing and new collaborative models of working = **3 x 3 = 9**
	BAF5 The Trust's Quality Improvement approach does not help address the highest clinical challenges = **3 x 3 = 9**	**BAF9** Failure to use high quality activity and patient outcome data to assess quality of care = **3 x 4 = 12**	**BAF12** Failure to create the conditions for an effective organisational culture = **4 x 2 = 8**	**BAF15** Inadequate financial management, budgetary controls, and efficiency planning = **4 x 2 = 8**	**BAF18** The Trust fails to play its part in a successful Cheshire System **Inactive***	**BAF21** Failure to develop leadership capacity and capability throughout the organisation = **4 x 3 = 12**
	BAF6 Failure to proceed with EPR development and implementation ⇩ **4 x 2 = 8**					

Risk Rating	Priority
1 to 6 but excluding rare events with major or catastrophic impact	Green – Low
8 to 12 plus rare events with major or catastrophic impact	Amber – Medium
15 to 25	Red – High

*This risk was identified was not considered to have direct relevance during this financial year and has been incorporated into the refreshed risks for 2021/22

Appendix 2: integrated risk dashboards (current scores)

Strategic Objective 1	**Manage the impact of the Covid-19 pandemic and ensure safe recovery** of the organisation post pandemic by using the established control structure

Principal risks	Risk score (IxL)
BAF1. Inadequate arrangements for safe management of pandemic against national guidance (**COO**)	**8 (4x2)**
BAF2. Failure to manage risks to business continuity identified during Covid (**DCEO/DF**)	**Closed**

Ref	High scoring operational risks (15+)	Risk score (IxL)
TW0028	COVID-19 Pandemic	**15 (5x3)**
IPC0006	Major outbreak of new or existing disease	**15 (5x3)**

Risk and controls commentary

- The controls in place for BAF1 aim to ensure adherence with national guidance. Monthly review of actions taken by Silver Command has been undertaken to gain assurance of compliance with national guidance and to continue to adapt Command and Control processes to ensure optimum effectiveness.
- BAF2 controls have been transitioned into business as usual and its closure was approved by the Board in January 2021.

Strategic Objective 2	**Deliver outstanding care and patient experience** focusing on staffing, standardisation and digitalisation

Principal risks	Risk score (IxL)
BAF3. Inability to close the nurse staffing vacancy gap (**DN&Q**)	**8 (4x2)** ⇩
BAF4. The Trust's environments are not adequately safe and secure for staff, patients and visitors (**DCEO/DF**)	**12 (4x3)**
BAF5. The Trust's Quality Improvement approach does not help address the highest clinical challenges (**DN&Q**)	**9 (3x3)**
BAF6. Failure to proceed with EPR development and implementation (**CIO**)	**8 (4x2)**

Ref	High scoring operational risks (15+)	Risk score (IxL)
EF0609	Clinical Waste Collection – Disruption	**16 (4x4)**
HSEF0004	Trustwide Fire Risk Assessment – Compliance with the Regulatory Reform (Fire Safety) Order 2005	**15 (5x3)**
HSEF0006	Compliance with the Estates and Facilities Alert EFA/2018/005 – Assessment of Ligature Points	**15 (5x3)** ⇧
PA0308	Paediatric Audiology UKAS accreditation	**15 (5x3)**

Risk and controls commentary

- Focused initiatives to address BAF3 have been successful and the Quality & Safety Committee approved a reduced risk rating in April 2021.
- There is a suite of policies, processes and procedures in place to control the Health & Safety risks within the Trust's environments (BAF4). A key focus over the last quarter has been ensuring all Fire Safety Management Assessments are completed across the Trust. A Violence Reduction Strategy has been developed to meet national requirements and will be reviewed by the Health & Safety Group in May.
- There are currently three high priority operational risks relating to BAF4:
  - EF0609: the extra clinical waste generated as a result of COVID-19 led to the current contractor being unable to meet the Trust's requirements. The situation has improved, therefore the risk is due to be reassessed.
  - HSEF0004 – a phased risk-based plan has been developed to gain access to and maintain fire dampers until the end of 2023.
  - HSEF0006 – this has increased from a previous score of 10 due to a delay in designing out ligature points in Mental Health Assessment rooms.
- BAF5 actions completed during the last quarter: Quality Audit heatmap incorporated into Quality reporting for 2021/22. Actions due within the next quarter: Quality Improvement approach to be submitted to the Board; maternity services non-compliances to be addressed; Quality CQC 'should-dos' to go to Exec Groups as a standing agenda item. The operational risk relating to Paediatric Audiology UKAS accreditation is due to be reviewed after a decision about funding the accreditation application.
- In relation to BAF6, the Programme Director and an Assistant IT Project Manager are now in place to focus on the next phases to deliver the Digital Clinical System (EPR).

Strategic Objective 3	**Deliver the most effective care to achieve the best possible outcomes** with the right capacity, latest learning and data driving decision making

Principal risks	Risk score (IxL)
BAF7. Inability to provide sufficient capacity to meet demand and achieve operational standards (**COO**)	**20 (4x5)**
BAF8. Insufficiently robust processes for clinical audit and quality improvement, learning and implementation of new practice (**MD**)	**9 (3x3)**
BAF9. Failure to use high quality activity and patient outcome data to assess quality of care (**MD**)	**12 (4x3)**

Ref	High scoring operational risks (15+)	Risk score (IxL)
EC0466	Lack of Out of Hours Upper GI Bleed Service	**20 (5x4)**
DC1069	Unreliable Clinical Haematology Service	**20 (5x4)**
TW0045	Inadequate processes and procedures to keep patients on waiting lists safe	**20 (5x4) NEW**
TW0028	Significant impact of the Covid-19 pandemic on organisational performance	**20 (4x5) NEW**
TW0040	Unable to plan effectively for workforce changes and requirements	**20 (4x5) NEW**
TW0007	Insufficient outpatient capacity leading to extended waiting times	**20 (4x5)** ⇧
TW0036	Unable to deliver key cancer standards	**16 (4x4) NEW**
TW0039	Unable to deliver urgent care in line with national standards	**16 (4x4) NEW**

Risk and controls commentary

- There are several high scoring operational risks mapped to SO3, all of which are aligned to BAF7 and underpin the assessment of that principal risk as 'high' priority. This risk profile reflects the exacerbated pressures on services during Covid-19 and the uncertainties around the resumption of services. There has been a considerable impact on services and patient waiting times as a direct result of the pandemic.
- Aspects of the restoration plans approved by the Board in October 2020 were superseded by the third wave of the pandemic. The Trust has started the process of resuming and restoring services and clinical activity following the recent wave of Covid-19. The draft service restoration plan was presented to the Performance and Finance Committee and Board in April, with the final plans to be developed by May.
- BAF8 actions completed since the last report include restarting the Advancing Quality Programme Group, developing the Clinical Audit Plan for 2021/22 and establishing an escalation process for non-compliance with NICE guidelines. The Clinical Audit Policy is due to be refreshed by the end of Q1.

Strategic Objective 4	**Ensure MCHFT is the best place to work** by meeting the needs of our staff better than anywhere else

Principal risks	Risk score (IxL)
BAF10. Failure to attract, retain and support a high performing workforce (**DW&OD**)	**12 (4x3)**
BAF11. Failure to harness the benefits of technology to integrate, streamline and improve systems of working	**12 (4x3)**
BAF12. Failure to create the conditions for an effective organisational culture (**CEO**)	**8 (4x2)**

Risk and controls commentary

- The majority of operational capacity risks that have been mapped to BAF7 on the previous page cite clinical staffing vacancies as causation factors, which also relate to BAF10. There are a range of initiatives in progress to help analyse, monitor, and respond to recruitment and retention challenges and to support the workforce in the wake of an intensely taxing 12 months due to the Covid pandemic. A number of actions have been completed during Q4, including analysis of the 2020/21 staff survey from which key areas of focus have been identified: reducing work related stress, improving team working, reducing violence in the workplace, and further improving the safety culture. In addition, mental health support schemes have been developed following Covid. There will be a strong focus over the next quarter on implementing the People Recovery Plan and delivering the Health & Wellbeing Implementation Plan.
- A key action in relation to BAF11 is the refresh of the Digital Strategic Plan which is aligned to the refresh of the new Trust Strategy.
- Actions relating to organisational culture (BAF12), a review of the Equality, Diversity & Inclusion Strategic Plan is planned during Q1 to incorporate feedback from the workforce and the Board. A new Associate Director of Communications & Engagement has taken up post during April and will lead the implementation of the Communications and Engagement Strategic Plan.
- There are currently no operational risks assessed as high priority relating to SO4.

Strategic Objective 5	**Provide safe and sustainable healthcare to our population** by ensuring our estate, infrastructure and planning focuses on the long term

Principal risks	Risk score (IxL)
BAF13. Failure to provide modern, efficient, sustainable estate, infrastructure and equipment (**DCEO/DF**)	**20 (5x4)** ⇧
BAF14. Failure to adequately plan future workforce requirement (**DW&OD**)	**12 (4x3)**
BAF15. Inadequate financial management, budgetary controls, and efficiency planning (**DCEO/DF**)	**8 (4x2)**

Ref	High scoring operational risks (15+)	Risk score (IxL)
TW0048	Ineffective contracting arrangements with commissioners (CCG/NHSE)	**16 (4x4) NEW**
TW0040	Unable to plan effectively for workforce changes and requirements	**20 (4x5) NEW**

Ref	High scoring operational risks (15+)	Risk score (IxL)
HSEF0007	Failure of RAAC planking at Leighton Hospital resulting in disruption to clinical services	**20 (5x4)**
EF0548	Critical Risk Adjusted Backlog Maintenance	**20 (4x5)** ⇧
DTIS50	PCS hardware support is 'end of life', which could lead to prolonged downtime in the event of a fault	**15 (5x3)**
DTIS73	Increase of temporary/missing casenotes resulting in incomplete data for national submissions	**15 (3x5)**
DTIS74	Bed Management System not updated in real time leasing to inaccurate reportable data	**15 (3x5)**
EF0605	MRI 1, 2 and 3 failure to achieve temperature and humidity conditions	**16 (4x4)**
EF0606	Inability to carry out key IT and Estate works to previous South Cheshire Hospital	**16 (4x4)**
DC1044	Laboratory Information Management System (LIMS) for Pathology - End of Life	**15 (5x3)**
CSOG14	SQL 2005 out of support increasing Trust exposure to cyber threat	**15 (3x5)**
CSOG15	Windows Server 2003 out of support increasing Trust exposure to cyber threat	**16 (4x4)**

Risk and controls commentary

- There are currently ten high priority operational risks mapped to BAF13 which relate to equipment and aspects of the estate, critical infrastructure and IT systems. These underpin the increased risk score for the principal risk.
- Key actions to note in relation to BAF13 are: the development of a new Estates Strategic Plan (discussed at the Performance and Finance Committee in March and to be submitted to the Trust Board in May 2021), the action plan arising from the Critical Infrastructure Review, the development of the Strategic Outline Case for the Leighton Hospital re-development (due to be presented to the Board in April 2021), and the programme of RAAC beams surveys and ensuing 'make-safe' work.

Strategic Objective 6	**Provide strong system leadership by working together** in our place, our system and ICS

Principal risks	Risk score (IxL)
BAF16. Failure to enable a successful Integrated Care Partnership and carry out its hosting responsibility (**DSP**)	**9 (3x3)**
BAF17. Ineffective capacity across the Health and Social Care system (**COO**)	**12 (4x3)**
BAF18. The Trust fails to play its part in a successful Cheshire System (**CEO**)	**Inactive**

Ref	High scoring operational risks (15+)	Risk score (IxL)
CP0115	Provision of ambulatory wound care within CCICP	**15 (3x5)**
TW0041	Suboptimal flow of patients	**16 (4x4) NEW**

Risk and controls commentary

- In relation to BAF16, there have been two ICP Board development sessions to review its priorities for 2021/22 with reference to the health and social care white paper and latest planning guidance. The final plan will be presented to the ICP Board in May. A roadmap programme has begun, facilitated by ICS leaders, which includes an assessment of the maturity of commissioning arrangements. An ICP risk register is in development and will be managed and monitored though the MCHFT infrastructure as part of its hosting role.
- In relation to BAF17, an evaluation of the system-wide Winter/Covid plan will be carried out to ensure lessons are learned to inform future plans. A concerted focus on patient discharges in the wider system during the Winter period resulted in Mid Cheshire demonstrating the best improvement in discharges across Cheshire and Mersey for the period January to March 2021.
- There are two high priority operational risks relating to BAF17 around challenges to integrating systems across the health and social care economy. Development work at Winsford to increase ambulatory wound care capacity has been completed; the business case for investment in workforce is still being considered by the CCG (CP0115). TW0041 has been added as a new risk as part of the review of the COO's portfolio of risk; a 12-month action plan is place.

Strategic Objective 7	**Be well governed and clinically led** guided by the expertise and capable leaders with clear processes and practices

Principal risks	Risk score (IxL)
BAF19. Ineffective governance systems to foster a risk assurance culture (**CEO**)	**9 (3x3)**
BAF20. Failure to establish appropriate governance and risk mitigation around existing and new collaborative models of working (**CEO**)	**9 (3x3)**
BAF21. Failure to develop leadership capacity and capability throughout the organisation (**DW&OD**)	**12 (4x3)**

Risk and controls commentary

- The focused programme of work to strengthen the Trust's governance and risk management systems over the past year has resulted in positive assurance from the Trust's internal auditors. The planned training programme was delayed over the Winter period; however, three sessions have been completed with DTIS, Estates & Facilities and Finance, and Quality Governance. The programme will continue with senior managers in all areas to have received training by the end of Q1. After a successful pilot with DTIS, the Executive Team made a decision to move operational risks to 4Risk, the system that has been used to manage the BAF since July 2020. A substantive Corporate Risk & Assurance Manager is now in post within the Corporate Governance team and will project manage the transition to 4Risk and will also focus on embedding a robust and joined-up approach to risk assurance through the BAF for the Board and its Committees.
- Actions in relation to BAF20 will be reviewed in the context of system reform and incorporated into the revised BAF for 2021/22.
- A recent action completed in relation to BAF21 was a review of the Leadership Development Framework. The timeline for the Shadow Board Programme was revised due to the third wave of Covid; the programme evaluation has been deferred to Q3. During Q1 there will be a focus on embedding ED&I into leadership development, and setting up a BAME Advisory Panel.
- There are currently no high operational risks associated with SO7.

Board Assurance Framework (BAF)

Mid Cheshire Hospitals NHS
NHS Foundation Trust

Report Date	22 Apr 2021
Risk Status	Open
Risk Area	1.Principal Risks
Control Status	Existing
Action Status	Outstanding

1.Principal Risks

Risk Ref	Risk Title	Cause & Consequence	Inherent Risk Score	Risk Control	Control Assurance (1st Line Assurance)	1st Line Assurance Assurance Level	Control Assurance (2nd Line Assurance)	2nd Line Assurance Assurance Level	Control Assurance (3rd Line Assurance)	3rd Line Assurance Assurance Level	Current Risk Score	Action Required	Target Risk Score
BAF 1	IF arrangements in place to ensure safe management of pandemic against national guidance are inadequate THEN patients and staff could be harmed **Executive Risk Lead:** Oliver Bennett **Risk Owner:** **Last Updated:** 20 Apr 2021 **Latest Review Date:** **Latest Review By:** **Last Review Comments:**	**Cause(s)** 1. Limited leadership capacity and experience 2. Lack of agility and pace 3. Poor governance of decision-making 4. Lack of coordinated approach internally and system-wide 5. Insufficient use of evidence to inform plans 6. Inadequate communication, sharing information and engagement **Consequence(s)** 1. Patient care and safety 2. Workforce safety and morale 3. Reputation 4. Regulatory	I = 4 L = 5 20	1. Command and control structure to respond to and deliver all necessary plans and preparations in relation to pandemic management **Control Owner:** Oliver Bennett	Covid 19 - Trust Response & Planning for Wave 2 reported to PAF August 2020	Acceptable					I = 4 L = 2 8	Review of Winter/Covid Plan including lessons learned on Board workplan for May/June 2021 **Action Owner:** Oliver Bennett **Target Implementation Date:** 30 Jun 2021	I = 4 L = 1 4
				2. SOPs to reflect National emergency planning and business continuity requirements **Control Owner:** Oliver Bennett	Emergency Preparedness, Resilience and Response annual report to Board November 2020	Acceptable			NHSE/I accepted Aug 2020 Trust assurance submission on the submission of EPRR Core Standards	Acceptable		External review of Covid impact on quality, services and finances, together with lessons learned to inform Trust Strategy **Action Owner:** Oliver Bennett **Target Implementation Date:** 30 Sep 2021	
				3. Winter/COVID Plan - Trust-wide and system-wide (Cheshire) approved by PAF and the Board October 2020 **Control Owner:** Oliver Bennett	Winter plan tracked and progress documented at the Winter Planning Group with updates documented at Silver Command and escalated to Gold if necessary.	Acceptable							

1.Principal Risks

Risk Ref	Risk Title	Cause & Consequence	Inherent Risk Score	Risk Control	Control Assurance (1st Line Assurance)	1st Line Assurance Assurance Level	Control Assurance (2nd Line Assurance)	2nd Line Assurance Assurance Level	Control Assurance (3rd Line Assurance)	3rd Line Assurance Assurance Level	Current Risk Score	Action Required	Target Risk Score
BAF 3	IF the widening nurse staffing vacancy gap is not closed THEN patient care could be detrimentally impacted **Executive Risk Lead:** Julie Tunney **Risk Owner:** **Last Updated:** 09 Apr 2021 **Latest Review Date:** 09 Apr 2021 **Latest Review By:** Gilly Conway **Last Review Comments:** Director of Nursing and Quality will propose to the Q&S Committee that the risk be reduced to target level 8 due to evidence that the risk is controlled.	**Cause(s)** 1. National shortages 2. Competition between providers 3. Poor perception of pay and working conditions and the impact of COVID experience 4. Geographical location and transport access 5. Impact of Brexit on overseas workforce availability 6. Inability to secure international nurse recruits from overseas due to COVID 7. Inability to attract pre-registration nurses due to lack of bursaries 8. Failure to deliver UK Adaptation Programme 9. Failure to consider alternative opportunities to support nursing workforce **Consequence(s)** 1. Patient care and safety 2. Financial: agency expenditure 3. Workforce morale 4. Reputation as employer / of nursing 5. Regulatory	I = 4 L = 5 20	1. Closing the gap' plan 2023 **Control Owner:** Heather Barnett	'Closing the gap' report to EWAG	Acceptable	1. NMC Registered Staff Group Vacancy Analysis submitted to PAF, WDT and Q&S Aug, Sept & Oct 2020 2. Safe Staffing reported annually to Board	Acceptable	CQC assessment		I = 4 L = 2 8	Deliver the Health & Wellbeing Phase 2 implementation plan **Action Owner:** Heather Barnett **Target Implementation Date:** 30 Jun 2021	I = 4 L = 2 8
				2. Workforce Supply Group monitors 3 workstreams: Attraction/Recruitment, Retention, and Workforce Demand & Planning **Control Owner:** Heather Barnett	Monthly updates to Multi-disciplinary Clinical Workforce Group								
				3. Health & Wellbeing agenda (relevant aspects eg. sickness etc) **Control Owner:** Heather Barnett	1. Health & Wellbeing quarterly report to EWAG 2. Sickness Absence Analysis Report submitted to WDT Committee Dec 2020	Partial			NHSI/E Organisational Pulse Survey results reported to EWAG and to WTGC				
				4. Nurse Vacancy Project Plan **Control Owner:** Heather Barnett			Update report on the Nursing Vacancy Plan to Q&S Committee August 2020	Acceptable					
				5. International Recruitment Programme **Control Owner:** Heather Barnett			Update report on the Nursing Vacancy Plan including International Recruitment to Q&S Committee August 2020	Acceptable	Reports from Cheshire International Recruitment Collaboration	Acceptable			

1.Principal Risks

Risk Ref	Risk Title	Cause & Consequence	Inherent Risk Score	Risk Control	Control Assurance (1st Line Assurance)	1st Line Assurance Assurance Level	Control Assurance (2nd Line Assurance)	2nd Line Assurance Assurance Level	Control Assurance (3rd Line Assurance)	3rd Line Assurance Assurance Level	Current Risk Score	Action Required	Target Risk Score
BAF 4	IF the Trust does not ensure safe and secure environments for staff, patients and visitors THEN avoidable harm could occur **Executive Risk Lead:** Russell Favager **Risk Owner:** **Last Updated:** 21 Apr 2021 **Latest Review Date:** **Latest Review By:** **Last Review Comments:**	**Cause(s)** 1. Inadequate focus on H&S 2. Water safety (legionella) 3. Ineffective security arrangements 4. Asbestos 6. Fire safety compliance 7. Contamination with dangerous substances 8. Slips, trips & falls **Consequence(s)** 1. Health & Safety 2. Workforce morale 3. Reputation 4. Legal 5. Financial	I = 4 L = 5 20	1. Fire Management Improvement Plan in place through to to 2023 **Control Owner:** Russell Favager	Workplace inspections - Fire Safety Assessments				1. Cheshire Fire & Rescue (CFR) Audit Programme Sept 2018 - Positive Audit Feedback 2. Annual audit by Authorising Engineer reported to Estates Divisional Board and H&S Group	Acceptable	I = 4 L = 3 12	Violence reduction strategy needs to be in place by April 2021 to meet National Requirements. **Action Owner:** Russell Favager **Target Implementation Date:** 30 Jun 2021	I = 4 L = 2 8
				2. Asbestos Management Plan (AMP) and Register of ACMs (Asbestos Containing Materials) **Control Owner:** Russell Favager					Annual audit by Authorising Engineer reported to Estates Divisional Board and H&S Group			Asbestos register to be validated and formal appointments of Asbestos Authorising Person and Responsible Person. **Action Owner:** Russell Favager **Target Implementation Date:** 30 Jun 2021	
				3. H&S Policy and procedures **Control Owner:** Russell Favager	Workplace inspections risk assessments		Incident reporting to H&S Group (including RIDDOR)					Outstanding Fire Safety Management Assessments to be completed. **Action Owner:** Russell Favager **Target Implementation Date:** 30 Jun 2021	
				4. Control of Substances Hazardous to Health (COSHH) register **Control Owner:** Russell Favager	Compliance checks by H&S Manager with outcomes reported to H&S Group							Stress Survey to be undertaken, followed by improvements plans to be developed based on feedback from Focus Groups in identified hotspot locations. **Action Owner:** Russell Favager **Target Implementation Date:** 31 Dec 2021	
				5. Management of Aggressive Behaviour Procedure (Security Team) **Control Owner:** Russell Favager	Incident reporting via Ulysses								
				6. Water Safety Group (WSG) is in place as required by HTM04. Responsible Person is formally appointed and is Head of Estates. There is an appointed external Authorising Engineer who produces an action plan following the annual audit which is monitored by WSG. **Control Owner:** Russell Favager	Progress reports to Water Safety Group and Estates Divisional Board				Annual audit by Authorising Engineer (September 2020) to Estates Divisional Board and H&S Group				
				7. Staff safety workstreams (HSE focus): - Stress Culture Survey undertaken bi-annually - Stress Management training available for managers - Managing Work Related Procedure in place - Proactive Preventative Psychology Well-being Improvement Plan **Control Owner:** Russell Favager	Workstreams monitored via Health & Safety Group and issues escalated to ESSEG								

1.Principal Risks

Risk Ref	Risk Title	Cause & Consequence	Inherent Risk Score	Risk Control	Control Assurance (1st Line Assurance)	1st Line Assurance Assurance Level	Control Assurance (2nd Line Assurance)	2nd Line Assurance Assurance Level	Control Assurance (3rd Line Assurance)	3rd Line Assurance Assurance Level	Current Risk Score	Action Required	Target Risk Score
BAF 5	IF the Trust does not introduce a Quality Improvement approach to its highest risk clinical challenges THEN it is less likely to resolve them **Executive Risk Lead:** Julie Tunney **Risk Owner:** **Last Updated:** 09 Apr 2021 **Latest Review Date:** **Latest Review By:** **Last Review Comments:**	**Cause(s)** 1. QI methodoogy not embedded throughout organisation 2. Quality improvement not underpinned by evidence 3. Approach not developed in consultation with all relevant stakeholders **Consequence(s)** 1. Patient care, safety and experience 2. Reputation as an employer for clinical staff 3. Regulatory 4. Public perception	I = 3 L = 5 15	1. Quality & Safety Improvement Strategy 2020/21 **Control Owner:** Julie Tunney			1. Quality & Safety metrics reported monthly to Committees and Board via IPR 2. Quality Account to Q&S and Board annually (Dec 2020)	Acceptable	1. CQC report May 2020		I = 3 L = 3 9	Quality Improvement approach to be submitted to the Board following approval of the Trust Strategy in April **Action Owner:** Murray Luckas **Target Implementation Date:** 28 May 2021	I = 3 L = 2 6
				2. IPC Strategy (DIPC policies/procedures) **Control Owner:** Julie Tunney			1. IPC BAF Aug Board approved 2. IPC BAF updates 6 monthly to Q&S (last submission Jan 2021; progress report due June 2021)	Partial	1. CQC inspections 2. MIAA audit 2018			Quality CQC 'should-dos' and 'must-dos' to go to Exec Groups as a standing agenda item **Action Owner:** Julie Tunney **Target Implementation Date:** 30 Jun 2021	
				3. Ward accreditation programme including CCICP **Control Owner:** Julie Tunney			Annual Report to Q&SC		1. CQC full inspection 2. MIAA Internal Audit Report on Ward Quality Spot Checks (Sept 2019)	Acceptable		All maternity services non-compliances to be addressed (ref Ockenden report) **Action Owner:** Julie Tunney **Target Implementation Date:** 30 Jun 2021	
				4. Self-assessment in response to Ockenden Report December 2020 (investigation into maternity services at Shrewsbury & Telford NHS Trust) **Control Owner:** Julie Tunney			Gap analysis report submitted to Q&SC and Board January 2021	Partial				Quality Improvement 'should do' actions arising from the 2019 CQC inspection **Action Owner:** Julie Tunney **Target Implementation Date:** 31 Dec 2021	
				5. Implementation of 'Falls Bundle' in response to analysis of falls trend data **Control Owner:** Julie Tunney			Effectiveness of initiative monitored by Falls Steering Group						
BAF 6	IF the Trust is unable to proceed with EPR development and implementation THEN the Trust will be unable to improve safety to its desired standard **Executive Risk Lead:** Amy Freeman **Risk Owner:** **Last Updated:** 22 Apr 2021 **Latest Review Date:** **Latest Review By:** **Last Review Comments:**	**Cause(s)** 1. Insufficient financing 2. Inadequate business case to meet regulatory requirements 3. Business case approval process changing creating uncertainty 4. Relationship changes lead to affordability issues **Consequence(s)** Fall-back is status quo which is not sustainable and would negatively affect: 1. Patient care and safety 2. Reputation 3. Efficiency benefits 4. Running costs 5. Cyber security 6. Clinical audit	I = 4 L = 5 20	1. £250k NHSX funding received and external support contract in place with Apira to support development of the Full Business Case **Control Owner:** Amy Freeman	EPR update reports to W&DTC monthly				Approval of the OBC from DoHSC and NHSEI 25/09/20	Acceptable	I = 4 L = 2 8	OGC Gateway 1 (Business Justification) **Action Owner:** Amy Freeman **Target Implementation Date:** 30 Jun 2021	I = 4 L = 1 4
				2. Trust Systems Support Model self-assessment for EPR readiness **Control Owner:** Amy Freeman	TSSM self-assessment results to DTIS Group 30/06/20	Acceptable						Gateway Reviews to be reported to the Digital Transformation Programme Board when in place **Action Owner:** Amy Freeman **Target Implementation Date:** 30 Jun 2021	
				3. Five OGC gateway reviews **Control Owner:** Amy Freeman			1. OGC Gateway 0 review included in Business Case approved by Board Jan 2019						
				4. MoU with partners signed off by the Board Nov 2019 **Control Owner:** Amy Freeman									
				5. Procurement process documented in the OBC being undertaken by a joint Task & Finish Group (MCHFT, East Cheshire and Apira) **Control Owner:** Amy Freeman	T&F Group reports to DTIS				Independent assessment of procurement process by Apira				

Mid Cheshire Hospitals NHS
NHS Foundation Trust

1.Principal Risks

Risk Ref	Risk Title	Cause & Consequence	Inherent Risk Score	Risk Control	Control Assurance (1st Line Assurance)	1st Line Assurance Assurance Level	Control Assurance (2nd Line Assurance)	2nd Line Assurance Assurance Level	Control Assurance (3rd Line Assurance)	3rd Line Assurance Assurance Level	Current Risk Score	Action Required	Target Risk Score

1.Principal Risks

Risk Ref	Risk Title	Cause & Consequence	Inherent Risk Score	Risk Control	Control Assurance (1st Line Assurance)	1st Line Assurance Assurance Level	Control Assurance (2nd Line Assurance)	2nd Line Assurance Assurance Level	Control Assurance (3rd Line Assurance)	3rd Line Assurance Assurance Level	Current Risk Score	Action Required	Target Risk Score
BAF 7	IF the Trust does not provide sufficient capacity to meet demand and achieve operational standards THEN it may cause harm to its patients and be unable to meet its regulatory requirements **Executive Risk Lead:** Oliver Bennett **Risk Owner:** **Last Updated:** 15 Apr 2021 **Latest Review Date:** **Latest Review By:** **Last Review Comments:**	**Cause(s)** 1. Workforce gaps 2. IPC measures including social distancing 3. Changing patterns of demand 4. Access to the independent sector 5. Physical environment is restrictive **Consequence(s)** 1. Patient care and experience 2. Patient outcomes 3. Reputation 4. Regulatory	I = 4 L = 5 20	1.1. A&E: successful capital bid to build new A&E **Control Owner:** Oliver Bennett							I = 4 L = 5 20	Deliver a revised restoration programme for elective work that is signed off by PAF Committee following Covid 3rd wave. **Action Owner:** Oliver Bennett **Target Implementation Date:** 30 Apr 2021	I = 4 L = 3 12
				1.2. A&E: NHS 111 Implementation Plan **Control Owner:** Oliver Bennett	Highlight report included within COO Report on implementation to PAF Jan 2021 following soft launch Nov 2020							Ensure that PAF Committee has clear oversight of the backlog of patients, clinical prioritisation and risks emerging. **Action Owner:** Oliver Bennett **Target Implementation Date:** 30 Apr 2021	
				2.1. RTT: Elective Care Restoration Plan submitted to PAF and Board September and October 2020 respectively **Control Owner:** Oliver Bennett	Monthly update to PAF							Urgent Care Implementation Plan to be developed **Action Owner:** Oliver Bennett **Target Implementation Date:** 30 Apr 2021	
				2.2. RTT: National contracts with independent sector to increase capacity **Control Owner:** Oliver Bennett					ISP Utilisation Report identifies MCHFT uptake of available IS capacity			Ensure that the overarching risk assessment around Covid Escalation provides adequate and effective information on how delayed and cancelled patients will be treated. **Action Owner:** Oliver Bennett **Target Implementation Date:** 30 Apr 2021	
				3.1. Diagnostics: Phase 3 Restoration Plan submitted to PAF and Board in September and October 2020 respectively **Control Owner:** Oliver Bennett			Monthly Integrated Performance Report provides performance data as evidence of progress against plan	Partial				Deliver the A&E build and new staffing model. **Action Owner:** Oliver Bennett **Target Implementation Date:** 30 Sep 2021	
				3.2. Diagnostics: independent sector capacity (national contracts) **Control Owner:** Oliver Bennett									
				4. Cancer Services: Restoration Plan **Control Owner:** Oliver Bennett	Details of Cancer Services Restoration Plan within monthly Restoration Report submitted to PAF monthly	Acceptable							
				5. Winter/COVID Plan - Trust-wide and system-wide (Cheshire) approved by PAF and the Board October 2020 **Control Owner:** Oliver Bennett	1. Review including lessons learned to be submitted to BoD May 2021. 2. Winter plan tracked and progress documented at Winter Planning Group with updates documented at Silver Command and escalated to Gold if necessary.		Evidence of deviation from plan within the IPR and escalated by exception to PAF and Board via Chair's Assurance Report and potentially the CEO Report						
				6. International Recruitment programme **Control Owner:** Heather Barnett	International Recruitment of Medical Staff Report to December WDT Committee	Acceptable							

1.Principal Risks

Risk Ref	Risk Title	Cause & Consequence	Inherent Risk Score	Risk Control	Control Assurance (1st Line Assurance)	1st Line Assurance Assurance Level	Control Assurance (2nd Line Assurance)	2nd Line Assurance Assurance Level	Control Assurance (3rd Line Assurance)	3rd Line Assurance Assurance Level	Current Risk Score	Action Required	Target Risk Score
				7. LLPs providing additional clinical capacity **Control Owner:** Oliver Bennett									
BAF 8	IF the Trust does not have robust processes for audit, learning & implementation of new practice THEN it may hinder quality improvement and could be unable to meet regulatory requirements **Executive Risk Lead:** Murray Luckas **Risk Owner:** **Last Updated:** 09 Apr 2021 **Latest Review Date:** **Latest Review By:** **Last Review Comments:**	**Cause(s)** 1. Lack of coordinated approach 2. Poor dissemination of information 3. Complex Governance processes **Consequence(s)** 1. Patient care and safety 2. Reputation 3. Regulatory	I = 3 L = 5 15	1. Programme of National Audits and actions plans **Control Owner:** Murray Luckas	Divisional Governance monitoring of action plans with exception reporting to Trust Improvement Group and non-compliance escalated to EQGG		Clinical Audit and Effectiveness Annual Report 2019/20 to Audit Committee July 2020 - evidences delivery against the National Clinical Audit Patient Outcomes Programme	Acceptable	CQC review of compliance with national audits and implementation of action plans		I = 3 L = 3 9	Implementation of actions arising from CQC inspection to be evidenced **Action Owner:** Murray Luckas **Target Implementation Date:** 30 Jun 2021 Clinical Audit Policy refreshed and to be submitted to Trust Quality Improvement Group and Audit Committee. **Action Owner:** Murray Luckas **Target Implementation Date:** 30 Jul 2021	I = 3 L = 2 6
				2. The Trust participates with the Advancing Quality programme (AQuA) and the implementation of recommendations is tracked (suspended due to pandemic) **Control Owner:** Murray Luckas			Benchmarked data and improvement plans reported quarterly						
				3. Arrangements for assessing compliance with NICE guidance and process for escalation of non-compliance **Control Owner:** Murray Luckas	Compliance included in Divisional governance dashboards		Exceptions reported to Trust Quality Improvement Group (from February 2021)						
				4. Incident Reporting, Management, Learning and Improvement Policy **Control Owner:** Murray Luckas					Internal Audit 2020 - Incident Management & Reporting submitted to Audit Committee Sept 2020 and Q&S Committee Oct 2020	Acceptable			
BAF 9	IF the Trust does not use high quality activity and patient outcome data to assess the quality of its care THEN it may miss trends and signals and encounter less positive patient outcomes **Executive Risk Lead:** Murray Luckas **Risk Owner:** **Last Updated:** 09 Apr 2021 **Latest Review Date:** **Latest Review By:** **Last Review Comments:**	**Cause(s)** 1. Accessibility of data 2. Data quality 3. Inadequate data analysis capacity and capability 4. Inadequate data management software 5. Limited scope of existing data to surgical outcomes **Consequence(s)** 1. Patient care 2. Reputation 3. Regulatory	I = 4 L = 5 20	1. Learning from Deaths Policy & Mortality Review Process (Divisional & Corporate) **Control Owner:** Murray Luckas	Divisional Mortality reports		Quarterly Learning from Deaths Report to QSC and Board (January 2021)	Acceptable	1. Nationally benchmarked mortality data 2. AQuA Quarterly Mortality Report		I = 3 L = 4 12	Develop a business case for 7 day service for consultant ward rounds (Ockenden report action) **Action Owner:** Murray Luckas **Target Implementation Date:** 30 Sep 2021 Lessons learnt report for nosocomial infection patient deaths to go to QSC and Trust Board **Action Owner:** Murray Luckas **Target Implementation Date:** 31 Dec 2021	I = 3 L = 3 9
				2. Action planning based on GIRFT findings (GIRFT on hold due to pandemic) **Control Owner:** Murray Luckas	Departmental plans monitored locally				GIRFT revisit to assess specialty action plans (date tbc)				
				3. Participation with Outcome Registries **Control Owner:** Murray Luckas	Departmental plans monitored locally				Annual registry reports				
				4. End of Life Care outcome measures (Strategic Collaborative for Palliative and End of Life Care in Cheshire) **Control Owner:** Julie Tunney					National Audit of Care at the End of Life reported to Q&S Committee January 2021	Partial			

1.Principal Risks

Risk Ref	Risk Title	Cause & Consequence	Inherent Risk Score	Risk Control	Control Assurance (1st Line Assurance)	1st Line Assurance Assurance Level	Control Assurance (2nd Line Assurance)	2nd Line Assurance Assurance Level	Control Assurance (3rd Line Assurance)	3rd Line Assurance Assurance Level	Current Risk Score	Action Required	Target Risk Score
BAF 10	IF the Trust cannot attract, retain and support a high performing workforce THEN quality of care is likely to deteriorate **Executive Risk Lead:** Heather Barnett **Risk Owner:** **Last Updated:** 09 Apr 2021 **Latest Review Date:** **Latest Review By:** **Last Review Comments:**	**Cause(s)** 1. National shortages 2. Limited flexible working options 3. Competition between providers 4. Geographical location and transport access 5. Perception as an employer 6. Impact of Brexit on overseas workforce availability 7. Inadequate performance management and appraisal processes 8. Limited career pathways 9. Mismatch between skills and learning needs and education provision 10. Lack of University presence to attract students 11. Failure to embrace diversity & inclusion 12. Poor leadership **Consequence(s)** 1. Workforce capacity & capability 2. Organisational resilience 3. Workforce morale 4. Reputation as an employer 5. Regulatory 6. Patient care and experience	I = 4 L = 5 20	1. Our Workforce Matters Strategy 2019-21 approved by Trust Board Nov 2018 and delivered via an action plan monitored by WDTC **Control Owner:** Heather Barnett	Our Workforce Matters quarterly updates to WDT		Medical staffing workforce metrics included in the Workforce Report reported via WDTC to Board of Directors				I = 4 L = 3 12	Analysis of recruitment metrics from new recruitment trac.jobs system **Action Owner:** Heather Barnett **Target Implementation Date:** 30 Jun 2021	I = 4 L = 3 12
				10. Suite of HR policies that support management of high performing workforce (confirmed by the Workforce Governance Group to have been reviewed and in date) **Control Owner:** Heather Barnett					Internal Audits reported to WDTC - Electronic Staff Record 2019?			Implement the People Recovery Plan phases 1-6 **Action Owner:** Heather Barnett **Target Implementation Date:** 30 Jun 2021	
				11. People Recovery Plan approved by Workforce Silver Group, EWAG, Health & Wellbeing Project Board, and Restoration and Transformation Group April 2021 **Control Owner:** Heather Barnett								Deliver Health & Wellbeing Implementation Plan **Action Owner:** Heather Barnett **Target Implementation Date:** 30 Jun 2021	
				2. Education and Training Programme **Control Owner:** Heather Barnett	Training & Education Quarterly Report to WDTC		Self Assessment against Health Education England's priorities 2019/20	Acceptable				Develop the strategic workforce plan for 2021-23 into an action plan and monitor **Action Owner:** Heather Barnett **Target Implementation Date:** 30 Jun 2021	
				3. Health & Wellbeing Plan **Control Owner:** Heather Barnett			Health & Wellbeing quarterly report to EWAG	Partial	NHSI/E Organisational Pulse Survey results reported to EWAG and to WTGC			Review of Workforce Matters Strategy following approval of Trust Strategy - to be submitted to EWAG and WDTC **Action Owner:** Heather Barnett **Target Implementation Date:** 30 Jul 2021	
				4. Annual Staff Survey process and action planning **Control Owner:** Heather Barnett			Survey report to EWAG	Acceptable				Review of ED&I Strategy and key objectives to ensure the implementation plan reflects Board and wider workforce feedback, and remains relevant within current social, political and environmental context **Action Owner:** Heather Barnett **Target Implementation Date:** 30 Jul 2021	
				5. Workforce Supply Group monitors 3 workstreams: Attraction/Recruitment, Retention, and Workforce Demand & Planning **Control Owner:** Heather Barnett	Workforce Supply Group report to EWAG							Implement plans in key areas of focus identified from the Staff Survey for 2020/21: - reducing work related stress - improving team working - reduce violence in the workplace - further improve safety culture **Action Owner:** Heather Barnett **Target Implementation Date:** 30 Sep 2021	
				6. Apprenticeships **Control Owner:** Heather Barnett			Apprenticeship levy usage report to EWAG and JCNC					Implement and monitor new Agile Working Policy **Action Owner:** Heather Barnett **Target Implementation Date:** 31 Dec 2021	
				7. ED&I Strategy 2020-24 **Control Owner:** Heather Barnett			Annual ED&I report to WDTC May 2020 and Board		1. National benchmarking WRES and WDES report to WDTC and Board 2. Gender pay gap results to WDTC and Board	Partial			
				8. Recruitment policies & process **Control Owner:** Heather Barnett	International Recruitment Medical Staff - update to WDT Committee Dec 2020	Acceptable	MIAA Audit tool (covers all elements of workforce for dealing with COVID) results reported to EWAG and WDT		Internal Audit - Vacancy Management (deferred from 2020/21 to 2021/22 audit plan)				

1.Principal Risks

Risk Ref	Risk Title	Cause & Consequence	Inherent Risk Score	Risk Control	Control Assurance (1st Line Assurance)	1st Line Assurance Assurance Level	Control Assurance (2nd Line Assurance)	2nd Line Assurance Assurance Level	Control Assurance (3rd Line Assurance)	3rd Line Assurance Assurance Level	Current Risk Score	Action Required	Target Risk Score
				9. Measures put in place to support BAME staff during the Covid-19 pandemic **Control Owner:** Heather Barnett	Detailed response submitted to NHSE/I in June 2020 re Trust compliance with risk assessments for at-risk staff groups. Board advised of 100% compliance via CEO Report & Workforce Report in July 2020	Acceptable							
BAF 11	IF the Trust fails to harness the benefits of technology to integrate, streamline and improve systems of working THEN this could lead to reduced productivity and safety **Executive Risk Lead:** Amy Freeman **Risk Owner:** **Last Updated:** 22 Apr 2021 **Latest Review Date:** **Latest Review By:** **Last Review Comments:**	**Cause(s)** 1. Insufficient financing 2. Inadequate business cases 3. Poor prioritisation processes 4. Low digital maturity 5. Limited ability to attract digital skills **Consequence(s)** 1. Patient care, safety and experience 2. Reputation as provider and as an employer 3. Use of resources (efficiency, effectiveness, economy) 4. Workforce morale and productivity 5. Cyber security	I = 4 L = 5 20	1. IT Strategy aligned with DIGIT@LL Strategy 2018-22 (refresh to align with new Trust Strategy 2021) **Control Owner:** Amy Freeman	Updates to DTIS every two months						I = 4 L = 3 12	Decisions on investment and pressures list for 2021/22 **Action Owner:** Amy Freeman **Target Implementation Date:** 30 Jun 2021	I = 4 L = 2 8
				2. Healthcare Information and Management Systems Society (HIMSS) Electronic Medical Record Adoption Model identifies gaps in systems for medical use (June 2020) **Control Owner:** Amy Freeman					HIMSS report to WDTC with discussion about priorities				
				3. Horizon scanning events with suppliers to identify innovation in the sector **Control Owner:** Amy Freeman	Updates to DTIS and WDTC								

1.Principal Risks

Risk Ref	Risk Title	Cause & Consequence	Inherent Risk Score	Risk Control	Control Assurance (1st Line Assurance)	1st Line Assurance Assurance Level	Control Assurance (2nd Line Assurance)	2nd Line Assurance Assurance Level	Control Assurance (3rd Line Assurance)	3rd Line Assurance Assurance Level	Current Risk Score	Action Required	Target Risk Score
BAF 12	IF the Trust does not create the conditions for an effective organisational culture THEN this could affect quality, efficiency and workforce standards **Executive Risk Lead:** James Sumner **Risk Owner:** **Last Updated:** 20 Apr 2021 **Latest Review Date:** **Latest Review By:** **Last Review Comments:**	**Cause(s)** 1. Poor leadership (tone from the top) 2. Misalignment of strategy and culture 3. Inadequate strategic focus on culture 4. Inadequate / inappropriate internal communications and cascade mechanisms 5. Poor understanding of overarching culture and sub-cultures 6. Insufficient focus on embedding culture at all levels **Consequence(s)** 1. Workforce behaviours and morale 2. Patient care and experience 3. Reputation as an employer 4. Public perception 5. Regulatory	I = 4 L = 5 20	1. Trust strategic priorities 2020-21 include culture **Control Owner:** James Sumner							I = 4 L = 2 8	Identify and engage a Quality Improvement partner (third party) to embed QI methodology within the Trust **Action Owner:** Heather Barnett **Target Implementation Date:** 30 Jun 2021	I = 4 L = 2 8
				2. Our Workforce Matters Strategy 2019-21 **Control Owner:** Heather Barnett	Our Workforce Matters annual report		Workforce metrics reporting and analysis reported to EWAG and via Integrated Performance Report to WDTC and Board					Review of ED&I Strategy and key objectives to ensure the implementation plan reflects Board and wider workforce feedback, and remains relevant within current social, political and environmental context **Action Owner:** Heather Barnett **Target Implementation Date:** 30 Jul 2021	
				3. Communication and Engagement Strategy **Control Owner:** Heather Barnett	Comms and Engagement bi-annual report to Workforce Group								
				4. Leadership Behaviours Framework **Control Owner:** Heather Barnett	Learning from Covid presentation							Define, raise awareness and embed leadership behaviours within current practice **Action Owner:** James Sumner **Target Implementation Date:** 31 Dec 2021	
				5. ED&I Strategy 2020-24 **Control Owner:** Heather Barnett			Annual ED&I report to WDTC and Board		1. National benchmarking WRES and WDES report to WTGC and Board 2. Gender pay gap results to WTGC and Board				
				6. Annual Staff Survey Process and action planning **Control Owner:** Heather Barnett			Staff survey results reported to EWAG, WDTC and Board	Acceptable	Annual National Staff Survey results				
				7. Quality Improvement strategy and action plan include culture elements **Control Owner:** Heather Barnett			Internal OD Diagnostic reported to Execs and Board (organisational readiness assessment)		Annual Patient Survey results includes culture of care and compassion to Board				

1.Principal Risks

Risk Ref	Risk Title	Cause & Consequence	Inherent Risk Score	Risk Control	Control Assurance (1st Line Assurance)	1st Line Assurance Assurance Level	Control Assurance (2nd Line Assurance)	2nd Line Assurance Assurance Level	Control Assurance (3rd Line Assurance)	3rd Line Assurance Assurance Level	Current Risk Score	Action Required	Target Risk Score
BAF 13	IF the Trust fails to provide modern, efficient, sustainable estate, infrastructure and equipment THEN this could lead to high cost business continuity issues in future **Executive Risk Lead:** Russell Favager **Risk Owner:** **Last Updated:** 21 Apr 2021 **Latest Review Date:** 06 Apr 2021 **Latest Review By:** Gilly Conway **Last Review Comments:** The Board agreed to raise the risk score to 20 after considering the priority levels assigned to a number of linked operational risks	**Cause(s)** 1. Old buildings / deteriorating physical environment 2. Ageing medical equipment 3. Competing priorities for investment 4. Lack of strategic approach to estates planning 5. Environmental sustainability considerations insufficiently embedded 6. Concrete (RAAC) roof planks 7. Unsupported IT systems and databases **Consequence(s)** 1. Patient care, safety and experience 2. Workforce morale 3. Reputation 4. Regulatory	I = 5 L = 5 25	1. Estates Strategy in place to 2020 and is currently being updated with assistance from Property Consultants Archus **Control Owner:** Russell Favager	Estates & Facilities Divisional Assurance Framework reports to Divisional Board		1. Estates Annual report		New Build Certification		I = 5 L = 4 20	SOC to cover Leighton Hospital re-build to Trust Board **Action Owner:** Russell Favager **Target Implementation Date:** 28 May 2021	I = 5 L = 3 15
				10. Cyber security action plan and risk register monitored by the Audit Committee **Control Owner:** Amy Freeman	Cyber report to DTIS and Audit Committee every six months	Partial			1. Annual penetration tests 2. Internal Audit of cyber security processes 2020	Acceptable		Relocation of VIN to Weaver Square is at feasibility stage and Business Case is due for completion by May 2021 **Action Owner:** Russell Favager **Target Implementation Date:** 31 May 2021	
				11. Medical Devices Group in place. Maintenance and upgrade plans form part of the overall capital planing process **Control Owner:** Russell Favager	Updates on action plan following Internal Audit report submitted to Audit Committee January 2021	Partial			Internal Audit 2020 - Medical Devices (operational and technical controls)	Low		55% of RAAC beams surveys to be completed (63% including Residencies being 'moth-balled') by end of January. SOC to cover re-build of the areas affected by RAAC is due to go to the Trust Board in May 2021. **Action Owner:** Russell Favager **Target Implementation Date:** 31 May 2021	
				2. Capital programme expenditure agreed annually by Executive Safe and Sustainable Environment Group (ESSEG) and monitored by Performance and Finance Committee **Control Owner:** Russell Favager	Capital Exceptions report to IDG and Divisional Board (cost and programme)							IT investment for electronic tracking of medical devices business case to be developed **Action Owner:** Russell Favager **Target Implementation Date:** 30 Jun 2021	
				3. Six Facets Estate Survey database provided by NIFES and validated by Head of Estates will be used to inform the updated Estates Strategy **Control Owner:** Russell Favager	Self audits against NHS sustainability audit tool (every six months)							Estates environmental sustainability to be part of Corporate Social Responsibility Group to be led by the Director of Workforce & Organisational Development. It will include review of the NHS Environmental Assessment Tool (NEAT) and production of an action plan to improve performance in agreed key areas **Action Owner:** Russell Favager **Target Implementation Date:** 31 Dec 2021	
				4. Compliance of Trust's environments with Equalities Act **Control Owner:** Russell Favager					PLACE Assessments (members of the public) reported to Divisional Board (&?) before published nationally				
				5. Survey programme re RAAC beams in progress **Control Owner:** Russell Favager									
				6. Backlog Maintenance planning (£6.5m of backlog maintenance risk to be addressed in 2020/21 utilising NHSE/I funding) **Control Owner:** Russell Favager			Annual ERIC returns to NHSI provide information about the physical condition of the Estate (includes 6 Facets information)						

1.Principal Risks

Risk Ref	Risk Title	Cause & Consequence	Inherent Risk Score	Risk Control	Control Assurance (1st Line Assurance)	1st Line Assurance Assurance Level	Control Assurance (2nd Line Assurance)	2nd Line Assurance Assurance Level	Control Assurance (3rd Line Assurance)	3rd Line Assurance Assurance Level	Current Risk Score	Action Required	Target Risk Score
				7. Hospital Redevelopment Programme provides long term sustainable solution to significant estate issues supported by a dedicated governance structure **Control Owner:** James Sumner	1. Monthly Programme Updates to Board via Chair's Assurance Report/CEO report 2. Highlight reports to BoD Part II as required								
				8. IT Strategy and plan outline the priorities for maintenance and improvement of key systems **Control Owner:** Amy Freeman									
				9. IT contracts review process **Control Owner:** Amy Freeman									

1.Principal Risks

Risk Ref	Risk Title	Cause & Consequence	Inherent Risk Score	Risk Control	Control Assurance (1st Line Assurance)	1st Line Assurance Assurance Level	Control Assurance (2nd Line Assurance)	2nd Line Assurance Assurance Level	Control Assurance (3rd Line Assurance)	3rd Line Assurance Assurance Level	Current Risk Score	Action Required	Target Risk Score
BAF 14	IF the Trust does not plan its workforce requirement for the future THEN it is likely to create high cost expenditure and lead to workforce gaps which could impact standards of care **Executive Risk Lead:** Heather Barnett **Risk Owner:** **Last Updated:** 09 Apr 2021 **Latest Review Date:** **Latest Review By:** **Last Review Comments:**	**Cause(s)** 1. Poor horizon scanning and forecasting 2. Poor understanding of expectations of young people entering workforce 3. Insufficient consideration of workforce in strategic planning 4. Misalignment of workforce planning, activity and finance 5. Lack of accurate and up-to-date workforce information and data 6. Lack of workforce planning capacity and capability 7. Poor communication between education providers / HEE / Providers **Consequence(s)** 1. Sustainability of services 2. Workforce morale 3. Reputation as an employer 4. Regulatory 5. Patient care and experience	I = 4 L = 5 20	1. Our Workforce Matters Strategy 2019-21 approved by Trust Board Nov 2018 and delivered via an action plan monitored by WDTC **Control Owner:** Heather Barnett	Our Workforce Matters annual report		Workforce metrics reporting and analysis reported to EWAG and via Integrated Performance Report to WDTC and Board				I = 4 L = 3 12	Implement phase 1 of the new ESR hierarchy and work structures **Action Owner:** Heather Barnett **Target Implementation Date:** 31 May 2021	I = 4 L = 2 8
				2. Workforce Plan 2020-23 (including volunteers) approved by WDTC December 2020 **Control Owner:** Heather Barnett	Closing the Nursing Workforce Gap report to EWAG Annual workplan report to WDTC	Acceptable			Annual NHSI/E Workforce plan submission reported to WDTC			Develop the medical and wider clinical workforce gap trajectories **Action Owner:** Heather Barnett **Target Implementation Date:** 30 Jun 2021	
				3. Workforce Systems Project group and action plan **Control Owner:** Heather Barnett	Quarterly progress report to EWAG and 6 monthly to WDTC							Develop the strategic workforce plan for 2021-23 into an action plan and monitor **Action Owner:** Heather Barnett **Target Implementation Date:** 30 Jun 2021	
				4. E-roster project implementation plan **Control Owner:** Julie Tunney	E-roster reporting on nursing / HCA staff groups		E-roster report to EWAG					Develop an Apprenticeship Strategic Plan **Action Owner:** Heather Barnett **Target Implementation Date:** 30 Jul 2021	
				5. Recruitment Policies and Process **Control Owner:** Heather Barnett			MIAA Audit tool results reported to EWAG and WDT		Internal Audit - Vacancy Management (deferred from 2020/21 to 2021/22 audit plan)				
				6. Apprenticeships **Control Owner:** Heather Barnett			Apprenticeship levy usage report to EWAG and JCNC						
				7. Physician Associates in place as part of strategy to increase workforce **Control Owner:** Heather Barnett			Physicians Associate report submitted to EWAG December 2020						
				8. Workforce Supply Group monitors 3 workstreams: Attraction/Recruitment, Retention, and Workforce Demand & Planning **Control Owner:** Heather Barnett									
				9. Talent Board is in place and succession planning process is aligned to the Divisions **Control Owner:** Heather Barnett									

1.Principal Risks

Risk Ref	Risk Title	Cause & Consequence	Inherent Risk Score	Risk Control	Control Assurance (1st Line Assurance)	1st Line Assurance Assurance Level	Control Assurance (2nd Line Assurance)	2nd Line Assurance Assurance Level	Control Assurance (3rd Line Assurance)	3rd Line Assurance Assurance Level	Current Risk Score	Action Required	Target Risk Score
BAF 15	IF financial management, budgetary controls and efficiency planning are not robust THEN the Trust may not deliver its financial targets **Executive Risk Lead:** Russell Favager **Risk Owner:** **Last Updated:** 21 Apr 2021 **Latest Review Date:** **Latest Review By:** **Last Review Comments:**	**Cause(s)** 1. Inappropriate financial planning 2. Poor financial data 3. Low understanding of local budgetary responsibilities 4. Poor compliance with financial controls 5. Cash releasing savings plans that are not fully identified and may not be fully delivered 6. Cost pressures arising from the use of agency staff 7. The use of non-recurrent measures may also contribute to a risk to the Trusts longer term sustainability 8. Failure to agree control total with NHSI/E 9. Inability to invest in development of service **Consequence(s)** 1. Regulatory 2. Sustainability of services 3. Reputation 4. Patient care	I = 4 L = 5 20	1. Corporate Governance Framework Manual including Standing Financial Instructions and Scheme of Delegation (approved by Audit Committee and Board of Directors) **Control Owner:** Russell Favager			Compliance with SFIs reported to Audit Committee on quarterly basis		Annual Internal Audit Key Financial Controls - report received High Assurance January 2021	Acceptable	I = 4 L = 2 8	Revised SFIs and Scheme of Delegation incorporated into Corporate Governance Manual to be approved by the Audit Committee and Trust Board **Action Owner:** Russell Favager **Target Implementation Date:** 30 Apr 2021	I = 4 L = 2 8
				2. Budgetary Controls - each Division has a dedicated financial accountant **Control Owner:** Russell Favager	Monthly divisional meetings with Accountant		Monthly Finance reports to PAF and Board					Financial benchmarking data (reference cost) to be shared with the key divisional areas; corporate area to be reviewed for potential collaboration at scale opportunities. **Action Owner:** Russell Favager **Target Implementation Date:** 30 Apr 2021	
				3. Contracts with Commissioners (suspended in 2020/21) **Control Owner:** Russell Favager	Signed contract with Commissioners		Monthly Contract financial reports to Commissioners						
				4. Financial plan **Control Owner:** Russell Favager	Signed off by the PAF and the Board		Monthly monitoring performance via Finance reports to PAF and Board		Annual Use of Resources (External Audit)			Annual report on financial benchmarking to be presented to PAF Q4 2020/21. **Action Owner:** Russell Favager **Target Implementation Date:** 30 Jun 2021	
				5. Annual reference costs (cost improvement plans only being pursued during 2020/21 where no impact on patient services) **Control Owner:** Russell Favager			Signed off by PAF					PLICS data to be rolled out across targeted specialities, and linked with patient related outcomes in Q4 2020/21. **Action Owner:** Russell Favager **Target Implementation Date:** 30 Jun 2021	
				6. End of year financial accounting processes **Control Owner:** Russell Favager			Annual Accounts scrutinised and signed off by Audit Committee		External Audited Annual Accounts			Updated training for budget holders to be rolled out Q4 2020/21 **Action Owner:** Russell Favager **Target Implementation Date:** 30 Jun 2021	
				7. Collaboration at scale (projects ongoing during 2020/21 but only for non patient facing services) **Control Owner:** Russell Favager	Directors of Finance meet fortnightly		Monthly Cheshire meetings chaired by the CEO		Head of Internal Audit Opinion				
				8. Information shared across divisions outlining benchmarking opportunities **Control Owner:** Russell Favager					External Benchmarking information received by the Trust including Model Hospital				
				9. Cheshire System Financial Recovery Plan (on hold - awaiting National guidance on financial regime for Cheshire/Merseyside system) **Control Owner:** Russell Favager	Monthly CEO and DOF meetings				NHSI/E Performance Meetings				

1.Principal Risks

Risk Ref	Risk Title	Cause & Consequence	Inherent Risk Score	Risk Control	Control Assurance (1st Line Assurance)	1st Line Assurance Assurance Level	Control Assurance (2nd Line Assurance)	2nd Line Assurance Assurance Level	Control Assurance (3rd Line Assurance)	3rd Line Assurance Assurance Level	Current Risk Score	Action Required	Target Risk Score
BAF 16	IF the Trust does not focus on enabling a successful Integrated Care Partnership and carry out its hosting responsibility THEN this could lead to substandard out of hospital care **Executive Risk Lead:** Denise Frodsham **Risk Owner:** **Last Updated:** 21 Apr 2021 **Latest Review Date:** **Latest Review By:** **Last Review Comments:**	**Cause(s)** 1. Failure to overcome organisational politics 2. Senior capacity 3. Ineffective governance 4. Lack of agreement of shared goals and plans 5. Poor communication 6. Failure to have single data source across the system **Consequence(s)** 1. Patient care and experience including inequality of provision 2. Reputation 3. Financial 4. Regulatory intervention	I = 3 L = 5 15	1. Local transformation funding to support the programme of work **Control Owner:** Denise Frodsham	Task and Finish Groups report to Transformation Board (part of Cheshire East ICP governance structure)						I = 3 L = 3 9	ICP risk register to be established and incorporated with MCHFT systems **Action Owner:** Denise Frodsham **Target Implementation Date:** 30 Jun 2021	I = 3 L = 2 6
				2. CEICP Board includes CEO representation from MCHFT **Control Owner:** James Sumner	Monthly risk reports to ERAG (from October)		Monthly report to the Board of Directors from the Chair of the ICP					ICP Board development session to agree Board development programme for 2021 **Action Owner:** Denise Frodsham **Target Implementation Date:** 30 Jun 2021	
				3. Cheshire East Place 5 year plan presented to Board October 2019 **Control Owner:** Denise Frodsham			Update reports go to Place Partnership Board						
				4. Memorandum of Understanding agree between health partners and agreed in principle with Local Authority **Control Owner:** Denise Frodsham									
				5. ICP Strategy and Transformation Plan **Control Owner:** Denise Frodsham	Monthly highlight report for each workstream to ICP Transformation Board								
BAF 17	IF there continues to be ineffective capacity and demand management across the Health and Social Care system THEN the risk to patients of being hospitalised unnecessarily will continue to increase **Executive Risk Lead:** Oliver Bennett **Risk Owner:** **Last Updated:** 15 Apr 2021 **Latest Review Date:** **Latest Review By:** **Last Review Comments:**	**Cause(s)** 1. Poor understanding of key failure points 2. Poor system-wide data 3. Parters not delivering on their commitments 4. Inadequate focus on embedding new ways of working 5. Poor communication **Consequence(s)** 1. Hospital capacity 2. Patient care and experience 3. Reputation	I = 4 L = 5 20	1. Winter/COVID Plan - Trust-wide and system-wide (Cheshire) approved by PAF and the Board October 2020 **Control Owner:** Oliver Bennett	1. Review including lessons learned on Board workplan for May/June 2021. 2. Winter plan tracked and progress documented at the Winter Planning Group with updates documented at Silver Command and escalated to Gold if necessary.						I = 4 L = 3 12	**Action Owner:** **Target Implementation Date:**	I = 4 L = 2 8
				2. Cheshire system-wide urgent care delivery Board **Control Owner:** Oliver Bennett									

1.Principal Risks

Risk Ref	Risk Title	Cause & Consequence	Inherent Risk Score	Risk Control	Control Assurance (1st Line Assurance)	1st Line Assurance Assurance Level	Control Assurance (2nd Line Assurance)	2nd Line Assurance Assurance Level	Control Assurance (3rd Line Assurance)	3rd Line Assurance Assurance Level	Current Risk Score	Action Required	Target Risk Score
BAF 19	IF the Trust does not have effective governance systems and processes in place to move to a risk assurance culture THEN it is less likely to manage its key risks, resulting in quality and financial challenges **Executive Risk Lead:** James Sumner **Risk Owner:** **Last Updated:** 20 Apr 2021 **Latest Review Date:** 06 Apr 2021 **Latest Review By:** Gilly Conway **Last Review Comments:** Agreed at January Board to reduce current score to 9	**Cause(s)** 1. Low openness to change 2. Low understanding of risk & assurance 3. Inability to effect culture change 4. Poor perception of governance requirement 5. Lack of senior buy-in **Consequence(s)** 1. Governance 2. Regulatory 3. Reputation 4. Patient care	I = 3 L = 5 15	1. Phase 1 Risk & Assurance project plan outputs July-Oct 2020 in place: - Risk Management Strategy & Process - Risk reporting through the governance structure with new reporting formats - ERAG and Risk Sub-Group set up and operational - BAF in 4Risk - Exec and Board training on BAF, assurance and risk appetite Design and delivery assisted by external expert resource **Control Owner:** Caroline Keating	Company Secretary holds weekly project meetings to review progress	Acceptable	Audit Committee Task & Finish Group consultation sessions	Acceptable	Internal Audit - Assurance Framework and Risk Management Process Q4 2020-21	Acceptable	I = 3 L = 3 9	Phase 1 risk management training programme **Action Owner:** Caroline Keating **Target Implementation Date:** 30 Jul 2021	I = 3 L = 2 6
				2. Risk Management Strategy approved by the BoD August 2020 sets the overarching approach **Control Owner:** Caroline Keating									
				3. Final version Assurance & Escalation Framework agreed by the Audit Committee November 2020 and approved by Board December 2020 documents key mechanisms **Control Owner:** Caroline Keating			Internal compliance testing by Governance Team						
				4. CQC improvement planning and implementation **Control Owner:** Julie Tunney	Quality Summit reviews progress on actions		Must-dos reported quarterly to QSC						
				5. Redesigned Governance Structure approved by Board July 2020 **Control Owner:** Caroline Keating	Annual evaluation of effectiveness of Exec Groups, Board Committees and the Board of Directors				Well-led governance reviews every 3 years				
				6. Risk Management Process Guide approved by Audit Committee November 2020 and distributed to key groups sets out the risk management methodology to be followed by all staff **Control Owner:** Caroline Keating			Monthly Risk Sub -Group Workplan focuses on checking and challenging compliance with agreed process	Partial	Internal Audit Advisory Review of Compliance planned for Q4 2020/21				
				7. Data Security and Protection Toolkit (ICO requirement) **Control Owner:** Amy Freeman					Internal Audit May 2020	Acceptable			

1.Principal Risks

Risk Ref	Risk Title	Cause & Consequence	Inherent Risk Score	Risk Control	Control Assurance (1st Line Assurance)	1st Line Assurance Assurance Level	Control Assurance (2nd Line Assurance)	2nd Line Assurance Assurance Level	Control Assurance (3rd Line Assurance)	3rd Line Assurance Assurance Level	Current Risk Score	Action Required	Target Risk Score
BAF 20	IF the Trust fails to establish appropriate governance and risk mitigation around existing and new collaborative, system wide models of working THEN it may expose itself to risk of which it is unaware **Executive Risk Lead:** James Sumner **Risk Owner:** **Last Updated:** 22 Apr 2021 **Latest Review Date:** **Latest Review By:** **Last Review Comments:**	**Cause(s)** 1. Low understanding of benefits of appropriate governance 2. Poor understanding of partnership risks 3. Ineffective communication between partners 4. Failure to learn and adapt to system-wide thinking 5. Lack of coterminosity 6. Failure to plan for partnership service changes **Consequence(s)** 1. Governance 2. Reputation 3. Regulatory 4. Patient care 5. Financial	I = 3 L = 5 15	1. CEO member of Integrated Care Partnership Board and Trust is host of the new arrangements **Control Owner:** James Sumner	Chief Executive's report to the BoD						I = 3 L = 3 9	Cheshire East breast screening integration **Action Owner:** Denise Frodsham **Target Implementation Date:** 30 Jun 2021	I = 3 L = 2 6
				2. CEO member of CE Place Partnership. CEICP collaboration agreement to be signed off by BoD Sept 2020 **Control Owner:** James Sumner	Chief Executive's report to the BoD							MCHFT governance guidance/policy for entering collaborative arrangements **Action Owner:** Caroline Keating **Target Implementation Date:** 30 Jun 2021	
				3. DSP member of CWICP Board. Memorandum of Understanding approved by MCHFT Board June 2020 **Control Owner:** Denise Frodsham								Governance for ICP hosting **Action Owner:** Caroline Keating **Target Implementation Date:** 30 Sep 2021	
				4. Blueprint for partnership agreements in place (cf Pathology agreement - approved by Board Nov 2020) **Control Owner:** James Sumner									
BAF 21	IF the development of leadership capacity and capability throughout the organisation is not a priority THEN the Trust's ambitions are unlikely to be met **Executive Risk Lead:** Heather Barnett **Risk Owner:** **Last Updated:** 09 Apr 2021 **Latest Review Date:** **Latest Review By:** **Last Review Comments:**	**Cause(s)** 1. Inadequate planning of leadership requirement 2. Lack of clarity about development paths 3. Inadequate investment 4. Failure to address leadership culture 5. Low senior engagement 6. Low clinical leadership engagement 7. Lack of capacity to release staff for development 8. Lack of resources to deliver adequate development opportunities 9. Perceived or real cultural barriers for BAME staff **Consequence(s)** 1. Leadership 2. Strategy 3. Change management 4. Culture 5. Workforce morale	I = 4 L = 5 20	1. Leadership Development matrix and implementation plan **Control Owner:** Heather Barnett	Leadership development plan progress reports to EWAG and WDT	Acceptable					I = 4 L = 3 12	ED&I Strategy review **Action Owner:** Heather Barnett **Target Implementation Date:** 30 Jul 2021	I = 4 L = 2 8
				2. Our Workforce Matters Strategy approved by Board of Directors November 2018 **Control Owner:** Heather Barnett	Quarterly updates to WDT committee. Last update mapped against 'We are the NHS: People Plan 2020/21"	Acceptable	Workforce metrics reporting and analysis reported to EWAG and via Integrated Performance Report to WDTC and Board					Set up BAME Advisory Panel **Action Owner:** Heather Barnett **Target Implementation Date:** 30 Jul 2021	
				3. Coaching & mentoring scheme **Control Owner:** Heather Barnett	Education, Learning and OD report to EWAG quarterly							Annual review of the talent and succession plan **Action Owner:** Heather Barnett **Target Implementation Date:** 30 Sep 2021	
				4. Medical leadership programme **Control Owner:** Murray Luckas	Education Committee?							Review of recruitment practices and establish diverse stakeholder panels for senior appointments **Action Owner:** Heather Barnett **Target Implementation Date:** 30 Sep 2021	
				5. Talent Board is in place and succession planning process is aligned to the Divisions **Control Owner:** Heather Barnett	Annual review of talent and succession plan to EWAG and WDTC	Acceptable						Evaluate the Shadow Board programme **Action Owner:** Heather Barnett **Target Implementation Date:** 29 Oct 2021	
				6. Staff Survey action plans relating to leadership are in place **Control Owner:** Heather Barnett			Staff Survey focus groups and action plan review includes feedback about leadership		Annual National Staff Survey results				
				7. Leadership Development Programme 21/22 and associated investment approved by EWAG April 2021 **Control Owner:** Heather Barnett									

Mid Cheshire Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

Agenda Item	**7.2**	Date of Meeting: 29/04/2021
Report Title	**Proposed strategic objectives & principal risks 2021/22**	
Executive Lead	James Sumner, Chief Executive	
Lead Officer	Caroline Keating, Company Secretary; Gilly Conway, Risk & Governance Consultant	
Action Required	To approve	

☐ **Acceptable assurance** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐ **Partial assurance** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Low assurance** Evidence indicates poor effectiveness of controls

Key Messages of this Report *(2/3 headlines only)*

- The proposed strategic objectives for 2021/22 have been identified through the development of the new 5 year Trust Strategy
- The draft set of principal risks for the 2021/22 BAF has been developed to include articulation of causes and consequences, proposed inherent risk scores, and relevant controls from the current BAF

Next Steps (*actions to be taken following agreement of recommendation/s by Board/Committee)*

- The principal risks will be uploaded to 4Risk where the BAF detail will be managed and tracked
- Further work to develop the BAF detail with Executive Risk Leads will take place during May

Strategic Objective(s) *(indication of which objective/s the report aligns to)*

• Manage Covid response and recovery	☐	• Provide safe and sustainable services	☐
• Provide outstanding care/patient experience	☐	• Provide strong system leadership by working together	☐
• Deliver most effective care to achieve best possible outcomes	☐	• Be well governed and clinically led	✓
• Be the best place to work	☐		

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

• Quality	☐	• Compliance	☐
• Finance	☐	• Legal	☐
• Workforce	☐	• Risk/BAF Click here to select relevant risk	
• Equality	☐		

Equality Impact Assessment (*must accompany the following submissions)*

Strategy ☐ Policy ☐ Service Change ☐

REPORT DEVELOPMENT

Committee/ Group Name	Date	Report Title	Lead	Brief summary of key issues raised and actions agreed
Executive Team	30/03/21	Draft principal risks 2021/22	Caroline Keating	Draft risks agreed prior to Board Development Day
Board Development Day	01/04/21	Strategic Risk Workshop	Caroline Keating	Feedback provided to refine principal risks
Audit Committee	15/04/21	Board Assurance Framework arrangements for 2021/22	Caroline Keating	Arrangements for managing and reporting the BAF noted
Executive Team	20/04/21	Draft principal risks 2021/22	Caroline Keating	Articulation of principal risks reviewed prior to presentation to the Board

Proposed Strategic Objectives & Principal Risks 2021/22

Introduction

1. The Board Assurance Framework (BAF) is an important component of the Trust's corporate governance and risk management framework. It is a monitoring tool used by the Board to assess the organisation's capacity to achieve its strategic objectives, and to ensure it has appropriate oversight of the management of key risks.

2. The Trust's BAF approach was reviewed and redesigned during Q1 2020/21. The new arrangements approved by the Board in June 2020 provided:

    - clear alignment between strategic objectives, principal risks, key controls and assurance evidence;
    - a systematic process using technology to manage the data and facilitate reporting;
    - clarity about roles, responsibilities and accountability;
    - streamlined reporting on risk that facilitates focused discussion at Board meetings.

3. The approach was reviewed in March 2021 by MIAA, the Trust's internal auditors, and findings reported to the Audit Committee 15 April 2021. The resulting internal audit opinion provides independent assurance that the structure of the BAF meets NHS requirements, it is visibly used by the Board and its Committees, and it reflects the risks discussed by the Board and its Committees.

4. It is good practice to conduct an annual review of the principal risks that are monitored and reported through the BAF to ensure they remain relevant in the context of strategic objectives and the Trust's operating environment. This coincides this year with the identification of revised strategic objectives for 2021/22 through the development of a new Trust strategy.

5. This report presents the new strategic objectives and a revised and aligned set of principal risks for approval by the Board.

Development of refreshed principal risks

6. The strategic objectives that emerged through Board debate on the development of the Trust Strategy are set out below:

    - Provide safest and best care which is equitable and centred on the patient and their family's health, well-being and care needs
    - Become a leading and sustainable health care system, providing seamless care to our local population in collaboration with our partners
    - Be the best place to work, where our staff are empowered to innovate and provide consistently excellent care
    - Push boundaries in clinical, technology and digital innovation to provide the tools and infrastructure to deliver best possible care

7. A strategic risk questionnaire was issued to all Board members at the start of March to gain their input about the key risks facing the Trust in the context of the new strategy. The responses were analysed and presented to the Executive Team for discussion during a workshop session on 15 March 2021. The key areas of risk identified during the workshop were used to develop a set of principal risks that have been mapped to the draft strategic objectives and discussed by the Board at its Development Day 01 April.

8. The wording of the risks has since been revised to take into account feedback from the Board and individual risk owners and presented back to the Executive Team 20 April 2021 (Appendix 1).

9. Causes and consequences for each risk have been drafted and these underpin the proposed inherent risk scores. In addition, relevant controls from the 2020/21 BAF have been mapped to the refreshed set of risks (Appendix 2).

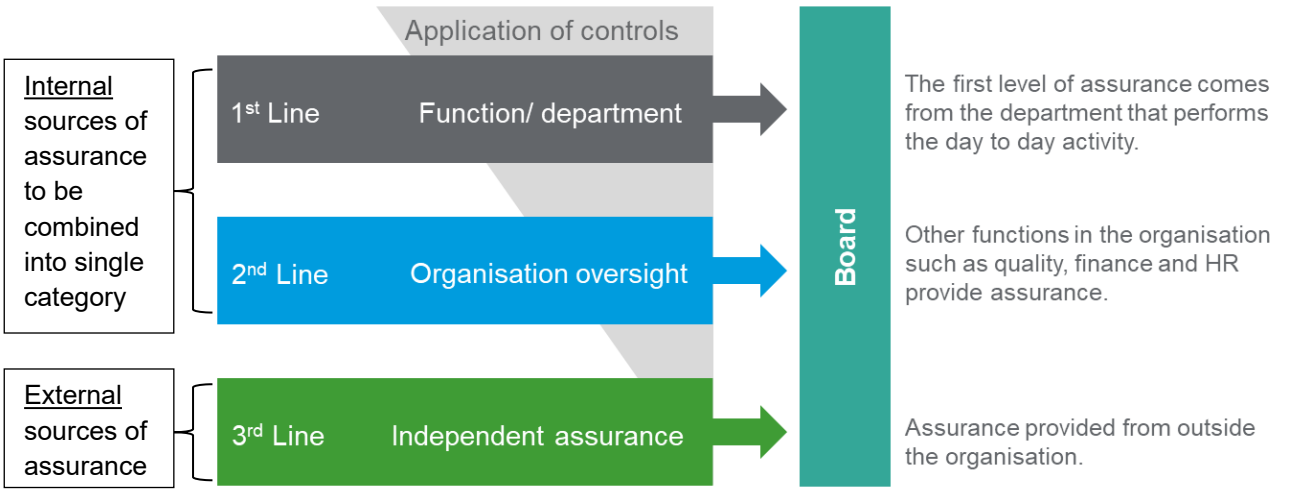
10. Appendix 3 shows how the proposed risks for 2021/22 compare with those monitored by the Board during 2020/21.

11. Once agreed by the Board, the risks will be input to 4Risk and further work will be undertaken to develop the full set of key controls and action plans, and ensure assurances are relevant and up to date. The Corporate Governance team will work with assigned Executive Risk Leads to do this during May.

Change to categorisation of assurances

12. It is good practice to categorise sources of assurance to indicate their degree of independence. The approach adopted during 2020/21 was to align the classification of assurances according to the 'three lines of defence' risk management model as shown in the image below. Feedback from risk and control owners is that it is often difficult to categorise internal sources of assurance as first or second line, which is leading to confusion and inconsistency of application.

13. A proposal was approved by the Audit Committee 15 April 2021 to simplify the categorisation of assurances for the purpose of reporting the BAF. Assurances originating from the first or second lines of defence will be grouped as 'internal' and assurances provided from third line sources will be categorised as 'external'. In this way the process is simplified but clarity is maintained about which assurances can be considered as having the greatest degree of independence. It should be noted that the three lines of defence model still applies within the Trust in relation to the design and application of the system of internal control.



Recommendations

14. To approve the revised strategic objectives and the proposed set of principal risks set out in Appendix 1.

Author: Gilly Conway, Risk and Governance Consultant
Date: 21 April 2021

Appendix 1: proposed strategic objectives and principal risks 2021/22

Patient Experience & Quality of Services Provide safest and best care which is equitable and centred on the patient and their family's health, well-being and care needs	**New Ways of Working** Become a leading and sustainable health care system, providing seamless care to our local population in collaboration with our partners	**Best Place to Work** Be the best place to work, where our staff are empowered to innovate and provide consistently excellent care	**Build for the Future** Push boundaries in clinical, technology and digital innovation to provide the tools and infrastructure to deliver best possible care
BAF1. IF demand exceeds operational capacity while the Trust adapts to the 'new normal', THEN service restoration may be ineffective and impact negatively on patient care, outcomes and experience **Risk owner: Oliver Bennett**	BAF5. IF we fail to establish formal place-based partnerships with good governance and assurance, THEN we are unlikely to deliver new ways of working across the health and social care system **Risk owner: James Sumner**	BAF8. IF we fail to develop the capacity and capability to deliver a consistent and coordinated continuous improvement methodology, THEN we will not deliver our strategic ambitions **Risk owner: James Sumner**	BAF11. IF our estate, infrastructure and equipment are not fit for the future, THEN we will fail to achieve our strategic ambitions **Risk owner: Russ Favager**
BAF2. IF our workforce wellbeing and resilience are reduced, THEN our capacity to restore services and adapt to future challenges will be compromised **Risk owner: Heather Barnett**	BAF6. IF we are unable to achieve a sufficient level of influence within the ICS, THEN commissioning decisions may prevent us from achieving our strategic aims **Risk owner: James Sumner**	BAF9. IF the conditions for shaping leadership and organisational culture are sub-optimal, THEN our strategic ambitions will not be realised **Risk owner: Heather Barnett**	BAF12. IF a major incident occurs as a result of RAAC plank failure, THEN people may be harmed and the Trust could be subject to legal and regulatory investigation **Risk owner: Russ Favager**
BAF3. IF we do not maintain a robust and consistent focus on the quality of care, THEN there may be a negative impact on patient safety, outcomes and experience **Risk owner: Julie Tunney**	BAF7. IF we are unable to agree a financial control total, THEN it could jeopardise delivery of strategy **Risk owner: Russ Favager**	BAF10. IF we are unable to harness data to understand the needs of our population and inform our decisions, THEN we will fail to improve healthcare outcomes and address health inequalities **Risk owner: Amy Freeman**	BAF13. IF we fail to deliver the technological and people aspects required to implement Digital Clinical System, THEN intended benefits for patients may not be realised and the financial investment would be wasted **Risk owner: Amy Freeman**
BAF4. IF a significant H&S incident occurs within the Trust, THEN people may be harmed and the Trust could be subject to legal and regulatory investigation **Risk owner: Russ Favager**			BAF14. IF workforce plans do not align with the future operating model, THEN it is likely that there will be increased costs and workforce gaps that could affect standards of care **Risk owner: Heather Barnett**

Appendix 2: Principal risks 2021/22 with causes and consequences, and relevant controls mapped from 2020/21 BAF

The following table articulates the inherent (*uncontrolled*) risk in terms of causes (2nd column) and consequences (3rd column). The inherent risk scores shown in the first column have been determined with reference to the causes and consequences: the ***Causes*** influence the ***Likelihood*** score and the ***Consequences*** influence the ***Impact*** score. The final column lists controls from the 2020/21 BAF that may have continued relevance for the refreshed principal risks. These controls will be reviewed by Executive Risk Leads to update and add to during May when they will also identify control and assurance gaps and develop action plans to address them.

Draft risks 2021/22 and inherent risk score (Likelihood x Impact)	Causes (inherent risk)	Consequences (inherent risk)	Controls mapped from 2020/21 BAF
BAF1. IF demand exceeds operational capacity while the Trust adapts to the 'new normal', THEN service restoration may be ineffective and impact negatively on patient care, outcomes and experience **Risk owner: Oliver Bennett, Chief Operating Officer** **5x4=20**	1. Changing patterns of demand 2. Workforce gaps 3. Covid threat alters the operating environment indefinitely 4. Waiting list backlogs 5. Population health needs change due to long-term effects of Covid	1. Ineffective restoration of services 2. Detrimental impact on patient care and experience 3. Poorer outcomes for patients 4. Regulatory and reputational impact	1. A&E – capital bid for new A&E + NHS 111 implementation 2. RTT – elective care restoration plan + national contracts with independent sector 3. Diagnostics phase 3 restoration plan + national contracts with independent sector 4. Cancer Services restoration plan 5. Winter/Covid Plan 6. International recruitment prog 7. LLPs additional capacity
BAF2. IF our workforce wellbeing and resilience are reduced, THEN our capacity to restore services and adapt to future challenges will be compromised **Risk owner: Heather Barnett, Director of Workforce & OD** **4x4=16**	1. Increase in mental health issues post Covid 2. Staff with 'long Covid' 3. Staff burn-out 4. Further surges/new variants	1. Loss of goodwill and staff engagement 2. Fluctuating capacity 3. Increase in long-term sickness 4. Increased staff turnover 5. Disruption to services	1. Our Workforce Matters Strategy 2. People Recovery Plan 3. Health & Wellbeing Plan 4. Measures put in place to support BAME staff during Covid

Draft risks 2021/22 and inherent risk score (Likelihood x Impact)	Causes (inherent risk)	Consequences (inherent risk)	Controls mapped from 2020/21 BAF
BAF3. IF we do not maintain a robust and consistent focus on the quality of care, THEN there may be a negative impact on patient safety, outcomes and experience **Risk owner:** **Julie Tunney, Director of Nursing & Quality** **4x5=20**	1. Pressures of responding to backlogs 2. Covid part of the long-term operating context 3. Population health needs change due to long-term effects of Covid 4. Insufficient workforce capacity 5. Nosocomial outbreaks 6. Increased patient dependency and acuity 7. Inconsistent compliance with clinical governance processes	1. Increased incidents 2. Quality standards not met 3. Lower CQC rating 4. Negative impact on patient experience 5. Poorer outcomes for patients 6. Reputational damage	1. Quality & Safety Improvement Strategy 2. IPC Strategy/policies 3. Ward accreditation programme 4. Falls Bundle 5. Clinical audit programme 6. Advancing Quality programme 7. Compliance with NICE 8. Incident Reporting, Management, Learning and Improvement Policy 9. Learning from Deaths & Mortality Review 10. End of Life Care outcome measures 11. Self-assessment in response to Ockenden report 12. Action planning based on GIRFT findings
BAF4. IF a significant H&S incident occurs within the Trust, THEN people may be harmed and the Trust could be subject to legal and regulatory investigation **Risk owner:** **Russ Favager, Deputy CEO/ Director of Finance** **4x5=20**	1. Low profile of H&S across Trust 2. Legionella risk 3. Presence of asbestos in older buildings 4. Inconsistencies in security awareness amongst staff 5. Fire safety risk 6. Contamination risk – dangerous substances 7. Slips, trips and falls	1. Avoidable harm to persons 2. HSE investigation and potential for prosecution / fines 4. Disruption to services 5. Reputational damage	1. Fire Management Plan 2. Asbestos Management Plan 3. H&S policy and procedures 4. COSHH register 5. Management of Aggressive Behaviour Procedure 6. Water Safety Group 7. Staff safety workstreams

Draft risks 2021/22 and inherent risk score (Likelihood x Impact)	Causes (inherent risk)	Consequences (inherent risk)	Controls mapped from 2020/21 BAF
BAF5. IF we fail to establish formal place-based partnerships with good governance and assurance, THEN we are unlikely to deliver new ways of working across the health and social care system **Risk owner:** **James Sumner, Chief Executive** **4x4=16**	1. Organisational politics 2. Senior capacity and relevant experience 3. New governance models required, including risk management 4. Development of Provider Collaborative and lack of shared goals and plans 5. Lack of single data sources across the system 6. Lack of accountability 7. Ineffective communication between partners	1. Inequality of service provision 2. Disjointed care pathways 3. Poor patient experience 4. Failure to realise efficiencies 5. Failure to innovate 6. Reduced CQC rating 7. Reputational damage	1. Local transformation funding (Cheshire East) 2. CEO on CEICP Board 3. Cheshire East Place 5 year plan 4. MoU between health partners and LA (Cheshire East) 5. CEICP Strategy & Transformation Plan 6. CEO member of CE Place Partnership 7. DSP member of CWICP Board + MoU in place 8. Blueprint for partnership agreements in pace (cf Pathology)
BAF6. IF we are unable to achieve a sufficient level of influence within the ICS, THEN commissioning decisions may prevent us from achieving our strategic aims **Risk owner:** **James Sumner, Chief Executive** **3x4=12**	1. Leadership capacity 2. Immature stakeholder strategy 3. New commissioning arrangements 4. Requirement to work within Provider Collaborative model 5. Challenge of selling MCHFT's vision and new strategy	1. Loss of autonomy 2. Requirement to revise strategic ambitions 3. Financial uncertainty	N/A

Draft risks 2021/22 and inherent risk score (Likelihood x Impact)	Causes (inherent risk)	Consequences (inherent risk)	Controls mapped from 2020/21 BAF
BAF7. IF we are unable to agree a financial control total, THEN it could jeopardise delivery of strategy **Risk owner:** **Russ Favager, Deputy CEO/ Director of Finance** **3x4=12**	1. Changes to the commissioning regime 2. Increased costs associated with pandemic and recovery 3. Inability to drive out further efficiencies while managing recovery	1. Insufficient funding to deliver strategy	N/A
BAF8. IF we fail to develop the capacity and capability to deliver a consistent and coordinated continuous improvement methodology, THEN we will not deliver our strategic ambitions **Risk owner:** **James Sumner, Chief Executive** **4x3=12**	1. QI methodology not embedded throughout organisation 2. Quality improvement not underpinned by evidence 3. Insufficient engagement from relevant stakeholders	1. Failure improve ways of working and future-proof services 2. Failure to realise efficiencies 3. Failure to adapt to the changing health needs of the population and address inequalities	N/A

Draft risks 2021/22 and inherent risk score (Likelihood x Impact)	Causes (inherent risk)	Consequences (inherent risk)	Controls mapped from 2020/21 BAF
BAF9. IF the conditions for shaping leadership and organisational culture are sub-optimal, THEN our strategic ambitions will not be realised **Risk owner:** **Heather Barnett, Director of Workforce & OD** **4x4=16**	1. Cultural and leadership development required to adapt to system reforms and strategic ambitions 2. Tone from the top doesn't model desired cultural behaviours 3. Limited understanding of prevailing culture and sub-cultures 4. Insufficient focus on embedding culture at all levels and across all areas 5. Different cultures between partner organisations 6. Lack of staff and leadership engagement 7. Perceived or real cultural barriers for BAME staff	1. Workforce behaviours don't support delivery of strategy 2. Workforce morale suffers 3. Poorer patient experience 4. Inability to adapt quickly enough to keep up with system reform 5. Ineffective leadership 6. Reputational damage	1. Leadership development matrix and implementation plan 2. Our Workforce Matters Strategy 3. Coaching & mentoring scheme 4. Medical leadership programme 5. Talent Board and succession planning 6. Staff Survey action plans 7. Leadership Development Programme & investment 8. Leadership Behaviours Framework 9. Communication & Engagement Strategy 10. ED&I Strategy 11. Quality Improvement Strategy and action plan include culture elements
BAF10. IF we are unable to harness data to understand the needs of our population and inform our decisions, THEN we will fail to improve healthcare outcomes and address health inequalities **Risk owner: Amy Freeman, Chief Information Officer** **5x3=15**	1. Lack of investment 2. Lack of staff capacity and right skills 3. Lack of coordinated partnership approach to develop a place-based system 4. Inconsistent and unreliable data quality	1. Inability to address health inequalities 2. Failure to achieve duty to improve population health outcomes 3. Ineffective decision making 4. Misdirected resources 5. Failure to improve CQC rating	1. Participation with outcome registries

Draft risks 2021/22 and inherent risk score (Likelihood x Impact)	Causes (inherent risk)	Consequences (inherent risk)	Controls mapped from 2020/21 BAF
BAF11. IF our estate, infrastructure and equipment are not fit for the future, THEN we will fail to achieve our strategic ambitions **Risk owner:** **Russ Favager, Deputy CEO/ Director of Finance** **5x4=20**	1. Old buildings / deteriorating physical environment 2. Ageing medical equipment 3. Lack of coordinated approach to asset tracking and management 4. Competing priorities for investment 5. Lack of strategic approach to estates planning 6. Environmental sustainability considerations insufficiently embedded 7. Unsupported legacy IT systems and databases	1. Poor patient experience 2. Poor staff morale 3. Inefficient use of resources 4. Exposure to cybersecurity threats 5. Increased risk of harm to people 6. Failure to modernise services 7. Reputational damage 8. Failure to improve CQC rating	1. Estates Strategy 2. Capital programme expenditure 3. Six Facets Estate Survey database 4. Compliance of Trust's environments with Equalities Act 5. Backlog maintenance planning 6. Hospital redevelopment programme 7. IT Strategy and plan 8. IT contracts review process 9. Cyber security action plan and risk register 10. Medical Devices Group + maintenance and upgrade plans
BAF12. IF a major incident occurs as a result of RAAC plank failure, THEN people may be harmed and the Trust could be subject to legal and regulatory investigation **Risk owner:** **Russ Favager, Deputy CEO/ Director of Finance** **4x5=20**	1. Presence of concrete (RAAC) roof planks (subject of SCOSS Alert May 2019)	1. Potential for serious injuries / fatalities in occupied spaces 2. Loss of building 3. Disruption to services 4. Negative media attention 5. Investigation and potential prosecution / fines 6. Reputational damage	1. RAAC beams survey programme

Draft risks 2021/22 and inherent risk score (Likelihood x Impact)	Causes (inherent risk)	Consequences (inherent risk)	Controls mapped from 2020/21 BAF
BAF13. IF we fail to deliver the technological and people aspects required to implement the Digital Clinical System, THEN intended benefits for patients may not be realised and the financial investment would be wasted **Risk owner:** **Amy Freeman, Chief Information Officer** **4x4=16**	1. Insufficient funding 2. Poor planning 3. Lack of project capacity and skills 4. Low staff engagement 5. Changing partnership landscape	1. Inability to achieve intended benefits for patient care and safety 2. Lost opportunity to modernise 3. Inefficient use of resources 4. Unsustainable operating costs 5. Exposure to cybersecurity threats 6. Reputational damage	1. NHSX funding and external support to develop FBC 2. Trust Systems Support Model self-assessment for EPR readiness 3. Five OGC Gateway Reviews 4. MoU with partners 5. Procurement process
BAF 14. IF workforce plans do not align with the future operating model, THEN it is likely that there will be increased costs and workforce gaps that could affect standards of care **Risk owner:** **Heather Barnett, Director of Workforce & OD** **4x4=16**	1. Poor horizon scanning and forecasting 2. Poor understanding of expectations of young people entering the workforce 3. Insufficient consideration of workforce in strategic planning 4. Misalignment of workforce planning, activity and finance 5. Lack of accurate and up-to-date workforce information and data 6. Lack of workforce planning capacity and capability 7. Poor communication between education providers	1. Unsustainable services 2. Increased staff turnover 3. Widening vacancy gaps 4. Inability to plan capacity effectively 5. Reduced workforce morale 6. Poorer patient care and experience 7. Damage to reputation as an employer 8. Failure to improve CQC rating	1. Our Workforce Matters Strategy 2. Workforce Plan 3. Workforce Systems Project 4. E-roster implementation plan 5. Recruitment policies and process 6. Apprenticeships 7. Physician Associates 8. Workforce Supply Group workstreams 9. Talent Board and succession planning 10. Education and training programme 11. ED&I Strategy

Appendix 3: proposed principal risks 2021/22 compared with 2020/21 BAF

Draft risks 2021/22	2020/21 BAF
1. IF demand exceeds operational capacity while the Trust adapts to the 'new normal', THEN service restoration may be ineffective and impact negatively on patient care, outcomes and experience	7. IF the Trust does not provide sufficient capacity to meet demand and achieve operational standards THEN it may cause harm to its patients and be unable to meet its regulatory requirements 17. IF there continues to be ineffective capacity and demand management across the Health and Social Care system THEN the risk to patients of being hospitalised unnecessarily will continue to increase
2. IF our workforce wellbeing and resilience are reduced, THEN our capacity to restore services and adapt to future challenges will be compromised	10. IF the Trust cannot attract, retain and support a high performing workforce THEN quality of care is likely to deteriorate
3. IF we do not maintain a robust and consistent focus on the quality of care, THEN there may be a negative impact on patient safety, outcomes and experience	8. IF the Trust does not have robust processes for audit, learning & implementation of new practice THEN it may hinder quality improvement and could be unable to meet regulatory requirements BAF9. IF the Trust does not use high quality activity and patient outcome data to assess the quality of its care THEN it may miss trends and signals and encounter less positive patient outcomes
4. IF a significant H&S incident occurs on hospital premises, THEN people may be harmed and the Trust could be subject to legal and regulatory investigation	4. IF the Trust does not ensure safe and secure environments for staff, patients and visitors, THEN avoidable harm could occur
5. IF we fail to establish formal place-based partnerships with good governance and assurance, THEN we are unlikely to deliver new ways of working across the health and social care system	16. IF the Trust does not focus on enabling a successful Integrated Care Partnership and carry out its hosting responsibility THEN this could lead to substandard out of hospital care 20. IF the Trust fails to establish appropriate governance and risk mitigation around existing and new collaborative, system wide models of working THEN it may expose itself to risk of which it is unaware
6. IF we are unable to achieve a sufficient level of influence within the ICS, THEN commissioning decisions may prevent us from achieving our strategic aims	18. IF the Trust fails to play its part in a successful Cheshire System THEN it is unlikely to enable the required reduction in the running costs of the Health System
7. IF we are unable to agree a financial control total, THEN it could jeopardise delivery of strategy	N/A
8. IF we fail to develop the capacity and capability to deliver a consistent and coordinated continuous improvement methodology, THEN we will not deliver its strategic ambitions	5. IF the Trust does not introduce a Quality Improvement approach to its highest risk clinical challenges THEN it is less likely to resolve them

Draft risks 2021/22	2020/21 BAF
9. IF the conditions for shaping leadership and organisational culture are sub-optimal, THEN our strategic ambitions will not be realised	12. IF the Trust does not create the conditions for an effective organisational culture THEN this could affect quality, efficiency and workforce standards 21. IF the development of leadership capacity and capability throughout the organisation is not a priority THEN the Trust's ambitions are unlikely to be met
10. IF we are unable to harness data to understand the needs of our population and inform our decisions, THEN we will fail to improve healthcare outcomes and address health inequalities	N/A
11. IF our estate, infrastructure and equipment are not fit for the future, THEN we will fail to achieve our strategic ambitions	13. IF the Trust fails to provide modern, efficient, sustainable estate, infrastructure and equipment, THEN this could lead to high cost business continuity issues in future
12. IF a major incident occurs as a result of RAAC plank failure, THEN people may be harmed and the Trust could be subject to legal and regulatory investigation	N/A
13. IF we fail to deliver the technological and people aspects required to implement Digital Clinical System, THEN intended benefits for patients may not be realised and the financial investment would be wasted	6. IF the Trust is unable to proceed with EPR development and implementation THEN the Trust will be unable to improve safety to its desired standard
14. IF workforce plans do not align with the future operating model, THEN it is likely that there will be increased costs and workforce gaps that could affect standards of care	10. IF the Trust cannot attract, retain and support a high performing workforce THEN quality of care is likely to deteriorate 14. IF the Trust does not plan its workforce requirement for the future THEN it is likely to create high cost expenditure and lead to workforce gaps which could impact standards of care
N/A – managed and to be closed	1. IF arrangements in place to ensure safe management of pandemic against national guidance are inadequate THEN patients and staff could be harmed
N/A – managed and to be closed	3. IF the widening nurse staffing vacancy gap is not closed THEN patient care could be detrimentally impacted
N/A – to be corporate risk	19. IF the Trust does not have effective governance systems and processes in place to move to a risk assurance culture THEN it is less likely to manage its key risks, resulting in quality and financial challenges
N/A – to be corporate risk	15. IF financial management, budgetary controls, and efficiency planning are not robust, THEN the Trust may not deliver its financial targets

Mid Cheshire Hospitals
NHS Foundation Trust

Board of Directors
Integrated Performance Report

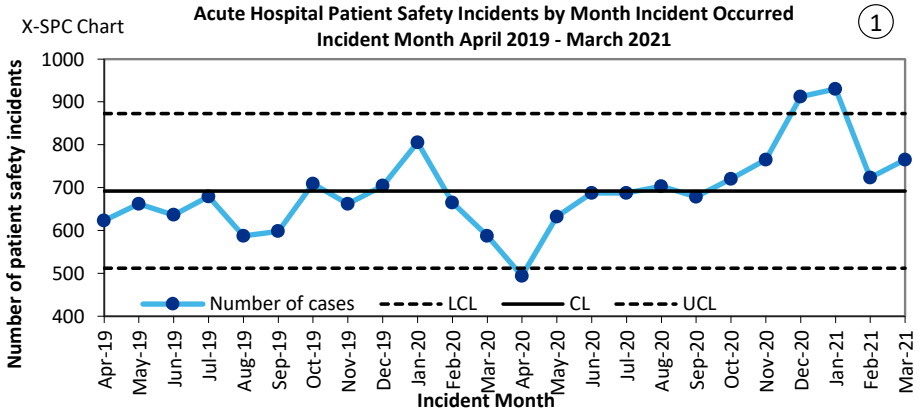
March 2021

"To Deliver Excellence in Healthcare through Innovation & Collaboration"

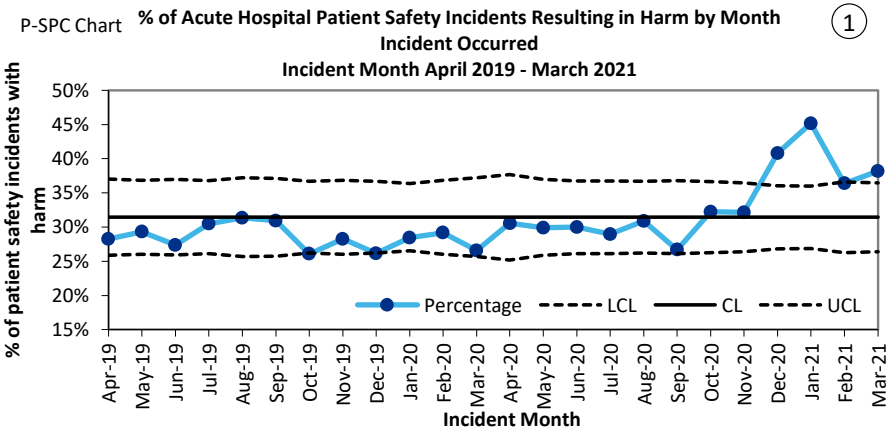
Quality, Safety & Patient Experience

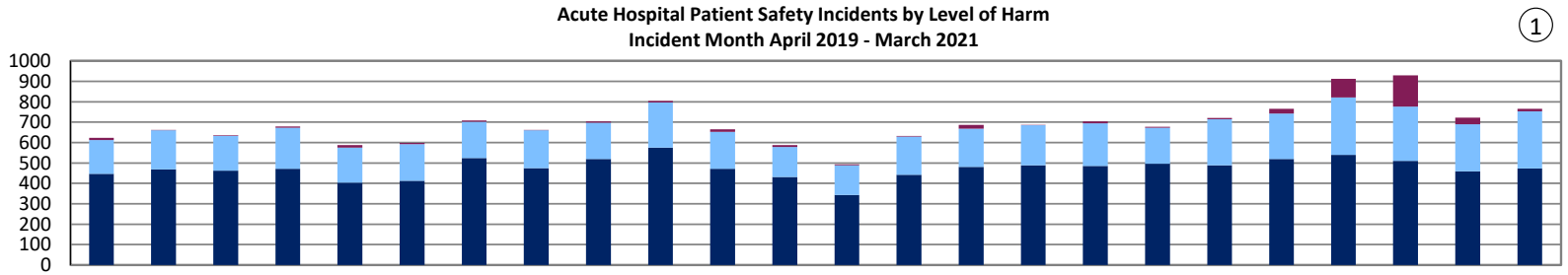
Acute Hospital Patient Safety Incidents (Excludes CCICP)

X-SPC Chart



P-SPC Chart





	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Moderate and Above	10	1	3	6	11	5	7	2	6	9	12	8	5	3	19	2	8	5	5	22	91	153	33	12
Low Harm	166	193	171	201	173	180	178	185	178	220	182	148	146	186	187	197	209	176	227	224	281	267	230	280
No Harm	447	468	462	472	403	413	524	475	520	576	471	431	343	443	481	488	486	497	488	519	540	510	460	473

Accountable: Medical Director
Data Owner: Quality Governance
To note: P-SPC charts adjust the control limits to take into account each month's denominator.

Key Narrative: 765 incidents are currently shown for March 2021 of which 38% resulted in harm.

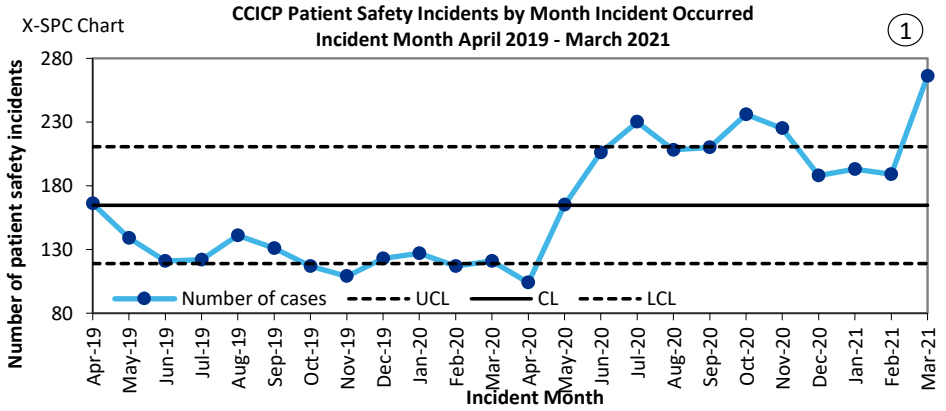
Low Harm 280, Moderate Harm 12, Serious Incident 0

Data Rating: ①captured locally, ②system captured, ③published/benchmarked

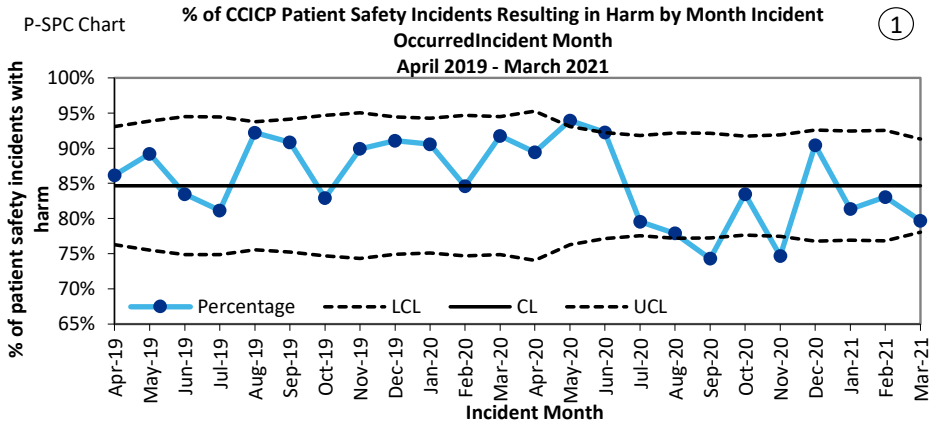
Quality, Safety & Patient Experience

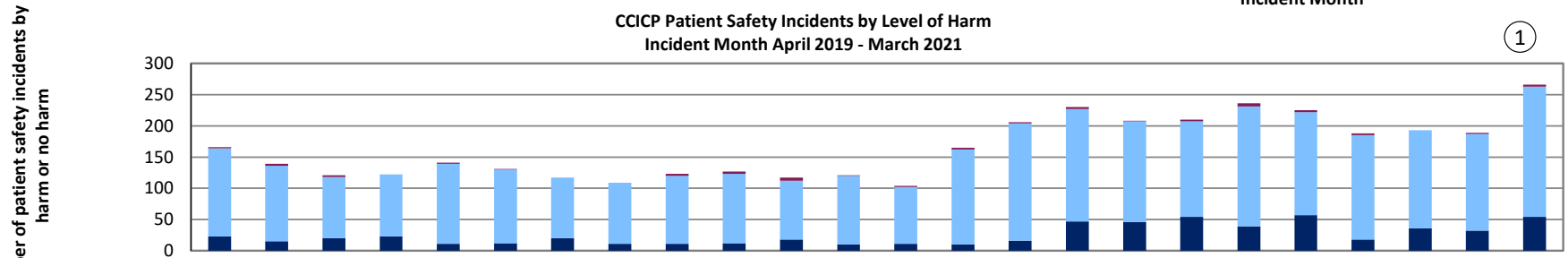
Central Cheshire Integrated Care Partnership (CCICP) Patient Safety Incidents

X-SPC Chart



P-SPC Chart





	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Moderate and Above	2	3	3	-	2	1	-	-	3	4	5	1	2	3	2	3	1	3	5	3	3	-	2	3
Low Harm	141	121	98	99	128	118	97	98	109	111	94	110	91	152	188	180	161	153	192	165	167	157	155	209
No Harm	23	15	20	23	11	12	20	11	11	12	18	10	11	10	16	47	46	54	39	57	18	36	32	54

Accountable: Medical Director
Data Owner: Quality Governance
To note: P-SPC charts adjust the control limits to take into account each month's denominator.

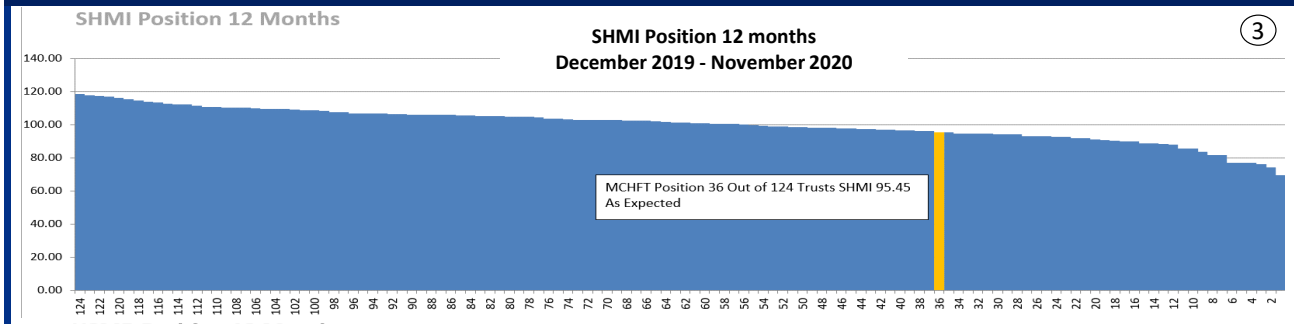
Key Narrative: 266 CCICP patient safety incidents are currently shown for March 2021 of which 80% resulted in harm.

Low Harm 209, Moderate Harm 3, Serious Incident 0

Data Rating: ①captured locally, ②system captured, ③published/benchmarked

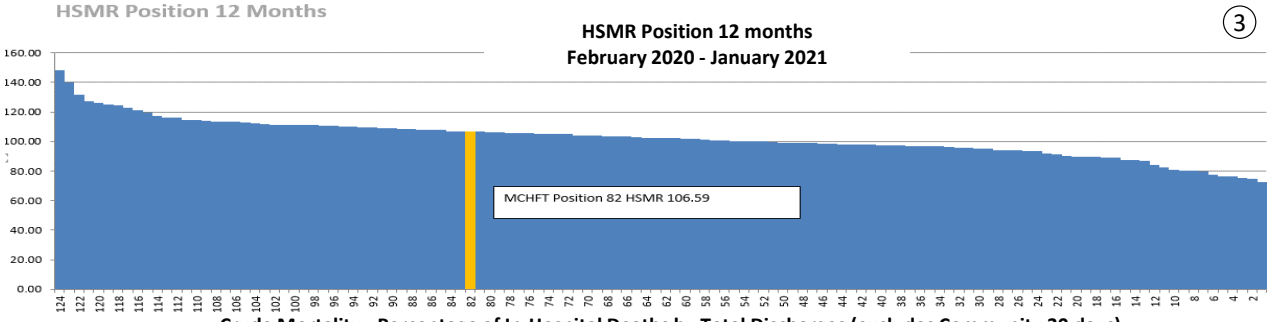
Quality, Safety & Patient Experience

Mortality



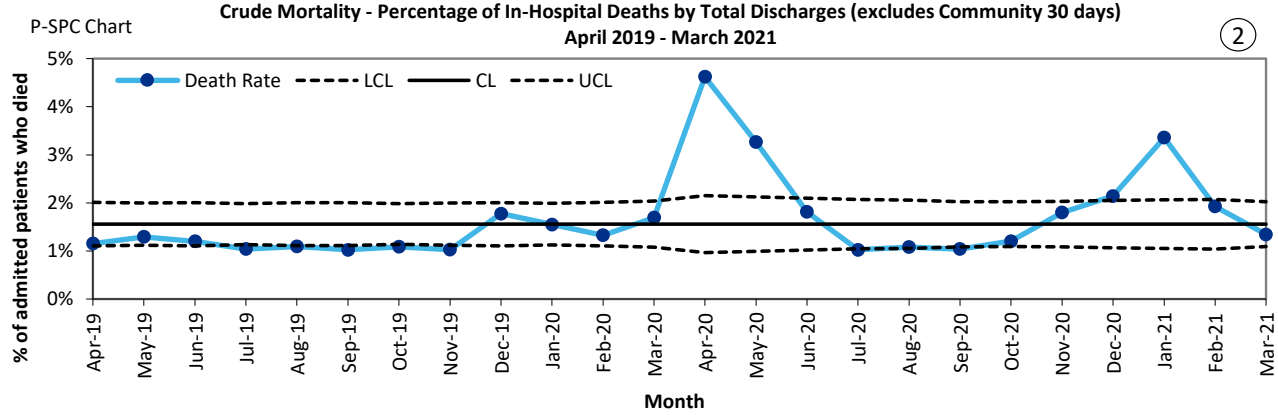
③

Key Narrative: The latest release of SHMI is 95.45 (rank 36) against the previous value of 95.45 (rank 33). This is still in the 'as expected' range. Please note that the number of submitting Trusts has dropped from 129 to 124 due to Trust mergers that is now reflected in the data.



③

Key Narrative: The latest HSMR release is 106.59. Recent releases had shown an improvement in HSMR which is likely to be the result of improving rates of palliative coding (still low compared to other Trusts). This release shows another slight improvement. Please note that the Trust mergers in SHMI are reflected in this data.



②

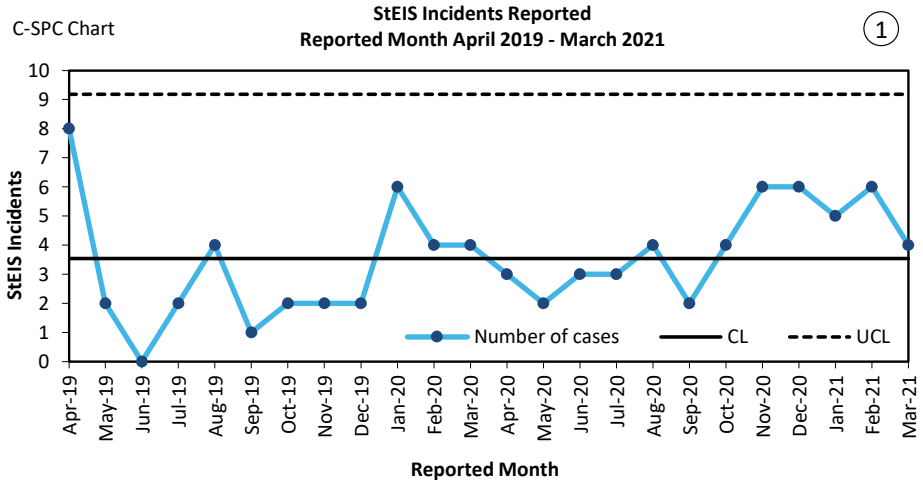
Key Narrative: Crude mortality has remained largely consistent over the time period; exceptions are December 2019, March-May 2020, December 2020 & January 2021 where the rate increased and shows special cause variation on the chart. The latter 3 periods represent periods of increasing incidence of patients with Covid 19 in the Trust. March 2021 shows a return to normal limits and is lower than March 2020.

Accountable: Medical Director
Data Owner: Quality Governance
To note: P-SPC charts adjust the control limits to take into account each month's denominator.

Data Rating: ①captured locally, ②system captured, ③published/benchmarked

Quality, Safety & Patient Experience

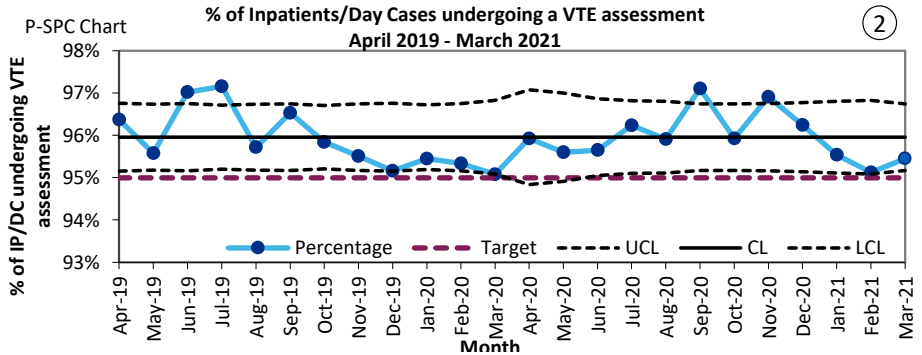
StEIS Incidents - Trust Total



Accountable: Medical Director **Data Owner:** Quality Governance

Key Narrative: There were 4 serious incidents reported to StEIS in March 2021.

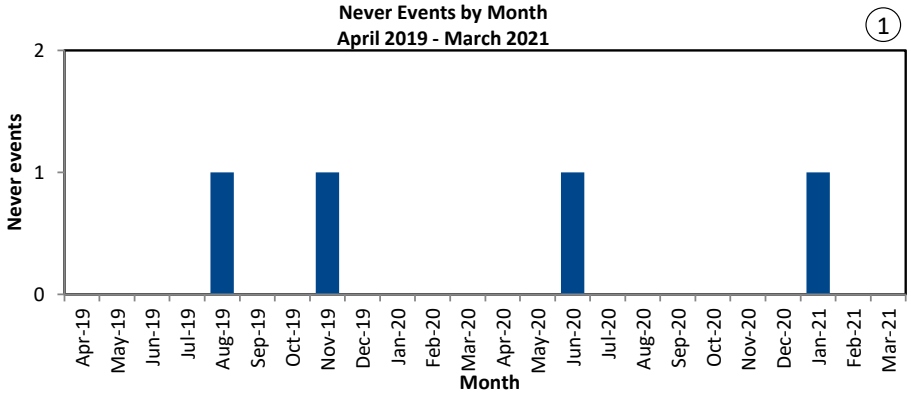
VTE



Accountable: Medical Director **Data Owner:** Information Services

Key Narrative: The percentage of VTE assessments completed remains above target, achieving 95.5% in March 2021. The P-SPC charts adjust the control limits to take into account each month's denominator.

Never Events - Trust Total



Accountable: Medical Director **Data Owner:** Information Services

Key Narrative: There were no never events reported in March 2021.

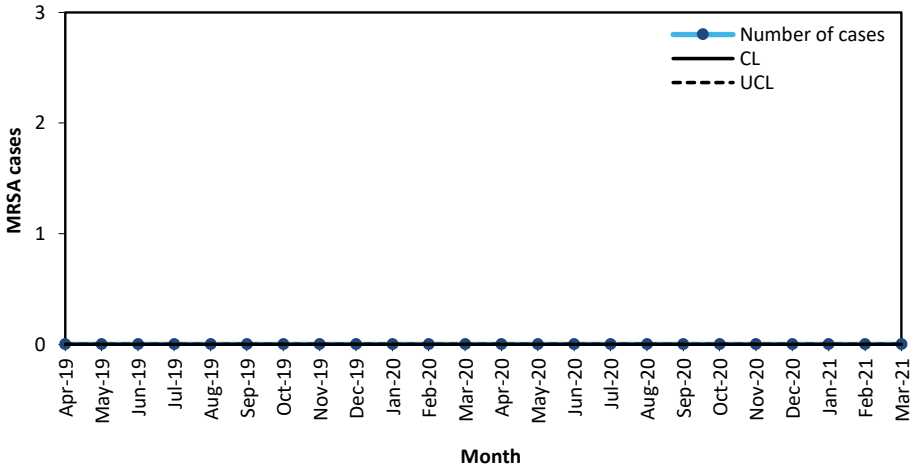
Quality, Safety & Patient Experience

MRSA

C-SPC Chart

MRSA Bacteraemia Cases Reported Within the Trust
April 2019 - March 2021

①



Accountable: Director of Nursing and Quality
Data Owner: Infection Prevention Control Team

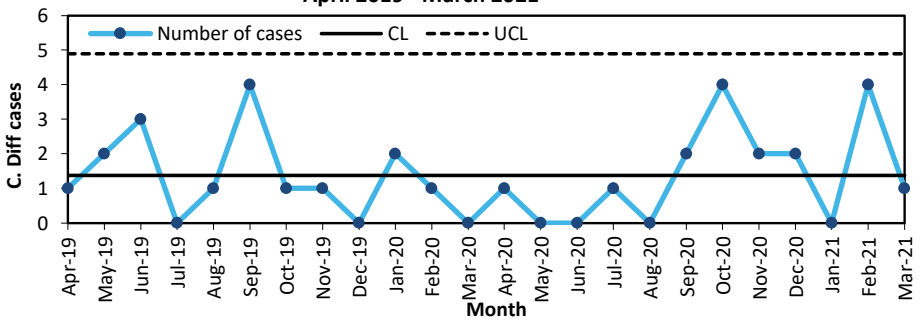
Key Narrative: There have been no MRSA bacteraemia cases reported since March 2019.

C. Diff Positive Cases

C-SPC Chart

Hospital Onset Healthcare Acquired C. Diff Cases
April 2019 - March 2021

①



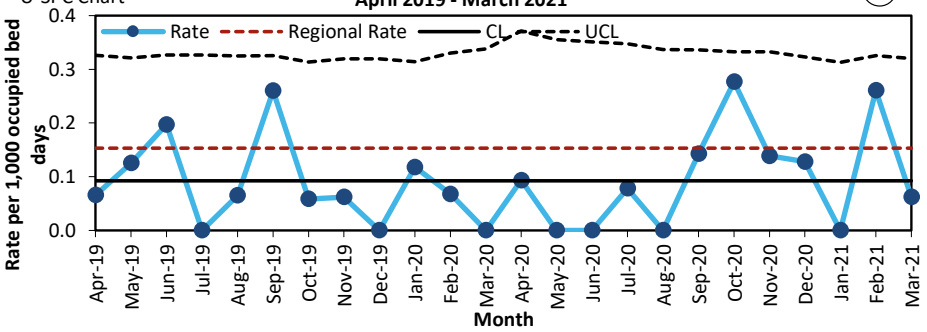
	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Avoidable	0	0	0	1	0	0	0	0	0	0	0	0
Unavoidable	1	0	0	0	0	1	4	0	0	0	0	0
Awaiting Confirmation	0	0	0	0	0	1	0	2	2	0	4	1

Hospital Onset Healthcare Acquired C.Diff Rate per 1,000 Occupied Bed Days

U-SPC Chart

April 2019 - March 2021

①



Accountable: Director of Nursing and Quality
Data Owner: Infection Prevention Control Team
Key Narrative: 1 hospital onset healthcare acquired C.Diff case was recorded in March 2021 with a rate of 0.06 per 1,000 occupied bed days, below the regional rate for the month. The year to date rate is currently 0.10. The P-SPC charts adjust the control limits to take into account each month's denominator.

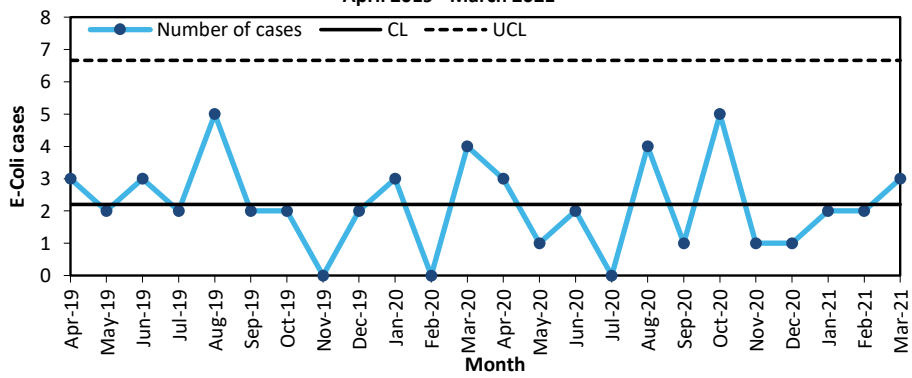
Quality, Safety & Patient Experience

E-Coli Cases

C-SPC Chart

E-Coli Cases Reported Within the Trust
April 2019 - March 2021

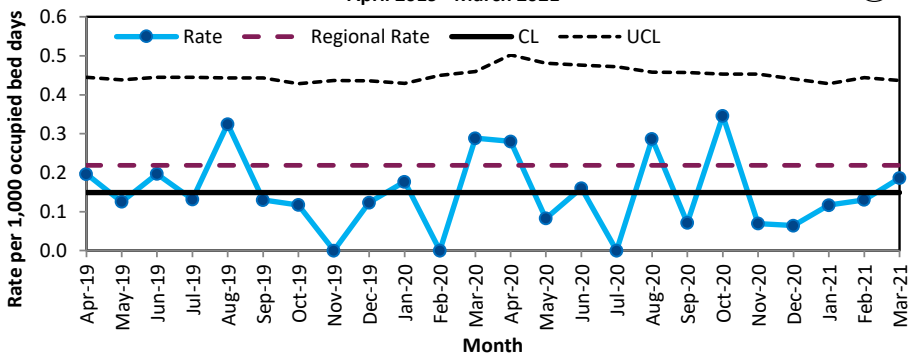
①



U-SPC Chart

E. Coli Rate per 1,000 Occupied Bed Days
April 2019 - March 2021

①



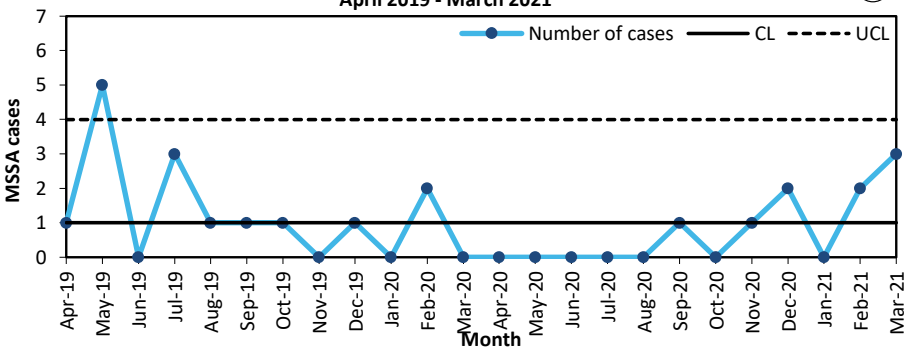
Accountable: Director of Nursing and Quality
Data Owner: Infection Prevention Control Team
Key Narrative: 3 E-Coli case were recorded in March 2021 with a rate of 0.19 cases per 1,000 occupied bed days, below the current regional rate. The U-SPC chart adjusts the control limits to take into account each month's denominator.

MSSA

C-SPC Chart

MSSA Cases Reported Within the Trust
April 2019 - March 2021

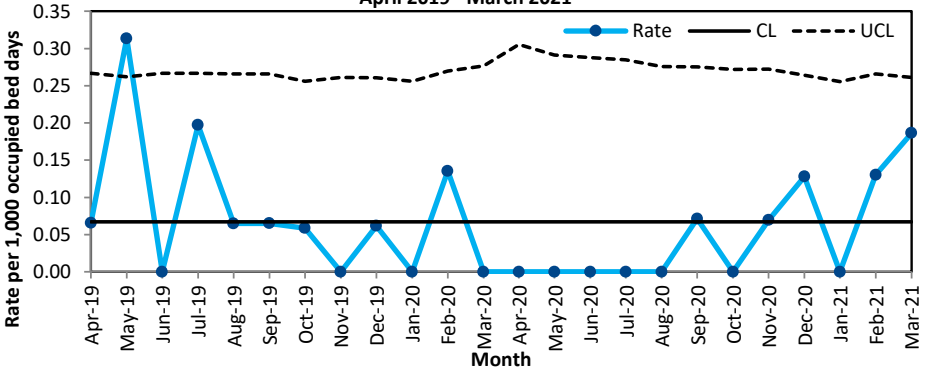
①



U-SPC Chart

MSSA Rate per 1,000 Occupied Bed Days
April 2019 - March 2021

①



Accountable: Director of Nursing and Quality
Data Owner: Infection Prevention Control Team
Key Narrative: There were 3 MSSA case reported in March 2021 with a rate of 0.19 per occupied bed days. The U-SPC chart adjusts the control limits to take into account each month's denominator.

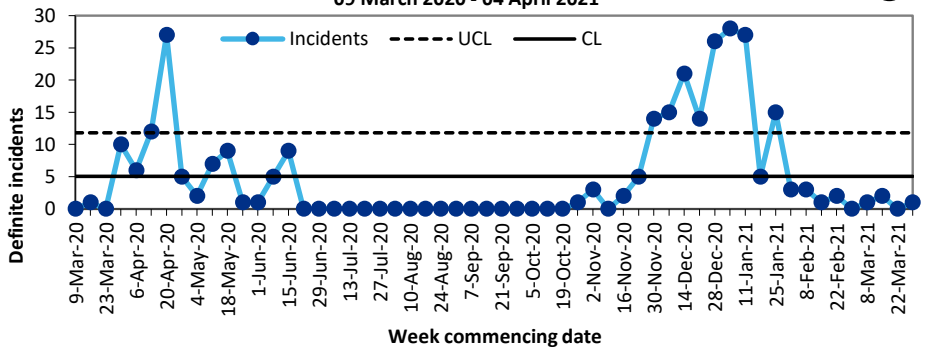
Quality, Safety & Patient Experience

COVID-19 Healthcare Acquired Infections

C-SPC Chart

MCHFT Definite COVID-19 Incidents by Result Week
09 March 2020 - 04 April 2021

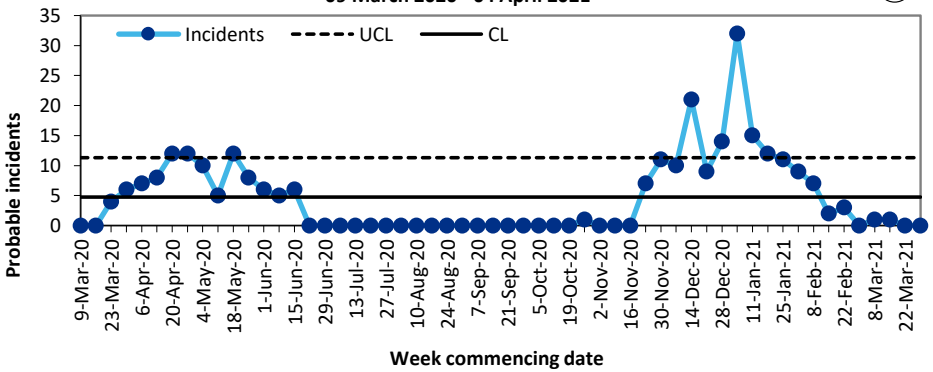
①



C-SPC Chart

MCHFT Probable COVID-19 Incidents by Result Week
09 March 2020 - 04 April 2021

①

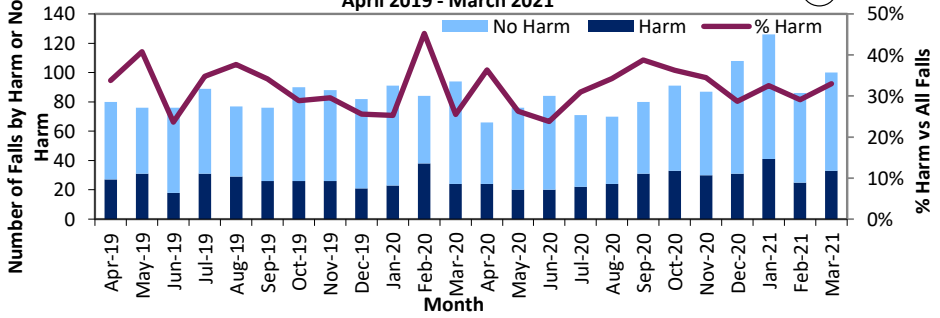


Accountable: Director of Nursing and Quality **Data Owner:** Information Services
Key Narrative: The latest week reported, week commencing 29th March 2021, shows 1 definite incidents and 0 probable incidents.

Falls

Falls Rate Harm Vs No Harm
April 2019 - March 2021

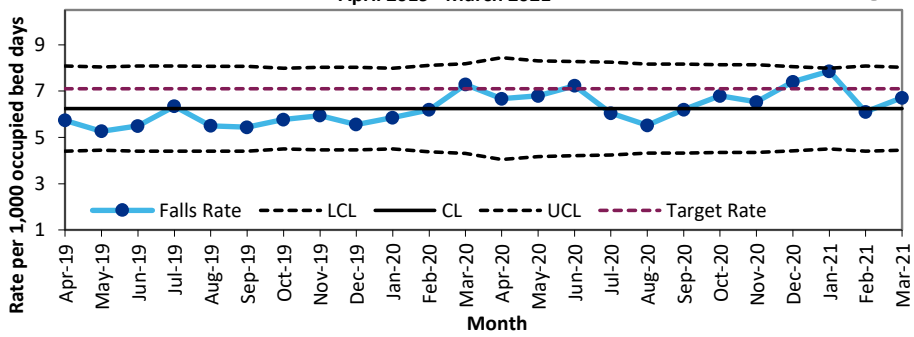
②



U-SPC Chart

Falls Rate per 1,000 Occupied Bed Days
April 2019 - March 2021

②

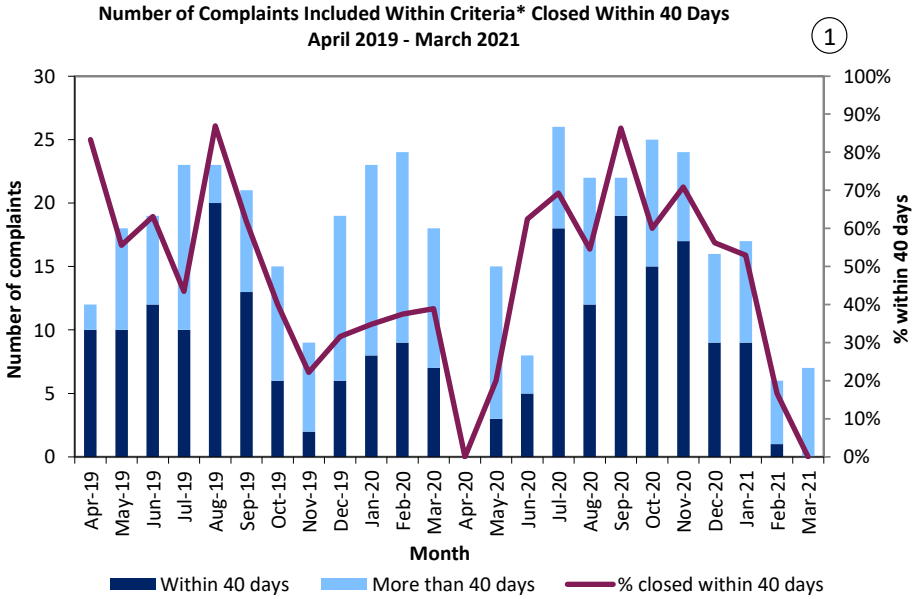


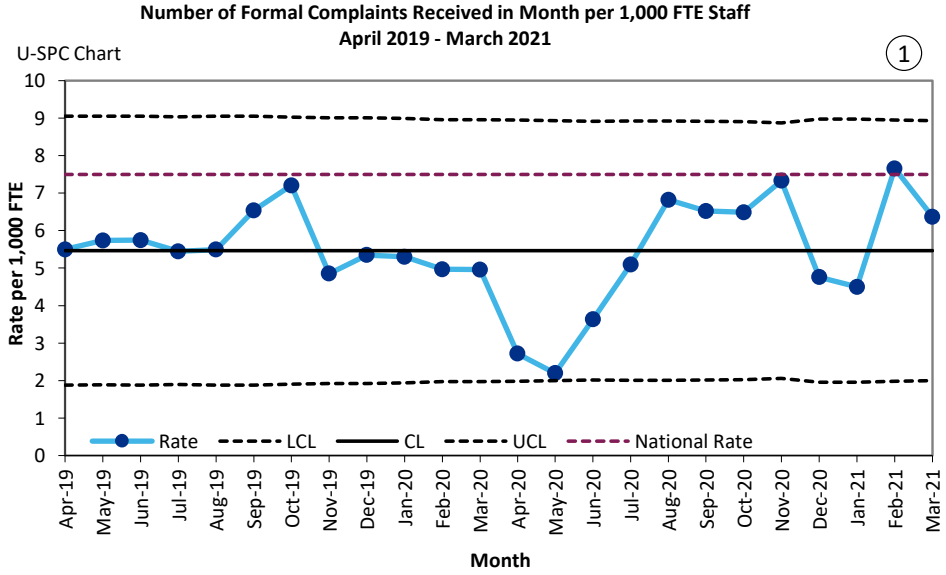
Accountable: Director of Nursing and Quality **Data Owner:** Nursing Quality Team
Key Narrative: 100 falls were reported in March 2021 with a rate of 6.2 per 1,000 occupied bed days, below the target rate of 6.6. 33 falls resulted in harm (33%), of which 33 were low harm.
The U-SPC chart adjusts the control limits to take into account each month's denominator.

Data Rating: ①captured locally, ②system captured, ③published/benchmarked

Quality, Safety & Patient Experience

Formal Complaints





Accountable: Director of Nursing and Quality
Data Owner: Customer Care Team

Key Narrative: 7 complaints were closed in March 2021, of which 0 were closed within 40 days (0%). The rate of formal complaints received in March 2021 was 6.37 per 1,000 FTE staff, below the national rate.

Due to the second wave of the covid pandemic, complaint responses were stood down from November 2020 to be recommenced in March 2021.

**exclusion criteria includes, for example: complaints linked to an investigation, multi-agency and cross-divisional and complaints, withdrawn complaints, complaints put on hold during the COVID-19 period.*

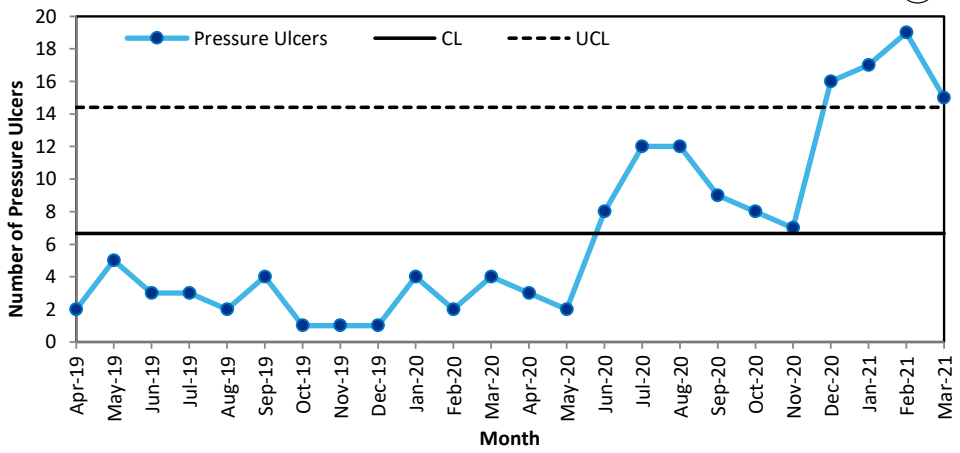
Quality, Safety & Patient Experience

Acute Hospital Pressure Ulcers

C-SPC Chart

Acute Hospital Pressure Ulcers - Lapses in Care Identified
April 2019 - March 2021

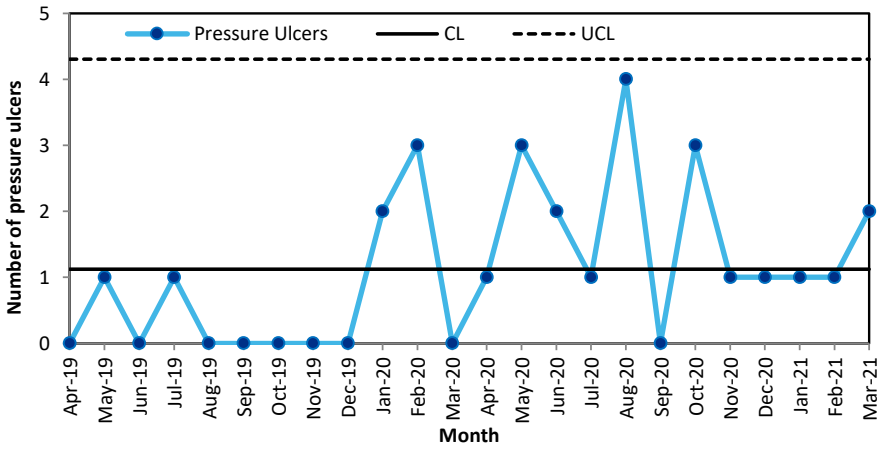
①



C-SPC Chart

Community Pressure Ulcers - Lapses in Care Identified
April 2019 - March 2021

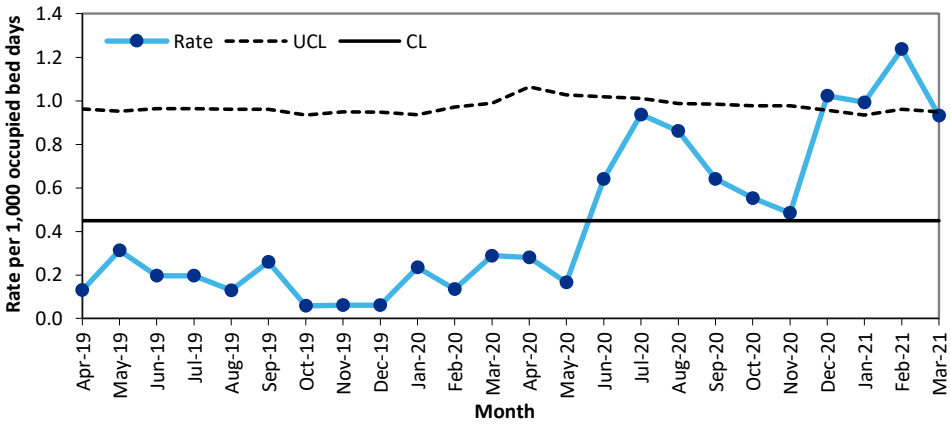
①



U-SPC Chart

Acute Hospital Pressure Ulcers - Lapses in Care Rate per 1,000 Occupied Bed Days
April 2019 - March 2021

①



To note: U-SPC charts adjust the control limits to take into account each month's denominator.

Accountable: Director of Nursing and Quality
Data Owner: Nursing Quality Team

Key Narrative:

Acute: 15 acute hospital lapses in care have currently been identified in March 2021 with a rate of cases per 1,000 occupied bed days of 0.93. Latest months data correct at time of reporting, however, may increase as further cases identified. An increase is shown for December 2020 to February 2021 from previously reported data due to the validation process. There have been 128 acute lapses of care reported in the current financial year with the number of acute cases reported in the last 4 months falling above the upper control limit. A deep dive will be completed.

Community: 2 community lapses of care have currently been identified in March 2021. There have been 20 community lapses of care reported in the current financial year.

Current financial year reported cases subject to validation.

Quality, Safety & Patient Experience

Safer Staffing Divisional Analysis

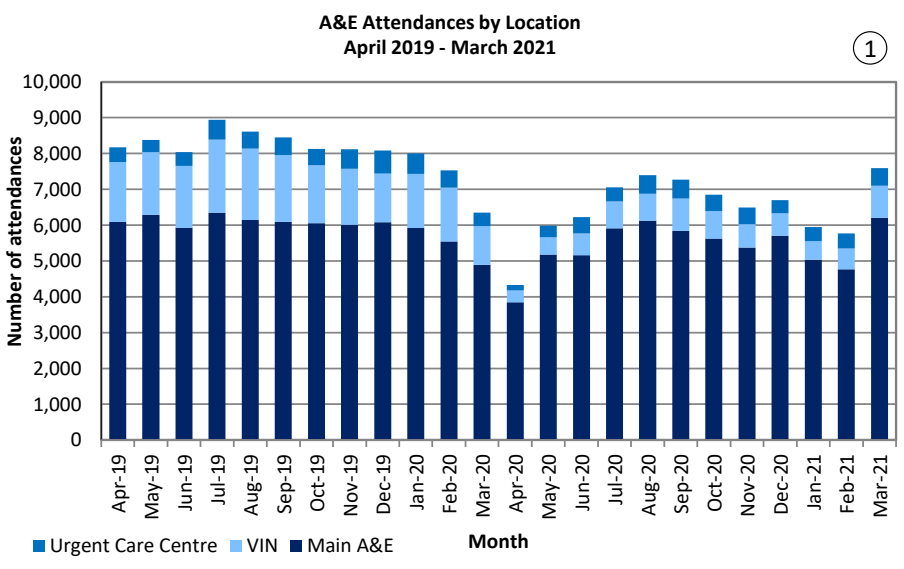
①

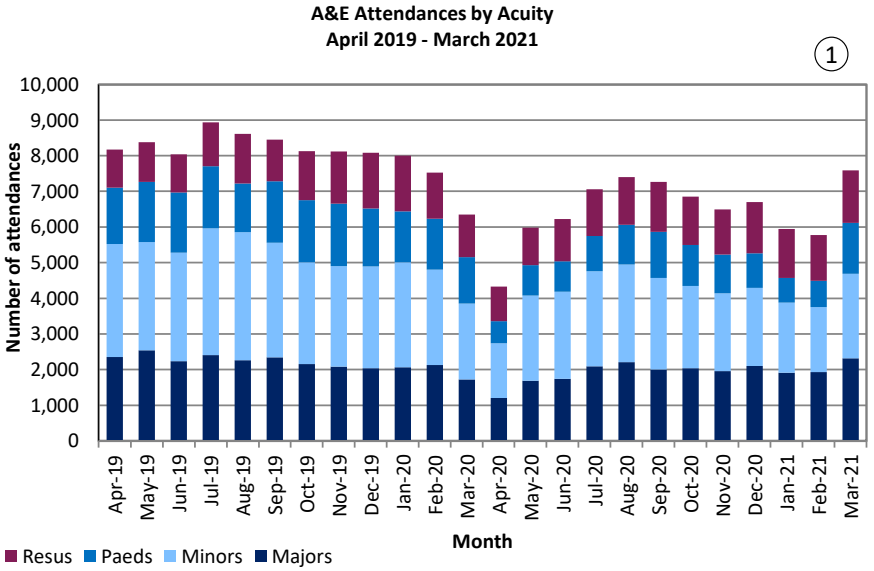
Ward Name	Day				Night				Day		Night	
	Qualified		Unqualified		Qualified		Unqualified		Qualified	Unqualified	Qualified	Unqualified
	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Fill Rate	Fill Rate	Fill Rate	Fill Rate
MCHFT	48055.0	42014.9	43121.5	36353.1	37791.2	33943.5	32307.0	27401.5	87%	103%	90%	95%
Acute Medical Unit	1887.0	1863.5	2094.0	2104.0	1908.0	1836.0	1524.0	1547.3	99%	100%	96%	102%
Child & Adolescent Unit	2186.8	2202.3	1085.0	1082.6	2184.0	2187.8	622.0	622.3	101%	100%	100%	100%
CLOSED Ward 13 Medical	1416.0	669.5	1566.0	867.5	864.0	383.5	1188.0	732.0	47%	55%	44%	62%
Critical Care Unit (HIGH)	4313.0	3716.5	616.0	539.5	4235.5	3626.0	768.0	201.3	86%	88%	86%	26%
Elmhurst	774.5	752.0	2495.5	2530.0	756.0	746.0	1760.5	1881.5	97%	101%	99%	107%
Maternity Unit (Ward 23)	1314.1	1260.2	784.3	758.8	743.7	745.5	744.2	726.6	96%	97%	100%	98%
Midwifery Led Unit	861.8	858.7	0.0	0.0	864.0	816.4	0.0	0.0	100%		94%	
NICU Ward 22	1930.8	1852.6	1155.0	512.6	1365.3	1226.4	688.0	313.9	96%	44%	90%	46%
South Cheshire Surveillance (HIGH)	2280.5	1972.8	2715.5	2457.5	2220.0	1994.5	2592.0	2186.5	87%	90%	90%	84%
Ward 1 Coronary Care	2152.0	2124.5	1249.0	1133.0	1575.0	1539.0	936.0	862.0	99%	91%	98%	92%
Ward 10 Ortho Trauma	2349.0	1952.0	3029.0	2651.5	1140.0	1139.0	2076.0	1883.5	83%	88%	100%	91%
Ward 11 Surgical/Gynae	2028.5	1853.5	1614.0	1540.0	1200.0	1164.0	1152.0	1128.0	91%	95%	97%	98%
Ward 12 SAU	1342.7	1280.9	786.0	714.0	840.0	732.0	756.0	708.0	95%	91%	87%	94%
Ward 12 Surgical Speciality	1128.0	1056.0	794.0	714.0	756.0	720.0	396.0	360.0	94%	90%	95%	91%
Ward 13 Elective	1316.3	969.8	1014.0	511.0	960.0	840.0	756.0	252.0	74%	50%	88%	33%
Ward 14 Gastro	1592.5	1559.8	1837.5	1654.0	1272.0	1259.5	1464.0	1406.5	98%	90%	99%	96%
Ward 21b Rehabilitation	1210.5	1155.8	2851.0	2583.8	1164.0	1105.3	1620.0	1457.0	95%	91%	95%	90%
Ward 26 Labour	3051.4	2870.1	586.2	506.0	2500.3	2456.2	378.3	355.2	94%	86%	98%	94%
Ward 3 Short Stay Medical	2668.0	2418.0	2110.5	1811.0	1859.5	1811.5	1896.0	1764.0	91%	86%	97%	93%
Ward 4 Elderly	1436.0	1415.5	2184.0	1985.5	1128.0	923.5	1872.0	1739.0	99%	91%	82%	93%
Ward 5 Covid (HIGH)	2343.5	1499.5	1800.5	1289.5	1728.0	1473.0	1721.0	1097.5	64%	72%	85%	64%
Ward 6 Rehab	1914.0	1815.8	2460.0	2148.0	1536.5	1499.0	1356.0	1344.0	95%	87%	98%	99%
Ward 7 Medical	1338.0	1206.5	2422.0	1766.5	1164.0	1080.0	1476.0	1212.0	90%	73%	93%	82%
Ward 9 Ortho Elective	1948.5	1587.3	2551.0	2017.5	1188.0	1043.5	2100.5	1681.5	81%	79%	88%	80%
Winter Ward 18	1454.0	1307.0	1776.5	1549.8	1092.0	984.0	1252.5	1182.0	90%	87%	90%	94%
Winter Ward 19	1817.5	795.0	1545.0	925.5	1547.5	612.0	1212.0	758.0	44%	60%	40%	63%

Accountable: Director of Nursing and Quality
Data Owner: Information Services
Key Narrative: The highlighted cells reflect wards where the qualified staffing rate is below 85% of planned levels.

Performance

A&E Activity



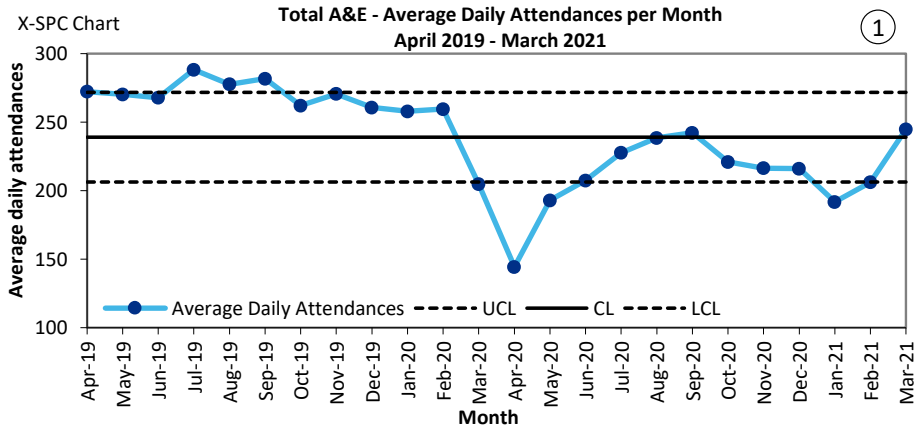


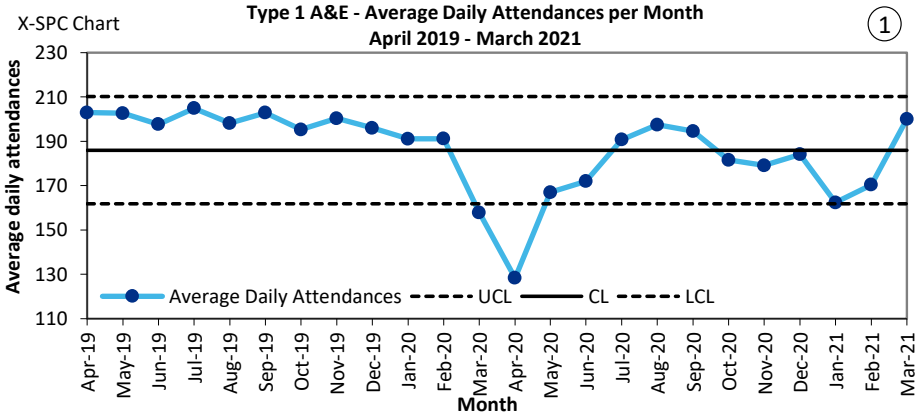
Accountable: Chief Operating Officer
Data Owner: Information Services

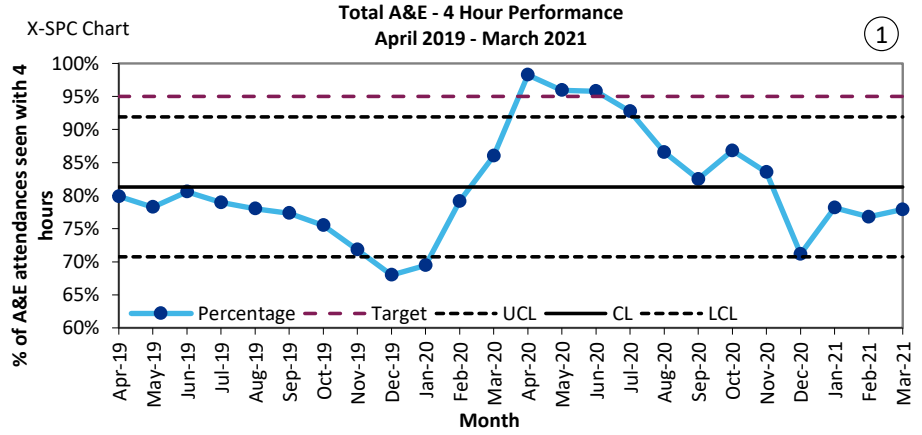
Key Narrative: March 2021 shows 7,591 total A&E attendances across all locations, a 31% increase on the previous month and 20% higher than the same period in the previous year, which was the start of the pandemic. There were 6,203 attendances reported in March 2021 for the main A&E department at Leighton Hospital (type 1), 30% higher than the previous month. March 2021 activity variance compared to previous month by acuity: Majors +386, Minors +547, Paeds +689, Resus +197.

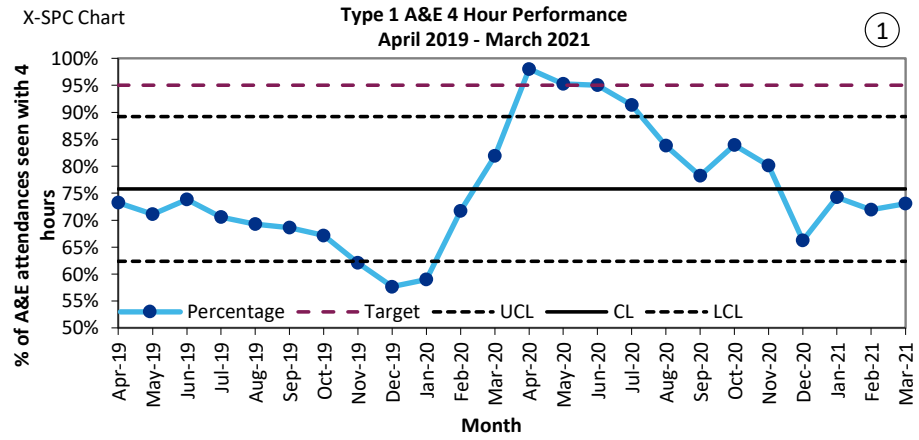
Performance

A&E Performance









Accountable: Chief Operating Officer
Data Owner: Information Services

Key Narrative: The average total daily A&E attendances for March 2021 was 245, an increase on the previous month and above the 24-month average. The type 1 average attendances follows a similar pattern with March 2021 showing an average rate of 200 per day.

Performance against the 4 hour standard in March was 77.9%, just over 1% better than the previous month, and 73.1% for type 1.

Data Rating: ①captured locally, ②system captured, ③published/benchmarked

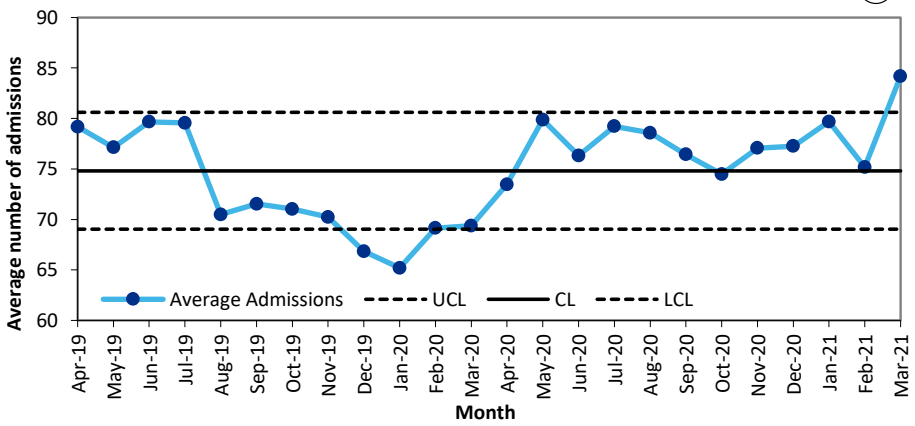
Performance

Unplanned Admissions

X-SPC Chart

Average Daily Admissions from A&E
April 2019 - March 2021

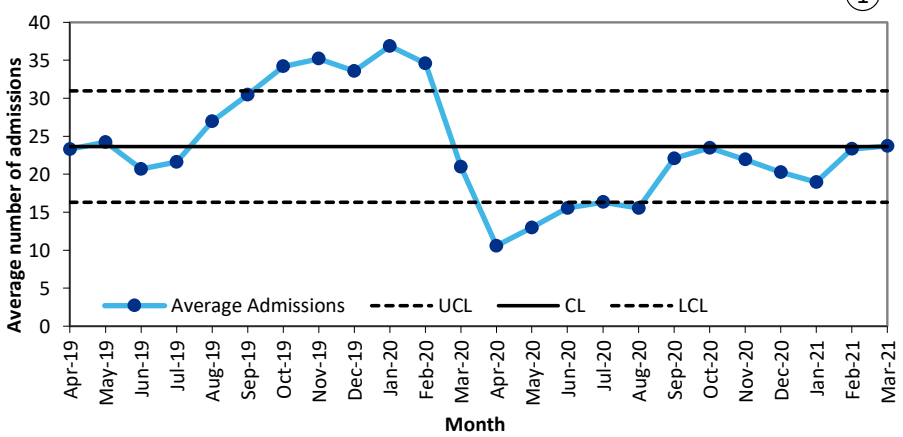
1



X-SPC Chart

Average Daily Admissions per Month - GP Referred
April 2019 - March 2021

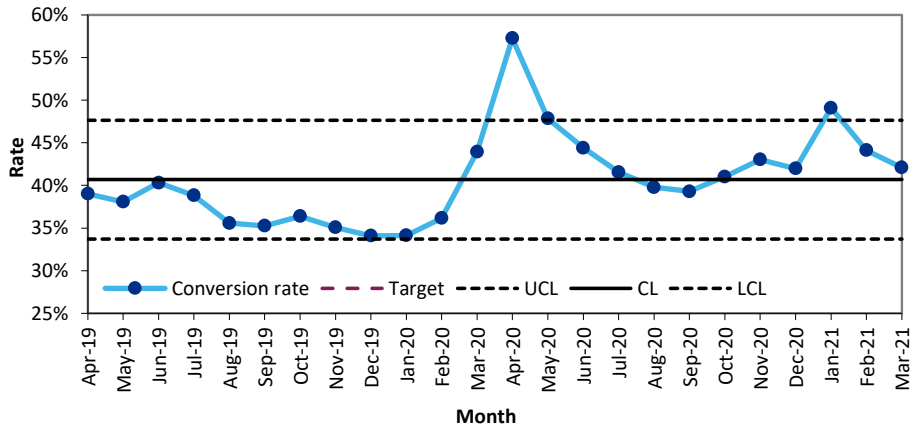
1



X-SPC Chart

Type 1 Attendance to Admissions Conversion Rate - Overall
April 2019 - March 2021

1



Accountable: Chief Operating Officer **Data Owner:** Information Services

Key Narrative: There was a change in recording of activity between admissions from A&E and via GP from August 2019 driving some of the variation seen in the average daily admission charts from August 2019 until the onset of the covid pandemic. Activity from March 2020 to date includes admissions to RAU reflecting a new pathway designed to support the covid pandemic averaging 214 admissions per month, which has inflated the position.

The average daily admissions from A&E for March 2021 was 84.2, above the average admission rate for February 2021 (75.2) and the highest rate seen over the 24-month period.

The average daily admissions for GP-referred patients in March 2021 was 23.7, a slight increase to the average admission rate for February 2021 (23.3) and close to the 24-month average.

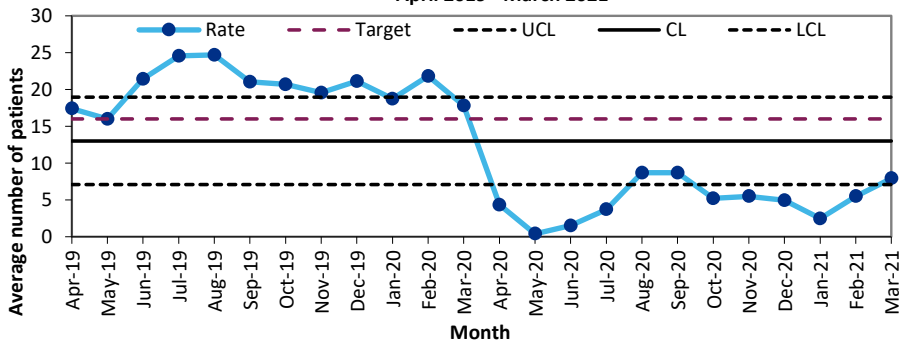
The type 1 admission conversion rate for March 2021 was 42.1%.

Performance

Inpatient Metrics

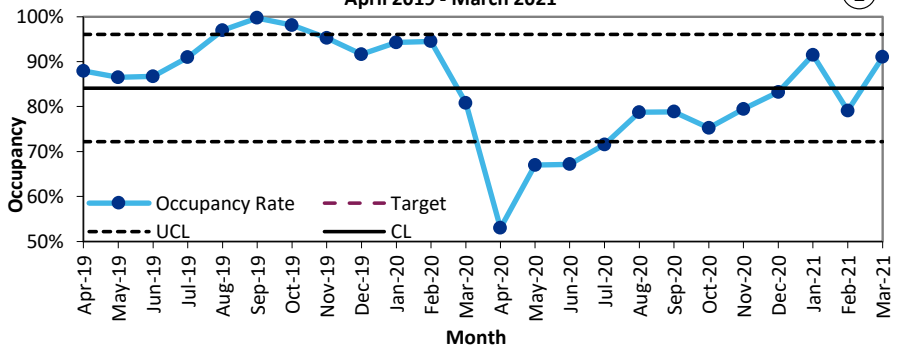
X-SPC Chart

Average Number of People Delayed per Day
April 2019 - March 2021



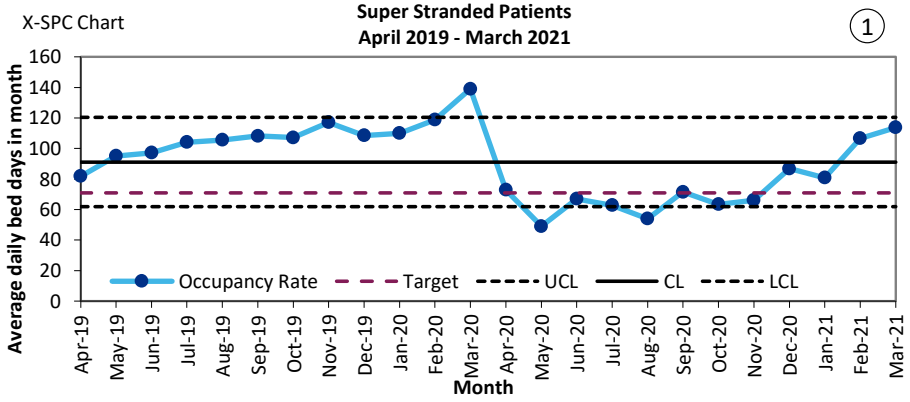
X-SPC Chart

Bed Occupancy
April 2019 - March 2021



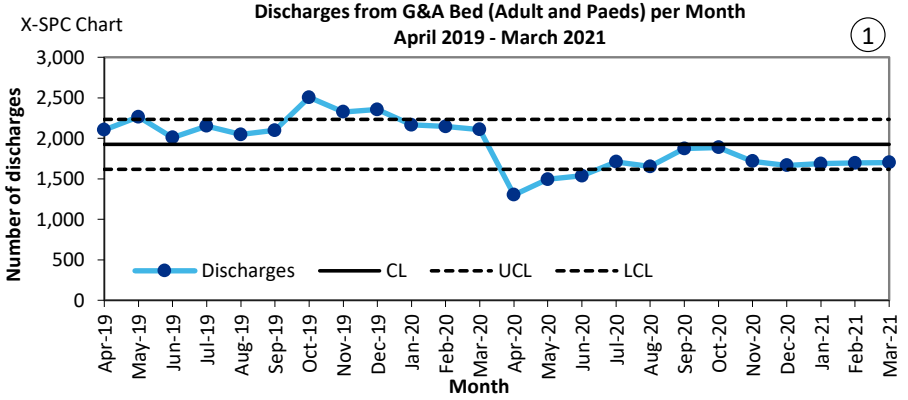
X-SPC Chart

Super Stranded Patients
April 2019 - March 2021



X-SPC Chart

Discharges from G&A Bed (Adult and Paeds) per Month
April 2019 - March 2021



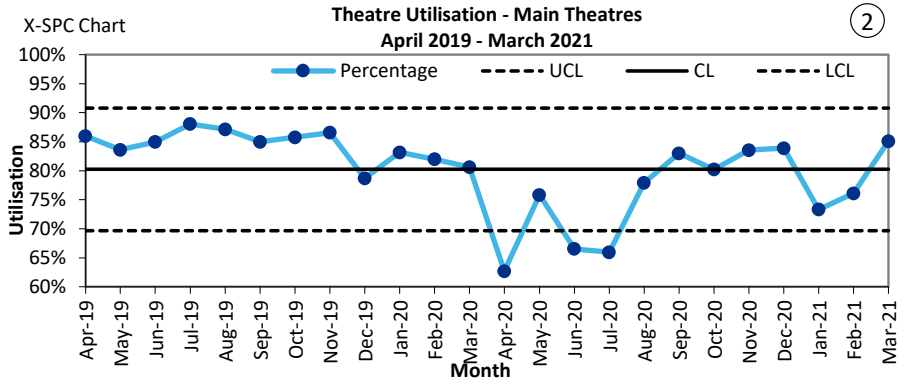
Accountable: Chief Operating Officer **Data Owner:** Information Services

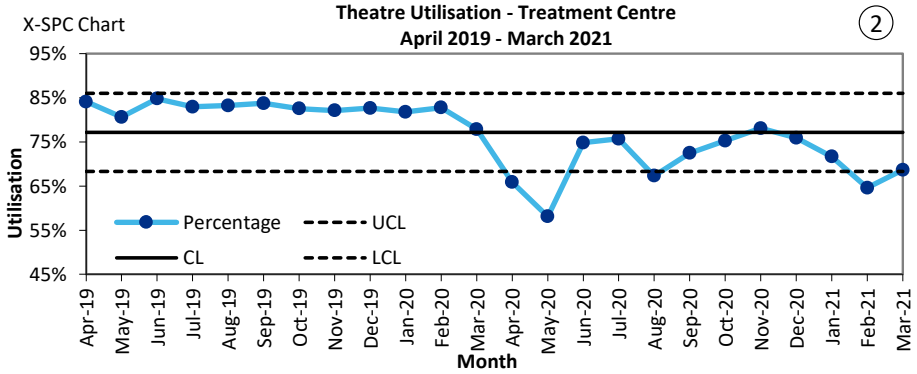
Key Narrative: The average number of people delayed per day during March 2021 was 7.9, an increase on February 2021 (5.5) and has remained below target since the onset of the covid pandemic. The average number of super stranded patients delayed per day in the hospital increased from 106.6 in February 2021 to 113.7 in March 2021. The percentage bed occupancy rate for March 2021 was 91.0%, an increase on the February 2021 occupancy rate of 79.1%. The bed occupancy figure reported does not exclude lost beds that are not suitable for patient admissions for infection prevention and control (IPC) reasons. The number of discharges from G&A beds remains steady.

**bed stock numbers used to calculate the bed occupancy rate have been updated from July 2020 to reflect covid ward changes*

Performance

Theatre Utilisation



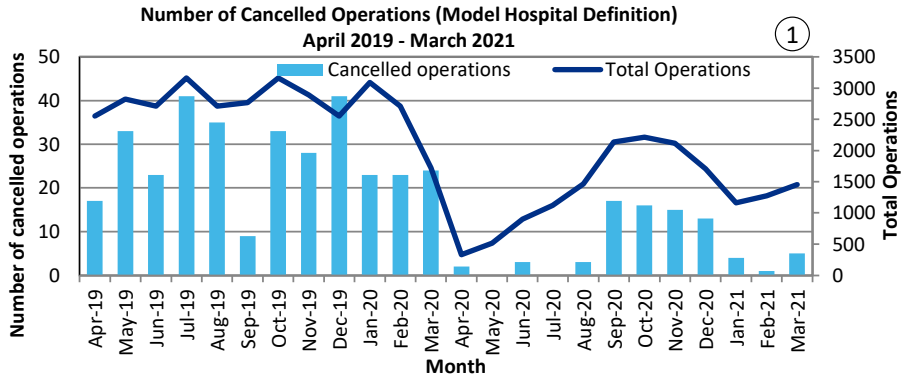


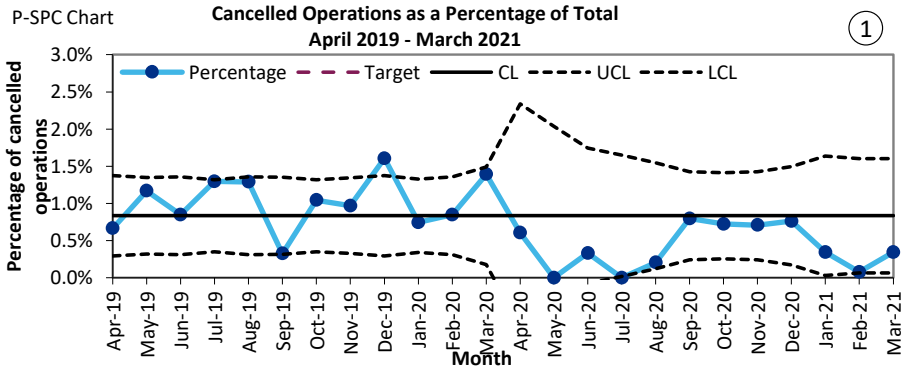
Accountable: Chief Operating Officer **Data Owner:** Information Services

Key Narrative: Theatre utilisation rate for March 2021 was 85.1% in Main Theatres, an increase on the February 2021 position of 76.1% and above the March 2020 position of 80.6%.

Theatre utilisation rate for the Treatment Centre in March 2021 was 68.7%, an increase on the February 2021 position of 64.6%.

Cancelled Operations





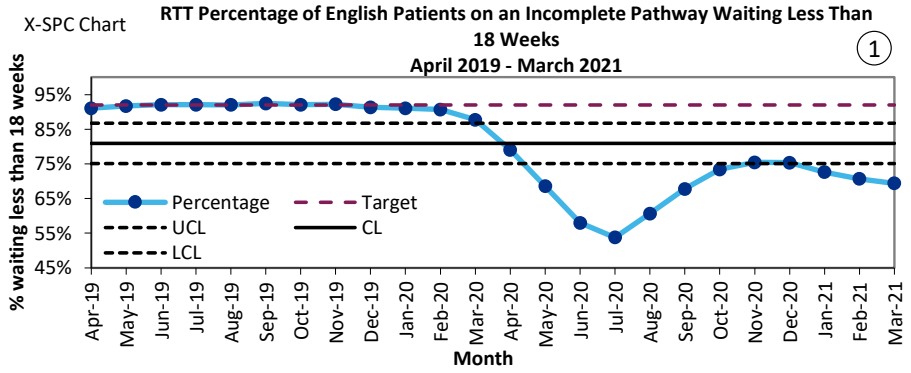
Accountable: Chief Operating Officer **Data Owner:** Information Services

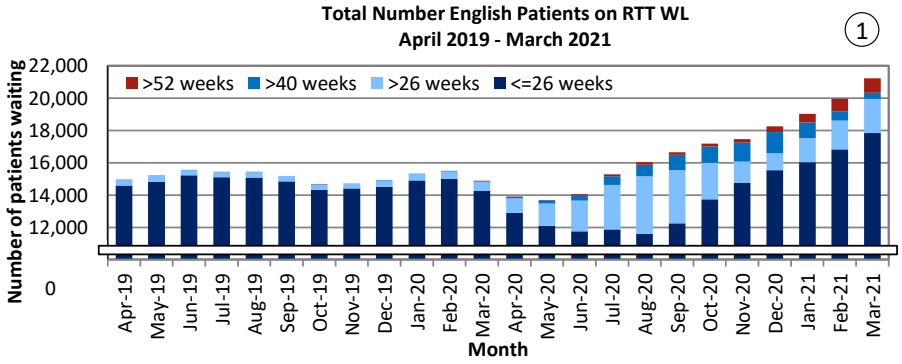
Key Narrative: 5 operations were cancelled on the day of admission by the hospital for non-clinical reasons in March 2021 (0.3%).

The P-SPC chart adjusts the control limits to take into account each month's denominator.

Performance

Referral to Treatment Waiting Times (RTT)



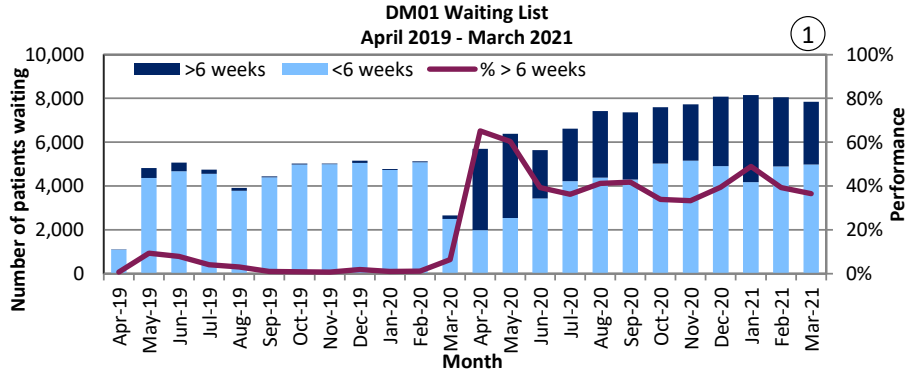


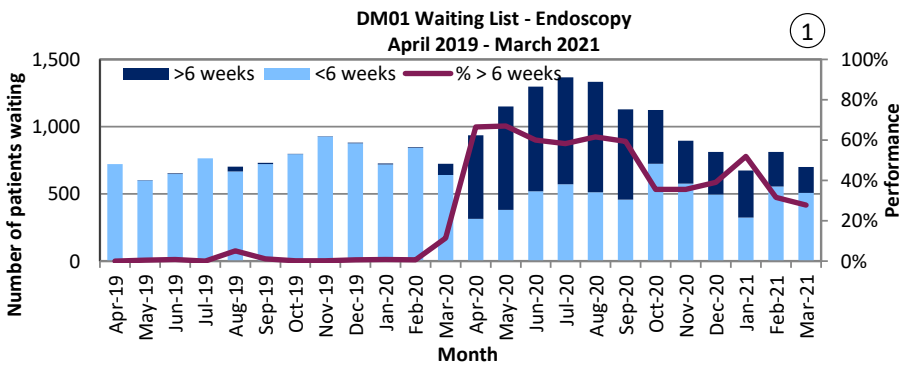
Accountable: Chief Operating Officer **Data Owner:** Information Services

Key Narrative: The total number of patients on the RTT WL continues to grow with 21,212 patients waiting at the end of March 2021, of which 877 patients were waiting for more than 52 weeks, 89 more than reported in February.

March 2021 RTT performance shows 69.4% of patients waiting less than 18 weeks against a standard of 92%. This is a slight decline from February 2021 performance of 70.7%.

Diagnostic Waiting Times





Accountable: Chief Operating Officer **Data Owner:** Information Services

Key Narrative: The total number of patients on the DM01 diagnostic waiting list for March 2021 was 7,838, 2.6% lower than February 2021's total of 8,046.

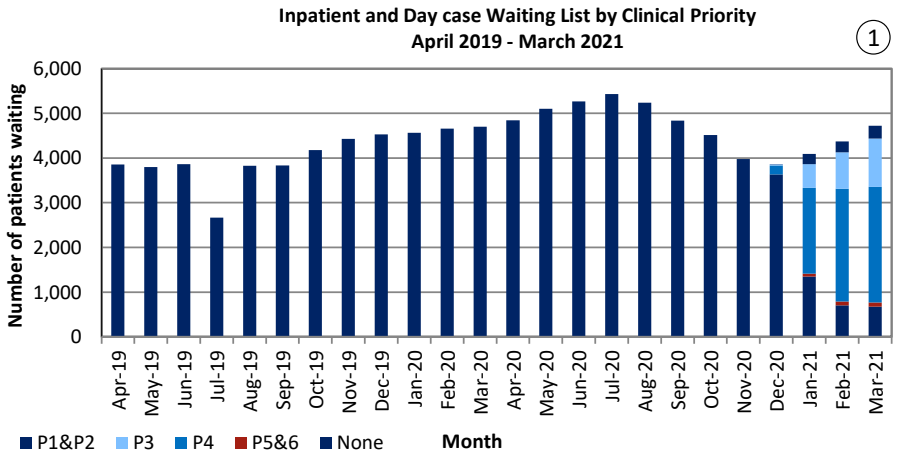
Performance against the 6 week diagnostic standard improved from 39.3% in February 2021 to 36.5% in March 2021 but remains above the 1% target.

Performance for the Endoscopy DM01 modalities improved from 31.6% in February 2021 to 27.7% in March 2021.

Data Rating: ①captured locally, ②system captured, ③ published/benchmarked

Performance

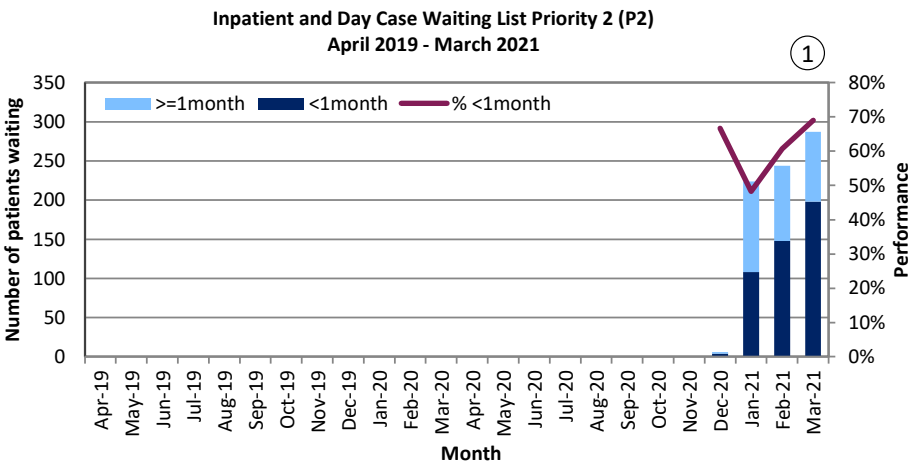
Inpatient and Day Case Clinical Prioritisation

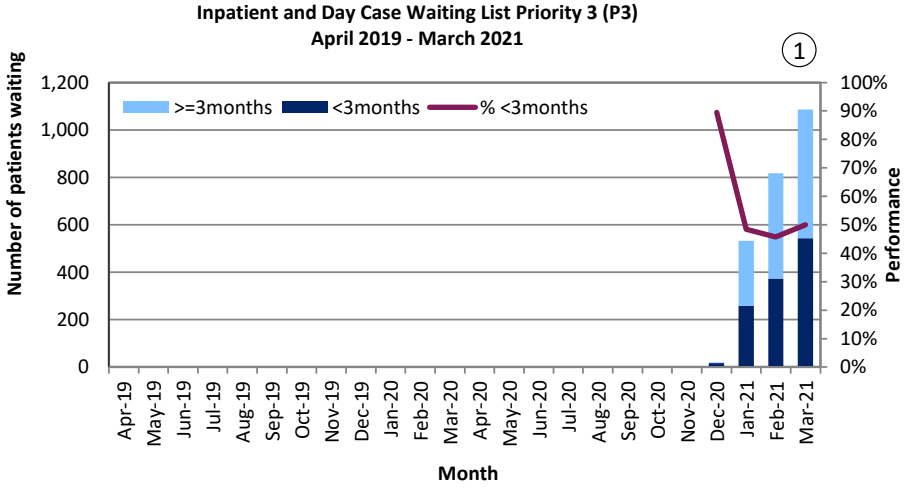


Accountable: Chief Operating Officer **Data Owner:** Information Services

Key Narrative: These are new charts introduced this month. All patients on the inpatient waiting list have now been assigned a 'priority' code defining when they should undergo their operation. P1 = 1-3 days, P2 = <1 month, and P3 = <3 months. P5&6 relate to patients who have chosen to delay treatment for covid and non-covid reasons. The charts show the recording of clinical priority codes on the PAS system from December 2020. The waiting list at the end of March 2021 288 patients had been categorised as P1 and P2, 1,086 as P3, 2,581 as P4 and 94 patients categorised as either P5 or P6.

In March 2021 the percentage of patients classified as P2 and currently waiting less than 4 weeks for treatment was 69%; an improving trend. For P3 patients it was 50% getting their operation in <3 months.

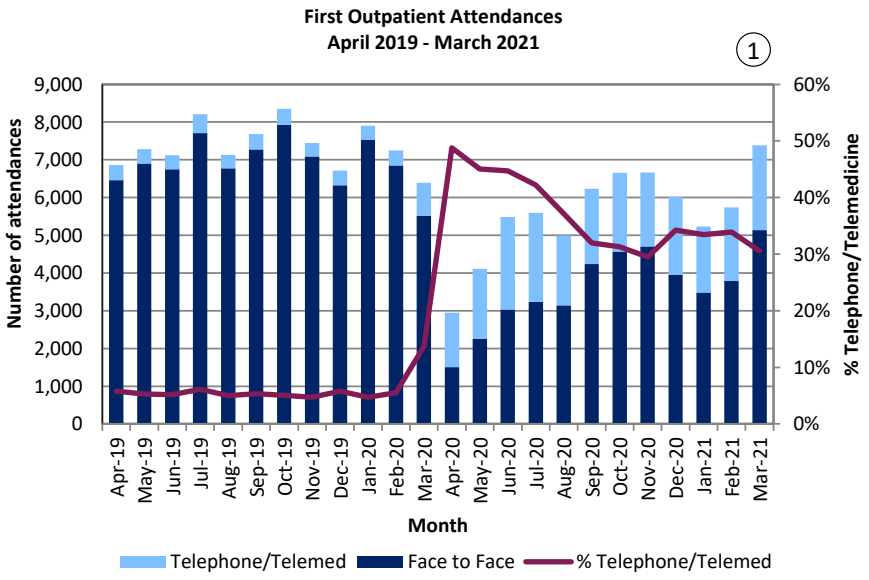


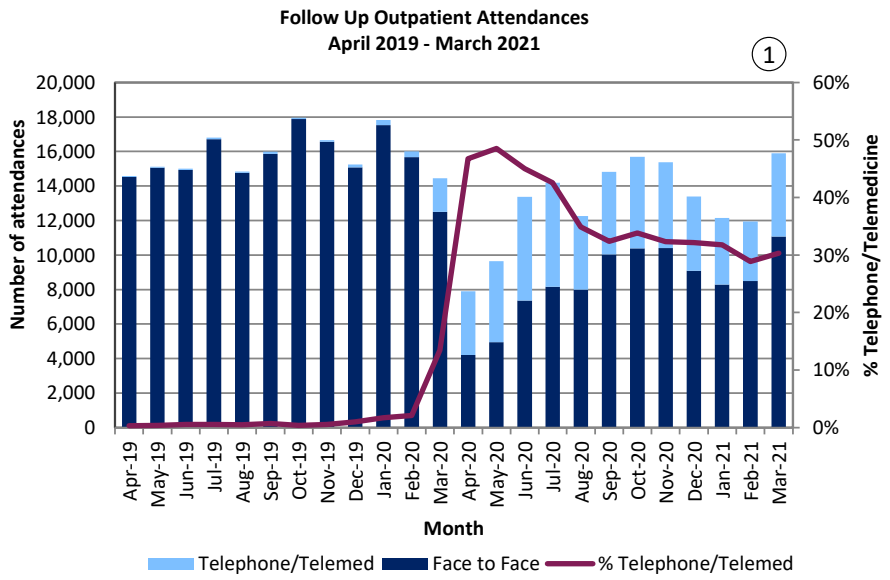


Data Rating: ①captured locally, ②system captured, ③published/benchmarked

Performance

Outpatient Activity





Accountable: Chief Operating Officer **Data Owner:** Information Services

Key Narrative: 7,387 total first outpatient appointments were attended in March 2021, an increase on recent months and 115.5% of activity compared to March 2020, which was the start of the Covid pandemic. The proportion of non face to face appointments for March 2021 was 30.5%, similar to the previous months.

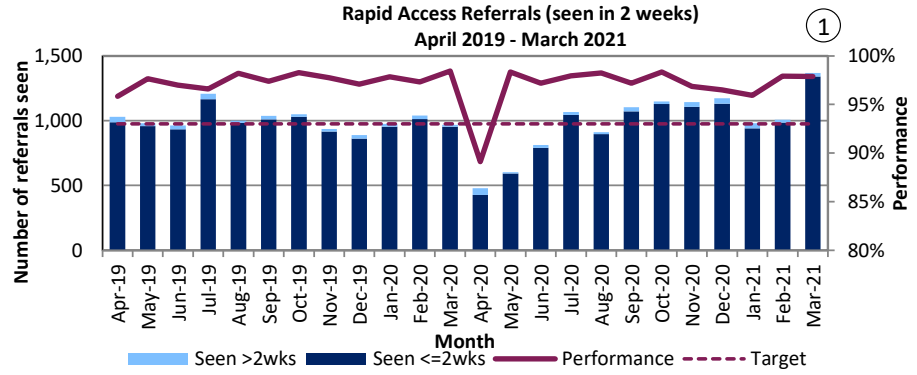
There were 15,905 total follow up outpatient appointments attended in March 2021, delivering 110.1% of March 2020. The proportion of non face to face appointments for March 2021 was 30.3%, similar to recent months.

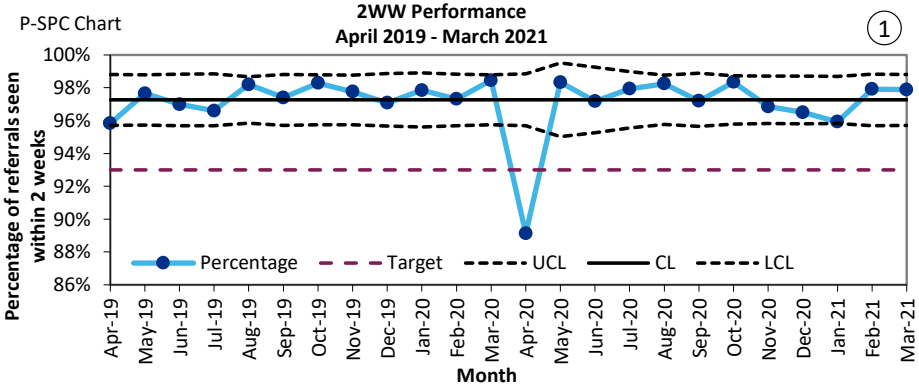
March 2021 was the highest level of outpatient activity, both new attendances and follow up attendances, in the last year.

Data includes contracted specialties.

Performance

Rapid Access Referrals





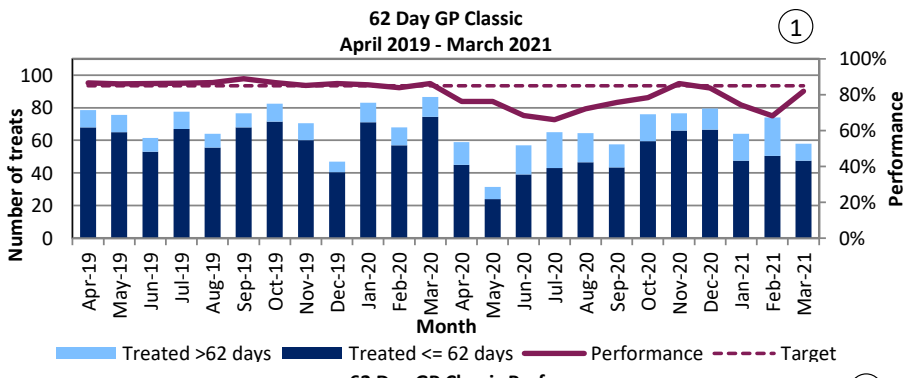
Accountable: Chief Operating Officer **Data Owner:** Cancer Performance

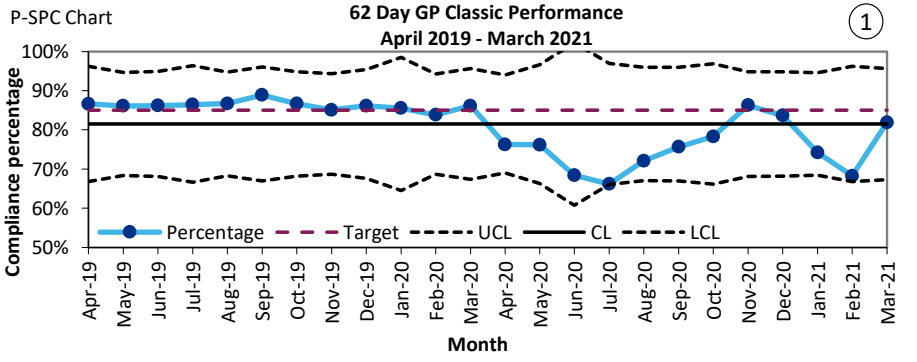
Key Narrative: 1,369 rapid access referrals were seen in March 2021, an increase of 36.1% from the previous month and above the 24-month average.

The 2 week wait performance has consistently delivered above the 93% standard with the exception of April 2020. March 2021 performance was 97.9%. The P-SPC chart adjusts the control limits to take into account the denominator.

Latest month's data provisional.

62 Day





	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
104+day Confirmed Cancer	3	2	1	8	20	7	2	3	3	5	4	2	1

Accountable: Chief Operating Officer **Data Owner:** Cancer Performance

Key Narrative: Provisional performance against the 62-day standard for March 2021 currently reported at 81.9% subject to validation of tertiary referrals and transfer dates, this is likely to improve. The volume of treatments remains below pre-pandemic levels.

The P-SPC chart adjusts the control limits to take into account the denominator.

Latest month's data provisional.

Data Rating: ①captured locally, ②system captured, ③ published/benchmarked

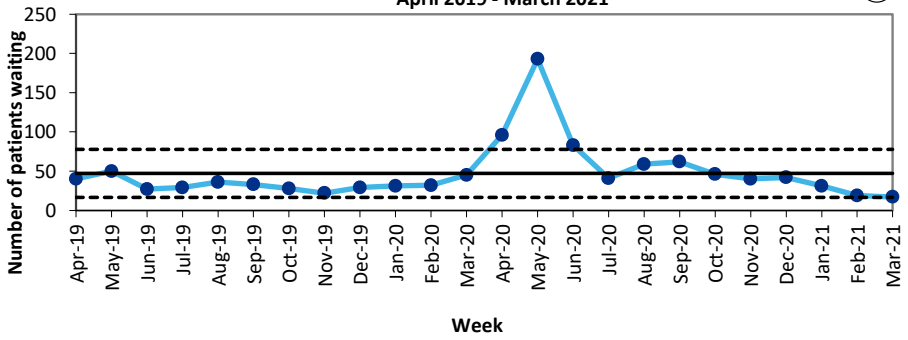
Performance

Cancer Waits Without DTT

X-SPC Chart

Rapid Access GP Referrals waiting 63-104 days without a decision to treat
April 2019 - March 2021

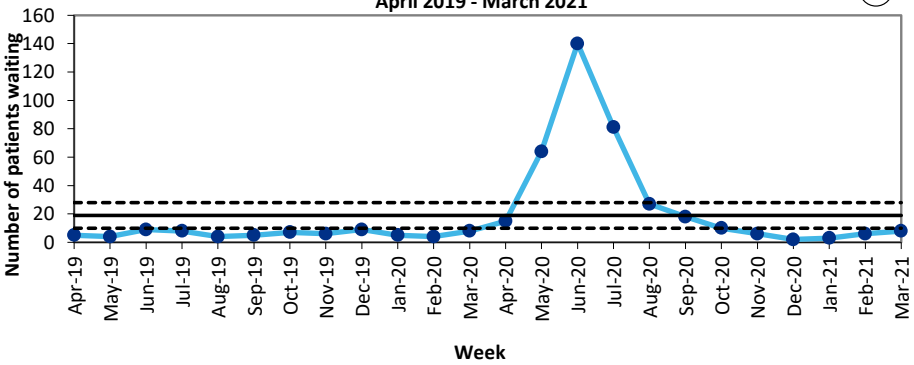
①



X-SPC Chart

Rapid Access GP Referrals waiting more than 104 days without a decision to treat
April 2019 - March 2021

①



Accountable: Chief Operating Office **Data Owner:** Cancer Performance

Key Narrative: There were 17 patients waiting between 63 and 104 days without a decision to treat (DTT) at the end of March 2021, and 8 patients waiting more than 104 days.

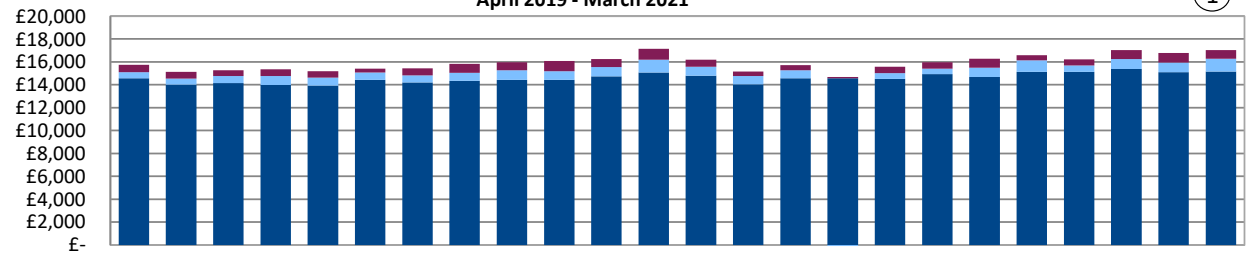
Data based on the last Monday of the month

Data Rating: ①captured locally, ②system captured, ③ published/benchmarked

Workforce

Finance and Costings

Workforce Expenditure by Month £000's
April 2019 - March 2021

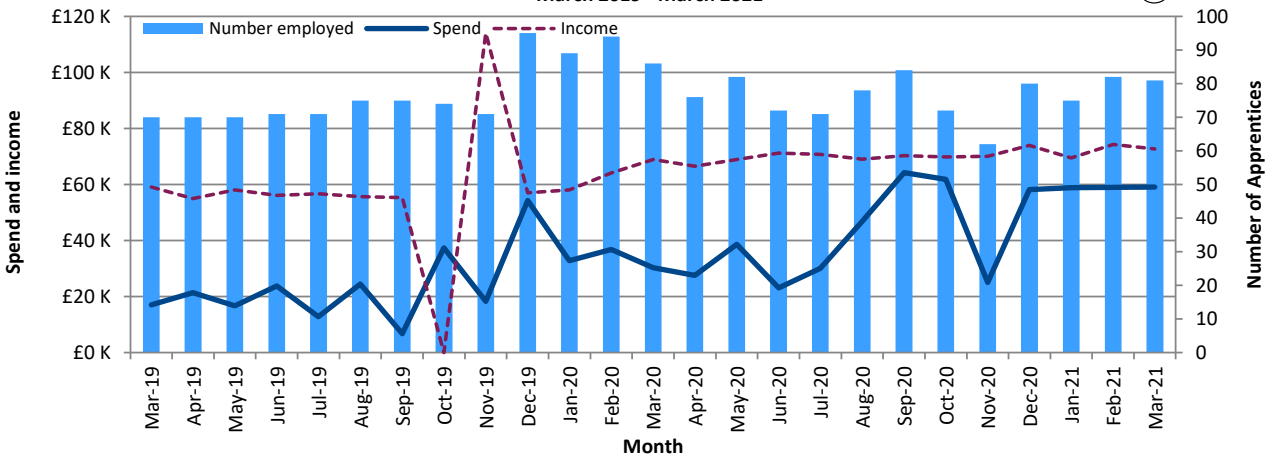


	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Agency	£638	£570	£510	£591	£566	£341	£619	£765	£706	£881	£695	£955	£631	£384	£451	£105	£543	£567	£784	£456	£531	£780	£836	£771
Bank	£554	£556	£595	£761	£713	£646	£636	£711	£832	£750	£817	£1,12	£786	£727	£692	-£88	£513	£481	£819	£991	£571	£886	£832	£1,12
Substantive	£14,5	£13,9	£14,1	£13,9	£13,9	£14,4	£14,1	£14,3	£14,4	£14,4	£14,7	£15,0	£14,7	£14,0	£14,5	£14,5	£14,5	£14,9	£14,6	£15,1	£15,1	£15,3	£15,0	£15,1

Accountable: Director of Workforce & Organisational Development
Data Owner: Workforce Directorate

Key Narrative: Total workforce expenditure for March 2021 is £17,038k, a decrease of £273k (1.6%) from the previous month but 0.7% lower than March 2020. The full year expenditure is £1,843k below budget (-0.9%).

Apprenticeship Spend by Month
March 2019 - March 2021



Accountable: Director of Workforce & Organisational Development
Data Owner: Workforce Directorate

Key Narrative: The number of Apprentices employed in March 2021 was 81, 5.8% lower than the number employed in March 2020 (86).

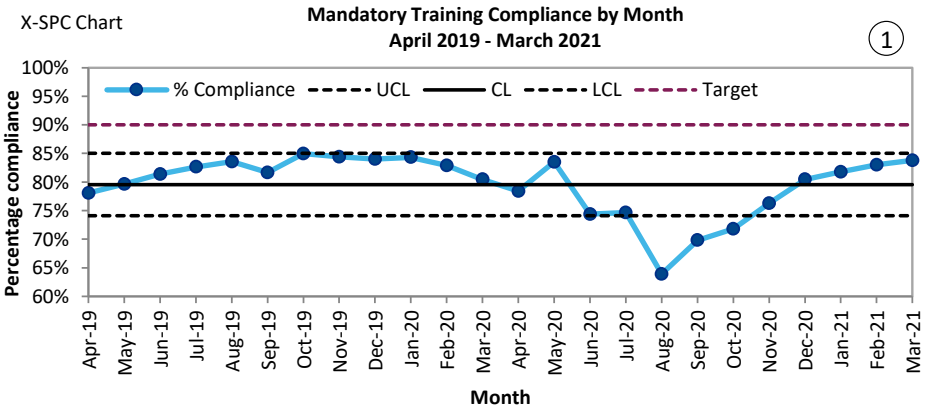
Apprenticeship spend remains below income.

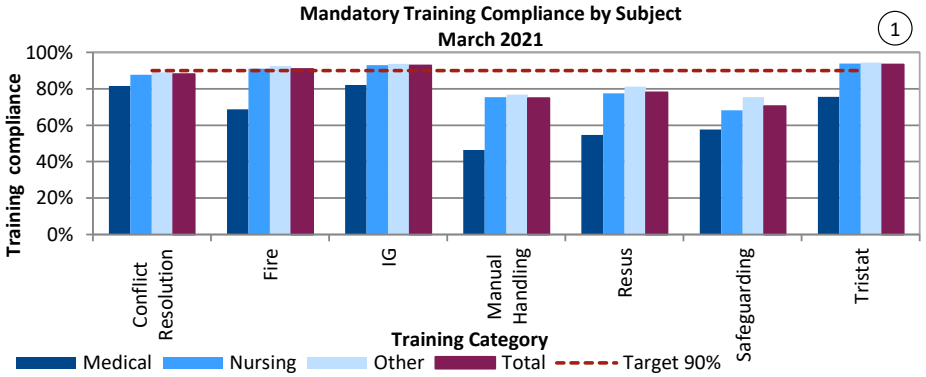
Data Rating: ①captured locally, ②system captured, ③ published/benchmarked

Workforce

Training

X-SPC Chart

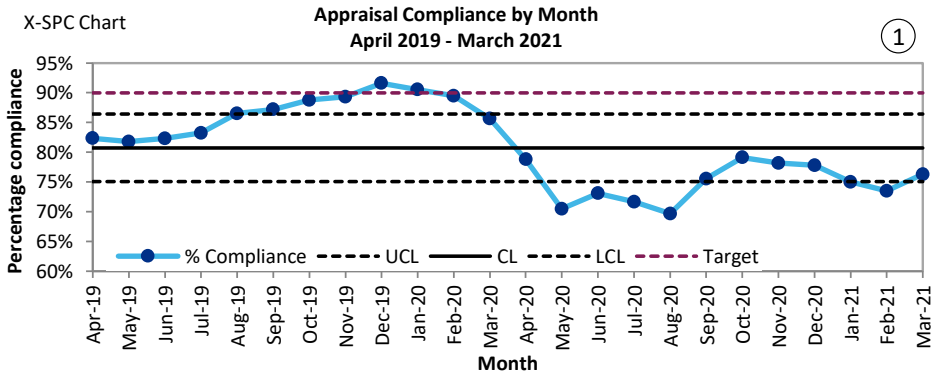


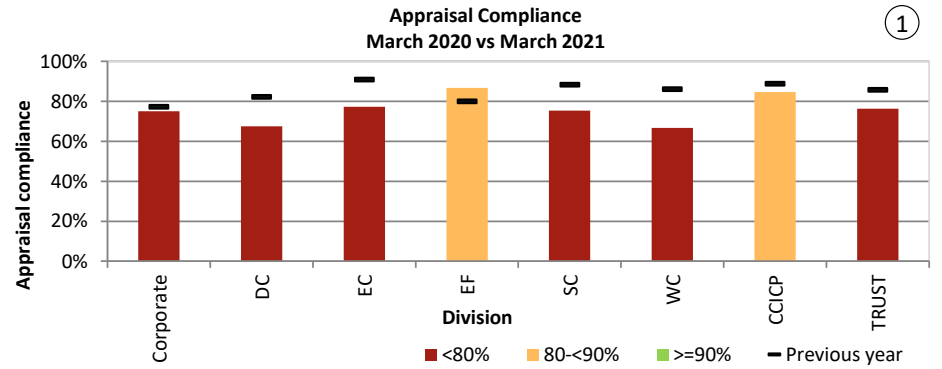


Accountable: Director of Workforce & Organisational Development
Data Owner: Workforce Directorate
Key Narrative: Mandatory training compliance has been improving over the last 7 months achieving 83.8% in March 2021 from the lowest compliance of 63.9% reported in August 2020. Training compliance remains below the 90% target.

Appraisals

X-SPC Chart



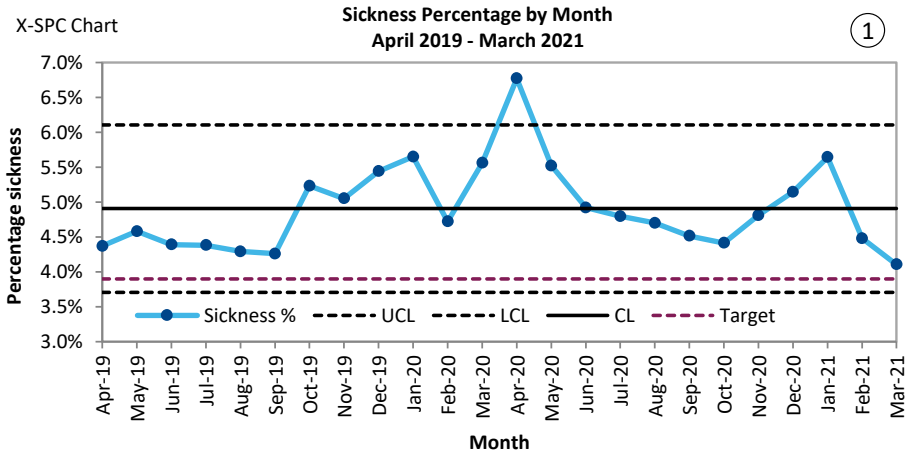


Accountable: Director of Workforce & Organisational Development
Data Owner: Workforce Directorate
Key Narrative: The reported appraisal compliance for March 2021 is 76.3%, a slight increase from the 73.5% compliance reported in February 2021. Appraisal compliance remains below the target rate of 90% which was only achieved in December 2019 and January 2020 over the 24-month period shown.

Data Rating: ①captured locally, ②system captured, ③ published/benchmarked

Workforce

Sickness

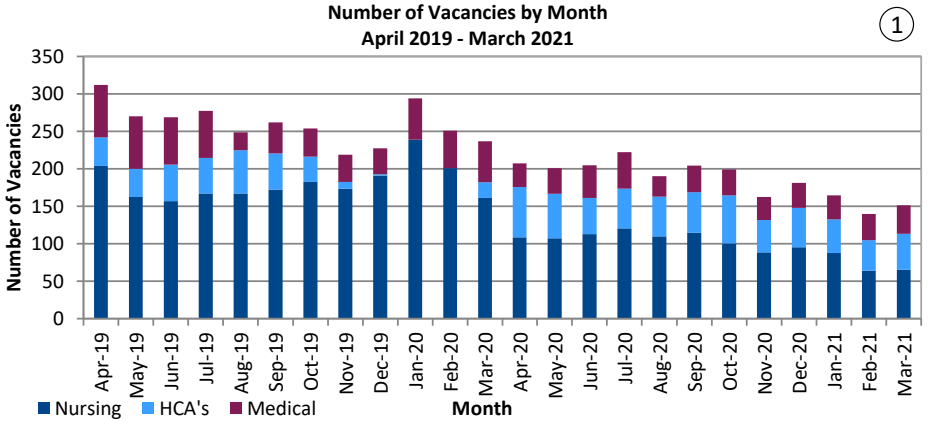


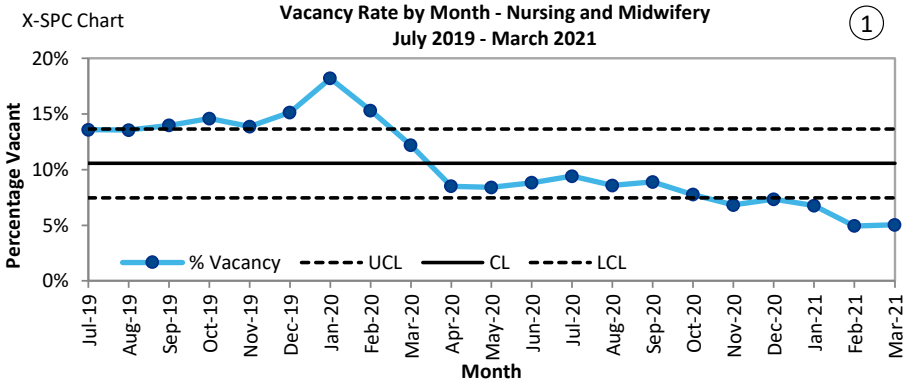
Accountable: Director of Workforce & Organisational Development
Data Owner: Workforce Directorate

Key Narrative: The sickness rate for March 2021 was 4.1%, a decrease to the 4.5% sickness rate reporting for February 2021 and lower than the sickness rate reported in March 2020 (5.6%).

The target has not been met over the 24-month period reported.

Vacancies

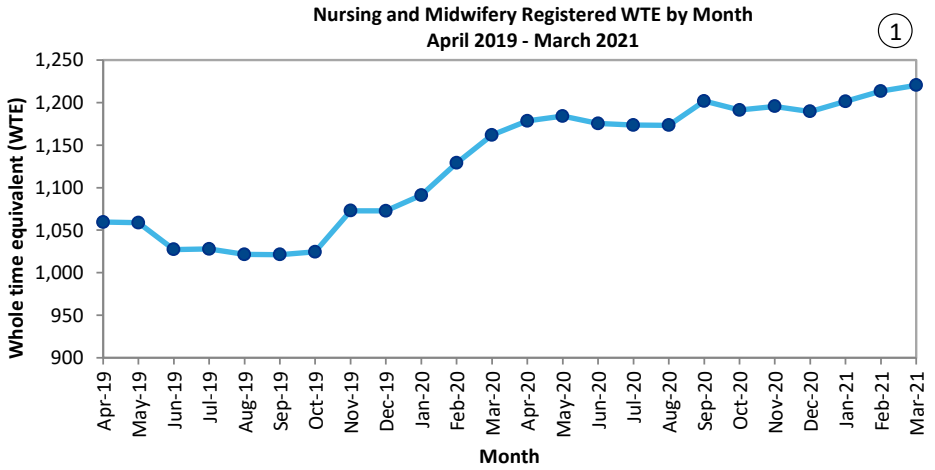


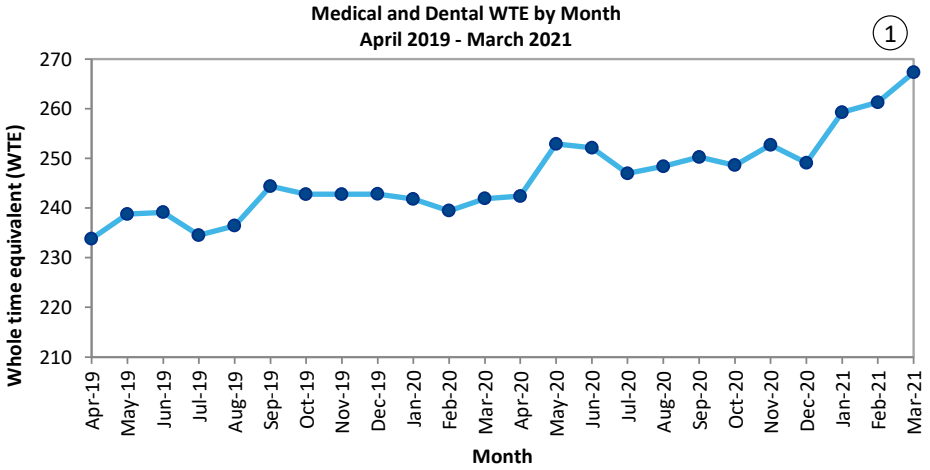


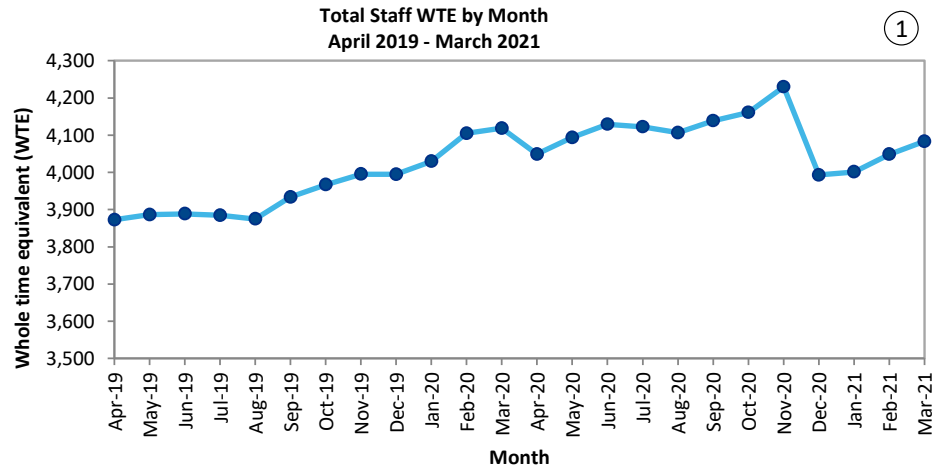
Accountable: Director of Workforce & Organisational Development
Data Owner: Workforce Directorate
Key Narrative: The vacancy figures for the current financial year have been restated to exclude International Recruitment, Nurse Apprentices and COVID. There has been a marked improvement in the number and percentage of vacancies in the current financial year with a vacancy rate of 5.0% in March 2021.

Workforce

Total Staff Whole Time Equivalent (WTE)







Accountable: Director of Workforce & Organisational Development
Data Owner: Workforce Directorate

Key Narrative: Nursing and Midwifery staff have increased by 160.9 WTE (15.2%) over the 24-month period and Medical and Dental staff by 33.5 (14.3%). The graphs include corrected figures for February 2021.

The Pathology Services (~278 staff, 243.8 WTE) transferred across to UHNM on the 1st December 2020 via a TUPE process, accounting for a drop in WTE of total staff from December 2020.

Data from ESR report: Monthly staff in post (WTE)

Quality & Safety Committee (QSC)
Chair's Assurance Report
April 2021

Report to	Board of Directors
Date	21 April 2021
Report from	Lesley Massey, NED Chair
Report prepared by	Katharine Dowson, Head of Corporate governance
Executive Lead/s	Julie Tunney, Deputy Director of Nursing Clare Hammell, Deputy Medical Director *(representing Murray Luckas, Medical Director)*
Committee meeting quoracy	Yes ☒ No ☐

KEY AREAS OF ASSURANCE

Covid-19: There are currently only a few Covid positive patients still in the hospital, but the acuity and dependency of the remaining patients is higher. Also, an increased acuity of patients arriving at Emergency Department (ED), which may be due to delaying attendance during Covid. Significant numbers of patients presenting daily who are unable to access primary care services; this is impacting on ED flow and is a potential patient safety concern if demand remains high. QSC asked that the issue is escalated to commissioners at pace.

Board Assurance Framework (BAF) Q4 2020/21 – QSC aligned risk
Evidence reviewed that the risk score should be reduced from 3 x 4 =12 to 2 x 4 =8 on BAF 3 *Inability to reduce the nurse staffing gap* as likelihood of risk has reduced significantly following successful focused nursing recruitment and retention work. QSC commended the excellent work between the senior nursing team and HR teams, and the strong pastoral support in place through Practice Education Facilitators and others which had contributed significantly to the success of the project. Case study write up to be considered to share success further.

Integrated Performance Report (IPR):

- Patient Safety incidents resulting in moderate harm are back within control levels, incidents in Cheshire Care Integrated Care Partnership continue to increase but as level of harm is reducing, this is evidence of an improving safety culture
- Gradual and sustained increase in lapses of care of Pressure Ulcers is being addressed through a deep dive, to be reported back to QSC in May with potential change to control limit in IPR graph
- Bi-annual report including greater detail on complaints, themes and findings is being developed to increase Board oversight on nature of complaints (First report September 2021)
- Staffing levels were discussed for those wards lower than the expected 85% Registered Nurse fill rate and QSC advised that a strong narrative was provided by Executive Director in terms of the reasons and controls in place.
- Capacity for Neonatal Life Support resuscitation training needs to increase to meet new requirement for annual training (part of CNST3) an application to national funding being made.

Executive Quality Governance Group Chair's Report:
All high risks reviewed monthly by the EG and at Executive Risk and Assurance Group (ERAG):

- Upper GI Bleed – progress being made to recruit additional consultants to create capacity for a full rota onsite
- Clinical Haematology – linked to two Strategic Executive Information System (StEIS) incidents in March, a number of. Interim actions put into place, and long-term options being considered.

Six new operational risks were identified in month including *A risk of failure to identify and appropriately manage the deteriorating patient* (risk score 20) following a slow rise seen in the number of clinical incidents across wards. Covid has impacted breadth of roll out of NEWS2 (National Early Warning Score) (launched November 2019); A trust wide project has commenced to ensure consistent processes and systems across all wards/areas; interim safety measures include a revision of safety huddles and a review of local audits across all areas. New risk also identified for access to all Trust documents, guidelines and procedures to ensure these can be accessed in a timely way (risk score 16).

In addition, ten documents reviewed linked to BAF risks, including child safeguarding flowchart, local safety standards for invasive procedures (LocSIPPS) and Clinical Harm Reviews (over 2,500 completed since November for patients on waiting list), less than 3% recorded as showing harm.

Serious Incidents March 2021 – Acceptable Assurance: Overview provided of four Strategic Executive Information System (StEIS) incidents, including actions taken to prevent recurrence and lessons learnt. Two linked to Clinical Haematology risk and will form part of a cluster review with a number of low/no harm incidents also identified. Service Level Agreement (SLA) with service providers being reviewed and alternative delivery options being considered.

Care Quality Commission (CQC)
New approach to review of CQC action plan from last inspection to ensure appropriate Subgroups are reviewing areas for actions/ recommendations and plan for future inspections, using Key Lines of Enquiry (KLOE).

KEY CONCERNS/RISKS

- Higher attendance numbers and higher patient acuity than usual within ED. Reasons are multifactorial, include delays in people accessing healthcare due to Covid along with difficulties in accessing primary care services in some circumstances. This has a potential risk to patient safety due to overcrowding in ED. Work to improve ambulatory care pathways in progress.
- Oversight of the quality of Clinical Haematology following a number of incidents, some resulting in harm, in a service which is delivered by a partner organisation through a SLA

Priority Areas: DECISIONS MADE

- Recommend to the Board that BAF 3 risk scoring is reduced from 3 x 4 =12 to 2 x 4 = 8 as a result of a successful programme to recruit more nurses.

RECOMMENDATION

To note.

NHS
Mid Cheshire Hospitals
NHS Foundation Trust

Board of Directors

Agenda Item	**10**	Date of Meeting: 29/04/2021
Report Title	**Serious Incidents Report for March 2021**	
Executive Lead	Murray Lucas, Medical Director	
Lead Officer	Sheila Kasaven, Associate Director of Quality Governance	
Action Required	To note	

X **Acceptable assurance** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐ **Partial assurance** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Low assurance** Evidence indicates poor effectiveness of controls

Key Messages of this Report *(2/3 headlines only)*

There have been 4 Serious incidents reported in March 2021

Next Steps (*actions to be taken following agreement of recommendation/s by Board/Committee)*

For information

Strategic Objective(s) *(indication of which objective/s the report aligns to)*

• Manage Covid response and recovery	☐	• Provide safe and sustainable services	☐
• Provide outstanding care/patient experience	✓	• Provide strong system leadership by working together	✓
• Deliver most effective care to achieve best possible outcomes	✓	• Be well governed and clinically led	☐
• Be the best place to work	☐		

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

• Quality	✓	• Compliance	✓
• Finance	☐	• Legal	☐
• Workforce	☐	• Risk/BAF BAF9 Activity and patient outcome data	
• Equality	☐		

Equality Impact Assessment (*must accompany the following submissions)*

Strategy ☐ Policy ☐ Service Change ☐

REPORT DEVELOPMENT

Committee/ Group Name	Date	Report Title	Lead	Brief summary of key issues raised and actions agreed
TPSG	16.04.21	Serious Incident report	Associate Director of Quality Governance	
Quality and Safety Committee	19.04.21	Serious Incident report	Associate Director of Quality Governance	

Serious Incidents

Introduction

1. This report provides the Committee with details of serious incidents declared during March 2021. The report reflects a key control for the strategic objectives to deliver outstanding care and patient experience and deliver the most effective care to achieve best possible outcomes.

Background and Analysis

2. Serious Incidents in health care are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified. The national Serious Incident Framework (NHS England, 2015) describes the circumstances in which such a response may be required and the process and procedures for achieving it, to ensure that Serious Incidents are identified correctly, investigated thoroughly and, most importantly, learned from to prevent the likelihood of similar incidents happening again.

3. Serious Incidents include acts or omissions in care that result in; unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm - including those where the injury required treatment to prevent death or serious harm, abuse, Never Events, incidents that prevent (or threaten to prevent) an organisation's ability to continue to deliver an acceptable quality of healthcare services and incidents that cause widespread public concern resulting in a loss of confidence in healthcare services

4. **Incidents reported in Month**

4.1 There have been four serious incidents declared in March 2021

1) SI 2021/67728 (134515) External transfer for cooling

A mother had an unforeseen complication (shoulder dystocia – difficulty in delivery of the baby's shoulders) during her delivery. Subsequently there was a need to transfer her baby externally for cooling. A case note review has been conducted by the Obstetric, midwifery and Paediatric teams with no initial lapses in care being identified.

In line with national guidance this is reportable to HSIB and StEIS. The HSIB have confirmed they will be undertaking the investigation.

2) & 3) SI 2021/4700 (131329) and SI 20214917 (132106)

There have been two incidents relating to the Clinical Haematology Service. Review of these incidents revealed similar themes which include; requesting appropriate medical imaging to monitor treatment response, reviewing images in a timely fashion, delays in follow up appointments. Both incidents resulted in a delay to patients receiving the appropriate treatment resulting in significant patient harm.

Immediate actions include discussions between Executives of the Trust & the Trust who run the service and have resulted in a number of measures being put in place to prevent recurrence. The Trust is leading a joint cluster investigation with the service provider to fully investigate these incidents and to put in place a robust agreement between the two Hospitals to ensure a high quality service.

4) SI 2021/4631

An elderly gentleman has developed a category 4 pressure ulcer whilst an inpatient on Ward 6. Lapses in care have been identified and have resulted in a number of immediate actions including the tissue viability team supporting the ward with training and audits.

Conclusions

5. The Trust has declared four serious incidents in the reported period, March 2021; immediate actions to prevent further occurrences happening have been instigated.

6. The Trust continues to demonstrate ongoing learning from incidents and ensures these are disseminated widely within the organisation.

Recommendations

7. The Committee is to note the assurance that the Trust has processes in place to identify, investigate and learn from serious incidents.

Author: Sheila Kasaven, Associate Director of Quality Governance
Date: 08/04/2021

Mid Cheshire Hospitals NHS Foundation Trust

PAF Committee
Chair's Assurance Report
April 2021

Report to	Board of Directors
Date	22 April 2021
Report from	Trevor Brocklebank, Non-Executive Director
Report prepared by	Katharine Dowson, Head of Corporate Governance
Executive Lead/s	Oliver Bennett, Chief Operating Officer Russell Favager, Deputy Chief Executive and Director of Finance
Committee meeting quoracy	Yes ☒ No ☐

KEY AREAS OF ASSURANCE

Board Assurance Framework Q4 2021/22 – PAF aligned risks

Two operational risks highlighted which link to BAF7- *Inability to provide sufficient capacity to meet demand and achieve operational standards:*

- Upper GI Bleeds - funding now agreed to develop a fully comprehensive 24/7 service at Leighton Hospital which will negate transfer of patients offsite
- Clinical Haematology - significant backlog of patients requiring clinical input. Some controls in place which has improved the situation. Service Level Agreement under review with service provider

Actions not yet completed against the finance BAF risks were highlighted:

- Medical Devices tracking system – requires significant investment
- Budget holder training - refreshed but not rolled out due to Covid
- Benchmarking - less nationally available data this year due to Covid and question of legitimacy of data this year given change in financial regime including mutual aid

Description re risk hierarchy to be sufficiently clear to ensure consistency and compliance – to be addressed in on-going risk management training and reinforced across all groups and committees.

Covid-19

- Numbers significantly down, six positive inpatients remaining with none in Critical Care (CCU) which is now fully de-escalated
- 36k+ people and over 90% of staff vaccinated
- Gradual lifting of visiting restrictions started this week - to be reintroduced gradually over next two months in line with national guidance
- End of year report on Covid costs - **acceptable assurance:** costs reviewed to understand which might be recurring and which will reduce/cease.

Integrated Performance Report - additional metrics included from this month which illustrate discharge rates, Cancer backlogs and Priority Codes (P-Codes) to support management of operational performance and waiting lists.

Executive Delivery and Performance Executive Group (EDPG) Chair's Assurance Report

Group met for the first time this month and agreed structure and function. Number of key risks reviewed:

- Referral to Treatment (RTT) waiting list - will continue to increase and take some time to recover
- 52-week wait numbers - increased from zero pre-Covid to just under 900 patients in March. Restoration Plan to address this
- Diagnostic capacity – continues to improve each month; backlog reducing, reliance on some outsourcing and mobile scanner on site
- A&E performance - improved in March despite 31% increase in attendances and higher acuity, leading to more admissions, longer length of stay and potential overcrowding in ED. Threshold for referral from primary care appears lower than pre-Covid. Improvement plan in place including new building, participation in national flow project and consolidation of ambulatory care. Victoria Infirmary Minor Injuries Unit planned re-provision of full opening hours by August
- Cancer backlog - reduced significantly to lowest in Cheshire & Merseyside and 62-day standard near to achieving compliance

PAF challenged differences in scoring between different elements of operational risks that related to waiting time backlogs; explanation accepted that this was due in part to varying levels of recovery across different areas but all scores to be reviewed this month to ensure consistency.

Restoration Plan

First draft of the Restoration Plan was presented. Three initial priority groups outlined: Workforce, patients with urgent clinical need and finally the longest waiters. Trust trajectories for restoring pre-Covid levels of work more ambitious than national guidance. Next step will be an 18 month to 2 year restoration plan.

Internal Audit E-referral system review - acceptable assurance: Substantial assurance received and accepted by Audit Committee; recommendations factored in the Outpatient Transformation Plan.

Financial Plan 2021/22

Draft plan to be submitted to NHS Improvement by 23 April; final submission 4 May, £6.6m base deficit position excluding restoration, pressure re capital charges. Trust block income confirmed but Health and Care Partnership for Cheshire and Merseyside (HCP) system allocations indicative figures, still to be agreed - includes Covid support. National efficiency schemes requirement of 0.28% although more expected from HCP once system Control Total received.

Financial Position 2020/21

2020/21 Year End operational position deficit of £4.4m (excluding technical adjustments). Position includes £2.4m provisions for 2020/21 untaken annual leave and £0.4m for Flowers case ruling. Position £600k above previous forecast due to prudent approach taken over provisions, following negotiations and increase in forecast accepted by NHSI.

Capital Programme 2021/22 - acceptable assurance: Capital system changed this year to system-based approach with Capital Resource Limit set at HCP level; HCP set resource limits at organisational levels. Trust demand for Capital schemes will outstrip the Capital limit set; written assurance received from HCP to find a way to increase resource to match likely spend.

Executive Safety and Sustainable Environment Group (ESSEG) Chair's Assurance Report

£22m confirmed for RAAC plank works; to be used to complete work that dovetails into wider redevelopment plans. Plans also required for alternative staff rest area once CCU expansion works begin. Health & Safety focus on Display Screen Equipment assessments and online training given musculoskeletal implications and link to sickness, with provision for those working at home.

Strategic Outline Case (SOC) for Leighton Hospital Redevelopment - acceptable assurance:
Economic and financial key headlines demonstrate a positive case. Preferred option has best benefit cost ratios, second largest floor area, lowest costs per sqm and the fastest route to completion and to zero carbon; includes maximum level of investment in digital and technology; highest risk-adjusted net present social value and lowest risk value. Consideration made of optimism bias. Additional operational long-term revenue costs of £2m p.a. offset by additional benefits. Additional Capital Charges material (circa. £22m), potential change in system, to be discussed with Centre as part of business case

KEY CONCERNS/RISKS

- Significant rise in A&E attendances and emergency admissions, resulting in overcrowding.
- Unmet need for routine, semi-urgent care in communities might lead to higher than expected level of GP referrals; could challenge proposed trajectories in Restoration Plan and impact on patient waiting times

Priority Areas: DECISIONS MADE

- PAF agreed to provide assurance to the Board that the finance and economic case of the SOC was robust
- Recommendation to Board to approve the Restoration Plan

RECOMMENDATION

To note

BOARD OF DIRECTORS

Agenda Item	**11.2**	Date of Meeting: 29/04/2021
Report Title	**Covid-19 Restoration Plan**	
Executive Lead	Oliver Bennett, Chief Operating Officer	
Lead Officer	Mark Wilde, Director of Operations	
Action Required	To note	

☐ **Acceptable assurance** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐ **Partial assurance** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Low assurance** Evidence indicates poor effectiveness of controls

Key Messages of this Report *(2/3 headlines only)*

- This paper provides an overview of the people recovery plan and the priorities for restoration of services for the first half of 2021/22.

Next Steps (*actions to be taken following agreement of recommendation/s by Board/Committee)*

- Submit the final draft plan to NHSEI via the Cheshire and Mersey HCP by 6 May, followed by the final submission in June.
- Develop the medium and longer-term service and performance restoration and recovery plan that includes a detailed summary of the investment proposal to support the plan. It is anticipated this will be completed in May.
- Develop the full Trust Operational Plan encompassing the full set of requirements and deliverables outlined in the recently published NHS planning guidance. This is expected to be completed and submitted to the PAF Committee in May.

Strategic Objective(s) *(indication of which objective/s the report aligns to)*

• Manage Covid response and recovery	✓	• Provide safe and sustainable services	
• Provide outstanding care/patient experience	☐	• Provide strong system leadership by working together	☐
• Deliver most effective care to achieve best possible outcomes	☐	• Be well governed and clinically led	☐
• Be the best place to work	☐		

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

• Quality	☐	• Compliance	☐
• Finance	☐	• Legal	☐
• Workforce	☐	• Risk/BAF **BAF7 Operational capacity to meet demand**	
• Equality	☐		

Equality Impact Assessment (*must accompany the following submissions)*

Strategy ☐ Policy ☐ Service Change ☐

REPORT DEVELOPMENT

Committee/ Group Name	Date	Report Title	Lead	Brief summary of key issues raised, and actions agreed
PAF Committee	22/4/21	Covid-19 Restoration Plan	Oliver Bennett Chief Operating Officer	Paper noted by the PAF Committee. Planning assumptions to be updated (inc. assumption around Covid fourth wave and include in the briefing to the Board.

COVID-19 RESTORATION PLAN

1. Executive Summary

This paper provides a briefing on the Covid-19 restoration plan, specifically:

- Provides a summary of the People Recovery Plan; and
- Outlines the activity and performance plan for the first six months of 2021/22 in line with recently published NHS planning guidance.

The Trust has developed and has started the process of implementing the initial phases of the People Recovery Plan which is intended to ensure that staff are provided with the opportunity to recover, recuperate, access support if required and to reflect of how they may have grown in the last year during the pandemic. The highlights of the plan are outlined in this paper.

This paper sets out the activity and performance priorities for the first six months of 2021/22, the main points to note are:

- Waiting list backlogs have increased significantly during the pandemic and likely to continue to grow over the coming months.
- Most clinical services have resumed, and some services and pathways have had to be redesigned because of the pandemic.
- Patients whose clinical need is greater will be prioritised, followed by those who have waited the longest and capacity and resources will be allocated accordingly.
- The Trust has set activity recovery trajectories that go beyond what is expected from NHSEI and will result in more patients being seen sooner.
- The Trust is currently considering a detailed restoration and investment plan that would help to deliver activity in excess of NHSEI thresholds, as set out in the national planning guidance, and in excess of pre-pandemic levels. This is will be necessary to make material inroads in to backlogs.

2. Introduction

The Trust has now exited the third wave of the Covid-19 pandemic with a significant reduction in the number of Covid-19 hospitalisations. Whilst it continues to respond to the pandemic and many Covid-19 related arrangements remain in place, the focus has now shifted to the restoration and recovery of clinical services and staff.

There has been a significant increase in the number of non-Covid patients waiting and whom are waiting longer for planned treatment than they would have done pre-pandemic. Because of the pandemic, the operational performance of the Trust has deteriorated significantly over the last year. It is, however, important to strike the right balance between the restoration and rebuilding of clinical services with the recovery and recuperation of the workforce and this will be a consistent theme throughout the process.

The NHS has recently published its Priorities and Operational Planning guidance for 2021/22. The Executive Team are currently considering the full detail and this paper therefore does not address the full scope of the recently published guidance. The full Operational Plan for the Trust will be presented to the Performance and Finance Committee in June 2021. This paper

outlines the draft activity and performance trajectories submitted to the Cheshire and Mersey Healthcare Partnership (HCP).

The final draft plan is not due to be submitted to NHSE/I until 6 May with the final version expected 3 June 2021. The Board will be kept up to date with developments over the coming months.

3. Aim

The aim of this paper is to set out the immediate priorities for the Trust in the first half of the financial year 2021-22. The focus of this paper is twofold:

1. Provide a summary of the People Recovery Plan; and
2. Outlines the activity and performance plan and priorities for the next six months.

The aim of the overall restoration and recovery programme, is to **continue to innovate and restore clinical services and activity that will deliver a significantly improved patient experience and reduce waiting list backlogs and ensure that we continue to prioritise the health and wellbeing of our people.**

The scope of work and priorities over the first half of 2021/22 will likely widen and be more comprehensive following due consideration of the new NHS Operational Planning guidance which details other specific priorities, i.e. around maternity and urgent and emergency care services that is currently being considered by the Executive Team.

4. Key Focus & Priorities

4.1 What has changed during the pandemic?

Before this paper describes the focus for improvement going forward, it may be helpful to show what has changed during the pandemic which has and will continue to result in many more patients waiting longer for care and treatment. Some key facts below which compare the position before Covid-19 with what it is currently:

- GP referrals have started to recover close to pre-pandemic levels at 4,096 in February 2021 and are above the total seen in March 2020 (3,635) when referral levels started to be affected. However, there has been a significant drop off in overall referrals during the last year. In 2019/20, the Trust received just over 60,000 GP referrals. This fell by 15,000 to 45,000 in 2020/21, a 25% drop. At February 2021, C&M ICP has seen a decrease of 36% in GP referrals over the 12-month period.
- The number of patients on an RTT waiting list for treatment to commence has increased from nearly 15,000 to just over 21,000 and will likely continue to grow for months and could be further compounded if GP referrals rise above pre-pandemic levels. Overall, the C&M ICP RTT waiting list has grown from 190,000 in April 2020 to 225,000 in February 21 an increase of 18%.
- The average wait for a patient on an open RTT pathway (awaiting treatment) in March 2020 was 7 weeks, it is now 11 weeks and increasing. The 92nd percentile waiting time in March 2020 was 21 weeks, it has risen to 36 weeks. Nationally, in February 2021 the average wait was 12.6 weeks and the 92nd percentile was above 52 weeks.
- The number of patients who have waited 52+ weeks for treatment has increased from zero before the pandemic to nearly 900, which remains one of the lowest positions in

C&M ICP. In February 2021, C&M ICP had 16,034 52-week waiters with Mid Cheshire accounting for 4.9% of these.

- The number of patients waiting a first outpatient appointment following GP referral has increased from nearly 10,000 to just under 15,000 despite the fall in referrals throughout the pandemic.
- The number of patients waiting a follow up outpatient appointment has increased from 19,000 to over 23,000.
- The inpatient waiting list was 4,659 and is now 4,543, but at the peak it was 5,450 (August 2020).
- The number of patients waiting 63+ days for a cancer diagnosis and or treatment went from minimal numbers pre-pandemic to nearly 200 during the pandemic, but this has since recovered to near pre-pandemic levels and remains the lowest in the C&M ICP.

The remainder of this paper outlines how we are going to start to recover performance back to pre-pandemic levels.

4.2 Immediate Priorities Going Forward

The Trust has carefully considered its capacity and capability to restart and restore its clinical services and activity following the third wave of the pandemic. It has also taken into consideration that staff will require a period of rest and recuperation. It is therefore imperative that we continue to prioritise the health and wellbeing of our staff as we did so before and during the Covid-19 response.

There are several priorities set out in the NHS planning guidance for 2021/22 and the next phase of the restoration and recovery of services and activity. The focus will be on:

1. **Workforce:** continue to look after our staff, their health and wellbeing and provide them with the support they need to recover and recuperate.
2. **Patients whose clinical need is greater:** seeing, diagnosing and treating those patients that are a clinical priority and who require care the most, which will include urgent and cancer patients.
3. **Long-waiters:** those patients who have waited longer than 52 weeks for treatment.

5. People Recovery Plan ~ 'Forward Together'

As the Trust comes out of the pandemic, it is vital that we ensure our staff are given an opportunity to reflect and compute the experiences that they have lived through over the last 12 months to enable them to recover and rebalance their lives.

Over the last few weeks, the Trust has been working on a six-phase process to create and develop a plan to support staff as part of the Covid-19 People Recovery Plan.

The Six- Phase People Recovery Plan

The table below provides a summary of the six-phase Covid-19 People Recovery Plan:

WHAT….	***WHO….***	***HOW….***	***WHEN….***

Phase 1: Research • Staff feedback • Review current offers	**Working Group Members:** Communications, HR, Nursing and Medical Leads	• All staff questionnaire • Posters in clinical areas • Collation of resources currently available	**By 26th Mar '21**
Phase 2: Review • Review outcomes of Phase 1 • Gap Analysis	**Working Group Members:** Communications, OH, HR	• Assessment of the data provided via the questionnaire • Assessment of the data provided via the targeted approach • Comparison of this data against what is already available at the Trust	**By 2nd Apr '21**
Phase 3: Recommend • Create Process and documentation	**Working Group Members:** Communications, Nursing and Medical Leads, OH, HR, E-Rostering, Finance	• Agree what the process will be • Create template documentation to support the programme	**Start: 22nd Mar '21, Complete: 16th Apr '21**
Phase 4: Realise • Pilot Phase 3 in Critical Care and Ward 5	**Working Group Members:** Communications, Nursing and Medical Leads, OH, HR, E-Rostering	• Utilise plan and resources identified in Phase 3	**Start 19th Apr '21**
Phase 5: Reflect • Review outcomes of Phase 4 • Plan Trust rollout	**Working Group Members:** Nursing and Medical Leads, OH, HR, E-Rostering	• Review feedback from individuals who have been through a Recovery Programme • Review feedback from the Managers who took part in the implementation of the People Recovery Plan • Review feedback from OH and E-Rostering	**Start: 19th Apr '21, Complete: 7th May '21**
Phase 6: Rollout • Rollout to wider Trust areas	**Working Group Members:** Nursing and Medical Leads, HR, E-Rostering	• To be determine following Phase 5	**Commence from 10th May '21**

5.1 The People Recovery Plan (Forward Together)

As part of the work undertaken in phases one, two and three of the six-phase plan, the following key approaches were identified:

- All members of staff including Line Managers should be afforded the opportunity to have an individual conversation tailored to their own experiences and support requirements as a result of working through the pandemic.

- Teams have responded to rapid changes throughout the pandemic and should be supported to have some time to come back together as a group

What are we offering - phases one, two and three of the six-phase plan provided us with vital insight on how we need to shape plans to incorporate ensuring that support is offered to those who may need it from a wellbeing perspective, but also that we need to build on the positive experiences that staff may have taken as well. For example, some staff may have learnt new skills which they would like to continue to develop after the pandemic. In addition, we learnt that it is important to ensure that we support staff to be able to acknowledge and normalise the experiences they have been through over the last 12 months and reflect on how they can positively move forward from these in the future.

In light of this we have developed a *'My Personal Forward Together Plan'* template which encourages staff to have a conversation which enables them to select from a list of supportive offers available in the Trust which they may find useful. In addition to this a number of team offerings are also being developed which will sit alongside any individual conversations. In addition, staff will also be encouraged to take time to review other areas such as how they spend their rest breaks and what actions they may be able to take outside of work to support their health and wellbeing overall.

How will we deliver this - a two-week pilot rollout commenced on 19 April 2021 whereby individual conversations and team interventions are being trialled within Critical Care and Ward 5. The feedback from this pilot will then inform the plans regarding the most effective approach to take with the full Trust rollout which is due to commence from 10 May 2021. The pilot phase will draw on existing resources available in order to carry out individual conversations and trial some team interventions.

What resources are required - it has been identified that in order to deliver this plan, we will need to create a wellbeing 'team' from existing and new resources and potentially invest in some external resource to support with our offer to staff. We will also need to build capacity into rotas to enable individual and team development/recovery and funding will be required to support this capacity. We will need to ensure appropriate funding for the release time of existing resources such as our Mental Health First Aiders and from a medium to long term perspective, we will need to ensure that we can continue to support the health and wellbeing of staff, along with further investing in expansion of wellbeing space.

How will this be measured - we have already utilised earlier phases in the six-step approach to obtain feedback from staff and incorporated that feedback into the development of the 'My Personal Forward Together Plan' template. In addition to this, phase 5 of the plan allows for a further review and assessment of the pilot which will consist of feedback from staff and managers who have taken part in order to inform the full rollout from 10 May 2021 onwards.

In relation to measuring the impact of this People Recovery (Forward Together) Plan overall, arrangements will be made to ensure we consider our Trust metric data against this plan and gather further feedback from to staff which will be reported back through the appropriate Trust governance processes once the full rollout has been embed in all areas.

6. Service Restoration

The complex process of resuming and restoring clinical services has commenced. Most clinical services have now restarted, including community, outpatient, diagnostic and endoscopy services as has routine elective operating. Cancer screening programmes remained operational throughout the last wave as did the cancer programme except for 2-3 weeks. There are significant backlogs in most of these areas and the Trust is working hard to resume as much activity as possible over the coming months in a safe, measured and gradual way that continues to have regard to necessary IPC measures, keeping patients safe and is also aligned to the People Recovery Plan.

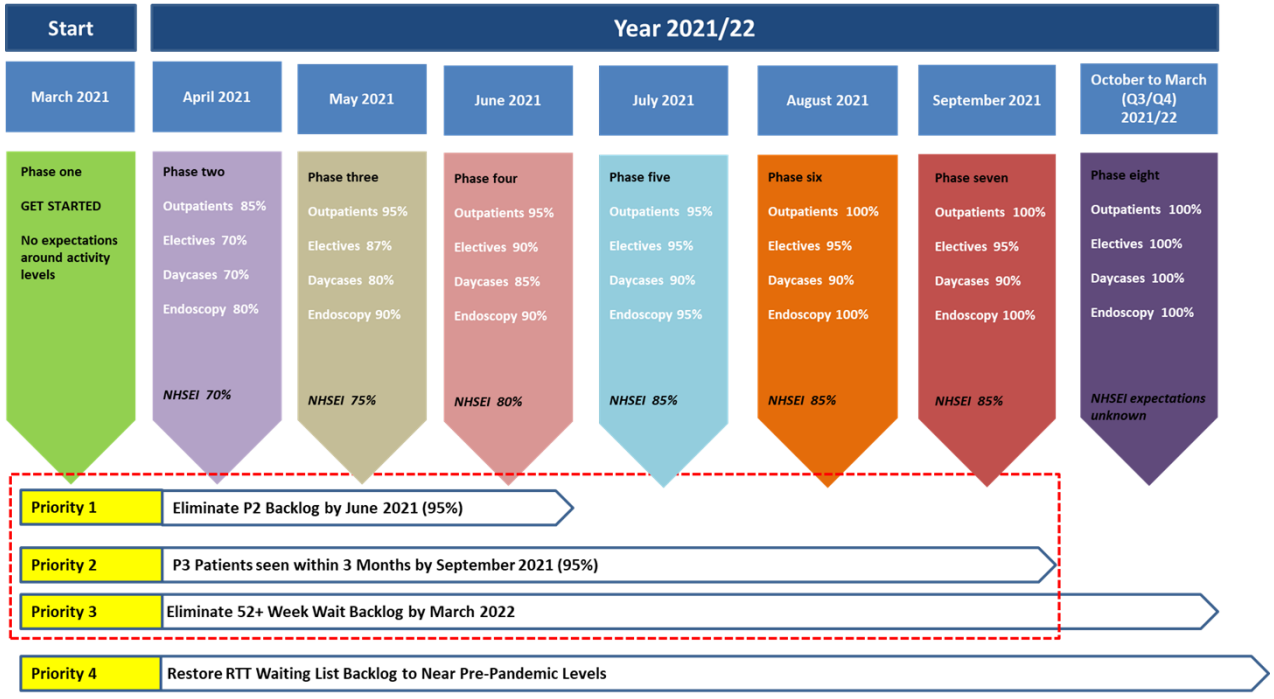
This section of the paper outlines the draft activity and performance trajectories submitted to the Cheshire and Mersey Health Care Partnership. The final draft, along with the financial plan, is required 6 May and the final version 3 June.

6.1 Activity Trajectories

NHSEI have outlined in the recently published NHS Operational Planning guidance that Trusts should resume 70 per cent of pre-pandemic activity in April, based on 2019/20 baseline, rising by 5 percentage points each month until reaching 85 per cent in July and sustaining that in August and September. Expectations beyond that is yet unknown.

The activity trajectories set by the Trust for 2021/22 are outlined in the below infographic. These are more ambitious than the expectations laid out in the NHS planning guidance. This is because there is a high confidence level than we can achieve a greater degree of activity resumption and there are also plans being considered to invest in services as part of the national Elective Recovery Fund (ERF) available to systems to support activity above the NHSEI 'thresholds'. It is important to note that these trajectories remain draft and may change ahead of the final submission on the 3 June. The Trust is also considering plans that would provide capacity to exceed pre-pandemic levels, which would require further investment and new ways of working.

Mid Cheshire (draft) Activity & Performance Trajectories 2021/22



The Trust did not set any activity expectations in March 2021 as it was keen to provide an opportunity for the organisation to pause and give people a window to start the process of recovery. The focus was to start the process of resuming clinical services at a pace that individual specialties considered was safe and deliverable.

It is important to note that NHSEI activity expectations for the second half of 2021/22 are yet unknown and not covered in the recently published NHS planning guidance. There are also no specific timelines established by NHSEI for systems to restore activity to meet or exceed pre-pandemic levels. However, systems have been asked in the planning guidance to identify

approaches to tackle backlogs (when feasible) to move beyond 2019/20 activity baselines, which is something the Trust is currently considering and will provide further detail in due course.

6.2 Performance Priorities

As the Trust has set out activity trajectories as part of a developing Covid restoration plan, it has also set out several trajectories for eliminating waiting backlogs of patients whose need is seen as a clinical priority (as shown in the above infographic), namely:

- Long waiters which are those waiting in excess of one year for treatment.
- Those patients whose clinical need is considered a priority and who require an operation within a) 1 month and b) less than 3 months. It is important to note at this stage that as part of a clinical review and validation of the inpatient elective waiting list, in response to national guidance, all patients on said waiting list have now been categorised with a "p-code". "P-codes" is a way of categorising patients according to when they require their operation defined in brackets of time as outlined in the below table. There is a focus on patients identified in the category P2 and P3 from an elective point of view. P1 patients are considered emergencies and therefore treated through the urgent and emergency care pathways, not an elective pathway and therefore out of scope of this paper.

P Code	Timeframe
P1	<24 hours (1a) or <72 hours (1b)
P2	< 1 month
P3	< 3 months
P4	> 3 months
P5	Patient chosen to delay due to Covid reasons
P6	Patient chosen to delay due to non-Covid reasons

Infographic one above shows four performance priorities and are explained in more detail in the below table. Resource and capacity should be deployed to address these priorities so that those patients who need care the most receive it as timely as possible. Addressing health inequalities, magnified during the pandemic, will be a key factor to consider throughout this planning process.

Priority	Priority 1	Priority 2	Priority 3	Priority 4
Description	Eliminate the backlog of P2 patients which are those that require an operation <1 month	Eliminate the backlog of P3 patients which are those that require an operation >3 months	Eliminate the backlog of patients that are waiting 52+ weeks for a routine operation. Note: some of these patients fall under priority 2 as they may well be a P2 patient	Restore RTT waiting list backlog to near pre-pandemic levels
Timescale	June 2021	September 2021	March 2022	Not covered in the recent NHS Planning guidance, but will take longer

				than 2021/22 to recover

Cancer performance and the full restoration and recovery of all cancer services, including screening programmes, is also a key priority for the NHS and the Trust. It is therefore important that we continue to focus on reduction in the 63+ day backlogs. Cancer backlogs are expected to be at pre-pandemic levels by end of Q1. It is also important that the Trust focuses on restoring 62-day cancer performance back to pre-pandemic levels and address the shortfall in the number of first treatments by March 2022. There should also be a focus on all other cancer standards. Resumption of pre-pandemic cancer performance against core standards to pre-pandemic levels and timetable for achieving this is still being carefully considered. Finally, there is a specific requirement in the planning guidance to deliver the 'Faster Cancer Diagnosis' standard, whereby all patients referred on a cancer pathway receive a definitive diagnosis within 28 days by Q3 ~ the minimum standard will be 75 per cent, which the Trust is already exceeding.

6.3 Key Planning Assumptions

There are a significant number of planning assumptions made in the development of the activity and performance restoration plan, which are in the main, agreed at system-level. The key assumptions to note are:

- There will not be a Covid-19 fourth wave and Covid general and acute bed occupancy remains below 5%.
- Overall bed occupancy does not exceed 90%.
- Assuming 10 and 15% reduction in elective productivity due to observing IPC measures.
- Local assumption (standard) set for 95% of P2 patients seen >1 month.
- GP referrals at 100% of pre-Covid levels but have been asked to consider 20% referral 'bounce back'. Cancer rapid referrals 10-15% above pre-Covid level.
- A&E attendances and non-elective hospital admissions at 100% of pre-Covid levels.

7. The Elective Recovery Fund (ERF)

The financial arrangements for the first half of 2021/22 will effectively reflect those in place in the second half of last year, with the main difference being financial accountability will be on a system-wide not organisational basis.

The NHS planning guidance refers to the Elective Recovery Fund (ERF) which makes available up to £1 billion to support organisations who can exceed the minimum activity thresholds outlined in the NHS planning guidance (as described above) and meets certain "gateway" criterion. If providers exceed the 85% threshold each month, Trusts could access the ERF.

The Trust is currently developing a detailed restoration plan in order to exceed the activity thresholds outlined in the NHS planning guidance, i.e. >85 per cent and possibly beyond 100 per cent in the second half of 2021/22 and in 2022/23. To significantly exceed the activity thresholds set out in the NHS planning guidance, it would require additional investment and funding above 'core' financial budgets. The plans will need to be deliverable and realistic and considered on a system wide basis along with plans from all other providers. There is therefore a degree of uncertainty about how ambitious individual Trust plans can be in relation to restoration and recovery.

8. Summary

This paper has set out the requirements of the first phase of the restoration of services and activity following the third wave of the pandemic and in line with national NHS planning guidance. The key messages are:

- The ongoing health and wellbeing of staff is and remains the top priority of the NHS and the Trust and a People Recovery Plan has been developed and being implemented.
- Most clinical services have now been restored. But there is a significant waiting list backlog that has built up over the last year.
- A set of trajectories to restore clinical activity to pre-pandemic levels have been proposed and the Trust has planned to exceed the monthly thresholds outlined in the NHS planning guidance.
- Priority will be given to those patients whose clinical need is greater followed by those that have waited the longest. The Trust expects to clear the backlog of patients waiting for urgent treatment (<1 month) by June 2021, and those requiring "semi-urgent" treatment (<3 months) by September 2021. But it will probably take at least until March 2022 to eliminate the backlog of patients waiting 52+ weeks.
- The Trust has an opportunity to invest in its restoration plan through access to the National Elective Recovery Fund (£1b) and is actively seeking to do this through the system-wide planning process.
- The PAF committee has received assurance on the plans set out in this paper and will be monitoring progress on a monthly basis and as plans develop further.
- The full scope of the recently published NHS Planning guidance will be presented to the PAF Committee in May as part of the Mid Cheshire Hospitals NHS FT Operational Plan 2021/22 and assurance will be provided to the Board in May or June.

9. Next Steps

The next steps as part of the planning cycle is:

- Submit the final draft plan to NHSEI via the Cheshire and Mersey HCP by 6 May, followed by the final submission in June. Some of the trajectories outlined in this paper may change as part of the planning cycle.
- Consider how the Board will gain assurance on delivery of the restoration plan via the PAF Committee.
- Develop the medium and longer-term service and performance restoration and recovery plan that includes a detailed summary of the investment proposal to support the plan. It is anticipated this will be completed in May.
- Develop the full Trust Operational Plan encompassing the full set of requirements and deliverables outlined in the recently published NHS planning guidance. This is expected to be completed and submitted to the PAF Committee in May.

10. Recommendation

To note

Oliver Bennett
Chief Operating Officer

Heather Barnett
Director of Workforce and OD

April 2021

Workforce and Digital Transformation Committee
Chair's Assurance Report
April 2021

Report to	Board of Directors
Date	19 April 2021
Report from	Lorraine Butcher, Non-Executive Director
Report prepared by	Katharine Dowson, Head of Corporate Governance
Executive Lead/s	Jenny Grant, Deputy Director of Workforce and OD *(representing Heather Barnett, Director of Workforce and OD)* Amy Freeman, Chief Information Officer Oliver Bennett, Chief Operating Officer
Committee meeting quoracy	Yes ☒ No ☐

KEY AREAS OF ASSURANCE

Board Assurance Framework (BAF) Q4 2020/21
Importance of workforce engagement for digital transformation flagged, also identified in Audit Committee through discussions on the E-referral system Internal Audit report. Digital Clinical System (DCS) programme risk on adoption is in risk register and discussions with Workforce have begun.

Integrated Performance Report (IPR)
New ESR structure to be created in May; may impact May data in June IPR. Slight improvement in appraisal rates, plans to further improve to be reviewed by Executive Workforce Assurance Group (EWAG) in May. Positive trends in workforce metrics reflect significant improvement work.

Executive Workforce Assurance Group Chair's Report
Risk WOD022 (Nursing Vacancy gap) reduced as a result of a successful reduction in nursing vacancies. Recommendation to be made to Board to reduce the risk scoring for BAF risk 3 (*Inability to close the nurse staffing vacancy gap*) from 4x3 = 12 to 4x2 = 8 as a result.

WDT raised impact on the Trust of legal decision on overtime (Flowers case); requested update by September with report to be submitted to Performance and Finance Committee.

Annual Report for Committee received, majority of objectives achieved. Subgroups established.

Digital Transformation and Information Services (DTIS) Executive Group – Chair's Report
Actions in place to mitigate high risks by May. Further projects in pipeline identified by DTIS prioritisation process. Decision on DCS procurement on track for May Board of Directors. E-expenses system now live. Additional investment obtained from NHS Digital for Cyber Security to enable internal penetration testing to take place alongside formal externally commissioned testing, also to identify Medical Devices on the network in response to recommendation of Internal Audit report.

Vacancy Gap Update – Acceptable Assurance: Original target of 95% fill of Band 5/6 registered nurses by January 2021 achieved with slight delay to April 2021. Projections impacted by Covid travel/quarantine disruption. Increased use of agency through Covid reflects requirements for higher numbers of staff. Project to continue, to ensure vacancy gap remains closed; will address increase in vacancies due to Emergency Department recruitment/ Winter Preparedness. Focus moving to retention of workforce.

Health and Wellbeing Guardian Diagnostic Framework Report – Acceptable Assurance: Assessment against NHS Improvement and NHS England (NHSIE) Wellbeing Offer Diagnostic tool scored well in Board Leadership, Healthy Work Environment and Mental Health. Areas for improvement identified i.e. Data Driven Decision Making, Musculoskeletal Health and Healthy Living to be added to Health And Wellbeing Board workplan.

Leadership Programme Report – Partial Assurance: Introduction of new talent development pathways as part of progression of talent management maturity. WDT challenged how impact would be measured outside of staff survey.

NHS People Plan Update - Partial Assurance: action plan has been underway through Covid with majority of recommendations moved from partial to full. Each EWAG subgroup tasked with addressing areas that remain outstanding. Impact to be measured through a variety of measures e.g. staff survey and Pulse surveys

People Recovery Plan – Acceptable Assurance: engagement with staff to develop plan and enable all staff to develop their own personal recovery plan; resource to support this being explored. To be aligned with personal development conversations and with appraisal to provide a comprehensive approach.

KEY CONCERNS/RISKS

- Impact of 'Flowers' overtime legal case
- Consistent completion of Equality Impact Assessments (EIAs) and submission with relevant documents

Priority Areas: DECISIONS MADE

- Workplan 2021/22 agreed
- Recommendation to Board to reduce the BAF 3 score from 3 x 4 =12 to 4 x 2 = 8

RECOMMENDATION

To note

Mid Cheshire Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

Agenda Item	**12.1**	Date of Meeting: 29/04/2021
Report Title	**Workforce Health and Wellbeing Diagnostic Framework Report**	
Executive Lead	Heather Barnett, Director of Workforce and OD	
Lead Officer	Bobby Sharma, Occupational Health Manager	
Action Required	To approve	

X **Acceptable assurance** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐ **Partial assurance** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Low assurance** Evidence indicates poor effectiveness of controls

Key Messages of this Report *(2/3 headlines only)*

- The NHSE/I workforce diagnostic framework provides a tool to self-assess against the Health & Wellbeing framework
- Key strengths identified in areas of Board Leadership, Healthy Work Environment & Mental Health
- Areas for development identified in areas of Data and Communications, Musculoskeletal & Healthy Lifestyles
- NED Health and Wellbeing Guardian role to be agreed

Next Steps (*actions to be taken following agreement of recommendation/s by Board/Committee)*

- Health & Wellbeing Project Board to incorporate areas for development identified into workplan for progress
- Progress report to Board in 6 months time (Oct 2021)

Strategic Objective(s) *(indication of which objective/s the report aligns to)*

• Manage Covid response and recovery	✓	• Provide safe and sustainable services	✓
• Provide outstanding care/patient experience	✓	• Provide strong system leadership by working together	✓
• Deliver most effective care to achieve best possible outcomes	✓	• Be well governed and clinically led	✓
• Be the best place to work	✓		

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

• Quality	☐	• Compliance	☐
• Finance	☐	• Legal	☐
• Workforce	☐	• Risk/BAF BAF12 Organisational culture	
• Equality	☐		

Equality Impact Assessment (*must accompany the following submissions)*

Strategy ☐ Policy ☐ Service Change ☐

REPORT DEVELOPMENT

Committee/ Group Name	Date	Report Title	Lead	Brief summary of key issues raised and actions agreed
Health and Wellbeing Project Board	31.03.21	Health and Wellbeing Diagnostic Framework	Bobby Sharma	Wider input required therefore agreed to circulate to BAME and EDI networks
Executive Workforce Assurance Group	07.04.21	Health & Wellbeing Diagnostic Framework	Bobby Sharma	Insights welcomed and agreed to escalate to WDT

Workforce Health and Wellbeing Diagnostic Framework Report

Introduction

1. This paper provides a summary of the Workforce Health and Wellbeing Framework introduced by NHSE/I. The diagnostic tool provides a way for organisations to self-assess against each section of the Framework. Key strengths identified as a result of the diagnostic included Board Leadership, Healthy Work Environment and Mental Health. Areas for the Trust where further development is required were identified as Data and Communications, Musculoskeletal and Healthy Lifestyles. Summary slides are attached to this report with further details.

Background and Analysis

2. The diagnostic tool is divided into five sections: Enablers, Mental Health, Musculoskeletal (MSK), Healthy Lifestyles and Framework Dashboard. Members of the Health & Wellbeing Project Board worked through each section, assessing performance against a red, amber, green status and providing the supporting evidence.

3. Outputs were then shared with the EDI Lead and BAME network prior to presentation to EWAG.

4. The diagnostic tool enables the Trust to better understand areas where it is performing well and those where further improvements are identified.

5. The Framework Dashboard revealed the following areas of strength for the Trust:
    - **Board Leadership** – demonstrating the Board is engaged with the staff health and wellbeing agenda and take responsibility for advancing it across the Trust
    - **Healthy Work Environment** – demonstrating the Trust provides a physical and cultural environment that enables and actively promotes health and wellbeing at work and that staff have access to healthy food and drink at work
    - **Mental Health** – demonstrating the Trust proactively manages working practices and conditions that contribute to poor mental health and that workplace support is available for staff to maintain good mental health in the workplace.

6. The Framework Dashboard revealed the following areas where further development or improvement is required:
    - **Data Driven Decision Making** – where decisions related to staff health and wellbeing are informed by the effective use of data
    - **MSK** – where support is available for staff to maintain good MSK health, a culture of self-care is promoted and timely access to physiotherapy is provided
    - **Healthy Lifestyles** – where workplace support is available for staff to maintain good health and manage conditions in the workplace (such as smoking, sleep, alcohol/drug misuse, debt, physical activity and obesity)

Conclusions

7. The Trust has made good progress in promoting and prioritising the health and wellbeing of staff in recent years. Whilst much support was already in place previously, this work has been accelerated and processes formalised during the pandemic. The establishment of a Health and Wellbeing Project Board, chaired by an Executive Lead, with engagement from across the Trust and from different staff groups has been a catalyst in delivering projects and in endorsing the Trust's commitment to this agenda. This will be reinforced with the appointment of a NED to the role of Health and Wellbeing Guardian.

8. The Diagnostic Framework recognises much of the good work carried out in the way the Trust supports and promotes the wellbeing of staff. This is evidenced not only in the strengths identified in this report but also in the areas where further work is still required.

9. The Health and Wellbeing Project Board will incorporate the findings of this Diagnostic Framework into its' Work Plan and assign sub-groups to address areas for development.

10. Progress will be reported through EWAG as part of standing governance arrangements.

Recommendations

11. To approve the appointment of a named NED as Health and Wellbeing Guardian

Author: Bobby Sharma
Date: 12/04/21

NHS
Mid Cheshire Hospitals
NHS Foundation Trust

Health & Wellbeing Diagnostics Tool 2021

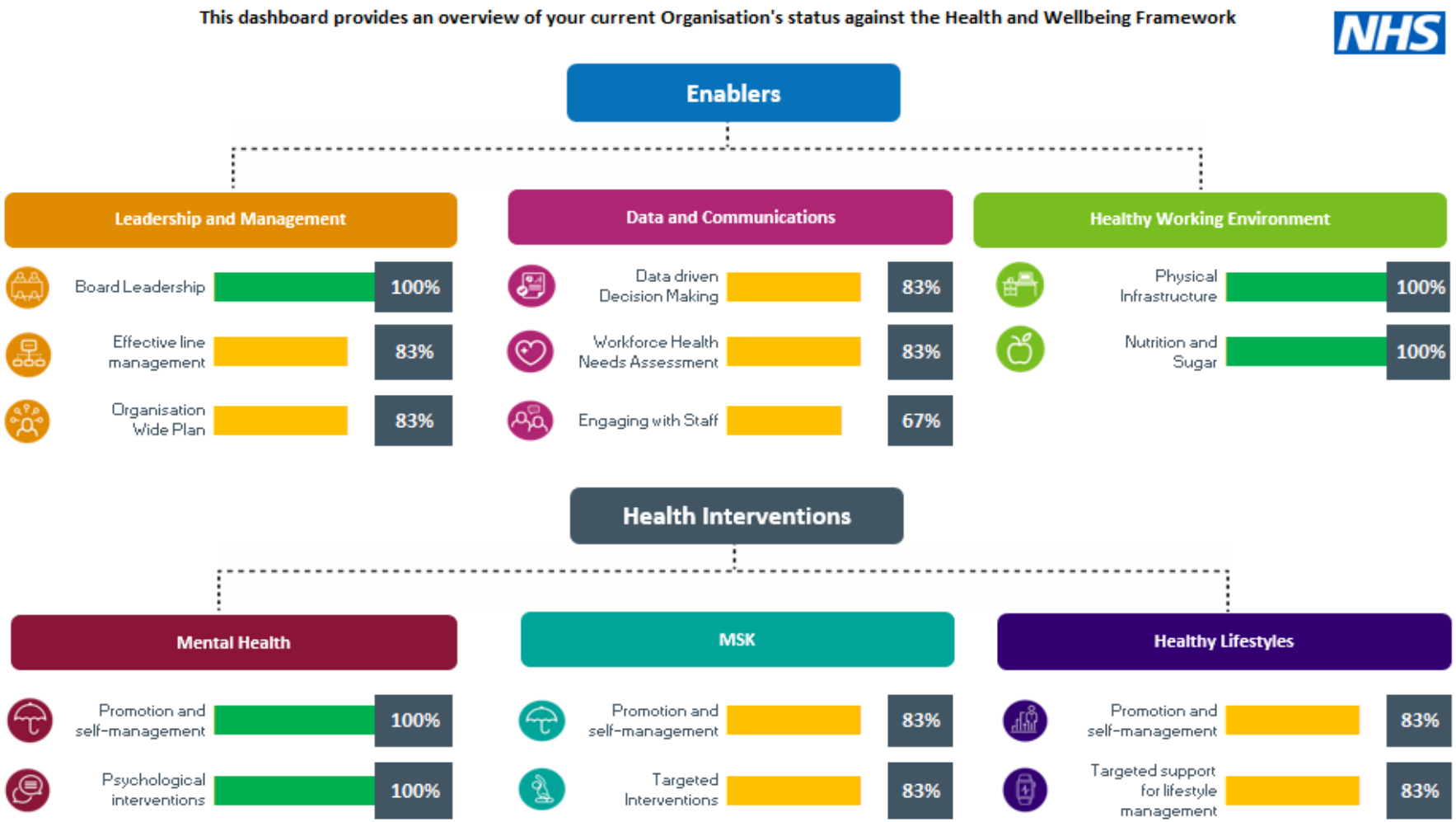
Overview

This tool provides a quick and easy way to self-assess your organisation against each section of the Health and Wellbeing Framework.

The tool should support you to:

- **Quickly understand your status against the Framework**
- **Help you prioritise and order areas to focus on**

Framework Dashboard



Strengths

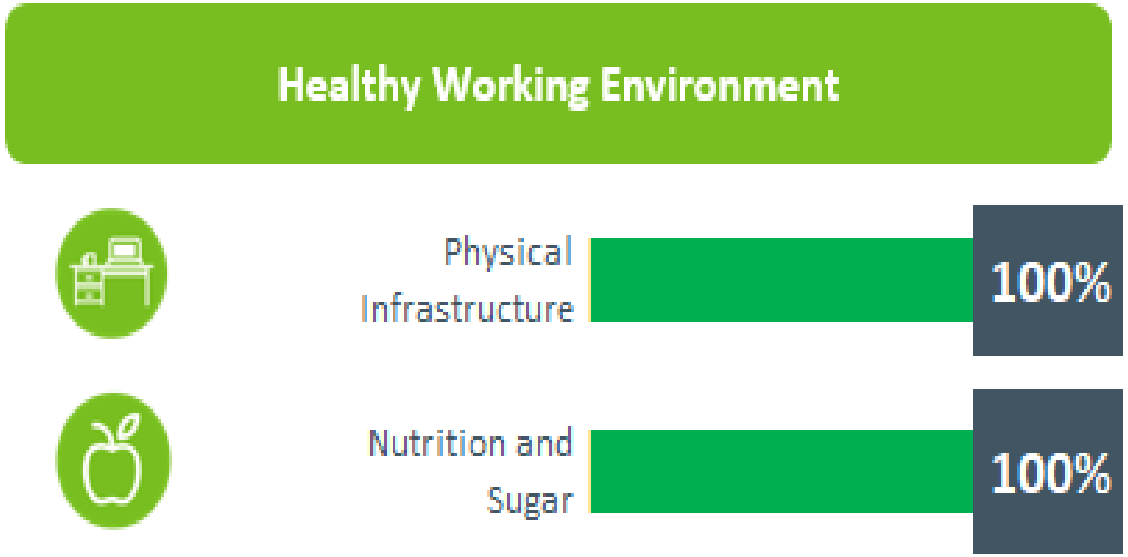
RAG status of Green, giving the Trust **100%** in Board Leadership. This was achieved through having the following in place:

- “Our workforce matters“
- Health and wellbeing budget in place
- Exec lead for wellbeing - Director of Workforce & OD
- Non-Executive director to be appointed as wellbeing guardian
- Health & Wellbeing Project Board

Strengths (2)

RAG status of Green, giving the Trust **100%** Healthy Working Environment. This was achieved through having the following in place:

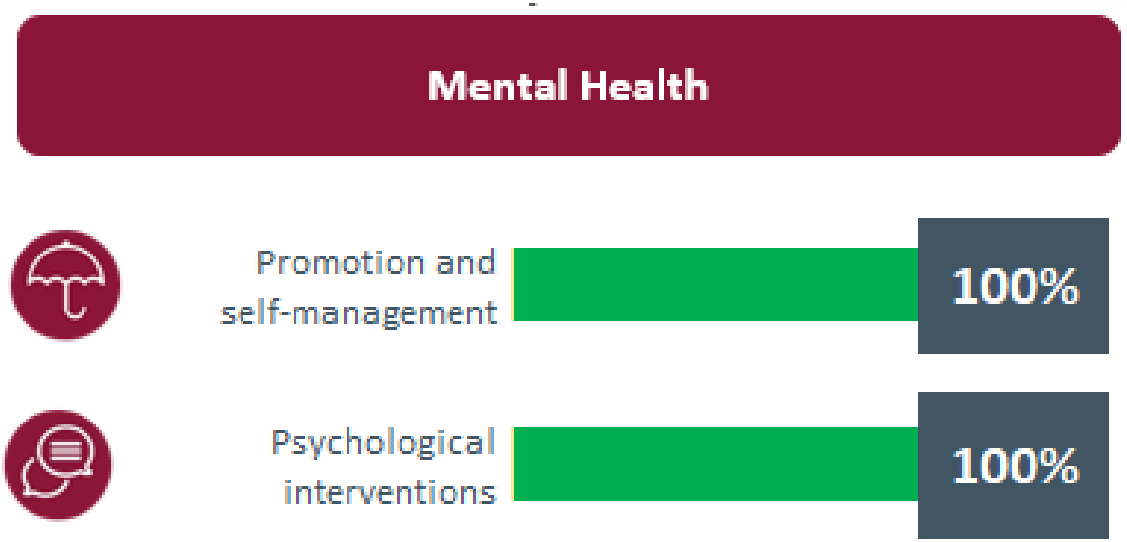
- 5 ways to wellbeing
- Virtual Pilates / yoga
- Installation of water stations
- Outdoor Areas Launched 2020/21
- Healthy options are promoted in cafes and restaurants
- Ensure that staff across all sites have access to nutritious food options
- Staff working nightshifts have access to nutritious food options 24/7



Strengths (3)

RAG status of Green, giving the Trust **100%** in Mental Health. This was achieved through having the following in place:

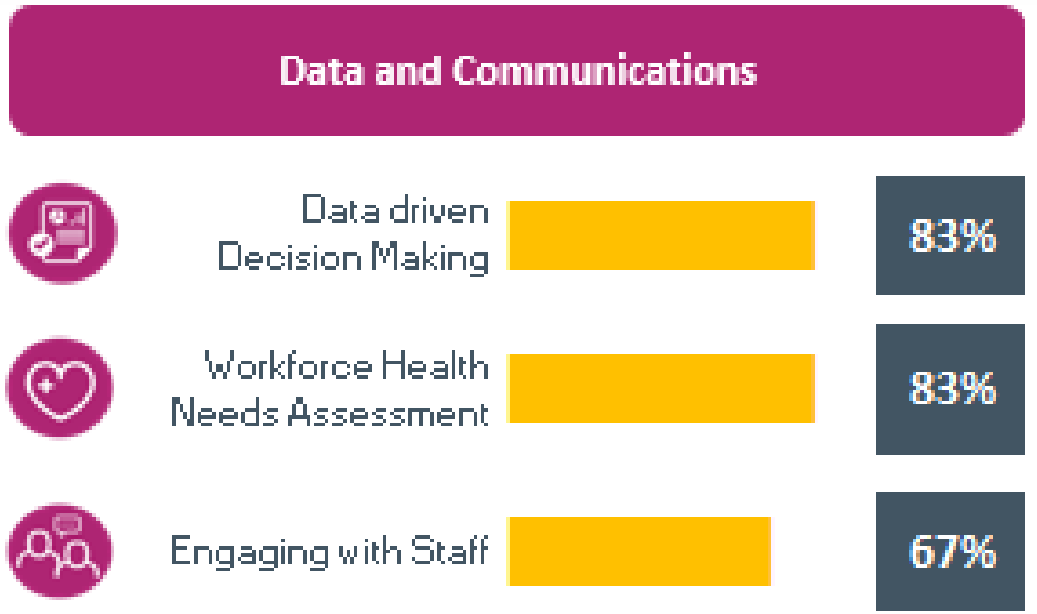
- EAP in place for all staff with access to 24/7 counselling
- Resilience Training
- Mindfulness Sessions
- The People Recovery Plan
- Fast Track access to psychological support
- Clear Referral Pathways



Areas for Development

Data and Communication has fallen one of the lowest rated. ***'Engaging with Staff'*** coming in at 67% the Trust needs to improve on the following in order to get the RAG rating to green:

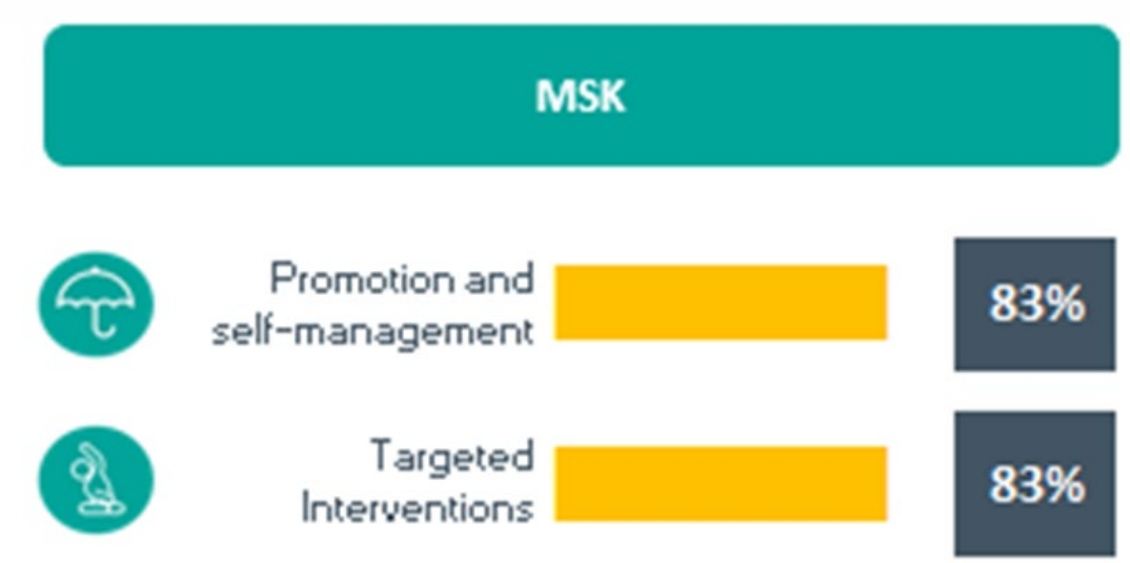
- Use the evolving BAME staff network to support organisational decision making
- Use targeted engagement - Further work required to identify staff groups where there are barriers to accessing support.
- Showcase board and senior managers championing H&W initiatives.



Areas for Development (2)

MSK fell in one of the lowest with 83% in both areas under MSK. The Trust will need to improve on the following in order to get the RAG rating to green:

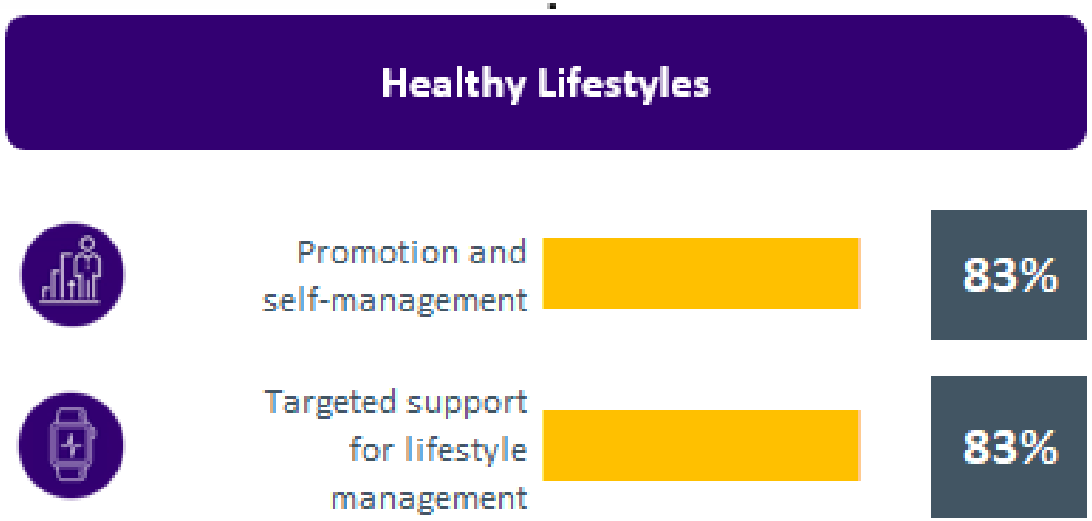
- Systems (Cardinus for online Workstation (DSE) e-learning and individual assessments) are in place in currently and several staff are trained DSE follow-up assessors – Trust has plateaued in terms of compliance at 53-54% - need to investigate option to improve compliance.
- NB: paused during pandemic and will need to be revisited as part of reset



Areas for Development (3)

Healthy Lifestyles fell in one of the lowest with 83% in both areas under Healthy Lifestyles. The Trust will need to improve on the following in order to get the RAG rating to green:

- Continue to roll out Wellbeing conversations will support the disclosure of health and non-health conditions
- Additional work required in targeted support for lifestyle management – A clear and concise formal pathway needs to be introduced.



Next Steps…

- Share with BAME Staff Network and ED&I groups for comments by 12th April
- Share with WDT on the 19th April
- Paper to be submitted to Board on 29th April
- H&W Project Board to ensure areas of development are built into their workplan to progress
- Progress update to Board in 6 months time

Mid Cheshire Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

Agenda Item	**13**	Date of Meeting: 29/04/2021
Report Title	**Freedom to Speak Up (FTSU Report - Quarter 4 2020/21**	
Executive Lead	James Sumner, Chief Executive	
Lead Officer	Sian Axon – Freedom to Speak up Guardian	
Action Required	To note	

X **Acceptable assurance** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐ **Partial assurance** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Low assurance** Evidence indicates poor effectiveness of controls

Key Messages of this Report *(2/3 headlines only)*

- 9 new concerns were raised and 7 of these concerns met the Freedom to Speak Up criteria and therefore will be reported to the National Guardians Office as required.
- A Drop in ' Open Door' Session was held on 24th March 2021 and proved to be successful

Next Steps (*actions to be taken following agreement of recommendation/s by Board/Committee)*

- Continue with 'Open Door' drop in sessions rotating across organisation
- Enhance FTSU Trust Web page
- Further FTSU role promotion

Strategic Objective(s) *(indication of which objective/s the report aligns to)*

• Manage Covid response and recovery	☐	• Provide safe and sustainable services	✓✓
• Provide outstanding care/patient experience	✓	• Provide strong system leadership by working together	✓
• Deliver most effective care to achieve best possible outcomes	✓	• Be well governed and clinically led	
• Be the best place to work	✓		

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

• Quality	✓	• Compliance	☐ ☐
• Finance	☐	• Legal	
• Workforce	✓	• Risk/BAF **BAF12 Organisational culture**	
• Equality	☐		

Equality Impact Assessment (*must accompany the following submissions)*

Strategy ☐ Policy ☐ Service Change ☐

REPORT DEVELOPMENT

Committee/ Group Name	Date	Report Title	Lead	Brief summary of key issues raised and actions agreed
NA				

FREEDOM TO SPEAK UP GUARDIAN REPORT
Jan-Mar 2021 (Quarter four)

Introduction

1. Speaking up at the earliest opportunity can protect patients, improve the experience of the NHS workforce and help the Trust embed a culture of continuous learning and improvement.

2. The Freedom to Speak Up Guardian's role is to provide staff with someone to go to if they have a concern about a patient safety risk, a wrong-doing or malpractice. The role also includes a requirement to report to the Board on all speaking up matters (including whistleblowing) and support the organisation in developing an open and transparent culture.

3. This report provides an update on the current position during quarter four in relation to speaking up and raising concerns.

Analysis of Quarter 4

4. During the period 1st January to 31st March 2021, 9 new concerns were raised using the various Freedom to Speak Up reporting mechanisms. 7 of these concerns met the Freedom to Speak Up criteria and therefore will be reported to the National Guardians Office as required. This compares to 7 concerns being raised during the previous quarter and 5 concerns highlighted during quarter two in 2020-2021.

5. The concerns raised during Quarter four are set out below:

Quarter Four

Staff Group	Method of reporting	Patient Safety / Staff issue	Actions taken	Issue closed and feedback reported
Estates and Ancillary	Face to Face	Staff intimidation / staff dissatisfaction	FTSU Guardian raised with Estates & Facilities Senior Management Team	Feedback to individual from FTSU Guardian
Estates and Ancillary	Email to Guardian	Bullying and Harassment / intimidation	FTSU Guardian raised with Estates & Facilities Senior Management Team	Feedback to individual from FTSU Guardian
Estates and Ancillary	Face to Face with group	Intimidation / staff support	Group meeting held	Investigation underway
Administration & Clerical Unknown Division	Anonymous concern	Patient and Staff Safety	Communications reiterated Trust wide re hand Gel use at mask stations	Feedback to Patient Safety Summit
Nursing & Midwifery	Telephone call to Guardian	Staff intimidation /	Raised with Head of Nursing	Issue actioned & closed

		staff dissatisfaction	for Urgent & Emergency Care	
Administration & Clerical DMEC	Anonymous concern	Staff safety re Site work	Raised with Estates and further signage and provision made	Issue actioned & closed
Nursing & Midwifery	'Open Door' event-Face to Face	Issues with role and Job Description	Signposted to meet with Manager / HR	Ongoing- not reportable as a concern
Nursing & Midwifery	'Open Door' event-Face to Face	Issues with role and Job Description	Signposted to meet with Manager / HR	Ongoing- not reportable as a concern
Nursing & Midwifery	'Open Door' event-Face to Face	Patient and Staff Safety concerns	Raised with Head of Nursing for Medicine	Issue actioned & closed Feedback from Head of Nursing & FTSU Guardian

Division	Number of concerns raised Q4
Surgery and Cancer	0
Medicine and Emergency Care	3
CCICP	0
Diagnostics & Clinical Support	2
Estates & Facilities	3
Women & Children	0
Corporate	0
Unknown	1

6. The majority of concerns raised during quarter four were predominant from Nursing and Midwifery; however two of these were not reportable to the Freedom to speak up office. In reportable groups the Estates and Ancillary staff group had a total of three concerns.

7. Intimidation appears to be part of the themes seen and links in strongly to staff dissatisfaction as part of the concern. One concern has moved to a wider investigation which is underway.

8. A Freedom to Speak up Open Door Session was held on Wednesday 24th March 2021. This was advertised widely to all staff and was well received by those who attended.

9. The Freedom to Speak up Guardian has been working closely with the Organisational Development team to ensure the role is included as part of the corporate induction programme.

Conclusion

10. Quarter four has seen an increase in the number of concerns raised compared to the previous reporting period.

Next Steps

11. The data included in this report will be shared with the National Guardians Office for the Quarter four returns to ensure compliance and national learning.

12. Further work continues by the Freedom to Speak up Guardian to promote and raise the profile of the role and service offered across the Organisation.

13. Continue to promote the joint working relationship of the Freedom to Speak Up Guardian and the Anti-Fraud Specialist.

14. Enhance FTSU Trust Web page.

Recommendation

15. To note

Report Author: Sian Axon, Freedom to Speak up Guardian
Date: 20 April 2021

Mid Cheshire Hospitals NHS Foundation Trust

Audit Committee
Chair's Assurance Report
April 2021

Report to	Board of Directors
Date	15 April 2021
Report from	Les Philpott, Non-Executive Director
Report prepared by	Katharine Dowson, Head of Corporate Governance
Executive Lead	Russell Favager, Deputy Chief Executive and Director of Finance
Committee meeting quoracy	Yes ☒ No ☐

KEY AREAS OF ASSURANCE

Cyber Security Update - Partial Assurance: Good progress over last 12 months despite growth in incident numbers. Good controls in place and external assurance received on these. Agreed assurance rating should be based on quality of system of control, not on levels of incidents which are unlikely to reduce. Further report requested for July meeting, to include Trust performance against national reference reports, following which acceptable assurance may be achieved

Committee Effectiveness Evaluations - Acceptable Assurance: Review of Audit Committee performance received alongside report on all Board Committees. Improved, robust process for both and common themes identified across Committees to be taken forward in 2021/22.

Corporate Governance Framework Manual - Acceptable Assurance: Substantial review conducted to reflect changes to governance processes in past year. Recommended for approval to Board including revised Standing Financial Instructions and levels of delegation for expenditure.

Annual Report & Accounts - Acceptable Assurance: The following reports were reviewed and accepted:

- Annual Report and Report of Audit Committee
- Accounting issues
- Annual Governance Statement – high quality and comprehensive draft statement approved for inclusion in Annual Report
- Accounting Policies – approved
- Updated External Audit Plan

Information Governance Annual Statement - Partial Assurance: updated governance and reporting processes embedded through the year. Committee requested complementary report on compliance against Subject Access Requests from Quality Governance. Audit Committee to be advised of IG incidents as they occur in future.

Internal Audit Reports

- **Risk Maturity Review - Acceptable Assurance:** Level 4 assurance 'Risk Managed' evidence of cultural shift in year, embedding required to achieve highest level 5 in future.

- **Assurance Framework: Acceptable Assurance.** Annual review found Trust met requirements; improvements in year recognised in review
- **E-referral Final Report: Acceptable Assurance.** Substantial assurance rating achieved. Committee challenged assurance level robustly as the report included a higher than normal number of low and moderate recommendations, notably clinical engagement. Internal Auditors advised standard matrix applied to reach rating and report had been through robust moderation process within MIAA.

Head of Internal Audit Report 2020/21: Acceptable Assurance. Substantial assurance rating given. Areas of consideration received for the Committee include the impact of Covid and partnership working and engagement as part of wider system working.

Financial Arrangements for 2021/22

Committee noted the interim arrangements put in place in the absence of final income figures and control total totals from NHSI/C&M HCP

Draft Internal Audit Plan 2021/22
Proposed audits challenged by Committee to ensure they review systemic issues and add value. Programme to be balanced between finance, governance, workforce and quality.

Internal Audit Tracker
Request for extension to two Internal Audit recommendations (access issues to ward areas through Covid) agreed but Committee challenged length of extensions and requested reduced time.

Anti-Fraud, Bribery & Corruption. Committee signed off annual report and workplan for 2021/22 which reflected new national fraud risk assessment process.

KEY CONCERNS/RISKS

None

Priority Areas: DECISIONS MADE

- Approved Annual Governance Statement for inclusion in Annual Report
- Approved Accounting Policies
- Approved Anti-Fraud, Bribery & Corruption Annual Report for 2020/21 and workplan for 2021/22

RECOMMENDATION

To note

Mid Cheshire Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

Agenda Item	**14.2**	Date of Meeting: 29/04/2021
Report Title	Corporate Governance Framework Manual	
Executive Lead	Caroline Keating, Company Secretary	
Lead Officer	Katharine Dowson, Head of Corporate Governance	
Action Required	To approve	

X **Acceptable assurance** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐ **Partial assurance** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Low assurance** Evidence indicates poor effectiveness of controls

Key Messages of this Report *(2/3 headlines only)*

- The Manual has been substantially edited and reviewed with the Non-Financial Risk section removed as the Risk Assurance Framework should be read in conjunction with this
- Standing Financial Instructions have been fully reviewed and delegation levels amended which requires specific approval by the Board

Next Steps (*actions to be taken following agreement of recommendation/s by Board/Committee)*

- Manual to be published on the intranet as a reference tool for staff

Strategic Objective(s) *(indication of which objective/s the report aligns to)*

• Manage Covid response and recovery	☐	• Provide safe and sustainable services	☐☐
• Provide outstanding care/patient experience	☐	• Provide strong system leadership by working together	✓
• Deliver most effective care to achieve best possible outcomes	☐	• Be well governed and clinically led	
• Be the best place to work	☐		

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

• Quality	☐	• Compliance	☐☐
• Finance	☐	• Legal	
• Workforce	☐	• Risk/BAF Click here to select relevant risk	
• Equality	☐		

Equality Impact Assessment (*must accompany the following submissions)*

Strategy ☐ Policy ☐ Service Change ☐

REPORT DEVELOPMENT

Committee/ Group Name	Date	Report Title	Lead	Brief summary of key issues raised and actions agreed
Audit Committee	15/04/21	Corporate Governance Framework Manual	K Dowson	Minor issues raised which have been addressed.

Mid Cheshire Hospitals
NHS Foundation Trust

Corporate Governance Framework Manual

Author	Company Secretary		
Approval	Audit Committee Board of Directors	**Approval Date**	15 April 2021 29 April 2021
Publication date	March 2021	**Review**	Annual
Related documents:	• Trust Strategy • Risk Management Strategy • Risk Management Process Guidance • Assurance & Escalation Framework • MCHFT Constitution v.12 (2021)		
Equality, Diversity & Inclusion			
Accessibility	This document can be made available in a range of alternative formats on request e.g. large print, Braille etc.		

Document Change History: changes from previous issues of document (if appropriate)

Version number	Page	Changes made with rationale and impact on practice	Date
10		Review of Manual	March 2021

Contents

Words in this document importing the masculine gender only shall include the feminine gender; words importing the singular shall import the plural and vice-versa.

Glossary of Terms

Accounting Officer	The **Chief Executive** of the **Trust**, who is responsible for ensuring the proper stewardship of public funds and assets
Act	The National Health Service Act 2006 as amended by the Health and Social Care Act (2012)
Board Committee	A committee appointed by the **Board of Directors** made up of **Board** Members with specific terms of reference to discharge delegated duties of the **Board of Directors**
Board or **Board of Directors**	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	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	The **Director** or member of staff with delegated authority to manage finances (income and expenditure) for a specific area of the Trust
Chairman	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
Chief Executive	The most senior officer of the **Trust**, whose appointment is made by the **Non-Executive Directors** and approved by the **Council of Governors**
Class	A subdivision of a **Constituency**
Commercial Sponsorship	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	Process for determining the need for, and for obtaining the supply of, healthcare and related services by the **Trust** within available resources
Committee members	Persons formally appointed to sit on, or to chair specific committees; or persons co-opted as members of any specific committee
Company Secretary	A person who is appointed by the **Board** to provide advice on corporate governance issues to the **Board** and the **Chairman** and monitor the Trust's compliance with **Standing Orders**, legislation, and related guidance.
Constituency	The areas from which **Members** can be drawn, this could be a geographical area for **Public Governors** or the Staff and Volunteers constituency as the context requires and “constituencies” means two or more of them together

Constitution	A document which sets out the rules which guide how the Trust works, what powers individuals and committees have and the means of keeping those powers in check
Contracting and procuring	The systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets
Council of Governors	The body formally constituted in accordance with the Constitution, meeting in public (other than exceptionally) and presided over by the **Chairman**
Council of Governors Committees	A committee appointed by the **Council of Governors** with specific terms of reference, chairman, and membership approved by the Council
Deputy Chairman	The **Non-Executive Director** appointed to take on the Chairman's duties if the **Chairman** is absent for any reason
Director	The **Chairman**, a **Non-Executive Director** or an **Executive Director** appointed in accordance with the Constitution
Director of Finance	The chief financial officer of the **Trust,**
Effective Date	The date on which the **Standing Orders** came into effect
Emergency	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	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.
Family	The spouse, partner, children, grandchildren, other dependants, parents or grandparents of any **Governor**, **Director**, or **Officer** of the **Trust**.
Funds Held on Trust	Those funds which the Trust held on the date of incorporation, received 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	A person elected or appointed to the **Council of Governors** in accordance with the Constitution.
Legal Adviser	A properly qualified person appointed by the **Trust** to provide legal **a**dvice
Manager	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	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
Monitor	The regulator for Foundation Trusts set out in the **Act,** that from April 2016 became part of NHS Improvement
Motion	A formal proposition to be discussed and voted on during the course of a meeting
NAO	National Audit Office
NHS Improvement	The body corporate formerly known as Monitor, as provided by Section 61 of the 2012 Act
Nominated Officer	An officer charged with the responsibility for discharging specific tasks within **Standing Orders** and **Standing Financial Instructions**
Non-Executive Director	A person appointed to the **Board of Directors** by the **Council of Governors**, who is not a member of staff **Trust** and is not to be treated as an officer of the Trust.
Officer	A member of staff of the Trust or any other person holding a paid appointment or office with the **Trust**
Public Governor	A **Governor** is a **Member** who is elected to the Council of Governors by other **Members**
Standing Financial Instructions (SFI)	The document which outlines all the financial responsibilities to be observed by the NHS Board and its employees. They cover all activities, including those entered into in partnership with other organisations
Staff	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	The document regulating the proceedings of the Trust's **Board of Directors** or its **Council of Governors**
Trust	A person who is appointed by the **Board** to provide advice on corporate governance issues to the **Board** and the **Chairman** and monitor the Trust's compliance with **Standing Orders**, legislation, and related guidance

CORPORATE GOVERNANCE FRAMEWORK MANUAL

FOREWORD

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

NHS foundation trusts (FT) are created as legal entities in the form of public benefit corporations by the National Health Service (NHS) Act 2006[1]. The legislation constitutes NHS FTs with a governance regime that enables the NHS FT boards of directors to have autonomy to make financial and strategic decisions. They also have a framework of local accountability to members through a Council of Governors. Externally, whilst remaining part of the NHS, FTs are authorised by, and accountable for the operation of their licence to NHS Improvement, rather than the Secretary of State for Health. FTs 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 which role they are accountable to the Charity Commission for those funds deemed to be charitable.

Effective corporate governance is a fundamental cornerstone for the success of Mid Cheshire Hospitals NHS Foundation Trust. The autonomy that the Trust enjoys, its public service purpose and the fact it is entrusted with public funds demands that its Board of Directors, its Council of Governors and all its employees operate according to the highest standards of corporate governance. It is essential, therefore, that all employees and the Board of Directors and Committee members understand clearly the key principles of good governance and how to apply them. To this end, this Handbook will be placed on the intranet with directors and relevant senior managers required to ensure that all staff for whom they are responsible are advised of its existence.

The Corporate Governance Framework Manual

The purpose of the Corporate Governance Framework Manual is to set out the control framework within which the Trust's objectives are delivered. The legal framework within which the Trust was established and continues to operate is set out in the Trust's Constitution. This Handbook complements that document.

The Manual takes full account of the revised NHS Foundation Trust Code of Governance[2] (July 2014), published by NHS Improvement. This Code sets out a common overarching framework for the corporate governance of NHS foundation trusts and complements the statutory and regulatory obligations on them.

Key documents in the Corporate Governance Framework, requiring compliance by the FT, its Executive and Non-Executive directors, senior managers, officers and employees are:

[1] As amended by the Health & Social Care Act 2012 (the amended Act)
[2] (Monitor) NHS Improvement 2014

Mid Cheshire Hospitals NHS FT

- The Accountable Officer Memorandum
- Standards of Business Conduct
- Standing Orders as a framework for internal governance
- Standing Financial Instructions as a framework for financial governance.

Any queries relating to the contents of these documents should be directed to the Company Secretary or myself who will be pleased to provide clarification.

James Sumner, Chief Executive

1. Authoritative Bodies

1.1 The Board of Directors

The Role

1.1.1 The Board takes corporate responsibility for all activities of Mid Cheshire Hospitals Hospital NHS Foundation Trust, taking into account the new general duties on Directors as identified in the Health & Social Care Act 2012 (and referenced in the Trust Constitution).

1.1.2 The Board's main duties are:

- Setting the organisation's strategic aims, taking into consideration the views of the Council of Governors, ensuring the necessary financial and human resources are in place for it to meet its objectives, and reviewing management performance
- Collective responsibility for ensuring the quality and safety of healthcare services, education, training and research delivered by the Trust and applying the principles and standards of clinical governance set out by the Department of Health, the Care Quality Commission and other relevant NHS bodies
- Collective responsibility for adding value to the organisation by promoting its success through the direction and supervision of its affairs
- Providing proactive leadership within a framework of prudent and effective controls which enable risk to be assessed and managed
- Setting and maintaining the organisation's vision, values and standards of conduct, whilst ensuring its obligations to members, patients and other stakeholders including the local community and the Secretary of State are understood and met.

1.1.3 The Board is expected to bring about change by making best use of all its resources – financial, staffing, physical infrastructure and knowledge – and working with staff and partner organisations to meet the public's and patient's expectations. As leaders, board members are expected to understand opportunities for improving services and motivate others to bring them about.

1.1.4 The Board makes plans to achieve the Government's objectives for healthcare, guided by the targets and delivery dates set out in NHS Improvement's Risk Assessment Framework as well as the detailed objectives in the NHS Plan. The Board also signs off an annual plan, setting out the year's objectives, and it is the function of the Board to ensure progress.

Membership

1.1.5 The Board consists of Executives, Non-Executive Directors and a Chair. The Chair and Non-Executive Directors include lay people drawn the Trust's membership who are selected with a view to ensuring a balance of skills and experience. They are accountable to the Council of Governors.

The Chairman and the Chief Executive

1.1.6 There is a clear division of responsibility between the chairing of the Board of Directors and Council of Governors on the one hand and the executive responsibility for the running of the Trust's business on the other.

1.1.7 The overall role of the Chairman is one of enabling and leading so that the attributes and specific roles of the Executive team and the Non-Executives are brought together in a constructive partnership to take forward the organisation'[3]

The **Chairman** is responsible for:

- providing leadership of the Board of Directors and the Council of Governors, ensuring their effectiveness on all aspects of their role and setting their agenda
- ensuring that the Board and the Council work together effectively
- ensuring that directors and governors receive accurate, timely and clear information that is appropriate for their respective duties
- ensuring that there is effective communication with patients, members, staff and other stakeholders
- facilitating the effective contribution of all executive and non-executive directors to the Board's affairs and ensuring that the Board acts as a team
- appraising the performance of the Chief Executive and the Non-Executive Directors[4].

The Chief Executive is accountable to the Chairman and Non-Executive Directors for ensuring that the Board is empowered to govern the Trust and that the objectives it sets are accomplished through effective and properly controlled executive action. The Chief Executive should be allowed full scope, within clearly defined delegated powers, for action in fulfilling the decisions of the Board'[5].

The **Chief Executive** is responsible for:

- performing the duties of 'Accounting Officer' as set out in the NHS Act 2006
- overseeing risk management within the Trust and signing the Annual Governance Statement
- organising, managing and staffing the Trust
- developing and maintaining procedures for the Trust
- protecting the Trust's reputation and integrity locally and nationally, by ensuring the Trust is open and honest in its communications and through the development of strong partnerships with all stakeholders
- ensuring the quality of service provision.

1.1.8 **Non-Executive Directors**

As members of a unitary board, Non-Executive Directors have a duty to ensure that there is constructive challenge of the decisions of the Board. Non-Executive Directors are responsible for:

- bringing independent judgement to bear on issues of strategy, performance, risk

[3] Code of Accountability in the NHS, 2004, p.5
[4] NHS FT Code of Governance, July 2014
[5] Code of Accountability in the NHS, 2004, p.5-6

management and key appointments
- satisfying themselves as to the integrity and robustness of financial, clinical and other information
- determining appropriate levels of remuneration of Executive Directors (through the Remuneration Committee)
- appointing and where necessary removing Executive Directors, and succession planning[6]
- ensuring that 'the Board acts in the best interests of the public and is fully accountable to the public for the services provided by the Trust and the public funds it uses'
- undertaking the work of the Audit Committee.

A Non-Executive Director will be appointed Chair of the Audit Committee. Other appointments include the Senior Independent Director and Deputy Chairman.

1.1.9 **Executive Directors**

The Executive Directors are:
- Chief Executive
- Deputy CEO/Director of Finance
- Director of Nursing & Quality
- Medical Director
- Chief Operating Officer
- Director of Workforce & OD

They have responsibilities as members of the Board of Directors and as the most senior managers of the operations of the Trust.

1.1.10 **In Attendance**

The following are expected to be in attendance at Board meetings:
- Chief Information Officer
- Company Secretary

1.1.11 The Standing Orders of the Board of Directors are also located in the Trust Constitution – Annex 7

1.2 Council of Governors

1.2.1 The Council of Governors comprises elected and appointed governors. Elected governors represent two main groups: staff and members of the public. The staff group is divided into constituencies as detailed within the Constitution. Partnership governors represent key stakeholders of the Trust.

1.2.2 In broad terms, the Council of Governors is responsible for representing the interests of the Trust's members and the partner organisations in the communities served by the Trust. To this end, it prepares and, from time to time, reviews the Trust's Membership Strategy.

1.2.3 Governors provide their views to the Board on the Trust's forward plans and are presented

[6] NHS Code of Governance, July 2014

with the Annual Report and Accounts, and the Quality Account. Particular responsibilities of the Council are:

- appoint or remove the Chairman and the other Non-Executive Directors
- decide the remuneration and allowances, and the other terms and conditions of office, of the Chair and the other Non-Executive Directors
- approve the appointment of the Chief Executive
- hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors
- approve 'significant transactions' and any application by the Trust to enter into a merger, acquisition, separation or dissolution
- approve any proposed increases in private patient income of 5% or more (in proportion to the Trust's total income) in any financial year
- approve amendments to the Trust's Constitution
- appoint or remove the Trust's auditor
- receive the FT's annual accounts, any report of the auditor on them and the annual report.

1.2.4 Further details on the Council of Governors are to be found in the Trust's Constitution, with the Standing Orders located in Annex 6.

2. Trust Vision and Values

2.1 Our vision is to:

'to deliver excellence in healthcare through innovation and collaboration'

through living our values:

- Putting patients first
- Commitment to quality & safety
- Respect, dignity & compassion
- Listening, learning and leading
- Creating the best outcomes together
- Everyone matters

The above values take into consideration the guiding principles of the NHS as set out in the NHS Constitution[7]. Details are available on the Department of Health & Social Care website (www.gov.uk) or via the hyperlink below:

The NHS Constitution for England - GOV.UK

[7] Published in March 2012 (updated 1 January 2021)

3. Board Committees

The Board has established the following committees:

- Audit Committee
- Quality & Safety Committee
- Performance & Finance Committee
- Workforce & Digital Transformation
- Remuneration & Nominations Committee
- Corporate Trustees

The terms of reference of these Committees are approved by the Board on an annual basis. A brief description of their role follows.

3.1 Audit Committee

'The Codes of Conduct and Accountability, issued in April 1994, set out the requirement for every NHS Board to establish an Audit Committee. That requirement remains in place today and reflects not only established best practice in the private and public sectors, but the constant principle that the existence of an independent Audit Committee is a central means by which a Board ensures effective internal control arrangements are in place. In addition, the Audit Committee provides a form of independent check upon the executive arm of the Board.' *(The NHS Audit Committee Handbook, 2018).*

NHS Improvement's (Monitor) *Code of Governance* states that this Committee must be 'composed of Non- Executive Directors which should include at least three independent Non-Executive Directors'. At least one member of the Committee must have 'recent and relevant financial experience' (*2014, p.26*).

The Audit Committee has primary responsibility for monitoring the integrity of the financial statements, assisting the Board of Directors in its oversight of risk management and the effectiveness of internal control, oversight of compliance with corporate governance standards and matters relating to the external and internal audit functions. The Audit Committee shall provide the Board of Directors with a means of independent and objective review of financial and corporate governance, assurance processes and risk management across the whole of the Trust's activities (clinical and non-clinical) both generally and in support of the Annual Governance Statement.

3.2 Quality & Safety Committee

The purpose of the Quality & Safety Committee is to obtain and provide the Board with assurance on the development and implementation of the Quality & Safety Improvement Strategic Plan. It ensures that high standards of care are provided by the Trust and, in particular, that adequate and appropriate governance structures, processes and controls are in place throughout the Trust to:

- promote safety and excellence in patient care
- identify, prioritise and manage risk arising from clinical care

- ensure the effective and efficient use of resources through evidence-based clinical practice
- ensure compliance with legal, regulatory and other obligations.

3.3 Performance & Finance Committee

The purpose of the Performance & Finance Committee is to provide advice and assurance to the Board on the effectiveness of financial strategy and stewardship of the Trust's finances and sustainability, on the operational performance of the Trust, and on strategic investments and the development of Trust infrastructure, including the delivery of the Trust's enabling strategic plans that are relevant to the remit of the Committee (Finance and Estates Strategic Plan). PAF will also provide assurance to the Board on achievement of NHS national operational performance standards.

3.4 Workforce & Digital Transformation Committee

The purpose of the Committee is to obtain and provide the Board with assurance on the development and implementation of the Trust's People Strategic Plan and the Trust's Digital Strategic Plan.

The Committee ensures there is a positive working environment which promotes an inclusive culture that addresses the holistic needs of individuals. It seeks assurance that the Trust has a sufficient, suitably skilled and empowered workforce that results in the Trust being the best place to work. It seeks to align the workforce and digital agendas to ensure that the Trust is prepared for the current and future workforce for changes in models of care and transformation associated with the digitisation of MCHFT. It ensures the Trust shapes its digital future by using digital technology throughout the Trust in an innovative, effective and efficient way to ensure the workforce becomes digitally enabled.

3.5 Appointments and Remuneration Committee (RemCo)

The Appointments and Remuneration Committee advises the Board of appropriate remuneration and allowances, and other terms and conditions of office for the Chief Executive, the Executive Directors and other senior staff. It also considers the appointment of Executive Directors as their posts fall vacant.

3.6 Corporate Trustees

The Corporate Trustees are responsible for administering on behalf of the Board, those gifts, donations and endowments made under the relevant charities' legislation and held on trust for purposes relating to the National Health Service, the objects of which are for the benefit of the National Health Service in England. The Board, acting wholly or mainly relating to Mid Cheshire Hospitals NHS Foundation Trust, is the sole corporate trustee of the Charity governed by the laws applicable to Trusts, principally the Trustees Act 2000 (and as amended 2015) and the Charities Act.

4. Internal Control

4.1 Overview

Internal control entails having in place processes and procedures which together ensure that the Trust is meeting the terms of its authorisation, running effectively, smoothly and safely and keeping risks to a minimum. Internal control also entails the Trust having clearly identifiable objectives and identifying the risks to achieving those.

4.2 Strategic Objectives

Each year, the Board sets a series of objectives which help the Trust work toward achieving its vision. In 2020/21, these objectives are to:

- Listen to and respond to our population and provide the **safest and best care** which is equitable, inclusive and centred on the patient and their family's health, wellbeing and care needs
- Become a leading and **sustainable health and care system** providing seamless care to our local population in collaboration with our partners
- **Be the best place to work** where our staff are empowered to innovate and provide consistently excellent care
- Push boundaries in **clinical, technology and digital innovation** to provide the tools and infrastructure to deliver the best possible care

4.3 Assurance & Escalation Framework

This describes the responsibility and accountability for the Trust's governance structure and systems through which the Board receives assurance or escalated concerns/ risks related to quality of services, performance targets, service delivery and achievement of strategic objectives. It also addresses performance and ensures that potential performance problems are identified early and rectified.

The framework describes how the Trust's policies, procedures, quality systems and organisational learning is monitored by an effective committee structure.

This provides the Board with assurance about how the organisation is able to identify, monitor, escalate and manage concerns in a timely fashion at an appropriate level.

4.4 Board Assurance Framework

The NHS continues to work within a culture of decentralisation, increasing local autonomy and local accountability. The Board, therefore, needs to be confident that the systems, policies and people it has put in place are operating in a way that is effective in driving the delivery of objectives by focusing on minimising risk. The Board must be able to demonstrate that it has been properly informed about the totality of its risks, both clinical and non-clinical.

To do this, the Board needs to be able to provide evidence that it has systematically identified its objectives and managed the principal risks to achieving them. The Board Assurance Framework (BAF) fulfils this purpose. The BAF provides the Trust with a simple

but comprehensive method for the effective and focused management of the principal risks to meeting its objectives. It also provides a structure for the evidence to support the Annual Governance Statement.

The Board must:

- establish key goals
- identify the principal risks that may threaten the achievement of these objectives
- identify and evaluate the design of key controls intended to manage these principal risks
- set out the arrangements for obtaining assurance on the effectiveness of key controls across all areas of principal risk
- evaluate the assurance across all areas of principal risk (assurances can be internal or external)
- identify positive assurances and areas where there are gaps in controls and/or assurances
- put in place plans to take corrective action where gaps have been identified in relation to principal risks
- maintain dynamic risk management arrangements including a well founded risk register.

Each lead Director reviews the BAF monthly and the Executive Team collectively examines the risks also on a monthly basis, leading to the relevant Board Committees and Board of Directors reviewing the BAF every quarter. At the end of each financial year, the Chief Executive considers the BAF and other sources of assurance to complete the Annual Governance Statement. This document is contained within the Trust's Annual Report and is made available to the public.

4.5 Processes and Procedures

There are two broad categories of internal processes and procedures which ensure the proper running of the Trust. First, there are those which provide a comprehensive framework for the proper conduct of business:

- Standing Orders of the Board of Directors including the Matters Reserved to the Board and the Scheme of Delegation
- Standing Orders of the Council of Governors
- Standing Financial Instructions.

All Board members and managers should be aware of the existence of these documents and, where appropriate, should be familiar with the detailed provisions. In particular, staff should pay attention to the detailed scheme of delegation (Appendix VI*)* as any action that they take which is outside of their delegated authority could have serious consequences for both the Trust and the individual.

Secondly, there are the internal risk management processes and procedures which together constitute the Risk Management Framework.

4.6 Risk Management

Risk management is the key system through which clinical, organisational and financial risks are managed by all staff to the benefit of patients, visitors, staff and other stakeholders.

The Trust has a Risk Management Strategy which:

- is approved by the Board
- sets out the Trust's risk appetite
- defines the structures for the management and ownership of risk and for the management of situations in which the failure of controls leads to material realisation of risks
- specifies how both new and existing activities are assessed for risk and incorporated into risk management structures
- ensures common understanding of terminology used in relation to risk
- defines the processes and considerations which inform the assessment of risk
- defines the way in which the risk register is regularly reviewed.

The Risk Register is a database of all the risks which are recorded within the Trust. It identifies which staff member is leading on the management of that risk and also identifies the risk grading. The Register also includes details of action plans to mitigate the risks and identify progress against these plans.

4.6.1 Assurances on Controls in place to Manage Risk

Assurance is an evidence-based assessment of how effective controls are in managing the risks they were designed for. The three lines of defence model clarifies roles and responsibilities with respect to risk management and the application of controls.

First Line of Defence - ownership by staff and their line managers to understand their roles and responsibilities in relation to managing risk on a day to day basis.

Second Line of Defence - specialist risk oversight functions support operational management and ensure consistency across the organisation by setting policies, providing guidance and monitoring compliance.

Third Line of Defence - groups external to the Trust responsible for providing independent review of the effectiveness of controls applied through the first and second lines of defence.

For the purpose of reporting assurance, for example through the Board Assurance Framework, the Trust categorises assurance information provided by the first two lines of defence as 'internal' sources and assurance from the third line as 'external'

The Board Committees that are key to this assurance framework are:

- Audit Committee
- Quality & Safety Committee
- Performance & Finance Committee

4.7 Performance

The Board monitors the Trust's financial and operational performance against the Trust's key compliance targets via the Integrated Performance Report. This is also submitted to the relevant Board Committees to consider in parallel with the Chair's Summary Report/s from the appropriate Executive Group. These reports are also submitted to the Executive Risk & Assurance Group prior to the Board Committees to enable risk to performance to be considered across the Trust. This Group is chaired by the Chief Executive with membership from the Executive Team, Divisional triumvirates and senior management within Corporate Services.

4.8 Annual Governance Statement (AGS)

The Board needs to demonstrate that it has reviewed and been properly informed about the totality of its risks. The Chief Executive is required to sign an Annual Governance Statement, as part of the statutory Annual Report & Accounts, confirming that the Board and the Chief Executive have reviewed the system of internal control within the Trust and have received assurance on that system.

The AGS is submitted annually to NHS Improvement and covers the following:

- the scope of the responsibility of the Accounting Officer (Chief Executive)
- the purpose of the system of internal control
- the Trust's capacity to handle risk
- the risk and control framework
- the process used to ensure that resources are used economically, efficiently and effectively
- confirmation that a review of effectiveness has been undertaken and that a plan is in place to address any weaknesses
- the process for maintaining the system of internal control and details of actions planned or taken to deal with any significant internal control issues. These might include:
- an issue which seriously prejudiced or prevented achievement of a principal objective
- an issue which resulted in a need to seek additional funding, or in a significant diversion of resources
- an issue which the External Auditor or the Head of Internal Audit or the Audit Committee considers to be significant
- an issue which attracted significant adverse public interest or seriously damaged the reputation of the Trust.

The AGS is signed off by the Chief Executive, as Accounting Officer, on behalf of the Board of Directors. The Head of Internal Audit provides an annual opinion on the adequacy an effectiveness of the risk management, control and governance processes to support the AGS.

The full AGS can be found in the Annual Report & Accounts.

5. Independent Control and Regulation

5.1 Internal Audit

The Internal Audit Terms of Reference provide the Trust with the framework for the provision and conduct of an Internal Audit service, in accordance with the requirements of the NHS Internal Audit Standards, the NHS Audit Committee Handbook (2018) and the Trust's Standing Financial Instructions (see Appendix V).

Internal Audit is an independent and objective appraisal service which has no executive Responsibilities within the line management structure. It pays particular attention to any aspects of risk management, control or governance affected by material changes to the Trust's risk environment, subject to Audit Committee approval.

Internal Audit embraces two key areas:

- The annual provision of an independent and objective opinion to the Accounting Officer, the Board and the Audit Committee on the degree to which risk management, control and governance support the achievement of the Trust's agreed objectives
- The provision of an independent and objective consultancy service specifically to help line management improve the Trust's risk management, control and governance arrangements.

The Head of Internal Audit's annual report presents the opinion on the overall adequacy and effectiveness of the Trust's risk management, control and governance processes. This opinion encompasses the Board Assurance Framework and requirements in relation to the Care Quality Commission Standards, as well as the conclusions arising from internal audit assignments.

In addition to the formal annual report, the Head of Internal Audit reports interim progress to the Audit Committee and Accounting Officer in the course of the year. Such interim reports detail objectives, findings and performance against plan. Additionally, progress against the implementation of agreed recommendations is followed up and reported to the Audit Committee.

5.1.1 The Head of Internal Audit

The Senior Audit Manager, as appointed by Internal Audit, acts as Head of Internal Audit. He/she reports to the Accounting Officer via the Director of Finance (except when this may impinge on the objectivity of the audit).

The Head of Internal Audit, or an appropriate representative of the internal audit team, attends meetings of the Audit Committee unless, exceptionally, the Audit Committee decides that they should be excluded from either the whole meeting or for particular agenda items.

The Head of Internal Audit has an independent right of access to the Chairman of the Audit Committee. In exceptional circumstances, where normal reporting channels may be seen to impinge on the objectivity of the audit, he/she may report directly to the Chairman of the Trust.

If the Head of Internal Audit considers that the level of audit resources or the terms of reference in any way limit the scope of internal audit, or prejudice the ability to deliver a satisfactory service, he/she will advise the Audit Committee accordingly.

5.2 Fraud and Probity

Managing the risk of fraud is the responsibility of line management. The Trust has a comprehensive Counter Fraud Policy and Response Plan, a Local Counter Fraud Specialist and information for staff.

The relationship between the Trust's Local Counter Fraud Specialist, the Head of Interna Audit and the Trust's Director of Finance is formally defined in accordance with the Secretary of State's Directions.

5.3 External Audit

All foundation trusts must have their accounts audited by independent external auditor who are appointed by the Council of Governors. The audited annual accounts must be laid before Parliament.

The External Auditor's opinion on the annual accounts reports on whether:

- the financial statements give a true and fair view, in accordance with the accounting policies directed by NHS Improvement of the state of the Trust's affairs and of its income and expenditure for the year as then ended
- the part of the Remuneration Report to be audited has been properly prepared in accordance with the accounting policies directed by NHS Improvement
- information which comprises the Director's Strategic Report including the Operational and Financial Review, and the Quality Account, included within the Annual Report, is consistent with the financial statements.

5.4 NHS Improvement

NHS Improvement assesses NHS trusts for foundation trust status and ensures that foundation trusts are well led, in terms of quality and finances. It licenses foundation trust with other eligible providers of NHS services to be licensed from April 2014 and:

- sets prices for NHS-funded care in partnership with NHS England
- enables integrated care
- safeguards choice and prevents anti-competitive behaviour which is against the interests of patients; and
- supports commissioners to protect essential health care services for patients if a provider gets into financial difficulties.

The relationship with NHS Improvement is based on effective self-governance and self-certification of compliance, with the Board of Directors taking primary responsibility for compliance with its Provider Licence. NHS Improvement may intervene if necessary where there is considered to be a significant breach of the terms of the Provider Licence.

The Trust reports to NHS Improvement annually (by way of an Annual Plan) and on a quarterly basis in accordance with the Single Oversight Framework[8] which is regularly reviewed by NHS Improvement and available on its website.

5.5 Care Quality Commission (CQC)

The CQC brings together independent regulation of health, mental health and adult social care. It is responsible for registering, reviewing and inspecting health, adult social care and mental health services, working with providers to encourage them to improve the quality of their services. It has powers to issue warnings, impose fines and refuse to register service providers.

Performance ratings resulting from the review of all NHS Bodies in England are published annually. Information about the Trust's current position is available at: www.cqc.org.uk

[8] NHS Improvement/ NHS England annual framework (last issued 2019-20)

APPENDICES

- Appendix I Board Committees' Terms of Reference
- Appendix II Matters Reserved for the Board
- Appendix III Delegation of Powers by the Board of Directors
- Appendix IV Standing Orders for the Practice and Procedure of the Board of Directors
- Appendix V Standing Financial Instructions
- Appendix VI Scheme & Schedule of Delegation
- Appendix VII Codes of Conduct

APPENDIX I

BOARD COMMITTEES' TERMS OF REFERENCE

Audit Committee

Authority/Constitution

1. The Audit Committee ("the Committee") is constituted as a standing committee of the Trust's Board of Directors. Its constitution and terms of reference shall be as set out below, subject to amendment at future Board of Directors' meetings. The Audit 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. The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Audit Committee.

3. The Committee is authorised by the Board of Directors to obtain outside legal or other independent professional advice and to secure the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for or expedient to the carrying out of its function.

4. The Audit Committee has the authority to oversee and take decisions relating to the organisation's activities which also support the achievement of the organisation's objectives.

5. The Committee is authorised to create advisory or working groups as are necessary to fulfil its responsibilities within its terms of reference. The Group may not delegate executive powers and remains accountable for the work of any such group. Any of these groups will report directly to the Committee which will oversee their work.

Purpose

6. The Audit Committee has primary responsibility for monitoring the integrity of the financial statements, assisting the Board of Directors in its oversight of risk management and the effectiveness of internal control, oversight of compliance with corporate governance standards and matters relating to the external and internal audit functions. The Audit Committee shall provide the Board of Directors with a means of independent and objective review of financial and corporate governance, assurance processes and risk management across the whole of the Trust's activities (clinical and non-clinical) both generally and in support of the Annual Governance Statement.

7. The Audit Committee supports the Board of Directors in its responsibility for ensuring effective financial decision-making and internal control including:

    - management of the Trust's activities in accordance with statute and regulations

- the establishment and maintenance of a system of internal control to give reasonable assurance that assets are safeguarded, waste or inefficiency avoided and reliable financial information produced, and that value for money is continuously sought.

Membership

8. The Committee/Group shall be composed of at least three independent Non-Executive Directors, at least one of whom should have recent and relevant financial experience and should be appointed Chair of the Committee by the Board.

9. At least one of the members will also be a member of the Quality & Safety Committee but not the Chair of that Committee.

10. The Audit Committee will be deemed quorate when two members are present.

11. The Chair of the Trust shall not chair or be a member of the Committee although may be invited to attend meetings of the Audit Committee as required.

12. The following are required to attend in a non-voting capacity:

    - Director of Finance/Deputy CEO
    - Company Secretary
    - Deputy Director of Finance
    - Head of Corporate Governance

13. External advisors (e.g. internal audit, external audit and local counter fraud service) may be invited to attend meetings of the Audit Committee.

14. Other management or clinical staff may be co-opted or requested to attend for specific agenda items as necessary.

Requirements of Membership

15. Members must attend at least 75% of all meetings each financial year but should aim to attend all scheduled meetings. Attendance will be recorded and monitored.

16. Conflicts of Interest – the NHS England "Managing Conflicts of Interest in the NHS, 2016 defines a conflict of interest as 'a set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold.' The relevant interest, once declared, will be recorded in a register of interests, maintained by the Company Secretary.

Duties

17. In order to fulfil its role and obtain the necessary assurance, the Audit Committee will:

Financial Statements and the Annual Report

- Monitor the integrity of the financial statements of the Trust, any other formal announcements relating to the Trust's financial performance, reviewing the significant financial reporting judgements contained in them
- Review the annual statutory accounts, before they are presented to the Board of Directors, in order to determine their completeness, objectivity, integrity and accuracy. This review will cover, but is not limited to:
  - the meaning and significance of the figures, notes and significant changes
  - areas where judgement has been exercised
  - adherence to accounting policies and practices
  - explanation of estimates or provision having material effect
  - the schedule of losses and special payments
  - any unadjusted statements
  - any reservations and disagreements between the external auditors and management which have not been satisfactorily resolved
- Review the Annual Report and Annual Governance Statement before they are submitted to the Board of Directors to determine completeness, objectivity, integrity and accuracy
- Review each year the accounting policies of the Trust and make appropriate recommendations to the Board of Directors
- Review all accounting and reporting systems for reporting to the Board of Directors, including in respect of budgetary control

Internal Control and Risk Management

- Review the Trust's internal financial controls to ensure the provision and maintenance of an effective system of financial risk identification and associated controls, reporting and governance
- Review and maintain an oversight of the Trust's general internal controls and risk management systems
- Review processes to ensure appropriate information flows to the Audit Committee from Executive management and other Board Committees in relation to the Trust's overall internal control and risk management position
- Review the adequacy of the policies and procedures in respect of all counter-fraud work
- Review the adequacy of underlying assurance processes that indicate the degree of achievement of strategic objectives and the effectiveness of the management of principal risks
- Review the adequacy of policies and procedures for ensuring compliance with relevant regulatory, legal and conduct requirements

Whistleblowing

- Review arrangements that allow staff and other individuals, where relevant, to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety and other matters
- Ensure that arrangements are in place for the proportionate and independent investigation of such matters, and for appropriate follow-up action, and ensure safeguards are in place for those who raise concerns.

Corporate Governance

- Monitor corporate governance compliance (e.g. compliance with terms of the licence, constitution, codes of conduct, standing orders, standing financial instructions, maintenance of registers of interest)

Internal Audit

- Monitor and review the effectiveness of the Trust's internal audit function, taking into consideration relevant UK professional and regulatory requirements
- Review and approve the internal audit strategy and programme, ensuring that it is consistent with the needs of the organisation
- Oversee on an on-going basis the effective operation of internal audit in respect of:
  - adequate resourcing
  - its co-ordination with external audit
  - meeting relevant internal audit standards
  - providing adequate independent assurances
  - it having appropriate standing within the Trust
- Consider the major findings of internal audit investigations and management's response and their implications and monitor progress on the implementation of recommendations
- Consider the provision of the internal audit service, the cost of the audit and any questions of resignation and dismissal of internal audit staff
- Conduct an annual review of the internal audit function

External Audit

- Review and monitor the effectiveness of the audit process, taking into consideration relevant UK professional and regulatory requirements
- The Council of Governors should take the lead in agreeing with the Audit Committee the criteria for appointing, reappointing and removing external auditors. To support them in this task, the Committee should:
  - provide information on the external auditor's performance, including details such as the quality and value of the work, the timeliness of reporting and fees
  - make recommendations to the Council of Governors in respect to the appointment, re-appointment and removal of an external auditor and related fees as applicable. To the extent that a recommendation is not adopted by the Council of Governors, this should be included in the Annual Report, along with the reasons that the recommendation was not adopted
- Discuss with the external auditor, before the audit commences, the nature and scope of the audit, and ensure co-ordination, as appropriate, with other external auditors in the local health economy
- Assess the external auditors work and fees each year and based on this assessment, to make the recommendation to the Council of Governors with respect to the re-appointment or removal of the auditor. This assessment should include the review and monitoring of the external auditor's independence and objectivity and effectiveness of the audit process in light of relevant professional and regulatory standards
- Oversee the conduct of a market testing exercise for the appointment of an auditor at least once every five years and, based on the outcome, make a recommendation to the Council of Governors with respect to the appointment of the auditor

- Review external audit reports, including the annual audit letter, together with the management response, and to monitor progress on the implementation of recommendations
- Develop and implement a policy on the engagement of the external auditor to supply non-audit services, taking into account relevant ethical guidance.

Standing Orders, Standing Financial Instructions and Standards of Business Conduct

- Review, on behalf of the Board of Directors, the operation of, and proposed changes to, the standing orders, standing financial instructions, the constitution, codes of conduct and standards of business conduct, including maintenance of registers
- Examine the circumstances of any significant departure from the requirements of any of the foregoing, and whether those departures relate to a failing, an overruling or a suspension
- Review the scheme of delegation.

Other

- Review performance indicators relevant to the remit of the Audit Committee
- Examine any other matter referred to the Audit Committee by the Board of Directors and initiate investigation as determined by the Audit Committee
- Develop and use an effective assurance framework to guide the Audit Committee's work. This will include utilising and reviewing the work of the internal audit, external audit and other assurance functions as well as reports and assurances sought from directors and management and other investigatory outcomes so as to fulfil its functions in connection with these terms of reference
- Review the work of all other Board Committees in connection with the Audit Committee's assurance function
- Consider the outcomes of significant reviews carried out by other bodies which include but are not limited to regulators and inspectors within the health sector and professional bodies with responsibilities that relate to staff performance and functions

18. The Committee is committed to protecting and respecting data privacy. The Committee will have regard to UK General Data Protection (GDPR) and demonstrate, where applicable, compliance with data protection legislation, in particular the Data Protection Act 2018 (DPA) and Caldicott Guidelines.

Equality, Diversity & Inclusion

19. In conducting its business, the Audit Committee will at all times seek to promote its commitment to equality and diversity by the creation of an environment that is inclusive for both our workforce, patients and service users, including those who have protected characteristics and vulnerable members of our community.

Reporting

20. The Audit Committee will be accountable to the Board of Directors which will be informed of the Committee's work through an assurance report from the Chair submitted following each meeting. The submission to the Board of Directors shall include details of any matters in respect of which actions or improvements are needed. This will include evidence of

potentially ultra vires, otherwise unlawful or improper transactions, acts, omissions or practices or any other important matters.

21. The minutes of all meetings of the Audit Committee shall be formally recorded and circulated for comment to the Chair and other Committee members in advance of the next meeting.

22. The Trust's Annual Report shall include a section describing the work of the Audit Committee in discharging its responsibilities. This report shall include:
    - The significant issues that the committee considered in relation to financial statements, operations and compliance, and how these issues were addressed
    - An explanation of how the Committee has assessed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted
    - If the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded.

Administration of Meetings

23. Meetings shall be held as required but not less than five times a year with additional meetings held on an exception basis at the request of the Chair or any two members of the Committee.

24. The Company Secretary will make arrangements to ensure that the Committee is supported administratively. Duties in this respect will include development and monitoring of a workplan, agenda setting, taking minutes of the meeting and providing appropriate advice to the Chair and Committee members.

25. Agendas will be produced and agreed by the Chair in conjunction with the Executive Lead. Agendas and papers will be circulated at least 4 working days in advance of the meeting.

26. Minutes will be circulated to members for comment as soon as is reasonably practicable.

Review

27. The Terms of Reference shall be reviewed annually (next review date: January 2021).

28. The Audit Committee will undertake an annual review of its collective performance against its workplan and MCHFT's Annual Plan in order to evaluate the achievement of its duties. This review will be considered by the Board of Directors.

Mid Cheshire Hospitals NHS FT

Performance and Finance Committee

Authority/Constitution

1. The Performance & Finance Committee ("PAF" or "The Committee") is constituted as a standing committee of the Board of Directors. Its constitution and terms of reference shall be as set out below, subject to amendment at future Board of Directors' meetings.

2. The Committee is authorised by the Board of Directors to act within its terms of reference. It has no executive powers other than those specifically delegated in these Terms of Reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

3. The Committee has the authority to oversee and take decisions relating to the organisation's activities which also support the achievement of the organisation's objectives.

4. The Committee has the authority to instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions.

5. The Committee is authorised to create advisory or working groups as are necessary to fulfil its responsibilities within its terms of reference. The Committee may not delegate executive powers and remains accountable for the work of any such group. Any of these groups will report directly to PAF which will oversee their work.

Purpose

6. The purpose of the Performance & Finance Committee is to provide advice and assurance to the Board on the effectiveness of financial strategy and stewardship of the Trust's finances and sustainability, on the operational performance of the Trust, and on strategic investments and the development of Trust infrastructure, including the delivery of the Trust's enabling strategic plans that are relevant to the remit of the Committee (Finance, Estates Strategic Plan and the Digital Strategic Plan). PAF will also provide assurance to the Board on achievement of NHS national operational performance standards.

Membership

7. The Committee shall be comprised of the following members:
   - Two Non-Executive Directors, one of whom will be the Chair
   - Director of Finance
   - Chief Operating Officer

8. The following are required to attend in a non-voting capacity:
   - Company Secretary
   - Deputy Director of Finance
   - Director of Operations
   - Head of Corporate Governance

9. The PAF will be deemed quorate when three members are present, including at least one Non-Executive Director, the Director of Finance and the Chief Operating Officer or delegated representatives. Members may only nominate a deputy to attend on their behalf

if they have sufficient understanding of the area they are representing to be able to contribute effectively to the Committee's business; however, this should only be in exceptional circumstances. Deputies will count towards the quorum.

10. Other staff or external advisers may be co-opted or requested to attend for specific agenda items as necessary.

Requirements of Membership

11. Members must attend at least 75% of all meetings each financial year but should aim to attend all scheduled meetings. Attendance will be recorded and monitored.

12. Conflicts of Interest – NHS England[9] defines a conflict of interest as 'a set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold.' The relevant interest, once declared, will be recorded in a register of interests, maintained by the Company Secretary.

Duties

13. In order to fulfil its role, the PAF will:
    - receive as standing items, the following:
        - Board Assurance Framework matrix/heatmap
        - Integrated Performance Report
        - Chair's reports from the Executive Delivery and Performance Group and the Safe and Sustainable Environment Group
    - agree the annual operational and financial plan and receive assurance on delivery
    - receive assurance on the operational performance of the organisation and its services, including delivery of all national access and performance standards
    - receive assurance that where operational and financial plans are not being delivered there are robust and effective remedial improvement plans agreed to mitigate the impact of non-compliance
    - receive and agree the annual service improvement and service transformation plan and receive assurance on delivery
    - receive assurance that the operating model and performance framework is reviewed on an annual basis to ensure it is robust, responsible, highly reliable, effective and patient-centred
    - ensure alignment of the strategic financial principles, priorities, risk and performance parameters to support the organisation's strategic objectives and its long-term sustainability
    - seek assurance that the organisation's degree of exposure to financial risk, and any potential to compromise the achievement of the strategic objectives is being effectively managed
    - agree the annual estates, environment and capital plans and receive assurance on delivery

[9] Managing Conflicts of Interest in the NHS, 2016

receive assurance that all financial and operational issues and risks, aligned to the PAF Committee, are being managed effectively

- receive a quarterly report on any significant investments relevant to the PAF Committee and to receive assurance on benefits realisation and return on investment
- receive assurance that all aspects of Emergency Planning and Resilience statutory requirements are being met
- ensure Trust compliance with current statutory and external reporting standards and requirements, including NHS and Treasury policies and procedures
- ensure that the Trust's resources and assets are being used effective and efficiently
- review the Trust in-year and future year's development and delivery of annual efficiency savings programmes
- review the outputs of benchmarking exercises and consider appropriate actions.

Risk & Assurance

14. The Committee will ensure that governance and assurance systems operate effectively and underpin operational risk delivery. It will monitor the principal risks assigned annually by the Board by ensuring that relevant assurances are sought with respect to the effectiveness of existing risk controls and that future actions are focused on managing risks to an acceptable level. It will monitor the management of key operational risks relevant to its remit and consider their impact on the strategic risks

15. PAF is committed to protecting and respecting data privacy. The Committee will have regard to UK General Data Protection (GDPR) and demonstrate, where applicable, compliance with data protection legislation, in particular the Data Protection Act 2018 (DPA).

Equality, Diversity & Inclusion

16. In conducting its business, the Committee will at all times seek to promote its commitment to equality and diversity by the creation of an environment that is inclusive for both our workforce, patients and service users, including those who have protected characteristics and vulnerable members of our community.

Reporting

17. PAF will be accountable to the Board of Directors. The Board will be informed of PAF's work through an assurance report from the Chair submitted following each meeting.

Administration of Meetings

18. Meetings shall be held monthly with additional meetings held on an exception basis at the request of the Chair or any three members of the Committee.

19. The Company Secretary will make arrangements to ensure that the Committee is supported administratively. Duties in this respect will include development and monitoring of a workplan, agenda setting, taking minutes of the meeting and providing appropriate support to the Chair and Committee members.

20. Minutes will be circulated to members for comment as soon as is reasonably practicable.

Review

21. The Terms of Reference shall be reviewed annually (next review date: March 2022).

22. The Committee will undertake an annual review of its performance against its work plan and MCHFT's Annual Plan in order to evaluate the achievement of its duties. This review will be considered by the Board of Directors.

Mid Cheshire Hospitals NHS FT

Quality and Safety Committee

Authority/Constitution

1. The Quality & Safety Committee ("Q&S" or "the Committee") is constituted as a standing committee of the Board of Directors. Its constitution and terms of reference shall be as set out below, subject to amendment at future Board of Directors' meetings.

2. The Committee is authorised by the Board of Directors to act within its terms of reference It has no executive powers other than those specifically delegated in these Terms of Reference. It is authorised to request specific reports from individual functions within the organisation and to seek any information it requires from any member of staff in order to perform its duties.

3. The Committee has the authority to oversee and take decisions relating to the organisation's activities which also support the achievement of the organisation's objectives.

4. The Committee has the authority to instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions.

5. The Committee is authorised to create advisory or working groups as are necessary to fulfil its responsibilities within its terms of reference. The Committee may not delegate executive powers and remains accountable for the work of any such group. Any of these groups will report directly to the Quality & Safety Committee which will oversee their work.

Purpose

6. The purpose of the Quality & Safety Committee is to obtain and provide the Board with assurance on the development and implementation of the Quality & Safety Improvement Strategic Plan. It ensures that high standards of care are provided by the Trust and, in particular, that adequate and appropriate governance structures, processes and controls are in place throughout the Trust to:

    - Promote safety and excellence in patient care and experience
    - Identify, prioritise and manage risk arising from clinical care
    - Ensure the effective and efficient use of resources through evidence-based clinical practice
    - Ensure compliance with legal, regulatory and other obligations.

Membership

7. The Committee/Group shall be comprised of the following members:
    - Two Non-Executive Directors, one of whom will be the Committee Chair
    - Medical Director
    - Director of Nursing & Quality

8. The following are required to attend in a non-voting capacity:
    - Company Secretary
    - Associate Director of Quality Governance

- Head of Corporate Governance

9. The Committee will be deemed quorate when three members are present, including at least one Non-Executive Director and one Executive Director. Members may only nominate a deputy to attend on their behalf if they have sufficient understanding of the area they are representing to be able to contribute effectively to the Committee's business; however, this should only be in exceptional circumstances. Deputies will count towards the quorum.

10. Other staff or external advisers may be co-opted or requested to attend for specific agenda items as necessary.

Requirements of Membership

11. Members must attend at least 75% of all meetings each financial year but should aim to attend all scheduled meetings. Attendance will be recorded and monitored.

12. Conflicts of Interest – NHS England[10] defines a conflict of interest as 'a set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold.' The relevant interest, once declared, will be recorded in a register of interests, maintained by the Company Secretary.

Duties

13. In order to fulfil its role and obtain the necessary assurance, the Quality & Safety Committee will:

- set an annual workplan aligned with the Board's annual Cycle of Business and report to the Board on its progress
- receive the following standing items:
  - The Board Assurance Framework matrix/heatmap
  - The Integrated Performance Report
  - The Chair's Summary Report from the Executive Quality Governance Group

Strategy

- review and agree the Trust's Quality & Safety Improvement Strategic Plan, related delivery programmes and plans
- assess the strategic priorities and investments needed to support high quality clinical outcomes and improve clinical effectiveness in the Trust, and advise the Board accordingly, liaising with the Performance & Finance Committee as appropriate.

Outcomes and Processes

- be assured of the integrity of the Trust's systems, processes and procedures that ensure the following:
  - high quality care (through the Trust's quality review processes)
  - compliance with quality and safety standards
  - patient safety and harm reduction

[10] Managing Conflicts of Interest in the NHS, 2016

  - infection prevention and control
  - clinical audit
  - introduction of new clinical pathways and procedures
  - introduction of new clinical roles (in conjunction with the Workforce & Digital Transformation Committee, and the Performance & Finance Committee)
  - dissemination and implementation of statutory guidance
  - escalation and resolution of quality concerns
  - patient and carer involvement and engagement
- ensure the effective operation of processes relating to clinical practice and performance, including early detection of issues and problems, escalation, corrective action and learning.

Research

- ensure the research programme and governance framework is implemented and monitored.

Patient Care (safety and excellence)

- be assured that procedures stipulated by professional regulators of chartered practice (i.e. General Medical Council and National Midwifery Council) are in place and performed to a satisfactory standard
- be assured there are processes in place that safeguard children and adults within the Trust
- ensure that there is an appropriate process in place to monitor and promote compliance across the Trust with clinical standards and guidelines, including but not limited to NICE guidance and guidelines
- ensure that internal standards are set and monitored, including:
  - the registration criteria of the Care Quality Commission continuing to be met
  - monitor the implementation of the Trust's policy on reporting issues of concern
  - robust arrangements for review of patient safety incidents (including near-misses, complaints, claims reports from HM Coroner) from within the Trust and wider NHS identification of similarities or trends and areas for focussed or organisation-wide learning
  - identification of actions for improvement identified in incident reports, reports from HM Coroner and other similar documents are addressed
  - identification of areas for improvement in respect of incident themes and complaint themes from the results of national patient survey/PALS and ensure appropriate action is taken
  - Trust compliance with the national standards of quality and safety of the Care Quality Commission and the NHS Provider Licence conditions that are relevant to the Quality & Safety Committee's area of responsibility in order to provide relevant assurance to the Board so that the Board may approve the Trust's annual declaration of compliance and corporate governance statement
- monitor trends in complaints received by the Trust and commission actions in response to adverse trends where appropriate
- ensure there is an appropriate mechanism in place for action to be taken in response to results of clinical audit and the recommendations of any relevant external reports (e.g. from the Care Quality Commission)
- ensure that where practice is of high quality, it is recognised and propagated across the Trust.

Learning

- be assured of the effectiveness of systems and processes used for continuous learning, innovation and quality improvement, establishing ways of gaining assurance that appropriate action is being taken including the application and dissemination of lessons learned
- be assured of the effectiveness of communication, engagement and development activities designed to support patient safety and improve clinical governance.

Patient and Public Engagement

- be assured of the effectiveness of a credible process for assessing, measuring and reporting on the 'patient experience' consistently over time, including the appropriateness and effectiveness of processes for patient engagement in support of the Trust's strategic objectives and programmes of work.

Risk & Assurance

14. The Committee will ensure that governance and assurance systems operate effectively and underpin operational risk delivery. It will monitor the principal risks assigned annually by the Board by ensuring that relevant assurances are sought with respect to the effectiveness of existing risk controls and that future actions are focused on managing risks to an acceptable level. It will monitor the management of key operational risks relevant to its remit and consider their impact on the strategic risks

15. The Committee is committed to protecting and respecting data privacy. The Committee will have regard to UK General Data Protection (GDPR) and demonstrate, where applicable, compliance with data protection legislation, in particular the Data Protection Act 2018 (DPA) and Caldicott Guidelines.

Equality, Diversity & Inclusion

16. In conducting its business, the Quality & Safety Committee will at all times seek to promote its commitment to equality and diversity by the creation of an environment that is inclusive for both our workforce, patients and service users, including those who have protected characteristics and vulnerable members of our community.

Reporting

17. The Quality & Safety Committee will be accountable to the Board of Directors which will be informed of the Committee's work through an assurance report from the Chair submitted following each meeting.

Administration of Meetings

18. Meetings shall be held monthly with additional meetings held on an exception basis at the request of the Chair or any three members of the Quality & Safety Committee.

19. The Company Secretary will make arrangements to ensure that the Committee is supported administratively. Duties in this respect will include development and monitoring of the Committee Workplan, agenda setting, taking minutes of the meeting and providing appropriate support to the Chair and Committee members.

20. Agendas and papers will be circulated at least 4 working days in advance of the meeting.

21. Minutes will be circulated to members for comment as soon as is reasonably practicable.

Review

22. The Terms of Reference shall be reviewed annually (next review date: March 2022).

23. The Quality & Safety Committee will undertake an annual review of its performance against its work plan and MCHFT's Annual Plan in order to evaluate the achievement of its duties. This review will be considered by the Audit Committee on behalf of the Board of Directors.

Mid Cheshire Hospitals NHS FT

Workforce and Digital Transformation Committee

Authority/Constitution

1. The Workforce & Digital Transformation Committee ("WDT" or "The Committee") is constituted as a standing committee of the Board of Directors. Its constitution and terms of reference shall be as set out below, subject to amendment at future Board of Directors' meetings.

2. The Committee is authorised by the Board of Directors to act within its terms of reference It has no executive powers other than those specifically delegated in these Terms of Reference. It is authorised to request specific reports from individual functions within the organisation and to seek any information it requires from any member of staff in order to perform its duties.

3. The Committee has the authority to oversee and take decisions relating to the organisation's activities which also support the achievement of the organisation's objectives.

4. The Committee is authorised to create advisory or working groups as are necessary to fulfil its responsibilities within its terms of reference. The Committee may not delegate executive powers and remains accountable for the work of any such group. Any of these groups will report directly to the WDT Committee which will oversee their work.

Purpose

5. The purpose of the Committee is to obtain and provide the Board with assurance on the development and implementation of the Trust's People Strategic Plan and the Trust's Digital Strategic Plan.

6. The Committee ensures there is a positive working environment which promotes an inclusive culture that addresses the holistic needs of individuals. It seeks assurance that the Trust has a sufficient, suitably skilled and empowered workforce that results in the Trust truly is the best place to work. It seeks to align the workforce and digital agendas to ensure that the Trust is prepared for the current and future workforce for changes in models of care and transformation associated with the digitisation of MCHFT. It ensures the Trust shapes its digital future by using digital technology throughout the Trust in an innovative, effective and efficient way to ensure the workforce becomes digitally enabled.

Membership

7. The Committee shall be comprised of the following members:
   - Two Non-Executive Directors (one of whom will be designated as Chair)
   - Director of Workforce & Organisational Development
   - Chief Information Officer
   - Chief Operating Officer

8. The following are required to attend in a non-voting capacity:
   - Company Secretary

- Head of Corporate Governance
- Deputy Director of Workforce

9. The Committee will be deemed quorate when three members are present, including a Non-Executive Director and an Executive Director. Members may only nominate a deputy to attend on their behalf if they have sufficient understanding of the area they are representing to be able to contribute effectively to the Committee/Group's business; however, this should only be in exceptional circumstances. Deputies will count towards the quorum.

10. Other staff or external advisers may be co-opted or requested to attend for specific agenda items as necessary.

Requirements of Membership

11. Members must attend at least 75% of all meetings each financial year but should aim to attend all scheduled meetings. Attendance will be recorded and monitored.

12. Conflicts of Interest – NHS England[11] defines a conflict of interest as 'a set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold.' The relevant interest, once declared, will be recorded in a register of interests, maintained by the Company Secretary.

Duties

13. In order to fulfil its role and obtain the necessary assurance, the WDT Committee will:

- Set an annual workplan aligned with the Board's annual Cycle of Business and report to the Board on its progress
- Receive the following standing items:
  - The Board Assurance Framework matrix/heatmap
  - The Integrated Performance Report
  - The Chair's Summary Report from the Executive Workforce Assurance Group (EWAG) and the Executive Digital Technology and Information Services Group (EDTIS)

Workforce

- Oversee the development and delivery of a People Strategic Plan, taking into account best practice and alignment with the strategic objectives of the Trust
- Ensure the Trust has robust recruitment and retention plans in place to support the delivery of high-quality patient care and experience, aligned to the Trust's strategic objectives
- Review the senior leadership succession and development plans
- Monitor the development of the future workforce, through an effective workforce plan
- Ensure that feedback from staff surveys are appropriately analysed and improvement actions in place to drive employee engagement and the desired organisational culture

[11] Managing Conflicts of Interest in the NHS, 2016

- Ensure the Trust is compliant with relevant legislation relating to Equality, Diversity & Inclusion; maintain oversight of the Trust's Equality, Diversity and Inclusion agenda, and receive regular reports from the Equality and Diversity Lead
- Oversee the development and implementation of the Trust's Education, Training and Leadership Plans to seek assurance on improvement performance, return on investment and capability to deliver the Trust's strategic objectives
- Ensure the Trust has a suitable framework to deliver the strategic plan and related policies; ensure these align with the relevant CQC and NHS Improvement workforce standards[12], including statutory and mandatory training compliance
- Ensure that processes are in place to support the health and well-being of staff
- Review and monitor the integrated workforce opportunities across Cheshire and Cheshire & Merseyside.

Digital Transformation

- Ensure the portfolio of digital projects (excluding LIMS, DCS and infrastructure projects) have robust implementation and benefits realisation plans
- Ensure the establishment, efficiency and professionalisation of a clinical informatics capability including CCIOs, CNIOs, Digital Clinical Champions
- Ensure the establishment and efficiency of the clinical intelligence service to work alongside the business intelligence service, enabling clinicians to benefit from information
- Ensure the digital services are ready for when the dependency on IT increases, ensuring support processes are mature and robust, looking to adopt Service Standards such as ISO 20001.
- Monitor the digital maturity of the Trust using nationally recognised methodologies either from NHS Digital, HIMSS, KLAS and associated improvement plans.
- Ensure the establishment and efficiency of the digital-ready workforce programme which aims to enable staff with the skills and confidence to use technology in the delivery of their work (this will encompass "Nudge")
- Scrutinise specific aspects of the proposed Electronic Patient Record as required by the Board or requested by the Digitally Enabled Clinical System Transformation Board
- Scrutinise the digital and information implications of QI initiatives
- Ensure services which are digitally enabled do not lead to digital exclusion for patients who do not have access or skills to use technology
- Consider the implications of any Cheshire and Merseyside Health and Care Partnership digital initiatives and national digital initiatives.

Risk & Assurance

14. The Committee will ensure that governance and assurance systems operate effectively and underpin operational risk delivery. It will monitor the principal risks assigned annually by the Board by ensuring that relevant assurances are sought with respect to the effectiveness of existing risk controls and that future actions are focused on managing risks to an acceptable level. It will monitor the management of key operational risks relevant to its remit and consider their impact on the strategic risks

[12] The NHS People Plan, NHS England, July 2020

15. The Committee is committed to protecting and respecting data privacy. The Committee will have regard to UK General Data Protection (GDPR) and demonstrate, where applicable, compliance with data protection legislation, in particular the Data Protection Act 2018 (DPA).

Equality, Diversity & Inclusion

16. In conducting its business, the Committee will at all times seek to promote its commitment to equality and diversity by the creation of an environment that is inclusive for both our workforce, patients and service users, including those who have protected characteristics and vulnerable members of our community.

Reporting

17. The WDT Committee will be accountable to the Board of Directors. The Board will be informed of WDT's work through an assurance report from the Chair submitted following each meeting.

Administration of Meetings

18. Meetings shall be held monthly with additional meetings held on an exception basis at the request of the Chair or any three members of the Committee.

19. The Company Secretary will make arrangements to ensure that the Committee is supported administratively. Duties in this respect will include development and monitoring of a workplan, agenda setting, taking minutes of the meeting and providing appropriate support to the Chair and Committee/Group members.

20. Agendas and papers will be circulated at least 4 working days in advance of the meeting.

21. Minutes will be circulated to members for comment as soon as is reasonably practicable.

Review

22. The Terms of Reference shall be reviewed annually (next review date: March 2022).

23. The Committee will undertake an annual review of its performance against its work plan and MCHFT's Annual Plan in order to evaluate the achievement of its duties. This review will be considered by the Board of Directors.

APPENDIX II

Board of Directors
Matters Reserved for the Board

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:

2. **General Enabling Provision**

   The Board may determine any matter it wishes in full session within its statutory powers.

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.

4. **Regulation and Control**

   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.

   4.2 Suspend Standing Orders

   4.3 Vary or amend the Standing Orders.

   4.4 Ratify in a Board meeting any urgent decisions taken by the Chairman and Chief Executive in accordance with SO.

   4.5 Approve a scheme of delegation or powers from the Board to committees.

   4.6 Approval of a scheme of delegation of powers from the Board to directors and officers.

   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.

   4.8 Requiring and receiving the declaration of interests from officers which may conflict with those of the Trust.

   4.9 Disciplining Directors who are in breach of statutory requirements, SOs, SFIs, or any other approved Policy or Procedure.

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.

4.11 Establish committees of the Board including their terms of reference and reporting arrangements.

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.

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.

4.14 Approval of arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust.

4.15 Approval of arrangements relating to the discharge of the Trust's responsibilities as a bailee for patients' property.

4.16 Authorise use of the seal.

4.17 Ratify or otherwise instances of failure to comply with Standing Orders brought to the Audit Committee's attention.

4.18 Compliance with the NHS Provider Licence, its Constitution, and all statutory and regulatory obligations.

5. **Appointments/Dismissal**

5.1 Appointment of the Deputy Chairman of the Board, in consultation with the Council of Governors.

5.2 Appoint and dismiss committees (and individual members) that are directly accountable to the Board.

5.3 The appointment, appraisal, disciplining and dismissal by Non-Executive Directors of Executive Directors in accordance with the **Constitution**.

5.4 The appointment, appraisal, disciplining and dismissal of the Company Secretary.

5.5 Approve proposals of the Appointments and Remuneration Committee regarding Executive Directors.

6. **Strategy and Business Plans and Budgets**

6.1 In consultation with the Council of Governors, to define the strategic aims and objectives of the Trust.

6.2 In consultation with the Council of Governors, to determine key objectives to meet the needs of stakeholders.

6.3 Approve the Full Business Cases for Capital Investment to the limits set by the Board.

6.4 Approve budgets for revenue, capital and working capital.

6.5 Approve proposals for acquisition, disposal or change of use of land and/or buildings.

6.6 Approve PFI proposals.

6.7 Approve the opening of bank accounts.

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 £1million over a 3 year period or the period of the contract if longer.

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 £1million per annum, or greater than £5million 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:

- The Board has approved a business case in relation to the expenditure / commitment and the contract is in line with the values approved
- Replacement of existing lease arrangements which are affordable within approved budgets.

6.10 Review and approve the Trust's insurance against significant risks, including use of the NHS Litigation Authority's risk pooling schemes.

6.11 Approval annually of plans in respect of:

- Health investment and purchasing intentions.
- The application of available financial resources.

6.12 Financial Forecasts and Plans.

6.13 Approval of strategic developments and associated Business Plans.

6.14 Approval of Working Capital Facility

7. Risk Management

7.1 Approval and monitoring of the Trust's strategy for the management of risk, specifically its Board Assurance Framework (BAF)

8. Direct Operational Decisions

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 £1m. 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 up to a maximum of 6 months and a total commitment of no more than £500,000 or £500,000 to £1m approval by the Chair, Chief Executive, Director of Finance and the Chair of the Performance and Finance Committee. The Board will be informed of such commitments through the Performance & Finance Committee.

Any extensions to the 6 months must receive prior Board approval.

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 jointly and reported to the next Board meeting.

The Board may delegate to the Director of Finance a part of the capital in line with the contingency arrangements set out in Section 4.

8.3 To agree action on litigation against or on behalf of the Trust, except that the Director of Finance shall be authorised to take all necessary action to recover debts due to the Trust.

9. Financial and Performance Reporting Arrangements

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 NHS Improvement and the Charity Commission shall be reported, at least in summary, to the Board.

9.2 Receive reports from Director of Finance on financial performance against budget and business plan.

9.3 Receipt and approval of NHS service contracts signed in accordance with arrangements approved by the Chief Executive.

9.4 Receive reports from the Chief Executive on actual and forecast income from service Commissioners.

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.

9.6 Consideration and approval of the Trust's Annual Report including the Annual Accounts and Quality Account

9.7 Receipt and approval of an annual report from the Audit Committee regarding internal control and requiring designated signatures.

9.8 Receipt of a Chair's assurance report from each meeting and an annual evaluation report of performance of Board Committees, and receipt and approval of all annual workplans of all Board Committees.

9.9 Receipt and approval of the Directors' Statement on Compliance as may be required by the Secretary of State.

9.10 Appointment of Bankers.

9.11 Insurance Arrangements.

9.13 Approval of the Annual Governance Statement

10. **Audit Arrangements**

10.1 To approve audit arrangements and to receive reports of the Audit Committee meetings and take appropriate action.

10.2 The receipt of the annual management letter received from the External Auditor and consideration of any action recommended by the Audit Committee.

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.

APPENDIX III

Delegation of Powers by the Board of Directors

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.

A 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 NHS Improvement 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.

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 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 annually 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 NHS Improvement 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.

APPENDIX IV

Standing Orders for the Practice and Procedure of the Board of Directors

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.

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.

1. Introduction

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 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
- assess performance against agreed objectives and targets
- manage and minimise risk
- make well-informed and high-quality decisions based on intelligent information
- 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. The Board shall at all times seek to comply with the NHS Foundation

Trust Code of Governance which builds on the Combined Code of Corporate Governance

- have regard to the NHS Constitution in performing the Trust's NHS functions

1.3 NHS Codes

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

Fig 1. 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
- The Fraud Policy and Response Plan
- The Bribery Act 2011

New or revised Financial Codes of Procedures shall have effect as if incorporated into standing orders by virtue of the Director of Finance 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 later in this document in Standing Orders: Reservation and Delegation of Powers 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 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 an 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. 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

Save as stipulated in Standing Orders 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-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 2006 Act, these powers may only be delegated to a committee of Directors or to an executive director. 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, or the Company 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 The Board of Directors will normally work with an external organisation recognised as expert at appointments to identify the skills and experience required for non-executive directors.

Appropriate candidates will be identified by a Nominations Committee through a process of open competition, which takes account of skills and experience required.

The Nominations Committee will comprise the Chairman (or, when a Chairman is being appointed, the Deputy Chair unless they are standing for appointment, in which case another non-executive director), and representative Governors. The Committee would be advised by an independent assessor, who may be chair of another NHS foundation trust. The Chief Executive will be entitled to attend meetings of the Nominations Committee unless the Committee decides otherwise and the Committee shall take into account the Chief Executive's views.

The Nominations Committee will make a recommendation to the Council of Governors for approval.

3.4 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. Where concerns are raised, an investigation may take place in line with the Recruitment and Selection Policy.

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.

3.5 Appointment and Powers of Deputy Chair

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.

3.6 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, which appointment shall be approved by 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.

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 Company Secretary.

3.7 Appointment of Executive Directors

The Board shall appoint a committee of the Chairman, the Chief Executive and the Non-Executive Directors to appoint or remove Executive Directors; and an Appointments and Remuneration Committee comprising the Chairman and Non-Executive Directors 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 Company Secretary

The Board shall appoint a Company 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 Company 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

4.1 Admission of Members, the Public and the Press

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 Company Secretary.

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.

4.2 Calling Meetings

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.

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.

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.

4.3 Notice of Meetings

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 five consecutive calendar days before the meeting. In exceptional circumstances, the Chairman may agree to unavoidably late papers to be sent after this deadline.

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.

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.

4.4 Setting the Agenda

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

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.

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.

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.

4.5 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.

4.6 Notices of Motion

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.

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.

4.7 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.

4.8 Motions

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

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 proceeds 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.

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.

4.9 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 meeting shall be final.

4.10 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.

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.

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.

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

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.

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.

4.11 Minutes

The Chairman shall ensure that the minutes of the proceedings of a meeting are drawn up under the supervision of the Company 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.

The Company 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.

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

4.12 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.

4.13 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.

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

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

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

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

4.14 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.

4.15 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.

4.16 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.

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.

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.

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

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.

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.

5.1 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.

5.2 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.

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.

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

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.

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

5.3 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.

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.

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

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.

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

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.

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.

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.

6.2 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

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.

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

8. Declaration of 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 actual and potential 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:

- Any position of authority or trust, i.e. Directorships, Senior Management, in another NHS organisation or commercial, charity, voluntary, professional, statutory or other body
- Any decision-making role in any advisory groups or other unpaid or paid forums that can influence how that organisation spends taxpayers' money
- Employment with any private company, business or consultancy
- Any shareholdings and other ownership interests in any publicly listed, private or not-for-profit company, business, partnership or consultancy which is doing, or might be reasonably expected to do, business with the Trust. This does not include shares held as part of a managed fund, pension fund or unit trust. Research funding or grants that may be received by an individual or their department
- Any patents or intellectual property rights held in the fields of health or social care or that could be utilised by the Trust in its day to day operations.

8.3 The interests of the director shall include members of close associates and his family. "Family" shall mean spouse, partner, children, grandchildren, other dependents, parents and grandparents.

8.4 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.

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

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

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.

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).

8.7 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.

8.8 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.

8.9 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.

8.10 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.

8.11 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.

8.12 The Chief Executive will ensure that a register of interests is established and maintained by the Company 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.

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.

The register shall be available to the public, and the Company 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 Company Secretary in a secure place and shall be secured by two separate locks.

9.2 Sealing of Documents

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 Company 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 annually. 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

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 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.

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

APPENDIX V

Board of Directors
Standing Financial Instructions

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 (SFIs) setting out the responsibilities of individuals. These Directions are not mandatory 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 Trust) must follow when taking action on behalf of the Board.

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

Board of Directors
Standing Financial Instructions

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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 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.**

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 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 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, 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 Standing Orders: Reservation and Delegation of Powers to the Board section.

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 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 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
(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
(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.

1.3.12 The Director of Finance 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 Anti-Fraud, Bribery and Corruption Policy as appropriate.

2 Audit

2.1 Director of Finance

2.1.1 The Director of Finance is responsible for:

(a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective internal audit function
(b) ensuring that the internal audit is adequate and meets the NHS mandatory audit standards
(c) ensuring compliance with the Anti-fraud, Bribery and Corruption policy
(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 Social Care, NHS Improvement and NHS England, 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 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, stock or other property of the Trust under a member of the Board and member of staff's control
(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 Social Care, NHS Improvement and NHS England.

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 and the Local Counter Fraud specialist 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. The reporting system for internal audit shall be agreed between the Director of Finance, the Audit Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Internal Audit Manual. The reporting system shall be reviewed at least every 3 years.

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 Anti-fraud, Bribery and Corruption Policy has been adopted by the Trust to ensure full compliance with the NHS Counter Fraud & Corruption Manual and the Chief Executive and Director of Finance shall monitor and ensure compliance with Secretary of State Directions on fraud, bribery and corruption.

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 will:

a) provide monthly reports in the form required by the Board or regulators
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 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 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 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
(f) identify potential risks and mitigation.

4.2.3 The Director of Finance 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 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 will provide annual plans for NHS Improvement 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 to enable budgets to be compiled.

4.2.7 The Director of Finance has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage 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
(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 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 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
(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 will monitor recruitment and appointment activity on behalf of the Board so as to facilitate this control. The Director of Finance will establish procedures for authorisation of recruitment within recruitment budgets. The Director of Finance 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 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 is responsible for ensuring that the appropriate monitoring forms are submitted to NHS Improvement on a timely basis, according with NHS Improvement's timescales.

4.6.2 In respect of the Self Certification of financial risk rating and governance risks, the Director of Finance 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 will obtain Chief Executive and Chairman's approval prior to formal submission to NHS Improvement.

5 Annual Accounts and Reports

5.1 The Director of Finance, 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 and Social Care, Treasury, or NHS Improvement;
(b) prepare annual financial reports for the Secretary of State or regulators certified in accordance with current guidelines and to the timetable prescribed by the Department of Health and Social Care or NHS Improvement.

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 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 NHS Improvement's FT Accounting Reporting Manual and been submitted to NHS Improvement in line with prescribed deadlines.

6 Bank and GBS Accounts

6.1 General

6.1.1 The Director of Finance is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account guidance/ Directions issued

from time to time by the Department of Health and Social Care, NHS Improvement and HM Treasury.

6.1.2 The Board shall approve the banking arrangements.

6.1.3 In line with 'Cash Management in the NHS' Trusts should minimize the use of commercial bank accounts and consider using Governance Banking Service (GBS) accounts for all banking services.

6.2 Bank and GBS accounts

6.2.1 The Director of Finance 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 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 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 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 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 will review the banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money. This review is not necessary for GBS banking.

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 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 is also responsible for the prompt banking of all monies received.

7.2 Fees and charges

7.2.1 The Director of Finance 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 and Social Care's Commercial Sponsorship – Ethical standards in the NHS shall be followed.

7.2.2 All employees must inform the Director of Finance promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings (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 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 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.

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 regarding:

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

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 £1million 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 recommendation.

8.5 The Chief Executive shall report to the Board at the next meeting, all agreements where the estimated revenue income or expenditure is less than £1million.

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 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 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

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

9.3.2 The Director of Finance 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 Payroll 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
(d) agreeing method of payment.

9.4.2 The Director responsible for Payroll 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 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

(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 Payroll's instructions and in the form prescribed by the Director responsible for Payroll
(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 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 Payroll 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 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 of Workforce and Organisational Development 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
(b) dealing with variations to, or termination of, contracts of employment.

9.5.2 The Director of Workforce and Organisational Development 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 Workforce and Organisational Development 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.

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

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

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

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

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

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

10.2.3 The Director of Finance will:

(a) advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds 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 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 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 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)

(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 if problems are encountered.

10.2.5 Official Orders must:

(a) be consecutively numbered

(b) be in a form approved by the Director of Finance

(c) state the Trust's terms and conditions of trade

(d) only be issued to, and used by, those duly authorised by the Director of Finance

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 and that:

(a) the Director of Finance 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

(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 in advance of any commitment being made

(c) contracts above specified thresholds are advertised and awarded in accordance with The Public Procurement (Amendment etc.) (EU Exit) Regulations 2020 underpinned by the Competition Act 1998 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 and Social Care

(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) 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) 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

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

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

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

10.2.7 The Director of Finance shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the NHS Estates guidance 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. 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 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 and Social Care or NHS Improvement. The Director of Finance 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 or by a member of staff so delegated by him.

11.1.3 The Director of Finance 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.

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 NHS Improvement, 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.

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 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 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
(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

(b) that the Director of Finance 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, 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 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 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 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), 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 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
(d) A full business case is produced in line with NHS Improvement'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.

12.3 Asset registers

12.3.1 The Chief Executive shall delegate to the Director of Finance his responsibility for the maintenance of register of assets. The Director of Finance 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 *Group Accounting Manual* as issued by the Department of Health and Social Care or NHS Improvement.

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

(c) lease agreements in respect of assets held under a finance lease and capitalised.

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

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

12.3.6 The Director of Finance 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 and in line with accepted accounting practice.

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

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. 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
(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.

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 Procurement 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. An appropriate charge may be raised and the member of staff must:

a) sign an appropriate receipt form designed by the Director of Finance
b) arrange for insurance as advised by the Director of Finance.

12.4.8 The Director of Finance 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 and Social Care or NHS Improvement 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 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. 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 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 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 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.

13.8 The designated Manager/Pharmaceutical Officer shall be responsible for a system approved by the Director of Finance for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Director of Finance any evidence of significant overstocking and of any negligence or malpractice (see also SFI 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 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 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 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 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

(b) recorded by the Condemning Officer in a form approved by the Director of Finance 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.

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 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 £100,000) shall be subject to prior approval by the Board.

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

14.2 Losses and special payments

14.2.1 The Director of Finance must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments. (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 (or an officer nominated by him) or inform an officer charged with responsibility for responding to concerns involving loss confidentially. (See Anti-fraud, Bribery and Corruption Policy and Response Plan and/or the Trust's Whistle Blowing Policy). This officer will then appropriately inform the Director of Finance.

14.2.3 The Trust's "Fraud and Response Plan" as set out in the Anti-fraud, Bribery and Corruption Policy shall be considered 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 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 and Social Care (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, 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 shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

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

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

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

15 Information Technology

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

(a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which he 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 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 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 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 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 staff have access to such data
(d) such computer audit reviews are being carried out as are considered necessary.

16 Patient's 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 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 and Social Care 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.

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 defines how those responsibilities are to be discharged. 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. 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.

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 the Mid Cheshire Hospitals Charity Governance document.

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

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

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

17.7 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, 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.

17.8 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, 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.

17.9 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.

17.10 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 before accepting such gifts. Further guidance is available in the Board of Directors and Staff Code of Conduct Section 2 of this document.

17.11 The Director of Finance 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.

17.12 The Director of Finance 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 who alone shall be empowered to give an executor a good discharge.

17.13 In the absence of an executor of a deceased person, the Director of Finance 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 and Social Care 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 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 NHS Resolution 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, to be inadequate.

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

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

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

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, Bribery and Corruption

21.1 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 NHS Protect's Standards for Providers 2013 and the General Conditions (GC6) of the NHS Standard Contract 2013/14.

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

21.3 The Trust shall prepare an Antifraud, Bribery and Corruption Policy and Procedures to guide staff. The Policy & Procedures shall be prepared in line with SFI 21 and SFIs shall have priority if in doubt.

21.4 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.

Reporting Suspected Fraud or Corruption

21.5 Authority for investigating fraud has been delegated to the Director of Finance 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 shall inform and consult the Chairman, Chief Executive, Chairman of the Audit Committee and Director of Risk Management in all cases.

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

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

- Chairman of the Audit Committee (or any other Non-Executive Director)
- Chief Executive
- Director of Finance (or any other Executive Director)
- Local Counter Fraud Specialist

Details of the key points of contact are recorded in Annex 1 of the Anti-Fraud, Bribery and Corruption Policy.

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

21.8 All staff have a duty to protect the assets of the Trust which include information and goodwill as well as property. Staff who have concerns should refer to the Anti-fraud, Bribery and Corruption Policy.

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

21.10 A log of all reported suspicions, including those dismissed as minor or otherwise not investigated will be maintained by the Director of Finance. 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.

Recovering a Loss

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

21.12 If the loss may be covered by insurance the Director of Finance 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.

21.13 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.

21.14 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:

- Anti-fraud, Bribery and Corruption Policy
- Disciplinary Policy

Mid Cheshire Hospitals NHS FT

- Freedom to Speak up /Raising Concerns Policy

All are available through the Trust Intranet under Policies.

Mid Cheshire Hospitals NHS Foundation Trust

STANDING FINANCIAL INSTRUCTIONS – SCHEDULE I

LOCAL COUNTER FRAUD SPECIALIST (LCFS)

Operational Responsibilities	Liaison Responsibilities
A. To routinely investigate all cases involving the 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 (i.e. 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 is in agreement. C. To provide assistance involving cases under investigation by the relevant NHS Protect Regional National Team involving the Trust.	• To inform NHS Protect Regional Team of every case which is investigated. • To refer other FHS fraud cases to the relevant Trust LCFS. • 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	**Delegated Limits per Case**
Category of loss/special payment	**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, e.g. 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 e.g. 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 NHS Improvement and HM Treasury

APPENDIX VI

Scheme and Schedule of Delegation

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 (CEO), the Director of Finance (DoF) and other directors. These responsibilities are summarised in Appendix III and IV.

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

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 For the sake of clarity, certain significant matters are delegated to the Chief Executive, Executive Directors and their line managers.

Deleted: ¶
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….

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 Procurement Manager and/or Director of Finance 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 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 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 (e.g. 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 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 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 in line with the Retail Price Index (All items) and the Director of Finance shall recommend such changes to the Board for approval.

4.2. Authorisation of requisitions for Revenue Expenditure (inclusive of VAT)

Commented [KD1]: These are the updated amounts agreed July 2020 by board for Executive Directors/Deputy Directors

Authorised Signatory	Cash Reim-bursements	Using Procurement Processes	Not Using Procurement Processes	Call-off Requisitions	Virements
Joint CEO / Director of Finance/Chair with the Non-Executive Chair of the Performance and Finance Committee			500,000 <1,000,000		
Joint CEO / Director of Finance		Unlimited	200,000 to <£500,000	Unlimited	
Chief Executive or Director of Finance (solely) (Deputy CEO/Deputy Director of Finance as deputies)	-	<100,000	<200,000	Unlimited	Unlimited
Executive Director or Divisional Director	50	75,000	-	35,000	35,000
Deputy Director of Finance	50	100,000			
Divisional General Manager	50	50,000	-	20,000	20,000
Deputy Divisional General Manager	50	25,000			
Senior Divisional Nurse, Clinical Lead, Associate Medical Director or Functional Head	50	20,000	-	10,000	10,000
Matron/Service Manager	50	10,000	-	Unlimited	5,000
Ward or Departmental Manager	50	5,000	-	10,000	

Commented [GD(MCT2]: In the old one it was >£100,000* *whilst the requisition will physically be signed off by Joint CEO and Director of Finance and Strategic planning, the Board of Directors will be required to give formal approval for this, prior to sign off

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	Chief Information Officer
iii)	Consultancy Services	Chief Executive or Director of Finance
iv)	Telephones	Chief Information Officer

* whilst the requisition will physically be signed off by joint CEO and Director of Finance, 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 shall be consulted in all cases of doubt.

4.3.1 All proposals to lease assets must be approved by the Director of Finance.

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.

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) prior to authorisation.

Capital Authorised Signatories

Principal Purchase Requisitions			
Authorised Signatory	**Using Procurement Procedures £**	**Not Using Procurement Procedures £**	**Call-off requisitions £**
Buildings & Equipment Chief Executive jointly with Director of Finance, Chair and the Non-Executive Chair of the Performance and Finance Committee		500,000 to <1,000,000	
Joint CEO / Director of Finance	Unlimited	200,000 to <500,000*	
Chief Executive or Director of Finance (solely) (Deputy CEO/Director of Finance as deputies)	<200,000	<200,000	>100,000
Deputy Director of Finance	<100,000		
Divisional Director of Estates & Facilities	10,000 – 50,000	5,000	<100,000
Information Technology			
Chief Executive jointly with Director of Finance, Chair and the Non-Executive Chair of the Performance and Finance Committee		500,000 to <1,000,000	
Joint CEO and Director of Finance	Unlimited	100,000 to <500,000*	
Chief Executive or Director of Finance (solely) (Deputy CEO/Deputy Director of Finance as deputies)	<200,000	<200,000	>100,000
Deputy Director of Finance	<100,000		
Chief Information Officer	50,000	-	50,000
Medical Director	10,000 – 50,000	5,000	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, the Board of Directors will be required to give formal approval for this, prior to sign off.

Commented [GD(MCT3]: The amendments to the Scheme of Delegation earlier in the year only changed revenue. I have amended in line with the original but increased the limits that but in my view not approved

Commented [GD(MCT4]: In the old one this was £100,000* * whilst the requisition will physically be signed off by joint CEO and Director of Strategic Planning, the Board of Directors will be required to give formal approval for this, prior to sign off

Commented [GD(MCT5]: In the old one this was £100,000* * whilst the requisition will physically be signed off by joint CEO and Director of 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 Procurement 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 Procurement Manager and Ward/Department Manager. In the event of disagreement, the matter shall be referred to the Director of Finance for authorisation.

4.4.4 The Procurement 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.

Mid Cheshire Hospitals NHS FT

Section 5 Authorised Cheque Signatories

A **Cheques with a value of up to £5,000**

One of the following, jointly:

J Sumner	Chief Executive
R Favager	Director of Finance
R Davies	Deputy Director of Finance
C Birch	Accounts Manager
D Goff	Deputy Director of Finance, Financial Services

B **Cheques with a value greater than £10,000**

Two of the above of which at least one must be as follows:

J Sumner	Chief Executive
R Favager	Director of Finance
D Goff	Deputy Director of Finance, Financial Services
R Davies	Deputy Director of Finance

C **Authorisation of Payroll Advances**

J Sumner	Chief Executive
R Favager	Director of Finance
D Goff	Deputy Director of Finance, Financial Services
R Davies	Deputy Director of Finance, Head of Business Intelligence
H Barnett	Director of Workforce and OD
S Conroy	Head of Financial Services and Strategic Developments

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	SO 9
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	
d) Approval of rent based on professional assessment	Director of Finance	SFI 7
3. Audit		
a) Provide independent and objective view on internal control and probity	Audit Committee	SFI 2
b) Provide adequate internal audit service	Director of Finance	
c) Review, evaluate and report on internal financial control	Director of Finance	
d) Review, appraise and report in accordance with NHS Internal Audit Manual and best practice		
e) Ensure cost-effective external audit		
4. Board & Meetings		
a) Final Authority in interpretation of SOs	Chairman	SO 2.1
b) Calling meetings	Board of Directors & Chairman	SO 4.2

c) Notice of Meetings	Chairman	SO 4.3
d) Chair all board meetings and associated responsibilities	Chairman	SO 4.5
e) Setting agendas for meetings	Chairman	SO 8.9
f) Interpretation of SFIs	Chairman	SFI 1
5. Budget Management		
i. Submit budgets to the Board.	Director of Finance	SFI 4
ii. Monitor performance against budget, submit to Board financial estimates and forecasts.	Director of Finance	
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	
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	SFI 12.1.3
c) Submit bids for capital funds not in Capital Programme to the Board	Director of Finance	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	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	SFI 12.3 & SofD 4.3

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	SFI 12.2
7. Clinical Trials – Authorisation	Medical Director after taking advice from Director of Finance on costs and reimbursement	SO 13.44 – 13.45
8. Condemning & Disposal		
a) Condemning Officer		SFI 14
i) Medical equipment	EBME Chief Medical Technical Officer	
ii) Computer equipment	IT Support Manager	
iii) Drugs	Director of Pharmacy & Medicines Management	
iv) All other	Divisional Director of Estates & Facilities	
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	Procurement Manager	
ii) with current purchase new price >£5000	Director of Finance	
9. Drugs (New) – Authorisation		SFIs Section 10.3
- Estimated total yearly cost up to £25,000	Clinical Lead	
- Estimated total yearly cost above £25,000	Safe Medicines Committee and referred to EMB for information	
10. Engagement of Trust's Solicitors	Company Secretary	
11. Extended Role Activities		Nurse/Midwives/ Health Visitors Act Midwives Rules / Code of Practice
Approval of Nurses to undertake duties / procedures which can properly be described as beyond the normal scope of Nursing Practice.	Director of Nursing & Quality	

		NMC Code of Professional Conduct
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 pro 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	
c) Annual Accounts– preparation	Director of Finance	SFI 5.1
d) Annual Reports preparation	Company Secretary	
e) Banking arrangements	Director of Finance	SFI 6.1.1
f) Prompt payment of accounts	Director of Finance	SFI 12.2.2 & 12.2.3
g) Advise Board on borrowing and investment needs and prepare procedural instructions	Director of Finance	SFI 11
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	SFI 12.3.8
j) Responsible for accuracy and security of computerised financial data	Director of Finance	SFI 15

15.	**Financial Policies & Procedures & Records**		
a)	Implementing the Trust's financial policies and coordinating corrective action and ensuring detailed financial procedures and systems are prepared and documented.	Director of Finance	SFI 1.3.8
b)	Provision of financial advice.	Director of Finance	
b)	Form and adequacy of financial records of all departments	Director of Finance	SFI 1.3.8
c)	Review, evaluate and report on internal financial control	Director of Finance	SFI 2.1
d)	Income systems and debt recovery	Director of Finance	SFI 7
e)	Advise the Board on level of delegation of non-pay expenditure to budget managers	Director of Finance	SFI 1.12 & SofD 4.3
f)	Maintain lists of managers with authority levels	Director of Finance	SofD 4.2 & 4.3 SFI 10.1
g)	Authorise who may use and be issued with official orders	Director of Finance	SFI 10.2.5
h)	Maintenance of asset registers	Director of Finance	SFI 12.3
i)	Calculate capital charges and pay dividends in accordance with DOH requirements	Director of Finance	SFI 12.3.8
j)	Approval of asset control procedures	Director of Finance	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
l)	Responsible for systems of control over stores & receipt of goods	Director of Finance	SFI 13.2 & 13.4
m)	Responsibility for the control of stores in accordance with Director of Finance guidance	Departmental/Ward Managers	SFI 13.2
n)	Identify persons authorised to requisition and accept goods from Procurement stores or NHS SUPPLY CHAIN regional stores	Director of Finance	SFI 13.3 SFI 18.1

o) Retention of document procedures - clinical - other	Medical Director and Deputy Chief Executive Director of Finance	
16. Fire Precautions – review	Director of Finance	
17. Fraud & Theft a) Investigate any suspected cases of fraud or other irregularity	Local Counter Fraud Specialist and Director of Finance	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	
18. Hospitality – Authorisation	Director of Finance	SO 8
19. Infectious Diseases & Notifiable Outbreaks	Senior Manager on call, or Infection Control Lead	
20. Insurance Policies	Director of Finance	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).	Director of Finance	SFI 17
22. Losses, Write-off & Compensation		
a) For general condemnation, losses and special payments	See Sch II SFIs	
b) For clinical negligence and personal injury claims to public up to £100,000 (negotiated settlements) where cost to the Trust is <£20,000	Director of Nursing & Quality	
c) For all other clinical negligence claims and personal injury claims from the public	Chief Executive	
d) For personal injury claims to staff Up to £10,000 (including plaintiff's costs)	Director of Workforce and Organisational Development	

	e) For personal injury claims from staff above £10,000	Chief Executive	
23.	**Maintenance / Operation of Bank Accounts**	Director of Finance	SFI 6
24.	**Patients & Relatives Complaints**		
	a) Overall responsibility for ensuring that all complaints are dealt with effectively	Director of Nursing & Quality	
	b) Responsibility for ensuring complaints relating to a directorate are investigated thoroughly.	Divisional Clinical Lead	
	c) Legal Complaints Co-ordination of their management.	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	SFI 16.3
26.	**Workforce, Employment Pay & Pensions**	Director of Workforce and Organisational Development	SFI 9.3.1 (a)
	a) Nominate officers to enter into contracts of employment, regrading staff, agency staff or consultancy service contracts		
	b) To ensure all employees and Directors, present and future, are notified of and receive appropriate training on the Corporate Governance Framework Manual	Director of Finance	SFI 9.5.1 (a)
	c) To ensure there are procedures for agreeing objectives for all staff carrying out staff appraisals and identifying development needs	Director of Workforce and Organisational Development	SFI 9.5.2
	d) Appointments & Remuneration Committee to be established	Board of Directors	
	e) Proposals for setting of remunerations and conditions of service for all employees.	Director of Workforce and Organisational Development	SFI 9.5.3

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	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	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	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 and Director of Workforce and Organisational Development	SFI 9.3.2
	iii) booking of Bank or Nurse Agency Staff	Nurse Bank Coordinator	
	iv) Medical Locums and Medical Agency Staff	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) Upgrading & Regrading 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) Pay		
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 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) Leave		
i) Approval of annual leave		
Medical staff	Clinical Leads	
- Clinical Leads	Divisional Director	
- Divisional Directors	Line Manager	
- All other staff	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	
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	Line Manager	
- paternity leave		
- carers leave	Line Manager	
- up to 3 days		
- over 3 days	Executive Director, Divisional Clinical Lead	
	Divisional Clinical Lead, Executive Director	
vii) Leave without pay in line with Trust policies		
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	
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 & 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	
v) <u>Redundancy</u>	Chief Executive on the advice of the Director of Finance 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 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	

x) Dismissal	Executive Director	Disciplinary Procedures
y) Fit and Proper Person Requirements	Director of Workforce and Organisational Development	
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	
z) Injury Benefit	Divisional Heads of Nursing, Divisional General Managers, Divisional Clinical Leads	
i) Temporary Injury Allowance	Executive Director	
ii) TIA Appeal	Divisional Heads of Nursing, Divisional General Managers, Divisional Clinical Leads	
iii) Permanent Injury Allowance	Executive Director	
v) PIA Appeal		
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	SFI 12.4.1
c) Responsibility for security of Trust assets including notifying discrepancies to DOF, and reporting losses	All Managers & Staff	SFI 12.4.3
in accordance with Trust procedure	Director of Finance	SFI 12.4.8
d) Insurances		
28. Provisions of Services		
a) Negotiating Service Agreements	Chief Executive	SFI 8
after taking advice from …….	Director of Finance	
b) Submission of Service Agreements to Board	Chief Executive	

c) Reporting of changes to Service Agreements >£100,000 to the Board	Chief Executive	SFI 8
d) Reporting of changes to Service Agreements <£100,000 to the Board	Chief Executive	
e) Monitoring Reports to the Board on Service Agreements		
- Financial	Director of Finance	
- Other	Director of Finance	
f) Arrangements for payment of NHS contracts and Out of Area Treatments (OATs)	Director of Finance	
g) Varying prices from the national tariff	Director of Finance	
h) Variation of operating and clinic sessions within existing numbers	Divisional Clinical Lead	
- Outpatients	Divisional Clinical Lead	
- Theatres	Divisional Clinical Lead	
- Other		
NB Income or cost changes will require a business case to be considered by the Board		
i) All proposed changes in bed allocation and use		
- Temporary Change	Chief Operating Officer and	
- Permanent Change	Divisional Clinical Lead	
NB An executive director must be informed before such changes take effect.		
j) Private Patient, Overseas Visitors, Income Generation and other patient related services	Director of Finance or Nominated Deputy	
k) Price of NHS Contracts Calculation of charges for all NHS Contracts, be they block, cost per case, cost and volume, spare capacity.	Director of Finance	

29. Quotation, Tendering & Contract Procedures		
a) Best value for money is demonstrated for all services provided under contract or in-house	Chief Executive	SFI 10.2
b) Demonstrate that the use of private finance represents best value for money	Director of Finance	
c) Nominate an officer to oversee and manage the contract on behalf of the Trust	Chief Executive	
d) Officer responsible for procuring goods and services		
• Capital Building Contracts (major jobs)	Director of Estates	
• Adhoc Building Contracts (small jobs)	Director of Estates	
• Medicines	Director of Pharmacy & Medicines Management	
• All other goods and services	Director of Finance	
e) Officer responsible for ensuring all procurement is in line with Standing Orders and Public Procurement (Amendment etc.) (EU Exit) Regulations 2020	Director of Finance	
f) Approve and sign all building, engineering, property or capital documents	Chief Executive & Director of Finance	
g) Advise the Board, level of delegation of non-pay expenditure to budget managers	Director of Finance	
h) Advise on best value for money)Authorise who may use and be issued with official orders	Procurement Manager Director of Finance	
i) Discretionary expenditure up to value of £15,000 exclusive of VAT	Ward or Departmental Manager, Matrons, Service Managers, Clinical Leads, Divisional General managers, divisional Clinical Leads	

j) Between £15,000 - £25,000 excluding VAT – Minimum of 2 written quotes required to demonstrate Value For Money, These can be formal written supplier quotes or informal supplier emails specifying costs. If these cannot be sourced a Single Tender Action will be required	Procurement Manager
k) For expenditure between £25,000 excluding VAT to Public Procurement threshold £122,976 excluding VAT a formal tender is required. A formal tender is a tender via the Procurement Tendering platform which is locked until tender closure and fully auditable. With the exemption of the following: • Direct award through a compliant framework - a framework compliant with NHS Bodies. *NB: Where a single supplier compliant framework is available the service must aim to ensure value for money via a formal or non-formal benchmarking exercise before award. If value is not proven, then a framework mini competition route or Single Tender Action will be required.* • An award following a mini competition exercise through a compliant framework – a framework compliant with NHS Bodies where the most advantageous supplier has been chosen. Please note a Single Tender Action will be required where the award is not given to the top scoring supplier after the competition exercise.	Procurement Manager
l) Above £122,976 excluding VAT a Find a Tender must be undertaken. With the exemption of the following: • Direct award through a compliant framework - a framework compliant with NHS Bodies.	Procurement Manager

NB where a single supplier compliant framework is available the service must aim to ensure value for money via a formal or non-formal benchmarking exercise before award. If value is not proven then a framework mini competition route, OJEU route or Single Tender Action will be required. • An award following a mini competition exercise through a compliant framework – a framework compliant with NHS Bodies where the most advantageous supplier has been chosen. *NB. a Single Tender Action will be required where the award is not given to the top scoring supplier after the competition exercise*. m) Expenditure between NHS bodies will be exempt from the tendering process at any value. *UK Public sector bodies will be exempt from the tender process up to the value of £75,000 inclusive of VAT but above £75,000 including VAT the SFI tendering process above is enforced.* *Public Sector bodies may include: -* • *Universities and Colleges* • *Ministry of Defense* • *UK Councils* • *National Institute of Clinical Excellence* *In exceptional circumstances at that time a decision may be made to approve by the Director of Finance or Deputy Director of Finance.* *A single tender action will be required if any of the above are not being met.*	Procurement Manager	

The Public Procurement limit for £122,976 excluding VAT is for Supply, Services and Design Contracts. The SFIs apply to revenue, capital, leases, endowment and charitable funds. All formal and Fina a Tender will be conducted through a locked and auditable tender portal where all supplier tender submissions will only be released and visible by Procurement after the formal tender deadline has been passed. Framework contracts are contracts that have been put in place by national or regional organisations following an Public Procurement procedure. Therefore, by utilising these contracts the Trust automatically ensures compliance with SFI's. However, it should be noted that a direct award to one supplier is not always possible and further competition is often required (i.e. essentially a mini-tender). This also ensures the Trust will achieve value for money. Frameworks must explicitly state can be used by NHS Bodies for compliance purposes. The value of any contract must be calculated over the whole life of a contract – for instance a 3 year contract at £15,000 per year has a value of £45,000. It is not permissible to try and break down a requirement into smaller constituent requirements in order to by-pass the constraints imposed by the above SFI thresholds. Public Procurement Works Contracts has an Public Procurement threshold of £4,733,252 excluding VAT. Works Contracts are those Major Capital projects managed solely by the Trust's Estates Department which fall outside Supply, Services and Design contracts threshold of £122,976 excluding VAT. Any concerns over thresholds please speak to the Procurement Department for clarity.		

30. Relationships with Press a) Non-Emergency General Enquiries - Within Hours - Outside Hours b) Emergency - Within Hours - Outside Hours	Associate Director of Communications 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 Director of Finance 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
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	Chief Information Officer	
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 b) Maintaining sound system of internal control	 Board of Directors Chief Executive	

	c) Implementing systems of risk management and prepare procedures	Chief Executive	
	d) Maintaining systems of risk management	Chief Executive	
	e) Ensuring that all staff have risk management responsibilities in employment contracts, job descriptions and objectives	Director of Workforce and OD	
	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) Objective view on internal control independent of executive and line management	Audit Committee.	
	j) Recommend Risk Management Strategy & Framework	Chief Executive	
	k) Prioritising risk and recommendation to Board for resources	Chief Executive	
	l) Annual Review of Risk Management Strategy & Framework	Chief Executive	
	m) Annual Risk Management Plan to prepare and to include staff information, instruction and training	Chief Executive	
	n) Verification that internal control exists	Internal Auditors	
	o) Recommend Complaints Policy to Board	Director of Nursing & Quality	
	p) Reporting complaints and claims regularly to the Board	Director of Nursing & Quality	
	q) Recommend Patient/User Involvement Policy to the Board	Director of Nursing & Quality	
	r) Annual Review of Patient/User Involvement Policy	Director of Nursing & Quality	
	s) Patient Surveys – review and evaluate data	Director of Nursing & Quality	
38.	**Sponsorship deals – Authorisation**	Director of Finance	CC 2.14 – 2.16
39.	**Trust Strategy**		
	a) Compile and submit to the Board a Trust Strategy	Chief Executive	SFI 4.1.1

40. The keeping of Registers.		
a) Register(s) of Director's interest	Company Secretary	SO 8
b) Register of staff interests	Director of Finance	CC 2.2 - 2.7
c) Register of offers of hospitality or gifts	Director of Finance	CC 2.5 -2.8
c) Register of commercial sponsorship	Director of Finance	CC 2.14 – 2.16
d) Register of Outside Employment (including Private Practice)	Director of Finance	CC 2.11 - 2.12 CC for Priv. Prac.
e) Register of Patents and Intellectual Property	Director of Finance	CC 2.17
g) Register of Donations	Director of Finance	CC 2.13
41. The keeping of a register of Sealings		SO 9
a) Keep seal in a 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	
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	
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	
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	

Appendix VII

Codes of Conduct

Contents

1. Codes of Conduct for the Board and Staff

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
- 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
- share their learning and development with others.

1.12 Directors and managers will follow the codes of conduct and ethics of their own profession with due regard to the Nolan Principles and the NHS Managers Code of Conduct 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
- 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

2.1 Bribery and Fraud

2.1.1 Bribery

Bribery and corruption involve offering, promising or giving a payment of benefit-in-kind in order to influence others to use their position in an improper way to gain an advantage.

The Bribery Act 2010 came into force on 1 July 2011 to provide an effective legal framework to combat bribery in the public or private sectors. The main changes brought about by the Act are as follows:

- Replacing the complex system of offences under common law and in the Prevention of Corruption Acts 1889-1916.
- Creating two general offences covering the offering, promising or giving of an advantage, and requesting, agreeing to receive or accepting an advantage.
- Creating a new offence of failure by a commercial organisation to prevent a bribe being paid for or on its behalf.
- The Bribery Act 2010 creates a new offence under section 7 which can be committed by commercial organisations which fail to prevent persons associated with them from bribing another person on their behalf. The Trust is classed as a commercial organisation for the purposes of the Act. Mid Cheshire expects all employees to act appropriately when conducting business on its behalf and declare relevant commercial interests.

2.1.2 Fraud

Fraud involves dishonestly making a false representation, failing to disclose information or abusing a position held, with the intention of making a financial gain or causing a financial loss.

The Fraud Act 2006 brought in three offences relating to ways in which fraud can be committed. It is no longer necessary to prove that a person has been deceived. The focus is now on the dishonest behaviour of the suspect and their intent to make a gain or cause a loss.

The new offence of fraud can be committed in three ways:

- Fraud by false representation (s.2) – lying about something using any means, e.g. by words or actions
- Fraud by failing to disclose (s.3) – not saying something when you have a legal or contractual duty to do so
- Fraud by abuse of a position of trust (s.4) – abusing a position where there is an expectation to safeguard the financial interests of another person or organisation.

It should be noted that all offences under the Fraud Act 2006 occur where the act or omission is committed dishonestly and with intent to cause gain or loss to the organisation. The gain or loss does not have to succeed, so long as the intent is there.

The Trust has an Anti-fraud, Bribery and Corruption Policy which outlines the roles and responsibilities for the prevention and detection of fraud, bribery and corruption within Mid Cheshire Hospitals NHS Foundation Trust.

2.1.3 Principles of Conduct

The Chief Executive, Company Secretary and Director of Finance 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 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 to 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
- declare and record any financial or personal interest (e.g. 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 be 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 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.

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 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 or the Chief Executive.

Staff should use a commonsense approach to make a reasonable estimate to the value of any hospitality.

Staff shall advise the Director of Finance of all other offers of gifts, hospitality or entertainment and shall politely but firmly decline. If in doubt, they should seek advice from the Company Secretary or the Director of Finance.

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 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.

Staff should complete the Declaration of Interest form using the Declaration of Interest app which can be found on the intranet if they think they may have an interest.

The Director of Finance shall establish systems to communicate this requirement to staff and inform the Chief Executive if there are any interests.

The Director of Finance shall introduce whatever measures he considers necessary to ensure that the Trust's interests and those of patients are adequately safeguarded.

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 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 or vouchers 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.

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.

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.

2.8 Donations

Acceptance of donations made by suppliers or bodies seeking to do business with an organisation should be treated with caution and not routinely accepted. In exceptional circumstances a donation from a supplier may be accepted but should always be declared. A clear reason should be recorded as to why it was deemed acceptable, alongside the actual or estimated value.

Staff should not actively solicit charitable donations unless this is a prescribed or expected part of their duties for the Mid Cheshire Hospitals Charity or other charitable body and is not for their own personal gain. Staff must obtain permission from their organisation if in their professional role they intend to undertake fundraising activities on behalf of a pre-approved charitable campaign.

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.

Employees should not engage in any employment whilst off sick or while suspended from employment.

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).

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.

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, 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
- where the event or meeting will result in a clear benefit for the organisation and the NHS
- the Director of Finance 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, 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. 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 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 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 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 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 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. There will be situations when interests will not be identified, declared or managed appropriately and effectively. This may happen innocently, accidentally, or because of the deliberate actions of staff or other organisations. For the purposes of this code of conduct these situations are referred to as ‘breaches’.

Staff who are aware about actual breaches of this policy, or who are concerned that there has been, or may be, a breach, should report these concerns to any of the following:

- Russ Favager, Director of Finance and Strategic Planning: (01270) 273760
- Philip Leong Local Counter Fraud Specialist, Mersey Internal Audit, (0151) 285 4531
- Katharine Dowson, Head of Corporate Governance (01270) 612128

- To ensure that interests are effectively managed staff are encouraged to speak up about actual or suspected breaches. Ever individual has a responsibility to do this. For further information about how concerns should be raised refer to the Freedom to Speak up /Raising Concerns Policy and Procedure.

The organisation will investigate each reported breach according to its own specific facts and merits and give relevant parties the opportunity to explain and clarify any relevant circumstances.

Following investigation, the organisation will:

- Decide if there has been or is potential for a breach and if so the what severity of the breach is.
- Assess whether further action is required in response – this is likely to involve any staff member involved and their line manager, as a minimum.
- Consider who else inside and outside the organisation should be made aware
- Take appropriate action as set out in the next section.

The Chairman and Directors shall be responsible for taking firm, prompt and fair disciplinary action against any Executive Director or staff member 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.

Action taken in response to breaches of this policy will be in accordance with the disciplinary procedures of the Trust and could involve organisational leads for staff support (e.g. Human Resources), fraud (e.g. Local Counter Fraud Specialists), members of the management or executive teams and organisational auditors.

Breaches could require action in one or more of the following ways:

- Clarification or strengthening of existing policy, process and procedures
- Consideration as to whether HR/employment law/contractual action should be taken against staff or others
- Consideration being given to escalation to external parties. This might include referral of matters to external auditors, NHS Protect, Police, statutory health bodies (such as NHS England, NHS Improvement or the CQC), and/or health professional regulatory bodies.

Inappropriate or ineffective management of interests can have serious implications for the organisation and staff. There will be occasions where it is necessary to consider the imposition of sanctions for breaches.

Sanctions should not be considered until the circumstances surrounding breaches have been properly investigated. However, if such investigations establish wrong-doing or fault then the organisation can and will consider the range of possible sanctions that are available, in a manner which is proportionate to the breach. This includes:

- Employment law action against staff, which might include
    - Informal action (such as reprimand, or signposting to training and/or guidance)
    - Formal disciplinary action (such as formal warning, the requirement for additional training, re-arrangement of duties, re-deployment, demotion, or dismissal)
- Reporting incidents to the external parties described above for them to consider what further investigations or sanctions might be
- Contractual action, such as exercise of remedies or sanctions against the body or staff which caused the breach
- Legal action, such as investigation and prosecution under fraud, bribery and corruption legislation.

Reports on breaches, the impact of these, and action taken will be considered by the Audit Committee at the next meeting following a breach. To ensure that lessons are learned and management of interests can continually improve, anonymised information on breaches, the impact of these, and action taken will be prepared and published on the Trust website, or made available for inspection by the public upon request.

Breaches by the Chairman, Governors or Non-Executive Directors shall be brought to the attention of the Council of Governors.

2.21 Freedom to Speak up Guardian (Whistleblowing)

Staff are encouraged through to speak up and report any behaviours that are contrary to this code of conduct especially if it presents a risk to patient care.

The Head of Nursing for Emergency Preparedness is the Trust's Freedom to Speak up Guardian and as such is responsible for putting into place a variety of ways by which staff can report concerns and for developing a culture of openness within the Trust. Raising concerns is a positive action and staff will be listened to and concerns acted upon.

Staff should refer to the Freedom to Speak Up/ Raising Concerns Policy or concerns can be reported through a variety of methods including:

- Employee Support Advisors
- Freedom to Speak up Guardian
- Line Managers
- Incident reporting system
- Confidential Staff Support Voicemail – 01270 612**2118**

2.22 Audit

The Director of Finance shall set up systems to monitor the requirements of 2 – Standards of Business Conduct and Declaration of Interest and will include a review of this in the Internal Audit Plan at regular intervals.

3. 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.

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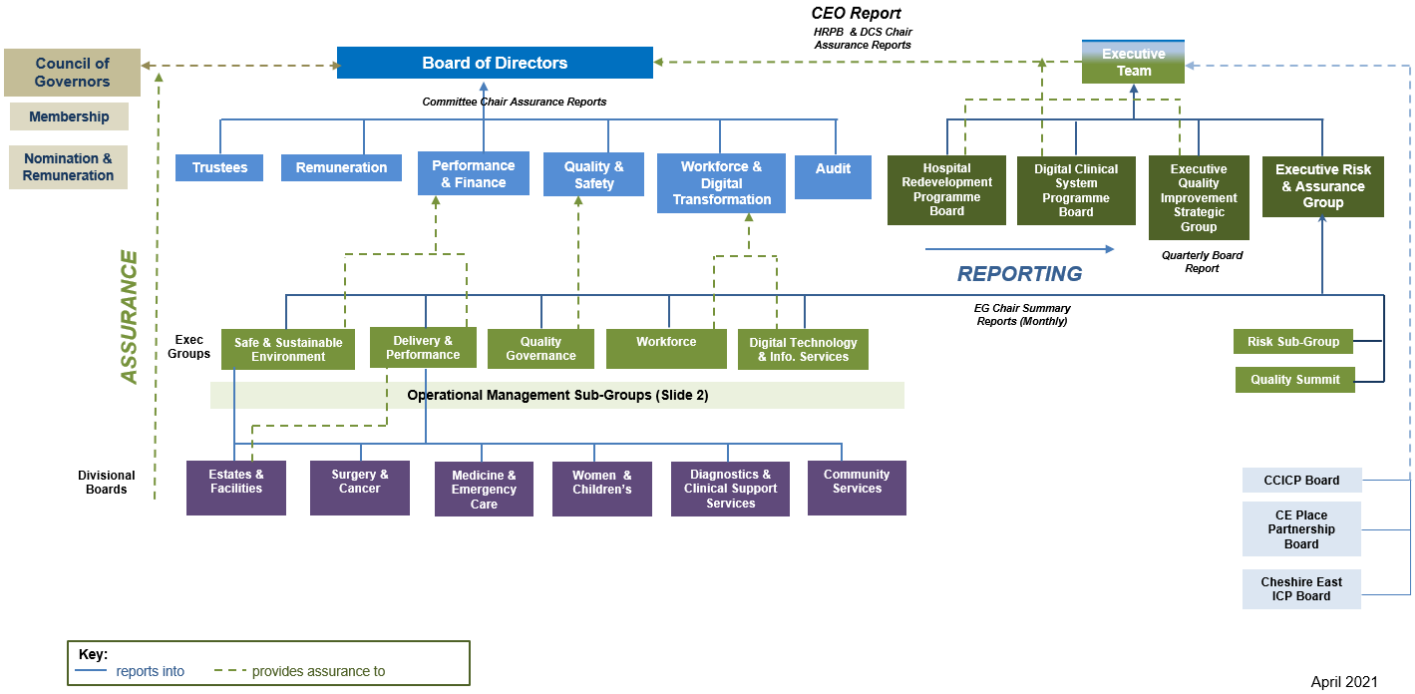
MCHFT Governance Structure



April 2021

Mid Cheshire Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

Agenda Item	**15**	Date of Meeting: 29/04/2021
Report Title	Annual Board Committee Effectiveness Evaluation 2020/21	
Executive Lead	Caroline Keating, Company Secretary	
Lead Officer	Katharine Dowson, Head of Corporate Governance	
Action Required	To note	

X **Acceptable assurance** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐ **Partial assurance** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Low assurance** Evidence indicates poor effectiveness of controls

Key Messages of this Report *(2/3 headlines only)*

- The evaluation process demonstrates that the Board Committee system is working effectively
- Committees have agreed their Terms of Reference and assessed their workplans for 2021/22

Next Steps (*actions to be taken following agreement of recommendation/s by Board/Committee)*

- None.

Strategic Objective(s) *(indication of which objective/s the report aligns to)*

• Manage Covid response and recovery	☐	• Provide safe and sustainable services	☐
• Provide outstanding care/patient experience	☐	• Provide strong system leadership by working together	☐
• Deliver most effective care to achieve best possible outcomes	☐	• Be well governed and clinically led	✓
• Be the best place to work	☐		

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

• Quality	☐	• Compliance	☐ ☐
• Finance	☐	• Legal	
• Workforce	☐	• Risk/BAF **BAF19 Governance systems and risk assurance**	
• Equality	☐		

Equality Impact Assessment (*must accompany the following submissions)*

Strategy ☐ Policy ☐ Service Change ☐

REPORT DEVELOPMENT

Committee/ Group Name	Date	Report Title	Lead	Brief summary of key issues raised and actions agreed
Audit Committee	14.01.21	Board Committee Effectiveness & Performance Review	Caroline Keating	Approval of revised process for Committee Reviews
Quality and Safety Committee	17.03.21	Annual Committee Effectiveness Evaluation	Katharine Dowson	Received and noted evaluation report
Performance and Finance Committee	18.03.21	Annual Committee Effectiveness Evaluation	Katharine Dowson	Received and noted evaluation report
Workforce and Digital Transformation Committee	22.03.21	Annual Committee Effectiveness Evaluation	Katharine Dowson	Received and noted evaluation report
Audit Committee	15.04.21	Annual Committee Effectiveness Evaluation	Katharine Dowson	Received and noted

Annual Evaluation of Board Committee Effectiveness 2020/21

Introduction

1. The Trust needs to be confident that each Board Committee is discharging the duties delegated to it by the Board of Directors and that the Board Committees are fulfilling their responsibilities appropriately. Best practice requires committees and groups to have robust terms of reference (ToR) that are reviewed at least annually to ensure they remain relevant and up to date and match the focus and workplan of each committee. The Board of Directors reviews these annually as part of its annual review of the Corporate Governance Handbook (now renamed Corporate Governance Framework Manual).

2. The Audit Committee supports this assessment by reviewing whether the committee structure is working appropriately as part of the system of internal control. It does this by receiving regular reports on the work of the Committees and the assurances provided by them as well as reviewing the annual overview of performance for the other three Board committees. This report also incorporates the findings and themes from the Audit Committee's own evaluation of its effectiveness.

3. The Committees covered by this report are:

   - Performance and Finance (PAF) Committee
   - Quality and Safety (Q&S) Committee
   - Workforce and Digital Transformation (WDT) Committee
   - Audit Committee (AC)

Evaluation Process

4. In January 2021, the Audit Committee agreed a revised approach to committee evaluation, following best practice and guidance. This involved the following stages:

   - Survey of members' views on the effectiveness of each Committee which included proposals for areas of focus for 2021/22
   - Desk top review conducted by Corporate Governance of the extent to which each Committee has followed its workplan and fulfilled the duties set out in the ToR, identifying any areas omitted from the workplan
   - A review at each Committee of the findings of the survey and discussion of the key areas of focus
   - A review at each Committee of the ToR and appropriate revisions
   - A review at each Committee of the workplan for 2021/22, incorporating any areas of focus.

Key Themes & Findings

5. Across the Committees, there were a number of key themes:

   - Greater focus required on strategic, rather than operational detail

- New risk management process welcomed, recognised as a work in progress and further work required to embed a risk and assurance approach
- More challenge required at Committee level from Directors
- Committees have found this annual process useful and three of the Committees have planned in-depth sessions to focus on the findings and consider how to take them forward.

6. Through the desk top reviews, evidence was provided to demonstrate that the Committees had each fulfilled their ToR and addressed all areas delegated to them. The only exception to this was Q&S where further work was required so that the Committee receives sufficient assurance about how the Trust ensures it is meeting all requirements for CQC registration. A new programme of reporting is being established for 2021/22 to provide this assurance.

Next Steps

7. Terms of Reference to be approved by the Board of Directors

8. Each Committee is finalising its workplan for 2021/22 and will revisit their Terms of Reference once the new principal risks and Trust Strategy are approved and the impact on Committees has been reviewed.

9. The Board Development Programme for 2021/22 will incorporate any relevant areas identified through the Committee evaluation process.

Conclusion

10. The system of Board Committees is working well and addressing the appropriate areas, as delegated to them by the Board of Directors. The Committees are agreed that their Terms of Reference are correct, their workplans reflect the appropriate areas to provide assurance and that their duties were fulfilled in 2020/21, with the one exception in Para 6 above which is being addressed.

11. Each Committee has taken the opportunity to consider its own performance and identified areas of improvement which will be taken forward in 2021/22.

Recommendation

12. The Board of Directors notes the completed evaluation process and findings of the review which demonstrate that the system of Board Committees is working appropriately.

13. The Board of Directors approves the amended Terms of Reference for Board Committees. These are submitted as Appendix I of the Corporate Governance Framework Manual.

Author: Katharine Dowson, Head of Corporate Governance
Date: 19 April 2021

BOARD OF DIRECTORS

Agenda Item	**CO1**	Date of Meeting: 29/04/2021
Report Title	**Trust Constitution**	
Executive Lead	Caroline Keating, Company Secretary	
Lead Officer	Katharine Dowson, Head of Corporate Governance	
Action Required	To approve	

X **Acceptable assurance** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐ **Partial assurance** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Low assurance** Evidence indicates poor effectiveness of controls

Key Messages of this Report *(2/3 headlines only)*

- Changes to the constituency borders and the removal of the Patient/Carer constituency were approved at the Board of Directors meeting on 25 March 2021. These have now been enacted into the Constitution for ratification.

Next Steps (*actions to be taken following agreement of recommendation/s by Board/Committee)*

- Constitutional changes to be ratified at the Annual Members Meeting in October.

Strategic Objective(s) *(indication of which objective/s the report aligns to)*

• Manage Covid response and recovery	☐	• Provide safe and sustainable services	☐
• Provide outstanding care/patient experience	☐	• Provide strong system leadership by working together	☐
• Deliver most effective care to achieve best possible outcomes	☐	• Be well governed and clinically led	✓
• Be the best place to work	☐		

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

• Quality	☐	• Compliance	☐
• Finance	☐	• Legal	☐
• Workforce	☐	• Risk/BAF **BAF19 Governance systems and risk assurance**	
• Equality	☐		

Equality Impact Assessment (*must accompany the following submissions)*

Strategy ☐ Policy ☐ Service Change ☐

REPORT DEVELOPMENT

Committee/ Group Name	Date	Report Title	Lead	Brief summary of key issues raised and actions agreed
Council of Governors	14/01/21	Constituency Changes	K Dowson	Further review of options requested and of impact on membership activities
Membership and Communications Committee	08/02/21	Membership Engagement Plan	K Dowson	Agreed that strategy was still applicable and relevant if constitution changes agreed
Extra Ordinary Council of Governors	02/03/21	Constitution Changes	K Dowson	Approved, pending approval by Board of Directors
Board of Directors	25/03/21	Constitution Changes	K Dowson	Approved, pending ratification at Annual Members Meeting and approval of updated Constitution document
Council of Governors	08/04/21	Trust Constitution	K Dowson	Approved updated Trust Constitution pending ratification at Annual Members Meeting and approval at Board of Directors

Trust Constitution
Changes to the Constitution

Introduction

1. The Trust Constitution sets out the rules and principles by which the Trust's governance structures are defined. Periodically this is reviewed to ensure it reflects changes in legislation and practice and continues to meet the needs of the Trust. A full legal review took place in July 2018 to provide assurance that the constitution continued to meet statutory and legislative guidance. In July 2020, minor updates were made and approved.

2. In November 2020, the Nomination and Remuneration Committee recommended that the eligibility for Non-Executive Director (NED) appointments should be widened to include neighboring areas outside of Cheshire in an effort to widen the diversity of candidates. This was in line with the Board's commitment to widening the diversity of the Board. The changes also reflected a recognition of the changing system landscape, with proposed legislative changes in prospect, which would create an Integrated Care System across Cheshire & Merseyside.

3. Following a period of discussion and engagement these changes, along with the removal of the patient and carer constituency, were approved at the Council of Governors on 2 March 2021 and Board of Directors on 25 March 2021. On 8 April 2021 the Council of Governors approved this updated version of the Trust Constitution.

Changes to the Constitution

4. The full Constitution with tracked changes is in Appendix I, with substantive changes summarised in the table below.

Section	Page	Change Proposed	Reason
Standing Orders 5.1	6	**Membership and Constituencies:** Removal of 5.1.3 Patients and Carers' Constituency	This was an artificial distinction which was optional when the Trust became a Foundation Trust. This has been confusing for Members at election time.
Standing Orders 9	7	**Patients and Carers' Constituency:** Removal of section 9 defining this constituency. Renumbering of subsequent standing orders.	As above.
Standing Orders 22	11	**Trust Secretary:** Removal of requirement for Board of Directors and Council of Governors to approve the appointment/ removal	This is not a statutory requirement, the appointment is made by the Chief Executive in conjunction with the Chairman.

Section	Page	Change Proposed	Reason
Standing Orders 25.2	11	**Board of Directors: Qualification for Appointment as a Non-Executive Director:** Removal of Patient/Carer constituency as eligibility for being a Non-Executive Director	A Non-Executive Director must be a member of a Trust constituency and as the Patient & Carers' constituency is removed, the reference here has been updated.
Standing Orders 34	14	**Registers: Inspection and Copies:** Removal of reference to Patient/Carer constituency	No distinction now required between constituencies and general reference added about Register of Members
Annex 1	19 - 28	**The Public Constituency:** Expansion of Electoral Wards list	To include all wards who are eligible to become Trust Members
Annex 3	30	**The Council of Governors: Composition** **Elected Governors:** Public Constituency Names Changed, numbers of Governors changed.	To reflect new Constituency names and the removal of the Patient and Carers' Constituency. To confirm the changes to the number of Governors elected in each constituency
Annex 6	78	**Annex 6 – Council of Governors Standing Orders:** Updating of phrasing 7.38 Removal of reference to Patient and Carer Constituency	To reflect removal of Patient and Carers' Constituency
Annex 8 1.13 and 4.41	 105-106	**Further Provisions in Relation to Members** Removal of reference to Patient and Carers' Constituency	As above
Annex 9	109	**Glossary of Terms** Update to Constituency Definitions.	To exclude reference to Patient and Carers'

Recommendations

5. The Board of Directors is asked for its approval to:
   - Agree the new Constitution
   - recommend that the changes are presented for ratification at the Annual Members Meeting on 7 October 2021.

Author: Katharine Dowson, Head of Corporate Governance
Date: 19 April 2021

Appendix I

Mid Cheshire Hospitals NHS Foundation Trust

CONSTITUTION

Certified as a true and up to date copy

Signed: …….. Date ----------

Name: Caroline Keating

Position: Company Secretary

Version Control

Version	Date	Author	Changes
1	April 2008	-	-
2	April 2010	R Alcock	• Amendments to names of the Public Constituency to reflect changes in Borough Council • Removal of appointed Governor from Cheshire County Council and replaced by an appointed Governor from Cheshire East Council and Cheshire West & Chester Council • Removal of requirement for an appointed Governor from University Hospital of South Manchester NHS FT • Amendments to wording for Gifts & Bequests
3	December 2011	R Alcock	• To extend boundaries of Public Constituencies • To enable the PCT appoint a second Governor • To remove the GP Leads meeting as a Partnership Organisation able to appoint a Governor • Replace the Voluntary Action groups with 'Community and Voluntary Service Cheshire East and Cheshire Community Development Trust' as partnership organisations • Increase the number of Governors sitting on the Nominations & Remuneration Committee • Amendment to ways of advertising Annual Members' Meetings
4	March 2013	M Steele	Changes to reflect second commencement Order of the Health & Social Care Act 2012 which included reference to the Health & Social Care Act 2012 and amendments to • the principal purpose of the Trust • wording for Annual Report & Accounts to reflect changes relating to non-NHS Income • the definition of Monitor • whom the direction on the Annual Accounts is received
5	April 2014	M Steele	Following a full review of the Constitution, amendments were made to consider requirements under the Health & Social Care Act, Monitor's revised Model Constitution, current practice and advice from the Trust's Legal Advisors.
6	December 2014	M Steele & J Davies	• Inclusion of revised Model Election Rules • Changes to incorporate Fit and Proper Test
7	January 2016	L Hughes	Addition of 12.5 to allow elections to be held once a year for all vacancies to the Council of Governors.
8	October 2016	K Dowson	Addition of paragraph in Annex 3 to allow an additional temporary Staff Governors constituency to be appointed for up to 18 months following significant staff changes.

9	July 2017	K Dowson	Change to section 7.4 and Annex 8.1 to allow Volunteer Members to choose whether to move into the Volunteer constituency when they become eligible or to remain as a public Member.
10	April 2018	K Dowson	• Increase the number of Governors sitting on the Nominations & Remuneration Committee • To add additional categories to those not eligible to stand as Governors (Annex 5) • General review with legal advice from Hill Dickinson.
11	July 2020	C Keating	• To change the categories of Partnership Governors • To update the Standing Orders of the Trust • To allow for a Non-Executive Director's term to be extended for a maximum of 12 months in particular circumstances
12	April 2021	C Keating	• To change the Trust constituencies to include Members from neighbouring counties and metropolitan areas • To remove the Patient and Carers constituency

Contents

Annexes

1 Name

The name of the Foundation Trust is Mid Cheshire Hospitals NHS Foundation Trust (the Trust).

2 Interpretation and definitions

Unless otherwise stated, words or expressions contained in this constitution shall bear the same meaning as in the National Health Service Act 2006 as amended by the Health and Social Care Act 2012

Words importing the masculine gender only shall include the feminine gender; words importing the singular shall import the plural and vice-versa.

The **Accounting Officer** is the person who from time to time discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act.

Constitution means this constitution and all annexes to it.

Monitor is the body corporate known as Monitor, as provided by Section 61 of the 2012 Act.

The NHS Provider Licence is the Licence issued by Monitor to the Trust under Chapter 3 of Part 3f the 2012 Act.

A voluntary organisation is a body, other than a public or local authority, the activities of which are not carried on for profit.

the 2006 Act is the National Health Service Act 2006.

the 2012 Act is the Health and Social Care Act 2012.

3 Principal purpose

3.1 The principal purpose of the Trust is the provision of goods and services for the purpose of the health service in England.

3.2 The Trust does not fulfil its principal purpose unless, in each financial year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes.

3.3 The Trust may provide goods and services for any purposes related to:

3.3.1 the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and

3.3.2 the promotion and protection of public health.

3.4 The Trust may also carry on activities other than those mentioned in the above paragraph for the purpose of making additional income available in order to better carry on its principal purpose.

3.5 A supplementary purpose of the Trust is the provision of research and education for the purpose of the health service and related services in England and Wales.

4 Powers

4.1 The powers of the Trust are set out in the National Health Service Act 2006 (referred to hereafter as the 2006 Act) as amended by the Health & Social Care Act 2012 (referred to hereafter as the 2012 Act).

4.2 The powers of the Trust shall be exercised by the Board of Directors on behalf of the Trust.

4.3 Any of these powers may be delegated to a committee of directors, or to an executive director.

5 Membership and constituencies

5.1 The Trust shall have members, each of whom shall be a member of one of the following constituencies:

5.1.1 a Public Constituency; or

5.1.2 a Staff and Volunteers' Constituency~~; or~~

~~5.1.3 a Patients and Carers' Constituency~~

5.2 All membership is individual, and there shall be no facility for corporate membership, although an individual member of this Trust may also be a member of one or more other NHS foundation trusts. Members are not entitled to payment of any sort, or to preferential receipt of any healthcare provided by the Trust (see also **Annex 8**).

6 Application for membership

An individual who is eligible to become a member of the Trust may do so on application to the Trust at any time**.**

7 Public Constituency

7.1 An individual who lives in an area specified in **Annex 1** as an area for a Public Constituency may become or continue as a member of the Trust.

7.2 Those individuals who live in an area specified as an area for a Public Constituency are referred to collectively as a Public Constituency.

7.3 The minimum number of members in each Public Constituency is specified in **Annex 1**.

8 Staff and Volunteers Constituency

8.1 An individual who is employed by the Trust under a contract of employment with the Trust may become or continue as a member of the Trust provided that:

8.1.1 he is employed by the Trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months; or

8.1.2 he has been continuously employed by the Trust under a contract of employment for at least 12 months.

8.2 Individuals who exercise functions for the purposes of the Trust, otherwise than under a contract of employment with the Trust, may become or continue as members of the Staff and Volunteers' Constituency provided that such individuals have exercised these functions continuously for a period of at least 12 months. This would include an individual who is registered with the Trust to undertake individual voluntary work at premises, or in services managed by the Trust, or is registered with a voluntary organisation that is accredited by the Trust to undertake voluntary work at premises, or in services managed by the Trust.

8.3 Those individuals who are eligible for membership of the Trust by reason of the previous provisions are referred to collectively as the Staff and Volunteers' Constituency.

8.4 Individuals who meet the qualifying requirements for membership of the Staff and Volunteers' Constituency in 8.1 and 8.2, with the exception of the qualifying time periods, may become members of an alternative Constituency if they are eligible to do so, provided that they transfer to the relevant class of the Staff and Volunteers' Constituency when they have achieved the qualifying time periods defined in 8.1 or 8.2. The exception to this is registered volunteers who may choose to remain as members of an alternative constituency.

8.5 The Staff and Volunteers' Constituency shall be divided into seven descriptions of individuals who are eligible for membership of the Staff and Volunteers' Constituency, each description of individuals being specified within **Annex 2** and being referred to as a class within the Staff and Volunteers' Constituency.

8.6 The minimum number of members in each class of the Staff and Volunteers' Constituency is specified in **Annex 2**.

8.7 An individual who is:

8.7.1 eligible to become a member of the Staff and Volunteers' Constituency, and

8.7.2 invited by the Trust to become a member of the Staff and Volunteers' Constituency and a member of the appropriate class within the Staff and Volunteers' Constituency,

shall become a member of the Trust as a member of the Staff and Volunteers' Constituency and appropriate class within the Staff and Volunteers' Constituency without an application being made unless he informs the Trust that he does not wish to do so.

~~**9 Patients and Carers' Constituency**~~

~~9.1 An individual who:~~

~~9.1.1 is registered on the Master Patient Index maintained by the Trust, and who has, within the period specified below, attended any of the Trust's hospitals as a patient; or~~

~~9.1.2 is the principal carer of a patient defined in 9.1.1 above, other than as a requirement of a contract, whether paid or unpaid, with a statutory, voluntary or commercial agency, or as a volunteer for a voluntary organisation, and who has, within the period specified below, attended any of the Trust's hospitals as the carer of that patient may become or continue as a member of the Trust.~~

~~9.2 The period referred to above shall be the period of five years immediately preceding the date of an application by the patient or carer to become a member of the Trust.~~

~~9.3 Those individuals who are eligible for membership of the Trust by reason of the previous provisions are referred to collectively as the Patients and Carers' Constituency.~~

~~9.4 An individual providing care to a patient in pursuance of a contract (including a contract of employment), or as a volunteer for a voluntary organisation, does not come within the category of those who qualify for membership of the Patients and Carers' Constituency.~~

~~9.5 The minimum number of members in the Patients and Carers' Constituency is 250.~~

9~~10~~ Restriction on Membership

1~~9~~0.1 An individual who is a member of a constituency, or of a class within a constituency, may not while membership of that constituency or class continues, be a member of any other constituency or class. However, he may transfer existing membership of a constituency, or of a class within a constituency, to an alternative constituency, or of an alternative class within a constituency, of which he meets the qualifying membership criteria subject to paragraph 8.4.

1~~0~~9.2 The Trust Secretary shall, in accordance with the 2006 Act and the Constitution, determine the constituency and, where appropriate, the class within a constituency, of which an individual is eligible to be a member.

1~~0~~9.3 Further provisions as to the circumstances in which an individual may not become or continue as a member of the Trust are set out in **Annex 8.**

10~~1~~ Annual Members' Meeting

11~~0~~.1 The Trust shall hold an annual meeting of its members (Annual Members' Meeting). The Annual Members' Meeting shall be open to members of the public.

11~~0~~.2 Further provisions about the Annual Members' Meeting are set out in **Annex 8**.

12~~1~~ Council of Governors: Composition

11~~2~~.1 The Trust is to have a Council of Governors, which shall comprise both elected and appointed governors.

11~~2~~.2 The composition of the Council of Governors is specified in **Annex 3**.

11~~2~~.3 The members of the Council of Governors, other than the appointed members, shall be chosen by election by their constituency or, where there are classes within their constituency, by their class within that constituency. The number of governors to be elected by each constituency or, where appropriate, by each class of each constituency, is specified in **Annex 3**.

13~~2~~ Council of Governors: Election of Governors

12~~3~~.1 Elections for elected members of the Council of Governors shall be conducted in accordance with the Model Rules for Elections,

12~~3~~.2 The Model Rules for Elections, as may be varied from time to time, form part of this constitution. The Model Rules for Elections current as at the date of this version of the Trust's constitution are attached at **Annex 4**.

12~~3~~.3 A variation of the Model Rules as published by NHS Providers, or any other subsequent body with authority to do so, shall not constitute a variation of the terms of this constitution for the purposes of paragraph 44 of the constitution (amendment of the constitution).

12~~3~~.4 An election, if contested, shall be by secret ballot.

12~~3~~.5 Elections for elected members of the Council of Governors will normally be held annually within a financial year, at a time most appropriate, giving due regard to Governor vacancies.

14~~3~~ Council of Governors: Tenure

134.1 An elected or appointed governor may hold office for an initial period of up to three years.

143.2 An elected governor shall be re-eligible for re-election at the end of his initial term but may not hold office for more than three consecutive terms.

143.3 An elected governor shall cease to hold office if he ceases to be a member of the constituency or class by which he was elected.

143.4 A vacancy that arises amongst the elected governors for any reason other than expiry of term of office will be offered to the candidate who received the next highest number of votes in the same class and constituency in the most recent election, or, should that candidate decline, offered to each of the remaining next highest polling candidates in order until the seat is filled. If the election was uncontested, or if none of the previous candidates is willing to serve as a governor, a further election will be held.

143.5 An appointed governor shall be eligible for re-appointment at the end of his term but may not hold office for more than three consecutive terms.

143.6 An appointed governor shall cease to hold office if the appointing organisation withdraws its sponsorship of him.

143.7 Where a vacancy arises amongst the appointed governors, the appointing organisation shall be asked to appoint a replacement to hold the remainder of that term of office.

154 Council of Governors: Disqualification and Removal

154.1 The following may not become or continue as a member of the Council of Governors:

154.1.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

154.1.2 a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it;

154.1.3 a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him.

154.1.4 a person in relation to whom a moratorium period under a debt relief order applies under Part 7A of the Insolvency Act 1986;

145.2 Governors must be at least 16 years of age at the date they are nominated for election or appointment.

154.3 Further provisions as to the circumstances in which an individual may not become, or continue as, a member of the Council of Governors are set out in **Annex 5**.

154.4 Provisions for the removal or a governor are set out in **Annex 5**.

165 Council of Governors: Duties of Governors

156.1 The Council of Governors is accountable for several key functions that form part of the governance framework of the Trust:

- to hold Non-Executive Directors to account individually and collectively for the performance of the Board of Directors;
- to represent the interests of members of the Trust as a whole and the interests of the public.

165.2 Further details of the Council of Governors' powers are set out in **Annex 5**.

167 Council of Governors: Meetings of Governors

176.1 The Chairman of the Trust (*i.e.* the Chairman of the Board of Directors, appointed in accordance with the provisions of paragraph 25 below) shall preside at meetings of the Council of Governors. In his absence, the Deputy Chair (appointed in accordance with the provisions of paragraph 26 below) shall preside at meetings of the Council of Governors.

176.2 Meetings of the Council of Governors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons which may include for reasons of commercial confidentiality.

176.3 For the purposes of obtaining information about the Trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the Trust's or directors' performance), the Council of Governors may require one or more of the directors to attend a meeting.

187 Council of Governors: Standing Orders

The standing orders for the practice and procedure of the Council of Governors, as may be varied from time to time, are attached at **Annex 6**.

198 Council of Governors – Referral to the Panel

198.1 In this paragraph, the Panel means a panel of persons appointed by Monitor to which a governor of an NHS Foundation Trust may refer a question as to whether the Trust has failed or is failing:

198.1.1 to act in accordance with its Constitution, or

198.1.2 to act in accordance with provision made by or under Chapter 5 of the 2006 Act.

198.2 A governor may refer a question to the Panel only if more than half of the members of the Council of Governors voting, at a meeting of the Council of Governors, approve the referral.

2019 Council of Governors: Conflicts of Interest of Governors

If a governor has a pecuniary, personal or family interest, whether that interest is actual or potential, and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors, the governor shall disclose that interest to the members of the Council of Governors as soon as he becomes aware of it. The Standing Orders for the Council of Governors shall make provision for the disclosure of interests and arrangements for the exclusion of a governor declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.

201 Council of Governors: Travel Expenses

The Trust may pay travelling and other expenses to members of the Council of Governors at rates determined by the Trust, subject to the provisions of the Trust's policy on the payment of such expenses.

212 Council of Governors: Further Provisions

Further provisions with respect to the Council of Governors are set out in **Annex 5**.

223 Board of Directors: Composition

232.1 The Trust is to have a Board of Directors, which shall comprise both executive and non-executive directors. At least half of the Board, excluding the Chairman, shall be non-executive directors**.**

223.2 The Board of Directors is to comprise:

232.2.1 a non-executive Chairman;
223.2.2 A further six non-executive directors, one of whom shall be the Senior Independent Director nominated by the full Board of Directors; and one of whom shall be recruited by virtue of the financial experience and expertise that he has acquired in the commercial sector.
232.2.3 Six executive directors

232.3 One of the executive directors shall be the Chief Executive.

232.4 The Chief Executive shall be the Accounting Officer.

223.5 One of the executive directors shall be the Finance Director.

223.6 One of the executive directors is to be a registered medical practitioner, or a registered dentist (within the meaning of the Dentists Act 1984).

232.7 One of the executive directors is to be a registered nurse or a registered midwife.

223.8 The Trust shall have a Trust Secretary who shall be neither a governor nor a director but a senior manager who is accountable to the Board of Directors, and reports to the Chief Executive. The Chairman and Chief Executive ~~Board of Directors~~ shall appoint or remove the Trust Secretary~~. in consultation with the Council of Governors.~~

223.9 The Trust Secretary shall act in the same capacity for the Board of Directors and the Council of Governors, and his functions shall include:

- acting as Secretary to the Board of Directors and the Council of Governors, and keeping minutes of their meetings;
- attending all meetings of members as required~~,~~ and ensuring ~~keeping~~ minutes are taken ~~of those meetings~~;
- attending as necessary meetings of any committee established by either the Board of Directors or the Council of Governors;
- being the nominated addressee for all legal documents served on the Trust.
- ensuring that the register of members, and other registers and records required by this Constitution, are maintained and kept up to date;
- taking charge of the Trust's seal;
- publishing to members in an appropriate form any relevant information about the Trust's affairs;

243 Board of Directors – General Duty

The general duty of the Board of Directors and of each director individually is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public.

254 Board of Directors: Qualification for Appointment as a Non-Executive Director
A person may be appointed as a non-executive director only if

254.1 he is a member of the Public Constituency, or

~~25.2 he is a member of the Patients and Carers' Constituency, or~~

245.32 where any of the Trust's hospitals includes a medical or dental school provided by a university, he exercises functions for the purposes of that university, and

245.43 he is not disqualified by virtue of paragraph 29 below.

265 Board of Directors: Appointment and Removal of Chairman and Other Non-Executive Directors

256.1 The Council of Governors at a meeting of the Council of Governors shall appoint or remove the Chairman of the Trust and the other non-executive directors (see **Annex 5**).

256.2 Removal of the Chairman or another non-executive director shall require the approval of three-quarters of the members of the Council of Governors.

268 Board of Directors: Appointment and Removal of the Chief Executive and Other Executive Directors

286.1 The non-executive directors shall appoint or remove the Chief Executive.

268.2 The appointment of the Chief Executive shall require the approval of the Council of Governors.

268.3 A committee consisting of the Chairman, the Chief Executive and the other non-executive directors shall appoint or remove the other executive directors. The Chief Executive may appoint one of the executive directors as Deputy Chief Executive.

297 Board of Directors: Disqualification

A person may not become a Director of the Trust or shall be disqualified as a Director of the Trust if that person;

297.1 Is not considered a fit or proper person, that is, they do not satisfy all the requirements set out in paragraph (3) of Regulation 5 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014;

279.2 in the case of a Non-Executive Director, no longer satisfies paragraph 24

297.3 has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged.

279.4 has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it.

279.5 who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him

279.6 in relation to whom a moratorium period under a debt relief order applies under Part 7A of the Insolvency Act 1986 or

279.7 on the basis of disclosures obtained through a Disclosure and Barring Service check, is not considered suitable by the Chair and/or Chief Executive, with appropriate advice from Human Resources, to become or continue as a director.

2830 Board of Directors: Meetings

3028.1 Meetings of the Board of Directors shall be open to members of the public. Notice of a meeting of the Board of Directors will be given on the Trust's website. Members of the public may be excluded from a meeting for special reasons.

3028.2 Before holding a meeting, the Trust Secretary on behalf of the Board of Directors must send a copy of the agenda of the meeting to each Governor. As soon as practicable after holding a meeting, the Trust Secretary on behalf of the Board of Directors must send a copy of the minutes of the meeting to the Council of Governors.

3129 Board of Directors: Standing Orders

The standing orders for the practice and procedure of the Board of Directors are attached at **Annex 7**.

302 Board of Directors: Conflicts of Interest of Directors

320.1 The duties that a director of the Trust has by virtue of being a director include in particular –

320.1.1 A duty to avoid a situation in which the director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust.

302.1.2 A duty not to accept a benefit from a third party by reason of being a director or doing (or not doing) anything in that capacity.

320.2 The duty referred to in sub-paragraph 32.1.1 is not infringed if –

320.2.1 The situation cannot reasonably be regarded as likely to give rise to a conflict of interest, or

320.2.2 The matter has been authorised in accordance with the standing orders of the Trust.(Paragraph 8 of Annex 7 of this constitution).

320.3 The duty referred to in sub-paragraph 32.1.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

302.4 In sub-paragraph 32.1.2, "third party" means a person other than –

32.4.1 The Trust, or

32.4.2 A person acting on its behalf.

302.5 If a director of the Trust has in any way a direct or indirect interest in a proposed transaction or arrangement with the Trust, the director must declare the nature and extent of that interest to the other directors.

302.6 If a declaration under this paragraph proves to be, or becomes, inaccurate or incomplete, a further declaration must be made.

302.7 Any declaration required by this paragraph must be made before the Trust enters into the transaction or arrangement.

302.8 This paragraph does not require a declaration of an interest of which the director is not aware or where the director is not aware of the transaction or arrangement in question.

320.9 A director need not declare an interest –

320.9.1 If it cannot reasonably be regarded as likely to give rise to a conflict of interest;

302.9.2 If, or to the extent that, the directors are already aware of it;

302.9.3 If, or to the extent that, it concerns terms of the director's appointment that have been or are to be considered –

320.9.13.1 By a meeting of the Board of Directors, or

302.9.31.2 By a committee of the directors appointed for the purpose under the constitution.

313 Board of Directors: Remuneration and Terms of Office

313.1 The Council of Governors at a meeting of the Council of Governors shall decide the remuneration and allowances, and the other terms and conditions of office, of the Chairman and the other non-executive directors.

313.2 The Trust shall establish a committee of non-executive directors to decide the remuneration and allowances, and the other terms and conditions of office, of the Chief Executive and other executive directors.

342 Registers

The Trust shall have:

342.1 a register of members showing, in respect of each member, the constituency and, where there are classes within it, the class, to which he belongs;

342.2 a register of members of the Council of Governors;

324.3 a register of interests of the governors;

342.4 a register of directors; and

324.5 a register of interests of the directors.

353 Registers: admission to and removal from

Further provisions with respect to admissions to, and removals from, the registers are set out in Annex 5: Paragraph 3 and **Annex 8**: Paragraph 1.5.

346 Registers: Inspection and Copies

346.1 The Trust shall make the registers specified in paragraph 33 above available for inspection by members of the public, except in the circumstances set out below or as otherwise prescribed by regulations.

346.2 The Trust shall not make any part of its registers available for inspection by members of the public which shows details of any member of the Trust, if the Member so requests.~~:~~

~~36.2.1 any members of the Patients and Carers' Constituency; or~~

~~36.2.2 any other Member of the Trust if the member so requests.~~

364.3 So far as the registers are required to be made available:

364.3.1 they are to be available for inspection free of charge at all reasonable times; and

346.3.2 a person who requests a copy of or extract from the registers is to be provided with a copy or extract.

364.4 If the person requesting a copy or extract is not a member of the Trust, the Trust may impose a reasonable charge for doing so.

375 Documents available for public inspection

357.1 The Trust shall make the following documents available for inspection by members of the public free of charge at all reasonable times:

375.1.1 a copy of the current constitution;
357.1.2 a copy of the latest annual accounts and of any report of the auditor on them;
357.1.3 a copy of the latest annual report;

375.2 The Trust shall also make the following documents relating to a special administration of the trust available for inspection by members of the public free of charge at all reasonable times:

375.2.1 a copy of any order made under section 65D (appointment of trust special administrator), 65J (power to extend time), 65KC (action following Secretary of State's rejection of final report), 65L (trusts coming out of administration) or 65LA (trusts to be dissolved) of the 2006 Act.

375.2.2 a copy of any report laid under section 65D (appointment of trust special administrator) of the 2006 Act.

375.2.3 a copy of any information published under section 65D (appointment of trust special administrator) of the 2006 Act.

375.2.4 a copy of any draft report published under section 65F (administrator's draft report) of the 2006 Act.

375.2.5 a copy of any statement provided under section 65F(administrator's draft report) of the 2006 Act.

357.2.6 a copy of any notice published under section 65F(administrator's draft report), 65G (consultation plan), 65H (consultation requirements), 65J (power to extend time), 65KA(Monitor's decision), 65KB (Secretary of State's response to Monitor's decision), 65KC (action following Secretary of State's rejection of final report) or 65KD (Secretary of State's response to re-submitted final report) of the 2006 Act.

375.2.7 a copy of any statement published or provided under section 65G (consultation plan) of the 2006 Act.

357.2.8 a copy of any final report published under section 65I (administrator's final report),

357.2.9 a copy of any statement published under section 65J (power to extend time) or 65KC (action following Secretary of State's rejection of final report) of the 2006 Act.

357.2.10 a copy of any information published under section 65M (replacement of trust special administrator) of the 2006 Act.

375.3 Any person who requests a copy of or extract from any of the above documents is to be provided with a copy.

357.4 If the person requesting a copy or extract is not a member of the Trust, the Trust may impose a reasonable charge for doing so.

386 Auditor

368.1 The Trust shall have a financial auditor and may appoint auditors for other purposes.

368.2 The Council of Governors shall appoint or remove the financial auditor, or any other auditor, at a meeting of the Council of Governors.

397 Audit Committee

The Trust shall establish a committee of non-executive directors as an Audit Committee to perform such monitoring, reviewing and other functions as are appropriate.

4038 Annual Accounts

4380.1 The Trust must keep proper accounts and proper records in relation to the Accounts.

3840.2 Monitor may with the approval of the Secretary of State give directions to the Trust as to the content and form of its accounts.

3840.3 The accounts shall be audited by the Trust's financial auditor.

3840.4 The Trust shall prepare in respect of each financial year annual accounts in such form as Monitor may with the approval of the Secretary of State direct.

4038.5 The functions of the Trust with respect to the preparation of the annual accounts shall be delegated to the Accounting Officer.

3941 Annual Report, Forward Plans and non-NHS work

4139.1 The Trust shall prepare an annual report and send it to Monitor.

3941.2 The Trust shall give information as to its forward planning in respect of each financial year to Monitor.

3941.3 The document containing the information with respect to forward planning (referred to above) shall be prepared by the directors.

3941.4 In preparing the document, the directors shall have regard to the views of the Council of Governors.

3941.5 Each forward plan must include information about-

3941.5.1 the activities other than the provision of goods and services for the purposes of the health service in England that the Trust proposes to carry on, and

3941.5.2 the income it expects to receive from doing so.

4391.6 Where a forward plan contains a proposal that the Trust carry on an activity of a kind mentioned in sub-paragraph 39.740.5.1 the Council of Governors must, at a meeting of the Council of Governors, -

3941.6.1 determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfilment by the Trust of its principal purpose or the performance of its other functions, and

3941.6.2 notify the directors of the Trust of their decision

39.7 If the Trust proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the health service in England, it may implement the proposal only if more than half of the members of the Council of Governors of the Trust voting approve its implementation.

402 Presentation of the Annual Accounts and Reports to the Governors and Members

420.1 The following documents are to be presented to the Council of Governors at a meeting of the Council of Governors:

420.1.1 the annual accounts

402.1.2 any report of the auditor on them

402.1.3 the annual report.

420.2 The documents shall also be presented to the members of the Trust at the Annual Members' Meeting by at least one of the Board of Directors in attendance.

402.3 The Trust may combine a meeting of the Council of Governors convened for the purposes of sub-paragraph 42.1 with the Annual Members' Meeting.

413 Instruments

413.1 The Trust shall have a seal.

413.2 The seal shall not be affixed except under the authority of the Board of Directors.

424 Amendments to the Constitution

442.1 The Trust may make amendments of its constitution only if –

442.1.1 More than half of the members of the Council of Governors of the Trust voting, at a meeting of the Council of Governors, approve the amendments, and

424.1.2 More than half of the members of the Board of Directors of the Trust voting approve the amendments.

442.2 Amendments made under paragraph 44.1 take effect as soon as the conditions in that paragraph are satisfied, but the amendment has no effect in so far as the constitution would, as a result of the amendment, not accord with schedule 7 of the 2006 Act.

424.3 Where an amendment is made to the constitution in relation to the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Trust) –

442.3.1 At least one member of the Council of Governors must attend the next Annual Members' Meeting and present the amendment, and

424.3.2 The Trust must give the members an opportunity to vote on whether they approve the amendment.

If more than half of the members voting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect and the Trust must take such steps as are necessary as a result.

442.4 Amendments by the Trust of its constitution are to be notified to Monitor. For the avoidance of doubt, Monitor's functions do not include a power or duty to determine whether or not the constitution, as a result of the amendments, accords with Schedule 7 of the 2006 Act.

4~~5~~3 Mergers etc. and significant transactions

4~~3~~5.1 The Trust may only apply for a merger, acquisition, separation or dissolution with the approval of more than half of the members of the Council of Governors.

4~~3~~5.2 The Trust may enter into a significant transaction only if more than half the members of the Council of Governors voting, at a meeting of the Council of Governors, approve the Trust entering into the transaction.

4~~3~~5.3 "For the purposes of this paragraph:

4~~5~~2.3.1 A transaction is an investment or divestment; and

4~~3~~5.3.2 A transaction is significant if its value equates to more than 25% of the Trust's:

4~~5~~3.3.2.1 gross assets;

4~~3~~5.3.2.2 income; or

4~~3~~5.3.2.3 gross capital (following completion of the transaction),calculated with reference to the Trust's opening balance sheet for the financial year in which approval is being sought.

4~~5~~3.4 For the purposes of paragraph 43.3, the term 'transaction' shall not include a contract with a commissioning organisation for the provision of services for the purposes of the health service in England or Wales, unless such a contract includes or involves the provision of additional services by the Trust commissioned under that contract for the first time and those additional services meet the threshold set out in paragraph 44.3.2, in which case, the initial inclusion of those additional services in the contract will be deemed to be a "significant transaction."

4~~5~~3.5 If more than half of the members of the Council of Governors voting, at the meeting, decline to approve a significant transaction or any part of it, the Council of Governors must approve a written Statement of Reasons for its rejection, to be provided to the Board of Directors.

4~~5~~3.6 Nothing in this paragraph shall prevent the Board of Directors from appropriate engagement with the Council of Governors, as it sees fit, to provide information on any other transaction or arrangement which the Trust may enter, which does not constitute a "significant transaction" within the meaning of this paragraph.

Annex 1
The Public Constituency

~~The Public Constituency shall comprise the areas of the following local authorities based on the ward boundaries as defined in the Cheshire West and Chester (Electoral Changes) Order 2011 and the Cheshire East (Electoral Changes) Order 2011, both made under section 58 (4) of the Local Democracy, Economic Development and Construction Act 2009.~~

The public constituency shall consist of the following three areas (each a public constituency and collectively the 'Public Constituency'):

- Cheshire Borders
- Crewe and South Cheshire
- Vale Royal – Northwich and Region

~~Cheshire East Local Authority and Cheshire West and Chester Local Authority will be divided into three areas:~~

~~**The Area of** Congleton (and other surrounding areas) part of Cheshire East.~~

Cheshire Borders

Membership of this public constituency is open to any person resident in any of these electoral wards.

Minimum membership will be 650.

The Cheshire Borders public constituency shall consist of the following electoral areas (wards) of the following local authorities:
~~The Public Constituency shall comprise the areas of the following local authorities based on the ward boundaries as defined in legislation:~~

- Cheshire West and Chester ~~(Electoral Changes) Order 2011~~
- Cheshire East Council ~~(Electoral Changes) Order 2011~~
- Greater Manchester Combined Authority
- Liverpool City Region Combined Authority
- Shropshire Council
- Telford and Wrekin Council
- Warrington Borough Council
- Staffordshire County Council
- Stoke-on-Trent City Council
- Rossendale Borough Council

~~Alderley Edge }~~
~~Alsager }~~
~~Bollington }~~
~~Brereton Rural }~~
~~Broken Cross and Upton }~~
~~Chelford } Membership of the area is open to any~~
~~Congleton East } person resident in any of these electoral wards.~~
~~Congleton West } Minimum membership will be 450.~~
~~Dane Valley }~~
~~Disley }~~
~~Gawsworth }~~
~~Handforth }~~
~~High Legh }~~
~~Knutsford }~~
~~Macclesfield Central }~~
~~Macclesfield East }~~

~~Macclesfield Hurdsfield }~~
~~Macclesfield South }~~
~~Macclesfield Tytherington }~~
~~Macclesfield West and Ivy }~~
~~Middlewich }~~
~~Mobberley }~~
~~Odd Rode }~~
~~Poynton East and Pott Shrigley }~~
~~Poynton West and Adlington }~~
~~Prestbury }~~
~~Sandbach Elworth }~~
~~Sandbach Ettiley Heath and Wheelock }~~
~~Sandbach Heath and East }~~
~~Sandbach Town }~~
~~Sutton }~~
~~Wilmslow Dean Row }~~
~~Wilmslow East }~~
~~Wilmslow Lacey Green }~~
~~Wilmslow West and Chorley }~~

Cheshire East Council Wards		
Alderley Edge	Knutsford	Sandbach Elworth
Alsager	Macclesfield Central	Sandbach Ettiley Heath and Wheelock
Bollington	Macclesfield East	Sandbach Heath and East
Brereton Rural	Macclesfield Hurdsfield	Sandbach Town
Broken Cross and Upton	Macclesfield South	Sutton
Chelford	Macclesfield Tytherington	Wilmslow Dean Row
Congleton East	Macclesfield West and Ivy	Wilmslow East
Congleton West	Middlewich	Wilmslow Lacey Green
Dane Valley	Mobberley	Wilmslow West and Chorley
Disley	Odd Rode	Sandbach Elworth
Gawsworth	Poynton East and Pott Shrigley	
Handforth	Poynton West and Adlington	
High Legh	Prestbury	

Cheshire West and Chester Unitary Authority Wards		
Blacon	Great Boughton	Parkgate
Boughton	Handbridge Park	Rossmore
Chester City	Helsby	St Paul's
Chester Villages	Hoole	Saughall and Mollington
Dodleston and Huntington	Kingsley	Strawberry
Ellesmere Port Town	Lache	Sutton
Elton	Ledsham and Manor	Tarvin and Kelsall
Farndon	Little Neston and Burton	Tattenhall
Frodsham	Malpas	Upton
Garden Quarter	Neston	Whitby
Gowy	Netherpool	Willaston and Thornton
Grange	Newton	

Greater Manchester Combined Authority			
Borough	**Ward**	**Borough**	**Ward**
Bolton	Astley Bridge	**Manchester**	Ancoats and Clayton
	Bradshaw		Ardwick
	Breightmet		Baguley
	Bromley Cross		Bradford

	Crompton		Brooklands
	Farnworth		Burnage
	Great Lever		Charlestown
	Halliwell		Cheetham
	Harper Green		Chorlton
	Heaton and Lostock		Chorlton Park
	Horwich and Blackrod		City Centre
	Horwich North East		Crumpsall
	Hulton		Didsbury East
	Kearsley		Didsbury West
	Little Lever and Darcy Lever		Fallowfield
	Rumworth		Gorton North
	Smithills		Gorton South
	Tonge with the Haulgh		Harpurhey
	Westhoughton North and Chew Moor		Higher Blackley
	Westhoughton South		Hulme
Bury	Besses		Levenshulme
	Church		Longsight
	East		Miles Platting and Newton Heath
	Elton		Moss Side
	Holyrood		Moston
	Moorside		Northenden
	North Manor		Old Moat
	Pilkington Park		Rusholme
	Radcliffe East		Sharston
	Radcliffe North		Whalley Range
	Radcliffe West		Withington
	Ramsbottom		Woodhouse Park
	Redvales	**Oldham**	Alexandra
	St Mary's		Chadderton Central
	Sedgley		Chadderton North
	Tottington		Chadderton South
	Unsworth		Coldhurst
Rochdale	Balderstone and Kirkholt		Crompton
	Bamford		Failsworth East
	Castleton		Failsworth West
	Central Rochdale		Hollinwood
	East Middleton		Medlock Vale
	Healey		Royton North
	Hopwood Hall		Royton South
	Kingsway		Saddleworth North
	Littleborough Lakeside		Saddleworth South
	Milkstone and Deeplish		Saddleworth West and Lees
	Milnrow and Newhey		St James'
	Norden		St Mary's
	North Heywood		Shaw
	North Middleton		Waterhead
	Smallbridge and Firgrove		Werneth
	South Middleton	**Stockport**	Bramhall North
	Spotland and Falinge		Bramhall South
	Wardle and West Littleborough		Bredbury and Woodley
	West Heywood		Bredbury Green and Romiley
	West Middleton		Brinnington and Central
Salford	Barton		Cheadle and Gatley
	Boothstown and Ellenbrook		Cheadle Hulme North
	Broughton		Cheadle Hulme South
	Cadishead		Davenport and Cale Green

	Claremont		Edgeley and Cheadle Heath
	Eccles		Hazel Grove
	Irlam		Heald Green
	Irwell Riverside		Heatons North
	Kersal		Heatons South
	Langworthy		Manor
	Little Hulton		Marple North
	Ordsall		Marple South
	Pendlebury		Offerton
	Swinton North		Reddish North
	Swinton South		Reddish South
	Walkden North		Stepping Hill
	Walkden South	**Tameside**	Ashton Hurst
	Weaste and Seedley		Ashton St Michael's
	Winton		Ashton Waterloo
	Worsley		Audenshaw
	Abram		Denton North East
Wigan	Ashton		Denton South
	Aspull New Springs Whelley		Denton West
	Astley Mosley Common		Droylsden East
	Atherleigh		Droylsden West
	Atherton		Dukinfield
	Bryn		Dukinfield Stalybridge
	Douglas		Hyde Godley
	Golborne and Lowton West		Hyde Newton
	Hindley		Hyde Werneth
	Hindley Green		Longdendale
	Ince		Mossley
	Leigh East		St Peter's
	Leigh South		Stalybridge North
	Leigh West		Stalybridge South
	Lowton East	**Trafford**	Altrincham
	Orrell		Ashton upon Mersey
	Pemberton		Bowdon
	Shevington with Lower Ground		Broadheath
	Standish with Langtree		Brooklands
	Tyldesley		Bucklow-St Martins
	Wigan Central		Clifford
	Wigan West		Davyhulme East
	Winstanley		Davyhulme West
	Worsley Mesnes		Flixton
			Gorse Hill
Rossendale	Healey and Whitworth		Hale Barns
			Hale Central
			Longford
			Priory
			St Mary's
			Sale Moor
			Stretford
			Timperley
			Urmston
			Village

Liverpool Combined Regional Authority			
Borough	**Ward**	**Borough**	**Ward**
Halton	Appleton	**Knowsley**	Cherryfield
	Beechwood		Halewood North

	Birchfield		Halewood South
	Broadheath		Halewood West
	Halton Castle		Kirkby Central
	Daresbury		Longview
	Ditton		Northwood
	Farnworth		Page Moss
	Grange		Park
	Hale		Prescot East
	Halton Brook		Prescot West
	Halton Lea		Roby
	Halton View		St Bartholomews
	Heath		St Gabriels
	Hough Green		St Michaels
	Kingsway		Shevington
	Mersey		Stockbridge
	Norton North		Swanside
	Norton South		Whiston North
	Riverside		Whiston South
	Windmill Hill		Whitefield
Liverpool City	Allerton and Hunts Cross	**Sefton**	Ainsdale
	Anfield		Birkdale
	Belle Vale		Blundellsands
	Central		Cambridge
	Childwall		Church
	Church		Derby
	Clubmoor		Duke's
	County		Ford
	Cressington		Harington
	Croxteth		Kew
	Everton		Linacre
	Fazakerley		Litherland
	Greenbank		Manor
	Kensington and Fairfield		Meols
	Kirkdale		Molyneux
	Knotty Ash		Netherton and Orrell
	Mossley Hill		Norwood
	Norris Green		Park
	Old Swan		Ravenmeols
	Picton		St Oswald
	Princes Park		Sudell
	Riverside		Victoria
	St Michael's	**St Helen's**	Billinge and Seneley Green
	Speke-Garston		Blackbrook
	Tuebrook and Stoneycroft		Bold
	Warbreck		Earlestown
	Wavertree		Eccleston
	West Derby		Haydock
	Woolton		Moss Bank
	Yew Tree		Newton
Wirral	Bebington		Parr
	Bidston and St James		Rainford
	Birkenhead and Tranmere		Rainhill
	Bromborough		Sutton
	Clatterbridge		Thatto Heath
	Claughton		Town Centre
	Eastham		West Park
	Greasby, Frankby and Irby		Windle
	Heswall		

	Hoylake and Meols
	Leasowe and Moreton East
	Liscard
	Moreton West and Saughall Massie
	New Brighton
	Oxton
	Pensby and Thingwall
	Prenton
	Rock Ferry
	Seacombe
	Upton
	Wallasey
	West Kirby and Thurstaston

Warrington Unitary Council		
Appleton	Great Sankey South	Poulton North
Bewsey and Whitecross	Hatton, Stretton and Walton	Poulton South
Birchwood	Latchford East	Rixton and Woolston
Burtonwood and Winwick	Latchford West	Stockton Heath
Culcheth, Glazebury and Croft	Lymm	Westbrook
Fairfield and Howley	Orford	Whittle Hall
Grappenhall and Thelwall	Penketh and Cuerdley	
Great Sankey North	Poplars and Hulme	

Staffordshire County Council			
Borough	**Wards**	**Borough**	**Wards**
Cannock Chase	Brereton and Ravenhill	**East Staffordshire**	Abbey
	Cannock East		Anglesey
	Cannock North		Bagots
	Cannock South		Branston
	Cannock West		Brizlincote
	Etching Hill and The Heath		Burton
	Hagley		Churnet
	Hawks Green		Crown
	Heath Hayes East and Wimblebury		Eton Park
	Hednesford Green Heath		Heath
	Hednesford North		Horninglow
	Hednesford South		Needwood
	Norton Canes		Rolleston on Dove
	Rawnsley		Shobnall
	Western Springs		Stapenhill
Lichfield	All Saints		Stretton
	Alrewas and Fradley		Town
	Armitage with Handsacre		Tutbury and Outwoods
	Boley Park		Weaver
	Boney Hay		Winshill
	Bourne Vale		Yoxall
	Burntwood Central	**Newcastle under Lyme**	Audley and Bignall End
	Chadsmead		Bradwell
	Chase Terrace		Butt Lane
	Chasetown		Chesterton
	Colton and Mavesyn Ridware		Clayton
	Curborough		Cross Heath
	Fazeley		Halmerend

	Hammerwich		Holditch
	Highfield		Keele
	King's Bromley		Kidsgrove
	Leomansley		Knutton and Silverdale
	Little Aston		Loggerheads and Whitmore
	Longdon		Madeley
	Mease and Tame		May Bank
	St John's		Newchapel
	Shenstone		Porthill
	Stonnall		Ravenscliffe
	Stowe		Seabridge
	Summerfield		Silverdale and Parksite
	Whittington		Talke
South Staffordshire	Bilbrook		Thistleberry
	Brewood and Coven		Town
	Cheslyn Hay North and Saredon		Westlands
	Cheslyn Hay South		Wolstanton
	Codsall North	**Staffordshire Moorlands**	Alton
	Codsall South		Bagnall and Stanley
	Essington		Biddulph East
	Featherstone and Shareshill		Biddulph Moor
	Great Wyrley Landywood		Biddulph North
	Great Wyrley Town		Biddulph South
	Himley and Swindon		Biddulph West
	Huntington and Hatherton		Brown Edge and Endon
	Kinver		Caverswall
	Pattingham and Patshull		Cellarhead
	Penkridge North East and Acton Trussell		Cheadle North East
	Penkridge South East		Cheadle South East
	Penkridge West		Cheadle West
	Perton Dippons		Checkley
	Trysull and Seisdon		Cheddleton
	Wheaton Aston, Bishopswood and Lapley		Churnet
	Wombourne North and Lower Penn		Dane
	Wombourne South East		Forsbrook
	Wombourne South West		Hamps Valley
Stafford	Barlaston and Oulton		Horton
	Baswich		Ipstones
	Chartley		Leek East
	Church Eaton		Leek North
	Common		Leek South
	Coton		Leek West
	Eccleshall		Manifold
	Forebridge		Werrington
	Fulford	**Tamworth**	Amington
	Gnosall and Woodseaves		Belgrave
	Haywood and Hixon		Bolehall
	Highfields and Western Downs		Castle
	Holmcroft		Glascote
	Littleworth		Mercian
	Manor		Spital
	Milford		Stonydelph
	Milwich		Trinity

	Penkside		Wilnecote
	Rowley		
	St. Michael's		
	Seighford		
	Stonefield and Christchurch		
	Swynnerton		
	Tillington		
	Walton		
	Weeping Cross		

Stoke-on Trent City Council		
Abbey Hulton and Townsend	Etruria and Hanley	Little Chell and Stanfield
Baddeley, Milton and Norton	Fenton East	Meir Hay
Bentilee and Ubberley	Fenton West and Mount Pleasant	Meir North
Birches Head and Central Forest Park	Ford Green and Smallthorne	Meir Park
Blurton East	Goldenhill and Sandyford	Meir South
Blurton West and Newstead	Great Chell and Packmoor	Moorcroft
Boothen and Oak Hill	Hanford and Trentham	Penkhull and Stoke
Bradeley and Chell Heath	Hanley Park and Shelton	Sandford Hill
Broadway and Longton East	Hartshill and Basford	Sneyd Green
Burslem Central	Hollybush and Longton West	Springfields and Trent Vale
Burslem Park	Joiner's Square	Tunstall
Dresden and Florence	Lightwood North and Normacot	Weston Coyney
Eaton Park		

Shropshire Council Unitary Authority		
Abbey	Corvedale	Oswestry South
Albrighton	Ellesmere Urban	Oswestry West
Alveley and Claverley	Harlescott	Porthill
Bagley	Highley	Prees
Battlefield	Hodnet	Quarry and Coton Hill
Bayston Hill, Column and Sutton	Llanymynech	Ludlow South
Belle Vue	Longden	Radbrook
Bishop's Castle	Loton	Ruyton and Baschurch
Bowbrook	Ludlow East	St Martin's
Bridgnorth East and Astley Abbotts	Ludlow North	Gobowen, Selattyn and Weston Rhyn
Bridgnorth West and Tasley	Longden	Severn Valley
Broseley	Loton	Shawbury
Brown Clee	Ludlow East	Shifnal North
Burnell	Ludlow North	Shifnal South and Cosford
Castlefields and Ditherington	Ludlow South	Sundorne
Cheswardine	Market Drayton East	Tern
Chirbury and Worthen	Market Drayton West	The Meres
Church Stretton and Craven Arms	Meole	Underdale
Clee	Rea Valley	Wem
Cleobury Mortimer	Monkmoor	Whitchurch North
Clun	Much Wenlock	Whitchurch South
Copthorne	Oswestry East	Whittington
		Worfield

Telford and Wrekin Unitary Authority		
Apley Castle	Ercall Magna	Newport North
Arleston	Hadley and Leegomery	Newport South
Brookside	Haygate	Newport West
Church Aston and Lilleshall	Horsehay and Lightmoor	Park
College	Ironbridge Gorge	Priorslee
Cuckoo Oak	Ketley and Oakengates	St Georges
Dawley Magna	Lawley and Overdale	Shawbirch
Donnington	Madeley	The Nedge
Dothill	Malinslee	Woodside
Edgmond	Muxton	Wrockwardine
Ercall	Newport East	Wrockwardine Wood and Trench

~~**The Area of Crewe and South Cheshire (and other surrounding areas) part of Cheshire East**~~

Crewe and South Cheshire

Membership of the area is open to any person resident in any of these electoral wards.

Minimum membership will be 1,100

The Crewe and South Cheshire public constituency shall consist of the following electoral areas (wards) of Cheshire East local authority:

Audlem	Crewe West	Wistaston
Bunbury	Haslington	Wrenbury
Crewe Central	Leighton	Wybunbury
Crewe East	Nantwich North and West	
Crewe North	Nantwich South and Stapeley	
Crewe South	Shavington	
Crewe St Barnabas	Willaston and Rope	

Vale Royal – Northwich and Region

Membership of the area is open to any person resident in any of these electoral wards.

Minimum membership will be 1,000

The Northwich and Region public constituency shall consist of the following electoral areas (wards) of Cheshire West and Chester local authority:

Davenham and Moulton	Weaver and Cuddington	Winsford Wharton
Hartford and Greenbank	Winnington and Castle	Witton and Rudheath
Marbury	Winsford Over and Verdin	
Shakerley	Winsford Swanlow and Dene	
Tarporley	Weaver and Cuddington	

~~Blacon }~~
~~Boughton }~~
~~Broxton }~~
~~Chester City }~~
~~Chester Villages }~~
~~Davenham and Moulton }~~
~~Dodleston and Huntington }~~
~~Ellesmere Port Town }~~

~~Elton~~	~~}~~	
~~Farndon~~	~~}~~	
~~Frodsham~~	~~}~~	
~~Garden Quarter~~	~~}~~	
~~Gowy~~	~~}~~	
~~Grange~~	~~}~~	
~~Great Boughton~~	~~}~~	
~~Handbridge Park~~	~~}~~	~~Membership of the area is open to any~~
~~Hartford and Greenbank~~	~~}~~	~~person resident in any of these electoral wards.~~
~~Helsby~~	~~}~~	~~Minimum membership will be 1,200~~
~~Hoole~~	~~}~~	
~~Kingsley~~	~~}~~	
~~Lache~~	~~}~~	
~~Ledsham and Manor~~	~~}~~	
~~Little Neston and Burton~~	~~}~~	
~~Malpas~~	~~}~~	
~~Neston~~	~~}~~	
~~Netherpool~~	~~}~~	
~~Newton~~	~~}~~	
~~Rossmore~~	~~}~~	
~~Saughall and Mollington~~	~~}~~	
~~Marbury~~	~~}~~	
~~Shakerley~~	~~}~~	
~~St Pauls~~	~~}~~	
~~Strawberry~~	~~}~~	
~~Sutton~~	~~}~~	
~~Tarporley~~	~~}~~	
~~Tarvin and Kelsall~~	~~}~~	
~~Tattenhall~~	~~}~~	
~~Upton~~	~~}~~	
~~Weaver and Cuddington~~	~~}~~	
~~Whitby~~	~~}~~	
~~Willaston and Thornton~~	~~}~~	
~~Winnington and Castle~~	~~}~~	
~~Winsford Over and Verdin~~	~~}~~	
~~Winsford Swanlow and Dene~~	~~}~~	
~~Winsford Wharton~~	~~}~~	
~~Witton and Rudheath~~	~~}~~	

~~**Minimum Membership of the Public Constituency**~~
~~2,750 members~~

Annex 2
The Staff and Volunteers Constituency

The Staff and Volunteers Constituency shall comprise seven classes, based on the occupation or role of the individual member:

The Class of Medical Practitioners and Dental Staff
Membership of the class is open to any person employed by the Trust, or exercising functions for the purposes of the Trust, as a Medical or Dental Practitioner, in accordance with paragraph 7 above. Minimum membership will be 22.

The Class of Qualified Nursing and Midwifery Staff
Membership of the class is open to any person employed by the Trust, or exercising functions for the purposes of the Trust, as a qualified Nurse or Midwife, in accordance with paragraph 7 above. Minimum membership will be 179.

The Class of Other Professionally Qualified Clinical Staff
Membership of the class is open to any person employed by the Trust as a member of the professionally qualified clinical staff (other than medical practitioners or dental staff; or qualified nursing and midwifery staff) or exercising the functions of such staff for the purposes of the Trust, in accordance with paragraph 7 above. Minimum membership will be 57.

The Class of Clinical Support Staff [*e.g.* Administrative and Clerical staff supporting clinical services; HCA; AHP Assistant; Scientific and Technical]
Membership of the class is open to any person employed by the Trust as a member of the clinical support staff or exercising the functions of such staff for the purposes of the Trust, in accordance with paragraph 7 above. Minimum membership will be 189.

The Class of Non-Clinical Support Staff [*e.g.* Administrative and Clerical staff supporting non-clinical services; and staff in Estates, Facilities, Finance, Human Resources; Information Management and Technology *IM&T*]
Membership of the class is open to any person employed by the Trust as a member of the non-clinical-support staff or exercising the functions of such staff for the purposes of the Trust, in accordance with paragraph 7 above. Minimum membership will be 121.

The Class of Recognised Representatives of Trades Unions and Staff Organisations
Membership of the class is open to any person who is an accredited representative of a recognised trade union or staff organisation, and who is employed by the Trust in accordance with paragraph 7 above. Minimum membership will be 10.

The Class of Volunteers
Membership of the class is open to any person registered with the Trust to undertake individual voluntary work at premises, or in services, managed by the Trust; or registered with a voluntary organisation that is accredited by the Trust to undertake voluntary work at premises, or in services, managed by the Trust, in accordance with paragraph 7 above. Minimum membership will be 30.

Minimum Membership of the Staff and Volunteers Constituency
608 members

Annex 3
The Council of Governors: Composition

Elected Governors
Public Constituency

Members of the Public Constituency will elect sixteen governors in total, split across the three areas of the Public Constituency as follows:

- Members of the Cheshire Borders public constituency will elect two governors.
- Members of the Crewe and South Cheshire public constituency will elect eight governors.
- Members of the Northwich and Region public constituency will elect six governors.

~~Members in the areas of the Public Constituency will elect ten governors:~~

- ~~Members living in the Congleton (and other surrounding areas) part of Cheshire East, will elect two governors~~.
- ~~Members living in the Crewe and Nantwich (and other surrounding areas) part of Cheshire East will elect four governors.~~
- ~~Members living in the Vale Royal part and all other parts of Cheshire West and Chester will elect four governors.~~

~~**Patients and Carers' Constituency**~~
~~Members of the Patients and Carers' Constituency will elect six governors:~~

Staff and Volunteers Constituency
Members in the classes of the Staff and Volunteers Constituency will elect seven governors:

- Members in the Medical Practitioners and Dental Staff Class will elect one governor.
- Members in the Qualified Nursing and Midwifery Staff Class will elect one governor.
- Members in the Other Professionally Qualified Clinical Staff Class will elect one governor.
- Members in the Clinical Support Staff [*e.g.* HCA, AHP Assistant, Scientific and Technical] Class will elect one governor.
- Members in the Non-Clinical Support Staff [e.g. Non-Clinical Administrative and Clerical, Facilities Staff, Finance, Human Resources, Information Management and Technology IM&T, Estates] Class will elect one governor.
- Members in the Class of Recognised Representatives of Trades Unions and Staff Organisations will elect one governor.
- Members in the Volunteers Class will elect one governor.

Appointed Governors

Cheshire East Council shall appoint one governor.
Cheshire West and Chester Council shall appoint one governor

The Trust identifies the following partnership organisations, who may appoint a governor on the formal invitation of the Board of Directors in the first instance and on the formal invitation of the Council of Governors thereafter:

- Congleton Chamber of Commerce, South Cheshire Chamber of Commerce, and Warrington Chamber of Commerce and Industry are partnership organisations, and will be invited to appoint one governor among them
- University of Chester is a partnership organisation, and will be invited to appoint one governor
- Community and Voluntary Service Cheshire East and Healthwatch are partnership organisations, and will be invited to appoint one governor among them to represent the third sector

Annex 4 The Model Rules for Elections

The Trust has adopted the Model Election Rules contained in this annex. It will determine the results of elections using the 'first past the post' option (see Fpp below).

PART 1: INTERPRETATION

1. Interpretation

PART 2: TIMETABLE FOR ELECTION

2. Timetable
3. Computation of time

PART 3: RETURNING OFFICER

4. Returning officer
5. Staff
6. Expenditure
7. Duty of co-operation

PART 4: STAGES COMMON TO CONTESTED AND UNCONTESTED ELECTIONS

8. Notice of election
9. Nomination of candidates
10. Candidate's particulars
11. Declaration of interests
12. Declaration of eligibility
13. Signature of candidate
14. Decisions as to validity of nomination forms
15. Publication of statement of nominated candidates
16. Inspection of statement of nominated candidates and nomination forms
17. Withdrawal of candidates
18. Method of election

PART 5: CONTESTED ELECTIONS

19. Poll to be taken by ballot
20. The ballot paper
21. The declaration of identity (public and patient constituencies)

Action to be taken before the poll

22. List of eligible voters
23. Notice of poll
24. Issue of voting information by returning officer
25. Ballot paper envelope and covering envelope
26. E-voting systems

The poll

27. Eligibility to vote
28. Voting by persons who require assistance
29. Spoilt ballot papers and spoilt text message votes
30. Lost voting information
31. Issue of replacement voting information
32. ID declaration form for replacement ballot papers (public and patient constituencies)
33 Procedure for remote voting by internet
34. Procedure for remote voting by telephone

PART 1: INTERPRETATION

1. Interpretation

1.1 In these rules, unless the context otherwise requires:

"*2006 Act*" means the National Health Service Act 2006;

"*corporation*" means the public benefit corporation subject to this constitution;

"*council of governors*" means the council of governors of the corporation;

"*declaration of identity*" has the meaning set out in rule 21.1;

"*election*" means an election by a constituency, or by a class within a constituency, to fill a vacancy among one or more posts on the council of governors;

"*e-voting*" means voting using either the internet, telephone or text message;

"*e-voting information*" has the meaning set out in rule 24.2;

"*ID declaration form*" has the meaning set out in Rule 21.1; "internet voting record" has the meaning set out in rule 26.4(d);

"*internet voting system*" means such computer hardware and software, data other equipment and services as may be provided by the returning officer for the purpose of enabling voters to cast their votes using the internet;

"*lead governor*" means the governor nominated by the corporation to fulfil the role described in Appendix B to The NHS Foundation Trust Code of Governance (Monitor, December 2013) or any later version of such code.

"*list of eligible voters*" means the list referred to in rule 22.1, containing the information in rule 22.2;

"*method of polling*" means a method of casting a vote in a poll, which may be by post, internet, text message or telephone;

"*Monitor*" means the corporate body known as Monitor as provided by section 61 of the 2012 Act;

"*numerical voting code*" has the meaning set out in rule 64.2(b)

"*polling website*" has the meaning set out in rule 26.1;

"*postal voting information*" has the meaning set out in rule 24.1;

"*telephone short code"* means a short telephone number used for the purposes of submitting a vote by text message;

"*telephone voting facility*" has the meaning set out in rule 26.2;

"*telephone voting record*" has the meaning set out in rule 26.5 (d);

"*text message voting facility*" has the meaning set out in rule 26.3;

"*text voting record*" has the meaning set out in rule 26.6 (d);

"*the telephone voting system*" means such telephone voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by telephone;

"*the text message voting system*" means such text messaging voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by text message;

"*voter ID number*" means a unique, randomly generated numeric identifier allocated to each voter by the Returning Officer for the purpose of e-voting,

"*voting information*" means postal voting information and/or e-voting information

1.2 Other expressions used in these rules and in Schedule 7 to the NHS Act 2006 have the same meaning in these rules as in that Schedule.

PART 2: TIMETABLE FOR ELECTIONS

2. Timetable

2.1 The proceedings at an election shall be conducted in accordance with the following timetable:

Proceeding	Time
Publication of notice of election	Not later than the fortieth day before the day of the close of the poll.
Final day for delivery of nomination forms to returning officer	Not later than the twenty eighth day before the day of the close of the poll.
Publication of statement of nominated candidates	Not later than the twenty seventh day before the day of the close of the poll.
Final day for delivery of notices of withdrawals by candidates from election	Not later than twenty fifth day before the day of the close of the poll.
Notice of the poll	Not later than the fifteenth day before the day of the close of the poll.
Close of the poll	By 5.00pm on the final day of the election.

3. Computation of time

3.1 In computing any period of time for the purposes of the timetable:

(a) a Saturday or Sunday;

(b) Christmas day, Good Friday, or a bank holiday, or

(c) a day appointed for public thanksgiving or mourning,

shall be disregarded, and any such day shall not be treated as a day for the purpose of any proceedings up to the completion of the poll, nor shall the returning officer be obliged to proceed with the counting of votes on such a day.

3.2 In this rule, “bank holiday” means a day which is a bank holiday under the Banking and Financial Dealings Act 1971 in England and Wales.

PART 3: RETURNING OFFICER

4. Returning Officer

4.1 Subject to rule 69, the returning officer for an election is to be appointed by the corporation.

4.2 Where two or more elections are to be held concurrently, the same returning officer may be appointed for all those elections.

5. Staff

5.1 Subject to rule 69, the returning officer may appoint and pay such staff, including such technical advisers, as he or she considers necessary for the purposes of the election.

6. Expenditure

6.1 The corporation is to pay the returning officer:

(a) any expenses incurred by that officer in the exercise of his or her functions under these rules,

(b) such remuneration and other expenses as the corporation may determine.

7. Duty of co-operation

7.1 The corporation is to co-operate with the returning officer in the exercise of his or her functions under these rules.

PART 4: STAGES COMMON TO CONTESTED AND UNCONTESTED ELECTIONS

8. Notice of election

8.1 The returning officer is to publish a notice of the election stating:

(a) the constituency, or class within a constituency, for which the election is being held,

(b) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(c) the details of any nomination committee that has been established by the corporation,

(d) the address and times at which nomination forms may be obtained;

(e) the address for return of nomination forms (including, where the return of nomination forms in an electronic format will be permitted, the e-mail address for such return) and the date and time by which they must be received by the returning officer,

(f) the date and time by which any notice of withdrawal must be received by the returning officer

(g) the contact details of the returning officer

(h) the date and time of the close of the poll in the event of a contest.

9. Nomination of candidates

9.1 Subject to rule 9.2, each candidate must nominate themselves on a single nomination form.

9.2 The returning officer:

(a) is to supply any member of the corporation with a nomination form, and

(b) is to prepare a nomination form for signature at the request of any member of the corporation,

but it is not necessary for a nomination to be on a form supplied by the returning officer and a nomination can, subject to rule 13, be in an electronic format.

10. Candidate's particulars

10.1 The nomination form must state the candidate's:

(a) full name,

(b) contact address in full (which should be a postal address although an e-mail address may also be provided for the purposes of electronic communication), and

(c) constituency, or class within a constituency, of which the candidate is a member.

11. Declaration of interests

11.1 The nomination form must state:

(a) any financial interest that the candidate has in the corporation, and

(b) whether the candidate is a member of a political party, and if so, which party,

and if the candidate has no such interests, the paper must include a statement to that effect.

12. Declaration of eligibility

12.1 The nomination form must include a declaration made by the candidate:

(a) that he or she is not prevented from being a member of the council of governors by paragraph 8 of Schedule 7 of the 2006 Act or by any provision of the constitution; and,

(b) for a member of the public or patient constituency, of the particulars of his or her qualification to vote as a member of that constituency, or class within that constituency, for which the election is being held.

13. Signature of candidate

13.1 The nomination form must be signed and dated by the candidate, in a manner prescribed by the returning officer, indicating that:

(a) they wish to stand as a candidate,

(b) their declaration of interests as required under rule 11, is true and correct, and

(c) their declaration of eligibility, as required under rule 12, is true and correct.

13.2 Where the return of nomination forms in an electronic format is permitted, the returning officer shall specify the particular signature formalities (if any) that will need to be complied with by the candidate.

14. Decisions as to the validity of nomination

14.1 Where a nomination form is received by the returning officer in accordance with these rules, the candidate is deemed to stand for election unless and until the returning officer:

(a) decides that the candidate is not eligible to stand,

(b) decides that the nomination form is invalid,

(c) receives satisfactory proof that the candidate has died, or

(d) receives a written request by the candidate of their withdrawal from candidacy.

14.2 The returning officer is entitled to decide that a nomination form is invalid only on one of the following grounds:

(a) that the paper is not received on or before the final time and date for return of nomination forms, as specified in the notice of the election,

(b) that the paper does not contain the candidate's particulars, as required by rule 10;

(c) that the paper does not contain a declaration of the interests of the candidate, as required by rule 11,

(d) that the paper does not include a declaration of eligibility as required by rule 12, or

(e) that the paper is not signed and dated by the candidate, if required by rule 13.

14.3 The returning officer is to examine each nomination form as soon as is practicable after he or she has received it, and decide whether the candidate has been validly nominated.

14.4 Where the returning officer decides that a nomination is invalid, the returning officer must endorse this on the nomination form, stating the reasons for their decision.

14.5 The returning officer is to send notice of the decision as to whether a nomination is valid or invalid to the candidate at the contact address given in the candidate's nomination form. If an e-mail address has been given in the candidate's nomination form (in addition to the candidate's postal address), the returning officer may send notice of the decision to that address.

15. Publication of statement of candidates

15.1 The returning officer is to prepare and publish a statement showing the candidates who are standing for election.

15.2 The statement must show:

(a) the name, contact address (which shall be the candidate's postal address), and constituency or class within a constituency of each candidate standing, and

(b) the declared interests of each candidate standing,

as given in their nomination form.

15.3 The statement must list the candidates standing for election in alphabetical order by surname.

15.4 The returning officer must send a copy of the statement of candidates and copies of the nomination forms to the corporation as soon as is practicable after publishing the statement.

16. Inspection of statement of nominated candidates and nomination forms

16.1 The corporation is to make the statement of the candidates and the nomination forms supplied by the returning officer under rule 15.4 available for inspection by members of the corporation free of charge at all reasonable times.

16.2 If a member of the corporation requests a copy or extract of the statement of candidates or their nomination forms, the corporation is to provide that member with the copy or extract free of charge.

17. Withdrawal of candidates

17.1 A candidate may withdraw from election on or before the date and time for withdrawal by candidates, by providing to the returning officer a written notice of withdrawal which is signed by the candidate and attested by a witness.

18. Method of election

18.1 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is greater than the number of members to be elected to the council of governors, a poll is to be taken in accordance with Parts 5 and 6 of these rules.

18.2 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is equal to the number of members to be elected to the council of governors, those candidates are to be declared elected in accordance with Part 7 of these rules.

18.3 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is less than the number of members to be elected to be council of governors, then:

(a) the candidates who remain validly nominated are to be declared elected in accordance with Part 7 of these rules, and

(b) the returning officer is to order a new election to fill any vacancy which remains unfilled, on a day appointed by him or her in consultation with the corporation.

PART 5: CONTESTED ELECTIONS

19. Poll to be taken by ballot

19.1 The votes at the poll must be given by secret ballot.

19.2 The votes are to be counted and the result of the poll determined in accordance with Part 6 of these rules.

19.3 The corporation may decide that voters within a constituency or class within a constituency, may, subject to rule 19.4, cast their votes at the poll using such different methods of polling in any combination as the corporation may determine.

19.4 The corporation may decide that voters within a constituency or class within a constituency for whom an e-mail address is included in the list of eligible voters may only cast their votes at the poll using an e-voting method of polling.

19.5 Before the corporation decides, in accordance with rule 19.3 that one or more e-voting methods of polling will be made available for the purposes of the poll, the corporation must satisfy itself that:

(a) if internet voting is to be a method of polling, the internet voting system to be used for the purpose of the election is:

(i)configured in accordance with these rules; and

(ii) will create an accurate internet voting record in respect of any voter who casts his or her vote using the internet voting system;

(b) if telephone voting to be a method of polling, the telephone voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate telephone voting record in respect of any voter who casts his or her vote using the telephone voting system;

(c) if text message voting is to be a method of polling, the text message voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate text voting record in respect of any voter who casts his or her vote using the text message voting system.

20. The ballot paper

20.1 The ballot of each voter (other than a voter who casts his or her ballot by an e-voting method of polling) is to consist of a ballot paper with the persons remaining validly nominated for an election after any withdrawals under these rules, and no others, inserted in the paper.

20.2 Every ballot paper must specify:

(a) the name of the corporation,

(b) the constituency, or class within a constituency, for which the election is being held,

(c) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(d) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(e) instructions on how to vote by all available methods of polling, including the relevant voter's voter ID number if one or more e-voting methods of polling are available,

(f) if the ballot paper is to be returned by post, the address for its return and the date and time of the close of the poll, and

(g) the contact details of the returning officer.

20.3 Each ballot paper must have a unique identifier.

20.4 Each ballot paper must have features incorporated into it to prevent it from being reproduced.

21. The declaration of identity (public and patient constituencies)

21.1 The corporation shall require each voter who participates in an election for a public or patient constituency to make a declaration confirming:

(a) that the voter is the person:

(i) to whom the ballot paper was addressed, and/or

(ii) to whom the voter ID number contained within the e-voting information was allocated,

(b) that he or she has not marked or returned any other voting information in the election, and

(c) the particulars of his or her qualification to vote as a member of the constituency or class within the constituency for which the election is being held,

("declaration of identity")

and the corporation shall make such arrangements as it considers appropriate to facilitate the making and the return of a declaration of identity by each voter, whether by the completion of a paper form ("ID declaration form") or the use of an electronic method.

21.2 The voter must be required to return his or her declaration of identity with his or her ballot.

21.3 The voting information shall caution the voter that if the declaration of identity is not duly returned or is returned without having been made correctly, any vote cast by the voter may be declared invalid.

Action to be taken before the poll

22. List of eligible voters

22.1 The corporation is to provide the returning officer with a list of the members of the constituency or class within a constituency for which the election is being held who are eligible to vote by virtue of rule 27 as soon as is reasonably practicable after the final date for the delivery of notices of withdrawals by candidates from an election.

22.2 The list is to include, for each member:

(a) a postal address; and,

(b) the member's e-mail address, if this has been provided

to which his or her voting information may, subject to rule 22.3, be sent.

22.3 The corporation may decide that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list.

23. Notice of poll

23.1 The returning officer is to publish a notice of the poll stating:

(a) the name of the corporation,

(b) the constituency, or class within a constituency, for which the election is being held,

(c) the number of members of the council of governors to be elected from that constituency, or class with that constituency,

(d) the names, contact addresses, and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(e) that the ballot papers for the election are to be issued and returned, ifappropriate, by post,

(f) the methods of polling by which votes may be cast at the election by voters in a constituency or class within a constituency, as determined by the corporation in accordance with rule 19.3,

(g) the address for return of the ballot papers,

(h) the uniform resource locator (url) where, if internet voting is a method of polling, the polling website is located;

(i) the telephone number where, if telephone voting is a method of polling, the telephone voting facility is located,

(j) the telephone number or telephone short code where, if text message voting is a method of polling, the text message voting facility is located,

(k) the date and time of the close of the poll,

(l) the address and final dates for applications for replacement voting information, and

(m) the contact details of the returning officer.

24. Issue of voting information by returning officer

24.1 Subject to rule 24.3, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by post to each member of the corporation named in the list of eligible voters:

(a) a ballot paper and ballot paper envelope,

(b) the ID declaration form (if required),

(c) information about each candidate standing for election, pursuant to rule 61 of these rules, and

(d) a covering envelope;

("postal voting information").

24.2 Subject to rules 24.3 and 24.4, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by e-mail and/ or by post to each member of the corporation named in the list of eligible voters whom the corporation determines in accordance with rule 19.3 and/ or rule 19.4 may cast his or her vote by an e-voting method of polling:

(a) instructions on how to vote and how to make a declaration of identity (if required),

(b) the voter's voter ID number,

(c) information about each candidate standing for election, pursuant to rule 64 of these rules, or details of where this information is readily available on the internet or available in such other formats as the Returning Officer thinks appropriate, (d) contact details of the returning officer,

("e-voting information").

24.3 The corporation may determine that any member of the corporation shall:

(a) only be sent postal voting information; or

(b) only be sent e-voting information; or

(c) be sent both postal voting information and e-voting information;

for the purposes of the poll.

24.4 If the corporation determines, in accordance with rule 22.3, that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list, then the returning officer shall only send that information by e-mail.

24.5 The voting information is to be sent to the postal address and/ or e-mail address for each member, as specified in the list of eligible voters.

25. Ballot paper envelope and covering envelope

25.1 The ballot paper envelope must have clear instructions to the voter printed on it, instructing the voter to seal the ballot paper inside the envelope once the ballot paper has been marked.

25.2 The covering envelope is to have:

(a) the address for return of the ballot paper printed on it, and

(b) pre-paid postage for return to that address.

25.3 There should be clear instructions, either printed on the covering envelope or elsewhere, instructing the voter to seal the following documents inside the covering envelope and return it to the returning officer –

(a) the completed ID declaration form if required, and

(b) the ballot paper envelope, with the ballot paper sealed inside it.

26. E-voting systems

26.1 If internet voting is a method of polling for the relevant election then the returning officer must provide a website for the purpose of voting over the internet (in these rules referred to as "the polling website").

26.2 If telephone voting is a method of polling for the relevant election then the returning officer must provide an automated telephone system for the purpose of voting by the use of a touch-tone telephone (in these rules referred to as “the telephone voting facility”).

26.3 If text message voting is a method of polling for the relevant election then the returning officer must provide an automated text messaging system for the purpose of voting by text message (in these rules referred to as “the text message voting facility”).

26.4 The returning officer shall ensure that the polling website and internet voting system provided will:

(a) require a voter to:

(i) enter his or her voter ID number; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

in order to be able to cast his or her vote;

(b) specify:

(i) the name of the corporation,

(ii) the constituency, or class within a constituency, for which the election is being held,

(iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(iv) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(v) instructions on how to vote and how to make a declaration of identity,

(vi) the date and time of the close of the poll, and

(vii) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than he or she is

entitled to at the election;

(d) create a record ("internet voting record") that is stored in the internet voting system in respect of each vote cast by a voter using the internet that comprises of-

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(iii) the candidate or candidates for whom the voter has voted; and

(iv) the date and time of the voter's vote,

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this; and

(f) prevent any voter from voting after the close of poll.

26.5 The returning officer shall ensure that the telephone voting facility and telephone voting system provided will:

(a) require a voter to

(i) enter his or her voter ID number in order to be able to cast his or her vote; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

(b) specify:

(i)the name of the corporation,

(ii) the constituency, or class within a constituency, for which the election is being held,

(iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(iv) instructions on how to vote and how to make a declaration of identity,

(v) the date and time of the close of the poll, and

(vi) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("telephone voting record") that is stored in the telephone voting system in respect of each vote cast by a voter using the telephone that comprises of:

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(iii) the candidate or candidates for whom the voter has voted; and

(iv) the date and time of the voter's vote

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(f) prevent any voter from voting after the close of poll.

26.6 The returning officer shall ensure that the text message voting facility and text

messaging voting system provided will:

(a) require a voter to:

(i) provide his or her voter ID number; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

in order to be able to cast his or her vote;

(b) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("text voting record") that is stored in the text messaging voting system in respect of each vote cast by a voter by text message that comprises of:

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(ii) the candidate or candidates for whom the voter has voted; and

(iii) the date and time of the voter's vote

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(f) prevent any voter from voting after the close of poll.

The poll

27. Eligibility to vote

27.1 An individual who becomes a member of the corporation on or before the closing date for the receipt of nominations by candidates for the election, is eligible to vote in that election.

28. Voting by persons who require assistance

28.1 The returning officer is to put in place arrangements to enable requests for assistance to vote to be made.

28.2 Where the returning officer receives a request from a voter who requires assistance to vote, the returning officer is to make such arrangements as he or she considers necessary to enable that voter to vote.

29. Spoilt ballot papers and spoilt text message votes

29.1 If a voter has dealt with his or her ballot paper in such a manner that it cannot be accepted as a ballot paper (referred to as a "spoilt ballot paper"), that voter may apply to the returning officer for a replacement ballot paper.

29.2 On receiving an application, the returning officer is to obtain the details of the unique identifier on the spoilt ballot paper, if he or she can obtain it.

29.3 The returning officer may not issue a replacement ballot paper for a spoilt ballot paper unless he or she:

(a) is satisfied as to the voter's identity; and

(b) has ensured that the completed ID declaration form, if required, has not been returned.

29.4 After issuing a replacement ballot paper for a spoilt ballot paper, the returning

officer shall enter in a list ("the list of spoilt ballot papers"):

(a) the name of the voter, and

(b) the details of the unique identifier of the spoilt ballot paper (if that officer was able to obtain it), and

(c) the details of the unique identifier of the replacement ballot paper.

29.5 If a voter has dealt with his or her text message vote in such a manner that it cannot be accepted as a vote (referred to as a "spoilt text message vote"), that voter may apply to the returning officer for a replacement voter ID number.

29.6 On receiving an application, the returning officer is to obtain the details of the voter ID number on the spoilt text message vote, if he or she can obtain it.

29.7 The returning officer may not issue a replacement voter ID number in respect of a spoilt text message vote unless he or she is satisfied as to the voter's identity.

29.8 After issuing a replacement voter ID number in respect of a spoilt text message vote, the returning officer shall enter in a list ("the list of spoilt text message votes"):

(a) the name of the voter, and

(b) the details of the voter ID number on the spoilt text message vote (if that officer was able to obtain it), and

(c) the details of the replacement voter ID number issued to the voter.

30. Lost voting information

30.1 Where a voter has not received his or her voting information by the tenth day before the close of the poll, that voter may apply to the returning officer for replacement voting information.

30.2 The returning officer may not issue replacement voting information in respect of lost voting information unless he or she:

(a) is satisfied as to the voter's identity,

(b) has no reason to doubt that the voter did not receive the original voting information,

(c) has ensured that no declaration of identity, if required, has been returned.

30.3 After issuing replacement voting information in respect of lost voting information, the returning officer shall enter in a list ("the list of lost ballot documents"):

(a) the name of the voter

(b) the details of the unique identifier of the replacement ballot paper, if applicable, and

(c) the voter ID number of the voter.

31. Issue of replacement voting information

31.1 If a person applies for replacement voting information under rule 29 or 30 and

a declaration of identity has already been received by the returning officer in the name of that voter, the returning officer may not issue replacement voting information unless, in addition to the requirements imposed by rule 29.3 or 30.2, he or she is also satisfied that that person has not already voted in the election, notwithstanding the fact that a declaration of identity if required has already been received by the returning officer in the name of that voter.

31.2 After issuing replacement voting information under this rule, the returning officer shall enter in a list ("the list of tendered voting information"):

(a) the name of the voter,

(b) the unique identifier of any replacement ballot paper issued under this rule;

(c) the voter ID number of the voter.

32. ID declaration form for replacement ballot papers (public and patient constituencies)

32.1 In respect of an election for a public or patient constituency an ID declaration form must be issued with each replacement ballot paper requiring the voter to make a declaration of identity.

Polling by internet, telephone or text

33. Procedure for remote voting by internet

33.1 To cast his or her vote using the internet, a voter will need to gain access to the polling website by keying in the url of the polling website provided in the voting information.

33.2 When prompted to do so, the voter will need to enter his or her voter ID number.

33.3 If the internet voting system authenticates the voter ID number, the system will give the voter access to the polling website for the election in which the voter is eligible to vote.

33.4 To cast his or her vote, the voter will need to key in a mark on the screen opposite the particulars of the candidate or candidates for whom he or she wishes to cast his or her vote.

33.5 The voter will not be able to access the internet voting system for an election once his or her vote at that election has been cast.

34. Voting procedure for remote voting by telephone

34.1 To cast his or her vote by telephone, the voter will need to gain access to the telephone voting facility by calling the designated telephone number provided in the voter information using a telephone with a touch-tone keypad.

34.2 When prompted to do so, the voter will need to enter his or her voter ID number using the keypad.

34.3 If the telephone voting facility authenticates the voter ID number, the voter will be prompted to vote in the election.

34.4 When prompted to do so the voter may then cast his or her vote by keying in the numerical voting code of the candidate or candidates, for whom he or she wishes to vote.

34.5 The voter will not be able to access the telephone voting facility for an election once his or her vote at that election has been cast.

35. Voting procedure for remote voting by text message

35.1 To cast his or her vote by text message the voter will need to gain access to the text message voting facility by sending a text message to the designated telephone number or telephone short code provided in the voter information.

35.2 The text message sent by the voter must contain his or her voter ID number and the numerical voting code for the candidate or candidates, for whom he or she wishes to vote.

35.3 The text message sent by the voter will need to be structured in accordance with the instructions on how to vote contained in the voter information, otherwise the vote will not be cast.

Procedure for receipt of envelopes, internet votes, telephone votes and text message votes

36. Receipt of voting documents

36.1 Where the returning officer receives:

(a) a covering envelope, or

(b) any other envelope containing an ID declaration form if required, a ballot paper envelope, or a ballot paper,

before the close of the poll, that officer is to open it as soon as is practicable; and rules 37 and 38 are to apply.

36.2 The returning officer may open any covering envelope or any ballot paper envelope for the purposes of rules 37 and 38, but must make arrangements to ensure that no person obtains or communicates information as to:

(a) the candidate for whom a voter has voted, or

(b) the unique identifier on a ballot paper.

36.3 The returning officer must make arrangements to ensure the safety and security of the ballot papers and other documents.

37. Validity of votes

37.1 A ballot paper shall not be taken to be duly returned unless the returning officer is satisfied that it has been received by the returning officer before the close of the poll, with an ID declaration form if required that has been correctly completed, signed and dated.

37.2 Where the returning officer is satisfied that rule 37.1 has been fulfilled, he or she is to:

(a) put the ID declaration form if required in a separate packet, and

(b) put the ballot paper aside for counting after the close of the poll.

37.3 Where the returning officer is not satisfied that rule 37.1 has been fulfilled, he or she is to:

(a) mark the ballot paper “disqualified”,

(b) if there is an ID declaration form accompanying the ballot paper, mark it “disqualified” and attach it to the ballot paper,

(c) record the unique identifier on the ballot paper in a list of disqualified documents (the "list of disqualified documents"); and

(d) place the document or documents in a separate packet.

37.4 An internet, telephone or text message vote shall not be taken to be duly returned unless the returning officer is satisfied that the internet voting record, telephone voting record or text voting record (as applicable) has been received by the returning officer before the close of the poll, with a declaration of identity if required that has been correctly made.

37.5 Where the returning officer is satisfied that rule 37.4 has been fulfilled, he or she is to put the internet voting record, telephone voting record or text voting record (as applicable) aside for counting after the close of the poll.

37.6 Where the returning officer is not satisfied that rule 37.4 has been fulfilled, he or she is to:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) "disqualified",

(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents; and

(c) place the document or documents in a separate packet.

38. Declaration of identity but no ballot paper (public and patient constituency)[1]

38.1 Where the returning officer receives an ID declaration form if required but no ballot paper, the returning officer is to:

(a) mark the ID declaration form "disqualified",

(b) record the name of the voter in the list of disqualified documents, indicating that a declaration of identity was received from the voter without a ballot paper, and

(c) place the ID declaration form in a separate packet.

39. De-duplication of votes

39.1 Where different methods of polling are being used in an election, the returning officer shall examine all votes cast to ascertain if a voter ID number has been used more than once to cast a vote in the election.

39.2 If the returning officer ascertains that a voter ID number has been used more than once to cast a vote in the election he or she shall:

(a) only accept as duly returned the first vote received that was cast using the relevant voter ID number; and

(b) mark as "disqualified" all other votes that were cast using the relevant voter ID number

39.3 Where a ballot paper is disqualified under this rule the returning officer shall:

(a) mark the ballot paper "disqualified",

(b) if there is an ID declaration form accompanying the ballot paper, mark it

[1] It should not be possible, technically, to make a declaration of identity electronically without also submitting a vote.

"disqualified" and attach it to the ballot paper,

(c) record the unique identifier and the voter ID number on the ballot paper in the list of disqualified documents;

(d) place the document or documents in a separate packet; and

(e) disregard the ballot paper when counting the votes in accordance with these rules.

39.4 Where an internet voting record, telephone voting record or text voting record is disqualified under this rule the returning officer shall:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) "disqualified",

(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents;

(c) place the internet voting record, telephone voting record or text voting record (as applicable) in a separate packet, and

(d) disregard the internet voting record, telephone voting record or text voting record (as applicable) when counting the votes in accordance with these rules.

40. Sealing of packets

40.1 As soon as is possible after the close of the poll and after the completion of the procedure under rules 37 and 38, the returning officer is to seal the packets containing:

(a) the disqualified documents, together with the list of disqualified documents inside it,

(b) the ID declaration forms, if required,

(c) the list of spoilt ballot papers and the list of spoilt text message votes,

(d) the list of lost ballot documents,

(e) the list of eligible voters, and

(f) the list of tendered voting information

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

PART 6: COUNTING THE VOTES

STV41. Interpretation of Part 6

STV41.1 In Part 6 of these rules:

"*ballot document*" means a ballot paper, internet voting record, telephone voting record or text voting record.

"*continuing candidate*" means any candidate not deemed to be elected, and not excluded,

"*count*" means all the operations involved in counting of the first preferences recorded for candidates, the transfer of the surpluses of elected candidates, and the transfer of the votes of the excluded candidates,

"*deemed to be elected*" means deemed to be elected for the purposes of counting of votes but without prejudice to the declaration of the result of the poll,

"*mark*" means a figure, an identifiable written word, or a mark such as "X",

"*non-transferable vote*" means a ballot document:

(a) on which no second or subsequent preference is recorded for a continuing candidate,

or

(b) which is excluded by the returning officer under rule STV49,

"*preference*" as used in the following contexts has the meaning assigned below:

(a) "first preference" means the figure "1" or any mark or word which clearly indicates a first (or only) preference,

(b) "next available preference" means a preference which is the second, or as the case may be, subsequent preference recorded in consecutive order for a continuing candidate (any candidate who is deemed to be elected or is excluded thereby being ignored); and

(c) in this context, a "second preference" is shown by the figure "2" or any mark or word which clearly indicates a second preference, and a third preference by the figure "3" or any mark or word which clearly indicates a third preference, and so on,

"*quota*" means the number calculated in accordance with rule STV46,

"*surplus*" means the number of votes by which the total number of votes for any candidate (whether first preference or transferred votes, or a combination of both) exceeds the quota; but references in these rules to the transfer of the surplus means the transfer (at a transfer value) of all transferable ballot documents from the candidate who has the surplus,
"*stage of the count*" means:

(a) the determination of the first preference vote of each candidate,

(b) the transfer of a surplus of a candidate deemed to be elected, or
(c) the exclusion of one or more candidates at any given time,

"*transferable vote*" means a ballot document on which, following a first preference, a second or subsequent preference is recorded in consecutive numerical order for a continuing candidate,

"*transferred vote*" means a vote derived from a ballot document on which a second or subsequent preference is recorded for the candidate to whom that ballot document has been transferred, and

"*transfer value*" means the value of a transferred vote calculated in accordance with rules STV47.4 or STV47.7.

42. Arrangements for counting of the votes

42.1 The returning officer is to make arrangements for counting the votes as soon as is practicable after the close of the poll.

42.2 The returning officer may make arrangements for any votes to be counted using vote counting software where:

(a) the board of directors and the council of governors of the corporation have approved:

(i) the use of such software for the purpose of counting votes in the relevant election, and

(ii) a policy governing the use of such software, and

(b) the corporation and the returning officer are satisfied that the use of such software will produce an accurate result.

43. The count

43.1 The returning officer is to:

(a) count and record the number of:

(iii) ballot papers that have been returned; and

(iv) the number of internet voting records, telephone voting records and/or text voting records that have been created, and

(b) count the votes according to the provisions in this Part of the rules and/or the provisions of any policy approved pursuant to rule 42.2(ii) where vote counting software is being used.

43.2 The returning officer, while counting and recording the number of ballot papers, internet voting records, telephone voting records and/or text voting records and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique identifier on a ballot paper or the voter ID number on an internet voting record, telephone voting record or text voting record.

43.3 The returning officer is to proceed continuously with counting the votes as far as is practicable.

STV44. Rejected ballot papers and rejected text voting records

STV44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,

(b) on which the figure "1" standing alone is not placed so as to indicate a first preference for any candidate,

(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the ballot paper shall not be rejected by reason only of carrying the words "one", "two", "three" and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.2 The returning officer is to endorse the word "rejected" on any ballot paper which under this rule is not to be counted.

STV44.3 Any text voting record:

(a) on which the figure "1" standing alone is not placed so as to indicate a first preference for any candidate,

(b) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(c) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the text voting record shall not be rejected by reason only of carrying the words "one", "two", "three" and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.4 The returning officer is to endorse the word "rejected" on any text voting record which under this rule is not to be counted.

STV44.5 The returning officer is to draw up a statement showing the number of ballot papers rejected by him or her under each of the subparagraphs (a) to (d) of rule STV44.1 and the number of text voting records rejected by him or her under each of the sub-paragraphs (a) to (c) of rule STV44.3.

FPP44. Rejected ballot papers and rejected text voting records

FPP44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,

(b) on which votes are given for more candidates than the voter is entitled to vote,

(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.2 and FPP44.3, be rejected and not counted.

FPP44.2 Where the voter is entitled to vote for more than one candidate, a ballot paper is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP44.3 A ballot paper on which a vote is marked:

(a) elsewhere than in the proper place,

(b) otherwise than by means of a clear mark,

(c) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the paper is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

FPP44.4 The returning officer is to:

(a) endorse the word “rejected” on any ballot paper which under this rule is not to be counted, and

(b) in the case of a ballot paper on which any vote is counted under rules FPP44.2 and FPP 44.3, endorse the words “rejected in part” on the ballot paper and indicate which vote or votes have been counted.

FPP44.5 The returning officer is to draw up a statement showing the number of rejected ballot papers under the following headings:

(a) does not bear proper features that have been incorporated into the ballot paper,

(b) voting for more candidates than the voter is entitled to,

(c) writing or mark by which voter could be identified, and

(d) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of ballot papers rejected in part.

FPP44.6 Any text voting record:

(a) on which votes are given for more candidates than the voter is entitled to vote,

(b) on which anything is written or marked by which the voter can be identified except the voter ID number, or

(c) which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.7 and FPP44.8, be rejected and not counted.

FPP44.7 Where the voter is entitled to vote for more than one candidate, a text voting record is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP448 A text voting record on which a vote is marked:

(a) otherwise than by means of a clear mark,

(b) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the text voting record is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

FPP44.9 The returning officer is to:

(a) endorse the word “rejected” on any text voting record which under this rule is not to be counted, and

(b) in the case of a text voting record on which any vote is counted under rules FPP44.7 and FPP 44.8, endorse the words “rejected in part” on the text voting record and indicate which vote or votes have been counted.

FPP44.10 The returning officer is to draw up a statement showing the number of rejected text voting records under the following headings:

(a) voting for more candidates than the voter is entitled to,

(b) writing or mark by which voter could be identified, and

(c) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of text voting records rejected in part.

STV45. First stage

STV45.1 The returning officer is to sort the ballot documents into parcels according to the candidates for whom the first preference votes are given.

STV45.2 The returning officer is to then count the number of first preference votes given on ballot documents for each candidate and is to record those numbers.

STV45.3 The returning officer is to also ascertain and record the number of valid ballot documents.

STV46. The quota

STV46.1 The returning officer is to divide the number of valid ballot documents by a number exceeding by one the number of members to be elected.

STV46.2 The result, increased by one, of the division under rule STV46.1 (any fraction being disregarded) shall be the number of votes sufficient to secure the election of a candidate (in these rules referred to as “the quota”).

STV46.3 At any stage of the count a candidate whose total votes equals or exceeds the quota shall be deemed to be elected, except that any election where there is only one vacancy a candidate shall not be deemed to be elected until the procedure set out in rules STV47.1 to STV47.3 has been complied with.

STV47. Transfer of votes

STV47.1 Where the number of first preference votes for any candidate exceeds the quota, the returning officer is to sort all the ballot documents on which first preference votes are given for that candidate into sub- parcels so that they are grouped:

(a) according to next available preference given on those ballot documents for any continuing candidate, or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.2 The returning officer is to count the number of ballot documents in each parcel referred to in rule STV47.1.

STV47.3 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.1(a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.4 The vote on each ballot document transferred under rule STV47.3 shall be at a value ("the transfer value") which:

(a) reduces the value of each vote transferred so that the total value of all such votes does not exceed the surplus, and

(b) is calculated by dividing the surplus of the candidate from whom the votes are being transferred by the total number of the ballot documents on which those votes are given, the calculation being made to two decimal places (ignoring the remainder if any).

STV47.5 Where at the end of any stage of the count involving the transfer of ballot documents, the number of votes for any candidate exceeds the quota, the returning officer is to sort the ballot documents in the sub-parcel of transferred votes which was last received by that candidate into separate sub-parcels so that they are grouped:

(a) according to the next available preference given on those ballot documents for any continuing candidate, or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.6 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.5(a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.7 The vote on each ballot document transferred under rule STV47.6 shall be at:

(a) a transfer value calculated as set out in rule STV47.4(b), or

(b) at the value at which that vote was received by the candidate from whom it is now being transferred,

whichever is the less.

STV47.8 Each transfer of a surplus constitutes a stage in the count.

STV47.9 Subject to rule STV47.10, the returning officer shall proceed to transfer transferable ballot documents until no candidate who is deemed to be elected has a surplus or all the vacancies have been filled.

STV47.10 Transferable ballot documents shall not be liable to be transferred where any surplus or surpluses which, at a particular stage of the count, have not already been transferred, are:

(a) less than the difference between the total vote then credited to the continuing candidate with the lowest recorded vote and the vote of the candidate with the next lowest recorded vote, or

(b) less than the difference between the total votes of the two or more continuing candidates, credited at that stage of the count with the lowest recorded total numbers of votes and the candidate next above such candidates.

STV47.11 This rule does not apply at an election where there is only one vacancy.

STV48. Supplementary provisions on transfer

STV48.1 If, at any stage of the count, two or more candidates have surpluses, the transferable ballot documents of the candidate with the highest surplus shall be transferred first, and if:

(a) The surpluses determined in respect of two or more candidates are equal, the transferable ballot documents of the candidate who had the highest recorded vote at the earliest preceding stage at which they had unequal votes shall be transferred first, and

(b) the votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between those candidates by lot, and the transferable ballot documents of the candidate on whom the lot falls shall be transferred first.

STV48.2 The returning officer shall, on each transfer of transferable ballot documents under rule STV47:

(a) record the total value of the votes transferred to each candidate,

(b) add that value to the previous total of votes recorded for each candidate and record the new total,

(c) record as non-transferable votes the difference between the surplus and the total transfer value of the transferred votes and add that difference to the previously recorded total of non-transferable votes, and

(d) compare:

(i) the total number of votes then recorded for all of the candidates, together with the total number of non-transferable votes, with

(ii) the recorded total of valid first preference votes.

STV48.3 All ballot documents transferred under rule STV47 or STV49 shall be clearly marked, either individually or as a sub-parcel, so as to indicate the transfer value recorded at that time to each vote on that ballot document or, as the case may be, all the ballot documents in that sub-parcel.

STV48.4 Where a ballot document is so marked that it is unclear to the returning officer at any stage of the count under rule STV47 or STV49 for which

candidate the next preference is recorded, the returning officer shall treat any vote on that ballot document as a non-transferable vote; and votes on a ballot document shall be so treated where, for example, the names of two or more candidates (whether continuing candidates or not) are so marked that, in the opinion of the returning officer, the same order of preference is indicated or the numerical sequence is broken.

STV49. Exclusion of candidates

STV49.1 If:

(a) all transferable ballot documents which under the provisions of rule STV47 (including that rule as applied by rule STV49.11) and this rule are required to be transferred, have been transferred, and

(b) subject to rule STV50, one or more vacancies remain to be filled,

the returning officer shall exclude from the election at that stage the candidate with the then lowest vote (or, where rule STV49.12 applies, the candidates with the then lowest votes).

STV9.2 The returning officer shall sort all the ballot documents on which first preference votes are given for the candidate or candidates excluded under rule STV49.1 into two sub-parcels so that they are grouped as:

(a) ballot documents on which a next available preference is given, and

(b) ballot documents on which no such preference is given (thereby including ballot documents on which preferences are given only for candidates who are deemed to be elected or are excluded).

STV49.3 The returning officer shall, in accordance with this rule and rule STV48, transfer each sub-parcel of ballot documents referred to in rule STV49.2 to the candidate for whom the next available preference is given on those ballot documents.

STV49.4 The exclusion of a candidate, or of two or more candidates together, constitutes a further stage of the count.

STV49.5 If, subject to rule STV50, one or more vacancies still remain to be filled, the returning officer shall then sort the transferable ballot documents, if any, which had been transferred to any candidate excluded under rule STV49.1 into sub- parcels according to their transfer value.

STV49.6 The returning officer shall transfer those ballot documents in the sub-parcel of transferable ballot documents with the highest transfer value to the continuing candidates in accordance with the next available preferences given on those ballot documents (thereby passing over candidates who are deemed to be elected or are excluded).

STV49.7 The vote on each transferable ballot document transferred under rule STV49.6 shall be at the value at which that vote was received by the candidate excluded under rule STV49.1.

STV9.8 Any ballot documents on which no next available preferences have been expressed shall be set aside as non-transferable votes.

STV49.9 After the returning officer has completed the transfer of the ballot documents in the sub-parcel of ballot documents with the highest transfer value he or she shall proceed to transfer in the same way the sub-parcel of ballot documents with the next highest value and so on until he has dealt with each sub-parcel of a candidate excluded under rule STV49.1.

STV49.10 The returning officer shall after each stage of the count completed under this rule:

(a) record:

(i) the total value of votes, or

(ii) the total transfer value of votes transferred to each candidate,

(b) add that total to the previous total of votes recorded for each candidate and record the new total,

(c) record the value of non-transferable votes and add that value to the previous non-transferable votes total, and

(d) compare:

(i) the total number of votes then recorded for each candidate together with the total number of non-transferable votes, with

(ii) the recorded total of valid first preference votes.

STV49.11 If after a transfer of votes under any provision of this rule, a candidate has a surplus, that surplus shall be dealt with in accordance with rules STV47.5 to STV47.10 and rule STV48.

STV49.12 Where the total of the votes of the two or more lowest candidates, together with any surpluses not transferred, is less than the number of votes credited to the next lowest candidate, the returning officer shall in one operation exclude such two or more candidates.

STV49.13 If when a candidate has to be excluded under this rule, two or more candidates each have the same number of votes and are lowest:

(a) regard shall be had to the total number of votes credited to those candidates at the earliest stage of the count at which they had an unequal number of votes and the candidate with the lowest number of votes at that stage shall be excluded, and

(b) where the number of votes credited to those candidates was equal at all stages, the returning officer shall decide between the candidates by lot and the candidate on whom the lot falls shall be excluded.

STV50. Filling of last vacancies

STV50.1 Where the number of continuing candidates is equal to the number of vacancies remaining unfilled the continuing candidates shall thereupon be deemed to be elected.

STV50.2 Where only one vacancy remains unfilled and the votes of any one continuing candidate are equal to or greater than the total of votes credited to other continuing candidates together with any surplus not transferred, the candidate shall thereupon be deemed to be elected.

STV50.3 Where the last vacancies can be filled under this rule, no further transfer of votes shall be made.

STV51. Order of election of candidates

STV51.1 The order in which candidates whose votes equal or exceed the quota are deemed to be elected shall be the order in which their respective surpluses were transferred or would have been transferred but for rule STV47.10.

STV51.2 A candidate credited with a number of votes equal to, and not greater than, the quota shall, for the purposes of this rule, be regarded as having had the smallest surplus at the stage of the count at which he obtained the quota.

STV51.3 Where the surpluses of two or more candidates are equal and are not required to be transferred, regard shall be had to the total number of votes credited to such candidates at the earliest stage of the count at which they had an unequal number of votes and the surplus of the candidate who had the greatest number of votes at that stage shall be deemed to be the largest.

STV51.4 Where the number of votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between them by lot and the candidate on whom the lot falls shall be deemed to have been elected first.

FPP51. Equality of votes

FPP51.1 Where, after the counting of votes is completed, an equality of votes is found to exist between any candidates and the addition of a vote would entitle any of those candidates to be declared elected, the returning officer is to decide between those candidates by a lot and proceed as if the candidate on whom the lot falls had received an additional vote.

PART 7: FINAL PROCEEDINGS IN CONTESTED AND UNCONTESTED ELECTIONS

FPP52. Declaration of result for contested elections

FPP52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidate or candidates whom more votes have been given than for the other candidates, up to the number of vacancies to be filled on the council of governors from the constituency, or class within a constituency, for which the election is being held to be elected,

(b) give notice of the name of each candidate who he or she has declared elected:

(i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the chairman of the NHS Trust, or

(ii) in any other case, to the chairman of the corporation; and

(c) give public notice of the name of each candidate whom he or she has declared elected.

FPP52.2 The returning officer is to make:

(a) the total number of votes given for each candidate (whether elected or not), and

(b) the number of rejected ballot papers under each of the headings in rule FPP44.5,

(c) the number of rejected text voting records under each of the headings in rule FPP44.10,

available on request.

STV52. Declaration of result for contested elections

STV52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidates who are deemed to be elected under Part 6 of these rules as elected,

(b) give notice of the name of each candidate who he or she has declared elected –

(i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the chairman of the NHS Trust, or

(ii) in any other case, to the chairman of the corporation, and

(c) give public notice of the name of each candidate who he or she has declared elected.

STV52.2 The returning officer is to make:

(a) the number of first preference votes for each candidate whether elected or not,

(b) any transfer of votes,

(c) the total number of votes for each candidate at each stage of the count at which such transfer took place,

(d) the order in which the successful candidates were elected, and

(e) the number of rejected ballot papers under each of the headings in rule STV44.1,

(f) the number of rejected text voting records under each of the headings in rule STV44.3,

available on request.

53. Declaration of result for uncontested elections

53.1 In an uncontested election, the returning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election:

(a) declare the candidate or candidates remaining validly nominated to be elected,

(b) give notice of the name of each candidate who he or she has declared elected to the chairman of the corporation, and

(c) give public notice of the name of each candidate who he or she has declared elected.

PART 8: DISPOSAL OF DOCUMENTS

54. Sealing up of documents relating to the poll

54.1 On completion of the counting at a contested election, the returning officer is to seal up the following documents in separate packets:

(a) the counted ballot papers, internet voting records, telephone voting records and text voting records,

(b) the ballot papers and text voting records endorsed with "rejected in part",

(c) the rejected ballot papers and text voting records, and

(d) the statement of rejected ballot papers and the statement of rejected text voting records,

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

54.2 The returning officer must not open the sealed packets of:

(a) the disqualified documents, with the list of disqualified documents inside it,

(b) the list of spoilt ballot papers and the list of spoilt text message votes,

(c) the list of lost ballot documents, and

(d) the list of eligible voters,

or access the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage.

54.3 The returning officer must endorse on each packet a description of:

(a) its contents,

(b) the date of the publication of notice of the election,

(c) the name of the corporation to which the election relates, and

(d) the constituency, or class within a constituency, to which the election relates.

55. Delivery of documents

55.1 Once the documents relating to the poll have been sealed up and endorsed pursuant to rule 56, the returning officer is to forward them to the chair of the corporation.

56. Forwarding of documents received after close of the poll

56.1 Where:

(a) any voting documents are received by the returning officer after the close of the poll, or

(b) any envelopes addressed to eligible voters are returned as undelivered

too late to be resent, or

(c) any applications for replacement voting information are made too late to enable new voting information to be issued,

the returning officer is to put them in a separate packet, seal it up, and endorse and forward it to the chairman of the corporation.

57. Retention and public inspection of documents

57.1 The corporation is to retain the documents relating to an election that are forwarded to the chair by the returning officer under these rules for one year, and then, unless otherwise directed by the board of directors of the corporation, cause them to be destroyed.

57.2 With the exception of the documents listed in rule 58.1, the documents relating to an election that are held by the corporation shall be available for inspection by members of the public at all reasonable times.

57.3 A person may request a copy or extract from the documents relating to an election that are held by the corporation, and the corporation is to provide it, and may impose a reasonable charge for doing so.

58. Application for inspection of certain documents relating to an election

58.1 The corporation may not allow:

(a) the inspection of, or the opening of any sealed packet containing –

(i) any rejected ballot papers, including ballot papers rejected in part,

(ii) any rejected text voting records, including text voting records rejected in part,

(iii) any disqualified documents, or the list of disqualified documents,

(iv) any counted ballot papers, internet voting records, telephone voting records or text voting records, or

(v) the list of eligible voters, or

(b) access to or the inspection of the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage,

by any person without the consent of the board of directors of the corporation.

58.2 A person may apply to the board of directors of the corporation to inspect any of the documents listed in rule 58.1, and the board of directors of the corporation may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

58.3 The board of directors of the corporation's consent may be on any terms or conditions that it thinks necessary, including conditions as to –

(a) persons,

(b) time,

(c) place and mode of inspection,

(d) production or opening,

and the corporation must only make the documents available for inspection in accordance with those terms and conditions.

58.4 On an application to inspect any of the documents listed in rule 58.1 the board of directors of the corporation must:

(a) in giving its consent, and

(b) in making the documents available for inspection

ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established –

(i) that his or her vote was given, and

(ii) that Monitor has declared that the vote was invalid.

PART 9: DEATH OF A CANDIDATE DURING A CONTESTED ELECTION

FPP59. Countermand or abandonment of poll on death of candidate

FPP59.1 If at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) countermand notice of the poll, or, if voting information has been issued, direct that the poll be abandoned within that constituency or class, and

(b) order a new election, on a date to be appointed by him or her in consultation with the corporation, within the period of 40 days, computed in accordance with rule 3 of these rules, beginning with the day that the poll was countermanded or abandoned.

FPP59.2 Where a new election is ordered under rule FPP59.1, no fresh nomination is necessary for any candidate who was validly nominated for the election where the poll was countermanded or abandoned but further candidates shall be invited for that constituency or class.

FPP59.3 Where a poll is abandoned under rule FPP59.1(a), rules FPP59.4 to FPP59.7 are to apply.

FPP59.4 The returning officer shall not take any step or further step to open envelopes or deal with their contents in accordance with rules 38 and 39 and is to make up separate sealed packets in accordance with rule 40.

FPP59.5 The returning officer is to:

(a) count and record the number of ballot papers, internet voting records, telephone voting records and text voting records that have been received,

(b) seal up the ballot papers, internet voting records, telephone voting records and text voting records into packets, along with the records of the number of ballot papers, internet voting records, telephone voting records and text voting records and

ensure that complete electronic copies of the internet voting records telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

FPP59.6 The returning officer is to endorse on each packet a description of:

(a) its contents,

(b) the date of the publication of notice of the election,

(c) the name of the corporation to which the election relates, and

(d) the constituency, or class within a constituency, to which the election relates.

FPP59.7 Once the documents relating to the poll have been sealed up and endorsed pursuant to rules FPP59.4 to FPP59.6, the returning officer is to deliver them to the chairman of the corporation, and rules 57 and 58 are to apply.

STV59. Countermand or abandonment of poll on death of candidate

STV59.1 If, at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) publish a notice stating that the candidate has died, and

(b) proceed with the counting of the votes as if that candidate had been excluded from the count so that –

(i) ballot documents which only have a first preference recorded for the candidate that has died, and no preferences for any other candidates, are not to be counted, and

(ii) ballot documents which have preferences recorded for other candidates are to be counted according to the consecutive order of those preferences, passing over preferences marked for the candidate who has died.

STV59.2 The ballot documents which have preferences recorded for the candidate who has died are to be sealed with the other counted ballot documents pursuant to rule 54.1(a).

PART 10: ELECTION EXPENSES AND PUBLICITY

Election expenses

60. Election expenses

60.1 Any expenses incurred, or payments made, for the purposes of an election which contravene this Part are an electoral irregularity, which may only be questioned in an application made to Monitor under Part 11 of these rules.

61. Expenses and payments by candidates

61.1 A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election, other than expenses or payments that relate to:

(a) personal expenses,

(b) travelling expenses, and expenses incurred while living away from home, and

(c) expenses for stationery, postage, telephone, internet (or any similar means of communication) and other petty expenses, to a limit of £100.

62. Election expenses incurred by other persons

62.1 No person may:

(a) incur any expenses or make a payment (of whatever nature) for the purposes of a candidate's election, whether on that candidate's behalf or otherwise, or

(b) give a candidate or his or her family any money or property (whether as a gift, donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

62.2 Nothing in this rule is to prevent the corporation from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 63 and 64.

Publicity

63. Publicity about election by the corporation

63.1 The corporation may:

(a) compile and distribute such information about the candidates, and

(b) organise and hold such meetings to enable the candidates to speak and respond to questions,

as it considers necessary.

63.2 Any information provided by the corporation about the candidates, including information compiled by the corporation under rule 64, must be:

(a) objective, balanced and fair,

(b) equivalent in size and content for all candidates,

(c) compiled and distributed in consultation with all of the candidates standing for election, and

(d) must not seek to promote or procure the election of a specific candidate or candidates, at the expense of the electoral prospects of one or more other candidates.

63.3 Where the corporation proposes to hold a meeting to enable the candidates to speak, the corporation must ensure that all of the candidates are invited to attend, and in organising and holding such a meeting, the corporation must not seek to promote or procure the election of a specific candidate or candidates at the expense of the electoral prospects of one or more other candidates.

64. Information about candidates for inclusion with voting information

64.1 The corporation must compile information about the candidates standing for election, to be distributed by the returning officer pursuant to rule 24 of these rules.

64.2 The information must consist of:

(a) a statement submitted by the candidate of no more than 250 words,

(b) if voting by telephone or text message is a method of polling for the election, the numerical voting code allocated by the returning officer to each candidate, for the purpose of recording votes using the telephone voting facility or the text message voting facility ("numerical voting code"), and

(c) a photograph of the candidate.

65. Meaning of "for the purposes of an election"

65.1 In this Part, the phrase "for the purposes of an election" means with a view to, or otherwise in connection with, promoting or procuring a candidate's election, including the prejudicing of another candidate's electoral prospects; and the phrase "for the purposes of a candidate's election" is to be construed accordingly.

65.2 The provision by any individual of his or her own services voluntarily, on his or her own time, and free of charge is not to be considered an expense for the purposes of this Part.

PART 11: QUESTIONING ELECTIONS AND THE CONSEQUENCE OF IRREGULARITIES

66. Application to question an election

66.1 An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to Monitor for the purpose of seeking a referral to the independent election arbitration panel (IEAP).

66.2 An application may only be made once the outcome of the election has been declared by the returning officer.

66.3 An application may only be made to Monitor by:

(a) a person who voted at the election or who claimed to have had the right to vote, or

(b) a candidate, or a person claiming to have had a right to be elected at the election.

66.4 The application must:

(a) describe the alleged breach of the rules or electoral irregularity, and

(b) be in such a form as the independent panel may require.

66.5 The application must be presented in writing within 21 days of the declaration of the result of the election. Monitor will refer the application to the independent election arbitration panel appointed by Monitor.

66.6 If the independent election arbitration panel requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.

66.7 Monitor shall delegate the determination of an application to a person or panel of persons to be nominated for the purpose.

66.8 The determination by the IEAP shall be binding on and shall be given effect by the corporation, the applicant and the members of the constituency (or class within a constituency) including all the candidates for the election to which the application relates.

66.9 The IEAP may prescribe rules of procedure for the determination of an application including costs.

PART 12: MISCELLANEOUS

67. Secrecy

67.1 The following persons:

(a) the returning officer,

(b) the returning officer's staff,

must maintain and aid in maintaining the secrecy of the voting and the counting of the votes, and must not, except for some purpose authorised by law, communicate to any person any information as to:

(i) the name of any member of the corporation who has or has not been given voting information or who has or has not voted,

(ii) the unique identifier on any ballot paper,

(iii) the voter ID number allocated to any voter,

(iv) the candidate(s) for whom any member has voted.

67.2 No person may obtain or attempt to obtain information as to the candidate(s) for whom a voter is about to vote or has voted or communicate such information to any person at any time, including the unique identifier on a ballot paper given to a voter or the voter ID number allocated to a voter.

67.3 The returning officer is to make such arrangements as he or she thinks fit to ensure that the individuals who are affected by this provision are aware of the duties it imposes.

68. Prohibition of disclosure of vote

68.1 No person who has voted at an election shall, in any legal or other proceedings to question the election, be required to state for whom he or she has voted.

69. Disqualification

69.1 A person may not be appointed as a returning officer, or as staff of the returning officer pursuant to these rules, if that person is:

(a) a member of the corporation,

(b) an employee of the corporation,

(c) a director of the corporation, or

(d) employed by or on behalf of a person who has been nominated for election.

70. Delay in postal service through industrial action or unforeseen event

70.1 If industrial action, or some other unforeseen event, results in a delay in:

(a) the delivery of the documents in rule 24, or

(b) the return of the ballot papers,

the returning officer may extend the time between the publication of the notice of the poll and the close of the poll by such period as he or she considers appropriate.

Annex 5
Council of Governors: Additional Provisions

Contents

1 Eligibility to be a Governor

A person may not become a governor of the Trust, and if already holding such office will immediately cease to do so, if he:

1.1 is or has been subject to a Sexual Harm Prevention Order, Sexual Offences Prevention Order, a Foreign Travel Order, or a Risk of Sexual Harm Order made under the provisions of the Sexual Offences Act 2003;

1.2 is incapable by reason of mental disorder, illness or injury of managing or administering his property and affairs;

1.3 on the basis of disclosures obtained through an application to the Disclosure and Barring Service, is not considered suitable by the Trust's executive director responsible for workforce;

1.4 is a director of the Trust, or a governor or director of another NHS Foundation Trust or any other NHS body, unless such Foundation Trust or NHS body is an appointing organisation which is appointing him under this Constitution;

1.5 has had his tenure of office as the Chairman or as a member or director of a health service body terminated on the grounds that his appointment is not in the interests of the health service, for non-attendance at meetings, or for non-disclosure of a pecuniary interest;

1.6 has previously been removed from office as a governor of the Trust;

1.7 being a member of the Public Constituency, or the Patients and Carers' Constituency, fails to sign a declaration in the form specified by the Council of Governors of the particulars of his qualification to vote as a member of the Trust, and that he is not prevented from being a member of the Council of Governors;

1.8 has within the preceding two years been dismissed, otherwise than by reason of redundancy, from any paid employment with a health service body;

1.9 has had his name removed from any list maintained by the NHS Commissioning Board pursuant to Parts 4, 5, 6 and 7 of the 2006 Act, and has not subsequently had his name included in such a list, and due to the reason(s) for such removal, he is not considered suitable by the Trust's executive director responsible for workforce after due enquiry.

1.10 is the spouse, partner, parent or child of a member of the Council of Governors or Board of Directors of the Trust;

1.11 fails to agree to comply with the Trust's Code of Conduct for Governors;

1.12 is under eighteen years of age, though eligible to become a member at sixteen years of age;

1.13 is a member of a local authority's scrutiny committee covering health matters;

1.14 is a Member of Parliament or a candidate for election

1.15 is a CCG Chair or member of the Governing Body (unless appointed as the representative partnership Governor of the CCG)

1.16 Care Quality Commission Chair, member or employee

2 Requirement of Governor to notify Trust

Where a person has been elected or appointed to be a governor and he becomes disqualified from office under the provisions of this constitution, he shall notify the Trust Secretary in writing of such disqualification as soon as practicable upon becoming aware of it.

3 Termination of office and removal of Governors

A person holding office as a governor shall immediately cease to do so if:

3.1 he resigns by notice in writing to the Trust Secretary;

3.2 it otherwise comes to the notice of the Trust Secretary at the time that the governor takes office or later that the governor is disqualified,

3.3 he fails to attend two Council of Governor meetings in any financial year, unless the other governors are satisfied that:
(a) the absences were due to reasonable causes; and
(b) he will be able to start attending meetings of the Trust again within such a period as they consider reasonable.

3.4 in the case of an elected governor, he ceases to be a member of the Trust;

3.5 in the case of an appointed governor, the appointing organisation terminates the appointment;

3.6 he has failed to undertake any training which the Council of Governors requires all governors to undertake

3.7 he has failed to sign and deliver to the Trust Secretary a statement in the form required by the Council of Governors confirming acceptance of the Trust's Code of Conduct;

3.8 he is removed from the Council of Governors by a resolution approved by a majority of the remaining governors present and voting at a General Meeting on the grounds that:
(a) he has committed a serious breach of the Trust's Code of Conduct, or
(b) he has acted in a manner detrimental to the interests of the Trust, or
(c) he has failed to discharge his responsibilities as a governor.

4 Election of Governors

4.1 A member of one of the constituencies may nominate himself for election as a governor in his constituency and class and does not require sponsors.

5 Roles and Responsibilities

5.1 The statutory duties of the Governors are to:

5.1.1 Hold the Non-Executive Directors, individually and collectively, to account for the Performance of the Board of Directors

5.1.2 Represent the interests of the members of the Trust as a whole and the interests of the public

5.1.3 Appoint and, if appropriate, remove the Chair

5.1.4 Appoint and, if appropriate, remove the other Non-Executive Directors

5.1.5 Decide the remuneration and allowances and other terms and conditions of office of the Chair and other Non-Executive Directors

5.1.6 Approve (or not) any new appointment of a Chief Executive

5.1.7 Appoint and, if appropriate, remove the NHS Foundation Trust's Auditor; and

5.1.8 Receive the Trust's annual accounts, any report of the auditor on them, and the annual report at a meeting of the Council of Governors

5.1.9 Approve a Significant Transaction

5.1.10 Approve an application by the Trust to enter into a merger, acquisition, separation or dissolution

5.1.11 Approve proposals to increase by 5% or more the proportion of the Trust's total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the health service in England

5.1.12 Determine whether the level of non-NHS work specified in any financial plan by the Trust would significantly interfere with its principal purpose which is to provide goods and services for the health service in England, or performing its other functions and to notify the Board of Directors of its determination

5.1.13 Approve amendments to the Trust's Constitution.

5.2 Additional Powers

The Council of Governors also has a number of additional functions, as follows:

5.2.1 In preparing the Trust's forward plan, the Board of Directors must have regard to the views of the Council of Governors

5.2.2 The Council of Governors may require one or more of the Directors to attend a Governors' meeting to obtain information about performance of the Trust's functions or the Directors' performance of their duties and to help the Council of Governors to decide whether to propose a vote on the Trust's or Directors' performance

5.2.3 The Council of Governors may refer a question to Monitor's new Advisory Panel for Governors as to whether the Trust has failed or is failing to act in accordance with its constitution or the NHS Act 2006

5.3 Before each Board meeting, the Board must send a copy of the agenda to the Council of Governors. As soon as practicable after each Board meeting, the Board must send a copy of the minutes to the Council of Governors. The Trust must also take steps to ensure that Governors have the skills and knowledge they require to undertake their role.

5.4 Governors may also become involved in other areas not detailed under the 2006 Act as amended by the 2012 Act. Details of how Governors can become involved are noted in the Governor Handbook.

6 Appointment of Non-Executive Directors (including Chairman and Deputy Chairman)

6.1 The Council of Governors shall establish a nominations committee of the Council of Governors and the Board of Directors to assist in the process of appointment of non-executive directors (including the Chairman). The committee shall comprise six governors and two directors (at least one of whom will be a non-executive director who is not being considered for re-appointment). The committee may have an independent assessor in attendance if appropriate. The committee shall be chaired by the Chairman except where the Chairman is being considered for re-appointment, when it shall be chaired by another non-executive director who is not standing for appointment as the Chairman.

7 Remuneration of the Chairman and other Non–Executive Directors

In order to determine the proper level of remuneration and allowances that should be paid to the Chairman and other non-executive directors, the Council of Governors may, from time to time, and at least every three years shall, consult, at the Trust's expense, with external professional advisers recommended by the Trust Secretary and the Director responsible for Workforce.

Annex 6
Council of Governors: Standing Orders

Contents

1 Introduction

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.

The purpose of these standing orders is to ensure:

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

1.2 Principal Purposes

The Council of Governors is accountable for several key functions within the Trust's corporate governance framework. Further details of those functions are set out in Annex 5 and within the Governor Handbook.

1.3 NHS Codes

Governors must behave in accordance with the seven Nolan Principles of Behaviour in Public Life:

- selflessness,
- integrity
- objectivity,
- accountability,
- openness
- honesty, and
- leadership

Three crucial public service values shall underpin the work of the Trust:

- **Accountability:** Everything done by those who work in or for 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 transparency about the Trust's activities to promote confidence between the Trust and its patients, members, staff, and the public.

The Council shall at all times seek to comply with the NHS Foundation Trust Code of Governance, which builds on the Combined Code of Corporate Governance.

1.4 Powers

See also **Constitution** and **Board of Directors: Standing Orders** in respect of:

- specified powers to contract in the Trust's own name.
- the conduct of all business in the Trust's own name.
- the Trust's common law duty as a Bailee for patients' property held by the Trust on behalf of patients.
- the holding of all funds received in trust in the name of the Board as corporate trustee, and the exercise of the Board's powers in relation to funds held on trust.
- the Board's accountability to the Charity Commission for those funds deemed to be charitable.

1.5 Delegation of Powers to Committees and/or to Individual Governors

Subject to the powers that the Council of Governors retains for itself, the Council may agree from time to time to the delegation of its duties to committees or working groups that it has formally constituted and consisting wholly of persons who are governors. To ensure clarity of purpose, the constitution, terms of reference, and specific powers of each committee or working group (and, if necessary, those

retained by the Council), and other conditions (such as to reporting back to the Council of Governors), shall be laid out in accordance with Trust policy, and approved by the Council. For the avoidance of doubt, such committees or working groups shall be non-executive committees of the Council and have no remit other than that specifically delegated to them in their terms of reference. Committees and working groups shall not delegate their tasks to further committees or working groups, unless expressly authorised to do so by the Council of Governors.

1.6 Committees and working groups established by the Council shall investigate any activity within their terms of reference. In doing so, they may request relevant reports and briefings from Directors and managers; and may request the attendance, with due notice, of any director, clinician or other member of staff at one or more of its meetings. All reasonable requests shall be complied with.

1.7 The Council of Governors shall approve the membership to all committees and working groups and shall determine the governors to chair each committee or working group. Each chairman is to ensure that his committee or working group fulfils the purpose for which the Council has established it. In the absence of the chairman appointed by the Council, a committee or working group may nominate another governor to chair the meeting concerned.

1.8 With the agreement of the chairman of the committee or working group, non-governors may attend such committees and working groups, if appropriate under the committee's terms of reference, but they shall have no vote.

1.9 A management lead identified by the Chief Executive shall support the chairman of any committee or working group, ensuring that appropriate material is referred to the committee, and that committee actions approved by the Council are carried out. Together, the chairman and lead of each committee or working group shall:

- schedule all meetings to allow relevant papers to be circulated to the full Council meeting that falls immediately after the committee meeting concerned.
- produce their minutes and agenda to a standard format for presentation to the committee chairman 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.
- ensure that, if an issue to be considered is known to impact on another committee, the optimum timing is considered 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.
- at its discretion, by 31 May each year, prepare for the Council 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 Secretary to validate the extent to which business plans and action plans have been followed, and to assist the committee in identifying skills gaps.
- at its discretion, produce a work plan by 1 March each year, for the subsequent year beginning 1 April, for consideration by the Council.

1.10 These standing orders, as far as they are applicable, shall apply also, with appropriate alteration, to meetings of any committees and working groups so established by the Council of Governors.

1.11 The Council will review the function and value of each committee or working group each year, reviewing its terms of reference as necessary.

1.12 The Council of Governors may also delegate duties to an individual governor, but only under a clear remit approved by the Council, and subject to such restrictions and conditions as the Council deems fit.

1.13 Emergency Powers
The powers which the Council of Governors has retained to itself within these standing orders may in emergency be exercised by the Chairman after having consulted at least five elected governors. The exercise of such powers by the Chairman shall be reported to the next formal meeting of the Council for ratification.

1.14 Derogation of 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 Council for action or ratification. All governors 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.

1.15 Amendment of Standing Orders
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, or the Trust Secretary).

2.2 Any expression to which a meaning is given in the 2006 Act, or in regulations made under the Act shall have the same meaning in such interpretation.

3 The Council of Governors

3.1 The powers of the Trust established under statute shall be exercised by the Board of Directors. The Board shall be required to retain full and effective control over the Trust. The Chairman and non-executive directors are responsible for monitoring the executive management of the Trust.

3.2 The Council of Governors may resolve that certain powers and decisions may only be exercised by the Council in formal session.

3.3 For the composition of the Council, see **Constitution: 11.**

3.4 For the process and terms of appointment, including tenure, of the governors, see **Constitution 12, 13 and 14.**

4 Accountabilities, Duties and Responsibilities

4.1 The purpose of the Council of Governors' standing orders is to ensure that the highest standards of corporate governance and conduct are applied to all meetings of the Council and its associated deliberations. The Trust believes that public service values lie at its heart. High standards of corporate and personal integrity, based on a recognition that patients come first, is a fundamental value of the Trust. There should be sufficient transparency about the Trust's activities to promote confidence between the Trust and its staff, patients and the public. Everything that the Trust does should

be able to stand the test of scrutiny, public judgement on propriety, and professional codes of conduct.

4.2 The Council shall at all times seek to comply with the NHS Foundation Trust Code of Governance which builds on the UK Corporate Governance Code ~~Combined Code of Corporate Governance~~. On appointment, the governors, whether elected or appointed, shall be required to subscribe to a ~~the~~ Code of Conduct based on this.

4.3 A governor 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 governor, save where the governor has acted recklessly. On behalf of the Council of Governors, 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.

4.4 The Council of Governors is accountable for several key functions within the Trust's corporate governance framework. Further details of those functions are set out in Annex 5 and within the Governor Handbook.

4.5 The Board of Directors has overall responsibility for running the affairs of Trust. Its role is to:
• take advice from the Council
• set a strategic direction
• set organisational and operational targets
• identify and manage risk
• assess achievement against the above objectives
• ensure that action is taken to eliminate or manage, as appropriate, adverse deviations from objectives
• ensure that the highest standards of Corporate Governance are applied throughout the organisation.

4.6 Should a dispute arise between the Council of Governors and the Board of Directors, then the disputes resolution procedure set out below recognises the different roles of the Council of Governors and the Board of Directors as described above.

4.7 The Chairman (or Deputy Chair if the dispute involves the Chairman) shall first endeavour, through discussion with governors and directors or (to achieve the earliest possible conclusion) appropriate representatives of them, to resolve the matter to the reasonable satisfaction of both parties.

4.8 Failing resolution under 4.7 above, then 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.

4.9 The Trust 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 the Board of Directors as appropriate. That meeting shall agree the precise wording of a Response to Disputes Statement.

4.10 The Chairman (or Deputy Chair if the dispute involves the Chairman) shall immediately, or as soon as is practical, communicate the outcome to the other party and deliver the written Response to Disputes Statement. If the matter remains unresolved or only partially resolved, then the procedure outlined above shall be repeated.

4.11 If, in the opinion of the Chairman (or Deputy Chair if the dispute involves the Chairman) and following the further discussions prescribed in 4.10, 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 Chair, 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.

4.12 On the satisfactory completion of this disputes process, the Board of Directors shall implement agreed changes.

4.13 On the unsatisfactory completion of this disputes process, the view of the Board of Directors shall prevail.

4.14 Nothing in this procedure shall prevent the Council of Governors, if it so desires, from informing Monitor that, in the Council of Governors' 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 NHS Provider Licence.

5 Role of Chairman

The Chairman is responsible for leading the Council of Governors and the Board of Directors. Full detail on the role of the Chairman can be found in the Corporate Governance Framework Manual~~Handbook~~.

6 Appointment of Non-Executive Directors

The Council of Governors appoints non-executive directors to bring independent judgment and critical detachment to bear on issues of strategy, performance, key appointments, and accountability to the local community; and the Council determines their remuneration. See the Constitution and Board of Directors: Standing Orders for the functions of non-executive directors.

7 Meetings of the Council of Governors

7.1 **Frequency**
Meetings of the Council of Governors shall be held at least four times each year, at times and places that the Council may determine.

7.2 **Chairman of Meeting**
At any meeting of the Council of Governors, the Chairman, if present, shall preside. If the Chairman is absent from the meeting (including absence due to a declared conflict of interest) or the Council of Governors is meeting to appoint or remove the Chair or decide his remuneration and allowances and other terms and conditions of office or outcome of annual appraisal, the Deputy Chair shall preside. Otherwise, another Non- Executive Director, as requested by the Chairman shall preside.

Attendance by the Public and Press

7.3 Meetings of the Council of Governors must be open to the public, subject to the provisions below.

7.4 The Chairman may exclude any member of public from the whole or part of any meeting of the Council of Governors if:

- he is interfering with, or preventing the reasonable conduct of, the meeting;
- publicity would be prejudicial to the public interest, by reason of the confidential nature of the business to be transacted in the judgement of the Chairman;
- there are other special reasons stated in the resolution and/or arising from the nature of the business of the proceedings.

7.5 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 Council.

7.6 **Attendance by Officers of the Trust**

The Council of Governors may invite individual directors, officers, or members, to attend all or some of its meetings to assist the Council in its deliberations. Such invitees will not contribute to the numbers required for a quorum (as defined in standing order 7.38) and shall not vote on resolutions.

Furthermore, for the purposes of obtaining information about the Trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the Trust's or directors' performance), the Council of Governors may require one or more of the directors to attend a meeting.

Calling Meetings

7.7 Notwithstanding 7.1 above, the Chairman may at any time call a meeting of the Council of Governors.

Governors can also request the Chairman call a meeting. If the Chairman refuses to call a meeting after a requisition for that purpose, signed by a majority of the governors, or if without so refusing the Chairman does not call a meeting within fourteen days after requisition to do so, then the governors may forthwith call a meeting provided that:

- they have been requisitioned to do so by more than 50% of governors who shall sign the notice of the meeting; and
- no business is transacted at the meeting other than that specified in the notice.

Notice of Meetings

7.8 Before each meeting of the Council of Governors, a notice of the meeting, specifying the business proposed to be transacted at it, and signed by the Chairman, or in his absence by the Trust Secretary or by another officer of the Trust authorised by the Chairman to sign on his behalf, shall be delivered to every governor, or sent by post to the usual place of residence of such governor, in order to be available to him at least five clear days before the meeting. Lack of service of the notice on any governor shall not affect the validity of a meeting subject to paragraph 7.10.

7.9 Notwithstanding the above requirement for notice, the Chairman may waive notice on written receipt of the agreement of at least 50% of governors.

7.10 In the case of a meeting called by governors in default of the Chairman, the notice shall be signed by those governors calling the meeting and no business shall be transacted at the meeting other than that specified in the notice.

7.11 Failure to serve such a notice on more than three quarters of governors 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.

Setting the Agenda

7.12 The Council of Governors may determine that certain matters shall appear on every agenda for a meeting of the Council and shall be addressed prior to any other business being conducted. The Council of Governors shall review these topics and their sequence annually.

7.13 A governor desiring a matter to be included on an agenda shall make his request in writing 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.

Notices of Motions

7.14 A governor 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 are subject to the notice given being permissible under the appropriate regulations. This paragraph shall not prevent any motion being moved during the meeting, without notice, on any business mentioned on the agenda subject to 7.16 below.

7.15 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.

7.16 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 governors who give it and also the signature of four other governors. When any such motion has been disposed of by the Council it shall not be competent for any governor, 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.

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

7.18 When a motion is under discussion or immediately prior to discussion it shall be open to a governor 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 member who has not previously taken part in the debate and who is eligible to vote.

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

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

7.21 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.

7.22 **Chairman's Ruling**

Statements of governors made at meetings of the Council of Governors shall be relevant to the matter under discussion at the material time, and the decision of the Chairman of the meeting on questions of order, relevancy, regularity and any other matters shall be observed at the meeting.

Voting

7.23 Subject to the provisions of the Constitution and as otherwise required by law, 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 the governors present and voting. In the case of any equality of votes, the person presiding shall have a second or casting vote.

7.24 All decisions put to the vote shall, at the discretion of the Chairman of the meeting, be determined by oral expression or by a show of hands. A majority of Governors present may require a vote to be taken by anonymous paper ballot.

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

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

7.27 In no circumstances may an absent governor vote by proxy. Absence is defined as being absent at the time of the vote.

7.28 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.

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

Suspension of Standing Orders

7.30 Except where this would contravene any statutory provision, any one or more of these standing orders may be suspended at any meeting, provided that at least two-thirds of members of the Council of Governors are present and that a majority of those present vote in favour of suspension.

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

7.32 A separate record of matters discussed during the suspension of standing orders shall be made and shall be available to the Chairman and governors and also reviewed by the Audit Committee.

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

7.34 **Record of Attendance**

The names of the Chairman, governors, and any other person present at the meeting shall be recorded in the minutes, by surname and initials, and by constituency and class, or by professional capacity as applicable.

Minutes

7.35 Minutes of the proceedings of each meeting shall be drawn up and the Chairman will ensure that all matters of significance in the meeting are recorded and maintained as a public record. The minutes shall include details of any action to be taken, who will take the specified action, and the dates for its completion where appropriate. The Chairman will also ensure that the draft minutes are promptly circulated to Governors and submitted for agreement at the next ensuing meeting where they will be signed by the person presiding.

7.36 No discussion shall take place upon the minutes except upon their accuracy or where the Chairman considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

7.37 The wider circulation of the minutes shall be in accordance with the governors' wishes. The minutes of the meeting shall be made available to the public except for minutes relating to business conducted when members of the public are excluded in accordance with these standing orders.

Quorum

7.38 No business shall be transacted at a meeting of the Council of Governors unless at least one-third of the whole number of the governors are present, of which half shall be governors from the Public Constituency ~~and the Patients and Carers' Constituency~~, and at least one governor from the Staff and Volunteers Constituency.

7.39 If a governor 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. 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.

7.40 **Conduct of the Meeting**
The Chairman of the Meeting will ensure that adequate time is afforded for the proper consideration of each item on the agenda. Contributions by governors, and other persons invited to speak, 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 Meeting shall be observed.

Confidentiality

7.41 If the Council, at a Council of Governors meeting at which the public are excluded, or one of its committees resolves that a matter is confidential, a governor, a committee member or any other non-governor in attendance at any of its meetings shall not disclose that matter, even if it has been reported to the Council; or otherwise dealt with by, or brought before, the Council or committee, even if any associated action has been concluded, subject to any legal duties/requirements to disclose.

8 Compliance: Other Matters

Governors of the Trust shall comply with Standing Financial Instructions prepared by the Director of Finance and approved by the Board of Directors.

9 Council of Governors Performance

The Chairman shall, at least annually, lead a performance assessment process for the Council of Governors to enable the Council to review its roles, structure, composition and procedures taking into account emerging best practice.

10 Declaration of Governors' Interests

10.1 Governors are required to comply with the Trust's standards of business conduct and to declare to the Council any interests required to be declared by the Constitution or any other interests they have or that their family might have which are relevant and material. Governors shall declare to the Council 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. At the time governors' interests are declared, they will be recorded in the Council minutes. Any changes in interests shall be declared at the next Council meeting following the change occurring.

10.2 Interests 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 of, part-ownership of, or employment with private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.
- Employment with any private company, business or consultancy.
- Significant share holdings (more than 5%) in organisations likely or possibly seeking to do business with the NHS.
- A position of authority 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.

10.3 If a governor has any doubt about the relevance of an interest, he should discuss it with the Chairman who shall advise him whether or not to disclose the interest.

10.4 At the time governors' interests are declared, they should be recorded in the Council of Governors minutes and entered on a register of interests of governors to be maintained by the Trust Secretary. Any changes in interests should be declared at the next Council of Governors meeting following the change occurring.

10.5 Governors' directorships of companies likely or possibly seeking to do business with the NHS should be published in the Trust's Annual Report. The information shall be kept up to date for inclusion in succeeding Annual Reports.

10.6 During the course of a Council of Governors meeting, if a conflict of interest is established, the governor concerned shall disclose the fact, and withdraw from the meeting and play no part in the relevant discussion or decision. For the avoidance of doubt, the Council of Governors shall exclude the governor from any meeting of the Council while any matter in which he has a pecuniary interest is under discussion.

Register of Interests

10.7 The Trust Secretary will ensure that a register of interests is established to record formally declarations of interests of governors.

10.8 Details of the register will be kept up to date and reviewed annually.

10.9 The register will be available to the public.

10.10 Interests that are regarded as "relevant and material" are set out in 10.2 above.

10.11 Any allowances payable to the governor by virtue of the 2006 Act shall not be treated as a pecuniary interest for the purpose of this standing order.

10.12 For the purpose of this standing order, and subject to other standing orders, the governor 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 10.2 above.

The interests of the governor shall include members of his family as defined above.

10.13 The Chairman or governor shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only of an interest in any company, body or person with which he is connected as mentioned in standing order 10.2 above which is so remote or insignificant that it cannot reasonably be regarded as likely to influence the Chairman or governor in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

10.14 Where the Chairman or governor 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 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 other body, whichever is the less, and 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/her from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it, without prejudice however to his duty to disclose his interest.

10.15 The provisions of this standing order apply to members of a committee, sub-committee or joint committee as they apply to the Chairman and governors.

10.16 Governors 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.

10.17 The Trust Secretary will ensure the maintenance of register of interests in which declarations of interests of directors are formally recorded.

10.18 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.

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

Annex 7
Board of Directors Standing Orders:

Contents

1 Introduction

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 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 has overall responsibility for running the affairs of the Trust. Its role is to:

- ensure compliance with the Constitution and 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
- assess performance against agreed objectives and targets
- manage and minimise risk
- make well-informed and high-quality decisions based on intelligent information
- assess achievement against agreed objectives and targets
- 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. The Board shall at all times seek to comply with the NHS Foundation Trust Code of Governance which builds on the ~~Combined Code of Corporate Governance~~ UK Corporate Governance Code
- have regard to the NHS Constitution in performing the Trust's NHS functions

1.3 NHS Codes

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

- selflessness,
- integrity,
- objectivity,
- accountability,
- openness,
- honesty and

• leadership

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, 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;
- The Fraud Policy and Response Plan
- The Bribery Act 2010

New or revised Financial Codes of Procedures shall have effect as if incorporated into standing orders by virtue of the Director of Finance 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. See also **Constitution: 3**.

The Chairman and non-executive directors are responsible for monitoring 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-committee 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. 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

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 that it has formally constituted. The Board shall approve the constitution and terms of reference of these committees, or sub-committees, and their specific executive powers

Under Schedule 7 of the 2006 Act (as amended by the 2012 Act) these powers may only be delegated to a committee of Directors or to an executive director. 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 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 Chair, 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 The Board of Directors will normally work with an external organisation recognised as expert at appointments to identify the skills and experience required for non-executive directors.

Appropriate candidates will be identified by a Nominations Committee (Nominations and Remuneration Committee) through a process of open competition, which takes account of skills and experience required.

The Nominations and Remuneration ~~c~~Committee will comprise the Chairman (or, when a Chairman is being appointed, the Deputy Chair unless they are standing for appointment, in which case another non-executive director), and representative Governors. The Committee would be advised by an independent assessor, who may be chair of another NHS foundation trust. The Chief Executive will be entitled to attend meetings of the Nominations committee unless the Committee decides otherwise and the Committee shall take into account the Chief Executive's views.

The Nominations and Remuneration Committee will make a recommendation to the Council of Governors for approval.

3.4 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 and 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. Where concerns are raised an investigation may take place in line with the Recruitment and Selection Policy.

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.

3.5~~8~~ Appointment and Powers of Deputy Chair

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.~~9~~6 Appointment of Chief Executive

Collectively, the Chairman and non-executive directors of the Trust shall comprise the Appointments and Remuneration Committee (RemCo). In accordance with **Constitution: 27**, RemCo ~~the Appointments and Remuneration Committee~~ shall appoint the Chief Executive (which appointment shall be approved by 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 RemCo ~~Appointments and Remuneration Committee~~ may make such appointments as it deems appropriate within its terms of reference.

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 Secretary.

3.711 Appointment of Executive Directors

The Board shall appoint a committee of the Chairman, the Chief Executive and the non-executive directors to appoint or remove executive directors; and an Appointments and Remuneration Committee (RemCo) comprising the Chairman and non-executive directors to determine the remuneration and allowances and other terms and conditions of office of the executive directors .

3.812 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.

3.913 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.

3.1014 Trust Secretary

The Board shall appoint a Trust 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 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.

3.115 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 or her own personal resources any personal civil liability which is incurred in the execution, or purported execution, of his or her 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

4.1 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 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

4.2~~3~~ The Board of Directors will meet at a frequency (but not less than quarterly), and at a t~~t~~ime, 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

4.3~~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 five 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~~4 On an annual basis, **t**he 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.

4.513 **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, as the directors present shall choose, shall preside.

Notices of Motion

4.614 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.

4.716 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

4.817 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.

4.9 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 Meeting shall be final.

4.1021 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.

4.1127 Minutes

The Chairman shall ensure that the minutes of the proceedings of a meeting are drawn up under the supervision of the Trust 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 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.

4.1230 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.

4.1331 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.

4.1436 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.

4.1537 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.

Quorum

4.1638 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.

5.13 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 committees, or sub-committees, or joint-committees, which it has formally constituted. The constitution and terms of reference of these committees, or sub-committees, or joint committees, and their specific powers (and, if necessary, those retained by the Board) shall be approved by the Board.

5.24 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 an 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 to provide information and advise the Board in accordance with statutory requirements. Outside these statutory requirements, the Director of Finance 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 Secretary shall maintain a current management structure approved by the Board.

5.39 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 Cchairman.

6.2 The Board shall approve the appointment of committee cChairmen, 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-committee 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-committee but otherwise the committee or sub-committee 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 subcommittees. In doing so, they:

- may not delegate executive powers to the sub-committee unless the Board has expressly authorised them to do so;
- must determine the membership and terms of reference of such subcommittees;
- must require sight of the minutes of each subcommittee 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, subcommittees and joint committees have no powers to commit expenditure by the Trust, except where budgets have been specifically delegated by the Board.

6.28 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 Interest

8.1 Interests of Directors

In accordance with the Health and Social Care Act 2012 Directors will be open and transparent in the manner in which actual and potential 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:

- Any position of authority or trust, i.e. Directorships, Senior Management, in another NHS organisation or commercial, charity, voluntary, professional, statutory or other body
- Any decision-making role in any advisory groups or other unpaid or paid forums that can influence how that organisation spends taxpayers' money
- Employment with any private company, business or consultancy
- Any shareholdings and other ownership interests in any publicly listed, private or not-for-profit company, business, partnership or consultancy which is doing, or might be reasonably expected to do, business with the Trust. This does not include shares held as part of a managed fund, pension fund or unit trust. Research funding or grants that may be received by an individual or their department
- Any patents or intellectual property rights held in the fields of health or social care or that could be utilised by the Trust in its day to day operations

8~~7~~.3 The interests of the director shall include members of close associates and his family. “Family” shall mean spouse, partner, children, grandchildren, other dependents, parents and grandparents.

8.4~~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.

8.5~~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.

8.6~~5~~ During the course of a Board meeting, if a conflict of interest is established, if 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.

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 or she 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.

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).

8.7~~6~~ 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.

8.8~~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

8.9~~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.

8.109 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.

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

8.111 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.

8.122 The Chief Executive will ensure that a register of interests is established, and maintained by the Trust 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.

8.13 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 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 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 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 book provided for that purpose and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. A report of all sealings shall be made to the Board at least annually. (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 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 jointly subject to approvals contained in these standing orders.

Annex 8
Further Provisions in Relation to Members

Contents

1 Disqualification from Membership

1.1 A person may not become a Member of the Trust if within the last five years he has received a sanction under any policy or procedure approved by the Board of Directors for the care of patients who are violent or abusive, or if he has been involved in a serious incident of violence at any of the Trust's hospitals or facilities, or against any of the Trust's staff, or registered volunteers.

1.2 A person may not become a member of the Trust unless he is age 16 or above.

1.3 A member of Staff may not become or remain a member of the Public Constituency, ~~or of the Patients and Carers' Constituency~~ if he is eligible to become a member of the Staff and Volunteers Constituency.

1.4 A registered volunteer as described in Annex 2 may choose to remain a member of the Public Constituency even once eligible to become a member of the Staff and Volunteers Constituency.

1.5 A person may not be a member of more than one constituency, or of more than one class in any constituency.

1.6 Where the Trust is on notice that a member may be disqualified from membership, or may no longer be eligible to be a member, it shall give the member 14 days written notice to show cause why his name should not be removed from the register of members. On receipt of any such information supplied by the member, the Trust Secretary may, if he considers it appropriate, remove the member from the register of members. In the event of any dispute the ~~–~~Trust Secretary shall refer the matter to the Council of Governors to determine. All members of the Trust shall be under a duty to notify the ~~Trust~~ Secretary of any change in their particulars which may affect their entitlement as a member.

2 Termination of Membership

A member shall cease to be a member if:

2.1 he resigns on notice to the Trust Secretary;

2.2 he ceases to be entitled under this Constitution to be a member of his respective Constituency;

2.3 he is expelled under this Constitution.

2.4 if it appears to the Trust Secretary that he no longer wishes to be a member and, after enquiries made in accordance with a process approved by the Council of Governors, he fails to confirm that he wishes to continue to be a member of the Trust.

3 Expulsion

A member may be expelled by a resolution of the Council of Governors. The following procedure is to be adopted:

3.1 Any member may complain to the Trust Secretary that another member has acted in a way detrimental to the interests of the Trust.

3.2 If a complaint is made, the Council of Governors may itself consider the complaint having taken such steps as it considers appropriate to ensure that each member's point of view is heard and may either:
(a) dismiss the complaint and take no further action; or
(b) arrange for a resolution to expel the member complained of to be considered at the next meeting of the Council of Governors.

3.3 If a resolution to expel a member is to be considered at a meeting of the Council of Governors, details of the complaint must be sent to the member complained of not less than one calendar month before the meeting with an invitation to answer the complaint and attend the meeting.

3.4 At the meeting, the Council of Governors will consider any oral and written evidence produced in support of the complaint and any oral and written evidence submitted for or on behalf of the member about whom complaint has been made.

3.5 If the Member complained of fails to attend the meeting without due cause the meeting may proceed in their absence. A person expelled from membership will cease to be a member upon the declaration by the Chairman of the meeting that the resolution to expel them is carried.

3.6 No person who has been expelled from membership is to be re-admitted except by a resolution carried by the votes of two-thirds of the members of the Council of Governors present and voting at a meeting of the Council of Governors.

4 Voting at Elections for Governors by the Public Constituency and/or the Patients and Carers' Constituency

4.1 A person may not vote at an election for an elected governor in the Public Constituency~~, or in the Patients and Carers' Constituency~~, unless within the specified period he has made a declaration in the specified form setting out the particulars of his qualification to vote as a member of the constituency for which the election is being held. It is an offence to knowingly or recklessly make such a declaration which is false in a material particular.

5 Members Meetings

5.1 The Trust is to hold a members' meeting (called the Annual Members' Meeting) within nine months of the end of each financial year. Additional members' meetings may be held as and when considered necessary.

5.2 Members' meetings are open to all members of the Trust, governors and directors, and representatives of the financial auditor, and to members of the public. The Council of Governors may invite representatives of the media, and any experts or advisors whose attendance they consider to be in the best interests of the Trust, to attend a Members meeting.

5.3 All members' meetings are to be convened by the Trust Secretary by order of the Council of Governors.

5.4 The Council of Governors may decide whether a Members' meeting is to be held and may also for the benefit of members arrange for the Annual Members' Meeting to be held in a different venue each year.

5.5 At the Annual Members' Meeting:

5.5.1 the Board of Directors shall present to the members:

- the annual accounts
- any report of the financial auditor
- any report of any other external auditor of the Trust's affairs
- forward planning information for the next financial year.

5.5.2 the Council of Governors shall present to the members:

- the progress of the Membership Strategy
- any proposed changes to the policy for the composition of the Council of Governors and of the non-executive directors

- the results of any election, or appointment, to the Council of Governors; and the appointment of any non-executive director.

5.6 Notice of a members meeting is to be given:

- by notice prominently displayed at the Trust's head office; and
- by notice on the Trust's website
- by advertisement in the local press
- by notices in public places as appropriate
- at least fourteen clear days before the date of the meeting.

5.7 The notice must:

- be given to the Council of Governors and to the Board of Directors, and to the financial auditor;
- state whether the meeting is an Annual Members Meeting;
- give the time, date and place of the meeting; and
- indicate the business to be dealt with at the meeting.

5.8 Before a members' meeting can undertake business, there must be a quorum present. Except where this Constitution says otherwise, a quorum is one member present from each of the Trust's Constituencies. In the case of the Annual Members Meeting, a quorum shall be one member present from each of the Trust's Constituencies, one governor elected from each of the Trust's Constituencies, one appointed governor, one executive director, the Chairman (or, in his absence, the Deputy Chair, or, in his absence, a non-executive director appointed by the Council of Governors to fulfil the role of Chairman) and one other non-executive director.

5.9 The Trust may make arrangements for members to vote by post, or by using electronic communications.

5.10 It is the responsibility of the Chairman of the meeting to ensure that at any members meeting:

- the issues to be decided are clearly explained;
- sufficient information is provided to members to enable rational discussion to take place.

5.11 The Chairman of the Trust, or in his absence the Deputy Chair, or in their absence one of the non-executive directors shall act as Chairman at all members meetings of the Trust.

5.12 If no quorum is present within half an hour of the time fixed for the start of the meeting, the meeting shall stand adjourned to the same day in the next week at the same time and place, or to such time and place as the Council of Governors determine. If a quorum is not present within half an hour of the time fixed for the start of the adjourned meeting, the number of members present during the meeting is to be a quorum.

5.13 A resolution put to the vote at a members meeting shall be decided upon by a poll.

5.14 Every member present and every member who has voted by post or using electronic communications is to have one vote. In the case of an equality of votes, the Chairman of the meeting is to have a second or casting vote.

5.15 The result of any vote will be declared by the Chairman and entered in the minute book. The minute book will be conclusive evidence of the result of the vote.

Annex 9

Glossary of Terms

The list of definitions, below, apply to the Constitution of Mid Cheshire Hospitals NHS Foundation Trust and the attaching Annexes. Words importing the masculine gender only shall include the feminine gender; words importing the singular shall import the plural and vice-versa.

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 as amended by the 2021 Act.

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 Chair** 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 mean 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 or ~~,~~ 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 Chair 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 N**on-Executive Director** or an E**xecutive Director** appointed in accordance with the Constitution.

Director of Finance means the chief financial officer of the **Trust**.

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 N**on-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 body corporate known as Monitor, as provided by Section 61 of the 2012 Act. Since 2016 Monitor has been part of NHS Improvement.

Motion means a formal proposition to be discussed and voted on during the course of a meeting.

NAO means National Audit Office.

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 mean 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 Secretary means a person who must be appointed by the **Board** to fulfil the formal role of Trust Secretary but may be known as the Company Secretary. They shall provide advice on corporate governance issues to the **Board** and the **Chairman** and monitor the Trust's compliance with **Standing Orders**, legislation, and related guidance.

Mid Cheshire Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

Agenda Item	**CO2**	Date of Meeting: 29/04/2021
Report Title	Guardian of Safe Working Hours Report 2020/21 Q4	
Executive Lead	Heather Barnett, Director of Workforce and OD	
Lead Officer	Douglas Robertson, Guardian of Safe Working Hours	
Action Required	To note	

X **Acceptable assurance** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐ **Partial assurance** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Low assurance** Evidence indicates poor effectiveness of controls

Key Messages of this Report *(2/3 headlines only)*

- Pressures from Covid19 reduced reporting rates, but they increased 'between waves'
- Actions to ensure that systematic under-reporting does not occur are being put in place

Next Steps (*actions to be taken following agreement of recommendation/s by Board/Committee)*

- None

Strategic Objective(s) *(indication of which objective/s the report aligns to)*

• Manage Covid response and recovery	✓	• Provide safe and sustainable services	☐
• Provide outstanding care/patient experience	☐	• Provide strong system leadership by working together	☐
• Deliver most effective care to achieve best possible outcomes	☐	• Be well governed and clinically led	✓
• Be the best place to work	✓		

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

• Quality	☐	• Compliance	☐
• Finance	☐	• Legal	☐
• Workforce	☐	• Risk/BAF BAF12 Organisational culture	
• Equality	☐		

Equality Impact Assessment (*must accompany the following submissions)*

Strategy ☐ Policy ☐ Service Change ☐

REPORT DEVELOPMENT

Committee/ Group Name	Date	Report Title	Lead	Brief summary of key issues raised and actions agreed
NA				

Report from the Guardian of Safe Working Hours

1st January 2021 – 31st March 2021 (Q4)

Introduction

This is a report to the Board on progress with the 2016 junior doctors contract and the work of the Guardian of Safe Working Hours (GoSWH), who is required to provide it on a quarterly basis summarising exception reports made, fines levied, and ensuring that the Trust take appropriate action to address any issues identified. A summary of the year 2020-21 is also included.

Current Position

There are over 150 'training grade' posts, all are now on 2016 Terms and Conditions of Service (TCS). During the increased demands and staff sickness caused by the Covid19 pandemic there have been challenges to fully staff rotas for Junior Doctors. However, the gaps were filled with locums and trainees who were redeployed from elective specialties or brought back "in house" from GP practices. During the most intense periods, there were very few exception reports received, but there were an increased number between waves of increased Covid pressures. Between waves, there was a particular increase in reporting from Foundation trainees, both related to hours of work/rest and education, particularly related to arrangements for self-directed learning.

Exception Reporting

Exception reporting is a contractual mechanism for junior doctors in training to report unsafe working practices and loss of training opportunities. This mechanism enables junior doctors to report patient safety, rostering and educational concerns which should be dealt with in the required timescales.

Q1: From **1st April to 30th June** there were no exception reports submitted.

Q2: During the period **1st July to 30th September** there were **32** exception reports from **10** individuals, all but 2 after the rotations of junior doctors in August 2020.

Q3: From **1st October to 31st December 2020** there were **11** exception reports from **7** individuals.

Q4: From **1st January to 31st March 2021** there were **11** exception reports from **4** individuals.

A trainee's Educational Supervisor is required to respond to exception reports within 7 days of a submission, in order to review and discuss the reasons with the trainee. This timescale was not well adhered to in 2020-21, and several of the Educational Supervisors needed repeated reminders. At year end, 13 overdue exception reports required to be signed off by the GoSWH.

The total number of exception reports in 2019-20 was 34, in 2020-21 there were 54 submitted. In each year one quarter of reports were educational, the rest related to hours of work and rest.

The predominant themes in 2020-21 were late finishing of shifts in General Surgery FY1 doctors on call, and in General Medicine on call at several grades. Several FY2 trainees in Medicine felt that their opportunities for 2 hours per week self-directed learning time (a new requirement from Health Education England) were limited, **2** individuals generated **12** Exception reports for this reason.

The most common outcome is time off in lieu (TOIL) or payment for hours worked if not possible. Fines are levied under the 2016 TCS on breach of one or more of the following provisions:

a) The 48 hour average weekly working limit
b) Contractual limit on a maximum of 72 hours worked within a 7 day consecutive period.
c) Minimum of 11 hours rest between shifts.
d) Where meal breaks are missed on more than 25% of occasions during a rota cycle.

None of these were breached, therefore no fines were levied in 2020-21. There was however a grant from NHS England under the Fatigue and Facilities Charter of £30,000 which was successfully spent on improving Junior Doctors' working lives in year.

GoSWH Actions in 2020-21

The current GoSWH has been in post since 1st June 2020 and has attended the virtual regional meetings of Guardians monthly since then. It was notable that the local picture of low exception reporting in Q1 was not universal. To assure the Board that there is not a culture of systematic under-reporting and to be aware of potential areas of concern the following actions have been taken:

1. Individual emails were sent to each trainee to thank them for their hard work in the Covid-19 outbreak and ask for informal feedback of any concerns and encouragement given to generate exception reports as appropriate. A small number of responses were received with informal identification of areas to watch, but despite resumption of national terms of service, only two exception reports were received prior to the rotation date in August.

2. The GoSWH and Director of Medical Education (DME) promoted exception reporting at induction in August 2020 to the new trainees. At the same time Educational Supervisors were reminded of the process and timelines of exception reporting by email.

3. To improve trainee engagement, a more representative Junior Doctor Forum meeting was formally relaunched. Terms of Reference were developed with trainees' and BMA input and approved by the JLNC. This meets alternate monthly, using virtual meeting technology, with wider representation to improve access for trainees. It considers workload, educational issues, and the spending of money from fines and the Fatigue and Facilities Charter grant. Between meetings, the Guardian is kept informed of concerns by trainee representatives and discusses them with appropriate service managers and lead clinicians.

4. A programme of raising awareness of exception reporting was carried out by the Mess President supported by the Guardian from July 2020. After that, with new trainees in August the exception reports increased sharply, feeding back difficulties with scheduling self-directed learning time for Foundation Year 2 doctors, and workload in areas known to have generated exception reports in the past.

5. The second & third waves of Covid19 brought increased workload and concerns about resilience of medical staff. However, as in the first wave, the frequency of exception reporting fell. A discussion with the Director of Medical Education has led to a plan to jointly re-launch awareness of exception reporting (and incident reporting for non-training doctors) to monitor these concerns, to assist operational teams identifying and addressing concerns. The emphasis is on acknowledgement of high workload through exception reporting, wider use of TOIL and support to juniors, avoiding burnout as normal services resume.

6. The Mess President and BMA trainee representatives have now surveyed junior doctors on three occasions in-year, with the most recent survey in late March. They have raised concerns about persisting poor morale and poor motivation to submit exception reports, particularly with the Foundation trainees. They have followed on with a further program to encourage trainees to report hours of work concerns but have asked the GoSWH for support in improving the responsiveness and assisting improving trainee confidence in the system.

7. Potential actions to improve confidence in the exception reporting system which have been discussed include:

    - Re-launching exception reporting with trainees with positive messages from GoSWH and DME at induction and at each rotation between clinical supervisors.
    - Ensuring better access to computers to allow timely exception reporting by trainees.
    - Awareness raising of educational and clinical supervisors to emphasise need for signing off reports promptly. Educator training days were paused in 2020 but are being restarted.
    - Reminders to Educational Supervisors to sign all overdue exception reports.
    - Encouraging service managers and clinical leads in Medicine & Surgery to ensure Foundation trainees' self-directed learning time is explicit in rotas.
    - Suggesting when TOIL is awarded, that rota coordinators formally record it and when it is taken, as currently done for annual leave, to identify pressures that prevent taking TOIL.

Conclusions & to note

This is the sixteenth quarterly report on the 2016 contract by the Guardian of Safe Working Hours. The Trust continues to take steps to implement the contract and its amendments for junior doctors in training. It includes a review of the year 2020-21.

Notably, there was a marked reduction in the amount of exception reports in the first wave of Covid19 admissions. This was not apparent in other Trusts, so a culture of under-reporting at Mid Cheshire was suspected. Feedback was sought by review of subsequent exception reporting and trainee survey and identified issues related to trainee confidence in the Trust's response effectively to exception reports.

Particular areas of concern from trainees include difficulty in integrating new Foundation training requirements into rotas and persisting heavy workloads on both medical and surgical wards.

The GoSWH has discussed these themes and concerns about exception reporting with the relevant clinical and service managers, with the Director of Medical Education, Foundation Lead and Deputy Medical Director to consider a response.

Author: Douglas Robertson, Guardian of Safe Working Hours

Date: 17.04.21

Mid Cheshire Hospitals NHS Foundation Trust

BOARD OF DIRECTORS

Agenda Item	**CO3**	Date of Meeting: 29/04/2021
Report Title	**Report on Use of the Trust Seal**	
Executive Lead	Caroline Keating, Company Secretary	
Lead Officer	Katharine Dowson, Head of Corporate Governance	
Action Required	To note	

X **Acceptable assurance** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐ **Partial assurance** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐ **Low assurance** Evidence indicates poor effectiveness of controls

Key Messages of this Report *(2/3 headlines only)*

- There have been two uses of the Trust Seal since the last report to Board
- Constitutional requirement to report to Board at least once per year

Next Steps (*actions to be taken following agreement of recommendation/s by Board/Committee)*

- None

Strategic Objective(s) *(indication of which objective/s the report aligns to)*

• Manage Covid response and recovery	☐	• Provide safe and sustainable services	☐
• Provide outstanding care/patient experience	☐	• Provide strong system leadership by working together	☐
• Deliver most effective care to achieve best possible outcomes	☐	• Be well governed and clinically led	✓
• Be the best place to work	☐		

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

• Quality	☐	• Compliance	✓
• Finance	☐	• Legal	☐
• Workforce	☐	• Risk/BAF Click here to select relevant risk	
• Equality	☐		

Equality Impact Assessment (*must accompany the following submissions)*

Strategy ☐ Policy ☐ Service Change ☐

REPORT DEVELOPMENT

Committee/ Group Name	Date	Report Title	Lead	Brief summary of key issues raised and actions agreed
NA				

Use of the Trust Seal 2020/21

Recommendation

The Board of Directors are asked to note the following sealings that have taken place since the last Board report in May 2020. This report notes, as required by Standing Order 9 of the Trust Constitution, that the following sealings were approved between 1 May 2020 and 31 March 2021.

Seal Number	Date of Board Approval	Details
106	25 March 2021	Contract for the Emergency Department building work with MTX Contracts
107	25 March 2021	Deed of Surrender for the Lease for the former School of Nursing with University of Chester