Mersey and West Lancashire Teaching Hospitals NHS Trust

Trust Board Meeting (Public)

To be held at 09.30 on Wednesday 28 February 2024
Boardroom, Level 5, Whiston Hospital / MS Teams Meeting

Time	Reference No	Agenda Item	Paper	Presenter
Preliminary Business				
09.30	1.	**Employee of the Month (February 2024)** *Purpose: To **note** the Employee of the Month presentations for February 2024*	Verbal	Chair *(15 mins)*
09.45	2.	**Chair's Welcome and Note of Apologies** *Purpose: To record apologies for absence and confirm the meeting is quorate*	Verbal	Chair *(10 mins)*
	3.	**Declaration of Interests** *Purpose: To record any Declarations of Interest relating to items on the agenda*	Verbal	
	4.	**MWL TB24/012 Minutes of the previous meeting** *Purpose: To **approve** the minutes of the meetings held on 31 January 2024*	Report	
	5.	**MWL TB24/013 Matters Arising and Action Logs** *Purpose: To consider any matters arising not included anywhere on agenda, review outstanding and **approve** completed actions*	Report	
Performance Reports				
09.55	6.	**MWL TB24/014 Integrated Performance Report** 6.1. Quality Indicators 6.2. Operational Indicators 6.3. Workforce Indicators 6.4. Financial Indicators *Purpose: To **note** the Integrated Performance Report for assurance*	Report	P Williams L Neary A-M Stretch G Lawrence *(30 mins)*
Committee Assurance Report				
10.25	7.	**MLW TB24/015 Committee Assurance Reports**	Report	

		7.1. Executive Committee *7.2.* Audit Committee 7.3. Quality Committee 7.4. Strategic People Committee 7.5. Finance and Performance Committee *Purpose: To **note** the Committee Assurance Reports for assurance*		A Marr I Clayton G Brown L Knight S Connor *(30 mins)*
Other Board Reports				
10.55	8.	**MWL TB24/016 6 monthly Maternity and Neonatal Services Assurance Report** *Purpose: To **note** the Maternity and Neonatal Services Assurance Report*	Report	S Redfern *(15 mins)*
11.10	9.	**MWL TB24/017 Corporate Governance Manual (including Standing Financial Instructions and Scheme of Delegation)** *Purpose: To **approve** the Corporate Governance Manual (including Standing Financial Instructions and Scheme of Delegation)*	Report	G Lawrence *(15 mins)*
Concluding Business				
11.25	10.	**Effectiveness of Meeting**	Verbal	Chair *(5 mins)*
11.30	11.	**Any Other Business** *Purpose: To **note** any urgent business not included on the agenda*	Verbal	Chair *(5 mins)*
		Date and time of next meeting: Wednesday 27 March 2024 at 09:30		**11.40 close**
15 minutes lunch break				

Chair: Richard Fraser

Minutes of the Trust Board Meeting
Held at Boardroom, Level 5, Whiston Hospital / on Microsoft Teams
Wednesday 28 February 2024
(Approved at Trust Board on Wednesday 27 March 2024)

Name	Initials	Title
Richard Fraser	RF	Chair
Ann Marr	AM	Chief Executive Officer
Anne-Marie Stretch	AMS	Deputy Chief Executive Officer & Director of Human Resources
Geoffrey Appleton	GA	Non-Executive Director & Deputy Chair
Gill Brown	GB	Non-Executive Director
Nicola Bunce	NB	Director of Corporate Services
Ian Clayton	IC	Non-Executive Director (via MS Teams)
Steve Connor	SC	Non-Executive Director
Rob Cooper	RC	Managing Director
Paul Growney	PG	Associate Non-Executive Director
Lisa Knight	LK	Non-Executive Director
Lesley Neary	LN	Chief Operating Officer
Hazel Scott	HS	University Non-Executive Director
Rani Thind	RT	Associate Non-Executive Director
Christine Walters	CW	Director of Informatics
Peter Williams	PW	Medical Director

In Attendance

Name	Initials	Title
Lynne Barnes	LB	Deputy Director of Nursing and Quality (Item 8)
Hannah Horsfield	HH	Executive Account Manager, GE Healthcare (observer)
Carole Spencer	CS	Associate Non-Executive Director Designate (observer)
Juanita Wallace	JW	Executive Assistant (Minute Taker via MS Teams)
Richard Weeks	RW	Corporate Governance Manager

Apologies

Name	Initials	Title
Angela Ball	AB	Halton Council Representative (Stakeholder Representative)
Gareth Lawrence	GL	Director of Finance and Information
Sue Redfern	SR	Director of Nursing, Midwifery and Governance

Agenda Item	Description
Preliminary Business	
1.	**Employee of the Month**

	1.1. The Employee of the Month for February 2024 was Andrew Turner, Medical Education Facilitator, Whiston Hospital, and the Board watched the film of AMS reading the citation and presenting the award to Andrew. **RESOLVED:** The Board **noted** Employee of the Month film for February 2024 and congratulated the winner.
2.	**Chair's Welcome and Note of Apologies**
	2.1. RF welcomed all to the meeting and in particular welcomed SC who had joined the Trust as a Non-Executive Director with effect from 01 February 2024. Additionally, RF welcomed CS and HH who were attending the meeting as observers. It was noted that LB would also be attending on behalf of Sue Redfern to present Agenda Item 8. 2.2. RF, on behalf of the Board, sent condolences to GL and his family on their recent bereavement. 2.3. It was noted that CW would be joining the meeting late as she was attending a NHSE meeting about the Electronic Patient Record (EPR) Outline Business Case. 2.4. RF acknowledged the following awards and recognition that the Trust had recently received: 2.4.1. Syliva Sinclair, Deputy General Manager, Medirest FM Services, Whiston Hospital was awarded a National Lifetime Achievement Award at the recent National Cleaning Awards in association with NHSE. 2.4.2. Robbie Graham, Volunteer at Ormskirk Hospital, and previous winner of the My Porter Lifetime Achievement Award was recognised again for his outstanding efforts as he was shortlisted in this year's Unsung Heros Awards, the only awards for non-medical, non-clinical NHS staff and volunteers. 2.4.3. Andrew O'Donnell, Portering Team Leader, Ormskirk Hospital was awarded the My Porter Leadership of the Year Award 2.4.4. Andrew O'Donnell, Portering Team Leader, Ormskirk Hospital, was awarded the title of Trust Amazing Apprentice 2024 as part of the National Apprenticeship celebrations at MWL. The other nominations for Amazing Apprenticeship 2024 were: 2.4.5. April West, Administration Team Leader, Southport Hospital 2.4.6. Hayley Ryan, Estates Compliance & Performance Manger, Ormskirk Hospital 2.4.7. Ali Crawford, Therapy Assistant, Whiston Hospital 2.4.8. Leanne Miller, Quality Improvement Facilitator, Whiston Hospital 2.4.9. Amy Disley, Radiography Helper, Southport Hospital Apologies for absence were **noted** as detailed above

3.	**Declaration of Interests**
	There were no declarations of interests in relation to the agenda items.
4.	**MWL TB24/012 Minutes of the previous meeting**
	4.1. The meeting reviewed the minutes of the meeting held on 31 January 2024 and approved them as a correct and accurate record of proceedings subject to the following amendment: 4.1.1. 9.2.1.1 to be amended to read 'The Committee had reviewed the CNST submission***s*** and recommended approval to the Board.' 4.2. GB noted that a response to her question regarding the importance of compliance with training for Nasogastric Tubes (NG) insertion was not included in the minutes (item 12.3) and requested that this be added. Following a review of the notes, SR was asked to provide a written response to the question which was added to the action log. **Action** SR to provide an update on the NG training compliance rates. **RESOLVED:** The Board **approved** the minutes from the meeting held on 31 January 2024 subject to the amendments detailed above
5.	**MWL TB24/013 Action Log and Matters Arising**
	5.1. The meeting considered the updates to the Action Log, which reflected the progress made in discharging outstanding and agreed actions. 5.2. It was noted that PW would provide a verbal update on MWL TB24/005 Quality Indicators as part of Agenda Item 6.1. **RESOLVED:** The Board **approved** the action log.
Performance Reports	
6.	**MWL TB24/014 Integrated Performance Reports**
	The Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) Integrated Performance Report (IPR) for January 2024 was presented.
6.1.	**Quality Indicators**
	6.1.1. PW, on behalf of SR, presented the Quality Indicators and advised that the Care Quality Commission (CQC) rating for Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) remained as Outstanding. PW highlighted the following:

	6.1.1.1. There had been no never events recorded in January 2024. It was noted that the never event recorded in December 2023 was still undergoing the Patient Safety Incident Investigation (PSII) process. 6.1.1.2. One category 3 or above pressure ulcer with lapses in care had been recorded in October 2023 and it was noted that this had been validated in January 2024. There had been three category 3 or above pressure ulcers with lapses in care occurring on heels recorded year to date (YTD) and a learning review has been completed and improvement actions in place. 6.1.1.3. There had been eight falls resulting in moderate or above harm in December 2023 of which one resulted in death and three resulted in severe harm. 72-hour reviews had been completed for immediate learning and any necessary actions were put in place. PW advised that there had been a lengthy discussion about falls at the Quality Committee. An increase in patients with cognitive impairment and the resultant issues around mobilising and being able to ask for assistance had been identified as a theme and PW noted that this sometimes made it difficult to complete the falls risk assessments. In several of these cases the review had highlighted that the risk assessment was underscored, and that the patient would have benefited from one-to-one supervision of bay tagging. 6.1.2. AM reflected on the numerous discussions at the Executive Committee about the amount of supplementary care being provided as well as the differences between the Whiston and Southport sites and queried the robustness of the risk assessment process in place as this did not triangulate with the amount of supplementary care being provided. PW agreed and noted that despite patients receiving supplementary care as well as increased frequency of observations there were still incidents, and this could be attributed to the care not being provided in the right areas. PW felt that bay tagging which involved the cohorting of high-risk patients rather than one to one care might be better use of the supplementary care resource, but acknowledged this was not always possible if there were also infection prevention control risks which meant the patient needed to be in a side room. 6.1.3. GB commented that from the reviews presented at Quality Committee other factors including the increased length of stay (LOS), whether a patient had complex discharge needs, bed occupancy on ward at time of fall, staffing (permanent versus bank or agency) as well as ward leadership, may also impact on the risk of falls. It was agreed that a review of all falls with moderate or higher levels of harm should be completed with a focus on these factors and considered at the Quality Committee. **Action** SR to commission a thematic review of the factors increasing the risk of falls to be presented to Quality Committee. 6.1.4. RT reflected on a recent quality ward round (QWR) she had attended on ward 3D where there had been a significant reduction in the number of falls,

	and asked if this was due to lower patient acuity. RC advised that this was unlikely as the ward cared for a challenging cohort of patients. RT had been impressed by the ward leadership and how the ward manager had understood the ward metrics and had taken action to drive improvement. RT suggested that some falls may be unavoidable, and PW clarified that the investigation identified if there had been any lapses in care, and if there was any learning that could prevent future falls. 6.1.5. RF reflected on the importance of cascading best practise, across all wards and departments. RT commented that the ward had created a falls trolley that contained all the necessary equipment, risk assessment and relevant information and asked if this was found on all the wards. GB commented that she expected the Trust's Falls Lead to pick up on these types of things and NB suggested that this should be part of the Trust falls strategy. 6.1.6. RC commented on the difference a focused and enthusiastic ward manager who had a good knowledge of all issues made to the ward and felt the individual should be commended. 6.1.7. LK commented on the discussion around leadership and asked how the Trust supported new leaders and ensured consistency of approach. AMS responded that the Trust provided leadership training but reflected that it was sometimes difficult for clinical leaders to attend because of operational pressures. There were also support programmes for managers who were identified as needing additional training and mentorship. 6.1.8. PW continued with the IPR report and noted the Trust had not reported any cases of Methicillin-Resistant Staphylococcus Aureus (MSRA) in January 2024; however, six cases had been reported YTD. 6.1.9. 97 Clostridium difficile (C.Diff) cases had been reported YTD against an annual trajectory of 85. All cases had been reviewed by the Infection, Prevention and Control (IPC) team and root cause analysis (RCAs) have been requested. It was noted that the cases reported at S&O sites still needed to be reviewed by the antimicrobial pharmacist. A common theme identified via the RCAs was the timeliness of initial testing and isolation of patients with diarrhoea. 6.1.10. GB noted the difference in the reporting of C.Diff cases as a result of lapses in care. PW clarified that C.Diff was formerly classified as hospital acquired or community acquired but essentially the review process was designed to identify if the correct pathways of care had been followed. 6.1.11. The Trust reported five Meticillin-sensitive Staphylococcus Aureus (MSSA) cases in January 2024, and these had been linked to Urinary Tract Infections (UTIs), chest infections and cannula site infections.

	6.1.12. The Trust reported ten cases of Escherichia coli (E.coli) in January 2024 (137 YTD against a target of 121) and it was noted that the majority of these infections were due to UTIs and were unavoidable. 6.1.13. The target of closing Stage 1 Complaints within 60 days, remained challenged (43.8% against a target of 80%) due to the ongoing operational pressures which resulted in the medical and nursing leadership not being able to compile responses to complaints and staff members not being able to submit statements. The Complaints Team continued to provide support. 6.1.14. The Family and Friends Test (FFT) rating for the Emergency Department had been affected by the long waits. The response rates for maternity services remained low. 6.1.15. There were no neonatal deaths reported in January 2024; and five had been reported YTD, the details of which had been reported to the Board. 6.1.16. PW provided an update on the Hospital Standardised Mortality Ratio (HSMR) and advised: 6.1.16.1. HSMR was currently running three months behind at the S&O sites partly due to a shortage of clinical coders and the delays in scanning case notes. 6.1.16.2. The HSMR figures in the IPR has therefore not been updated this month because of these delays. 6.1.16.3. PW noted, that due to the escalated HSMR at the Southport sites, an investigation had identified that the total number of deaths remained static, however, there had been an increase in HSMR due to an increase in expected deaths. PW advised that once a patient was discharged the notes were sent to the coders who recorded the interventions and outcomes, and this fed into the HSMR calculation. The investigation had found a decrease in palliative care coding since April 2023 which was then reflected in the numbers of expected deaths. PW reminded the meeting that HSMR was a measure of observed versus expected deaths. The reason for the decrease in palliative care coding was thought to have arisen following a system change and a reduction in the number of palliative care patients in the hospital as a result of Queenscourt Hospice introducing a virtual ward service. Palliative care admissions had reduced by 44%. The palliative care team was now emailing the list of patients receiving palliative care to the coders to ensure it was clear which patients needed to be coded for this care. PW reported that options to attract, train and retain clinical coders were being discussed with GL. 6.1.16.4. PW had also asked the Learning from Deaths team at Southport to conduct an audit on all patients admitted with a palliative care diagnosis to ensure that they were being seen by the palliative care team. 6.1.17. AM asked if there would be a reduction in mortality at the Southport Hospital site due to the creation of the virtual ward pathway by the Hospice. PW confirmed that he was examining referral patterns, but crude mortality rates had not changed.

	6.1.18. GA asked that a report be provided to the Strategic People Committee to provide assurance on the actions being taken to increase the numbers of clinical coders. IC commented on the financial risk of not correctly coding the Trust activity. **ACTION** The recruitment and retention plan for Clinical Coders to be presented at Strategic People Committee. 6.1.19. RF reflected that the IPR was showing that despite these difficulties the Trust was still benchmarking in the top 50% of trusts for HSMR. 6.1.20. RF also noted that while the Trust had exceeded the 90% Trust target recommendation rate, this benchmarked in the bottom 50%, indicating other trusts were performing better against this metric. PW agreed that there had been a downward trajectory on the FFT recommendation rate over the past few months and advised that he would ask SR to investigate the reasons for this. **ACTION** SR to investigate the reasons for the fall in FFT recommendation rates.
6.2.	**Operational Indicators**
	6.2.1. LN presented the operational indicators. LN noted that several of the metrics had been discussed in detail at the Finance and Performance (F&P) Committee as well as Quality Committee. LN highlighted the following: 6.2.1.1. Urgent Care Performance remained stable in January 2024 (72.3% against a target of 76%), national performance was 70% and Cheshire and Merseyside (C&M) 69%. LN advised that the performance masked the challenges in both Whiston and Southport Emergency Departments (ED) which included a large number of patients waiting for beds as well as high levels of bed occupancy (Southport site at 109% and Whiston site at 113%) and this equated to an additional 150 patients across MWL. 6.2.1.2. Winter plans including the opening of additional escalation beds due to the long waits in ED, use of corridors in the ED and holding of ambulances had all been enacted. An additional 41 beds had been opened at the Whiston site and at Southport the Same Day Emergency Care (SDEC) unit and Discharge Lounge were being used as additional overnight beds. This was as a result of the impact of the high number of patients who no longer met the Criteria to Reside (NCR) in an acute setting. 6.2.1.3. GA asked if there was more that could be done with the Integrated Care Board (ICB) and the PLACE Directors to speed up discharges. AM advised that this had been discussed at the ICB Executive meeting and the Chief Operating Officer of the C&M ICB had addressed this with the PLACE Directors, however, there had been little tangible impact following these interventions. The differences between the Local Authorities in relation to facilitating discharges were discussed and it was noted that different Councils still had different approaches, and their performance differed

	markedly. LN advised that AM had written to all the system partners requesting a call to action, however, there was not much of a change in the level of support received. AM noted that it was not possible to create extra beds or wards at the Southport site but there were plans being progressed to create step down facilities at Ormskirk Hospital to help relieve the pressures. 6.2.2. GB reflected on the increasing numbers of stranded and super stranded patients, the increase in patients who were NCR and longer ambulance handover times as well as all the escalation beds that had been opened and asked if there was a possibility that the Trust might reach a point where it was unable to admit any more patients. LN responded that this was not an option open to the Trust and advised that Primary Care and the community services were also challenged and noted that several of the Urgent Treatment Centres (UTC) either closed over the weekends or closed early due to staffing issues and this put more pressure on Hospital emergency departments. Graham Urwin (ICB CEO) had asked UTC providers to ensure that they were doing everything that they could to support the acute trusts. 6.2.3. LN reflected that when she started with S&O the average number of patients ready for discharge (RFD) had been 30 each day and now it had increased to 144 patients. This number now included fast track discharge patients who were end of life, which was very distressing, and LN had written to Sefton PLACE asking for their action plan to address this. GB asked if there was an impact of using the Discharge Lounge for in patients and LN acknowledged that this was something that the Trust was striving to avoid because it caused more problems with patient flow, and patients being discharged from ED and awaiting transport. 6.2.4. HS asked if the Trust used 'hospital at home' and 'triage at the front door' to divert patients who did not require admission. LN responded that this was used successfully at the Whiston site. RC commented that this was another area where all the PLACES needed to agree a common set of criteria for hospital at home and virtual wards. The system has been tasked with standardising the criteria for the top three categories, namely frailty, respiratory and general social care to help reduce attendances and prevent avoidable admissions. RC advised that the urgent community response (UCR) was also variable between PLACE areas and as a result there were still patients who attended A&E that did not need to. LN advised that in Southport there were no alternatives to attending A&E and noted that the nearest Urgent Care Treatment centre was in Ormskirk. HS asked if there were outreach teams. PW responded that there was an established frailty team based at the Whiston site and work was underway to replicate this service at Southport. If patients or carers contacted the Urgent Care hub which could take calls from the General Practitioners (GP) and '111' they could direct patients to the most appropriate urgent care service however, if a patient rang '999' the patients would invariably be brought to ED, and once

admitted it became difficult to discharge that patient to an appropriate alternative.

6.2.5. PG reflected that some councils would only retain a package of care for two days if a person was admitted to hospital, which meant that the package would have to be re-assessed and allocated for the person to be able to leave hospital again. LN responded that Local Authority social care was more difficult to access, due to the financial pressure that councils were facing.

6.2.6. GA asked if video consultations were an option to reduce attendances. PW responded that the community frailty service was able to offer this option if a patient was referred.

6.2.7. LN reported that the Trust was performing well against the 18-week Referral to Treatment (RTT) target compared to C&M and nationally. LN advised that during the first six months of 2023/24 there had been a significant decrease in the number of patients waiting for treatment, however, this had slowed due to the impact of industrial action and ongoing urgent care pressures. The national target of zero 65-week waiters by the end of March 2024 had now been pushed back to September. Plastics and orthopaedics were the two specialities with the largest number of long waiting patients. It was noted that there was currently one patient waiting over 78 weeks for treatment, however, this was due to patient choice.

6.2.8. In relation to diagnostics LN reported that 6-week performance had increased from 67.9% in October 2023 to 79.9% in January 2024. The improvement plans that were in place for two of the underperforming areas, has resulted in an improvement in non-obstetric ultrasound (56.1% to 97.9%) and endoscopy (56.9% to 72%). LN noted that, whilst there were actions in place to improve the performance for DEXA scans, it was not expected that these would have a significant impact on performance for another three to four months and noted that performance was impacted by workforce shortages and a 35% increase in referrals.

6.2.9. Cancer tumour specific action plans were in progress, but it was noted there were a new set of national trajectories for 2024/25, for each tumour site pathway to meet the 28-day faster diagnosis target. Performance against the 62-day Cancer standard was 78.4% against a target of 85.0% (nationally performance was 65.9% and C&M performance was 71.9%).

6.2.10. RF asked if LN could explain the new cancer faster diagnosis standard. LN advised that this was a target to complete diagnosis within 28 days and there were various best practice and timed pathways in place to achieve the target. LN noted that from 2024/25 the two key cancer performance targets would be the 28-day faster diagnosis standard and the 62-day pathway, and these replaced the 2-week waiting time target.

6.3.	**Workforce Indicators**
	6.3.1. AMS presented the Workforce Indicators and highlighted the following: 6.3.1.1. The MWL appraisal compliance rate was 83.7% against a target of 85% (0.9% decrease on the previous month). 6.3.1.2. The mandatory training compliance rate was 86.6% against a target of 85%. Core mandatory training was reviewed monthly at the Executive Committee. A review of compulsory training was being undertaken to align the training requirements for all MWL staff. 6.3.1.3. In month sickness absence was 6.4% against a target of 5% with stress, anxiety and depression remaining the highest causes for absence. It was noted that there had been a 1% increase in Health Care Assistants (HCA) sickness. There had been a decrease in sickness absence for qualified nurses. 6.3.1.4. AMS noted that there had been a slight reduction in sickness absence compared to the same time the previous year (6.8% in January 2023 and 6.4% in January 2024). The C&M benchmark for acute trusts was 6% compared to 5.5% in September 2023. 6.3.2. RF asked when the HCA banding reviews would be completed, and AMS advised that this was likely to be a lengthy process with ongoing discussions and regular meetings with Unison to work through the detail.
6.4.	**Financial Indicators**
	6.4.1. AMS, on behalf of GL, presented the Financial Indicators and highlighted the following: 6.4.1.1. The MWL financial plan for 2023/24 had included a surplus of £7.6m which assumed full achievement of CQUINS, delivery of £31.8m recurrent and £7.0m non-recurrent Cost Improvement Plans (CIP) and delivery of the 2023/24 activity plan. 6.4.1.2. At month 10 the Trust reported a £3m deterioration from plan which was due to industrial action costs of £1.6m, a reduction in income linked to industrial action of £1.4m. Additionally, there were further ongoing pressures which were currently being mitigated internally and included £6.9m of non-pay inflation above plan and a £3.3m YTD pay award pressure. 6.4.1.3. At month 10 the Trust's CIP schemes delivered or at the finalisation stage was £38.9m YTD with £27.0m recurrently. 6.4.1.4. The cash balance as at the end of month 10 was £2.7m with a forecast of £2.5m at the end of the financial year and it was noted that the Trust had received cash in line with the transaction support agreed with NHS England and the C&M Integrated Care Board (ICB). 6.4.1.5. The capital programme was £20m including PFI lifecycle costs, with significant spend profiled into Q4. **RESOLVED:**

	The Board **noted** the Integrated Performance Report.
Committee Assurance Reports	
7.	**MWL TB24/015 Committee Assurance Reports**
7.1.	**Executive Committee**
	7.1.1. AM presented the Executive Committee Assurance report covering the meetings held in January 2024. AM highlighted the following: 7.1.1.1. As part of the Thirlwell Enquiry the Trust had been requested to complete a questionnaire about staffing levels, culture, the ability to report concerns, governance structures and the number of reported incidents. It was noted that a follow up questionnaire had also been sent directly to staff members in the neonatal unit. 7.1.2. GB reflected on the increased level of reporting about maternity services and asked if this should be expanded to include neonatal services. AMS commented that previously the reporting for maternity services had included neonatal services as it was difficult to separate the two. AM confirmed that once the new divisional structure for the Women and Children's Division was in place these services would be managed together across MWL. 7.1.3. RT noted that the Maternity Voices Partnership (MVP) has now expanded to include neonatal as part of their remit. RT noted that the formal reporting and investigation processes for neonatal deaths were lengthy, although it was noted that there was prompt reporting to the Board. 7.1.4. GA reflected on the volume of information being presented for Maternity Services and the Board's reliance on the Executive to highlight any important issues. NB commented that there was work was ongoing refine the reporting template to focus on provide more focus on trends and exceptions. 7.1.5. AM noted that the ICB was now holding monitoring meetings with each PLACE with a greater focus on operational performance. RC, in his role as Managing Director, had been invited to attend the five PLACE meetings, where the Trust was a key stakeholder. 7.1.6. The Pathology Network had restarted work to create three pathology hubs across the C&M and MWL would be working with Warrington and Halton NHS Foundation Trust to create the East Hub. 7.1.7. AM highlighted that the Committee had received updates on the discussions with Unison regarding the HCA Banding issue. 7.1.8. RT asked about the new Care Quality Commission (CQC) assessment process and if this would affect how information was presented to the Quality Committee. It was noted that the new process would be based on continuous assessment rather than set piece inspections of the whole

	organisation. It was agreed that the presentation would be shared with the Quality Committee once there was some experience of how the new regime would operate. AM confirmed that the outcomes of all CQC visits and judgements about trust services would continue to be reported to the Board. The remainder of the report was **noted.**
7.2.	**Audit Committee**
	7.2.1. IC presented the Audit Committee Assurance Report for the meeting held on 21 February 2024 and highlighted the following: 7.2.1.1. The internal audit programme for 2023/24 was progressing to plan and the Committee had been assured by the positive audit results for key financial system controls. 7.2.1.2. The Committee received the Local Counter Fraud Progress Report and had discussed the risk of romance fraud. 7.2.1.3. The Committee had approved the Anti-Fraud, Bribery and Corruption Policy for MWL 7.2.1.4. For the 2023/24 accounts the timetable had been agreed. The draft accounts had to be submitted by 24 April and the final Annual Report and Accounts approved by 28 June. There would be a separate set of accounts prepared for the former Southport and Ormskirk Hospital Trust for the period 01 April to 30 June 2023. 7.2.2. IC alerted the meeting to the moderate assurance report received regarding the supporting processes for electronic discharge systems and the potential system weaknesses causing rejections and preventing discharge letters from being issued. There was a manual triage system in place to ensure that all urgent discharge letters were sent, and this fell under the control of the Medical Director, however, the systems and audit report fell under the control of the Director of Informatics. The Committee had requested a deep dive on the electronic discharge systems for further assurance. The remainder of the report was **noted.**
7.3.	**Quality Committee**
	7.3.1. GB presented the Quality Committee Assurance report and highlighted the following: 7.3.1.1. The Committee received the Nurse Safe Staffing Report and noted the increased use of agency staff in December 2023, due to bank staff being unable to fill shifts. Work was ongoing to reduce the reliance on agency staff. 7.3.1.2. Concerns were raised in relation to high sickness absence in some areas, especially with high levels of HCA and qualified nurses' sickness, and it was noted that these were being reviewed and managed in line with the Trust's policy. 7.3.1.3. The overall fill rates in December remained above target, with registered nurses/midwives at 98.3% and healthcare assistants at 119.7%. Concerns were raised regarding the clinical areas with lowest Care Hours per Patient

	Day (CHPPD) and a review of this was to be presented to the Executive Committee to analyse any areas of disparity with fill rates. Work was underway to ensure a consistent approach for reporting across all MWL sites going forward. 7.3.1.4. It was noted that work was ongoing to increase the number of bank staff and assurance was provided that all agency staff were required to complete all mandatory training and local induction prior to working. 7.3.1.5. The Supplementary Care Point Prevalence Audit report was presented and the number of patients that required supplementary care with a delayed discharge was discussed. 7.3.1.6. The E.coli Improvement Plan to reduce the number of infections, particularly due to urinary sources was presented and the Committee requested further reports to ensure the actions were delivering the expected performance improvement. 7.3.1.7. The Committee received an update on the delivery of the five annual Trust objectives aligned to the Quality Committee and the key areas that required additional actions were noted. The Executive team had requested that MSRA infections be included in the 2024/25 objectives, however, the Committee had suggested the inclusion of all healthcare acquired infections. 7.3.1.8. The Corporate Performance Report was discussed, and it was noted that the CQC reports following the Maternity Services inspections in December had not been received. 7.3.1.9. The maternity indicators had been reviewed and the committee had requested a review of practises across both units to share best practice in relation to third and fourth-degree tears and postpartum haemorrhages. 7.3.1.10. The Committee had received the 2023 Maternity Patient Experience Survey Report and, whilst there had been a number of improvements, further work was required in some areas. The MVP would be involved in developing the action plans. 7.3.1.11. The Clinical Effectiveness Council report provided an update on the lung telemonitoring pilot, which concluded that although it did not decrease contact with healthcare, it did improve the patient's self-confidence and empowerment. 7.3.2. GB alerted the meeting to the following: 7.3.2.1. Work was ongoing to reduce infections, including E.coli and to improve fluid balance recording. 7.3.2.2. There had been a significant decrease in compliance with the 20-day target for assessment with a consultant paediatrician in the Looked after Children (LAC) Health Assessments (Safeguarding). 7.3.3. RC agreed that there was a concern around the resilience of the community Paediatrician service, but this was being supported by the use of locums and advised that this service would fall under the new Women and Children's Division in the future and the makeup of the team would be resolved as part of the new structure.

	7.3.4. GB noted the increased number of red flags in relation to the key quality performance indicators, with a need for greater analysis of the causes and targeted actions that would improve performance. AM reflected on the earlier discussion about the QWR and felt that there was a need for a refresh on the key leadership actions at ward level and a back-to-basics approach for high quality care standards. 7.3.5. GB also asked if the Committee Performance Report (CPR) could be updated to include the number of escalation bed days. RC advised that, as this was reported on a daily basis, it could be added to the CPR for the Quality Committee. **Action** RC to request that the CPR be updated to include the number of escalation bed days. 7.3.6. RT asked about the national emergency laparotomy audit, how this would influence the best practice tariff and what would be the financial impact. PW advised that this applied to a small cohort of patients and the Trust would need to decide if, as an organisation, it wanted to go at risk to implement the best practice guidance. PW advised that the service would not need to be consultant led but could be led by speciality doctors or practitioners. The Clinical Directors for care of the elderly and general surgery had been asked to develop a pathway for the relatively small number of patients that required this service. The remainder of the report was **noted**.
7.4.	**Strategic People Committee**
	7.4.1. LK, presented the Strategic People Committee Assurance report and highlighted the following: 7.4.1.1. The Committee had reviewed the Workforce Performance Dashboard. 7.4.1.2. The Committee received an update on the Organisational Development (OD) plan delivery and noted that the 2024/25 plan would be presented to the Valuing People Council in March 2024. 7.4.1.3. The Committee, in response to a request from the Board, had received a detailed explanation of the methodology used to calculate the annual gender pay gap as well as an explanation of why a pay gap could occur. LN commented that the explanation had been excellent. 7.4.2. LK also advised that the national training for NEDs undertaking the designated board member role for the NHS Maintaining High Professional Standards (MHPS) investigations has now been completed and would be available shortly. The remainder of the report was **noted**.

7.5.	**Finance and Performance Committee**
	7.5.1. SC presented the Committee Assurance report and noted that this had been his first meeting as Chair of the Committee. SC confirmed the Committee had reviewed the CPR and monthly finance report, but the key points had already been discussed in other reports. Other points to highlight were: 7.5.1.1. The Committee received the Medical Care (STHK) CIP Presentation, and noted the good progress being made in delivering the CIP targets for 2023/24 and identifying CIP opportunities for 2024/25. 7.5.1.2. The Committee received an update on the draft 2024/25 Planning and Budget Setting Process. The impact of continuing industrial action and the ongoing urgent care pressures were noted. 7.5.1.3. The financial position included £3.0m expenditure which related to industrial action for December 2023 and January 2024 and the national instruction had been to assume that no additional funding would be provided, and this would impact the financial outturn for 2023/24. 7.5.2. SC advised that there was a possibility that all trusts in C&M would be subject to additional regulatory action should the ICB fail to deliver the 2023/24 financial plan. The remainder of the report was **noted**. **RESOLVED:** 8. The Board **noted** the Committee Assurance Reports
Other Board Reports	
9.	**MWL TB24/016 Maternity and Neonatal Services Assurance Report**
	9.1. LB, on behalf of SR, presented the Maternity and Neonatal Services Assurance Report which provided an update on the priorities and progress of the maternity and neonatal services and noted that this was the first combined report for the maternity and neonatal services provided by MWL. 9.2. LB highlighted the following: 9.2.1. The Trust had declared compliance with the ten safety actions for both Whiston and Ormskirk maternity units for the Clinical Negligence Scheme for Trusts (CNST) . The year 6 Maternity Incentive Scheme (MIS) safety actions for 2024 were still awaited, and an action plan would be developed as soon as they were received. 9.2.2. Saving Babies Lives (SBL) Care Bundle (version 2 and 3) was a requirement for safety action 6 and the Trust was fully compliant with all elements of SBL Care Bundle version 2 and planned to declare compliance with SBL version 3, by March 2024. 9.2.3. A 'Dads Matter' scheme was in place at both maternity units. 9.2.4. The Trust had completed and submitted the questionnaire to the Thirwell Enquiry

	9.2.5. The Ormskirk Unit was working to ensure that it met Northwest Coast Regional guidelines for induction of labour. The Whiston Unit needed to focus on supporting a smoke free pregnancy and reducing the percentage of smokers at the time of delivery. Two tobacco dependence advisors had been appointed to support the delivery of this target. 9.2.6. Perinatal Mortality - there had been four reportable deaths in Q3, and all cases had undergone a multidisciplinary review, and learning shared. 9.2.7. No never events had been reported in Q3. 9.2.8. In Q3 two serious incidents had been reported: 9.2.8.1. one divert at Whiston (October 2023) 9.2.8.2. one maternal death at Whiston (December 2023) – the results of the post mortem had not yet been received. 9.2.9. There had been one STEIS reportable incident in April 2023 (neonatal death at seven weeks) and feedback had now been received and an action plan was being developed in response to the findings and recommendations. 9.2.10. Following the CQC inspections in December informal feedback had been received but the formal reports were awaited. Maternity Safety Champions were being encouraged to report any issues as part of their quality walkabouts. 9.2.11. The results of the 2023 national maternity survey had been received and reported to the Quality Committee. 9.2.12. A 15 Steps Maternity and Neonatal event had taken place in February 2024. The feedback received was positive and included comments that the units had a family feel' and were safe and clean, however, additional work was required to translate information into other languages besides English. 9.2.13. All maternity quality and performance metrics were being harmonised and aligned across the two units. 9.2.14. RT reflected on the differences in the continuity of care approach across the two sites and commented that care should be standardised. LB clarified that the Continuity of Care model had been paused nationally but wherever possible the services were trying to provide continuity of care. **RESOLVED:** The Board **noted** the Maternity and Neonatal Services Assurance Report
10.	**MWL TB24/017 Corporate Governance Manual (including Standing Financial Instructions and Scheme of Delegation)**
	10.1. NB, on behalf of GL, presented the Corporate Governance Manual (including Standing Financial Instructions and Scheme of Delegation) which contained the key Trust policy documents governing the conduct and operation of the Trust. NB noted that much of the content was prescribed by the regulations that established the Trust. Legal advice had been taken and all relevant services in the Trust (Procurement, HR, Corporate Governance) had worked with the finance team to review and develop the new Corporate Governance Manual for MWL. The key changes were: 10.1.1. Updates to reflect changes in legislation. 10.1.2. Changes in wording to reflect the Trust's Equality, Diversity, and Inclusion

	(ED&I) policy. 10.1.3. Updates for job title changes. 10.1.4. Proposed amendments to delegated financial limits. 10.2. IC noted that the delegated limits did not include all the Deputy Directors and NB explained that this was linked to the size of the budgets that they managed. 10.3. IC asked for more assurance in relation to the proposed increase in delegated limits for the CEO and Director of Finance and Information, so that the Board was not delegating permission for virement between budgets up to £1m without Board approval. RF suggested that NB and GL work with IC to clarify the wording and intent of this section. IC felt that the remainder of the document was very comprehensive and mature. 10.4. GB commented on the Committee Structure and noted that only the Audit Committee and the Remuneration and Charitable Funds Committees were statutory. **ACTION** NB to arrange to meet with IC to discuss the delegated limits and to amend the reference to statutory committees. **RESOLVED:** The Board **approved** the Corporate Governance Manual (including Standing Financial Instructions and Scheme of Delegation) subject to the amendment and approval of the delegated limits by the Audit Committee Chair
Concluding Business	
11.	**Effectiveness of Meeting**
	11.1. The members reflected on the effectiveness of the meeting.
12.	**Any Other Business**
	12.1. GB reflected on the recent interview panels for the ED consultants that she and RC had been a part of and the positive feedback from the candidates who had commented on the teamwork in the department as well as the support from the management team. GB noted that all four candidates had worked in the Whiston ED at some stage of their training. RF commented that attracting high calibre candidates to work for the Trust was one of the key transaction benefits and it was pleasing to hear that this was happening. 12.2. RF reflected on the presentation at the North West Systems Leaders Call by Professor Shanley about the enquiry into Greater Manchester Mental Health NHS Foundation Trust (GMMH) and commented that the points raised in the presentation could apply to all trusts. In the presentation Professor Shanley had spoken about staff having a fear of reprisals if they raised concerns. The enquiry report also detailed how reports from GMMH committees had been

	amended prior to being presented at Board and this was not challenged by the relevant Committee Chairs. RF commented that he was assured that this would not happen in MWL. LK commented that she had not realised that at some Trusts NEDs did not chair the Board Committees and the report had highlighted the importance of strong governance so that issues could be escalated to the Board and the key role of the NEDs in the leadership of the Trust, to constructively challenge. The being no other business, the Chair thanked all for attending and brought the meeting to a close at 12.40. The next Board meeting would be held on **Wednesday 27 March 2024 at 09.30**

Meeting Attendance 2023/24												
Members	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Richard Fraser (Chair)				✓		✓	✓	✓		✓	✓	
Ann Marr				✓		✓	✓	✓		✓	✓	
Anne-Marie Stretch				✓		✓	✓	✓		✓	✓	
Geoffrey Appleton				✓		✓	✓	✓		✓	✓	
Gill Brown				✓		✓	✓	✓		✓	✓	
Nicola Bunce				✓		✓	✓	✓		✓	✓	
Ian Clayton				✓		✓	✓	✓		✓	✓	
Steve Connor											✓	
Rob Cooper				✓		✓	A	✓		✓	✓	
Paul Growney				A		✓	✓	✓		A	✓	
Lisa Knight				✓		✓	✓	✓		A	✓	
Jeff Kozer				✓		✓	✓	✓				
Gareth Lawrence				✓		✓	✓	✓		✓	A	
Lesley Neary				✓		✓	✓	✓		A	✓	
Sue Redfern				✓		A	✓	✓		✓	A	
Rani Thind				✓		✓	✓	✓		✓	✓	
Christine Walters				✓		✓	✓	✓		✓	✓	
Peter Williams				✓		✓	✓	✓		✓	✓	
In Attendance	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Angela Ball				✓		A	✓	✓		✓	-	
Richard Weeks				✓		✓	✓	A		✓	✓	
✓ = In attendance A = Apologies												

Trust Board (Public)

Matters Arising Action Log

Action Log updated 23 February 2024

Mersey and West Lancashire Teaching Hospitals NHS Trust

Status	
Yellow	On Agenda for this Meeting
Red	Overdue
Green	Not yet due
Blue	Completed

Agenda Ref	Meeting Date	Agenda Item	Action	Lead	Deadline	Forecast Completion *(for overdue actions)*	Status
6	25/10/2023	**MWL TB23/043 Integrated Performance Report** 6.2 Operational Indicators	AM commented that the STHK sites had prioritised the 62 day diagnosis to treatment pathway, rather than the two week referral pathway. It was agreed that the Executive Committee would review the cancer two-week referral target performance and potential improvements. <u>Update</u> The cancer pathway action plans are being reviewed by the Executive Committee in February and then will be reported to via the Finance and Performance Committee.	LN	Mar-24		**Delegated to Finance & Performance Committee**
7	25/10/2023	**MWL TB23/044 Committee Assurance Reports** 7.1 Executive Committee	Safe Staffing report - GB commented on the increase in medication errors noted on the neonatal ward and requested an update at the Quality Committee.	SR	Feb-24		**Delegated to the Quality Committee**
2	29/11/2023	**Patient Story**	The Board requested a review of the actions taken as a result of this patient story to provide assurance that a similar situation could not happen again.	SR	Mar-24		

7	29/11/2023	**MWL TB23/055 Integrated Performance Reports** 7.1 Quality Indicators	The Board asked for a report on the actions being taken to reduce E.Coli infections to achieve the Trust target for 2023/24.	SR	Mar-24		
2	31/01/2024	**Patient Story**	AM proposed a review of the provisions in both EDs, to ensure that support was being provided, which would be considered at the Executive Committee	SR	Mar-24		**Delegated to the Executive Committee**
7	31/01/2024	**MWL TB24/005 Integrated Performance Reports** 7.1 Quality Indicators	PW agreed with this and would continue to investigate the reasons for the increase in the HSMR rate and will provide an update to the Board. <u>Update</u> PW to provide a verbal update at the meeting	PW	Feb-24		
9	31/01/2024	**MWL TB24/008 Corporate Risk Register**	IC reflected that the Trust embedded the Cyber Security risk as part of the wider IT risks with an impact of 4 and asked whether this was too low. Additionally, IC asked if the Trust was an outlier or did other trusts include cyber security as part of their wider IT risks. CW agreed to review this and include in the next quarterly review	CW	Apr-24		
12	31/01/2024	**MWL TB24/010 Learning from Deaths Quarterly Report** 12.1 STHK sites	The Board requested a summary of the themes, learning and actions plans from the Quarterly Learning from Deaths Report be brought together in to an annual report each year. PW agreed to do this for July and NB to update the Board workplan to include this.	PW	Jul-24		

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**		**Date**	**28 February 2024**
Agenda Item	**MWL TB24/014**			
Report Title	**Integrated Performance Report**			
Executive Lead	Gareth Lawrence, Director of Finance and Information			
Presenting Officer	Gareth Lawrence, Director of Finance and Information			
Action Required		**To Approve**	X	**To Note**

Purpose

The Integrated Performance Report provides an overview of performance for MWL across four key areas:

1. Quality
2. Operations
3. Workforce
4. Finance

Executive Summary

Performance for MWL is summarised across 30 key metrics. Quality has 10 metrics, Operations 13 metrics, Workforce 4 metrics and Finance 3 metrics.

Financial Implications

The forecast for 23/24 financial outturn will have implications for the finances of the Trust.

Quality and/or Equality Impact

The 10 metrics for Quality provide an overview for summary across MWL

Recommendations

The Trust Board is asked to note performance for assurance.

Strategic Objectives

X	**SO1** 5 Star Patient Care – Care
X	**SO2** 5 Star Patient Care – Safety
X	**SO3** 5 Star Patient Care – Pathways
X	**SO4** 5 Star Patient Care – Communication
X	**SO5** 5 Star Patient Care – Systems
X	**SO6** Developing Organisation Culture and Supporting our Workforce
X	**SO7** Operational Performance
X	**SO8** Financial Performance, Efficiency and Productivity
X	**SO9** Strategic Plans

Integrated Performance Report

Integrated Intelligence & Improvement Service

Mersey and West Lancashire Teaching Hospitals NHS Trust

Board Summary

Overview

Mersey and West Lancashire Teaching Hospitals ("The Trust") has in place effective arrangements for the purpose of maintaining and continually improving the quality of healthcare provided to its patients.
The Trust has an unconditional CQC registration which means that overall its services are considered of a good standard and that its position against national targets and standards is relatively strong.
The Trust has in place a financial plan that will enable the key fundamentals of clinical quality, good patient experience and the delivery of national and local standards and targets to be achieved. The Trust continues to work with its main commissioners to ensure there is a robust whole systems winter plan and delivery of national and local performance standards whilst ensuring affordability across the whole health economy.

Quality	Period	Score	Target	YTD	Benchmark
Mortality - HSMR	Aug-23	100.9	100	93.4	Best 50%
FFT - Inpatients % Recommended	Jan-24	93.3%	90.0%	94.7%	Worst 50%
Nurse Fill Rates	Jan-24	96.2%	90.0%	97.3%	
C.difficile	Jan-24	8	85	97	
E.coli	Jan-24	10	121	137	
Hospital Acq Pressure Ulcers per 1000 bed days	Oct-23	0.00	0.00	0.00	
Falls ≥ moderate harm per 1000 bed days	Dec-23	0.21	0.00	0.21	
Stillbirths (intrapartum)	Jan-24	0	0	0	
Neonatal Deaths	Jan-24	0	0	5	
Never Events	Jan-24	0	0	1	
Complaints Responded In 60 Days	Jan-24	43.8%	80.0%	47.5%	

Operations	Period	Score	Target	YTD	Benchmark
Cancer Faster Diagnosis Standard	Dec-23	70.0%	75.0%	69.5%	Worst 40%
Cancer 62 Days	Dec-23	78.4%	85.0%	79.0%	Best 10%
% Ambulance Handovers within 30 minutes	Jan-24	36.3%	95.0%	61.3%	
A&E Standard (Mapped)	Jan-24	72.3%	76.0%	74.9%	Best 20%
Average NEL LoS (excl Well Babies)	Jan-24	4.3	4.0	4.1	Best 30%
% of Patients With No Criteria to Reside	Jan-24	26.7%	10.0%	26.4%	
Discharges Before Noon	Jan-24	18.8%	20.0%	17.9%	
G&A Bed Occupancy	Jan-24	91.7%	92.0%	90.2%	Worst 40%
Patients Whose Operation Was Cancelled	Jan-24	1.0%	0.8%	0.9%	
RTT % less than 18 weeks	Jan-24	60.5%	92.0%	60.5%	Best 40%
RTT 65+	Jan-24	831	0	831	Best 50%
% of E-discharge Summaries Sent Within 24 Hours	Jan-24	83.9%	90.0%	82.0%	
OP Letters to GP Within 7 Days	Dec-23	46.2%	90.0%	42.5%	

Workforce	Period	Score	Target	YTD	Benchmark
Appraisals	Jan-24	83.7%	85.0%	83.7%	
Mandatory Training	Jan-24	86.6%	85.0%	86.6%	
Sickness: All Staff Sickness Rate	Jan-24	6.4%	5.0%	5.9%	
Staffing: Turnover rate	Jan-24	1.0%	1.1%	1.0%	

Finance	Period	Score	Target	YTD	Benchmark
Capital Spend £ 000's	Jan-24		31,280	20,000	
Cash Balances - Days to Cover Operating Expenses	Jan-24	1.3	10		
Reported Surplus/Deficit (000's)	Jan-24		5,240	2,191	

Board Summary - Quality

Quality

Never Events - There were no never events in Jan and 1 YTD (reported in Dec). The Dec never event is still under the PSII investigation process.

Pressure Ulcers - There was 1 category 3 or above pressure ulcers with lapse in care in October. YTD 3 patient incident with category 3 or above pressure ulcers with lapse in care, occurring on heels. Learning review have been completed and improvement actions in place.

Patient Falls - There were 8 falls resulting in moderate or above harm in December (all at STHK site). Of these 1 resulted in death and 3 resulted in severe harm. 72 hour review completed for immediate learning and to ensure actions were put in place.

MRSA - There were no reported cases of MRSAB in January. YTD there have been 6 cases.

C.Diff - The Trust has reported 97 cases YTD against an annual trajectory of 85. All cases have been reviewed by the IPC Team and RCAs have been requested of clinical teams, formal feedback is awaited. Initial IPCT review indicates lapses in SIGHT, in the timely testing and isolation of patients with diarrhoea.

MSSA bacteraemia - There were 5 cases in January. RCAs ongoing. The majority of cases are linked to UTI and chest infections. YTD 2 of the 28 cases at STHK have been linked cannula site infections and 1 was avoidable.

E coli - The majority from urinary sources of infection and are unavoidable. An action plan is in place.

Stage 1 Complaints closed within 60 working days - Responding to complaints within 60 days remains challenging due to operational pressures in obtaining statements to compile the responses. The central teams continue to offer support to staff where possible.

Friends & Family Test - FFT response and recommendation rates were either above target or slightly below other than a rating of poor/very poor for ED which was 1.3% above the 9% target, due in the main to long waits in the department and for postnatal rating of poor/very poor due to the low response rates.

Neonatal Deaths - no neonatal deaths reported in January (YTD 5).

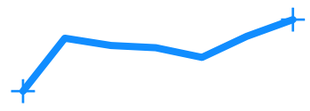
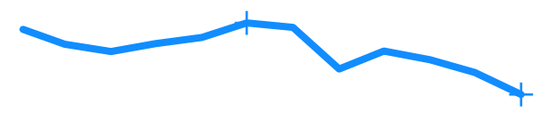
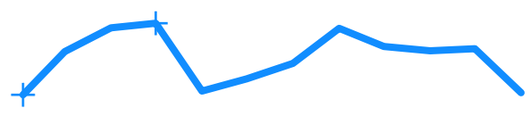
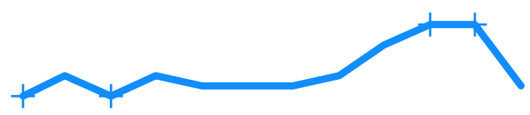
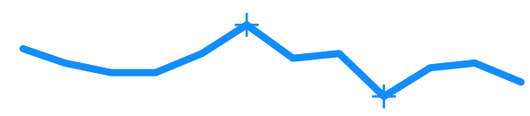
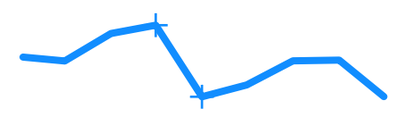
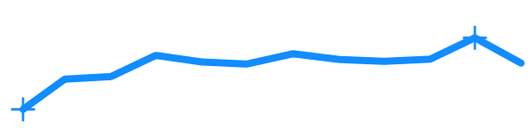
Mortality - The HSMR is currently running 3 months behind due to a lag in coded activity at the S&O site due to scanning. As a result, latest data is up to and including Aug-23. YTD the HSMR remains low at 93.4 however there has been an in month (Aug-23) rise in the HSMR to 100.9. This rise in the HSMR is at S&O site (Aug HSMR 116.5, YTD 99.1). Analysis shows that the increase in HSMR at S&O site is predominantly driven by a fall in palliative care coding. The Trust continues to monitor and investigate any alerting diagnosis groups. The SHMI remains within expected levels.

Integrated Performance Report

Integrated Intelligence & Improvement Service

Mersey and West Lancashire Teaching Hospitals NHS Trust

Board Summary - Quality

Quality	Period	Score	Target	YTD	Benchmark	Trend
Mortality - HSMR	Aug-23	100.9	100	93.4	Best 50%	
FFT - Inpatients % Recommended	Jan-24	93.3%	90.0%	94.7%	Worst 50%	
Nurse Fill Rates	Jan-24	96.2%	90.0%	97.3%		
C.difficile	Jan-24	8	85	97		
E.coli	Jan-24	10	121	137		
Hospital Acq Pressure Ulcers per 1000 bed days	Oct-23	0.00	0.00	0.00		
Falls ≥ moderate harm per 1000 bed days	Dec-23	0.21	0.00	0.21		
Stillbirths (intrapartum)	Jan-24	0	0	0		
Neonatal Deaths	Jan-24	0	0	5		
Never Events	Jan-24	0	0	1		
Complaints Responded In 60 Days	Jan-24	43.8%	80.0%	47.5%		

Board Summary - Operations

Operations

Urgent Care/Bed Pressures
In January 2024 there was unprecedented pressure across our main A&E departments, which is in line with the challenges seen across the country. Both Whiston and Southport sites declared OPEL 4, highest level of escalation across NHS Trusts, on a number of occasions during January 2024.
Winter plans were enacted which seen a number of schemes go live, including the opening of additional escalation beds. Due to more recent challenges, across both Whiston and Southport sites, this has had to be further extended.
In addition to opening escalation beds, extraordinary action has taken place and appropriate non-urgent activity has been stood down to support the trust with the management of these additional patients across the hospital.
In response to supporting the Trust with ensuring that patients who longer need to be in an acute hospital setting can be discharged in a timely manner and reduce the length of stay for our patients who have stayed with us the longest (stranded/super stranded) we have had system partners on site on a number of occasions. Capacity challenges outside of the acute hospital setting means that we are not seeing the reduction that is required.

Elective
The first 6 months of the year seen the trust see a significant reduction in those patients who were waiting the longest for their treatment, which has seen the number of patients waiting 78+ weeks and 65+ weeks reduce significantly.
Plastics and Orthopaedics are the two specialties with the largest volume of long waiters. In line with the national position, the rate of reduction has slowed down in the latter part of the year due to industrial action and urgent care pressures. The trust continues to risk stratify patients to ensure that our focus remains on those who are most clinically urgent (P2) and who have waited the longest.

Diagnostics
The Trust has seen an improvement in the overall diagnostics 6 week performance. From 67.9% in October 2024 to 79.9% in January 2024. Latest unpublished weekly data reports the Trust at 85.1%. The 3 key modalities that were under performing were endoscopy, non-obstetric ultrasound and DEXA scans. Improvement plans are in place for all 3 modalities and these have supported improvement in non-obstetric ultrasound (56.1% - 97.9%) and endoscopy (56.9% to 72%). Actions continue in improving the endoscopy performance with mutual aid being provided by the Ormskirk site. The initial focus has been on reducing over 13 week waiters. Dexa scan improvement has been limited due to workforce challenges coupled with a 35% increase in referrals. January 2024 and February 2024 have seen some additional capacity for the service, with further capacity planned for March. It is expected that the modality will be above 95% by end of June 2024.

Cancer
MWL treated more patients on a 62-day cancer pathway across Cheshire and Mersey and more patients within 62 days.
In addition, we have seen the 62-day cancer backlog improve and as a Trust we are ahead of the March 2024 target.
The cancer teams across both legacy Trusts have been brought together with 1 PTL being run for each tumour site.
Tumour specific improvement plans are being updated to reflect the new planning targets for 2024 and will be presented back to Board in March 2024.

Letters
Challenges continue with the production of letters following an outpatient appointment. However, urgent letters are being produced within 48 hours of appointment and routine within 14 days, which is line with internal targets. An interim solution has been approved for letter production, ahead of the roll out of the strategic voice recognition solution. There is phased rollout of the new solution through Quarter 1 24-25 starting with ED week commencing 29th

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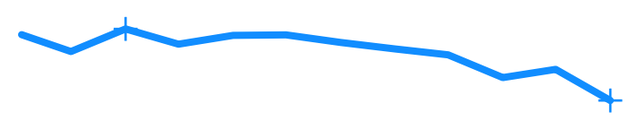
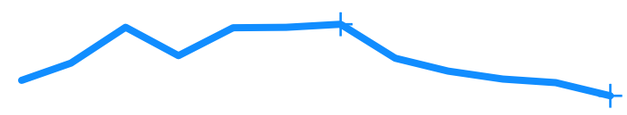
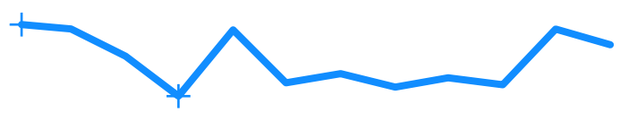
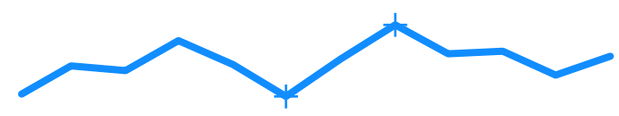
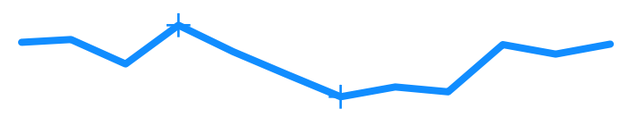
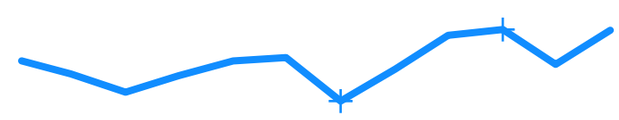
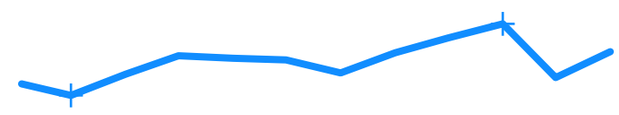
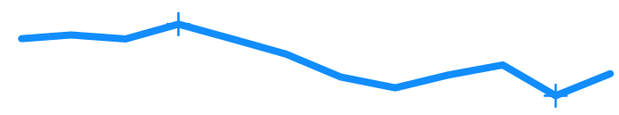
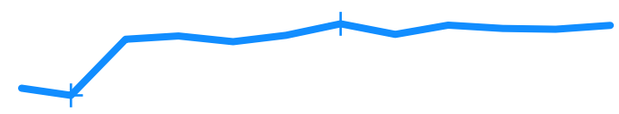
Board Summary - Operations

Operations	Period	Score	Target	YTD	Benchmark	Trend
Cancer Faster Diagnosis Standard	Dec-23	70.0%	75.0%	69.5%	Worst 40%	
Cancer 62 Days	Dec-23	78.4%	85.0%	79.0%	Best 10%	
% Ambulance Handovers within 30 minutes	Jan-24	36.3%	95.0%	61.3%		
A&E Standard (Mapped)	Jan-24	72.3%	76.0%	74.9%	Best 20%	
Average NEL LoS (excl Well Babies)	Jan-24	4.3	4.0	4.1	Best 30%	
% of Patients With No Criteria to Reside	Jan-24	26.7%	10.0%	26.4%		
Discharges Before Noon	Jan-24	18.8%	20.0%	17.9%		
G&A Bed Occupancy	Jan-24	91.7%	92.0%	90.2%	Worst 40%	
Patients Whose Operation Was Cancelled	Jan-24	1.0%	0.8%	0.9%		
RTT % less than 18 weeks	Jan-24	60.5%	92.0%	60.5%	Best 40%	
RTT 65+	Jan-24	831	0	831	Best 50%	
% of E-discharge Summaries Sent Within 24 Hours	Jan-24	83.9%	90.0%	82.0%		
OP Letters to GP Within 7 Days	Dec-23	46.2%	90.0%	42.5%		

Board Summary - Workforce

Workforce

Appraisals - The Trust has not achieved the appraisal target, achieving 83.7% against a target of 85%, a 0.9% decrease on the previous month. The lower compliance on the legacy S&O sites has improved in month (from 78.1% to 77.3%) however continues to be impacted by lengthy appraisal paperwork. S&O are in the process of transitioning to the STHK paperwork which will make the appraisal process easier.

Mandatory Training - The Trust is exceeding its mandatory target at 86.6% against a target of 85%.

Sickness - In-month sickness remains above target, at 6.4% against the 5% target.
The top reason for absence is Anxiety, Stress and Depression. This is consistent with the top reason for absence across the NHS. The Trust continues to focus on supporting all employees who are absent due to Anxiety/Stress/Depression by ensuring that all supportive actions have been undertaken. Further targeted work has also been undertaken as part of our overall absence management approach:
• Ensuring that welcome-back conversations (renamed from return to work), welfare meetings and trigger meetings are being undertaken
• Carrying out internal audits of areas to ensure the processes are being followed and providing support and training to line managers
• Delivering Attendance Management training sessions to new and existing managers.
• Holding bi-weekly review of Trust absences by HR Operations Team and HWWB Team.
• Facilitating early engagement of all employees who are absent due to musculoskeletal problems.
• Holding bi-weekly review of Trust absences by HR Operations Team and HWWB Team.
• Facilitating early engagement of all employees who are absent due to musculoskeletal problems.

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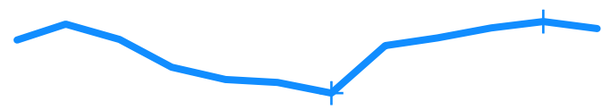
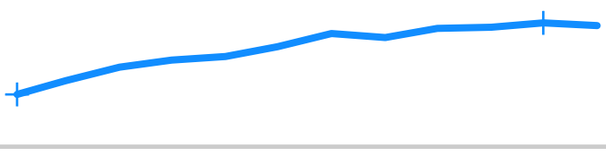
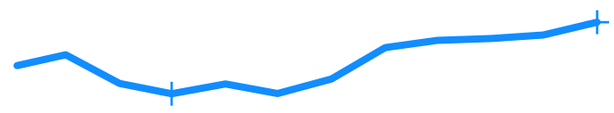
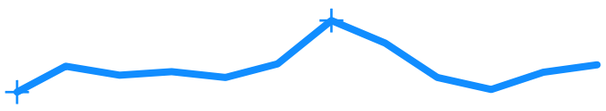
Board Summary - Workforce

Workforce	Period	Score	Target	YTD	Benchmark	Trend
Appraisals	Jan-24	83.7%	85.0%	83.7%		
Mandatory Training	Jan-24	86.6%	85.0%	86.6%		
Sickness: All Staff Sickness Rate	Jan-24	6.4%	5.0%	5.9%		
Staffing: Turnover rate	Jan-24	1.0%	1.1%	1.0%		

Board Summary - Finance

Finance

The final approved MWL financial plan for 23/24 (combining agreed STHK and S&O plans) gives a surplus of £7.6m, which assumes:
- Full achievement of CQUINs
- Delivery of £31.8m recurrent CIP
- Delivery of £7.0m non-recurrent CIP
- Delivery of the 23/24 activity plan, in order to achieve planned levels of income including ERF/API variable funding

Surplus/Deficit – At Month 10, the Trust is reporting a year to date surplus of £2m, which is a £3m deterioration from plan. This variance is in relation to industrial action costs of £1.6m over and above those funded earlier in the year of £4m, and a reduction in income linked to industrial action of £1.4m. The position also includes ongoing pressures currently being mitigated internally, including £6.9m non pay inflation above plan and a £3.3m YTD pay award pressure.

CIP - The Trust's combined 2023/24 CIP target is £41.6m of which £7.0m is non-recurrent. This includes the S&O delivery of £2.8m recurrent CIP prior to the acquisition. As at Month 10, schemes delivered or at finalisation stage totalled £38.9m in year (93%) and £27.0m (78%) recurrently.

Cash - At the end of M10, the cash balance was £2.7m, with a forecast of £2.5m at the end of the financial year. The Trust has received cash in line with the transaction support agreed with NHS England and C&M ICS.

Capital - Capital expenditure for the year to date (including PFI lifecycle maintenance) totals £20m. No PDC funding (provided by Department of Health & Social Care) has been used. There is significant capital spend profiled in Q4.

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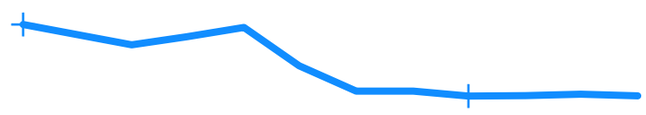
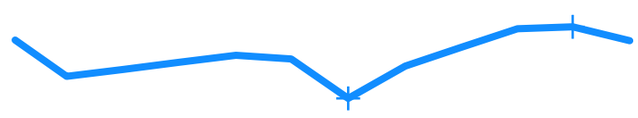
Board Summary - Finance

Finance	Period	Score	Target	YTD	Benchmark	Trend
Capital Spend £ 000's	Jan-24		31,280	20,000		
Cash Balances - Days to Cover Operating Expenses	Jan-24	1.3	10			
Reported Surplus/Deficit (000's)	Jan-24		5,240	2,191		

Integrated Performance Report

Integrated Intelligence & Improvement Service

NHS Mersey and West Lancashire Teaching Hospitals NHS Trust

Board Summary

Southport & Ormskirk

Quality	Period	Score	Target	YTD	Benchmark
Mortality - HSMR	Aug-23	116.5	100	99.1	
FFT - Inpatients % Recommended	Jan-24	90.7%	90.0%	94.2%	
Nurse Fill Rates	Jan-24	93.5%	90.0%	96.2%	
C.difficile	Jan-24	1	39	35	
E.coli	Jan-24	5	48	49	
Hospital Acq Pressure Ulcers per 1000 bed days	Oct-23	0.00	0.00	0.00	
Falls ≥ moderate harm per 1000 bed days	Dec-23	0.00	0.00	0.11	
Stillbirths (intrapartum)	Jan-24	0	0	0	
Neonatal Deaths	Jan-24	0	0	2	
Never Events	Jan-24	0	0	0	
Complaints Responded In 60 Days	Jan-24	53.3%	80.0%	69.8%	

Operations	Period	Score	Target	YTD	Benchmark
Cancer Faster Diagnosis Standard	Dec-23	71.1%	75.0%	70.1%	
Cancer 62 Days	Dec-23	63.4%	85.0%	63.1%	
% Ambulance Handovers within 30 minutes	Jan-24	35.3%	95.0%	66.4%	
A&E Standard (Mapped)	Jan-24				
Average NEL LoS (excl Well Babies)	Jan-24	6.1	4.0	5.2	
% of Patients With No Criteria to Reside	Jan-24	21.0%	10.0%	18.9%	
Discharges Before Noon	Jan-24	19.6%	20.0%	19.4%	
G&A Bed Occupancy	Jan-24	84.3%	92.0%	80.9%	
Patients Whose Operation Was Cancelled	Jan-24	0.7%	0.8%	0.7%	
RTT % less than 18 weeks	Jan-24	65.5%	92.0%	65.5%	
RTT 65+	Jan-24	9	0	9	
% of E-discharge Summaries Sent Within 24 Hours	Jan-24	81.6%	90.0%	79.1%	
OP Letters to GP Within 7 Days	Dec-23	65.9%	90.0%	69.9%	

Workforce	Period	Score	Target	YTD	Benchmark
Appraisals	Jan-24	77.3%	85.0%	77.3%	
Mandatory Training	Jan-24	90.3%	85.0%	90.3%	
Sickness: All Staff Sickness Rate	Jan-24	6.1%	6.0%	5.7%	
Staffing: Turnover rate	Jan-24	1.2%	1.1%	1.0%	

Finance	Period	Score	Target	YTD	Benchmark
Capital Spend £ 000's	Jan-24				
Reported Surplus/Deficit (000's)	Jan-24				

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Board Summary

St Helens & Knowsley

Quality	Period	Score	Target	YTD	Benchmark
Mortality - HSMR	Aug-23	94.4	100	91.0	
FFT - Inpatients % Recommended	Jan-24	94.4%	94.0%	94.9%	
Nurse Fill Rates	Jan-24	99.5%	90.0%	98.5%	
C.difficile	Jan-24	7	46	62	
E.coli	Jan-24	5	73	88	
Hospital Acq Pressure Ulcers per 1000 bed days	Oct-23	0.13	0.00	0.11	
Falls ≥ moderate harm per 1000 bed days	Dec-23	0.34	0.00	0.27	
Stillbirths (intrapartum)	Jan-24	0	0	0	
Neonatal Deaths	Jan-24	0	0	3	
Never Events	Jan-24	0	0	1	
Complaints Responded In 60 Days	Jan-24	35.3%	80.0%	33.2%	

Operations	Period	Score	Target	YTD	Benchmark
Cancer Faster Diagnosis Standard	Dec-23	69.3%	75.0%	69.0%	
Cancer 62 Days	Dec-23	83.2%	85.0%	84.2%	
% Ambulance Handovers within 30 minutes	Jan-24	37.0%	95.0%	57.2%	
A&E Standard (Mapped)	Jan-24				
Average NEL LoS (excl Well Babies)	Jan-24	3.7	4.0	3.7	
% of Patients With No Criteria to Reside	Jan-24	29.6%	10.0%	30.5%	
Discharges Before Noon	Jan-24	17.8%	20.0%	16.4%	
G&A Bed Occupancy	Jan-24	97.1%	92.0%	97.0%	
Patients Whose Operation Was Cancelled	Jan-24	1.1%	0.8%	1.1%	
RTT % less than 18 weeks	Jan-24	58.6%	92.0%	58.6%	
RTT 65+	Jan-24	822	0	822	
% of E-discharge Summaries Sent Within 24 Hours	Jan-24	84.5%	90.0%	82.9%	
OP Letters to GP Within 7 Days	Dec-23	34.1%	90.0%	26.4%	

Workforce	Period	Score	Target	YTD	Benchmark
Appraisals	Jan-24	87.3%	85.0%	87.3%	
Mandatory Training	Jan-24	85.1%	85.0%	85.1%	
Sickness: All Staff Sickness Rate	Jan-24	6.6%	5.0%	6.1%	
Staffing: Turnover rate	Jan-24	0.9%	1.1%	1.0%	

Finance	Period	Score	Target	YTD	Benchmark
Capital Spend £ 000's	Jan-24				
Cash Balances - Days to Cover Operating Expenses	Jan-24				
Reported Surplus/Deficit (000's)	Jan-24				

Committee Assurance Report			
Title of Meeting	**Trust Board**	**Date**	28 February 2024
Agenda Item	MWL TB24/015 (7.1)		
Committee being reported	Executive Committee		
Date of Meeting	This report covers the four Executive Committee meetings held in January 2024		
Committee Chair	Ann Marr, Chief Executive Officer		
Was the meeting quorate?	Yes		

Agenda items		
Title	**Description**	**Purpose**
There were four Executive Committee meetings held during January 2024. At every meeting bank or agency staff requests that breach the NHSE cost thresholds were reviewed, and the Chief Executive's authorisation recorded.		
04 January 2024		
Thirlwell Enquiry	• The Medical Director discussed the questionnaire that had been sent to all Medical Directors from the Thirlwell Enquiry Team asking for information about neonatal units. Committee reviewed the questions and noted that most questions were to obtain factual information about the service. It was also noted that the operational manager for the services was also being asked to complete a questionnaire response and most of the responses would be the same because of their factual nature. • The completed questionnaires had to be submitted by 05 January, following an error whereby the enquiry team had sent the MWL questionnaires to an incorrect email address.	Assurance
Partnership Update	• The Director of Integration presented the quarterly update. • The Integrated Care Board (ICB) were holding monitoring meetings with each place and the focus was on operational performance. A representative of the trusts in each place had been invited to attend. For MWL the Managing Director would attempt to attend the five relevant place meetings.	Assurance

	• St Helens place were in the process of refreshing their People Plan. • Halton Place were holding a “reset” meeting on 24 January. • The new Director of Adult Social Care for St Helens had now taken up post. • It was agreed that it would be useful for the Trust to review the relative performance of each place against the KPIs being monitored by the ICB.	
Trust Board	• Committee reviewed the Employee of the Month (EOTM) nominations received in December and selected a winner. • Committee reviewed the patient story to be presented at the January Board and noted some issues with the video quality that needed to be addressed.	Approval
Electronic Patient Records (EPR) Business Case	• The Director of Informatics reported that the national NHSE team review of the EPR Business Cases has generated several queries and requests for additional information, which were being addressed. The revised draft business case would be presented to the Executive Committee for re-approval.	Assurance
St Helens Sexual Health Contract	• The Director of Finance and Information reported that St Helens Council (Public Health) has requested that the current contract be extended for three months until 30 June 2024. • Committee agreed to this extension, but also recognised that the current funding envelope, which was not uplifted for inflation, had not kept pace with the cost of delivering the service and this created a risk for the Trust.	Assurance
Pathology Network	• The Managing Director reported that the Pathology Network had restarted the work to create pathology hubs across Cheshire and Merseyside. MWL would be working with Warrington and Halton Hospitals NHS Foundation Trust to create the East Hub. • The Director of Finance and Information reported that the ICB Director of Finance was proposing some financial risk sharing principles to facilitate this development.	Assurance

HCA Band 2 -3	• The Director of HR/Deputy CEO briefed the committee on the latest discussions with Unison to find a way forward and avoid industrial action, if possible.	Assurance
11 January 2024		
Sale of Cycle Path at Southport Hospital	• The Director of Corporate Services presented a proposal for Sefton Council to purchase from the Trust the narrow strip of land at the perimeter of the site. This land was currently leased to the council for use as a cycle path. An independent valuation of the land had been obtained. • Committee agreed that retaining this pathway within the Trust estate offered no advantage as this part of the site was already surrounded by houses. • Committee approved the sale of the cycle path to Sefton Council.	Approval
New CQC Assessment Process	• The Director of Nursing, Midwifery and Governance introduced the presentation which briefed the committee on the changes to the CQC assessment process. • The new process involved a continuous assessment of performance data and patient experience and was less focused on set piece inspections across all domains. Although focussed inspections remained part of the assessment process. • The new process was being rolled out during 2024 and although the domains and ratings system were unchanged the key lines of enquiry (KLOEs) were being replaced by Quality Statements. • Committee queried how the new process would work for whole system assessments but there had been no guidance published on this yet. • Committee discussed the importance of presenting a balanced view to the CQC in terms of both the positive and negative feedback received. • Committee agreed that staff would need information about the new process.	Assurance
Provider Selection Regime	• The Director of Finance and Information presented a briefing on the new Provider Selection Regime (PSR) that came into effect on 01 January 2024.	Assurance

	• The PSR removes the obligation on commissioners to market test services and removes the provisions that were introduced in 2012.	
Legacy STHK sites – Matron Flexible Working Proposal	• The Managing Director presented a proposal from the matrons to work four long days (for full time staff). • The proposal had been evaluated and risk assessed, and committee agreed a trial for six months which would then be evaluated to ensure there was no negative impact on nurse leadership and visibility.	Approval
EPR Business Case	• The Director of Informatics reported that the EPR business case had been revised to address the NHSE feedback and comments. • In relation to the procurement process four initial expressions of interest had been received and meetings were being arranged with each of these suppliers.	Assurance
Month 9 financial position	• The Director of Finance and Information presented the month 9 finance report and noted the drop in income associated with the period of industrial action and increase in urgent and emergency care demand in December.	Assurance
18 January 2024		
Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme	• The Director of Nursing, Midwifery and Governance introduced the presentations from the two Maternity Units. It was noted that for this year there were separate submissions for the Whiston and Ormskirk units but in future there would be a single MWL submission, • The Heads of Midwifery from each unit presented the position against each of the 10 safety actions and it was noted that both units were compliant with all the actions. Information published since the last regular maternity report was reviewed and discussed. • Committee agreed the approval process via the Quality Committee and then an extraordinary Board meeting, to meet the ICB deadline. • The final information that needed to be presented to the Quality Committee and the format of the papers was agreed.	Assurance

December Integrated Performance Report (IPR)	• The Director of Finance and Information presented the December IPR, and committee reviewed the metrics and the commentary. • HSMR for S&O sites was identified as an outlier and the Medical Director reported he was investigating the cause of the unexpected increase. • Committee noted the increase in hospital acquired infections and discussed the impact of escalation beds and corridor care in ED on the Trust's ability to segregate patients. It was acknowledged that whilst the number of patients no longer meeting the criteria to reside remained at the equivalent of 3 wards, this would continue to negatively impact patient flow.	Assurance
Core Mandatory and Compulsory Training Compliance	• The Director of HR/Deputy CEO presented the report which now included compulsory training compliance as well as the core mandatory training subjects. • It was noted that this was part of the process of aligning practice across the two legacy trusts and provide transparency on the training requirements set by the organisation for other subjects. • Core mandatory training compliance was 86% in December. • Compulsory training subjects and Training Needs Analysis (TNAs) were different for the legacy trusts and was in the process of being harmonised for the start of 2024/25. • Compulsory training subjects with compliance rates of less than 70% were highlighted and the subject matter experts had provided commentary on the actions being taken. • The compulsory training would be included in monthly reports going forward and an assurance report would be presented to the Quality Committee twice a year as the majority of the compulsory training requirements related to clinical skills/knowledge and therefore had a direct bearing on patient safety.	Assurance
Corporate Governance Manual (including the Standing Orders and	• The Director of Finance and Information summarised the work that had been undertaken to review and update the Corporate Governance Manual for MWL.	Assurance

Standing Financial Instructions)	• The proposed delegated limits for the larger trust were presented and supported and if approved would come into effect from 01 April 2024, when the clinical divisions would become fully operational. • Once finalised the new Corporate Governance Manual would be presented to the Board for approval.	
Risk Management Council (RMC) Assurance Report and Corporate Risk Register (CRR)	• The Director of Corporate Services presented the RMC assurance report, and the risks escalated to the CRR. • There were 1,065 open risks on the MWL combined risk register at the end of December 2023 and 53 risks were escalated to the CRR. • The RMC had been developing a single Risk Assurance Framework for MWL which would be presented to the Executive Committee for approval. • There were 12 trust policies aligned to the RMC which still needed to be agreed as single MWL policies, and all were in the process of being reviewed. • It was noted that the first combined CRR would be presented to the Board at the January meeting.	Assurance
Board Assurance Framework (BAF)	• The Director of Corporate Services presented the draft BAF for review before presentation to the Board. • Committee agreed the proposed changes to recommend to the Board.	Assurance
EPR Procurement Timetable	• Committee noted the revised EPR procurement timetable that had been adjusted to take account of the business case approval process. • The timetable continued to meet the NHSE requirements.	Assurance
Quarterly Policy Update	• The Director of Nursing, Midwifery and Governance presented the report which identified that 14% of legacy STHK policies were overdue for review. • The position for legacy S&O was worse however it was recognised that work has ceased on these policies and the focus shifted to developing single MWL policies wherever appropriate.	Assurance

25 January 2024		
Closure of S&O Organisational Code	• The Director of Informatics reported that the NHSE digital team had approved an extension to December 2024 to close the former S&O organisational code, to enable the IT systems to be aligned and ensure no patient information was lost or duplicated. • It was noted that current manual work arounds would need to remain in place until the code could be closed, and all reporting moved to the MWL code.	Assurance
Nurse Safer Staffing Report	• The Director of Nursing, Midwifery and Governance introduced the report which detailed the safer staffing analysis for November. • For the STHK sites the RN overall fill rate was 97.6% and the HCA overall fill rate 121.3% • For the S&O sites the RN overall fill rate was 101.1% and the HCA overall fill rate was 94.6% • There had been escalation beds open in November in response to increased demand. • Committee discussed the increase in temporary workforce shifts and agency spend in the light of above target nurse fill rates. • The report also included an update on the recruitment pipeline and the differences in approaches to HCA recruitment at the legacy organisations and the work being undertaken to have a single MWL approach. • Time to hire had been 41.6 days in November but the average had increased due to a small number of delays with overseas recruits.	Assurance
Paediatrics T1 and T2 Doctors Business Case	• The business case recommended the creation of two additional posts at the Whiston Hospital service to ensure paediatric rota gaps could be filled and the weekend rota frequency was more than 1 in 3. • The business case explained the impact of the high number of trainees working less than full time on the operational service provision. • It was recognised that the current rotas were non-compliant, and the business case was approved.	Approval
IT systems register	• The Director of Informatics presented the paper and explained as part of the post transaction integration work, MWL needed to update its IT	Assurance

	systems register and identify the correct Information Asset Owner (IAO) and Information Asset Manager (IAM) for every system. • As exercise was therefore being undertaken for each Director to review and update the IT asset register for their portfolio.	
HCA Band 2 – 3 grievance	• The Director of HR/Deputy CEO provided an update on the discussions with Unison and developments at other Cheshire and Merseyside Trusts.	Assurance
Measles	• The Director of Integration reported on the plans being put in place by the St Helens Public Health Team to prepare for a likely measles outbreak, as had been seen in other parts of the country. The Director of Nursing, Midwifery and Governance confirmed MWL had been engaged with the ICB preparations which included offering vaccination to members of staff who had not received the MMR vaccination.	Assurance
CQC	• The Director of Nursing, Midwifery and Governance reported that there had been a focused inspection at Southport Hospital the previous day to investigate a specific complaint that had been made. The initial feedback was that the inspectors found no issues of concern. A formal report would be issued. This would not impact the Trust overall CQC rating.	Assurance
Alerts:		
None		
Decisions and Recommendations:		
New investment decisions taken by the Committee during January were: 1. Paediatrics T1 and T2 Junior Doctors posts to create a compliant rota.		

Mersey and West Lancashire Teaching Hospitals NHS Trust

Committee/Council/Group Assurance Report			
Title of Meeting	**Board of Directors**	**Date**	**28 February 2024**
Agenda Item	**MWL TB24/015 (7.2)**		
Committee being reported	Audit Committee		
Date of Meeting	21 February 2024		
Committee Chair	Ian Clayton, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items		
Title	**Description**	**Purpose**
GT - External Audit Reports – Sector Update Report	The Sector update provides a summary of emerging national issues and developments. It provides links to insights from think tanks and networks to enhance awareness of issues.	**Assurance**
MIAA - Internal Audit Reports	All reports are progressing in accordance with the internal audit plan, with work on finalising the remaining reviews by the end of the year. In this reporting period three reviews have been finalised and there are currently seven reviews in progress. The Committee discussed the moderate assurance reported in relation to the supporting processes for electronic discharge systems including processes to identify and handle rejected discharge summaries. Overall, there is an adequate system of internal control, however, in some areas weaknesses in design and/or inconsistent application of controls puts the achievement of some aspects of the system objectives at risk. Further assurance is expected from the implantation of Electronic Patient Records (EPR). The Committee noted that the audit results for key financial system controls for MWL were positive.	**Assurance**
MWL Audit Action Logs	There were three finalised Internal Audit reports and four new External Audit reports added to the Log on this occasion. Seven reports have been finalised and signed off since the last Audit Committee. This leaves nine in progress reports, of which one is internal audit and eight are external audit.	**Assurance**

	The remaining internal audit report to be finalised, relates to Bank & Agency, and will be included in the next Audit Committee Agenda.	
MIAA - Local Counter Fraud Progress Report	There were five referrals to counter fraud brought forward from the previous period with seven new referrals this month, two have been closed in the reporting period, and five moved to investigation stage.	**Assurance**
Trust Anti-Fraud, Bribery and Corruption Policy and Response Plan	Updated policy to reflect the issue of latest NHS Counter Fraud Authority strategy document 2023-2026 and outlines the roles and responsibilities for the prevention and detection of fraud, bribery and corruption within Mersey and West Lancashire Teaching Hospitals NHS Trust.	**Assurance**
Audit Committee Annual Workplan and Meeting Dates	Setting out of annual workplan and discussion of meeting dates for the 24/25 year.	**Assurance**
Financial Reports - Losses and Special Payments	For the financial year to date, £349k losses and special payments have been registered, compared to £222k for St Helens & Knowsley for 2022/23 and £390k for Southport & Ormskirk for 2022/23.	**Assurance**
Financial Reports - Aged Debt Analysis	For the period to 31 January 2024, total invoiced debt is £26.9m of which £9.1m has been due for more than 90 days. Of this £9.1m, £5.2m is NHS debt and £3.9m is Non NHS debt.	**Assurance**
Financial Reports - Tenders and Quotation Waivers	Seven MWL waivers have been registered for the period since the last Audit Committee with a value £757k.	**Assurance**
Year End Update	Preparations have begun for year end process, internal timetables are being prepared and NHSE deadlines have been received. Headline dates for year end include draft accounts submission on 24 April 2024 and final accounts by 28 June 2024. The Trust expects to receive the proforma accounts including final NHSE accounting policies towards the end of March 2024.	**Assurance**
Legacy Southport & Ormskirk NHS Hospital Trust Accounts Preparation	Year end 30 June 2023 mostly complete and external auditors have now started the planning/interim audit. The accounts are prepared just prior to the transaction. NHSE have required the legacy Trust to continue to make monthly	**Assurance**

	submissions and an Annual Report is still required unless the Trust can provide evidence and to why this duty isn't required. The Trust is running to the same national deadlines for its part-year accounts with draft submission due 24 April 2024 and audited accounts submission 28 June 2024.	
Any other business	The Committee noted that overall, the Trust had received a generally clean audit on the financial systems and controls for 2022/23. Following the closure of the 2022/23 accounts the committee approved a plan to appoint external auditors for 2023/24	**Assurance**

Alerts:

- Deep dive on electronic discharge systems merited due moderate assurance and mixed ownership between Clinical and system elements.

Decisions and Recommendation(s):

None noted

Mersey and West Lancashire Teaching Hospitals NHS Trust

Committee Assurance Report

Title of Meeting	Trust Board	**Date**	28 February 2024
Agenda Item	MWL TB24/015 (7.3)		
Committee being reported	Quality Committee		
Date of Meeting	20 February 2024		
Committee Chair	Gill Brown, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items

Title	Description	Purpose
Minutes of the previous meeting	Minutes of the meeting held on 23 January were approved as a correct and accurate record of proceedings.	Approve
Nurse Safe Staffing Report – December 2023	Detailed report on safer staffing presented, noting the increased use of agency staff in December, due to bank staff being unable to fill shifts, with work ongoing to reduce reliance on agency staff and assurance provided that all requests are scrutinised at Executive level prior to approval. Concerns were raised in relation to high sickness absence in some areas, noting that these are being reviewed and managed in line with Trust policy and are being reviewed at Strategic People Committee. Overall fill rates in December remained above target, with registered nurses/midwives at 98.3% and healthcare assistants at 119.7%. Concerns were raised regarding clinical areas with lowest Care Hours per Patient Day (CHPPD), noting a review of care CHPPD is to be presented to the Executive Committee to analyse any areas of disparity with fill rates. Work is underway to ensure a consistent approach for reporting across all MWL sites going forward. Work is being undertaken to increase the number of bank staff. Confirmation was provided that agency staff are required to complete all mandatory training and local induction prior to working, which is outlined in contracts. The report included details of all escalation beds in use during the period, patient harms, appraisal and mandatory training rates, supplementary care, staffing gaps and recruitment and leaver activity.	Assurance

	It was noted that the use of escalation beds had incorporated learning from previous years and had been managed in a planned and supportive way. The report highlighted that recruitment pipelines were in a good position, with assurance provided regarding the staffing trajectory and timeline for the new theatres at Whiston. Information was provided regarding measures to monitor the impact of staffing on quality and concern was noted with some metrics contained in the Quality Dashboards, in particular a deep dive was requested regarding falls with moderate harm or above, to identify any trends or issues leading to the increase in incidents, in particular for patients with a delayed discharge.	
Supplementary Care Point Prevalence Audit	Detailed presentation provided following two point prevalence audits to identify if the Trust's policy and procedures were fit for purpose and being implemented appropriately. The findings concluded that the policy was in line with that of other organisations and was being correctly applied in the main, with the vast majority of patients' needs for supplementary care being correctly assessed at the right level, including 1-1 or bay tagging. The high number of patients requiring supplementary care with a delayed discharge was discussed and that a multi-agency discharge event (MADE) is being held on 21 February. Work is underway to bring together the previous organisations' policy and procedures for MWL. Eight workstreams are being introduced to drive this important work forward.	Assurance
Matters arising/action log	15 actions were noted on the action log with three not due and twelve discussed of which ten were closed and two carried forward to the next meeting.	Assurance
E Coli Improvement Plan	The Committee received an action plan to reduce the number of E coli infections, particularly in relation to those due to urinary sources, as the Trust is above trajectory. It was noted that work is ongoing regarding catheter training and improving recording of fluid balance. The Committee sought additional assurance that the actions were delivering the required improvements.	Assurance

Monitoring of Annual Trust Objectives aligned to Quality Committee	The quarter three position in delivering the five quality objectives was presented, noting the key areas where additional actions are being taken to achieve full compliance, including timely recording of observations and medical review for patients in the Emergency Department, recording of fluid balance, training in relation to deteriorating patients and review of patients with acute kidney injury stage 3. The Committee noted the progress to date and the impact of operational pressures/reduced patient flow.	Assurance
Corporate Performance Report (CPR)	The quality metrics were discussed, noting that the draft CQC reports for Maternity Services had not been received and that there had been an unannounced inspection at Southport in January for patients admitted under the Mental Health Act in relation to nutrition and hydration. Interim feedback had been positive, and the draft report is awaited. No never events had been reported since the previous meeting. One category 3 pressure ulcer was reported with learning shared to prevent further incidents. There were four open patient safety incident investigations. Reportable infections remain above trajectory with actions in place to address this, including antimicrobial pharmacist now in place for S&O sites. The Committee queried if staff were under too much pressure to fully comply with infection prevention requirements, noting that these are reinforced in a number of ways. The maternity indicators were reviewed, and the team were asked by the Committee to review practices across sites to share best practice in relation to 3rd/4th degree tears and massive postpartum haemorrhages.	Assurance
Safeguarding Quarterly Reports	Report received from Whiston-based team, noting that all key performance indicators are rated significant assurance other than training in three areas which is improving and looked after children health assessments completed within 20 days which had 31 breaches, due to capacity within the service. Work is taking place with commissioners to agree potential solutions. Two external reviews have been completed, with all required standards met for the Section 11 assessment and scrutiny undertaken by St Helens Safeguarding	Assurance

	Board and substantial assurance received following Mersey Internal Audit Agency review for both teams. A slight decrease in activity was noted, however deprivation of liberty safeguard applications have continued to increase and there has been a positive reduction in CAMHS admissions following increased provision by the response team. Southport-based Safeguarding Team noted compliance with majority of training requirements, with work ongoing to improve Mental Capacity Act uptake. Feedback from Sefton Place for the commissioning standards submitted is awaited. There were no unexpected deaths and activity remains fairly consistent with previous quarters, with an increase in adult safeguarding referrals which will be monitored.	
Patient Safety Council Report	A number of reports were received, including nursing care indicators which highlighted three areas requiring improvement, Bristol Stool Chart, cannula care and fluid balance, with action plans in place. Additional reports included Clinical Support Services, infection prevention, medicines safety, aggregated falls review, Maternity Services, CAS alerts and patient safety. The Committee sought assurance that gaps in the risk assessments for venous thromboembolism are being addressed.	Assurance
Maternity & Neonatal Quarterly Report	A combined detailed report was provided and the following key points were highlighted: • Actions taken to improve induction of labour, including ongoing auditing to monitor progress • Introduction of inhouse service to treat tobacco dependency at Whiston • 4 perinatal mortality incidents reported, with learning identified that would not have affected the outcome • 1 divert for 4 hours at Whiston • 3 open maternity and neonatal safety investigations with learning shared from reports received, for which the Committee sought confirmation that these would be monitored to ensure successful implementation • 22 neonatal closures due to acuity • Update on Saving Babies' Lives, red flags, complaints, workforce and response to Thirlwall enquiry were also noted	Assurance

	• The CQC action plan will be monitored through the CQC Assurance Group and will be reported to the Executive Team.	
Patient Experience Council Report	A number of papers were received by the Council, including patient story, quarter 3 patient experience report, complaints and PALS, estates and facilities, Chaplaincy, Nursing Care Indicators, Marshalls Cross patient survey action plan and Clinical Support Services. Healthwatch Knowsley provided a report on patient feedback, as well as noting that detailed reports had been shared relating to visit to the Emergency Department in December and patient experiences of Phlebotomy Services, which were shared with department leads for follow up. The majority of the feedback was positive with actions noted for ED to keep patients informed about waiting times and potential to re-introduce a limited number of walk-in slots for phlebotomy. Assurance was provided that there only remained one overdue policy within the remit of the Council, which was listed for March's meeting.	Assurance
2023 Maternity Patient Experience Survey Report	A report was shared outlining the findings of the latest survey published in February, noting that there had been a number of improvements made in the responses, with further work to do to address areas of concern including antenatal checkups to ensure staff are clear they have accessed the women's medical history and that there is sufficient time in the appointments to raise questions. The Maternity and Neonatal Voices Partnerships will support the further development of the action plans.	Assurance
Clinical Effectiveness Council Report	A number of procedural documents were approved, including MWL policies for resuscitation and do not attempt cardio-pulmonary resuscitation (DNACPR). The work of the lung telemonitoring pilot was presented, which concluded that although it did not decrease contact with healthcare, it did improve self-confidence and empowerment. Exception reports were received from Surgical Care Group, highlighting ongoing trauma demand and Planned Care, with reports also received regarding Drug and Therapeutics Group and HSMR. The Blood Transfusion report noted the work being undertaken to reduce wastage of Anti-D and improve	Assurance

	return rate of blood tracking forms, as well as looking at ways of providing face to face training for agency staff. The National Emergency Laparotomy Audit report highlighted changes to the requirements for best practice tariff to include input by peri-operative team experienced in management of older people for patients aged 80 or over or 65 or older and frail, which will be a challenge. NICE compliance in quarter 1 was good with follow up being completed for non-responders. Clinical audit teams are looking at a single system to manage audits going forward, with a business case being developed.	

Alerts:

- IPC : Ongoing work to reduce infections, including E coli and improve fluid balance recording.
- Safeguarding: Looked After Children (LAC) Health Assessments – significant decrease in compliance with 20 day target for assessment with a consultant paediatrician.

Decisions and Recommendation(s):

The Board is recommended to note the report and the assurances sought by the Committee.

Mersey and West Lancashire Teaching Hospitals NHS Trust

Committee Assurance Report			
Title of Meeting	Trust Board	**Date**	28 February 2024
Agenda Item	MWL TB24/015 (7.4)		
Committee being reported	Strategic People Committee		
Date of Meeting	19 February 2024		
Committee Chair	Lisa Knight, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items		
Title	**Description**	**Purpose**
SPC 0124/003 - Minutes of the previous meeting	The committee reviewed the minutes of the meeting held on the 22 January 2024 and approved them as a correct and accurate record of proceedings.	Decision
SPC 0224/004 Action Log and Matters Arising	SPC 0124/007 22 January 2024 (action log). • Equality, Diversity, and Inclusion (ED&I) Operational Plan Annual Assurance Update - DM provided the Committee with a report which provided members of the Committee with a more in depth understanding of the metrics regarding the gender pay gap, the reason why a gap occurs and what actions can be taken to address any gap.	Assurance
SPC 0124/005 – Workforce Dashboard	The Corporate Performance Report (CPR) dashboard was presented focusing on the key indicators for the SPC. It was noted that Mandatory training had exceeded target at 86.6% against an 85% target and that work is ongoing to align the two legacy organisations mandatory training requirements. Appraisals are below target at 83.7% with legacy STHK sites above target at 87.3% and legacy S&O sites below target (77.3%). Work is underway to implement MWL appraisal documentation to the legacy S&O staff. It is expected that performance will improve when the MWL appraisal paperwork and appraisal completion window is adopted across all sites as these are simpler documents which take less time to complete. Health Care Assistants (HCA) sickness remains challenged, a further deep dive into any trends across specific teams will be carried out. All staff sickness remains above target (6.4%). Turnover in month and over a rolling 12-month	Assurance

	period is below target (1% and 12.7% respectively) and time to hire is slightly above the target, at 46.1 days.	
SPC 0224/006 Organisational Development (OD) Operational Plan annual assurance update	The Committee noted that the Strategic Priorities 2022-2025 within the OD Operational Delivery Plan has been reviewed and revised taking account of our footprint and workforce and that a revised OD Operational Delivery plan will be presented to Valuing our People Council in March 2024 for approval. Examples of progress to date are as follows: • The Introduction of Preceptorship champions improving quality and reducing attrition of new nurses. • Successfully supporting individual teams and services through a range of internal & externally commissioned interventions. • Over 200 future & current leaders developed through in-house courses, apprenticeships, and CPD. • The introduction of an automatic recording process using RPA has saved managers c.158 workdays in administration. • Supported care groups/teams in delivery of actions from 2022 survey. • A values based corporate induction has been introduced for new starters to MWL. • There has been an increase in the number of 'live' apprentices supporting new roles, career & leadership development. • The Trust has delivered a series of workshops to support managers to lead through change. • Staff at all levels supported through access to in-house or external coaching support. • Staff supported to access Maths & English qualifications through local partners supporting individuals & their access to apprenticeships. • Supported the delivery of the NHS Succession Plan to identify aspiring future leaders. • New HCSWs have been provided with access to training early in their careers improving attrition rates. • c.2000 Nurses, Midwives & AHPs have accessed CPD funding for further development. • There has been an increase in the number of MWL 360 degree feedback facilitators trained to support leader's self-awareness & styles.	Assurance

	The three key priorities for 2024 as follows: • Review and Harmonisation of Mandatory Training • Harmonisation of Appraisal systems and processes • L&OD team effectiveness and operating model to meet the needs of MWL in 2024 and beyond.	
SPC 0224/007 Why have we got a Gender Pay Gap?	The committee received a presentation in response to a request by the Trust Board for a more detailed explanation of the methodology used to calculate the annual gender pay gap and to explain why a gender pay gap can occur. The presentation provided an overview of: • The potential causes of pay differences between staff on same band, different bands, and staff groups. • How pay differences occur by pay practices, e.g., clinical excellence awards and staff benefit policies. • An explanation of the calculation methodology • A summary of the overall causes of the gender pay gap at population level. A discussion followed regarding if there was anything that the Trust needed to particularly focus on to improve our gender pay gap. Assurance was provided that the gender pay gap is an ongoing matter for all organisations and is heavily influenced by societal challenges, but we were taking action where possible to reduce the gap.	Assurance
SPC 0224/008 - Assurance Reports from Subgroup(s)	The Strategic People Committee noted the Assurance Reports from the Valuing our People Council, People Performance Council, and the HR Commercial Services Council.	Assurance
SPC 0224/009 - Items for Escalation to Trust Board	No items to be escalated via the Assurance Report	
Alerts:		
Not applicable		
Decisions and Recommendation(s):		
• None		

Committee Assurance Report			
Title of Meeting	**Trust Board**	**Date**	28 February 2024
Agenda Item	**MWL TB24/015 (7.5)**		
Committee being reported	Finance and Performance Committee		
Date of Meeting	22 February 2024		
Committee Chair	Steve Connor, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items		
Title	**Description**	**Purpose**
MWL FC24/026 – Integrated Performance Report Month 10 2023/24	• Bed occupancy across MWL averaged 108.7% in December equating to 101 patients - a increase from 105.7% in November. • Average length of stay for emergency admissions is similar across both main sites with an overall average of 8.5 days, the impact of non criteria to reside (CTR) patients being 26.7% at Organisation level, slightly higher than December - (29.6% StHK and 21% S&O). • 4-Hour performance increased slightly in January achieving 67.9% (all types), national performance 70.3% and providers across Cheshire & Merseyside (C&M) averaging 68.9%. • 18 Week performance in January for MWL was 60.5%, S&O 65.5% and StHK 58.6%. National Performance (latest month December) was 56.6% and C&M regional performance was 53.6% • Diagnostic performance in January for MWL was 79.9%, S&O 75.7% and StHK 81.6%. National Performance (latest month November) was 73.2% and C&M regional performance was 84.2%. • The Trust had 2,631 52-week waiters at the end of January (145 S&O and 2,486 StHK) • Cancer performance for MWL in December was 76.7% for the 14-day standard (target 93%), • Industrial action and urgent care pressures have impacted activity in month. • Place partners involved in longer term solutions to urgent care pressures	Assurance
MWL FC24/026 – Finance Report Month 10 2023/24	• At the end of Month 10, the Trust is reporting a surplus position of £2.3m which is £3m adverse	Assurance

	to plan relating to unmitigated industrial action costs and income loss. • Trust forecast outturn for 2023/24 is a surplus of £4.6m which is adverse to the planned surplus of £7.6m and includes a £3m pressure relating to unmitigated industrial action costs and income loss. The forecast position is supported by further non-recurrent support. • The underlying financial position includes significant pressures relating to pay award and inflation above funded levels, these have been mitigated non recurrently to-date in 2023/24. As at M10 c£24m of mitigations including non-recurrent support, savings from financing costs and vacancy factors. • The Committee noted the challenges to the underlying position as a result of delivering the in year plan due to reasons outside of the Trusts control. • Agency costs £16.3m year to date. This equates to 3.8% of total pay spend, against a target of 3.7%. The Premium Payment Scrutiny Council (PPSC) continues to meet to look at the options to reduce agency in the long term. • Cost Improvement Programme (CIP) is on track to be delivered in line with target by the end of the year. • Capital expenditure for the year to date (including PFI lifecycle maintenance) totals £20m, significant amount of capital to be spent in the latter part of the year including £24m Public Dividend Capital (PDC) drawn down linked to planned projects. Risk factor of between £9 and £13m of brought forward capital prepayment. • At the end of M9, the cash balance was £2.8m, with a forecast of £2.5m at the end of the financial year.	
MWL FC24/028 – Month 10 2023/24 CIP Programme Update Alongside: MWL FC24/031 – Medical Care (STHK) CIP Presentation	• Total targets for 23/24 (including £2.8m recurrent CIP delivered by S&O during M1-M3) are £41.6m in year and £34.6m recurrently. • Schemes identified totalling £54.8m in year and £37.8m recurrently, • Delivered/low risk schemes currently total £38.9m in year (93% of target) and £27m recurrently (78% of target)	Assurance

	• Trust remains on track to deliver full CIP target by end of year. • Presentation included update to the Committee on progress in identifying schemes for 2024/25 • Committee noted the update and was assured by the report and presentations.	
MWL FC24/029 – 24/25 Planning & Budget Setting Process	• Presentation setting out ICS/NHSE process in advance of guidance being formally published. • Committee noted short timescales. • Draft planning assumptions shared and discussed in detail by committee in context of current operational and financial pressures faced by the Trust and system. • 2023/24 financial plan and emerging in year pressures discussed in detail along with potential mitigations. • Draft plan to be discussed at Board.	Assurance
MWL FC24/030 – Estates Return Information Collection (ERIC) 22/23 – Results and Benchmarking	• Overview of the annual ERIC results shared and discussion around items within.	Assurance
Assurance Reports from Subgroups:	• 16.1. MWL FC24/032 - CIP Council • 16.2. MWL FC24/033 - Capital Planning Council • 16.3 MWL FC24/034 –Estates & Facilities Management Council • 16.4. MWL FC24/035 – IM&T Council Update	Assurance/ Approval

Alerts:

Integrated Performance Report Month 10 2023/24

- The Committee noted the continued impact that industrial action and urgent care pressures are having on Trust targets, operational and financial.

Finance Report Month 10 2023/24

- The financial position includes £3.0m of expenditure relating Industrial Action for December and January, with the national instruction to assume no additional funding. Unless funding is provided, this and the additional industrial action in February presents a risk to the planned position.
- The underlying financial position further includes significant pressures relating to pay award and inflation above funded levels, these have been mitigated non recurrently to-date in 2023/24.
- The Committee noted that the Trust had not been requested to complete the forecast outturn protocol as a result of these new pressures not being included within the recent financial reset.
- The Committee noted that there was a possibility for the Trust to be subject to additional regulatory action should the system fail to deliver the 23/24 financial plan (excluding IA costs).

• The Committee noted the planning assumptions and timeframes for Board sign off of draft plan.
Decisions and Recommendation(s):
None

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**		**Date**	28 February 2024
Agenda Item	**MWL TB24/016**			
Report Title	Maternity and Neonatal Services Update			
Executive Lead	Sue Redfern, Director of Nursing, Midwifery and Governance			
Presenting Officer	Sue Redfern, Director of Nursing, Midwifery and Governance			
Action Required		**To Approve**	X	**To Note**

Purpose

To update and inform the Board regarding the priorities and progress of the maternity and neonatal services across Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL).

Executive Summary

A summary of the progress within maternity and neonatal services at MWL that includes:

- Maternity Incentive Scheme (MIS) – compliance declared for all ten safety standards.
- Perinatal Mortality.
- Incidents, complaints, and claims.
- Maternity and Newborn Safety Investigations (MNSI) (formally Healthcare Safety Investigation Branch) – one case submitted in Q3 (zero Ormskirk Site, one Whiston site).
- Saving Babies Lives (SBLv3) – compliant with current LMNS expectations.
- CQC inspection update and action plan
- Safety Champion's update
- Workforce update – Divisional structures, one to one care in labour, Neonatal Unit (NNU) nursing rotas, Allied Health Professionals (AHP) support, medical teams, continuity of carer (COC), sickness (including Covid).
- Thirlwall Enquiry – information requested from MWL and submitted to inquiry team.

The above reporting is based on a template provided by the Local Maternity and Neonatal System (LMNS). This is the first harmonised report as MWL (legacy trusts St Helens and Knowsley Teaching Hospitals NHS Trust (STHK) and Southport and Ormskirk Hospital NHS Trust (S&O)).

Financial Implications

Awareness of potential future investment into the Maternity Services

Quality and/or Equality Impact

Not applicable

Recommendations

The Board is asked to Maternity and Neonatal Services update.

Strategic Objectives

X	**SO1** 5 Star Patient Care – Care
X	**SO2** 5 Star Patient Care - Safety
X	**SO3** 5 Star Patient Care – Pathways`
X	**SO4** 5 Star Patient Care – Communication

X	**SO5** 5 Star Patient Care - Systems
	SO6 Developing Organisation Culture and Supporting our Workforce
	SO7 Operational Performance
	SO8 Financial Performance, Efficiency and Productivity
	SO9 Strategic Plans

This standardised report template has been developed by the Cheshire and Mersey Local Maternity and Neonatal System (LMNS) and includes the key issues identified within Maternity and Neonatal Services.

1. Maternity Incentive Scheme (MIS)

MIS Year 5 was received in June 2023 with a revised version received in July 2023. In January 2024, a detailed update paper and presentation was provided to Executive Committee, Quality Committee and Trust Board, in collaboration with the LMNS, to offer evidence for the 10 safety actions in scope.

All safety actions for both the Whiston and Ormskirk sites have been recommended as achieved to the MIS via the Board Declaration submission template. MWL awaits feedback.

MWL awaits the expectations for the MIS safety actions for Year 6. Updates will be provided as part of the Maternity and Neonatal quarterly report to Maternity and Neonatal Governance, Executives, Quality Committee and Trust Board.

2. Quality and Safety

2.1 Clinical Outcomes/ Dashboard

Maternity and Neonatal Dashboards

Performance is monitored via our local and regional dashboards. Regional and local clinical dashboards are monitored via local governance and presented via the IPR at Quality Committee.

Comparison to peers is usual governance. Current areas of focus include:

- IOL (Ormskirk) - actions that have been undertaken include review of the local guidance to bring in line with Northwest Coast Regional guideline. Regularly auditing the reasons for induction of labour. The audit includes the Perinatal Institute data tool to understand our compliance with guidance for fetal growth restriction /small for Gestational Age babies, as well as those induced for reduced fetal movements less than 39 weeks. Working with our Maternity Voices Partnership, an information leaflet was co-produced for service users.
- Smoking (Whiston) - A continued focus for referral of women who smoke at booking aimed at supporting a smoke free pregnancy and reducing the % of smokers at the time of delivery. The service has commenced an inhouse model in January 2024 following the appointment of 2 Tobacco dependant Advisors on fixed term contracts.

Where maternity and neonatal services are outliers with their peers, this is challenged by the LMNS and Trust responses are required. All Trust responses have been responded to in the requested timescales.

Harmonisation continues to align the sites for both maternity and neonatal teams post the transaction of the two legacy organisations.

2.2 Perinatal Mortality

Perinatal mortality includes any fetal loss from 22-week gestation, stillbirths, and neonatal deaths in the first week of life. MBRRACE-UK is notified of all eligible perinatal deaths and these deaths are reviewed using the national Perinatal Mortality Review Tool (PMRT).

All perinatal mortality incidents have an initial multidisciplinary review to determine the degree of harm caused, to identify if there is any immediate learning or if the incident is required to be STEIS reportable.

Quarter 3: 2023/24	
October 2023	0
November 2023	2 stillbirths
December 2023	1 stillbirth 1 Neonatal death

For the Q3 reporting period (2023/24) there were 4 reportable deaths.

All 4 cases have undergone a multidisciplinary review and the commencement of the PMRT review process. Care was reviewed and assessed for all cases using the MBRRACE categorisation.

Whiston Maternity
The first stillbirth in November the panel identified lessons that may have impacted on the outcome of the case. 33+3 gestation and IUD following attendance in triage. Findings indicated a lack of contemporaneous documentation in triage, with subsequent retrospective documentation and a failure to recommence a CTG within a reasonable period after the initial CTG had been stopped.

For the second stillbirth in November, a woman attended Maternity triage at 24 weeks gestation with a history of no fetal movements for 2 days and an intrauterine death was confirmed. The review panel found that the learning identified would not have been likely to affect the outcome.

A neonatal death occurred in December. A woman attended via ambulance at 31 weeks gestation with a placental abruption and underwent a Category 1 caesarean section. Baby was born in poor condition and extensive resuscitation was required and transfer to the neonatal unit at 70 minutes of age pending transfer to the tertiary referral unit. A decision to withdraw care was agreed prior to transfer and the baby remained on our Neonatal unit for palliative/comfort care. The panel agreed that there were examples of excellent care with no issues identified that would have affected the outcome. The final PMRT panel review for these cases has been delayed whilst awaiting the reports from the placental histology/post-mortem reports.

Ormskirk Maternity
1 stillbirth diagnosed at 21+5 weeks and delivered at 22+0 weeks. Notification to MBRRACE has taken place and the PMRT meeting took place 07/02/2024. Initial findings from the review group identified some care issues which would have made no difference to the outcome for the mother or baby.

Current practice in all cases of perinatal mortality which fulfils PMRT criteria, are that the incidents are reported at the weekly Patient Safety Meeting and multi-disciplinary rapid reviews undertaken. The PMRT process commences with initial meetings for all cases and the reports subsequently completed. For all investigations, parental involvement was sought to enable the parent's point of view to be considered as part of the final review.

2.3 Serious Incidents

Never Events

There have not been any never events for this reporting period.

STEIS Reportable Incidents

Serious incidents (SIs) are reported as they occur and are evidenced on the regional dashboard which is updated monthly. Serious incidents are detailed within the patient safety report presented at Quality Committee.

There has been 1 maternity divert on the Whiston site in Q3 due to increased acuity and lack of available beds. This incident is in the process of being reported to the ICB but does no longer meet the definition of a PSI within the PSIRF framework.

There was a Maternal Death in December 2023 on the Whiston site which has been reported to MBRRACE, MNSI and the Coroner's Office. Multidisciplinary review undertaken. The woman was a smoker with a history of coronary plaque disease. An elective caesarean section for placenta previa and possible accreta was undertaken. Massive obstetric haemorrhage occurred and following achievement of haemostasis several cardiac arrests occurred. The outcome of the post-mortem is awaited, with delay due to specialist cardiology investigations being undertaken. Once received the MDT panel will reconvene and prepare the final report. Support and ongoing communication with the family has been maintained.

The completed reports will be submitted to the LMNS for presentation at the C&M Serious Incident Review Panel meeting.

	Maternity Q3 2023/24	
October 23	1 Divert	A divert lasting 4 hours due to the service being unable to provide one to one care in labour. This was due to increased activity and no available beds.
November 23	Nil reported	
December 23	1 maternal death	MNSI and MBRRACE reportable case.

A final report for the STEIS reportable incident (April 2023) on the Ormskirk site has been received. This was a Neonatal Death at 7 days, transferred for cooling following HIE but died on day 7. An action plan in response to the findings and recommendations has been prepared and monitored via the Trust Scrutiny and Assurance Group and Maternity Governance. Representatives from the Trust, (Maternity Matron and Delivery Suite Clinical Lead Consultant) met with the family and HSIB as a tripartite meeting to feedback and share the outcome of the report and plan for future pregnancies with the family which was well received.

Feeback has also been given to staff involved and a copy of the report shared with them.

There were no STEIS reportable incidents for the Neonatal services at MWL for Q3.

There was 1 x neonatal STEIS reportable incident in Aug 23 at the Whiston NNU which was a medication error (10% glucose bolus administered instead of normal saline). Once detected, care and treatment escalated and managed appropriately. No long-term harm caused. Multi-factorial root causes identified due to policies, systems and processes not being followed resulting in inaccuracies with prescription/preparation/administration process of the fluids. Learning shared

appropriately at Paediatric Clinical Governance/MCG lessons learnt forum/Neonatal Unit departmental monthly meeting.

2.4 Maternity and Neonatal Safety Investigations (MNSI, formerly HSIB)

MNSI undertake independent investigations into incidents within Maternity Services which fall under a defined criteria that includes maternal deaths, stillbirths and babies that require cooling.

MNSI triage reported cases following a Trust referral based on the following criteria:

- Baby's MRI result.
- Family concerns regarding the care given.
- Trust concerns regarding the care given.

All investigations accepted by MNSI are reported on STEIS as a serious incident. Cases returned to the Trust are investigated with a full MDT review including an external representative from the Cheshire and Merseyside system.

The Trust is provided with a monthly update of cases reported to MNSI to support effective communication and to advise on the progression of investigations. MNSI case reviews are shared with the Trust for accuracy prior to being finalised and additionally shared with the woman and her family.

Cases to Date April 2019 to May 2023	
Total Referrals	67
Referrals / Cases Returned to the Trust / Rejected	28
Total Investigations to Date	39
Total Investigations Accepted	39
Total HSIB Investigations Completed	36
Current Active Cases	3

There was one Ormskirk case from April 23 which the Trust received the final report for in September 2023.

The following safety recommendations and learning points were identified.

- The Trust to ensure that staff can access support for interpreting CTGs when a mother has uterine activity but is not in established labour.
- The Trust to ensure that management decisions are based on a mother's complete clinical picture taking into consideration all cumulative risk factors, as well as the CTG.
- The Trust to ensure that the handover process between triage and labour ward supports staff to transfer complete, accurate information in a timely way to inform ongoing care.

Additional learning points:

- The importance of monitoring elevated blood pressure at antenatal appointments in line with national guidance.
- The importance of asking the duration of reduced fetal movements to inform the overall assessment when reduced fetal movements reported in calls to Triage.

- The importance of the cardiotocograph (CTG) remaining with the woman to ensure staff providing care always have access.
- The urgency of the caesarean section to be categorised as described in local and national guidance.
- The importance of relaying the clinical findings of a blood clot seen behind the placenta at the time of surgery to the Neonatal team to inform the Baby's ongoing care.
- A comprehensive action plan has been developed to address the safety recommendations and learning points.

The maternal death which occurred in December has been reported and accepted by MNSI. Provisional review has taken place internally. Family and staff have received appropriate support.

2.5 Saving Babies Lives (SBL) Care Bundle (Version 2 and 3)

This is a requirement for safety action 6 for the MIS**:** Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?

MWL are fully compliant with all the elements of Saving Babies Lives Care Bundle 2.

Saving Babies Lives Version 3, a care bundle for reducing perinatal mortality, was published on 1 June 2023.

Elements 1 to 5 below remain with the addition of a sixth element relating to diabetes.

Both Ormskirk and Whiston services are compliant from an MIS perspective and are working towards full compliance by March 2024. Regular meetings with the LMNS are in place to monitor, review current evidence,
and action plan progress.

Element 1: Reducing Smoking in Pregnancy

Ormskirk Service for Q3 were 100% compliant with SBLv3 Element 1.

Funding for specialist midwife confirmed for Sefton PH to continue 2024. Referral rate at booking for December was 91%. SBL KPI for carbon dioxide (CO) monitoring met in December 90% at booking and 90% at 36 weeks. In house service is now running at 100% coverage with all staff members fully trained to NCSCT standards to be able to deliver treating tobacco dependence program. There are 8 community outpatients clinics running.

- 3 in North Sefton (Southport).
- 3 in West Lancashire.
- 1 in South Sefton (Netherton) and 1 in Knowsley (Kirkby).

Ormskirk site also deliver the gold standard of direct supply nicotine replacement (NRT). Smoking status at booking is recorded 100% of the time and this exceeds the stretch ambition of 95%. Smoking status is captured at every antenatal contact and smoking at the time of delivery rates for Ormskirk site are below the National average.

Whiston site for Q3 were 50% compliant with SBLv3 Element 1.

- We are currently compliant with all process indicators, CO measurement at booking appointment, CO measurement at 36-week appointment, recording of smoking status at booking and at 36-week appointment.
- January 2024 saw the start of a maternity in house model with the commencement of 2 Tobacco dependant advisors that will enable further compliance to the opt-out referral requirement at booking to our in-house tobacco dependence treatment service. This will enable us to monitor the percentage of smokers that are referred for tobacco dependence

treatment who set a cessation date and the ability to supply directly nicotine replacement therapy.
- The in-house service will allow the collection of data for the remaining outcome indicators and there is a robust action plan in place to facilitate this and ensure that any mitigations are implemented that will allow the correct data to be collected until the Maternity Service transfers to Badgernet from Maternity Medway in 2024.
- There is an action plan in place to support full implementation by the end of March 2024 which has been accepted and monitored by the LMNS.

Element 2: Risk Assessment and Surveillance of Fetal Growth Restriction

Ormskirk and Whiston Service – Both are currently at 75% compliance with process indicators and outcomes for this element which is positive compared to peer and expectations of the SBL programme. All audits have been completed and have been uploaded to the implementation tool.

In addition, element 2 requires the implementation of blood pressure (BP) assessment with digital monitors at the booking risk assessment for hypertensive disorders, which impact on fetal growth restriction. An action plan has been developed and the maternity service is currently obtaining costings for approved digital BP machines to enable procurement as all community midwives will be required to have an electronic BP Machine. The LMNS have accepted the action plan as evidence for MIS.

Element 3: Raising Awareness of Reduced Fetal Movements

Ormskirk Service - Currently 50% compliant (target 100% by March 2024) with process indicators and outcomes for this element.

All audits are currently in progress and near to completion. The audits will be required to be uploaded to the implementation tool.

Whiston Service - Currently 50% compliant with process indicators and outcomes for this element. All audits completed and continued.

One recommendation is that less than 10% of women experiencing reduced fetal movements should be induced below 39 weeks gestation. Our audit for this indicator identified that a higher number of women were being induced below 39 weeks gestation, for the single indicator of RFM. Continued audits are ongoing with findings disseminated to ensure compliance by March 2024.

Element 4: Effective Fetal Monitoring in Labour

Ormskirk Service - Currently fully compliant with this element at 100%. All audits are carried out monthly and will be required to be uploaded to the implementation tool as evidence.

Whiston Service – Currently fully compliant with this element at 100% with ongoing quarterly audits to determine data for ongoing compliance.

Element 5: Reducing Preterm Birth

Ormskirk and Whiston Service – Ormskirk is currently 85% compliant and Whiston is 70% compliant with this element. There are 8 process indicators and 4 outcome indicators within this element of SBL which is data submitted as part of the Maternity and Neonatal collaborative. The maternity and neonatal service are working together to ensure compliance to the criterion and to ensure the data quality and documentation is in place and improved. The Trust is on target to achieve compliance with the development and monitoring of actions plans to address any deficits.

The maternity service is now fully compliant with the requirement to have in place key roles including an Obstetric Consultant, a Neonatal Consultant, a Preterm Birth Midwife and Neonatal Nursing lead for preterm birth. Following a successful recruitment process for a fixed term Preterm Birth Midwives on both sites who both commenced in post in November 2023, the teams are now fully compliant.

The neonatal unit have introduced new HDU/Intensive care booklets for staff (Covering positioning/VIP scores, etc).

Element 6: Management of pre-existing diabetes

Ormskirk and Whiston Service – Ormskirk is 83% compliant and Whiston is 67% compliant with this element. This new Element 6 covers the management of pre-existing diabetes in pregnancy for women with Type 1 or Type 2 diabetes as the most significant modifiable risk factor for poor pregnancy outcomes. It recommends multidisciplinary team pathways and an intensified focus on glucose management within maternity settings, in line with the NHS Long Term Plan and NICE guidance. It includes clear documentation of assessing glucose control digitally and offering consistent access to evidence based Continuous Glucose Monitoring (CGM) technology to improve glucose control.

Work is continuing to improve compliance to both the process indicators and outcome measures.

MWL maternity representatives are meeting with the LMNS in March 2024 for final sign off for full implementation of SBLv3 as required for March 2024. Both sites are on track to demonstrate this with evidence uploaded to the implementation tool on NHS Future Platforms.

This new element covers the management of pre-existing diabetes in pregnancy for women with Type 1 or Type 2 diabetes, it has been identified as also being a significant modifiable risk factor for poor pregnancy outcomes by MBRRACE. It recommends multidisciplinary team pathways and an intensified focus on glucose management within maternity settings, in line with the NHS Long Term Plan and NICE guidance. It includes clear documentation of assessing glucose control digitally and offering consistent access to evidence based Continuous Glucose Monitoring (CGM) technology to improve glucose control.

Work is continuing to improve compliance to both the process indicators and outcome measures.

Compliance data for both outcome indicators should be reported by ethnicity and deprivation to ensure focus on at-risk and under-represented groups which is being undertaken.

To be compliant with the process and outcome indicators, the guidance has been updated and the service will complete further audits and upload them to the implementation tool as required.

Evidence for women being offered and receiving continuous glucose monitoring is maintained quarterly and submitted to the LMNS.

2.6 Care Quality Commission CQC Review

A prearranged visit by CQC was undertaken at both Maternity sites on 7th & 8th December 2023. The inspection team visited the clinical areas and met with specialist midwives, safeguarding practitioners, and governance teams. MS Teams meetings were also undertaken with Maternity Safety Champions and the leadership triumvirates.

The Chief Executive and Director for Nursing, Midwifery and Quality received post inspection feedback on 19th December 2023. This was as follows:

Initial feedback	Areas for improvement
	Ormskirk • Triage phone line. There is no dedicated trained staff member to answer calls to triage and the phone system does not allow for staff to be aware there is a call waiting. This places women and birthing people at risk of delays. • We were told that that triage is not always staffed by 2 midwives and that are often women and birthing people referred and utilising the triage area as they did not meet the criteria for other areas of the service. This placed pressure on the triage service. • Safeguarding training is not in line with intercollegiate guidelines. • Disposal of excess Fentanyl with bupivacaine used in epidural is not recorded in the controlled drugs register. • The automatic closure on the Labour ward door on the day of inspection was closing slowly, leading to potential risk of tailgating. This was feedback on the day and may have been resolved. • Safe pool evacuation knowledge. Staff on the day said that they did not know where equipment for safe evacuation of the pool was kept. Training data for pool evacuation submitted to CQC. Whiston • Safeguarding training is not in line with intercollegiate guidelines. • Disposal of excess Fentanyl with bupivacaine used in epidural is not recorded in the controlled drugs register.
	Positive findings
	Ormskirk • Sound ear on the maternity ward to alert staff that the ward was becoming noisy following feedback from families. • Learning from incidents, staff were able to give us good examples of where the service had improved following learning. • Staff all told us they enjoyed working at the service due to the team working ethos. Whiston • The baby security tagging system was very effective, we were able to see this in action. • Learning from incidents, staff were able to give us good examples of where the service had improved following learning. • Staff all told us they enjoyed working at the service due to the team working ethos. • We saw very good pastoral care and support of staff following a major incident. • Wider theatre staff are included in PROMPT training.

An inspection action plan has been developed and can be found in appendix 1.

The annual National Maternity Survey was published on 9th February 2024. A comprehensive analysis and proposed action plan has been developed and the teams are working through the results and actions with the MNVP. Progress will be presented to the Patient Council, Executive Committee and Quality Committee as part of the reporting cycle in a separate report.

2.7 Safety Champions

The aim of Safety Champions is to ensure seamless communication from 'floor to Board' to ensure Board focus on Maternity issues and improving safety and outcomes. Maternity and Neonatal services have designated Safety Champions alongside an appointed Non-Executive Director Safety Champion. Safety Champion meetings held monthly. The first merged meeting for both maternity units at MWL took place at the beginning of December.

A schedule for Safety Champion Walkarounds is in place where Maternity and Neonatal Safety Champions undertake a walkaround in Maternity and Neonatal Services to meet frontline clinical and non-clinical staff alongside women and their families to provide an additional opportunity for any safety concerns to be raised.

The NED Safety Champion additionally undertakes walkarounds with feedback presented at the Maternity Safety Champions meetings.

At the Ormskirk site, the established MNVP Lead undertakes walkabouts with the Consultant Midwife and Healthwatch, with feedback presented at the Maternity and Neonatal Safety Champions meetings. An MNVP lead has now been appointed for the Whiston service.

A quality priority for 2023/24 has been jointly developed with maternity in consultation with stakeholders and staff to 'Improve the overall experience for women using the Trust's Maternity Services' to ensure the new organisation remains committed to providing the best possible experience for all the women accessing our Maternity Services. Interventions are in place to support the feedback received from the National maternity survey which is monitored through the Patient Experience Council.

A 15 steps Maternity and Neonatal Event took place 9th Feb (appendix 2) which is a review of maternity and neonatal services from service user perspective. This is being led by the MNVP and will generate a report to be submitted through Safety Champions. There are 4 key themes which small teams consisting of stakeholders such as service users and service providers will review the overall environment looking at is it:

- Welcoming and informative.
- Friendly and personal.
- Safe and clean.
- Organised and calm.

2.8 Complaints and Claims

The Maternity Service is required within Safety Action 9 CNST MIS Year 5 (2023) to submit a report to provide oversight of the Claims Scorecard, reviewed alongside the data from the incidents and complaints data for 2022/23 for the Maternity Service at Trust Board level, which has been discussed at the Safety Champions meeting.

Ormskirk Service: There were 40 claims from the period 2012/13 – 2021/22, 10 which remained open and 29 had been closed. The claims reflected 11% of the total claims made against the Trust

but represented 20% of the value of the claims awarded. Of the 29 cases closed 13 (45%) were closed with nil damages. 16 (55%) were settled with damages paid.

2022/23	Injury	Volume
1	Psychiatric/Psychological Damage	8
2	Fatality	4
3	Cerebral Palsy	4
4	Additional/Unnecessary Operation(s)	4
5	Stillborn	4
Total Top 5 injuries by Volume for Obstetrics		**24**

	Causes	Volume
1	Failure/Delay in Treatment	11
2	Failure to Recognise Complication of….	6
3	Failure to Monitor 2nd Stage Labour	3
4	Failure to Monitor 1st Stage Labour	3
5	Operator Error	2
Total Top 5 causes by Volume for Obstetrics		**25**

Whiston service: There were 40 claims from the period 2012/13 – 2021/22, 15 which remain open and 25 had been closed. The claims reflected 7% of the total claims made against the Trust but represented 20% of the value of the claims awarded. High value claims were 8.16% of these with the majority (91.84%) continuing to be low value claims. It is noted that most claims are for the period 2016 to 2019 (n=28) with 12 claims for the period 2020-23.

Since 2015/16 there have been no claims made relating to CTG monitoring, there is the potential that the investment in new equipment and staff training in CTG monitoring may be impacting the outcomes for families and reducing the number of claims in this category.

	Injury	Volume
1	Loss of a baby	4
2	Additional/Unnecessary Operation(s)	4
3	Psychiatric/Psychological Damage	4
4	Stillborn	4
5	Unnecessary pain	3
Total Top 5 injuries by Volume for Obstetrics		**19**

	Causes	Volume
1	Failure/Delay in Treatment	20
2	Failure to respond to an abnormal fetal heart rate.	4
3	Intra – Operable problems	3
4	Inappropriate treatment	3
5	Failure/ delay Diagnosis	2
Total Top 5 causes by Volume for Obstetrics		**2532**

These cases are heavily scrutinised locally, regionally, and nationally and significant recommendations and work has been undertaken as part of the Each Baby Counts Review, MBRRACE perinatal surveillance, Saving Babies Lives and HSIB investigations. The incidents relating to severe perineal trauma and obstetric complications are also discussed as these relate to additional / unnecessary operations and intra-operative problems.

Complaints

Ormskirk Maternity: In the financial year to date (April 23 – Dec 23) there have been 6 level 3 formal maternity complaints, 14 level 2 concerns and 3 level 1 concerns. The themes of the level 3 formal complaints related to:

Theme of complaint	Quantity
Clinical Care	4
Communications	2
Total	6

The themes of the level 1 and 2 concerns related to:

Theme of Concerns	Quantity
Clinical Care	8
Communications	7
Values/Attitude/Behaviours	4
Length of time awaiting appointment	1

*Some concerns have been assigned multiple themes

All complaints and concerns are reviewed and responded to by a suitably qualified and experienced colleague and if indicated by a multidisciplinary team within the speciality.

Whiston Maternity: In the financial year to date (April 23 – Dec 23) there have been 5 formal maternity complaints. One complaint was received in this reporting period with the key issues relating to miscommunication and difficulties in making an antenatal appointment at the GP practice.
The themes of the level 3 formal complaints related to:

Theme of complaint	Quantity
Communication	4
Clinical Care	4

Attitudes and behaviours	4
Total	12

*Some concerns have been assigned multiple themes

There were 64 PALs concerns raised for the same reporting period with the following top 3 themes:

Theme of Concerns	Quantity
Clinical treatment	23
Communications	20
Patient care/ nursing care	11

Ormskirk Neonatal:
In the financial year to date (April 23 – Dec 23) there has been 1 level 2 concern.

Theme of concern	Quantity
Delay in blood arriving on Unit for transfusion. Review of current process was requested.	1

All complaints and concerns are reviewed and responded to by a suitably qualified and experienced senior Neonatal nurse and Matron and if indicated by a multidisciplinary team within the CBU. Complaints are discussed monthly within the Paediatric patient safety meeting and noted at the monthly governance meeting.

Whiston Neonatal:
There was 1 formal upheld complaint which was a delayed diagnosis of spina bifida occulta in-utero and missed diagnosis during baby's physical newborn check. Baby doing well and remains under care of Alder Hey hospital for unrelated orthopaedic issues.

There were 6 PALs concerns raised for the neonatal unit for same reporting period with the following top 3 themes:

Theme of Concerns	Quantity
Clinical treatment	2
Communications	2
Patient care/ nursing care	1
Policies, procedures, record management	1

PALS
Currently the complaint process are categorised differently between the Ormskirk and Whiston sites. A review and standardisation of the complaints process will be undertaken in 2024 following the appointment of a new head of Complaints.

2.9 Maternity Red Flags

NICE Safe Midwifery Staffing guidance recommends utilising nationally recognised red flag indicators.

A Midwifery Red Flag event is considered as a potential early indicator warning sign. These incidents must be reported to the Maternity Shift Leader to identify and address and identify any immediate actions.

The following are the recommended red flags which require documenting via the Datix Incident Reporting System.

- Delayed or cancelled time critical activity.
- Missed or delayed care (delay of 60 minutes or more in washing and suturing).
- Missed medication during an admission to hospital or midwifery-led unit (e.g., diabetes medication).
- Delay of more than 30 minutes in providing pain relief.
- Delay of 30 minutes or more between presentation and triage.
- Full clinical examination not carried out when presenting in labour.
- Delay of 2 hours or more between admission for induction and beginning of process.
- Delayed recognition of and action on abnormal vital signs (e.g., sepsis or urine output).
- Any occasion when one midwife is not able to provide continuous one-to-one care and support to a woman during established labour.

Theme	**Total for Q3 2023/24**			
	October 2023	**November 2023**	**December 2023**	
Delayed or cancelled time critical activity	0	1	3	**4**
Missed or delayed care	1	0	0	**1**
Missed medication	0	0	0	**0**
Delay of more than 30 mins in pain relief	0	0	0	**0**
Delay of 15 minutes or more between presentation and triage	5	3	0	**10**
Delay of 30 minutes or more between presentation and triage	2	0	0	
Full clinical examination not carried out when presenting in labour	0	0	0	**0**
Delay of 2 hours or more between admission for induction	0	0	0	**0**
Delayed recognition of and action on abnormal vital signs	0	0	0	**0**
Any occasion when 1 Midwife is not able to provide continuous 121 care in labour	0	0	0	**0**
If Delivery Suite Coordinator was not supernumerary and the reason why?	0	0	0	**0**
TOTAL	**8**	**4**	**3**	**15**

Between October to December 2023 there were 15 Midwifery Red Flag Events reported which is a decrease of 7 from the 22 reported red flags in the last Quarter. There were 10 Red Flags reported for triage breaches which were due to a high acuity and capacity within the triage area. Work is

ongoing to harmonise the guideline for Triage across both maternity sites. Currently Whiston site report Triage breaches of 30 minutes as per NICE and Ormskirk report Triage breaches of 15 minutes as per Birmingham Symptom Specific Obstetric Triage System (BSOTS) recommendations. 3 red flags related to women been delayed in transfer to Delivery suite for the next stage of induction, related to a delay in suturing a 3rd degree tear and 1 related to the requirement to undertake a maternity divert in October.

The role of the Delivery Suite Shift Coordinator is a key role in the intrapartum area and are present 24/7 and are a recommendation within the Ockenden Report. The Delivery Suite Coordinator is supernumerary which is a pivotal role to enable them to undertake their role effectively in providing an overarching view, effective leadership, clinical expertise and facilitating communication between professionals whilst overseeing appropriate use of resources. No red flags have been reported in this reporting period due to compliance. A monthly audit is also undertaken which has confirmed 100% compliance to the Shift Coordinator being supernumerary and is presented at the Maternity Governance meeting.

The Red Flags are all Datix incidents, and any learning from Red Flag and Datix incidents is disseminated via ward meetings, safety huddles and the Maternity Governance & Quality meetings.

Consideration going forward will be given to red flags in the neonatal services. The ODN has been contacted to advise the teams.

3.Workforce

MWL has agreed that Women's and Children's services will have a dedicated Divisional structure in the future. This will include 2 maternity units, 2 gynae services, 2 children's wards and 2 local neonatal units.

A Divisional Director of Operations has been appointed. Active recruitment is in place for the Divisional Director of Midwifery and Divisional Medical Director.

Ormskirk Maternity Service:

The midwifery staffing budget review and the increase in uplift from 25% to 30% is complete. This reflects the average of all absences for the previous 3 years including sickness, maternity, study leave and annual leave in accordance with Ockenden recommendations. This resulted in an increase in the midwifery funded establishment by 5.27WTE bringing the overall funded establishment to 120.68 which is 10.84WTE above the recommended staffing set by Birthrate plus in January 2022.

Additional posts include dedicated staff for maternity elective caesarean lists and externally funded specialist midwives for pre-term birth, preceptorship, and maternity support worker retention. However, recruiting midwives has been challenging and the current vacancy rate is 13.76WTE.

The international midwife programme continues. Enhanced support and bespoke training plans for international midwives have been developed and are overseen by the preceptorship midwife. Initial feedback from the individuals is positive for the early stages.

Based on staff in post and available for work the current midwife to birth ratio is 1:23.68. This number is calculated with midwives in directly clinical posts.

To ensure safe staffing on the Maternity Unit the following is in place:

- Separate band 7 or above acting as Maternity bleep holder 07:30-20:00 7 days per week (bleep held by Shift Coordinators out of hours)
- Birthrate plus acuity tool completed 4hrly and shared with region.
- Uncovered gaps between acuity and staffing are covered by specialist midwives and managers working clinically.
- Uncovered shifts put out to NHSP as soon as rosters are published.
- 1 x daily sit rep to region submitted by bleep holder.
- 3 x daily sit reps to Senior Maternity Managers and discussed at acute Trust flow meetings.

Ormskirk Neonatal service:

Medical rotas are in place. Some gaps remain due to recruitment timescales, and we are currently exploring alternative ways to cover gaps during the recruitment process. There are 4 substantive ANNP's and 1 x ANNP on a zero hour contract now working an eight week rolling rota which supports the medical rota in line with CNST and BAPM standards.

The Neonatal Unit meets the BAPM neonatal nursing standards in MIS Year 5 utilising the Neonatal Workforce Calculator which was undertaken once within the MIS reporting period of the 30th May to 7th December. This has been shared with the ODN who agrees with compliance. We have recently employed an additional part time Clinical Educator to support the development and training of the Neonatal staff at all levels.

Whiston Maternity Service:

The current maternity staffing budget is inclusive of a 22% uplift for sickness, annual leave and training. The overall funded establishment is 176.31WTE which is divided into 161.92WTE direct clinical staff and 14.39 WTE non direct care staffing.

Currently the funded establishment equates to the BR+ recommendations based on the current model of staffing provided. Consideration is required to changing the model of ratio of MSW to midwives on the antenatal/ postnatal ward. If this was adapted there would be a variance of 3.59WTE midwives. The staffing requirement for non-clinical midwifery roles is based on 9% of the total clinical WTE and therefore aligns to BR+ recommendations and therefore no variance is noted.

The maternity service has several externally funded fixed term posts which include, a 0.6 bereavement midwife, a 1 WTE preceptorship/ workforce midwife, 0.4 WTE preterm birth midwife and funded for 3 WTE Tobacco dependant advisors of which 1.4 WTE are currently in post. These posts are required as per Ockenden or recommended in the 3 year delivery plan. For 2024, these need to be considered as substantive posts.

A rolling recruitment programme is in place to attempt to recruit as soon as vacancies arise and thereby minimise any gaps in staffing. The service is allowed to over recruit by 6 WTE substantively to cover maternity leave. 13.99 WTE newly qualified midwives commenced in October 23 and the current vacancy is 6 WTE which is currently out to advert.

Senior roles that have been recruited to in this reporting period include an extension to the externally funded pastoral support and preceptorship midwife for a further 12-month period, WOPD manager and 1 WTE matron due to retirement. There remains 1 WTE matron post vacant due to retirement that we have been unable to recruit to date and is currently back out to advert.

5 Internationally recruited midwives have joined the Trust since November 22 with one further midwife due to joining in Q3.

Midwife to birth ratio for this reporting period has been recorded as 1:28. The LMNS have been asked to support a review across C+M to ensure that the calculation of the midwife to Birth ratio is

standardised. The review should demonstrate consistency relating to non-direct care of staff included in the calculation and if reported on a rolling birth or monthly birth ratio.

Whiston Neonatal service:

A business case was approved in January to increase Tier 1 & Tier 2 doctors across paediatrics/neonates. Following recruitment, the neonatal unit will be fully staffed for all tiers of medical workforce, in accordance with BAPM standards.

The Neonatal nursing funded workforce is fully compliant for BAPM standards (as reported per CNST MIS Year 5). Currently there are vacancies for 2.31 WTE band 6 nurses, 0.41 WTE band 5 nurses, 0.85 WTE band 4 and 0.58 WTE band 2 staff. Recruitment is in progress with interviews scheduled throughout Feb 24. A business case was approved in January 2024 for 2 trainee Advanced Neonatal Nurse Practitioners.

Successful recruitments include a neonatal physio 1-2 days per week on the unit from Jan 2024 who will be provide developmental support and a Speech & Language Therapist, starting Mar 2024 (part of ODN AHP workforce strategy).

An educator role has been expanded to incorporate FIN & QIS studies, professional development and support plans for current staff.

The MWL Resus Training Team are now accredited for delivering NLS course on site 4 times a year which is supported by accredited neonatal and midwifery staff.

The Neonatal contract has been increased by Spec Comm with additional funding (£400k) agreed to enable the implementation of a full Transitional care model with dedicated neonatal nurses/midwifery support workers 24/7. Recruitment of staff to commence in February 2024. SOPs currently being finalised across neonates/maternity in preparation for full implementation.

FiCare Accreditation:

Ormskirk neonatal unit achieved FiCare Green accreditation January 2023 and are working towards stage two accreditation which is expected to be achieved by the end of 2024. The unit provides emotional support for staff and families for 1.5 days a week, through a qualified psychologist. There is a FiCare teaching timetable which runs throughout the week over 7 days. There is a plan to commence annual staff training. The FiCare Lead and BFI Lead are currently working together to try and implement this.

The Whiston site neonatal service has successfully achieved FiCare Accreditation in Dec 24.

A clinical in reach Psychologist now formalised providing fortnightly counselling/support to families on unit (supporting FiCare standards).

A ‘Dads Matter’ parent representative attends the neonatal unit weekly to provide support for fathers and the introduction of Trust Chaplain weekly walk-arounds with the ability to accept in-reach referrals.

ODN Updates

Whiston and Ormskirk Nursing staff representatives have now been recruited into all 10 of the ODN Special Interest Groups (e.g., Optimisation, Data, Education).

Exception reports are provided to the ODN. There have been no recurring themes (cardiac babies transferred to AHCH for surgical intervention/receiving Prostin, extreme pre-term babies born outside a tertiary unit, chest drain, ventilated more than 48 hours).

3.1 Sickness Including COVID

Sickness	October 2023	November 2023	December 2023
Ormskirk Maternity services	5.99%	4.97%	7.86%
Whiston Maternity services	9.26%	7.51%	6.03%
Ormskirk Neonatal services	7.86%	4.16%	6.02
Whiston Neonatal services	7.46%	5.34%	4.64%

Staff shortages were mitigated by offering extra shifts and bank hours. Staffing and activity are monitored frequently every day with staff being redeployed to the clinical area of greatest need. Redeployment additionally includes members of the Senior Management Team, Specialist Midwives and nurses utilisation of the escalation process as required.

3.2 Continuity of Carer

Ormskirk maternity currently has one team (Sapphire Team) providing continuity, the plan will be to launch two teams based on the Sapphire Team model for women and babies of Black, Asian and mixed ethnicity and those living in the most deprived neighbourhoods. Preparation for the roll out of MCoC has been temporary suspended until the newly qualified midwives recruited into continuity of carer job descriptions have completed their preceptorship.

Whiston maternity has one Homebirth team and 1 MCoC team. The MCOC team due to increased sickness has been unable to provide the intrapartum element of the model currently, with intrapartum support coming from the Delivery suite areas. The current MCoC position and expansion is currently on hold which has previously been agreed at Executive level. A revised plan for the delivery of a Maternity Continuity of Carer model in line with delivering 'Maternity Continuity of Carer Model at Full-Scale' guidance which identified that a whole new model of care is required utilising a mixed risk model has been developed. The action plan is based on the Maternity Services' current care provision which indicates that there would be approximately 72% of women eligible for MCoC.

To fully implement MCoC there would be a requirement of a minimum of 12 teams for the Whiston service with a focus for the initial teams to provide enhanced midwifery care to women and babies of Black, Asian and mixed ethnicity and those living in the 10% decile of deprivation. Further review of this model is required alongside a review of required staffing to support this revised model of care.

3.3 Maternity and Neonatal Diverts

The maternity and neonatal service utilises the Cheshire and Merseyside Escalation Policy in the event of a potential or actual requirement to divert services. This policy was replaced in August 2022 by the Northwest Maternity Escalation and Operational Pressures Escalation Levels Framework.

For the Q3 October maternity services were required to divert on one occasion within maternity on the Whiston site.

The Whiston maternity service diverted for 4 hours overnight on the 27/10/23 due to increased activity and lack of bed availability. No women required diverting to another Trust during this time period and no harms occurred as a result of the divert or due to increased pressures on the service.

The Maternity units have a bleep Holder present 12/7. The role is undertaken by a Band 7 or Band 8a Matron and has the responsibility of the overarching view of the service enabling a holistic view of clinical activity allowing redeployment of staff to the most areas of clinical need and escalating any concerns during daytime hours and then the shift coordinator holds this responsibility overnight with Trust on call support. The bleep holder undertakes a minimum of 4 hourly reviews assessing staffing, acuity, and activity. These assessments may necessitate redeployment of staff including members of the senior management team or specialist midwives to undertake clinical care, request the on-call community midwives to attend the inpatient areas or consideration of implementing the Cheshire and Merseyside Escalation Policy to ensure the provision of a safe service by initiating a maternity divert or the request of mutual aid from other maternity units by convening a Maternity Gold Command meeting. The rolling programme of recruitment and reduced sickness has all contributed to the improved staffing levels across each shift.

Ormskirk Neonatal Unit Closures

Month 2023	**Dates**	**Reason for closure**
Oct	Nil	-
Nov	9th	Acuity
Dec	5th – 11th	Acuity
Dec	14th	Acuity
Dec	28th – 31st	Acuity
Total closures	**13**	

Whiston Neonatal Unit Closures

Month 2023	**Dates**	**Reason for closure**
Oct	23 26-29 31	Acuity
Nov	11-12	Acuity
Dec	19	Acuity
Total closures	**9**	

Closures are reported through Datix, the neonatal, obstetric and midwifery management teams work closely to ensure women with the potential to birth prematurely are risk assessed, with arrangements made for Intra uterine transfer in collaboration with the Neonatal ODN and Cot Bureau.

3.4 One to One Care in Labour

Maternity Services aim to achieve 100% of one-to-one care to women in established labour and this is monitored and reported within the safe staffing report and the monthly dashboard. For the Q3 period there have been no occasions when one to one care in labour was not provided.

3.5 NHSE: Three-Year Delivery Plan for Maternity and Neonatal Services

This plan developed by NHSE sets out how the NHS will make maternity and neonatal care safer, more personalised, and more equitable for women, babies, and families. The plan has 4 themes and 12 objectives which are:

Theme 1: Listening to and working with women and families with compassion.
Objective 1: Care that is personalised.
Objective 2: Improve equity for mothers and babies.
Objective 3: Work with service users to improve care.

Theme 2: Growing, retaining, and supporting our workforce.
Objective 4: Grow out workforce.
Objective 5: Value and retain our workforce.
Objective 6: Invest in skills.

Theme 3: Developing and sustaining a culture of safety, learning and support.
Objective 7: Develop a positive safety culture.
Objective 8: Learning and improving.
Objective 9: Support and oversight.

Theme 4: Standards and structures that underpin safer, more personalised, and more equitable care.
Objective 10: Standards to ensure best practice.
Objective 11: Data to inform learning.
Objective 12: Make better use of digital technology in maternity and neonatal services.

An overarching action plan has been developed supported by the MNVP, LMNS and commissioners following a gap analysis (appendix 3). MWL action plans are being developed.

4. Thirlwall Enquiry

The Thirlwall Inquiry has been set up to examine the event of the Countess of Chester Hospital and their implications following the trial, and subsequent convictions, of former neonatal nurse Lucy Letby or murder and attempted murder of babies at the hospital.

The inquiry will investigate 3 broad areas:

A. The experiences of the Countess of Chester Hospital and other relevant NHS services, of all the parents of the babies named in the indictment.

B. The conduct of those working at the Countess of Chester Hospital, including the board, managers, doctors, nurses and midwives with regard to the actions of Lucy Letby while she was employed there as a neonatal nurse and subsequently, including:

(i) Whether suspicions should have been raised earlier, whether Lucy Letby should have been suspended earlier and whether the police and other external bodies should have been informed sooner of suspicions about her.

(ii) The responses to concerns raised about Lucy Letby from those with management responsibilities within the trust.

(iii) Whether the trust's culture, management and governance structures and processes contributed to the failure to protect babies from Lucy Letby.

C. The effectiveness of NHS management and governance structures and processes, external scrutiny and professional regulation in keeping babies in hospital safe and well looked after, whether

changes are necessary and, if so, what they should be, including how accountability of senior managers should be strengthened. This section will include a consideration of NHS culture.

Lady Justice Thirlwall requested information from MWL, along will all other NHS Trusts, in January 2024. This was completed and returned as requested. Information provided included:

- A description of services including number of cots and staffing provision.
- Management and governance structures including the role of the Trust Board.
- Staff survey responses.
- Culture and relationships.
- Parent/guardian involvement with neonates.
- Incidents, complaints and concerns.
- CDOP, Medical Examiner's Office, Unexplained deaths, Patient safety incidents.
- Policies.
- Bereavement and Counselling.

5. Next Steps / Priorities

- Await outcome from MIS Year 5 and await Year 6 instruction.
- Appointment and development of the new Divisional leadership triumvirate.
- Deliver action plan post CQC inspection feedback.
- Continue to develop and monitor the action plan for the immediate and essential actions of the Ockenden Final Report.
- Continue to work collaboratively with LMNS and MNVP.
- Respond to the voices of women from the National maternity survey results
- Completion of the Saving Babies Lives Care Bundle. V3 implementation tool and monitoring of progress and LMNS assurances.
- Continuation of the action plans for the CQC maternity survey and staff survey action plans.
- Continuation of monitoring of progress of the action plan incorporating all the elements of the Three-Year Delivery Plan for Maternity and Neonatal Services.
- Continue to engage in the Thirlwall Inquiry if required.

6. Recommendations

The Committee are asked to note and approve the contents of the report.

7. Appendices:

1. CQC Action Plan 2024
2. 15 Steps maternity toolkit
3. 3-year delivery plan LMNS gap analysis

Maternity assessment CQC action plan MWL update - DRAFT

Rating	Action completed	Action on track to be delivered by due date	At risk of missing due date	Overdue

Mersey and West Lancashire Teaching Hospitals NHS Trust

No	CQC Core Service	CQC Action	MWL Action	Responsibility ('To')	Job title	Due date	Monitoring Committee(s)	Date completed	Update
1	Maternity	Triage phone line system does not allow for staff to be aware there is a call waiting	Install appropriate phone system/software, with call waiting.	Natalie Nelson Nicki Jones Rachel Miller Janet Calland James Calvert	DS Manager Matron Clinical Lead Midwife Triage Matron IT Lead (S&O)	**Mar-24**	Obs and Gynae Governance and Quality meeting		Implementation of triage centralised phone system due to be implemented on Whiston site in February 2024. The system will have a centralised line with options for transfer to the appropriate departments with the aim of only triage related calls being diverted to triage. There will be a dedicated emergency line which will be option 1.The system will allow call waiting to be viewed, monitoring of calls, awareness of any abandoned calls if required. 14.02.24 Awaiting an update from IT
2		No dedicated trained staff member to answer calls to triage	Whiston - continue with ward clerk 24/7 for initial phone answering, with review to ensure consistent cover. Ormskirk - 2 midwives rostered to triage	Anne Stott Rachel Miller Rachel Cassidy	Directorate Manager Obstetrics & Gynaecology/Admissions/ Admin Services/Pre-op Surgical Care Clinical Lead Midwife Triage Directorate Manager for Obs &Gynae	**Jun-24**	Obs and Gynae Governance and Quality meeting		Whiston: Continued discussion with Anne Stott relating to Triage cover as triage is required to be treated as an A&E in accordance with the RCOG Good practice paper No 17: Maternity triage, Dec 2023 with the requirement of 24/7 cover 7 days per week. Ormskirk: currently staffed with 2 midwives 24/7 answering phone and providing care.
3		Not always two midwives to staff triage.	Ensure two midwives cover triage 24/7. Review of current Maternity Manager Bleep Holder responsibilities with possible harmonisation .	Sue Orchard Dawn Meredith	Head of Midwifery associate Director of Nursing and Midwifery and AHP.	**Mar-24**	Obs and Gynae Governance and Quality meeting		Whiston: Increased establishment for 2 midwives, 12 hour day shift 7 days per week. Triage staffed with 2 midwives 24/7 however business case required for the additional 2.7WTE needed for substantive staffing and increased establishment for night shifts. Ormskirk: Currently staffed with 2 midwives 24/7. However identified themes of moving staff in times of clinical escalation in relation to sickness and high acuity.
4		Inappropriate referrals to triage for those women/birthing people that don't meet criteria for other areas	Triage Guideline to be reviewed with clear flowchart for criteria.	Sumitra Pappala Rachel Miller Shirley Pennington Janet Calland	Consultant Obstetrician Clinical Lead Midwife Triage Lead Midwife Matron for Community and Outpatients Inpatient Matron	**Jun-24**	Obs and Gynae Governance and Quality meeting		Review of the new joint guideline.
5		Safeguarding training not in line with intercollegiate guidelines	Submitted rationale to CQC for current position - awaiting CQC response.	Sharon Seton Anne Montieth	Assistant Director of Safeguarding Assistant Director of Nursing Safeguarding	**Feb-24**	Safeguarding Assurance Group & Quality Committee		CQC requested assitional information Feb 22 - *•Safeguarding adults level 3. We are aware that staff are trained up to level 2. However our understanding of the guidance in Roles and Competencies for Health Care Staff Intercollegiate document is that staff should be trained to level 3. Please can you share where the decision was made, this may be executive board meeting minutes to train to level 2 and how this mitigates any risks in staff knowledge.*

6		Failure to record disposal of excess fentanyl with bupivacaine in CD book Matron to undertake regular audit and checks to ensure compliance.	Immediate review of CD book. Communications to staff at handover and safety huddles.	Natalie Nelson/Nicki Jones Ormskirk Leanne Rowley	DS Manager/Matron	**Dec-24**	Labour ward forum		Whiston/Ormskirk: Immediately addressed following identification. Disseminated to staff. Epidural book already available to enable documentation of discarded medication following discontinuation of epidural. New CD book ordered for Ormskirk site
7		Slow automatic closure on the labour ward door on day of inspection with potential for tailgating.	Addressed at time by Estates Team Consider alarms on doors if left open for period of time.	Natalie Nelson/ Zoe Jones Ormskirk Leanne Rowley	DS and ward 2E managers	**Mar-24**	Obs and Gynae Governance and Quality meeting		Whiston: All doors have tailgating information displayed. Robust procedures relating to Infant abduction with drills External doors alarm if not closed properly or open for moe than 19 seconds Ormskirk: Rectified immediately. Staff receive infant abduction training/drills
8		Not all staff aware of safe pool evacuation, including location of equipment. Requested training records.	Continually update training records for pool evacuation training and skill drills including home births	Natalie Nelson/ Carys Hammond/ Angela Black Ormskirk: Sharon Thomas Leanne Rowley Bethan Davies	DS manager/ community managers Ormskirk: Practice Development Midwife Delivery Suite Manager Community Manager	**Feb-24**	Obs and Gynae Governance and Quality meeting and Senior managers meeting	**March 2024**	Whiston: Staff aware of evacuation procedures including availability and use of evacuation equipment. Equipment available includes pool net, hoist and active birth bed. Regular skills drills undertaken for DS, MLU and bespoke community sessions undertaken. Pool evacuation training and use of equipment included in Moving and handling training on within maternity study day sessions. Ormskirk: Evacuation drill undertaken. Guideline recirculated to all staff. Pool evacuation on forward training plan, now to be incorporated into PROMPT. New nets procured, clear signage for net location installed. And added to huddles. Training records submitted to CQC inspection team.
9		Minutes of key meetings did not always provide assurance/decisions/actions required	Training to be made available for minute taker and standard templates for agenda/minutes/action tracker/cycle of business across MWL	Whiston: Sue Orchard Ormskirk: Dawn Meredith	Whiston: Head of Midwifery Ormskirk: Associate Director of Nursing and Midwifery and AHP.	**Mar-24**	Obs and Gynae Governance and Quality meeting and Senior managers meeting		Plan for admin support staff to attend a course to improve minute taking. Review of current templates for agendas, minutes action trackers and action plans
10		Audit programme did not provide sufficient evidence of comprehensive coverage or quality improvements and actions to be taken to address audit findings	Need to harmonise audit programme across both sites	Sarah Howard Laura Hall Janette Mills	Whiston Quality and safety Matron Interim Governance Lead and Head of Audit	**Apr-24**	Obs and Gynae Governance and Quality meeting		Plan to review audit schedule and frequency of audits. To ensure all required audits are identified, allocated and undertaken within agreed timescales meeting the requirements of all external regulations and guidance, CNST, CQC, Ockenden, SBLv3 etc. Requirement to review all audit tools to ensure fit for purpose and standardised across MWL service
11		Mandatory training below Trust compliance target.	Improve training compliance to meet Trust compliance targets	Nicki Jones/ Amy Helmy/ Sharon Bell Sharon Thomas	Maternity Matrons	**Mar-24**	Senior maternity managers meeting		Continuation of work to ensure all competencies are correctly assigned to each designated staff group with removal of any non required and addition of those needed. Completion of piece of work looking at total required training hours for each staff group within maternity to explore if current 21% uplift is adequate. Continued monitoring by senior maternity team of compliance rates and allocation of staff to improve mandatory core training

12		Staff unsure of what Health inequalities meant when asked without prompts	Raise awareness to staff of health inequalities	Sarah Howard/ Alesha Maguire Laura Hall	Quality and safety matron/ Quality and Safety midwife	**Sep-24**	Senior maternity managers meeting		Continue monitoring of mandatory training which includes health inequalities and The Oliver McGowan Mandatory Training on Learning Disability and Autism. Developing a schedule of raising awareness to staff regarding health inequalities. This will be undertaken on daily huddles, newsletters, posting on the learning hub with weekly updates and provision of sharing information via the quality bus. Topics will include, data in relation to our local population and actions to support care and address areas of concern, smoking, breastfeeding, sharing of actions linked to BAME action plan, social demographics, social demographic statistics etc
14		Consider review of Ormskirk processes for women requiring transfer to ICU	Plan for a review of Ormskirk processes for women requiring transfer to ICU to explore if all transfers should be to Whiston site as supportive on site Obstetric and midwifery care is available	Ormskirk: Mary jo Waldron/Cathy Langley	Consultant midwife/ Consultant lead for DS	**Sep-24**	Maternity Governance meeting		Guideline 39 in place to support current practice for transfer of women requiring ITU support from Ormskirk to Southport. Whiston site has on site ICU and HDU facilities. Guideline in place identifying the different levels of care which includes the criteria for women requiring ICU care and requiring transfer

Objective	Deliverables	MWL Whiston	
		Response	Comments
Objective 1: Care that is personalised	Is PCSP training included in the TNA?	Yes	
	Are Personalised care audits being undertaken regularly?	Yes	
	Is the trust in a position to roll out MCoC	No	Action plans in place but currently suspended and approved by Board
	Number of EMCoC teams operating in line with national guidance?	1	1 team providing continuty antentaally and postnatlly but not intrapartum care
	Number of EMCoC teams planned to be rolled out in line with national guidance?	7	Action plans in place but currently suspended and approved by Board
	Has the trust achieved UNICEF BFI accredirtation?	Maternity	BFI reaccreditation has been on hold since COVID. Trust status was Level 3, however as reassessment has not get taken place the status is currently at Level 2 pending assessment. Continuation of audits maintained and further discussion with UNICEF anticipated Jan/ feb 2024 to discuss when the next assessment will take place. Neonatal services are working towards accreditation
Objective 2: Improve equity for mothers and babies	Does the trust provide access to interpreter services, which adhers to the Accessible Information Standard?	Yes	Trust provides interpreter services as per standard.
	Is data collected and disaggregated based on population groups?	No	Certain data is disaggretaed and data can be broken down if required but not routimely undertaken only as required.
Objective 3: Work with service users to improve care	Are service users involved in quality, governance, and co-production when planning the design and delivery of maternity and neonatal services?	Yes	This was evidenced with the declaration of compliance /submission of Safety Action 7, Maternity Incentive Scheme
Objective 4: Grow our workforce	Date of last BR+	Started 2021 and final report october 2022	Final report received in October 22
	Funded to BR+ establishment	Yes	We are funded to BR+ using our current model. BR+ have suggested a reduction in our MSW in our postnatal areas which if adopted creates a midwifery deficit.
	Annual workforce plan for maternity and neonates including obstetrics in place?	Yes	Minimum Bi annual midwifery staffing papers undertaken. Consultant business case following workforce review approved 2023, with agreement for an additional 4 Consultants. Annual neonatal revew undertaken and disseminated to the ODN
	Does the annual workforce plan include support for newly qualified staff and midwives who wish to return to practice?	Yes	
	MW Vacancy Rate (please provide additional narrative to support data)	0	As per PWR data for Nov 23, there is a current over recruitment of 5.36WTE. The Trust is permitted to over recruit by 6WTE to cover materntiy leave.
	MW Leaver Rate (please provide additional narrative to support data)	22.20WTE	This data is for November 2023 and the preceeding 12 month period. This WTE includes staff wh have retired and retired
	MW Turnover Rate (please provide additional narrative to support data)	13.52%	This data is for November 2023 and the preceeding 12 month period
	Obstetric Consultant Vacancy Rate (please provide additional narrative to support data)	4WTE	Business case for additional consultants approved by the Executive team in 2023. The 4WTE is not a true vacancy but an increase in the estab;lishment following a successful business case. 1 Consultant recruited and due to commence April 24. interviews for a further 3 Consultants scheduled in january 2024.
	MSW Vacancy Rate (please provide additional narrative to support data)	7.19 WTE	As per PWR data for Nov 23, there was a vacancy rate of 7.19 WTE
	Is there a retention midwife in post? (please provide additional narrative to support data)	Yes	We have a pastoral support/ workforce midwife currently in post. This post is curently externally funded and has been extended until Nov 2024
Objective 5: Value and retain our workforce	Does the trust have a retention improvement action plan?	No	No specific action plan but we, discuss with potential leavers to see reasons and if any actions can be taken to support, undertake leaving interviews, flexible working policy, retire and return etc
	Is there a plan in place to reduce workforce inequalities?	Yes	Trust equality and Diversity leads, Equality impact risk assessments in job applications and when staff are offered jobs Freedom to speak out guardians in place Training in place regarding equality & diversity, and Freedom to speak up
	Is the trust signed up to the North West Black, Asian, and Minority Ethnic Assembly Anti-racist Framework?	Yes	
	Do the trust have a mechanism to Identify and address issues highlighted in student and trainee feedback surveys?	Yes	Students have PARE assessments which includes their feedback, if there is anything concerning the educational establishment will contract the Practice Educator Facilitators or member of senior team to address any issues. Student links and PEF's available
	Does the trust offer a preceptorship programme to every newly registered midwife, with supernumerary time during orientation and protected development time?	Yes	2 weeks initial orientation . As each newly qualified midwife rotates to their new clinical area as part of their orientation programme, they have two weeks supernumery in that clinical area. Protected development time provided. Individual plans of care as some staff midwives have required bespoke packages with extended periods of supernummary or supported time.

	Do the trust offer newly appointed Band 7 and 8 midwives support with a mentor?	Yes	
	Does the trust have a leadrship succession plan which reflects the ethnic background of the wider workforce? .	No	
Objective 6: Invest in skills	Does the trusts TNA aline with the core competency framework?	Yes	Evidenced in Safety Action 8 - MIS Year 5 submission/declaration.
	Do junior and SAS obstetricians and neonatal medical staff meet RCOG and BAPM guidance for clinical and support suppervison?	Both	Safety Action 3 MIS Year 5 evidences this objective
	Do temporary medical staff covering middle grade rota possess an RCOG certificate of eligibility for short-term locums?	Yes	Safety Action 3 MIS Year 5 evidences this objective
Objective 7: Develop a positive safety culture	Do maternity and neonatal leads have time within their job plan to access training and development, Including time to engage stakeholders, and MNVP leads?	Yes	
	Have senior leaders attended national leadership programmes, including board maternity and neonatal safety champions?	Yes	Currently undertaking the NHSE Perinatal Culture and leadership course.
	Does the trust board support the implementation of a focused plan to improve and sustain maternity and neonatal culture and regularly review progress?	Yes	Minimum quarterly updates to Qualty Committee
	Is there a clear and structured route for the escalation of clinical concerns? i.e. (Each Baby Counts: Learn and Support escalation toolkit).	Yes	Provide a minimum of quarterly maternity update to quality committee and board which includes updates on all national recommendations and requirements e.g. SBL3, Saving babies Lives, PMRT, MBRACCE, CNST etc. We have board level safety champions who provide updates to the Trust board and undertake regular walkabouts. Incident, claims and complaints reports. Staff have the opportunity to feedback any concerns directly to management in the maternity service. Senior management team walkabout. There is a monthly unit meeting for any staff member to raise any concerns or issues. Freedom to Speak up guardians in place, Whistleblowing policy and training in place.
	Is there a Freedom to Speak Up Guardian?	Yes	Posters raising awareness of who they are and how to contact them are on display in clinical areas. Available on Intranet
	Is there a FTSU training module for staff?	No	FTSU is included in mandatory training, however there is no specific training module.
Objective 8: Learn and improve	Has the trust implemented PSIRF?	Yes	
	Is there a formal structure to review and share learning? (with agreed timescales)	Yes	
	Has the organisation established effective, kind, and compassionate processes to respond to families who experience harm or raise concerns about their care?	Yes	
	Has the organisation adopted a single point of contact process for families where ongoing dialogue is required with the trust?	Yes	After duty of candour has been completed a designated focal contact point is provided.
	Is the organisation sensitive to culture, ethnicity, and language when responding to incidents?	Yes	
	Is there a process of triangulation of outcomes data, staff, and MNVP feedback, audits, incident investigations, and complaints, as well as learning from where things have gone well?	Yes	
Objective 9: Support and oversight	Does the organisation share open and honest information on the safety, quality, and experience of their services?	Yes	
	Does the organisation regularly review the quality of maternity and neonatal services?	Yes	Monthly Quality Surveillance tool goes to Board as per Safety Action 9 - MIS Year 5.
	Have maternity safety champions been appointed, including NED?	Yes	Evidenced in Safety Action 9 MIS Year 5
	Has the quadumverite been appointed?	Yes	Evidenced in Safety Action 9 MIS Year 5
	Are MNVPs involved in the development of the organisations complaints process?	No	MNVP have provided information from families that have enabled us to contact them directly and and discuss any concerns. MNVP not currently involved in our complaints process once a formal complaint has been received however they will be involved going forward as we have a new MNVP leade with supporting with themes and issues identified following complaints
	Are the MNVPs involved in the quality safety and surveillance group that monitors and acts on trends.	No	We have a new MNVP person just in post who will be involved going forward and will attend the Governance and safety meetings. . The previous MNVP attended maternity safety champions meeting
	Is FTSU data reported to board and acted upon?	Yes	
Objective 10: Standards to ensure best practice	Is the organisation on track to Implement version 3 of the Saving Babies' Lives Care Bundle by March 2024?	Yes	Met MIS Criteria in December 2023. Final quarterly meeting in March 24
	Is the organisation on track to adopt the national MEWS and NEWTT-2 tools by March 2025?	Yes	
	Does the organisation regularly review and act on local outcomes including stillbirth, neonatal mortality and brain injury, and maternal morbidity and mortality to improve services?	Yes	Evidence in SBLv3
	Has the organisation completed the national maternity self-assessment tool? .	Yes	

Objective 11: Data to inform learning	Does the organisation have a process for reviewing available data which draws out themes and trends and identifies and addresses areas of concern including consideration of the impact of inequalities?	Yes	All reviews, ie PMRT , serious incidents etc have a mandatory section that identiies inequalities which are collated as part of thematic analysis. E.g. English not first language, ethnicity, disabilities, smoking etc
	Does the organisation have a system that ensures high-quality submissions to the Maternity Services Data Set?	Yes	
	Does the organisation have robust processes in place to ensure referrals to NHSR, MNSI, and the National Perinatal Epidemiology Unit?	Yes	
Objective 12: Make better use of digital technology in maternity and neonatal services	Does the organisation have a digital maternity strategy and digital roadmap?	Yes	
	Is the digital strategy and roadmap being implemented?	Yes	The maternity service is curently transitioning to a fully electronic digital maternity system in 2024.
	Does the organisation have an EPR system that complies with national specifications and standards, including the Digital Maternity Record Standard and the Maternity Services Data Set?	Yes	
	Is there a process in place to ensure quality data is submitted for the neonatal national audit programme data and the neonatal critical care minimum data set?	Yes	The Trust uses the Badgernett neonatal EPR as a single record of care for all babies within the neonatal unit. The data within badger feeds into the numerous national QI/ audit standards e.g. MNAP and for loacl reporting to the NWODN

BRAG Rating	
	Action is complete
	Action is on track
	Action mainly on track with some minor issues (mitigation in comments)
	Action not on track wit major issues (mitigation in comments)

Objective	Deliverables	MWL Ormskirk	
		Response	Comments
Objective 1: Care that is personalised	Is PCSP training included in the TNA?	Yes	is being delivered this year as part of the TNA
	Are Personalised care audits being undertaken regularly?	No	elements of personalised care are audited regularly but this will be strengthend on the forward audit plan
	Is the trust in a position to roll out MCoC	No	Staffing vacancy rate of over 11% and sickness rate 9.35%
	Number of EMCoC teams operating in line with national guidance?	N/A	
	Number of EMCoC teams planned to be rolled out in line with national guidance?	2	
	Has the trust achieved UNICEF BFI accreditation?	Both	STAGE ONE FOR NEONATES AND STAGE TWO FOR MATERNITY. WILL BE GOING FOR STAGE 3 THIS YEAR ONCE RECRUITED TO 15 HOURS infant feeding lead
Objective 2: Improve equity for mothers and babies	Does the trust provide access to interpreter services, which adhers to the Accessible Information Standard?	Yes	Trust provides interpreter services as per standard.
	Is data collected and disaggregated based on population groups?	Yes	Trust Policy
Objective 3: Work with service users to improve care	Are service users involved in quality, governance, and co-production when planning the design and delivery of maternity and neonatal services?	Yes	This was evidenced with the declaration of compliance /submission of Safety Action 7, Maternity Incentive Scheme
Objective 4: Grow our workforce	Date of last BR+	Jan-22	
	Funded to BR+ establishment	Yes	br + completed based on 25% uplift. Funded posts are now based on 30% uplift for clinical staff to meet Ockenden requirements. In addition ther are also some externally funded posts.
	Annual workforce plan for maternity and neonates including obstetrics in place?	Yes	staffing review for maternity completed to meet Ockenden requirements. Recruitment ongoing with rolling advert.
	Does the annual workforce plan include support for newly qualified staff and midwives who wish to return to practice?	Yes	Full time preceptorship midwife in post
	MW Vacancy Rate (please provide additional narrative to support data)	11.34%	This is based o the increased uplift
	MW Leaver Rate (please provide additional narrative to support data)		21 midwives have left in past year. 4 for promotions at neighbouring Trusts, 2 relocating, 3 for health, 2 retirements, remaining 10 to neighbouring Trusts reasons stated work life balance due to travel or shifts.
	MW Turnover Rate (please provide additional narrative to support data)	12.18%	Turnover for year 1/12/22 - 30/11/23
	Obstetric Consultant Vacancy Rate (please provide additional narrative to support data)	1	Fetal medicine Consultant advertised to include other duties but primarily fetal medicine
	MSW Vacancy Rate (please provide additional narrative to support data)	0	no band 3 vacancies. Vacancies for band 2housekeepers not filled due to delays in getting job description approved following merger.
	Is there a retention midwife in post? (please provide additional narrative to support data)	Yes	preceptorship midwife post has supported retention of newly qualified staff. Band 6 midwife post supporting retention of support workers
Objective 5: Value and retain our workforce	Does the trust have a retention improvement action plan?	No	work ongoing to improve staff morale and engagement
	Is there a plan in place to reduce workforce inequalities?	Yes	Trust EDI plan
	Is the trust signed up to the North West Black, Asian, and Minority Ethnic Assembly Anti-racist Framework?	Yes	
	Do the trust have a mechanism to Identify and address issues highlighted in student and trainee feedback surveys?	Yes	
	Does the trust offer a preceptorship programme to every newly registered midwife, with supernumerary time during orientation and protected development time?	Yes	newly registered midwives have 18 month plan with 2-3 weeks supernumerary in each area. Designated newly qualified midwives days held reguarly. Preceptorshipplan adapted to suit needs of individuals.
	Do the trust offer newly appointed Band 7 and 8 midwives support with a mentor?	Yes	Trust guidance around mentorship for newly appointed band 7 & 8's in place
	Does the trust have a leadrship succession plan which reflects the ethnic background of the wider workforce? .	Yes	Leadership courses avaialble locally and nationally in relation to ethnic background.
Objective 6: Invest in skills	Does the trusts TNA aline with the core competency framework?	Yes	Evidenced in Safety Action 8 - MIS Year 5 submission/declaration.
	Do junior and SAS obstetricians and neonatal medical staff meet RCOG and BAPM guidance for clinical and support suppervison?		will forward information tomorrow as meeting with cd's
	Do temporary medical staff covering middle grade rota possess an RCOG certificate of eligibility for short-term locums?	Yes	Safety Action 3 MIS Year 5 evidences this objective
Objective 7: Develop a positive safety culture	Do maternity and neonatal leads have time within their job plan to access training and development, Including time to engage stakeholders, and MNVP leads?	Yes	recently agreed job plans for both neonatal and meternity leads
	Have senior leaders attended national leadership programmes, including board maternity and neonatal safety champions?	Yes	recent attendance at the culture programme
	Does the trust board support the implementation of a focused plan to improve and sustain maternity and neonatal culture and regularly review progress?	Yes	
	Is there a clear and structured route for the escalation of clinical concerns? i.e. (Each Baby Counts: Learn and Support escalation toolkit).	Yes	began the process

	Is there a Freedom to Speak Up Guardian?	Yes	attends both neonatal and maternity safety champions meetings to provide feedback
	Is there a FTSU training module for staff?	Yes	on esr
Objective 8: Learn and improve	Has the trust implemented PSIRF?	Yes	Trust has implemented and there is a regional psirf meeting specific for maternity to agree the format
	Is there a formal structure to review and share learning? (with agreed timescales)	Yes	Agreed through PS Trust lessons learned datix feedback
	Has the organisation established effective, kind, and compassionate processes to respond to families who experience harm or raise concerns about their care?	Yes	invite for debrief. Full process or SI are contacted and a letter with follow up when meetings are held. Reports are shared and an opportunity to attend for a further debrief
	Has the organisation adopted a single point of contact process for families where ongoing dialogue is required with the trust?	Yes	Allocated as part of the process
	Is the organisation sensitive to culture, ethnicity, and language when responding to incidents?	Yes	
	Is there a process of triangulation of outcomes data, staff, and MNVP feedback, audits, incident investigations, and complaints, as well as learning from where things have gone well?	Yes	reported through governance
Objective 9: Support and oversight	Does the organisation share open and honest information on the safety, quality, and experience of their services?	Yes	dashboards
	Does the organisation regularly review the quality of maternity and neonatal services?	Yes	Monthly Quality Surveillance tool goes to Board monthly as per Safety Action 9 - MIS Year 5.
	Have maternity safety champions been appointed, including NED?	Yes	Evidenced in Safety Action 9 MIS Year 5
	Has the quadumverite been appointed?	Yes	Evidenced in Safety Action 9 MIS Year 5
	Are MNVPs involved in the development of the organisations complaints process?	Yes	
	Are the MNVPs involved in the quality safety and surveillance group that monitors and acts on trends.	Yes	attendance at maternity and neonatal safety champions meeting and reports provided to quarterly MNVP meetings
	Is FTSU data reported to board and acted upon?	Yes	
Objective 10: Standards to ensure best practice	Is the organisation on track to Implement version 3 of the Saving Babies' Lives Care Bundle by March 2024?	Yes	Met MIS Criteria in December 2023. Final quarterly meeting in March 24
	Is the organisation on track to adopt the national MEWS and NEWTT-2 tools by March 2025?	Yes	regular meeting with regional lead re preterm optimisation also leading on NEWTT-2 and requested to be part of the piolt for implementation
	Does the organisation regularly review and act on local outcomes including stillbirth, neonatal mortality and brain injury, and maternal morbidity and mortality to improve services?	Yes	Evidence in SBLv3
	Has the organisation completed the national maternity self-assessment tool? .	No	plan to undertake this review late January 2024.
Objective 11: Data to inform learning	Does the organisation have a process for reviewing available data which draws out themes and trends and identifies and addresses areas of concern including consideration of the impact of inequalities?	Yes	
	Does the organisation have a system that ensures high-quality submissions to the Maternity Services Data Set?	Yes	dData extracted from the BI Team
	Does the organisation have robust processes in place to ensure referrals to NHSR, MNSI, and the National Perinatal Epidemiology Unit?	Yes	Evidenced in Safety Action 10 MIS Year 5
Objective 12: Make better use of digital technology in maternity and neonatal services	Does the organisation have a digital maternity strategy and digital roadmap?	Yes	Developed in October 2022. Now merged to become MWL and therefore merging the digital maternity strategy and digital roadmap
	Is the digital strategy and roadmap being implemented?	Yes	current review as now merged to become MWL
	Does the organisation have an EPR system that complies with national specifications and standards, including the Digital Maternity Record Standard and the Maternity Services Data Set?	No	Process in place to move away from system C and implement Bader net across MWL in order to be fully compliant. Aim for implementation within 6 months.
	Is there a process in place to ensure quality data is submitted for the neonatal national audit programme data and the neonatal critical care minimum data set?	Yes	Data Automatically pulled from Badgernet

BRAG Rating	
	Action is complete
	Action is on track
	Action mainly on track with some minor issues (mitigation in comments)
	Action not on track wit major issues (mitigation in comments)

Title of Meeting	**Trust Board**	**Date**	28 February 2024
Agenda Item	**MWL TB24/017**		
Report Title	Corporate Governance Manual		
Executive Lead	Gareth Lawrence, Director of Finance & Information		
Presenting Officer	Gareth Lawrence, Director of Finance & Information		

Action Required	X	**To Approve**		**To Note**

Purpose

The Corporate Governance Manual contains the following key Trust policy documents governing the business conduct of the Trust:

- Standing Orders (SOs)
- Standing Financial Instructions (SFIs)
- Scheme of Reservation and Delegation of Powers (including table of delegated limits)

This policy applies to all staff and services within Mersey and West Lancashire Teaching Hospital NHS Trust (MWL). The objective of this manual is to set out in a single document the regulatory framework for the Trust (its directors, managers and staff) which provides rules and guidelines on how the Trust conducts its business.

The manual is due for review post transaction.

Executive Summary

Standing Orders and Standing Financial Instructions set out in some detail the financial responsibilities of the Chief Executive, the Director of Finance and Information and other Directors. This includes a detailed schedule of delegated authority and an associated schedule of delegated financial limits. Changes to these schedules must be approved by the Board.

Pre transaction, policies were aligned between St Helens and Knowsley Teaching Hospitals NHS Trust (STHK) and Southport and Ormskirk (S&O) Hospital NHS Trust (S&O). This review updates the policy to reflect the corporate structure of MWL.

The existing MWL (historic STHK) Corporate Governance Manual has been used as the basis for the revised draft.

Amendments have been made as follows:

- Updates for changes in legislation
- Changes in wording to reflect the Trust's Equality, Diversity, and Inclusion (ED&I) policy
- Updates for job title changes
- Proposed amendments to delegated financial limits

This review has not significantly amended the detailed schedule of delegated authority except to amend job titles where appropriate.

Following review of the current financial limits the delegated financial limits have been updated to incorporate new Trust roles and amendments to values in light of the size of the organisation and inflation.

Proposed Financial Limits (Subject to funding available in budget)		Includes:-	
			Historic
Chief Executive	£1,000,000 (see *)	* Can authorise spend above £1,000,000 providing pre-approved by Board, eg. via annual approved budget or capital programme Each level requires approval by the manager i.e. level above. Note: it is possible for any of the above levels a manager at that level could be given a limit that is lower than the stated level here but not higher.	£250,000 (see *)
Deputy Chief Executive or Director of Finance and Information	£1,000,000		£250,000
Executive Board Directors (other than above), Deputy Director of Finance and Information , Director of Corporate Services, Director of Informatics, Head of Pharmacy	£200,000		£100,000
Divisional Directors / Deputy Director of Estates	£75,000		New
Assistant Directors / Head of PFI and Facilities Management	£50,000		£50,000
Pathology and Radiology Managers	£35,000		£35,000
Directorate Managers	£25,000		£25,000
Senior Manager Level 1	£10,000		£10,000
Senior Manager Level 2	£5,000		£5,000
Matron / Manager	£1,000		£1,000
Ward and Other Managers	£500 or less		£500 or less

Financial Implications

None noted

Quality and/or Equality Impact

None noted

Recommendations

The Trust Board is asked to approve the updated Corporate Governance Manual.

Strategic Objectives

	SO1 5 Star Patient Care – Care
	SO2 5 Star Patient Care - Safety
	SO3 5 Star Patient Care – Pathways`
	SO4 5 Star Patient Care – Communication
	SO5 5 Star Patient Care - Systems
X	**SO6** Developing Organisation Culture and Supporting our Workforce
	SO7 Operational Performance
X	**SO8** Financial Performance, Efficiency and Productivity
	SO9 Strategic Plans

Corporate Governance Manual

Version No: 1

Document Summary:

The Corporate Governance Manual is the key policy document that provides staff and directors of the Trust with the regulatory framework for how the Trust conducts its business affairs. It contains the Trust's standing orders (SOs), standing financial instructions (SFIs), scheme of reservation and delegation (SORD) including table of delegated limits.

Document status	Draft	
Document type	Policy	Trust wide
Document number	Document Control will provide document number if a new document	
Approving body	Trust Board	
Date approved	31/01/2024	
Date implemented	31/01/2024	
Review date	*3 years from approval date 31/01/2027	
Accountable Director	Director of Finance	
Policy Author	Assistant Director of Finance & Information	
Target audience	All staff	

The intranet version of this document is the only version that is maintained. Any printed copies should therefore be viewed as "uncontrolled", as they may not contain the latest updates and amendments.

Document Control

Section 1 – Document Information	
Title	Corporate Governance Manual
Directorate	Workforce
Brief Description of amendments	
New document, based on previous St Helens & Knowsley Trust Standards of Business Conduct Policy ***Please state if a document has been superseded.***	
Does the document follow the Trust agreed format?	Yes
Are all mandatory headings complete?	Yes
Does the document outline clearly the monitoring compliance and performance management?	Yes
Equality Analysis completed?	Yes
Data Protection Impact Analysis completed?	Yes

Section 2 – Consultation Information* *Please remember to consult with all services provided by the Trust, including Community & Primary Care			
Consultation Completed	☐ Trust wide ☐ Local ☐ Specific staff group		
Consultation start date	Click here to enter a date.	**Consultation end date**	Click here to enter a date.

Section 3 – Version Control		
Version	**Date Approved**	**Brief Summary of Changes**
1	31/01/2024	New document, based on previous St Helens & Knowsley Trust Corporate Governance Manual
	Click here to enter a date.	

Section 4 – Approval – *To be completed by Document Control*			
Document approved	☐ Approved ☐ Approved with minor amendments		
Assurance provided by author & Chair	☐ Minutes of meeting ☐ E-mail with Chair's approval		
Date approved	Click here to enter a date.	**Review date**	Click here to enter a date.

Section 5 – Withdrawal – *To be completed by Document Control*	
Reason for withdrawal	☐ No longer required ☐ Superseded
Assurance provided by author & Chair	☐ Minutes of meeting ☐ E-mail with Chair's approval
Date Withdrawn:	Click here to enter a date.

Contents

1. Executive Summary

Corporate governance is the system by which an organisation is directed and controlled, at its most senior levels, to achieve its objectives and meet the necessary standards of accountability and probity. Effective corporate governance, along with clinical governance, is essential for a 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. This is achieved through what the NHS calls “controls assurance”.

The NHS Act 2006 and subsequent regulations set out the legal framework within which the Trust operates. The Membership and Procedure Regulations set out who can be members of the Trust and how it should conduct its business. The Codes of Conduct and Accountability require Trust boards to adopt schedules of reservation and delegation of powers and to set out the financial framework within which the organisation operates.

Key documents in the Corporate Governance Framework for NHS Trusts requiring compliance by the Trust, its executive and Non-Executive directors, officers and employees are:

- The accountable officer memorandum;
- The codes of conduct and accountability issued by the Department of Health and Social Care.
- The Trust must also have agreed its own:
    - Standing Orders, as a framework for internal governance, and
    - Standing Financial Instructions as a framework for financial governance.

These documents together provide a regulatory framework for the business conduct of the Trust.

The Trust board will also need to appoint audit and remuneration committees and establish a framework for managing risk.

It is essential that all employees know of the existence of these documents and are aware of their responsibilities included within. To this end all directors, consultants, senior managers, directorate managers and heads of department have been issued with a copy of this manual and it is incumbent upon them to ensure that all staff in their charge are advised of its existence.

Any queries relating to the contents of these documents should be directed to the Director of Finance and Information or myself who will be pleased to provide clarification.

Chief Executive

2. Scope and Introduction

The Corporate Governance Manual contains the following key Trust policy documents governing the business conduct of the Trust:

- Standing Orders (SOs)
- Standing Financial Instructions (SFIs)
- Scheme of Reservation and Delegation of Powers (including table of delegated limits)

This policy applies to all staff and services within Mersey and West Lancashire Teaching Hospital NHS Trust.

3. Statement of Intent

The objective of this manual is to set out in a single document the regulatory framework for the Trust (its directors, managers and staff) which provides rules and guidelines on how the Trust conducts its business.

4. Definitions

Terminology

In the Standing Orders, Standing Financial Instructions: and Scheme of Reservation and Delegation the following definitions apply:

	Definition
The 2006 Act	National Health Service Act 2006 The consolidation repeals and re-enacts in its entirety the National Health Service Act 1977, which was itself a consolidation. It also incorporates provisions from: ▪ Health Act 2006 ▪ Health and Social Care (Community Health and Standards) Act 2003 ▪ National Health Service Reform and Health Care Professions Act 2002 ▪ Health and Social Care Act 2001, 2012 & 2022 ▪ Health Act 1999 ▪ Primary Care Act 1997 ▪ Health Authorities Act 1995 ▪ National Health Service and Community Care Act 1990.
Accounting Officer	The accounting officer has responsibility for the overall organisation, management and staffing of the Trust and for its procedures in financial and other matters. They shall be the Officer responsible and accountable for funds entrusted to the Trust in accordance with the NHS Trust Accounting Officer Memorandum. They shall be responsible for ensuring the proper stewardship of public funds and assets. The Chief Executive is the designated

	Accounting Officer
Board of Directors	the Board of Directors means the Chair, officer and non-officer members of the Trust collectively as a body.
Budget	a resource, expressed in financial or manpower terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.
Budget holder	The director or employee with delegated authority to manage finances (income and expenditure) for a specific area of the organisation.
Chair of the Board of Directors	is the person appointed by NHS England to lead the Board and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expression "the Chair of the Trust" shall be deemed to include the Deputy Chair of the Trust if the Chair is absent from the meeting or is otherwise unavailable.
Chief Executive	The chief officer of the Trust, appointed by the Board.
Committee	a committee or sub-committee created and appointed by the Board.
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.
Director	a member of the Board of Directors.
Director of Finance and Information	shall mean the chief finance officer and accounting officer of the Trust.

The Trust	Mersey and West Lancashire Teaching Hospitals NHS Trust
Funds held on Trust	those funds which the Trust holds at its date of incorporation, receives on distribution by statutory instrument, or chooses subsequently to accept under powers derived S.90 of the NHS Act 1977, as amended. Such funds may or may not be charitable.
Member	An officer or non-officer member of the Board as the context permits. Member in relation to the Board does not include its Chair.
Nominated Officer	an officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions.
Non-Officer member	A member of the Board who is not an officer of the Trust and is not to be treated as an officer by virtue of regulation 1(3) of the Membership, Procedure and Administration Arrangements Regulations.
Officer	an employee of the Trust or any other person holding a paid appointment or office with the Trust.
Partner	in relation to another person, a member of the same household living together as a family unit;
Secretary	a person appointed to act independently of the Board to provide advice on corporate governance issues to the Board and the Chair and monitor the Trust's compliance with the law, Standing Orders, and Department of Health and Social Care guidance.
Standing Financial Instructions	(SFIs) regulate the conduct of the Trust's financial matters
Standing Orders	(SOs) regulate the business conduct of the Trust

Note: All references to the masculine gender will be deemed to apply equally to the feminine gender when used within these instructions.

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

Wherever the term "employee" is used and where the context permits it shall be deemed to include employees of third parties contracted to the Trust when acting on behalf of the Trust (including nursing and medical staff and consultants practicing on the Trust premises and members of staff of the PFI contractor or Trust staff working for the contractor under retention of employment model).

5. Duties, Accountabilities and Responsibilities

Chief Executive – As the accountable officer for the Trust and policy sponsor, the Trust's Chief Executive Officer is required to ensure that the Trust has in place its own standing orders and standing financial instructions with a scheme of reservation and delegation of powers.

Director of Finance and Information – As the lead executive, the Trust's Director of Finance

and Information ensures that the corporate governance manual is periodically reviewed and appropriately distributed on behalf of the Chief Executive.

Assistant Director of Finance (Financial Services) – The Trust's Assistant Director of Finance (Financial Services) is expected to review and assist in the distribution of this policy, ensuring that it is consistent with other associated local policies, namely the Trust's Standards of Business Conduct and the Anti-Fraud, Bribery and Corruption Policy.

Internal Audit Manager – The Trust's internal audit service is expected to assist in the review of the manual and recommend to the Director of Finance and Information any changes where appropriate (eg. based on considered good practice).

Local Counter Fraud Specialist (LCFS) – The Trust's LCFS is expected to advise the Director of Finance and Information and Audit Committee of relevant changes in law and procedural rules associated with fraud, bribery, corruption and similar criminal activity that may impact on this policy, thereby ensuring the manual is up-to-date and relevant.

All directors, consultants, senior managers, directorate managers and heads of department - It is incumbent upon them to ensure that all staff in their charge are advised of its existence.

All Staff – All staff should be made aware of the manual's existence and appraise themselves of this manual and the duties/ responsibilities referred to within.

6. Standing Orders

6.1 Statutory Framework

Mersey and West Lancashire Teaching Hospitals NHS Trust (the Trust) is a body corporate which was established under the National Health Service Trust (Establishment) Order 2023 (SI 2023 No 711). The principle place of business of the Trust is Executive Office, 5th Floor Whiston Hospital, Warrington Road, Prescot, L35 5DR

NHS Trusts are governed by statute, mainly the National Health Service Act 2006, and the Health and Social Care Act, 2012. The statutory functions conferred on the Trust are set out in the NHS Act 2006 (Chapter 3 and Schedule 4) and in the Trust's Establishment Order.

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

The NHS Code of Governance for NHS Providers requires the Trust to adopt Standing Orders (S.O.s) for the regulation of its proceedings and business. The Trust must also adopt Standing Financial Instructions (SFIs) as an integral part of Standing Orders setting out the responsibilities of individuals.

6.2 NHS Framework

In addition to the statutory requirements, the Secretary of State, through the Department of Health and Social Care issues further directions and guidance. These are normally issued under cover of a circular or letter.

The Code of Accountability requires that, inter alia, Boards draw up a schedule of decisions reserved to the Board known as the 'Reservation of Powers', and ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives (a Scheme of Delegation). The code also requires the establishment of audit and remuneration committees with formally agreed terms of reference. The Code of Conduct makes various requirements concerning possible conflicts of interest of Board members.

The Code of Practice on Openness in the NHS (NHS Executive, 1995), as revised by the Freedom of Information Act, 2000 and the Environmental Information Regulations, 2004 sets out the requirements for public access to information on the NHS.

6.3 Delegation of Powers

The Trust has powers to delegate and make arrangements for delegation. The Standing Orders set out the detail of these arrangements. Under the Standing Order relating to the Arrangements for the Exercise of Functions the Trust is given powers to "make arrangements for the exercise, on behalf of the Trust of any of their functions by a committee, sub- committee or joint committee appointed by virtue of or by an officer of the Trust, in each case subject to such restrictions and conditions as the Trust thinks fit or as the Secretary of State may direct". Delegated powers are covered in a separate document (Scheme of Reservation and Delegation). This document has effect as if incorporated into the Standing Orders.

6.4 Standing Orders

It is the duty of the Chief Executive to ensure that existing Directors and officers and all new appointees are notified of and understand their responsibilities within Standing Orders and Standing Financial Instructions. Updated copies shall be issued to staff designated by the Chief Executive. New designated officers shall be informed in writing and shall receive copies where appropriate of SOs. The Director of Finance and Information will maintain a record of all recipients.

Standing Financial Instructions and Reservation of Powers and Scheme of Delegation shall have the effect as if incorporated into SOs.

Standing Orders shall be reviewed annually by the Trust. The requirement for review extends to all documents having the effect as if incorporated in SOs.

6.5 Policy Statements

The Trust Board will from time to time agree and approve Policy statements/ procedures which will apply to all or specific groups of staff employed by the Trust. The decisions to approve such policies and procedures will be recorded in an appropriate Trust Board minute and will be deemed where appropriate to be an integral part of the Trust's Standing Orders and Standing Financial Instructions. The Standing Orders and Standing Financial Instructions must be read in conjunction with the following guidance and any other issued by the Secretary of State for Health:

- Caldicott Guardian 1997;
- Human Rights Act 1998;
- Freedom of Information Act 2000.

These Standing Orders and Standing Financial Instructions must be read in conjunction with the following Policy statements:

- the Standards of Business Conduct (incorporating Managing Conflicts of Interest in the NHS) Policy for Trust staff;
- the staff Disciplinary and Appeals Procedures adopted by the Trust both of which shall have effect as if incorporated in these Standing Orders.

6.6 Chair's Responsibility

Save as permitted by law, at any meeting the Chair of the Trust shall be the final authority on the interpretation of Standing Orders (on which he/she should be advised by the Chief Executive or Board Secretary).

6.7 Terminology

Any expression to which a meaning is given in the Health Service Acts or in the Regulations or Orders made under the Acts shall have the same meaning in this interpretation and in addition. (See Definitions).

6.8 The Trust Board, Composition of Membership, Tenure and Role of Members

All business shall be conducted in the name of the Trust.

All funds received in trust shall be in the name of the Trust as corporate trustee. In relation to funds held on trust, powers exercised by the Trust as corporate trustee shall be exercised separately and distinctly from those powers exercised as a Trust.

The powers of the Trust established under statute shall be exercised by the Board meeting in public session except as otherwise provided in the Standing Orders.

The Trust has resolved that certain powers and decisions may only be exercised or made by the Board in formal session. These powers and decisions are set out in 'Reservation of Powers' and have effect as if

incorporated into the Standing Orders.

6.9 Composition of the Trust

In accordance with the Establishment Order and Membership and Procedure Regulations 1990 (as amended) the voting membership of the Board of the Trust shall comprise the Chair and six Non-Executive Directors (appointed by NHS England (NHSE), on behalf of the Secretary of State for Health), together with up to five Executive Directors. At least half of the membership of the Trust Board, excluding the Chair, shall be independent Non-Executive Directors.

In addition to the Chair, the Non-Executive Directors shall normally include:

- one appointee nominated to be the Deputy Chair
- one or more appointee who have recent relevant financial experience
- one or more appointee with a relevant clinical background or experience
- one nominated by the University of Liverpool

Appointees can fulfil more than one of the roles identified.

The Executive Directors will include:

- the Chief Executive
- the Director of Finance and Information
- the Medical Director
- the Director of Nursing, Midwifery and Governance
- Up to one other Executive Director to be awarded voting rights

The Board may appoint additional Executive Directors, in crucial roles in the Trust, to be non-voting members of the Trust Board.

Collective Responsibility - Legally there is no distinction between the Board duties of Executive and Non-Executive Directors, they both share responsibility for the direction and control of the organisation. All Directors are required to act in the best interest of the NHS. There are also statutory obligations such as health and safety that Board members need to meet. Each Director has a role in ensuring the probity of the organisation's activities and contributing to the achievement of its objectives in the best interest of patients and the wider public.

All Directors shall subscribe and adhere at all times to the principles contained in the Trust's Standards of Business Conduct.

NHS England has developed a fit and proper person test (FPPT) Framework in response to recommendations made by Tom Kark KC in his 2019 review of the FPPT (the Kark Review). This also takes into account the requirements of the Care Quality Commission (CQC) in relation to

directors being fit and proper for their roles

6.10 Terms of Office

The regulations governing the period of tenure of office of the Chair and Non-Executive Directors and the termination or suspension of office of the Chair and Non-Executive Directors are contained in the Membership and Procedure Regulations and as directed by NHS England, under its delegated authority from Secretary of State for Health.

6.11 Chair and Non-executive Directors

The Chair or Non-Executive Directors of an NHS Trust may resign their office at any time during the period of which they were appointed by giving notice in writing to NHS England.

Where during the period of directorship a Non-Executive Director of a trust is appointed Chair of the Trust, their tenure of office as a Non-Executive Director shall be terminated when their appointment as the Chair takes effect.

If NHS England are of the opinion that it is not in the interests of the health service for a person appointed as a Chair or Non-Executive Director of an NHS Trust to continue to hold office, NHS England on behalf of the Secretary of State may forthwith terminate the person's tenure of office.

If a Chair or Non-Executive Director of an NHS Trust has not attended a meeting of the Trust for a period of three months, NHS England on behalf of the Secretary of State shall forthwith terminate their tenure of office unless they are satisfied that-

(a) the absence was due to a reasonable cause; and

(b) the Chair or Non-Executive Director will be able to attend meetings of the Trust within such period as NHS England considers reasonable.

Where a person has been appointed the Chair or Non-Executive Director of an NHS Trust-

(a) if he/she becomes disqualified for appointment under regulation 11 Membership and Procedure Regulations 1990 (as amended) the appointing authority shall forthwith notify them in writing of such disqualification; or

(b) if it comes to the notice of the appointing authority that at the time of their appointment he/she was so disqualified it shall forthwith declare that he was not duly appointed and so notify them in writing, and upon receipt of any such notification, their tenure of office, if any, shall be terminated and he/she shall cease to act as Chair or Non-Executive Director.

If it appears to NHS England that the Chair or Non-Executive Director of an NHS Trust has failed to comply with regulation 20 (disclosure etc. on account of pecuniary interest) he/she may forthwith terminate that person's tenure of office.

6.12 Chief Executive and Director of Finance and Information

The Chief Executive and Director of Finance and Information shall hold office for as long as they hold the post in the Trust.

6.13 Other Executive Directors

The tenure of office of Executive Directors, other that the Chief Executive and Director of Finance and Information, shall be for such period as the relevant committee may specify on making the appointment.

If the relevant committee is of the opinion that it is not in the interests of the NHS Trust that an executive director other than the Chief Executive or Director of Finance and Information should continue to hold office as a Director the relevant committee shall forthwith terminate their tenure office.

If an executive director is suspended from their post in the Trust they shall be suspended from performing their function as a director for the period of the suspension.

An Executive Director other than the Chief Executive or Director of Finance and Information of an NHS Trust may resign their office at any time during the period for which they were appointed by giving notice in writing to the relevant committee.

6.14 Appointing Chief Executive & Other Directors

The Trust shall appoint a committee whose members shall be the Chair and Non-Executive Directors of the Trust whose function will be to appoint the Chief Executive as a Director of the Trust.

The Trust shall appoint a committee whose members shall be the Chair, the Non-Executive Directors and the Chief Executive whose function will be to appoint the other executive directors of the Trust

6.15 Appointment of Deputy Chair

For the purpose of enabling the proceedings of the Trust to be conducted in the routine absence of the Chair, the Chair, in consultation with the Chief Executive, may appoint a Non-Executive Director from amongst them to be Deputy Chair for such a period, not exceeding the remainder of their term as Non-Executive Director.

Any Non-Executive Director so appointed may at any time resign from the office of Deputy Chair by giving notice in writing to the Chair who may thereupon appoint another Non-Executive Director as Deputy Chair.

6.16 Powers of Deputy Chair

Where the Chair of an NHS Trust has died, or has otherwise ceased to hold

office or where he/she has been unable to perform their duties as Chair owing to illness, absence from England and Wales or any other cause, references to the Chair in the Schedule to these Regulations shall, so long as there is no Chair able to perform their duties, be taken to include references to the Deputy Chair.

6.17 Meetings of the Trust

All ordinary meetings of the Trust Board are public meetings. Members of the public can attend these meetings. As such they are considered to be meetings where the public may observe the decision-making process of the Trust. They are not open meetings where the public have a right to contribute to the debate. Contributions from the public at such meetings can be considered at the discretion of the Chair.

Members and Officers or any employee of the Trust in attendance shall not reveal or disclose the contents of papers marked 'In Confidence' or minutes headed 'Items Taken in Private' outside of the Trust, without the express permission of the Trust. This prohibition shall apply equally to the content of any discussion during the Board meeting which may take place on such reports or papers.

Exceptionally, there may be items of a confidential nature on the agenda of these ordinary meetings from which the public may be excluded. Such items will be business that:

- relates to a member of staff;
- relates to a patient;
- would commercially disadvantage the Trust if discussed in public; or,
- would be detrimental to the operation of the Trust.

The Trust shall set dates and times of regular Trust Board meetings for the forthcoming calendar year by the end of November of each year. Where part or whole of a meeting is to be open to the public official notice of the time, venue and agenda will be announced to the public via the Trust website.

Admission of the Public and the Press – The public and representatives of the press shall be afforded facilities to attend all formal meetings of the Board, either virtually or in person, but shall be required to withdraw upon the Board resolving as follows: "That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest" (Section 1(2) Public Bodies (Administration to Meetings) Act 1960).

The Chair (or person presiding the meeting) shall give such directions as he/she thinks fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Board's business shall be conducted without interruption

and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted. The public will be required to withdraw upon the Board resolving as follows: "That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Board to complete business without the presence of the public" (Section 1 (8) Public Bodies (Administration to Meetings Act 1960).

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

6.18 Calling Meetings

The ordinary meetings of the Board shall be held at regular intervals unless the Board shall by resolution otherwise decide. The meetings shall be held at such places as the Board may from time to time appoint.

The Chair may call a meeting of the Board at any time. If the Chair refuses to call a meeting after a request for that purpose, signed by at least one third of the whole number of directors, has been presented to them or if, without so refusing, the Chair does not call a meeting within seven days after such a request has been presented to them, such one third or more members shall forthwith call a meeting.

6.19 Notice of Meetings

Regular Meetings of the Trust – Agendas and supporting papers will be sent to members at least 5 days before the meeting, except in an emergency. Failure to serve such a notice on more than three Directors will invalidate the meeting. A notice shall be presumed to have been served at the time one day after sending.

Exceptional Meetings of the Trust – Before each meeting of the Trust, a notice of the meeting, specifying the business proposed to be transacted at it, and signed by the Chair or by an officer of the Trust authorised by the Chair to sign on their behalf shall be delivered to every Director/member, or sent by email, so as to be available to them at least three clear days before the meeting. Lack of service of the notice on any Director/member shall not affect the validity of a meeting.

Meetings Called by Directors – In the case of a meeting called by Directors in the event the Chair has not called the meeting, the notice shall be signed by those Directors and no business shall be transacted at the meeting other than that specified in the notice.

6.20 Agendas

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

A Director/member desiring a matter to be included on an agenda shall make their request in writing to the Chair at least 12 clear days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 12 days before a meeting may be included on the agenda at the discretion of the Chair.

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

6.21 Chair of Meeting

At any meeting of the Board, the Chair, if present, shall preside. If the Chair is absent from the meeting the Deputy Chair, if there is one and is present, shall preside. If the Chair and Deputy Chair are absent such Non-Executive Director as the Directors present shall choose shall preside.

If the Chair is absent from a meeting temporarily on the grounds of a declared conflict of interest the Deputy Chair, if present, shall preside.

The names of the Chair and Directors present at the meeting shall be recorded.

6.22 Annual Public Meeting

The Trust will publicise and hold an annual public meeting in accordance with the NHS Trusts (Public Meetings) Regulations 1991 (SI(1991)482). The meeting shall take place no later than 30 September each year. The Annual Report and Annual Accounts of the preceding year shall be presented at that meeting.

6.23 Notices of Motion

Notice of Motion -

(1) Subject to the provision of Standing Orders 'Motions: Procedure at and during a meeting' and 'Motions to rescind a resolution' a member of the Board wishing to move a motion shall send a written notice to the Chief Executive who will ensure that it is brought to the immediate attention of the Chair.

(2) The notice shall be delivered at least fifteen clear days before the meeting. The Chief Executive / Secretary shall include in the agenda for the meeting all notices so received that are in order and permissible under governing regulations. This Standing Order shall not prevent any motion being withdrawn or moved without notice on any business mentioned on the agenda for the meeting.

Emergency Motions -

Subject to the agreement of the Chair, and subject also to the provision of

Standing Order 'Motions: Procedure at and during a meeting', a member of the Board may give written notice of an emergency motion after the issue of the notice of meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. If in order, it shall be declared to the Board at the commencement of the business of the meeting as an additional item included in the agenda. The Chair's decision to include the item shall be final.

6.24 Motions: Procedure at and during a meeting

i) **Who may propose -** A motion may be proposed by the Chair of the meeting or any member present. It must also be seconded by another member.

ii) **Contents of motions -** The Chair may exclude from the debate at their discretion any such motion of which notice was not given on the notice summoning the meeting other than a motion relating to:

- the reception of a report;
- consideration of any item of business before the Board;
- the accuracy of minutes;
- that the Board proceed to next business;
- that the Board adjourn;
- that the question be now put.

iii) **Amendments to motions -** A motion for amendment shall not be discussed unless it has been proposed and seconded. Amendments to motions shall be moved relevant to the motion and shall not have the effect of negating the motion before the Board. If there are a number of amendments, they shall be considered one at a time. When a motion has been amended, the amended motion shall become the substantive motion before the meeting, upon which any further amendment may be moved.

iv) **Rights of reply to motions**

a) <u>Amendments</u>

The mover of an amendment may reply to the debate on their amendment immediately prior to the mover of the original motion, who shall have the right of reply at the close of debate on the amendment, but may not otherwise speak on it.

b) <u>Substantive/original motion</u>

The member who proposed the substantive motion shall have a right of reply at the close of any debate on the motion.

v) **Withdrawing a motion -** A motion, or an amendment to a motion, may be withdrawn.

vi) **Motions once under debate -** When a motion is under debate, no motion may be moved other than:

- an amendment to the motion;
- the adjournment of the discussion, or the meeting;
- that the meeting proceed to the next business;
- that the question should be now put;
- the appointment of an 'ad hoc' committee to deal with a specific item of business;
- that a member/director be not further heard;
- a motion under Section l (2) or Section l (8) of the Public Bodies (Admissions to Meetings) Act l960 resolving to exclude the public, including the press (see Standing Order).

In those cases where the motion is either that the meeting proceeds to the 'next business' or 'that the question be now put' in the interests of objectivity these should only be put forward by a member of the Board who has not taken part in the debate and who is eligible to vote.

If a motion to proceed to the next business or that the question be now put, is carried, the Chair should give the mover of the substantive motion under debate a right of reply, if not already exercised. The matter should then be put to the vote.

6.25 Motion to Rescind a Resolution

(1) Notice of motion to rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the member who gives it and also the signature of three other members, and before considering any such motion of which notice shall have been given, the Board may refer the matter to any appropriate Committee or the Chief Executive for recommendation.

(2) When any such motion has been dealt with by the Board it shall not be competent for any director/member other than the Chair to propose a motion to the same effect within six months. This Standing Order shall not apply to motions moved in pursuance of a report or recommendations of a Committee or the Chief Executive.

6.26 Chair's Ruling

Statements of Directors made at meetings of the Trust shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity (including procedure on handling motions) and any other matters shall be final including their interpretation of the Standing Orders and Standing Financial Instructions.

6.27 Voting

Save as provided under Suspension of Standing Orders - If a consensus decision is not reached at a meeting then the question shall be determined by a majority of the votes of the Directors present. In the case of any equality of votes, the Chair presiding the meeting shall have a second or casting vote.

All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the Directors present so request.

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 /member present voted or abstained.

If a Director/member so requests, their vote shall be recorded by name upon any vote (other than by paper ballot)

In no circumstances may an absent Director/member vote by proxy. Absence is defined as being absent at the time of the vote.

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 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.

6.28 Minutes

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

No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

The names of those in attendance at the meetings shall be recorded.

Any matters arising from the Minutes shall be subject to discussion at Chair's discretion. Where providing a record of a public meeting the minutes shall be made available to the public (required by Code of Practice on Openness in the NHS).

6.29 Joint Directors

Where a post of Executive Director is shared by more than one person:

(a) both persons shall be entitled to attend meetings of the Trust:

(b) either of those persons shall be eligible to vote in the case of agreement between them:

(c) in the case of disagreement between them no vote should

be cast;

(d) the presence of either or both of those persons shall count as one person for the purposes of Quorum, see below.

(e) If only one person attends the meeting, they shall be entitled to cast a vote.

6.30 Suspension of Standing Orders

Except where this would contravene any statutory provision or any direction made by the Secretary of State, any one or more of the Standing Orders (SOs) may be suspended at any meeting, provided that at least two-thirds of the Board are present, including one Executive Directors and one Non-Executive Directors, and that a majority of those present vote in favour of suspension.

- A decision to suspend SOs shall be recorded in the minutes of the meeting.
- A separate record of matters discussed during the suspension of SOs shall be made and shall be available to the Directors.
- No formal business may be transacted while SOs are suspended.
- The Audit Committee shall review every decision to suspend SOs.

6.31 Variation and Amendment of Standing Orders

These Standing Orders shall be amended only if:

- a notice of motion under the Standing Orders has been given; and
- upon recommendation of the Chair or Chief Executive included on the agenda for the meeting; and
- no fewer than half the total of the Trust's Non-Executive Directors vote in favour of amendment; and
- at least two-thirds of the Directors were present at the meeting where the variation or amendment was being discussed; and
- the variation proposed does not contravene a statutory provision or direction made by the Secretary of State.

6.32 Quorum

No business shall be transacted at a meeting of the Board unless 50% of the whole number of directors are present including at least one Executive Director and one Non-Executive Director.

An officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

If Chair or a member has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of

the declaration of a conflict of interest he/she 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.

The above requirement for at least one executive director to form part of the quorum shall not apply where the executive Directors are excluded from a meeting (for example when the Board considers the recommendations of the Remuneration and Terms of Service Committee).

6.33 Arrangements for the exercise of functions by delegation

Subject to the 'Scheme of Reservation and Delegation', and such directions as may be given by the Secretary of State, the Board may make arrangements for the exercise, on behalf of the Trust, of any of its functions by a Committee or Sub-Committee, appointed by virtue of the Standing Orders or by a Director /member or an officer of the Trust in each case subject to such restrictions and conditions as the Board thinks fit.

NHS Act 2006 allows for regulations to provide for the functions of Trusts to be carried out for the Trust by third parties. An NHS Trust may enter into arrangements for the carrying out, on such terms as the NHS Trust considers appropriate, of any of its functions jointly with any Commissioners or other NHS Trust, or any other body or individual.

Where a function is delegated by these regulations to another NHS body, the Trust has responsibility to ensure that the proper delegation is in place. In other situations, i.e. delegation to committees, sub committees or officers, the Trust retains full responsibility.

6.34 Framework for Delegation of Trust Board Authority

The ultimate responsibility for decisions taken under delegated powers remains with the Board, and the Trust must ensure that due regard has been given and can clearly demonstrate it has not come to an unreasonable decision.

To avoid possible allegations of unlawful exercise of discretion by the Board, a committee or Director/member acting under delegated powers must record in writing the matters which have been taken into account in reaching that decision, especially where significant sums or legal commitments are involved.

In making any decisions under delegated powers, a committee or Director/member must have due regard to the established policies of the Trust and shall not depart from them without due reason and consideration. Any such departure and the reason for it shall be drawn to the attention of the Board at the earliest opportunity.

In exercising any delegated power a committee or Director/member must

comply with any statutory provisions or requirements.

In cases of doubt or difficulty and/or where no policy guidelines exist, decisions should be referred to the Board.

The Board may require any particular delegated matter to be referred back to them for a decision.

6.35 Emergency Powers

The powers which the Board has retained to itself within these Standing Orders, may in emergency be exercised by the Chair and the Chief Executive after having consulted at least two Non-Executive Directors. The exercise of such powers by the Chair and the Chief Executive shall be reported to the next formal meeting of the Board for ratification in public session.

6.36 Delegation to Committees

The Board shall agree from time to time to the delegation of executive powers to be exercised by committees or sub-committees, which it has formally constituted in accordance with directions issued by the secretary of State. The constitution and terms of reference of these committees, sub-committees or joint committees, and their specific executive powers shall be approved by the Board, in respect of its sub-committees and appended within the Corporate Governance Manual.

When the Board is not meeting as the Trust in public session it shall operate as a committee and may only exercise such powers as may have been delegated to it by the Board in public session.

6.37 Delegation to Officers

Those functions of the Trust which have not been retained as reserved by the Board or delegated to other committee, sub-committee or joint committee shall be exercised on behalf of the Board by the Chief Executive. The Chief Executive shall determine which functions they will perform personally and shall nominate officers to undertake the remaining functions for which he/she will still retain accountability to the Board.

The Chief Executive shall prepare a scheme of delegation (as detailed within the 'Scheme of Reservation and Delegation') identifying their proposals which shall be considered and approved by the Board, subject to any amendment agreed during the discussion. The Chief Executive may periodically propose amendment to the Scheme of Reservation and Delegation which shall be considered and approved by the Board as indicated above.

Nothing in the Scheme of Reservation and Delegation shall impair the discharge of the direct accountability to the Board or the Director of Finance and Information or of any other executive director to provide information and advise the Board in accordance with any statutory or NHS England or Department of Health and Social Care requirements.

Outside these statutory requirements the role of the Director of Finance and

Information shall be accountable to the Chief Executive for operational matters.

The arrangements made by the Board as set out in the 'Scheme of Reservation and Delegation' shall have effect as if incorporated in these Standing Orders.

The Board must adopt a Reservation of Powers and Scheme of Delegation which define the powers retained by the Board. Any decision arising from these powers may only be made by the Board, subject to the Trust's Standing Orders relating to quorum.

6.38 Overriding 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 reported to the next formal meeting of the Board for action or ratification. All members of the Board and staff have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

6.39 Appointment of Joint Committees

Subject to such directions (and to guidance issued by the Department of Health and Social Care) as may be given by the Secretary of State, the Trust may appoint Committees of the Trust, or together with one or more Commissioners or other Trusts, appoint joint Committees, consisting wholly or partly of the Chair and members of the Trust or other health service bodies or wholly of persons who are not members of the Trust or other health service bodies in question.

A Committee or joint Committee appointed under this regulation may, subject to such directions as may be given by the Secretary of State or the Trust or other health service bodies in question, appoint Sub-Committees consisting wholly or partly of members of the Committee or joint Committee (whether or not they are members of the Trust or other health service bodies in question); or wholly of persons who are not members of the Trust or the other health service bodies or the Committee of the Trust or the other health service bodies in question.

The Standing Orders of the Trust, as far as they are applicable, shall apply with appropriate alteration to meetings of any Committees or Sub-Committee established by the Trust. In which case the term "Chair" is to be read as a reference to the Chair of other Committee as the context permits, and the term "member" is to be read as a reference to a member of other Committee also as the context permits. There is no requirement to hold meetings of Committees established by the Trust in public.

Each such Committee or Sub-Committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board), as the Board shall decide and shall be in accordance with any legislation and regulation or direction issued by the Secretary of

State. Such terms of reference shall have effect as if incorporated into the Standing Orders.

Committees may not delegate their executive powers to a Sub-Committee unless expressly authorised by the Board.

The Board shall approve the appointments to each of the committees which it has formally constituted. Where the Board determines and regulations permit that persons, who are neither Directors nor officers, shall be appointed to a committee, the terms of such appointment shall be determined by the Board subject to the payment of travelling and other allowances being in accordance with such sum as may be determined by the Secretary of State with the approval of the Treasury (see NHS & SC Act Sch 2 para 9).

Where functions are being carried out by Committees or Sub-Committees their members including those who are not Board members, are acting on behalf of the Trust. Members of Committees and Sub-Committees who are not Board members of the Trust, may claim certain travelling and other allowances but are not remunerated.

Where the Trust is required to appoint persons to a Committee and/or to undertake statutory functions as required by the Secretary of State, and where such appointments are to operate independently of the Trust such appointments shall be made in accordance with the regulations laid down by the Secretary of State.

The appointment of Board members to the Committees and Sub-Committees of the Trust comes to an end on the termination of their term of office as Board members.

6.40 Committee Structure

The following statutory Committees of the Board have been established:

a) **Audit Committee** - In line with the requirements of the NHS Audit Committee Handbook, NHS Codes of Conduct and Accountability, NHS Code of Governance for Provider Trusts and, an Audit Committee will be established and constituted to provide the Trust Board with an independent and objective review on its financial systems, financial information and compliance with laws, guidance, and regulations governing the NHS. The Terms of Reference will be approved by the Trust Board and reviewed on a periodic basis.

   A minimum of three Non-Executive Directors be appointed to the Audit Committee, unless the Board decides otherwise, of which one must have significant, recent and relevant financial experience.

b) **Remuneration and Terms of Employment Committee-** In line with the requirements of the NHS Codes of Conduct and Accountability, and the Code of Governance for NHS Provider Trusts , a Remuneration and Terms of Service Committee will be established and constituted.

   The committee will be comprised exclusively of Non-Executive Directors,

a minimum of three, who are independent of management.

The purpose of the Committee will be to determine the appropriate remuneration and terms of service for the Chief Executive and other Executive Directors including:

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

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

(iii) arrangements for termination of employment and other contractual terms.

c) Charitable Funds Committee- In line with its role as a corporate trustee for any funds held in trust, either as charitable or non-charitable funds, the Trust Board will establish a Charitable Funds Committee to administer those funds in accordance with any statutory or other legal requirements or best practice required by the Charities Commission.

d) Quality Committee -The Quality Committee meets 10 times a year once a month to review all aspects of quality. The Committee triangulates quality, activity and performance information to give a balanced overview of performance for different services, and those factors that can contribute towards improving or deteriorating outcomes. The Committee is supported by Councils that consider in detail issues around patient safety and experience as well as clinical effectiveness.

e) Finance and Performance Committee - The Finance and Performance Committee meets 10 times a year and reviews performance against financial and activity targets. The Finance and Performance Committee is supported in its work by Councils exploring performance information, procurement, cost improvements, IT and Estates and Facilities Management.

f) Strategic People Committee – The Strategic People Committee meets 10 times a year and provides assurance on the progress delivering the workforce, ED&I, Organisational development and Health Work and Wellbeing objectives agreed by the Board.

g) Executive Committee - The team of Executive Directors, led by a Chief Executive, is the senior operational management decision making group within the Trust and is responsible for planning, organising, directing and controlling the organisation's systems and resources to achieve objectives and quality improvement targets set by the Board. The Executive Committee exercises the authority delegated to the CEO and Directors to ensure that the organisation is effectively performance managed. The Executive Committee provides the Trust Board with evidence that the systems, policies and people in place to deliver operational performance are effective, comply with standards, are focused on key risks and are being appropriately managed.

The Full committee structure as approved by the Trust Board is provided with terms of reference for each of the committees in the Appendix section of the Corporate Governance Manual.

6.41 Confidentiality

A member of a Committee shall not disclose a matter dealt with by, or brought before, the Committee without its permission until the Committee shall have reported to the Board or shall otherwise have concluded on that matter.

A Director of the Trust or a member of a Committee shall not disclose any matter reported to the Board or otherwise dealt with by the Committee, notwithstanding that the matter has been reported or action has been concluded, if the Board or Committee resolves that it is confidential.

6.42 Declaration of Interests

The Code of Accountability and Code of Governance for NHS Provider Trusts requires Board members to declare interests, annually or as and when they arise, which are relevant and material to the NHS board of which they are a member. All existing Board members should declare such interests. Any Board members appointed subsequently should do so on appointment.

Interests, which should be regarded as “relevant and material”, are:

a) Directorships, including Non-Executive Directorships held in private companies or PLCs (with the exception of those of dormant companies).

b) Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.

c) Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.

d) A position of authority in a charity or voluntary organisation in the field of health and social care.

e) Any connection with a voluntary or other organisation contracting for NHS services.

f) research funding/grants that may be received by an individual or their department.

If Board Directors have any doubt about the relevance of an interest, this should be discussed with the Chair or Board Secretary. Financial Reporting Standards specify that influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

At the time Board Directors' interests are declared, they should be recorded in the Board minutes and the Register of Interests. Any changes in interests should be declared at the next Board meeting following the change occurring and recorded in the minutes of that meeting.

Board Directors' directorships of companies likely or possibly seeking to do business with the NHS should be published in the Trust's Annual Report. The

information should be kept up to date for inclusion in succeeding Annual Reports.

If it comes to the knowledge of an employee of the Trust that a contract in which they have a direct or indirect financial interest has been, or is proposed to be, entered into by the Trust he/she shall at once declare this position in writing to the Chief Executive.

During the course of a Board meeting, if a conflict of interest is established, the Director/members concerned should declare such likely conflict of interest and withdraw from the meeting, unless requested to remain by the Board members present. The Director/member should play no part in the relevant discussion or decision.

6.43 Register of Interests

The Chief Executive will ensure that a Register of Interests is established to record formally declarations of interests of Board or Committee members. The Register will include details of all directorships and other relevant and material interests which have been declared by both executive and Non-Executive Directors, as defined in the Standing Orders.

The Register of Interests shall be available to the public via the Trust publication scheme and shall be reviewed on an annual basis.

6.44 Disability of Directors in proceedings on account of pecuniary interest

Subject to the following provisions of this Standing Order, which is taken from the Membership Procedure Regulations 1990 (as amended), if the Chair or a member has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Trust Board at which the contract or other matter is the subject of consideration, he/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.

The Trust Board may exclude the Chair or a member of the Trust Board from a meeting of the Board while any contract, proposed contract or other matter in which that person has a pecuniary interest is under consideration.

Any remuneration, compensation or allowances payable to the Chair or a Director by virtue of the NHS (consolidation) Act 2006 Schedule 3 Part 1 para 10. (NHS Act 1997 Schedule 5A paragraph 11(4); 1999 Act Schedule 1) (pay and allowances) shall not be treated as pecuniary interest for the purpose of this regulation.

Subject to the Standing Orders and any conditions imposed by the Secretary of State, the Chair or a Director/member shall be treated for the purpose of this regulation as having indirectly a pecuniary interest in a contract, proposed contract or other matter if:

a) the Director/member, or a nominee of theirs, is a Director of a company or other body, not being a public body, with which the contract was made or

is proposed to be made which has a direct pecuniary interest in the other matter under consideration; or

b) the Director/member 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. In the case of married persons living together or co-habitees, the interest of one spouse/co-habitee shall, if known to the other, be deemed to be also the interest of that spouse/co-habitee.

For the sake of clarity the following definition of terms is to be used in interpreting this Standing Order.

'Spouse' shall include any person who lives with another person in the same household (any pecuniary interest one spouse shall, if known to the other spouse, be deemed to be an interest of that other spouse).

'Contract' shall include any proposed contract or other course of dealing.

The Chair or a Director/member shall not be treated as having pecuniary interest in any contract, proposed or other matter by reason only:

a) of their (or a person connected to them) membership of a company or other body if they have no beneficial interest in any securities of that company or other body;

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

c) the total nominal value of those securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less.

Provided however, that where paragraph (c) above applies the person shall nevertheless be obliged to disclose/declare their interest in accordance with the Standing Order.

It is important that members of the Board understand the need to be transparent. If there is any form of doubt about whether an interest is relevant - it should be declared immediately. Failure to do so may be classed as fraud/bribery/corruption and such matters will be referred to the Trust's Local Counter Fraud Specialist to investigate.

6.45 Powers of The Secretary of State

The Secretary of State may, subject to such conditions as he/she may think fit to impose, remove any disability imposed by this Standing Order in any case in which it appears to them in the interests of the National Health Service that the disability shall be removed.

6.46 Committees and Sub-Committees Responsibilities

This regulation applies to a Committee or Sub-Committee of the Trust as it applies to the Trust Board and applies to any member of any such Committee or Sub-Committee (whether or not he/she is also a Director of the Trust) as it applies to a Director of the Trust.

6.47 Policy

Staff must comply with the national guidance contained in the June 2017 NHS England guidance on managing conflicts of interest in the NHS. The following provisions should be read in conjunction with that guidance, Bribery Act 2010 and with the Trust's local policies on Standards of Business Conduct and Anti- Fraud, Bribery and Corruption.

It is the responsibility of all Trust staff to ensure that they are not placed in a position which risks, or appears to risk, conflict between their private interests and their official duties.

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

Breach of these provisions can render staff liable to dismissal and/or prosecution under the Bribery Act 2010. It is essential therefore that Directors and employees are transparent and understand the need to ensure that their actions cannot be misunderstood.

All staff should follow the correct reporting channels if they receive any form of gift or hospitality and seek further clarity from the Director of Finance and Information or another Executive Director if they are uncertain about what is acceptable.

6.48 Interest of Officers in Contracts

If it comes to the knowledge of a Director or an officer of the Trust that a contract in which they have any pecuniary interest not being a contract to which they are themselves a party, has been, or is proposed to be, entered into by the Trust they shall, at once, give notice in writing to the Chief Executive or Trust Secretary of the fact that they are 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.

An officer must also declare to the Chief Executive any other employment or business or other relationship of their partner, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict, with the interests of the Trust.

The Trust will require interests, employment or relationships so declared to be entered in a register of interests of staff.

It is important that members of the Board understand the need to be transparent. If there is any form of doubt about whether an interest is

relevant – it should be declared immediately. Failure to do so may be classed as fraud/bribery/corruption and such matters will be referred to the Trust's Local Counter Fraud Specialist to investigate.

6.49 Canvassing of, and Recommendations by, Directors in Relation to Appointments

Canvassing of Directors (members) of the Trust or members of any committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates.

A Director (members) of the Trust shall not solicit for any person any appointment under the Trust or recommend any person for such appointment: but this paragraph of this Standing Order shall not preclude a Director from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

Unsolicited informal discussions outside appointments panels or committees, should be declared to the panel or committee.

6.50 Relatives of Directors (members) or Officers

Candidates for any staff appointment shall when making application disclose in writing whether they are related to any Director or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render them liable to dismissal.

The Chair and every member and officer of the Trust shall disclose to the Trust Board any relationship with a candidate of whose candidature that Director or officer is aware. It shall be the duty of the Chief Executive to report to the Trust any such disclosure made.

On appointment, Directors (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the Trust whether they are related to any other Director or holder of any office under the Trust.

Where the relationship of an officer or another Director to a Director of the Trust is disclosed, the Standing Order headed `Disability of Directors in Proceedings on Account of pecuniary Interest' shall apply.

6.51 Custody of Seal

The Common Seal of the Trust shall be kept by the Chief Executive (or Secretary) in a secure place.

6.52 Sealing of Documents

Where it is necessary that a document shall be sealed, the seal shall be affixed in the presence of two Director duly authorised by the Chief Executive, and not also from the originating department, and shall be

attested by them.

6.53 Requirements to Seal

Use of the seal is required for:

(a) The sale or transfer or leasing (where the Trust is lessor) of any part of the Trust-owned estate (i.e. land and buildings)
(b) The purchase of land or buildings or leasing thereof (where the Trust is the lessee)
(c) Any other document where it is specifically requested by the other party to be signed under seal (e.g. contracts, lease agreements for equipment, etc.) Other contracts/documentation should be approved by an authorised signatory 'under hand', i.e. signed.

Before any material building, engineering, property or capital document is sealed it must be approved and signed by the Director of Finance and Information (or an officer nominated by them) and authorised and countersigned by the Chief Executive (or an officer nominated by them who shall not be within the originating directorate).

6.54 Register of Sealing

The Chief Executive shall keep a register, 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 or the Audit Committee at least annually. (The report shall contain details of the seal number, the description of the document and date of sealing).

6.55 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 Chief Executive or an officer acting on their behalf, 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.

The Chief Executive or nominated officers shall be authorised, by resolution of the Board, to sign on behalf of the Trust any agreement or other document (not required to be executed as a deed) the subject matter of which has been approved by the Board or committee or sub-committee to which the Board has delegated appropriate authority, as per the Reservation of Powers and Scheme of Delegation.

7. Standing Financial Instructions

7.1 Introduction

These Standing Financial Instructions (SFIs) are issued in accordance with

the Trust (Functions) Directions 2000 issued by the Secretary of State which require that each Trust shall agree 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. They shall have effect as if incorporated in the Standing Orders (SOs).

The Code of Conduct and Accountability in the NHS issued by the Department of Health and Social Care requires that each NHS organisation 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 SFIs are issued in accordance with the Code. They shall have effect as if incorporated in the SOs of the Trust.

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

These SFIs identify the financial responsibilities, which apply to everyone working for the Trust (see also below) and its constituent organisations including trading units. They do not provide detailed procedural advice. These statements should therefore be read in conjunction with the detailed departmental and financial procedure notes. The Director of Finance and Information must approve all financial procedures.

Should any difficulties arise regarding the interpretation or application of any of the SFIs then the advice of the Director of Finance and Information MUST BE SOUGHT BEFORE ACTING. The user of these SFIs should also be familiar with and comply with the provisions of the Trust's SOs.

FAILURE TO COMPLY WITH STANDING FINANCIAL INSTRUCTIONS AND STANDING ORDERS IS A DISCIPLINARY MATTER, WHICH COULD RESULT IN DISMISSAL.

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

7.2 Terminology

Guidance on terminology used can be found above.

Wherever the title Chief Executive, Director of Finance and Information, or

other nominated officer is used in these instructions, it shall be deemed to include such other directors or employees who have been duly authorised to represent them. Wherever the term "employee" is used and where the context permits it shall be deemed to include employees of third parties contracted to the Trust when acting on behalf of the Trust, including nursing and medical staff and consultants practising on the Trust premises and members of staff of the PFI contractor or trust staff working the contractor under retention of employment model.

7.3 Responsibilities and Delegation

The Board of Directors exercises financial supervision and control by:

- formulating the financial strategy;
- requiring the submission and approval of budgets within overall income;
- defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money) and by ensuring appropriate audit provision; and
- defining specific responsibilities placed on directors and employees as indicated in the Scheme of Delegation document.

The Board of Directors has resolved that certain powers and decisions may only be exercised by the Board of Directors in formal session. These are set out in the "Scheme of Reservation to the Board of Directors" document, published within the Scheme of Delegation. The Board of Directors will delegate responsibility for the performance of its functions in accordance with the Scheme of Delegation document adopted by the Trust.

Within the SFIs, it is acknowledged that the Chief Executive is ultimately accountable to the Board of Directors, and as the accounting officer for ensuring that the Board of Directors meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities, is responsible to the Board of Directors for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

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

It is a duty of the Chief Executive to ensure that existing directors and employees and all new appointees are notified of and understand their responsibilities within these Instructions. All staff shall be responsible for ensuring conformity with the Standing Orders, Standing Financial Instructions and financial procedures of the Trust.

The Director of Finance and Information is responsible for:

- implementing the Trust's financial policies and for co-ordinating any corrective action necessary to further these

policies; (The SFIs themselves do not provide detailed procedural advice. These statements should therefore be read in conjunction with the detailed departmental and financial procedure notes).

- 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;

- ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time;

and, without prejudice to any other functions of directors and employees to the Trust, the duties of the Director of Finance and Information include:

- the provision of financial advice to other members of the Board of Directors, and employees;
- the design, implementation and supervision of systems of internal financial control; and
- the preparation and maintenance of such accounts, certificates, estimates, records and financial reports as the Trust may require for the purpose of carrying out its statutory duties.

All directors and employees, severally and collectively, are responsible for:

- the security of the property of the Trust;
- avoiding loss;
- exercising economy and efficiency in the use of resources; and
- conforming with the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation.

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.

For all members of the Board and any employees who carry out a financial function, the form in which financial records are kept and the manner in which directors and employees discharge their duties must be to the satisfaction of the Director of Finance and Information.

7.4 Audit Committee

In accordance with Standing Orders the Board of Directors shall formally establish an Audit Committee, with clearly defines terms of reference and following guidance from the NHS Audit Committee Handbook, which will provide an independent and objective view of internal control by:

- overseeing Internal and External Audit services;
- reviewing financial and information systems and monitoring the integrity of the financial statements and reviewing of significant financial reporting judgements;
- the monitoring of compliance with Standing Orders and Standing Financial Instructions;
- reviewing schedules of losses and compensation and making recommendations to the Board of Directors.
- reviewing the effective implementation of corporate governance measures to enable the Trust to implement best practice as set out in appropriate guidance. This will include the Assurance Framework and control related disclosure statements, for example, the Annual Governance Statement and supporting assurance processes; together with any accompanying audit statement, prior to endorsement by the Board of Directors.
- reviewing aged debt reports with emphasis on over 90 day aged debt.
- review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.

The Board of Directors shall satisfy itself that at least one member of the Audit Committee has recent and relevant financial experience.

Where the Audit Committee considers there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the committee wish to raise, the Chair of the Audit Committee should raise the matter at a full meeting of the Board of Directors (to the Director of Finance and Information in the first instance.)

It is the responsibility of the Director of Finance and Information to ensure adequate internal and external audit services are provided and the Trust's Auditor Panel shall be involved in the selection process when an audit service provider is changed.

7.5 Director of Finance and Information

The Director of Finance and Information is responsible for:

- ensuring there are arrangements to review, evaluate and report on the effectiveness of internal control including the establishment of an effective internal audit function and the coordination of other assurance arrangements;
- ensuring that the internal audit is adequate and meets the NHS mandatory audit standards;
- deciding at what stage to involve the police in cases of fraud, misappropriation, and other irregularities not involving fraud, bribery or corruption;
- ensuring that an annual internal audit report is prepared for the consideration of the Audit Committee and the Board of Directors.

  The report must cover:

  i) a clear opinion on the effectiveness of internal controls in accordance with current assurance framework guidance issued by the Department of Health and Social Care including for example compliance with control criteria and standards,

  ii) major internal financial control weaknesses discovered,

  iii) progress on the implementation of internal audit recommendations,

  iv) progress against plan over the previous year,

  v) strategic audit plan,

  vi) a detailed plan for the coming year.

The Director of Finance and Information or designated auditors are entitled without necessarily giving prior notice to require and receive:

- access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;
- access at all reasonable times to any land, premises, members of the Board of Directors or employee of the Trust;
- the production of any cash, stores or other property of the Trust under a member of the Board of Directors or employee's control; and
- explanations concerning any matter under investigation.

7.6 Internal Audit

The NHS Trust Accounting Officer Memorandum requires the Trust to have an internal audit function.

The role of internal audit embraces two key areas:

- The provision of an independent and objective opinion to the Accountable Officer, the Board of Directors and the Audit Committee on the degree to which risk management, control and governance support the achievement of the organisation's agreed objectives.

- The provision of an independent and objective consultancy service specifically to help line management improve the organisation's risk management, control and governance arrangements.

Internal Audit will review, appraise and report upon:

- the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;
- the adequacy and application of financial and other related management controls;
- the suitability of financial and other related management data;
- the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from: fraud and other offences including bribery or corruption, waste, extravagance, inefficient administration, poor value for money or other causes.

Internal Audit shall also independently review Assurance Statements in accordance with guidance from the Department of Health and Social Care.

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 Information must be notified immediately.

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

The Head of Internal Audit shall be accountable to the Director of Finance and Information. The reporting system for internal audit shall be agreed between the Director of Finance and Information, the Audit Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Internal Audit Manual. The reporting system shall be reviewed at least every 3 years. Where, in exceptional circumstances, the use of normal reporting channels is thought to limit the objectivity of the audit, the Head of Internal Audit shall have access to report direct to the Chair or a non-executive member of the Trust's Audit Committee.

Managers in receipt of audit reports referred to them, have a duty to take appropriate remedial action within the agreed time-scales specified within the report. The Director of Finance and Information shall identify a formal review process to monitor the extent of compliance with audit recommendations. Where appropriate remedial action has failed to take place within a reasonable period, the matter shall be reported to the Director of Finance and Information.

7.7 External Audit

The External Auditor is appointed by the Public Sector Audit Appointments Ltd and paid for by the Trust and will be appointed by the Trust. The Auditor Panel must ensure a cost- efficient service. If there are any problems relating to the service provided by the External Auditor, then this should be raised with the External Auditor and referred on to the appointing body if the issue cannot be resolved.

7.8 Fraud, Bribery and Corruption

The Chief Executive and Director of Finance and Information shall monitor and ensure compliance with the anti-fraud, bribery and corruption NHS Counter Fraud Authority NHS Counter Fraud Standards for Providers.

The Trust shall nominate a suitable person to carry out the duties of the Local Fraud Specialist as specified by the NHS Counter Fraud Authority NHS Counter Fraud Manual.

The Local Fraud Specialist shall report to the Trust Director of Finance and Information and shall work with the staff from NHS Counter Fraud Authority as specified in the NHS Counter Fraud Authority NHS Counter Fraud Manual.

The Local Fraud Specialist will provide a written plan and report, at least annually on counter fraud work within the Trust.

7.9 Preparation and approval of business plans / Service Development Strategy (Local Delivery Plan) and budgets

The Chief Executive will compile and submit to the Board of Directors a Strategic Direction document (Local Delivery Plan) that encompasses an annual business plan and takes into account financial targets and forecast limits of available resources. The annual business plan / Integrated Business Plan (Local Delivery Plan) will contain:

- a statement of the significant assumptions on which the plan is based;
- details of major changes in workload, delivery of services or resources required to achieve the plan.

Prior to the start of the financial year the Director of Finance and Information

will, on behalf of the Chief Executive, prepare and submit budgets relating to income and expenditure for approval by the Board of Directors. Such budgets will:

- be in accordance with the aims and objectives set out in the Trust's annual business plan / Integrated Business Plan, and the commissioners' local delivery plans;
- accord with workload and manpower plans;
- be produced following discussion with appropriate budget holders;
- be prepared within the limits of available funds;
- identify potential risks;
- be based on reasonable and realistic assumptions

The Director of Finance and Information shall monitor the financial performance against budgets, periodically review it and report to the Board of Directors. Any significant variances should be reported by the Director of Finance and Information to the Board of Directors as soon as they come to light and the Board of Directors shall be advised of action to be taken in respect of such variances.

All budget holders must provide information as required by the Director of Finance and Information to enable budgets to be compiled.

All budget holders will sign up to their allocated budgets at the commencement of each financial year.

The Director of Finance and Information has a responsibility to ensure that adequate training is delivered on an on-going basis to all budget holders to help them manage successfully.

7.10 Budgetary delegation

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:

- the amount of the budget;
- the purpose(s) of each budget heading;
- individual and group responsibilities;
- authority to exercise virement;
- achievement of planned levels of service; and
- the provision of regular reports.

The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board of Directors.

Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Director of Finance and Information.

7.11 Budgetary control and reporting

The Director of Finance and Information will devise and maintain systems of budgetary control. These will include:

- regular financial reports to the Board of Directors in a form approved by the Board of Directors containing:
    - vii) income and expenditure to date showing trends and forecast year-end position;
    - viii) balance sheet, including movements in working capital,
    - ix) cash flow statement and details of performance within Prudential Borrowing Code.
    - iii) capital project spend and projected out-turn against plan,
    - iv) explanations of any material variances from plan/budget;
    - v) details of any corrective action where necessary and the Chief Executive's and/or Director of Finance and Information's view of whether such actions are sufficient to correct the situation;

- the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;
- investigation and reporting of variances from financial, and workload budgets;

- the monitoring of management action to correct variances;
- arrangements for the authorisation of budget transfers;
- advising the Chief Executive and Board of Directors of the consequences of changes in policy, pay awards and other events and trends affecting budgets and shall advise on the economic and financial impact of future plans and projects; and.
- review of the bases and assumptions used to prepare the budgets.

In the performance of these duties the Director of Finance and Information will have access to all budget holders on budgetary matters and shall be provided with such financial and statistical information as is necessary.

Each budget holder is responsible for ensuring that:

- any likely overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the Board of Directors;
- officers shall not exceed the budget limit set;
- 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,
- no permanent employees are appointed without the approval of the

Chief Executive other than those provided for in the budgeted establishment as approved by the Board of Directors.

The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Annual Business Plan/Integrated Business Plan and a balanced budget.

7.12 Capital expenditure

The general rules applying to delegation and reporting shall also apply to capital expenditure. The particular applications relating to capital are included within this document. A Project Sponsor will be identified who will assume responsibility for the budget relating to the scheme.

7.13 Financial returns

The Chief Executive is responsible for ensuring that the appropriate financial monitoring forms are submitted to the requisite organisation within the specified time-scales.

7.14 Annual Accounts and Reports

The Director of Finance and Information, on behalf of the Trust, will:

(a) prepare financial returns in accordance with the accounting policies and guidance given by the Department of Health and Social Care and the Treasury, the Trust's accounting policies, and international financial reporting standards insofar as they apply to the NHS;

(b) prepare and submit annual financial reports to the Department of Health and Social Care certified in accordance with current guidelines;

(c) submit financial returns to the Department of Health and Social Care for each financial year in accordance with the timetable prescribed by the Department of Health and Social Care.

The Trust's annual accounts must be audited by an auditor appointed by the Trust. Prior to the financial period 2017/18 NHS trusts' external auditors were appointed by Public Sector Audit Appointments Ltd (from April 2015) and the Audit Commission prior to that. The Trust's audited annual accounts must be presented to a public meeting and made available to the public.

7.15 Annual Reports

The Trust will publish an annual report, in accordance with guidelines on local accountability, and present it at a public meeting. The document will comply with the Department of Health and Social Care's Manual for Accounts. A Quality Account will also be prepared by the Director of Nursing, Midwifery and Governance on behalf of the Trust.

7.16 Bank and Government Banking Service Accounts

The Director of Finance and Information is responsible for managing the Trust banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. In line with 'Cash Management in the NHS' trusts should minimise the use of commercial bank accounts and consider using Government Banking Service (GBS) accounts for all banking services.

The Board of Directors shall approve the banking arrangements.

The Director of Finance and Information is responsible for:

- bank accounts and GBS accounts; and other forms of working capital financing that may be available from the Department of Health and Social Care.
- establishing separate bank accounts for the Trust's non-exchequer funds;
- ensuring payments made from bank or GBS accounts do not exceed the amount credited to the account except where arrangements have been made;
- reporting to the Board of Directors all arrangements made with the Trust's bankers for accounts to be overdrawn (together with the remedial action taken);

All accounts should be held in the name of the Trust. No officer other than the Director of Finance and Information shall open any account in the name of the Trust or for the purpose of furthering Trust activities.

7.17 Banking procedures

The Director of Finance and Information will prepare detailed instructions on the operation of bank and GBS accounts, which must include:

- the conditions under which each bank and GBS account is to be operated;
- the limit to be applied to any overdraft; and
- those authorised to sign cheques or other orders drawn on the Trust's accounts.

The Director of Finance and Information must advise the Trust's bankers in writing of the conditions under which each account will be operated.

The Director of Finance and Information shall approve security procedures for any cheques issued without a hand-written signature e.g. lithographed. Manually produced cheques shall be signed by the authorised officer(s) in accordance with the bank mandate.

All cheques shall be treated as controlled stationery, in the charge of a duly designated officer controlling their issue.

7.18 Tendering and Review

The Director of Finance and Information will review the commercial banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Trust's business banking.

Competitive tenders should be sought at least every 5 years. The results of the tendering exercise should be reported to the Board of Directors. This review is not applicable to GBS accounts.

7.19 Income, fees and charges and security of cash, cheques and other negotiable instruments

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

All such systems shall incorporate, where practicable, in full the principles of internal check and separation of duties.

The Director of Finance and Information is also responsible for the prompt banking of all monies received.

7.20 Fees and charges other than Trust Contract

The Trust shall follow the Department of Health and Social Care's advice in the 'Costing Manual' in setting prices for NHS service agreements.

The Director of Finance and Information is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health and Social Care or by Statute. 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. See also Standing Orders.

All employees must inform the Director of Finance and Information promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

7.21 Debt recovery

The Director of Finance and Information is responsible for the appropriate recovery action on all outstanding debts, including a formal follow-up procedure for all debtor accounts. Overpayments should be detected (or preferably prevented) and recovery initiated.

Income not received should be dealt with in accordance with losses

procedures.

7.22 Security of cash, cheques and other negotiable instruments

The Director of Finance and Information is responsible for:

- approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable. No form of receipt which has not been specifically authorised by the Director of Finance and Information should be issued.
- ordering and securely controlling any such stationery;
- 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
- prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

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

Staff shall be informed in writing on appointment of their responsibilities and duties for the collection, handling or disbursement of cash, cheques etc.

All cheques, postal orders, cash etc., shall be banked promptly intact under arrangements approved by the Director of Finance and Information.

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.

Any loss or shortfall of cash, cheques or other negotiable instruments, however occasioned, shall be the monitored and recorded within the Finance Department. Any significant trends should be reported to the Director of Finance and Information and Internal Audit via the incident reporting system. Where there is prima facie evidence of fraud, bribery or corruption this should follow the form of the Trust's Anti-Fraud, Bribery and Corruption Policy and the guidance provided by the NHS Counter Fraud Authority. Where there is no evidence of fraud, bribery or corruption the loss should be dealt with in line with the Trust's Losses and Compensations Procedures.

7.23 NHS Service agreements for provision of services

The Chief Executive, as the Accountable Officer, is responsible for ensuring the Trust enters into suitable Service Level Agreements (SLA) with service

commissioners for the provision of NHS services.

All SLAs should aim to implement the agreed priorities contained within the Local Delivery Plan (LDP) and wherever possible, be based upon integrated care pathways to reflect expected patient experience. In discharging this responsibility, the Chief Executive should take into account:

- the standards of service quality expected;
- the relevant national service framework (if any);
- the provision of reliable information on cost and volume of services;
- the NHS National Performance Assessment Framework;
- that SLAs build where appropriate on existing Joint Investment Plans;
- that SLAs are based on integrated care pathways.

A good SLA will result from a dialogue of clinicians, users, carers, public health professionals and managers. It will reflect knowledge of local needs and inequalities. This will require the Chief Executive to ensure that the Trust works with all partner agencies involved in both the delivery and the commissioning of the service required. The SLA will apportion responsibility for handling a particular risk to the party or parties in the best position to influence the event and financial arrangements should reflect this. In this way the Trust can jointly manage risk with all interested parties.

The Chief Executive, as the Accountable Officer, will need to ensure that regular reports are provided to the Board detailing actual and forecast income from the SLA. This will include information on costing arrangements, which increasingly should be based upon Healthcare Resource Groups (HRGs). Where HRGs are unavailable for specific services, all parties should agree a common currency for application across the range of SLAs.

7.24 Non Commercial Contract

Where the Trust enters into a relationship with another organisation for the supply or receipt of other services – clinical or non-clinical, the responsible officer should ensure that an appropriate non-commercial contract is present and signed by both parties. This should incorporate:

- A description of the service and indicative activity levels
- The term of the agreement
- The value of the agreement
- The lead officer
- Performance and dispute resolution procedures
- Risk management and clinical governance agreements.

Non-commercial contracts should be reviewed and agreed on an annual basis or as determined by the term of the agreement so as to ensure value for money and to minimise the potential loss of income.

7.25 Terms of Service, allowances and payment of members of the Board of Directors and Employees

In accordance with Standing Orders the Board of Directors shall establish a Remuneration and Terms of Service Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

The Committee will:

- determine the appropriate remuneration and terms of service for the Chief Executive and other executive directors (and other senior employees), including: all aspects of salary (including any performance-related elements/bonuses); provisions for other benefits, including pensions and cars; arrangements for termination of employment and other contractual terms;
- make such recommendations about the remuneration and terms of service of executive directors (and other senior employees) to ensure they are fairly rewarded for their individual contribution to the Trust - having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such staff where appropriate;
- monitor and evaluate the performance of the Chief Executive who, in turn, will monitor and evaluate the performance of the other executive directors (and other senior employees) to make recommendations to the Remuneration Committee; and
- advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

The decisions of the Committee will be recorded and shared with all the Non-Executive Board Directors.

The Trust will pay allowances to the Chair and non-officer members of the Board in accordance with instructions issued by the Secretary of State for Health.

7.26 Funded establishment

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

The funded establishment of any department may not be varied without the approval of the Chief Executive or individual nominated within the relevant section of the Scheme of Reservation and Delegation. The Finance Department are responsible for verifying that funding is available.

7.27 Staff appointments

No Executive Director or employee may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration unless authorised to do so by the Chief Executive; and within the limit of their approved budget and funded establishment as defined in the Scheme of Reservation and Delegation.

The Board of Directors will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc., for employees.

7.28 Processing of the payroll

The Director of Human Resources in conjunction with the Director of Finance and Information is responsible for:

- specifying timetables for submission of properly authorised time records and other notifications;
- the final determination of pay and allowances; including verification that the rate of pay and relevant conditions of service are in accordance with current agreements.
- making payment on agreed dates; and
- agreeing method of payment.

The Director of Human Resources will issue instructions regarding:

- verification and documentation of data;
- the timetable for receipt and preparation of payroll data and the payment of employees and allowances;
- maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;
- security and confidentiality of payroll information;
- checks to be applied to completed payroll before and after payment;
- authority to release payroll data under the provisions of the Data Protection Act;
- methods of payment available to various categories of employee;
- procedures for payment by cheque, bank credit, or cash to employees; -
- procedures for the recall of cheques and bank credits
- pay advances and their recovery;
- maintenance of regular and independent reconciliation of pay control accounts;
- separation of duties of preparing records and handling cash; and
- a system to ensure the recovery from leavers of sums of money and property

due by them to the Trust.

Appropriately nominated managers have delegated responsibility for:

- processing a signed copy of the contract/appointment form and such other documentation as may be required immediately upon an employee commencing duty.
- submitting time records, and other notifications in accordance with agreed timetables;
- completing time records and other notifications in accordance with the Director of Human Resource's instructions and in the form prescribed by the Director of Human Resources; and
- submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's resignation, termination or retirement. Where an employee fails to report for duty in circumstances that suggest they have left without notice, the Director of Human Resources must be informed immediately. In circumstances where theft might be suspected this must be reported to the Trust's Security Management Specialist or the Director of Finance and Information or the Police.

Regardless of the arrangements for providing the payroll service, the Director of Human Resources in conjunction with the Director of Finance and Information shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

7.29 Contracts of employment

The Board of Directors shall delegate responsibility to a manager for ensuring that all employees are issued with a Contract of Employment in a form approved by the Board of Directors and which complies with employment and Health & Safety legislation and dealing with variations to, or termination of, contracts of employment.

7.30 Non pay expenditure – Delegation of Authority

The Board of Directors will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget holders.

The Chief Executive will set out:

- the list of managers who are authorised to place requisitions for the supply of goods and services should be updated and reviewed on an ongoing basis and annually by the Supplies Department; and
- where the authorisation system is computerised the list will be maintained within the computerised system and the 'signature' will be in the form of electronic authorisation in accordance with the

access and authority controls maintained within the computerised system; and
- the maximum level of each requisition and the system for authorisation above that level.

The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

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

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 Department shall be sought. Where this advice is not acceptable to the requisitioner, the Director of Finance and Information (and/or the Chief Executive) shall be consulted.

The Director of Finance and Information shall be responsible for the prompt payment of properly authorised accounts and claims in accordance with the Better Payment Practice Code (BPPC). Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

The Director of Finance and Information will:
- advise the Board of Directors regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in Scheme of Reservation and Delegation and regularly reviewed;
- prepare procedural instructions where not already provided in the Scheme of Delegation or procedure notes for budget holders on the obtaining of goods, works and services incorporating the thresholds;
- be responsible for the prompt payment of all properly authorised accounts and claims;
- be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

    - A list of directors/employees (including specimens of their signatures) authorised to approve or incur expenditure. Where the authorisation system is computerised the list will be maintained within the computerised system and the 'signature' will be in the form of electronic authorisation in accordance with the access and authority controls maintained within the computerised system.

    - 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.

- A timetable and system for submission to the Director of Finance and Information of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

- Instructions to employees regarding the handling and payment of accounts within the Finance Department.

- be responsible for ensuring that payment for goods and services is only made once the goods and services are received, (except as below).

Prepayments outside of normal commercial arrangements, for example fully comprehensive maintenance contracts, rental, insurance are only permitted where exceptional circumstances apply. In such instances:

- 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.
- the appropriate officer in conjunction with the Procurement Department must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet their commitments;
- the Director of Finance and Information will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the EU public procurement rules where the contract is above a

stipulated financial threshold);

- the Budget Holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Chief Executive if problems are encountered.

Official Orders must be consecutively numbered; be in a form approved by the Director of Finance and Information; state the Trust terms and conditions of trade; and only be issued to, and used by, those duly authorised by the Chief Executive.

Managers must ensure that they comply fully with the guidance and limits specified by the Director of Finance and Information and that:

- 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 and Information in advance of any commitment being made;

- Contracts above specified thresholds are advertised and awarded in accordance with Public Contract Regulations 2015 GATT rules on public procurement and comply with the White Paper on Standards, Quality and International Competitiveness (CMND 8621);

- 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;

- Where an officer certifying accounts relies upon other officers to do preliminary checking, they shall wherever possible, ensure that those who check delivery or execution of work act independently of those who have placed orders and negotiated prices and terms.

No order shall be issued to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars; conventional hospitality, such as lunches in the course of working visits;

All offers of gifts or hospitality should be dealt with in accordance with the Trust's Standards of Business Conduct. Breach of these provisions can render staff liable to dismissal and/or prosecution under the Bribery Act 2010. For more information – see the Trust's Standards of Business Conduct Policy. No requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Director of Finance and Information on behalf of the Chief Executive;

All goods, services, or works are ordered on an official order except works and services executed in accordance with a contract and purchases from petty cash or on purchasing cards;

Verbal orders must only be issued very exceptionally - by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order, and clearly marked "Confirmation Order".

Orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

Goods are not taken on trial or loan in circumstances that could commit the Trust to a future un-competitive purchase;

Changes to the list of directors/employees authorised to certify invoices are notified to the Director of Finance and Information;

Purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Director of Finance and Information;

Petty cash records are maintained in a form as determined by the Director of Finance and Information; and,

Orders are not required to be raised for utility bills, NHS Recharges; audit fees and ad hoc services such as private hospital fees. Payments must be authorised in accordance with the delegated limits set for non pay.

The Chief Executive and Director of Finance and Information shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within CONCODE and the NHS Trust Capital Accounting Manual. The technical audit of these contracts shall be the responsibility of the relevant Director.

Under no circumstances should goods be ordered through the Trust for personal or private use.

7.32 Joint finance arrangements with local authorities and voluntary bodies

Payments to local authorities and voluntary organisations made under the powers of section 28A of the NHS Act shall comply with procedures laid down by the Director of Finance and Information which shall be in accordance with these Acts.

7.33 Public Dividend Capital

The Director of Finance and Information will advise the Board concerning

the Trust's ability to pay dividends on, and repay Public Dividend Capital and any proposed new borrowing, within the limits set by the Department of Health and Social Care. The Director of Finance and Information is also responsible for reporting periodically to the Board concerning the PDC debt and all loans and overdrafts.

The Board will agree the list of employees (including specimens of their signatures) who are authorised to make short term borrowings on behalf of the Trust. This must contain the Chief Executive and the Director of Finance and Information.

The Director of Finance and Information must prepare detailed procedural instructions concerning applications for loans and overdrafts.

All short-term borrowings should be kept to the minimum period of time possible, consistent with the overall cashflow position, represent good value for money, and comply with the latest guidance from the Department of Health and Social Care (DHSC)/NHS England (NHSE).

Any short-term borrowing must be with the authority of two members of an authorised panel, one of which must be the Chief Executive or the Director of Finance and Information. The Board must be made aware of all short term borrowings at the next Board meeting.

All long-term borrowing must be consistent with the plans outlined in the current LDP and be approved by the Trust Board. Also, in respect of borrowing and capital investment, reference should be made to the Capital Regime and Investment Business Case Approvals Guidance for NHS Trusts produced by NHSE.

7.34 Investment

Temporary cash surpluses must be held only in such public or private sector investments as notified by the Secretary of State and authorised by the Board.

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

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

7.35 Capital investment

The Chief Executive:

- shall ensure that there is an adequate appraisal and approval

process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;

- is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost; and
- shall ensure that the capital investment is not undertaken without the availability of resources to finance all revenue consequences, including capital charges.

For capital expenditure proposals the Chief Executive shall ensure (in accordance with the limits outlined in the Scheme of Delegation):

- that a business case (in line with the guidance contained within the NHS England Capital guidance* is produced setting out:
  - an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs; and
  - appropriate project management and control arrangements; and
  - the involvement of appropriate Trust personnel and external agencies; and
- that the Director of Finance and Information has certified professionally to the costs and revenue consequences detailed in the business case.

For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of “CONCODE/Estatecode” and the NHS England Capital guidance*. Stage payments should be in line with those authorised by the Project Manager utilising values from the Quantity Surveyor.

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

The Director of Finance and Information shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

The approval of a capital programme shall not constitute approval for expenditure on any scheme.

The Chief Executive shall issue to the manager responsible for any scheme: specific authority to commit expenditure; authority to proceed to tender; approval to accept a successful tender

The Chief Executive will issue a scheme of delegation for capital

investment management in accordance with “CONCODE/Estatecode” and the NHS England Capital guidance* guidance and the Trust's Standing Orders.

The Director of Finance and Information shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.
(* Or any successor manual or guidance should that become defunct.)

7.36 Private finance

Powers of NHS trusts to enter into externally financed development agreements as defined in the NHS Act 2006 (formally NHS (Private Finance Act 1997).

The powers of an NHS trust include power to enter into externally financed development agreements. For the purposes of this paragraph, an agreement is an externally financed development agreement if it is certified as such in writing by the Secretary of State. The Secretary of State may give a certificate under this paragraph if (a) in his opinion the purpose or main purpose of the agreement is the provision of facilities or services in connection with the discharge by the NHS trust of any of its functions, and (b) a person proposes to make a loan to, or provide any other form of finance for, another party in connection with the agreement.

If an NHS trust enters into an externally financed development agreement it may also, in connection with that agreement, enter into an agreement with a person who falls within sub-paragraph in relation to the externally financed development agreement. “Another party” means any party to the agreement other than the NHS trust. The fact that an agreement made by an NHS trust has not been certified under this paragraph does not affect its validity.

The Trust should normally test for PFI when considering capital procurement. When the Board proposes, or is required, to use finance provided by the private sector the following should apply:
(a) The Director of Finance and Information shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector,
(b) Where the sum involved exceeds delegated limits, the business case must be referred to the appropriate DOH for approval or treated as per current guidelines.
(c) The proposal must be specifically agreed by the Trust in the light of such professional advice as should reasonably be sought in particular with regard to vires.
(d) The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

7.37 Asset registers

The Chief Executive is responsible for the maintenance of registers of assets,

taking account of the advice of the Director of Finance and Information concerning the form of any register and the method of updating, and arranging for a physical check of assets against the Asset Register to be conducted periodically.

The Trust shall maintain an Asset Register recording fixed assets.

Additions to the fixed Asset Register must be clearly identified to an appropriate budget holder and be validated by reference to:

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

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).

The Director of Finance and Information shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

The value of each asset shall be adjusted to current values in accordance with methods specified in the Group Accounting Manual issued by the Department of Health and Social Care.

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

The Director of Finance and Information shall calculate depreciation in line with the Trust Accounting Policies.

(* Or any successor manual or guidance should that become defunct.)

7.38 Security of assets

The overall control of fixed assets is the responsibility of the Chief Executive advised by the Director of Finance and Information.

Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Director of Finance and Information. This procedure shall make provision for:

- recording managerial responsibility for each asset;

- identification of additions and disposals;
- identification of all repairs and maintenance expenses;
- physical security of assets;
- periodic verification of the existence of, condition of, and title to, assets recorded;
- identification and reporting of all costs associated with the retention of an asset; and
- reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

All significant discrepancies revealed by verification of physical assets to fixed Asset Register shall be notified to the Director of Finance and Information.

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

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

Where practical, assets should be marked as Trust property.

7.39 Stock, Stores and Receipt of goods

Stocks are defined as those goods normally utilised in day to day activity, but which at a given point in time have not been used or consumed. There are three broad types of store:

a) Controlled stores - specific areas designated for the holding and control of goods;
b) Wards & departments - goods required for immediate usage to support operational services.
c) Manufactured Items - where goods and consumables are being made or processes are being applied which add to the raw material cost of the goods.

Such stocks should be kept to a minimum and for controlled stores and other significant stores (as determined by the Director of Finance and Information) should be subjected to an annual stocktake or perpetual inventory procedures; and valued at the lower of cost and net realisable value.

Subject to the responsibility of the Director of Finance and Information for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Chief Executive. The day-to-day

responsibility may be delegated by them to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Director of Finance and Information. 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.

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

The Director of Finance and Information shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses. Stocktaking arrangements shall be agreed with the Director of Finance and Information and there shall be a physical check covering all items in store at least once a year.

Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Director of Finance and Information.

The designated manager shall be responsible for a system approved by the Director of Finance and Information for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles (see Disposal of Assets Policy) The designated Officer shall report to the Director of Finance and Information any evidence of significant overstocking and of any negligence or malpractice (see also Disposals and Condemnations, Losses and Special Payments). Procedures, within this document, for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

7.40 Receipt of Goods

A delivery note shall be obtained from the supplier at the time of delivery and shall be signed by the person receiving the goods. All goods received shall be checked, by the appropriate department, as regards quantity and/or weight and inspected as to quality and specification. Instructions shall be issued to staff covering the procedures to be adopted in those cases where a delivery note is not available.

All goods received shall be entered onto an appropriate goods received/stock record (whether a computer or manual system) on the day of receipt. If goods received are unsatisfactory, the records shall be marked accordingly. Further, where the goods received are found to be unsatisfactory, or short on delivery, they shall only be accepted on the authority of the designated officer and the supplier shall be notified immediately.

For goods supplied via the NHS Supply Chain central warehouses, the Chief Executive shall identify those authorised to requisition and accept

goods from the store. The authorised person shall check receipt against the delivery note to satisfy themselves that the goods have been received. The Finance Department will make payment on receipt of an invoice. This may also apply for high-level low volume items such as stationery.

7.41 Issue of Stocks

Where a 'topping up' system is used, a record shall be maintained as approved by the Director of Finance and Information. Regular comparisons shall be made of the quantities issued to wards/departments etc. and explanations recorded of significant variations.

All transfers and returns shall be recorded on forms/systems provided for the purpose and approved by the Director of Finance and Information.

7.42 Disposals and condemnations

The Director of Finance and Information must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers in accordance with the Trust's Disposal of Assets policy.

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 and Information of the estimated market value of the item, taking account of professional advice where appropriate.

All unserviceable articles shall be:

a) condemned or otherwise disposed of by an employee authorised for that purpose by the Director of Finance and Information;

b) recorded by the condemning officer in a form approved by the Director of Finance and Information which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Director of Finance and Information.

The condemning officer shall satisfy themself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Director of Finance and Information who will take the appropriate action.
See Disposal of Assets Policy

7.43 Losses and special payments

The Director of Finance and Information must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments. The Director of Finance and Information must also prepare a fraud response plan that sets out the action to be

taken both by persons detecting a suspected fraud and those persons responsible for investigating it.

Any employee or officer discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Director of Finance and Information who will liaise with the Chief Executive or inform an officer charged with responsibility for responding to concerns involving loss confidentially. This officer will then appropriately inform the Director of Finance and Information who will liaise with the Chief Executive.

Where a criminal offence is suspected, the Director of Finance and Information must immediately inform the police if theft or arson is involved. In cases of fraud, bribery or corruption or of anomalies which may indicate fraud, bribery or corruption, the Director of Finance and Information must inform their Local Counter Fraud Specialist.

For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial the Director of Finance and Information must immediately notify: the Board of Directors, the External Auditor, the local Security Management Specialist and the Police.

Within limits delegated by the Department of Health and Social Care the Board of Directors shall approve the writing-off of all losses and special payments in accordance with the Scheme of Delegation.

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

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

The Director of Finance and Information shall maintain a Losses and Special Payments Register in which write-off action is recorded. All losses and special payments must be reported to the Audit Committee.

7.44 Compensation Claims

The Trust is committed to effective and timely investigation and response to any claim which includes allegations of clinical negligence, employee and other compensation claims. The Trust will follow the requirements and note the recommendations of the Department of Health and Social Care, and NHS Resolution in the management of claims. Every member of staff is expected to co-operate fully, as required, in assessment and management of each claim.

The Trust will seek to reduce the incidence and adverse impact of clinical negligence, employee and other litigation by:

- Adopting prudent risk management strategies including continuous review.

- Implementing in full the NHS Complaints Procedure, thus providing an alternative remedy for some potential litigants.
- Adopting a systematic approach to claims handling in line with the best current and cost effective practice.
- Following guidance issued by NHS Resolution relating to clinical negligence.
- Achieving the Standards for Better Health.
- Implementing an effective system of Clinical Governance

The Deputy Chief Executive is responsible for clinical negligence: for managing the claims process and informing the Board of Directors of any major developments on claims related issues.

7.45 Information Technology - Responsibilities and duties of the Director of Finance and Information

The Director of Finance and Information, 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 they are responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998 (updated 2000) and the Computer Misuse Act 1990.
b) 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 adequate controls exist to maintain the security, privacy, accuracy and completeness of financial data sent via transmission networks.
e) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as they may consider necessary are being carried out.

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

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

7.46 Responsibilities and duties of other Directors and Officers in relation to computer systems of a general application

In the case of computer systems which are proposed General Applications (i.e. normally those applications which the majority of NHS organisations wish to sponsor jointly) all responsible directors and employees will send to the Director of Finance and Information:

a) details of the outline design of the system;
b) in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

7.47 Contracts for Computer Services with other health bodies or outside agencies

The Director of Finance and Information 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.

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

7.48 Requirement for Computer Systems which have an impact on corporate financial systems

Where computer systems have an impact on corporate financial systems the Director of Finance and Information shall satisfy himself that:

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

7.49 Risk Assessment

The Director of Finance and Information shall ensure that risks to the Trust arising from the use of IT are effectively identified and considered and appropriate action taken to mitigate or control risk. This shall include the

preparation and testing of appropriate disaster recovery plans.

7.50 Patient's Property

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.

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;

and that the Trust will not accept responsibility or liability for patients' property brought into its premises, unless it is handed in for safe custody and a copy of an official patient's property record is obtained as a receipt.

The Director of Finance and Information 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. The said instructions shall cover the necessary arrangements for withdrawal of cash or disbursement of money held in accounts of patients who are incapable of handling their own financial affairs. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

A patient's property record, in a form determined by the Director of Finance and Information shall be completed in respect of the following:

a) property handed in for safe custody by any patient (or guardian as appropriate); and

b) property taken into safe custody having been found in the possessions of:
   - mentally disordered patients
   - confused and/or disorientated patients
   - unconscious patients
   - patients dying in hospital
   - patients found dead on arrival at hospital (property removed by police)

c) A record shall be completed in respect of all persons in category b, including a nil return if no property is taken into safe custody.

The record shall be completed by a member of the hospital staff in the presence of a second member of staff and the patient (or representative) where practicable. It shall then be signed by both members of staff and by the patient, except where the latter is restricted by physical or mental incapacity. Any alterations shall be validated by signature as required in the original entry on the record.

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

Patients' income, including pensions and allowances, shall be dealt with in accordance with current Department of Works and Pensions instructions. For long stay patients, the Chief Executive shall ensure that positive action is taken to use their funds effectively and so reduce balances accruing.

Refunds of cash handed in for safe custody will be dealt with in accordance with current Department of Works and Pensions instructions. Property other than cash, which has been handed in for safe custody, shall be returned to the patient as required, by the officer who has been responsible for its security. The return shall be receipted by the patient or guardian as appropriate and witnessed.

The disposal of property of deceased patients shall be effected by the officer who has been responsible for its security, such disposal shall be in accordance with written instructions issued by the Director of Finance and Information, in particular, where cash or valuables have been deposited for safe custody, they shall only be released after written authority has been given by the Director of Finance and Information. Such authority shall include details of the lawful kin or other person entitled to the cash and valuables in question.

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.

Property handed over for safe custody shall be placed into the care of the appropriate administrative staff. Where there are no administrative staff present, in which case the property shall be placed in the secure care of the most senior member of nursing staff on duty.

In respect of deceased patients, if there is no will and no lawful next of kin the property vests in the Crown and particulars shall, therefore, be notified to the Treasury Solicitor.

Any funeral expenses necessarily borne by the Trust are a first charge on a deceased persons estate. Where arrangements for burial or cremation are not made privately, any element of the estate held by the Trust may be appropriated towards funeral expenses, upon the authorisation of the Director of Finance and Information.

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.

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.

7.51 Funds held on Trust

The Trust has a responsibility as a corporate trustee for the management of funds it holds on trust. The management processes may overlap with those of the organisation of the Trust, the trustee responsibilities must be discharged separately and full recognition given to its dual accountabilities to the Charity Commission.

The reserved powers of the Board of Directors and the Scheme of Delegation make clear where decisions where discretion must be exercised are to be taken and by whom.

As management processes overlap most of the sections of these Standing Financial Instructions will apply to the management of funds held on trust.

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.

Charitable Funds are those gifts, donations and endowments made under the relevant charities legislation and held on trust for purposes relating to the Trust and the objectives of which are for the benefit of the NHS in England. They are administered by the Board of Directors acting as Trustees.

The Director of Finance and Information shall maintain such accounts and records as may be necessary to record and protect all transactions and funds of the Trust as trustees of non-exchequer funds, including an Investment Register.

7.52 Existing Charitable Funds

The Director of Finance and Information shall arrange for the administration of all existing funds. A “Deed of Establishment” must exist for every fund and detailed codes of procedure shall be produced covering every aspect of

the financial management of charitable funds, for the guidance of fund managers. The Deed of Establishment shall identify the restricted nature of certain funds, and it is the responsibility of fund managers, within their delegated authority, and the Charitable Funds Committee, to ensure that funds are utilised in accordance with the terms of the Deed.

The Director of Finance and Information shall periodically review the funds in existence and shall make recommendations to the Charitable Funds Committee regarding the potential for rationalisation of such funds within statutory guidelines.

The Director of Finance and Information shall ensure that all funds are currently registered with the Charities Commission in accordance with the Charities Act 1993 or subsequent legislation.

7.53 New Charitable Funds

The Director of Finance and Information shall recommend the creation of a new fund where funds and/or other assets received for charitable purposes cannot adequately be managed as part of an existing fund. All new funds must be covered by a Deed of Establishment and must be formally approved by the Charitable Funds Committee.

The Deed of Establishment for any new fund shall clearly identify, inter alia, the objects of the new fund, the nominated fund manager, the estimated annual income and, where applicable, the Charitable Funds Committee's power to assign the residue of the fund to another fund contingent upon certain conditions e.g. discharge of original objects.

7.54 Sources of New Funds

All gifts accepted shall be received and held in the name of the Charity and administered in accordance with the Charity's policy, subject to the terms of specific funds. As the Charity can accept gifts only for all or any purposes relating to the NHS, officers shall, in cases of doubt, consult the Director of Finance and Information before accepting any gift. Advice to the Board of Directors on the financial implications of fund raising activities by outside bodies or organisations shall be given by the Director of Finance and Information.

All gifts, donations and proceeds of fund-raising activities, which are intended for the Charity's use, must be handed immediately to the Director of Finance and Information via the Cash Office to be banked* to the Charitable Funds bank account. (* Where it is administratively expedient in the first instance to process funds through the Trust's Exchequer account, then these should be transferred at the earliest opportunity to the Charitable Funds bank account.)

In respect of Donations, the Director of Finance and Information shall:

- Provide guidelines to officers of the Trust as to how to proceed when offered funds. These will include:

  i) The identification of the donors intentions;
  ii) Where possible, the avoidance of creating excessive numbers of funds;
  iii) The avoidance of impossible, undesirable or administratively difficult objects;
  iv) Sources of immediate further advice; and
  v) Treatment of offers for personal gifts (see Trust's Standards of Business Conduct Policy).

- Provide secure and appropriate receipting arrangements, which will indicate that donations have been accepted directly into the appropriate fund and that the donor's intentions have been noted and accepted.

In respect of Legacies and Bequests, the Director of Finance and Information shall be kept informed of and record all enquiries regarding legacies and bequests. Where required, the Director of Finance and Information shall:

- Provide advice covering any approach regarding:

  i) the wording of wills;

  ii) the receipt of funds/other assets from executors;

- After the death of a testator all correspondence concerning a legacy shall be dealt with on behalf of the Charity by the Director of Finance and Information who alone shall be empowered to give an executor a good discharge.
- Where necessary, obtain grant of probate, or make application for grant of letters of administration;
- Be empowered to negotiate arrangements regarding the administration of a Will with executors and to discharge them from their duty; and
- Be directly responsible, in conjunction with the Charitable Funds Committee, for the appropriate treatment of all legacies and bequests.

In respect of fund-raising, the final approval for major appeals will be given by the Board of Directors. Final approval for smaller appeals will be given by the Charitable Funds Committee. The Director of Finance and Information shall:

- Advise on the financial implications of any proposal for fund-raising activities;
- Deal with all arrangements for fund-raising by and/or on behalf of the Charity and ensure compliance with all statutes and regulations;
- Be empowered to liaise with other organisations/persons raising funds for the Charity and provide them with an adequate discharge;

- Be responsible for alerting the Charitable Funds Committee and the Board of Directors to any irregularities regarding the use of the Charity's name or its registration numbers; and
- Be responsible for the appropriate treatment of all funds received from this source.

In respect of Trading Income (see also NHS Charitable Funds Guidance), the Director of Finance and Information shall:

- Be primarily responsible, along with designated fund managers, for any trading undertaken by the Charity; and
- Be primarily responsible for the appropriate treatment of all funds received from this source.

In respect of Investment Income, the Director of Finance and Information shall be responsible for the appropriate treatment of all dividends, interest and other receipts from this source (see below).

7.55 Investment Management

The Charitable Funds Committee shall be responsible for all aspects of the management of the investment of charitable funds as delegated under the terms of the approved investment policy. The issues on which the Director of Finance and Information shall be required to provide advice to the Charitable Funds Committee shall include:

- the formulation of investment policy which meets statutory requirements (Trustee Investment Act 1961) with regard to income generation and the enhancement of capital value;
- the appointment of advisers, brokers and, where appropriate, investment fund managers and the Director of Finance and Information shall recommend the terms of such appointments; and for which written agreements shall be signed by the Chief Executive;
- pooling of investment resources and the preparation of a submission to the Charity Commission for them to make a scheme;
- the participation by the Charity in common investment funds and the agreement of terms of entry and withdrawal from such funds;
- that the use of assets shall be appropriately authorised in writing and charges raised within policy guidelines;
- the review of the performance of brokers and fund managers;
- the reporting of investment performance.

The Director of Finance and Information shall prepare detailed

procedural instructions concerning the receiving, recording, investment and accounting for Charitable Funds.

7.56 Expenditure from Charitable Funds

Expenditure from Charitable Funds shall be managed by the Charitable Funds Committee on behalf of the Board of Directors. In so doing the committee shall be aware of the following:

- the objects of various funds and the designated objectives;
- the availability of liquid funds within each trust;
- the powers of delegation available to commit resources;
- the avoidance of the use of exchequer funds to discharge endowment fund liabilities (except where administratively unavoidable), and to ensure that any indebtedness to the Exchequer shall be discharged by trust funds at the earliest possible time;
- that funds are to be spent rather than preserved, subject to the wishes of the donor and the needs of the Trust; and
- the definitions of "charitable purposes" as agreed by the Department of Health and Social Care with the Charity Commission.

Delegated authority to incur expenditure which meets the purpose of the funds are set out in the Scheme of Delegations; exceptions are as follows:

- Any staff salaries/wages costs require Charitable Funds Committee approval
- No funds are to be "overdrawn" except in the exceptional circumstance that Charitable Funds Committee approval is granted.

7.57 Banking Services

The Director of Finance and Information shall advise the Charitable Funds Committee and, with its approval, shall ensure that appropriate banking services are available in respect of administering the Charitable Funds. These bank accounts should permit the separate identification of liquid funds to each trust where this is deemed necessary by the Charity Commission.

7.58 Asset Management

Assets in the ownership of or used by the Trust, shall be maintained along with the general estate and inventory of assets of the Trust. The Director of Finance and Information shall ensure:

- that appropriate records of all donated assets owned by the Trust are maintained, and that all assets, at agreed valuations are brought to account;
- that appropriate measures are taken to protect and/or to replace assets. These to include decisions regarding insurance, inventory

control, and the reporting of losses;

- that donated assets received on trust shall be accounted for appropriately;
- that all assets acquired from Charitable Funds which are intended to be retained within the funds are appropriately accounted for.

7.59 Reporting

The Director of Finance and Information shall ensure that regular reports are made to the Charitable Funds Committee and Board of Directors with regard to, inter alia, the receipt of funds, investments and expenditure.

The Director of Finance and Information shall prepare annual accounts in the required manner, which shall be submitted, to the Board of Directors within agreed timescales.

The Director of Finance and Information shall prepare an annual trustees' report and the required returns to the Charity Commission for adoption by the Charitable Funds Committee.

7.60 Accounting and Audit

The Director of Finance and Information shall maintain all financial records to enable the production of reports as above and to the satisfaction of internal and external audit.

Distribution of investment income to the charitable funds and the recovery of administration costs shall performed on a basis determined by the Director of Finance and Information.

The Director of Finance and Information shall ensure that the records, accounts and returns receive adequate scrutiny by internal audit during the year. They will liaise with external audit and provide them with all necessary information.

The Charitable Funds Committee shall be advised by the Director of Finance and Information on the outcome of the annual audit.

7.61 Taxation and Excise Duty

The Director of Finance and Information shall ensure that the Charity's liability to taxation and excise duty is managed appropriately, taking full advantage of available concessions, through the maintenance of appropriate records, the preparation and submission of the required returns and the recovery of deductions at source.

7.62 Tendering and Contract Procedure - Duty to Comply

The procedure for making all contracts by or on behalf of the Trust shall comply with the Standing Orders and Standing Financial Instructions (except

where Suspension of Standing Orders is applied).

The Trust shall comply as far as is practicable with the requirements of the Public Contract Regulations 2015 and the Provider Selection Regime 2023. Department of Health and Social Care "Capital Investment Manual" and “Estate code” in respect of capital investment and estate and property transactions. In the case of management consultancy contracts the Trust shall comply as far as is practicable with Department of Health and Social Care guidance "The Procurement and Management of Consultants within the NHS".

The Trust should have policies and procedures in place for the control of all tendering activity carried out via e-tendering systems

The Trust should take all reasonable steps to ensure that they give consideration to the Bribery Act 2010 during a tender or contract process. More information can be found in the Trust’s Standards of Business Conduct policy.

7.63 EU Directives Governing Public Procurement

Since EU Exit, EU Directives have been superseded by the Public Contract Regulations 2015 and prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in the Standing Orders and Standing Financial Instructions

7.64 Formal Competitive Tendering

The Trust shall ensure that competitive tenders are invited for:

- the supply of goods, materials and manufactured articles and
- for the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the Department of Health and Social Care);
- for the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); and for disposals.

Where the Trust elects to invite tenders for the supply of healthcare these Standing Financial Instructions shall apply as far as they are applicable to the tendering procedure.

Formal tendering procedures are not required where:

- the estimated expenditure or income does not, or is not reasonably expected to, exceed the limit set in the Scheme of Reservation and Delegation, (this figure to be reviewed annually); or
- the supply is proposed under special arrangements negotiated by the Department of Health and Social Care in which event the said special arrangements must be complied with; or

- regarding disposals as set out in Standing Financial Instruction 'Disposals and Condemnations'.

As long as not breaching PCR 2025 or PSR 2023 formal tendering procedures **may be waived** in the following circumstances:

- in very exceptional circumstances where the Chief Executive decides that formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures, and the circumstances are detailed in an appropriate Trust record;
- where the requirement is covered by an existing contract;
- where national agreements are in place and have been approved by the Board of Directors;
- where a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members;
- where the timescale genuinely precludes competitive tendering but failure to plan the work properly would not be regarded as a justification for a single tender;
- where specialist expertise is required and is available from only one source;
- when the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate;
- there is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering;
- for the provision of legal advice and services providing that any legal firm or partnership commissioned by the Trust is regulated by the Law Society for England and Wales for the conduct of their business (or by the Bar Council for England and Wales in relation to the obtaining of Counsel's opinion) and are generally recognised as having sufficient expertise in the area of work for which they are commissioned.

  The Director of Finance and Information will ensure that any fees paid are reasonable and within commonly accepted rates for the costing of such work.
- where allowed and provided for in the NHS England Capital guidance*

The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.

Where it is decided that competitive tendering is not applicable and should be

waived, the fact of the waiver and the reasons should be documented and recorded in an appropriate Trust record and reported to the Audit Committee at each meeting.

7.65 Fair and Adequate Competition

Where the exceptions set out in within this document apply, the Trust shall ensure that invitations to tender are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate, and in no case less than two firms/individuals, having regard to their capacity to supply the goods or materials or to undertake the services or works required. If less than two are provided it remains the discretion of the Director of Finance and Information as to proceed.

7.66 List of Approved Firms

The trust will not hold list of approved firms as each contract will be reviewed on most advantageous principles (MAT)

7.67 Building and Engineering Construction Works

Competitive Tendering cannot be waived for building and engineering construction works and maintenance (other than in accordance with Concode) without Departmental of Health approval.

Items which subsequently breach thresholds after original approval - Items estimated to be below the limits set in this Standing Financial Instruction for which formal tendering procedures are not used which subsequently prove to have a value above such limits shall be reported to the Chief Executive and Director of Finance and Information, and be recorded in an appropriate Trust record.

(* Or any successor manual or guidance should that become defunct.)

7.68 Contracting/Tendering Procedure

Invitation to tender

(i) All invitations to tender shall be issued by an e-tendering system that bears an audit trail of when tenders were sent and when they were opened

(Where an e-tendering software package is used the supplier's response will be completed on-line and uploaded into a secure electronic mailbox until the opening time).

(ii) Every tender for goods, materials, services or disposals shall embody such of the NHS Standard Contract Conditions as are applicable.

(iii) Every tender for building or engineering works (except for maintenance work, when legal requirements and HBN guidance shall be followed)

shall embody or be in the terms of the current edition of one of the Joint Contracts Tribunal Standard Forms of Building Contract or Department of the Environment (GC/Wks) Standard forms of contract amended to comply with concode; or, when the content of the work is primarily engineering, the General Conditions of Contract recommended by the Institution of Mechanical and Electrical Engineers and the Association of Consulting Engineers (Form A), or (in the case of civil engineering work) the General Conditions of Contract recommended by the Institute of Civil Engineers, the Association of Consulting Engineers and the Federation of Civil Engineering Contractors. These documents shall be modified and/or amplified to accord with Department of Health and Social Care guidance and, in minor respects, to cover special features of individual projects.

7.69 Receipt and safe custody of tenders

The Chief Executive or their nominated representative will be responsible for the receipt, endorsement and safe custody of tenders received until the time appointed for their opening. Clear audit trials on the e-tendering system will provide evidence of this.

An e-tender system will hold all the tender information and this information must only be accessed by the Procurement team and/or Chief Executive at the appropriate time

7.70 Opening tenders and Register of tenders

(i) As soon as practicable after the date and time stated as being the latest time for the receipt of tenders, they shall be opened on the e-tendering system by the Procurement Department and not those from the originating department. There will be an audit trail of who has opened the tender and when

All actions and communications by both procurement staff and suppliers are recorded within the system audit reports).

(ii) The 'originating' Department will be taken to mean the department sponsoring or commissioning the tender.

(iii) The involvement of Finance Department staff in the preparation of a tender proposal will not preclude the Director of Finance and Information or any approved Senior Manager from the Finance Department from serving as one of the two senior managers to open tenders.

(iv) All Executive Directors/members will be authorised to open tenders regardless of whether they are from the originating department provided that the other authorised person opening the tenders with them is not from the originating department.

The Trust's Company Secretary will count as a Director for the purposes of opening tenders.

(v) Every tender received shall be marked with the date of opening this will be held within the e-tendering system

(vi) A register shall be maintained by the Chief Executive, or a person authorised by them, to show for each set of competitive tender invitations despatched:

- the name of all firms individuals invited;
- the names of firms individuals from which tenders have been received;
- the date the tenders were opened;
- the persons present at the opening;
- the price shown on each tender;
- a note where price alterations have been made on the tender.

Each entry to this register shall be signed by those present.

A note shall be made in the register if any one tender price has had so many alterations that it cannot be readily read or understood.

(vii) Incomplete tenders, i.e. those from which information necessary for the adjudication of the tender is missing, and amended tenders i.e., those amended by the tenderer upon their own initiative either orally or in writing after the due time for receipt, but prior to the opening of other tenders, should be dealt with in the same way as late tenders. (See also below).

7.71 Admissibility

If for any reason the designated officers are of the opinion that the tenders received are not strictly competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Chief Executive.

Where only one tender is sought and/or received, the Chief Executive and Director of Finance and Information shall, as far practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Trust.

7.72 Late tenders

Unless there are long term e-tendering system issues, late tenders are not to be accepted. If there are long term issues and these have been flagged by the supplier in reasonable time, then there may be grounds for an extension- to all suppliers

7.73 Acceptance of formal tenders

Any discussions with a tenderer which are deemed necessary to clarify

technical aspects of their tender before the award of a contract will not disqualify the tender.

The lowest tender, if payment is to be made by the Trust, or the highest, if payment is to be received by the Trust, may be accepted unless there are good and sufficient reasons to the contrary. A detailed specification and weighting will be applied when issuing tenders and this will outline the acceptance criteria. It is accepted that for professional services such as management consultancy, the lowest price does not always represent the best value for money. Other factors affecting the success of a project include:

- experience and qualifications of team members;
- understanding of client's needs;
- feasibility and credibility of proposed approach;
- ability to complete the project on time.

Where other factors are taken into account in selecting a tenderer, these must be clearly recorded and documented in the contract file, and the reason(s) for not accepting the lowest tender clearly stated.

No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.

The use of these procedures must demonstrate that the award of the contract was:

(a) not in excess of the going market rate / price current at the time the contract was awarded;

(b) that best value for money was achieved.

All tenders should be treated as confidential and should be retained for inspection.

7.74 Tender reports to the Board of Directors

Reports to the Board of Directors will be made on an exceptional circumstance basis only.

(a) Building and Engineering Construction Works

(i) Invitations to tender shall be made only to firms included on the approved framework compiled in accordance with this Instruction or on the separate maintenance lists compiled in accordance with legislation and HBN guidance.

(ii) tenderers shall ensure that when engaging, training, promoting or dismissing employees or in any conditions of employment, shall not discriminate against any person and must follow all UK legislation on equality

(iii) Firms shall conform at least with the requirements of the Health and Safety at Work Act and any amending and/or other related legislation concerned with the health, safety and welfare of workers and other persons, and to any relevant British Standard Code of Practice issued by the British Standard Institution. Firms must provide to the appropriate manager a copy of its safety policy and evidence of the safety of plant and equipment, when requested.

(b) Financial Standing and Technical Competence of Contractors

The Director of Finance and Information may make or institute any enquiries they deems appropriate concerning the financial standing and financial suitability of contractors. The Director with lead responsibility for clinical governance will similarly make such enquiries as is felt appropriate to be satisfied as to their technical / medical competence.

7.75 Quotations: Competitive and non-competitive

General Position on quotations: Quotations are required where formal tendering procedures are not adopted and where the intended expenditure or income exceeds, or is reasonably expected to exceed the sum defined In the Scheme of Reservation and Delegation.

Competitive Quotations

(i) In line with the appropriate thresholds, quotations should be obtained from at least 3 firms/individuals based on specifications or terms of reference prepared by, or on behalf of, the Trust.
(ii) Quotations should be in electronic format where possible. In exceptional circumstances telephone quotes may be obtained but Confirmation of telephone quotations should be obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in a permanent record.
(iii) All quotations should be treated as confidential and should be retained for inspection.
(iv) The Chief Executive or their nominated officer should evaluate the quotation and select the quote which gives the best value for money. If this is not the lowest quotation if payment is to be made by the Trust, or the highest if payment is to be received by the Trust, then the choice made and the reasons why should be recorded in a permanent record.

Non-Competitive Quotations

Non-competitive quotations in writing may be obtained in the following circumstances:

(i) the supply of proprietary or other goods of a special character and the rendering of services of a special character, for which it is not, in the opinion of the responsible officer, possible or desirable to obtain competitive quotations;

(ii) the supply of goods or manufactured articles of any kind which are required quickly and are not obtainable under existing contracts;

(iii) miscellaneous services, supplies and disposals;

(iv) where the goods or services are for building and engineering maintenance the responsible works manager must certify that the first two conditions of this SFI (i.e.: (i) and (ii) of this SFI) apply.

Quotations to be within Financial Limits

No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with Standing Financial Instructions except with the authorisation of either the Chief Executive or Director of Finance and Information.

7.76 Authorisation of Tenders and Competitive Quotations

Providing all the conditions and circumstances set out in these Standing Financial Instructions have been fully complied with, formal authorisation and awarding of a contract may be decided by the staff as defined in the Scheme of Reservation and Delegation. These levels of authorisation may be varied or changed. Formal authorisation must be put in writing. In the case of authorisation by the Board of Directors this shall be recorded in their minutes.

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

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

(a) The Trust shall use an NHSE approved framework for procurement of all goods and services unless the Chief Executive or nominated officers deem it inappropriate. The decision to use alternative sources must be documented.

(b) If the Trust does not use an NHSE approved framework - where tenders or quotations are not required, because expenditure is below the levels defined in the Scheme of Reservation and Delegation, the Trust shall procure goods and services in accordance with procurement procedures approved by the Director of Finance and Information .

7.78 Private Finance for capital procurement (see overlap with SFI)

The Trust should normally market-test for PFI (Private Finance Initiative funding) when considering a capital procurement. When the Board proposes, or is required, to use finance provided by the private sector the following should apply:

(a) The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.

(b) Where the sum exceeds delegated limits, a business case must be referred to the appropriate Department of Health and Social Care for approval or treated as per current guidelines.

(c) The proposal must be specifically agreed by the Board of the Trust.

(d) The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

7.79 Compliance requirements for all contracts

The Board may only enter into contracts on behalf of the Trust within the statutory powers delegated to it by the Secretary of State and shall comply with:

(a) The Trust's Standing Orders and Standing Financial Instructions;

(b) PCR 2015, PSR 2023 and other statutory provisions;

(c) any relevant directions including the NHS England Capital guidance, Estatecode and guidance on the Procurement and Management of Consultants;

(d) NHS Standard Contract Conditions as are applicable.

(e) NHS guidance.

(f) Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited.

(g) In all contracts made by the Trust, the Board shall endeavour to obtain best value for money by use of all systems in place. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.

(h) The Trust's Standards of Business Conduct policy.

7.80 Personnel and Agency or Temporary Staff Contracts

The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.

7.81 Healthcare Services Agreements (see overlap with SFI)

Service agreements with NHS providers for the supply of healthcare services shall be drawn up in accordance with the PSR 2023. Such service agreements are not contracts in law and therefore not enforceable by the courts. However, a contract with a Foundation Trust, being a Public Benefits Corporation, is a legal document and is enforceable in law.

The Chief Executive shall nominate officers to commission service agreements with providers of healthcare in line with a commissioning plan

approved by the Board of Directors (refer to Scheme of Reservation and Delegation).

7.82 Disposals (See overlap with SFI Condemnations and Disposals)

Competitive Tendering or Quotation procedures shall not apply to the disposal of:

(a) any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or their nominated officer;

(b) obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Trust;

(c) items to be disposed of with an estimated sale value of less than that defined on the Scheme of Delegation, this figure to be reviewed on a periodic basis;

(d) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;

(e) land or buildings concerning which DH guidance has been issued but subject to compliance with such guidance.

7.83 In-house Services

The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Trust may also determine from time to time that in-house services should be market tested by competitive tendering.

In all cases where the Board of Directors determines that in-house services should be subject to competitive tendering the following groups shall be set up:

(a) Specification group, comprising the Chief Executive or nominated officer/s and specialist.

(b) In-house tender group, comprising a nominee of the Chief Executive and technical support.

(c) Evaluation team, comprising normally a specialist officer, a supplies officer and a Director of Finance and Information representative.

All groups should work independently of each other and individual officers may be a member of more than one group but no member of the in-house tender group may participate in the evaluation of tenders.

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

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

7.84 Applicability of SFIs on Tendering and Contracting to funds held in trust (see overlap with SFI)

These Instructions shall not only apply to expenditure from Exchequer funds but also to works, services and goods purchased from the Trust's trust funds and private resources.

7.85 Acceptance of Gifts and Hospitality by Staff

The Director of Finance and Information shall ensure that all staff are made aware of the Trust policy on acceptance of gifts, hospitality and other benefits in kind received by staff. This policy should follow the guidance contained in the June 2017 NHS England guidance on managing conflicts of interest in the NHS and is also deemed to be an integral part of the Standing Orders and Standing Financial Instructions.

Refer also to Standing Orders and Standards of Business Conduct (incorporating Managing Conflicts of Interest in the NHS) policy.

7.86 Retention of documents

All NHS records are public records under the terms of the Public Records Act 1958 section 3 (1) – (2). The Secretary of State for Health and all NHS organisations have a duty under this Act to make arrangements for the safe keeping and eventual disposal of all types of records. In addition, the requirements of the Data Protection Act 1998 and the Freedom of Information Act 2000 must be achieved.

The Chief Executive and senior managers are personally accountable for records management within the organisation. Additionally, the organisation is required to take positive ownership of, and responsibility for, the records legacy of predecessor organisations and / or obsolete services. Under the Public Records Act all NHS employees are responsibility for any records that they create or use in the course of their duties. Thus any records created by an employee of the NHS are public records and may be subject to both legal and professional obligations.

The Chief Executive shall be responsible for maintaining archives for all documents required to be retained under the direction contained in Department of Health and Social Care guidance, Records Management Code of Practice.

Types of Record Covered by the Code of Practice - The guidelines apply to NHS records of all types (including records of NHS patients treated on behalf of the NHS in the private healthcare sector) regardless of the media on which they are held:

- Patient health records (electronic or paper based)
- Records of private patients seen on NHS premises;
- Accident and emergency, birth and all other registers;

- Theatre registers and minor operations (and other related) registers;
- Administrative records (including e.g. personnel, estates, financial and accounting records, notes associated with complaint-handling);
- X-ray and imaging reports, output and other images;
- Photographs, slides and other images;
- Microform (i.e. fiche / film)
- Audio and video tapes, cassettes, CD-ROM etc.
- Emails;
- Computerised records;
- Scanned records;
- Text messages (both out-going from the NHS and in-coming responses from the patient)

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

Documents held in accordance with the Records Management Code of Practice shall only be destroyed at the express instigation of the Chief Executive, records shall be maintained of documents so destroyed.

7.87 Risk Management

The Chief Executive shall ensure that the Trust has a programme of risk management, in accordance with current Department of Health and Social Care assurance framework requirements, which must be approved and monitored by the Board of Directors.

The programme of risk management shall include:

a) a process for identifying and quantifying risks and potential liabilities;

b) engendering among all levels of staff a positive attitude towards the control of risk;

c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

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

e) audit arrangements including; Internal Audit, clinical audit, health and safety review;

f) a clear indication of which risks shall be insured;

g) arrangements to review the Risk Management programme.

The existence, integration and evaluation of the above elements will assist in providing a basis to make a statement on the effectiveness of internal control within the Annual Report and Accounts as required by current Department of Health and Social Care guidance.

7.88 Insurance: Risk Pooling Schemes administered by NHS Resolution

The Board shall decide if the Trust will insure through the risk pooling schemes administered by NHS Resolution or self-insure for some or all of the risks covered by the risk pooling schemes. If the Board decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

7.89 Insurance arrangements with commercial insurers

There is a general prohibition on entering into insurance arrangements with commercial insurers. There are, however, **three exceptions** when Trust's may enter into insurance arrangements with commercial insurers. The exceptions are:

(1) Trust's may enter commercial arrangements for **insuring motor vehicles** owned by the Trust including insuring third party liability arising from their use;

(2) where the Trust is involved with a consortium in a **Private Finance Initiative contract** and the other consortium members require that commercial insurance arrangements are entered into; and

(3) where **income generation activities** take place. Income generation activities should normally be insured against all risks using commercial insurance. If the income generation activity is also an activity normally carried out by the Trust for a NHS purpose the activity may be covered in the risk pool. Confirmation of coverage in the risk pool must be obtained from NHS Resolution. In any case of doubt concerning a Trust's powers to enter into commercial insurance arrangements the Director of Finance and Information should consult the Department of Health and Social Care.

8. Scheme of Reservation and Delegation of Powers

Delegated Matters

Delegated Matter
Standing Orders/Standing Financial Instructions

Table A

Delegated Matter	Reference No.
Audit Arrangements	1
Authorisation Of Clinical Trials	2
Authorisation Of New Drugs	3
Bank/GBS Accounts (Excl Charitable Fund Accounts)	4
Capital Investment	5
Clinical Audit	6
Commercial Sponsorship	7
Complaints (Patients & Relatives)	8
Confidential Information	9
Data Protection Act	10
Declaration Of Interests	11
Disposal And Condemnations	12
Environmental Regulations	13
External Borrowing	14
Financial Planning/Budgetary Responsibility	15
Financial Procedures	16
Fire Precautions	17
Fixed Assets	18
Fraud	19
Funds Held On Trust	20
Health & Safety	21
Hospitality/ Gifts	22
Infectious Diseases & Notifiable Outbreaks	23
IM&T	24
Legal Proceedings	25
Losses, Write-Offs & Compensation	26
Meetings	27
Medical	28
Non Pay Expenditure	29
Nursing	30
Patients Services Agreements	31
Patients' Property	32
Personnel & Pay	33
Quotations, Tendering & Contract Procedures	34
Records	35
Reporting Incidents To The Police	36
Risk Management	37
Seal	38
Security Management	39
Setting Of Fees & Charges	40
Stores And Receipt Of Goods	41

TABLE B - DELEGATED FINANCIAL LIMITS

Delegated Limit	Reference No.
Charitable Funds	**1**
Gifts and Hospitality	**2**
Litigation Claims	**3**
Losses and Special Payments	**4**
Petty Cash Disbursements	**5**
Requisitioning Goods And Services, Contract Awards and Invoice Approvals	**6**
General Points	6.1
Agency Staff	6.2
Capital Expenditure	6.3
Removal Expenses	6.4
Quotations and Tenders	**7**
Virement	**8**

8.1 Reservation of Powers

The Standing Orders provides that "The Board of Directors may delegate any of its powers to a committee of Directors or to an executive Director". The Code of Accountability also requires that there should be a formal schedule of matters specifically reserved to the Trust.

The purpose of this document is to detail how the powers are reserved to the Board of Directors, while at the same time delegating to the appropriate level the detailed application of Trust policies and procedures. However, the Board of Directors remains accountable for all of its functions, even those delegated to committees, sub committees, 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.

8.2 Role of the Chief Executive

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

All powers delegated by the Chief Executive can be re-assumed by them should the need arise.

As Accountable Officer the Chief Executive is accountable to the Accounting Officer of the Department of Health and Social Care for the funds devolved to the Trust.

8.3 Caution over the Use of Delegated Powers

Powers are delegated to directors and officers on the understanding that they would not exercise delegated powers in a manner which in their judgement was likely to be a cause for public concern.

8.4 Absence of Directors or Officer to Whom Powers have been Delegated

In the absence of a director or officer to whom powers have been delegated those powers shall be exercised by that director or officer's superior unless alternative arrangements have been approved by the Board of Directors. If the Chief Executive is absent powers delegated to them may be exercised by the nominated officer acting in their absence after taking appropriate advice from the Director of Finance and Information.

If it becomes clear to the Board of Directors that the Accounting Officer is incapacitated and will be unable to discharge their responsibilities over a

period of four weeks or more, the Board of Directors should appoint an acting Accounting Officer, usually the Director of Finance and Information, pending the Accounting Officers return. The same applies if, exceptionally, the Accounting Officer plans an absence of more than four weeks during which they cannot be contacted.

8.5 Reservation of Powers to the Board of Directors - Accountability

The Code of Conduct and Accountability which has been adopted by the Trust requires the Board of Directors to determine those matters on which decisions are reserved unto itself. Board members share corporate responsibility for all decisions of the Board. These reserved matters are set out below.

8.6 Duties

It is the Board's duty to:

- act within statutory financial and other constraints;
- be clear what decisions and information are appropriate to the Board of Directors and draw up Standing Orders, a schedule of decisions reserved to the Board and Standing Financial Instructions to reflect these,
- ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives for the main programmes of action and for performance against programmes to be monitored and senior executives held to account;
- establish performance and quality measures that maintain the effective use of resources and provide value for money;
- specify its requirements in organising and presenting financial and other information succinctly and efficiently to ensure the Board can fully undertake its responsibilities;
- establish Audit and Remuneration Committees on the basis of formally agreed terms of reference that set out the membership of the sub-committee, the limit to their powers, and the arrangements for reporting back to the main Board.

8.7 General Enabling Provision

The Board of Directors may determine any matter, for which it has authority, it wishes in full session within its statutory powers.

8.8 Regulations and Control

The Trust Board remains accountable for all of its functions, even those delegated to individual committees, sub-committees, directors or officers and would therefore expect to receive information about the exercise of delegated functions to enable it is maintain a monitoring role. These following are decisions reserved to the board powers reserved to the Board generally represent matters for which it is held accountable to the Secretary of State,

while at the same time delegating to the appropriate level the detailed application of Trust policies and procedures. However, the Board remains accountable for all of its functions, even those delegated to individual sub-committees, directors or officers and would therefore expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

- Approval of Standing Orders (SOs), a schedule of matters reserved to the Board of Directors and Standing Financial Instructions for the regulation of its proceedings and business.
- Suspend Standing Orders.
- Vary or amend the Standing Orders.
- Ratification of any urgent decisions taken by the Chair and Chief Executive in public session in accordance with the Standing Orders.
- Approval of a scheme of delegation of powers from the Board of Directors to Committees.
- Requiring and receiving the declaration of Board members' interests which may conflict with those of the Trust and determining the extent to which that director may remain involved with the matter under consideration (see Standards of Business Conduct policy)
- Requiring and receiving the declaration of officers' interests which may conflict with those of the Trust (see Standards of Business Conduct policy).
- Approval of arrangements for dealing with complaints.
- Adoption of the organisational structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications thereto.
- To receive reports from committees including those which the Trust is required by the Constitution and the Health and Social Care (Community Health and Standards) Act 2003 superseded by the NHS (Consolidation) Act 2006 or other regulation to establish and to take appropriate action thereon.
- To confirm the recommendations of the Trust's committees where the committees do not have executive powers.
- Approval of arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust.
- To establish terms of reference and reporting arrangements of all committees and sub-committees that are established by the Board of Directors.
- Approval of arrangements relating to the discharge of the Trust's responsibilities as a bailer for patients' property.
- Authorise use of the seal.
- Ratify or otherwise instances of failure to comply with Standing Orders brought to the Chief Executive's attention in accordance with Standing Orders.

- Disciplining Board members' or employees who are in breach of Statutory Requirements or Standing Orders.
- Approval of the Trust's Major Incident Plan.

8.9 Appointments / Dismissal

- Appoint of the Vice Chair of the Board of Directors.
- The appointment and dismissal of committees (and individual members) that are directly accountable to the Board of Directors.
- The appointment, appraisal, disciplining and dismissal of Executive Directors and disciplinary procedures of the Trust.
- Confirm the appointment of members of any committee of the Trust or the appointment of representatives on outside bodies.
- The ratification of appointment of senior medical staff.
- Approve proposals received from the Remuneration Committee regarding the Chief Executive, Directors and senior employees.

8.10 Policy Determination

The approval of Trust management policies including:

- Human Resources policies incorporating the arrangements for the appointment, removal and remuneration of staff.
- Approve procedure for declaration of hospitality and sponsorship.
- Ensure proper and widely publicised procedures for voicing complaints, concerns about misadministration, breaches of Code of Conduct, and other ethical concerns.
- Approve a list of employees authorised to make short term borrowings on behalf of the Trust.

8.11 Strategy and Business Plans and Budgets

- Definition of the strategic aims and objectives of the Trust.
- Approve proposals for ensuring quality and developing clinical governance in services provided by the Trust, having regard to any guidance issued by the Secretary of State.
- Approval and monitoring of the Trust's policies and procedures for the management of risk.
- Approval annually of plans in respect of the application of available financial resources.
- Overall approval of programmes of investment to guide the letting of contracts for the supply of clinical services.
- Approve Outline and Final Business Cases for Capital Investment.
- Approve budgets.

- Approve annually Trust's proposed business plan
- Ratify proposals for acquisition, disposal or change of use of land and/or buildings
- Approve PFI proposals.
- Approve proposals on individual contracts, including purchase orders (other than NHS contracts) of a capital or revenue nature amounting to, or likely to amount to over £750,000 per annum or £2,000,000 in total if the period of the contract is longer than 3 years.
- Approve proposals in individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive and Director of Finance and Information.
- Approve proposals for action on litigation against or on behalf of the Trust where the likely financial impact is expected to exceed £10,000 or contentious or novel or likely to lead to extreme adverse publicity, excluding claims covered by the NHS risk pooling schemes.
- Review use of NHS risk pooling schemes.
- Approve the opening of bank accounts.
- Approve individual compensation payments.

8.12 Audit Arrangements

To approve audit arrangements (including arrangements for separate audit of funds held on trust) and receive reports of the Audit Committee meetings and take appropriate action:

- Receive the annual management letter received from the external auditor and agreement of proposed action, taking account of the advice, where appropriate, of the Audit Committee.
- Receive an annual report from the Internal Auditor and agree action on recommendations where appropriate of the Audit Committee.

8.13 Delegation to Committees

The Board of Directors may determine that certain of its powers shall be exercised by Standing Committees. The composition and terms of reference of such committees shall be that determined by the Board of Directors from time to time taking into account where necessary the requirements of the Secretary of State and/or the Charity Commissioners (including the need to appoint an Audit Committee and a Remuneration and Terms of Service Committee). The Board of Directors shall determine the reporting requirements in respect of these committees. In accordance with the Standing Orders committees may not delegate executive powers to sub-committees unless expressly authorised by the Board of Directors.

8.14 Delegation to Officers

Standing Orders and Standing Financial Instructions set out in some detail the financial responsibilities of the Chief Executive, the Director of Finance and Information and other directors. These responsibilities are summarised below. The following responsibilities are defined through the Accountable Officer Memorandum:

- Chief Executive:
    - Accountable through NHS Accounting Officer to Parliament for stewardship of Trust resource.
    - Sign a statement in the accounts outlining responsibilities as the Accountable Officer.
    - Sign a statement in the accounts outlining responsibilities in respect of internal control.
    - Ensures effective management systems that safeguard public funds and assist the Trust Chair to implement requirements of corporate governance including ensuring managers:
        - Have a clear view of their objectives and the means to assess achievements in relation to those objectives.
        - Be assigned well defined responsibilities for making the best use of resources.
        - Have the information, training and access to the expert advice they need to exercise their responsibilities effectively.
    - Achieve value for money from the resources available to the Trust and avoid waste and extravagance in the organisation's activities.
    - Follow through the implementation of any recommendations affecting good practice as set out on reports from such bodies as the National Audit Office.
    - Ensuring that expenditure by the Trust complies with Parliamentary requirements.
    - If the Chief Executive considers the Board or Chair is doing something that might infringe probity or regularity, he/she should set this out in writing to the Chair and the Board. If the matter is unresolved, he/she should ask the Audit Committee to inquire and if necessary contact NHS England and the DHSC.
    - If the Board is contemplating a course of action that raises an issue not of formal propriety or regularity but affects the Chief Executive's responsibility for value for money, the Chief Executive should draw the relevant factors to the attention of the Board. If the outcome is an overrule it is normally sufficient to ensure that advice and the overruling of it are clearly apparent from the papers. Exceptionally, the Chief Executive should inform NHS England and the DHSC. In such cases, and in those described above the Chief Executive should as a member of the Board vote against the course of action rather than merely abstain from voting.

Delegated matters in respect of decisions which may have a far reaching effect must be reported to the Chief Executive. The **'Delegated to'** authority is in accordance with the: Standing Orders and Standing Financial Instructions. The **'Operational Responsibility'** shown below is the lowest level to which authority is delegated.

Table A - Delegated Authority,
Table B - Delegated Financial Limits,

Delegation to lower levels is only permitted with written approval of the Chief Executive who will, before authorising such delegation, consult with other Senior Managers as appropriate. All items concerning Finance must be carried out in accordance with Standing Financial Instructions and Standing Orders.

Delegated Authority

If the Chief Executive is absent powers delegated to them may be exercised by the nominated officer(s) acting in their absence after taking appropriate financial advice, two directors will be required to ratify any decisions within the Chief Executive's thresholds.

	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
1.	**Standing Orders/Standing Financial Instructions**		
a)	Final authority in interpretation of Standing Orders	Chair	Chair
b)	Notifying Directors and employees of their responsibilities within the Standing Orders and Standing Financial Instructions and ensuring that they understand the responsibilities	Chief Executive	All Line Managers
c)	Responsibility for security of the Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming with Standing Orders, Financial instructions and financial procedures	Chief Executive	All Directors and Employees
d)	Suspension of Standing Orders	Board of Directors	Board of Directors
e)	Review suspension of Standing Orders	Audit Committee	Audit Committee
f)	Variation or amendment to Standing Orders	Board of Directors	Board of Directors
g)	Emergency powers relating to the authorities retained by the Board of Directors.	Chair and Chief Executive with two non-executives	Chair and Chief Executive with two non-executives
h)	Disclosure of non-compliance with Standing Orders to the Chief Executive (report to the Board of Directors).	All staff	All staff
i)	Disclosure of non-compliance with SFIs to the Director of Finance and Information (report to the Audit Committee)	All staff	All staff
j)	Advice on interpretation or application of SFIs and this Scheme of Delegation	Director of Finance and Information	Director of Finance and Information /Internal Audit

Table A - Delegated Matters

	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
1.	**Audit Arrangements**		
a)	To make recommendations to the Board of Directors in respect of the appointment, re- appointment and removal of the external auditor and to approve the remuneration in respect of the external auditor.	Auditor Panel (for recommendation to the Board of Directors for approval).	Director of Finance and Information
b)	Monitor and review the effectiveness of the external and internal audit function.	Auditor Panel	Director of Finance and Information
c)	Review, appraise and report in accordance with Government Internal Audit Standards (GIAS) and best practice.	Audit Committee	Head of Internal Audit
d)	Provide an independent and objective view on internal control and probity.	Audit Committee	Internal Audit / External Audit
e)	Ensure cost-effective audit service	Auditor Panel	Director of Finance and Information
f)	Implement audit recommendations	Chief Executive	Relevant Officers
2.	**Authorisation of Clinical Trials & Research Projects**	Chief Executive	Medical Director or Director responsible for Research
3.	**Authorisation of New Drugs**	Chief Executive	Drugs and Therapeutics Group
4.	**Bank/GBS Accounts/Cash (**Excluding Charitable Fund (Funds Held on Trust) Accounts**)**		
a)	Operation: • Managing banking arrangements and operation of bank accounts (Board of Directors approves arrangements)	Director of Finance and Information	Deputy Director of Finance and Information /Assistant Director of Finance (Financial Services)
	• Opening bank accounts	Director of Finance and Information	Director of Finance and Information
	• Authorisation of transfers between Trust bank accounts	Director of Finance and Information	To be completed in accordance with bank mandate/internal procedures
	• Approve and apply arrangements for the electronic transfer of funds	Director of Finance and Information	To be completed in accordance with bank mandate/internal procedures
	• Authorisation of: - GBS schedules - BACS schedules - Automated cheque schedules - Manual cheques	Director of Finance and Information	To be completed in accordance with bank mandate/internal procedures
b)	Investments: • Investment of surplus funds in accordance with the Trusts investment policy • Preparation of an investment procedures	Director of Finance and Information Director of Finance and Information	Deputy Director of Finance and Information /Assistant Director of Finance (Financial Services) Deputy Director of Finance and Information /Assistant Director of Finance (Financial Services)
c)	Petty Cash	Director of Finance and Information	**Refer To Table B Delegated Limits**
5.	**Capital Investment**		
a)	Programme: • Ensure that there is adequate appraisal and approval process for determining capital expenditure priorities and the effect that each has on business plans / Service development Strategy	Chief Executive	Director of Finance and Information
	• Preparation of Capital Investment Programme	Chief Executive	Director of Finance and Information
	• Preparation of a business case	Chief Executive	Chief Operating Officer (with advice from Management Accountants)

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
• Financial monitoring and reporting on all capital scheme expenditure including variations to contract	Director of Finance and Information	Deputy Director of Finance and Information /Assistant Director of Finance (Financial Services)
• Authorisation of capital requisitions	Chief Executive	Refer to Table B Delegated Limits
• Assessing the requirements for the operation of the construction industry taxation deduction scheme.	Director of Finance and Information	Deputy Director of Finance and Information /Assistant Director of Finance (Financial Services)
• Responsible for the management of capital schemes and for ensuring that they are delivered on time and within cost.	Chief Executive	Director of Finance and Information / Deputy Director of Finance and Information
• Ensure that capital investment is not undertaken without availability of resources to finance all revenue consequences.	Chief Executive	Director of Finance and Information
• Issue procedures to support: o capital investment o Staged payments	Chief Executive	Director of Finance and Information
• Issue procedures governing financial management, including variation to contract, of capital investment projects and valuation for accounting purposes.	Director of Finance and Information	Deputy Director of Finance and Information /Assistant Director of Finance (Financial Services)
• Issuing the capital scheme project manager with specific authority to commit capital, proceed / accept tenders in accordance with the SO's and SFI's	Chief Executive	Director of Finance and Information
b) Private Finance: • Demonstrate that the use of private finance represents best value for money and transfers risk to the private sector. Proposal to use PFI must be specifically agreed by the Board of Directors	Chief Executive	Director of Finance and Information
c) Leases (property and equipment) • Granting and termination of leases with Annual rent < £100k • Granting and termination of leases of > £100k should be reported to the Board of Directors	Chief Executive Board of Directors	Director of Finance and Information Chief Executive / Director of Finance and Information
6. Clinical Audit	Chief Executive	Medical Director
7. Commercial Sponsorship		
• Agreement to proposal	Chief Executive	Directors/ Divisional Directors of Operations/ Heads of Department. Approval and registration in line with Trust Standards of Business Conduct.
8. Complaints (Patients & Relatives)		
a) Overall responsibility for ensuring that all complaints are dealt with effectively	Chief Executive	Head of Complaints & Claims
b) Responsibility for ensuring complaints relating to a division / department are investigated thoroughly.	Chief Executive	Divisional Director of Operations
c) Medico - Legal Complaints Coordination of their management.	Chief Executive	Head of Legal Services
9. Confidential Information		
Review of the Trust's compliance with the Caldicott report on protecting patients'	Chief Executive	Director of IM & T

DELEGATED MATTER		DELEGATED TO	OPERATIONAL RESPONSIBILITY
	confidentiality in the NHS		
	Freedom of Information Act compliance code	Chief Executive	Director of IM & T
10.	**Data Protection Act**		
a)	Review of Trust's compliance	Chief Executive	Director of IM & T
11.	**Declaration of Interest**		
	• Maintaining a register of interests	Chief Executive	Director of Finance and Information
	• Declaring relevant and material interest	Board of Directors	Board of Directors / Senior Managers / Other employees who can influence expenditure decisions
12.	**Disposal and Condemnations**		
	• Items obsolete, redundant, irreparable or cannot be repaired cost effectively • Develop arrangements for the sale of assets	Director of Finance and Information	Deputy Director of Estates/ Deputy Director of Procurement/ Heads of Department in accordance with agreed policy Refer to Table B Delegated Limits
	• Disposal of Protected Property (as defined in the Terms of Authorisation)	Chief Executive (with authorisation of the Independent Regulator)	Chief Executive
13.	**Environmental Regulations**		
	Review of compliance with environmental regulations, for example those relating to clean air and waste disposal	Chief Executive	Director of Corporate Services
14.	**External Borrowing**		
a)	Advise Trust Board of the requirements to repay / draw down Public Dividend Capital.	Director of Finance and Information	Deputy Director of Finance and Information /Assistant Director of Finance (Financial Services)
b)	Approve a list of employees authorised to make short term borrowings on behalf of the Trust.	Board	Chief Executive, Director of Finance and Information
c)	Application for draw down of Public Dividend Capital, overdrafts and other forms of external borrowing.	Chief Executive / Director of Finance and Information	Director of Finance and Information
d)	Preparation of procedural instructions concerning applications for loans and overdrafts.	Director of Finance and Information	Deputy Director of Finance and Information /Assistant Director of Finance (Financial Services)
15.	**Financial Planning / Budgetary Responsibility**		
a)	Setting:		
	• Submit budgets to the Trust Board	Director of Finance and Information	Deputy Director of Finance and Information
	• Submit to Board financial estimates and forecasts	Chief Executive	Director of Finance and Information
	▪ Compile and submit to the Board a business plan/Service Development Strategy (SDS) which takes into account financial targets and forecast limits of available resources. The Business Plan/SDS will contain: o a statement of the significant assumptions on which the plan is based; o details of major changes in workload, delivery of services or resources required to achieve the plan.	Chief Executive	Director of Finance and Information / Managing Director
b)	Monitoring: o Devise and maintain systems of budgetary control.	Director of Finance and Information	Deputy Director of Finance and Information

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
○ Monitor performance against budget	Director of Finance and Information	Deputy Director of Finance and Information / Assistant Director of Finance (Financial Management)
○ Delegate budgets to budget holders	Chief Executive	Director of Finance and Information
○ Ensuring adequate training is delivered to budget holders to facilitate their management of the allocated budget.	Director of Finance and Information	Deputy Director of Finance and Information / Assistant Director of Finance (Financial Management)
○ Submit in accordance with the Independent Regulator's requirements for financial monitoring returns	Chief Executive	Director of Finance and Information
○ Identify and implement cost improvements and income generation activities in line with the Business Plan	Chief Executive	All budget holders
○ Preparation of Annual Accounts	Director of Finance and Information	Deputy Director of Finance and Information /Assistant Director of Finance (Financial Services)
○ Preparation of Annual Report	Chief Executive	Director of Finance and Information /Director of Corporate Affairs
○ Approval/adoption of accounts and annual report	Audit Committee (on behalf of the Trust Board unless submission deadlines permit the Trust Board to do this directly)	Director of Finance and Information
c) Budget Responsibilities Ensure that • no overspend or reduction of income that cannot be met from virement is incurred without prior consent of Board; • approved budget is not used for any other than specified purpose subject to rules of virement; • no permanent employees are appointed without the approval of the Chief Executive other than those provided for within available resources and manpower establishment.	Director of Finance and Information	Budget Holders
d) Authorisation of Virement: It is not possible for any officer to vire from non-recurring headings to recurring budgets or from capital to revenue / revenue to capital. Virement between different budget holders requires the agreement of both parties.	Chief Executive	Refer To Table B Delegated Limits
16. Financial Procedures and Systems		
a) Maintenance & Update on Trust Financial Procedures	Director of Finance and Information	Deputy Director of Finance and Information /Assistant Director of Finance (Financial Services)
b) Responsibilities:- • Implement Trust's financial policies and co-ordinate corrective action. • Ensure that adequate records are maintained to explain Trust's transactions and financial position. • Providing financial advice to members of the Board of Directors and staff. • Ensure that appropriate statutory records are maintained. • Designing and maintaining compliance with all financial systems	Director of Finance and Information	Deputy Director of Finance and Information /Assistant Director of Finance (Financial Services)

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
17. Fire precautions • Ensure that the Fire Precautions and prevention policies and procedures are adequate and that fire safety and integrity of the estate is intact.	Chief Executive	Director of Corporate Services
18. Fixed Assets		
a) Maintenance of asset register including asset identification and monitoring	Chief Executive	Deputy Director of Finance and Information /Assistant Director of Finance (Financial Services)
b) Ensuring arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with CONCODE and ESTATECODE.	Director of Finance and Information	Director of Corporate Services
c) Calculate depreciation in accordance with the guidance from the Department of Health and Social Care.	Director of Finance and Information	Deputy Director of Finance and Information /Assistant Director of Finance (Financial Services)
d) Responsibility for security of Trust's assets including notifying discrepancies to the Director of Finance and Information and reporting losses in accordance with Trust's procedures	Chief Executive	All staff
19. Fraud (See also 26, 36)		
a) Monitor and ensure compliance with the NHS Counter Fraud Authority Standards for Providers including the appointment of the Local Counter Fraud Specialist.	Chief Executive and Director of Finance and Information	Local Counter Fraud Specialist.
b) Notify NHS Protect and External Audit of all suspected Frauds	Director of Finance and Information	Local Counter Fraud Specialist.
20. Funds Held on Trust (Charitable and Non Charitable Funds)		
a) Management: • Funds held on trust are managed appropriately.	Charitable Trust Funds Committee	Director of Finance and Information / Deputy Director of Finance and Information / Assistant Director of Finance (Financial Services)
b) Maintenance of authorised signatory list of nominated fund holders.	Director of Finance and Information	Deputy Director of Finance and Information /Assistant Director of Finance (Financial Services)
c) Expenditure Limits	Director of Finance and Information	Refer To Table B Delegated Limits
d) Developing systems for receiving donations	Director of Finance and Information	Deputy Director of Finance and Information /Assistant Director of Finance (Financial Services)
e) Dealing with legacies	Director of Finance and Information	Deputy Director of Finance and Information /Assistant Director of Finance (Financial Services)
f) Fundraising Appeals	Charitable Trust Funds Committee	Deputy Director of Finance and Information /Assistant Director of Finance (Financial Services)
▪ Preparation and monitoring of budget	Director of Finance and Information	Deputy Director of Finance and Information /Assistant Director of Finance (Financial Services)
▪ Reporting progress and performance against budget.	Director of Finance and Information	Deputy Director of Finance and Information /Assistant Director of Finance (Financial Services)
g) Operation of Bank Accounts: • Managing banking arrangements and	Director of Finance and Information	Deputy Director of Finance and Information /Assistant

DELEGATED MATTER		DELEGATED TO	OPERATIONAL RESPONSIBILITY
	operation of bank accounts		Director of Finance (Financial Services)
	• Opening bank accounts	Director of Finance and Information	Director of Finance and Information
h)	Investments: • Nominating deposit taker	Charitable Trust Funds Committee	Director of Finance and Information
	• Placing transactions	Director of Finance and Information	Director of Finance and Information / Investment Broker
i)	Regulation of funds with Charities Commission	Director of Finance and Information	Deputy Director of Finance and Information / Assistant Director of Finance (Financial Services)
21.	**Health and Safety**		
	Review of all statutory compliance with legislation and Health and Safety requirements including control of Substances Hazardous to Health Regulations	Chief Executive	Director of Corporate Services
22.	**Hospitality/Gifts**		
a)	Keeping of hospitality register	Chief Executive	Director of Finance and Information
b)	Applies to both individual and collective hospitality receipt items. See Table B – "Delegated Financial Limits" for limits.		All staff declaration required in Trust's Hospitality Register
23.	**Infectious Diseases & Notifiable Outbreaks**	Chief Executive	Director responsible for Infection Prevention & Control
24.	**Information Management & Technology**		
	Financial Systems • Developing financial systems in accordance with the Trust's IM&T Strategy. • Implementing new systems ensure they are developed in a controlled manner and thoroughly tested. • Seeking third party assurances regarding financial systems operated externally.	Director of Finance and Information	Deputy Director of Finance and Information /Assistant Director of Finance (Financial Services)
	• Ensure that contracts for computer services for financial applications define responsibility re security, privacy, accuracy, completeness and timeliness of data during processing and storage.	Director of Finance and Information	Director of Finance and Information / Director of Informatics
	• Ensure that risks to the Trust from use of IT are identified and considered and that disaster recovery plans are in place.	Director of Finance and Information	Director of Informatics
25.	**Legal Proceedings**		
a)	Engagement of Trust's Solicitors / Legal Advisors	Chief Executive	Chief Executive
b)	Approve and sign all documents which will be necessary in legal proceedings, i.e. executed as a deed.	Chief Executive	Executive Director
c)	Sign on behalf of the Trust any agreement or document not requested to be executed as a deed.	Chief Executive	Executive Director
26.	**Losses, Write-off & Compensation**		
a)	Prepare procedures for recording and accounting for losses and special payments including preparation of an Anti-Fraud, Bribery and Corruption Policy and informing the NHS Counter	Chief Executive	Director of Finance and Information

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
Fraud Authority of alleged frauds		
<u>Losses</u> Losses of cash due to theft, fraud, overpayment & others.		
Fruitless payments (including abandoned Capital Schemes)		
Bad debts and claims abandoned.		
Damage to buildings, fittings, furniture and equipment and loss of equipment and property in stores and in use due to Culpable causes (e.g. fraud, theft, arson).		
Reviewing appropriate requirement for insurance claims	Director of Finance and Information	
d) A register of all of the payments should be maintained by the Finance Department and made available for inspection	Director of Finance and Information	Deputy Director of Finance and Information /Assistant Director of Finance (Financial Services)
e) A report of all of the above payments should be presented to the Audit Committee	Director of Finance and Information	Deputy Director of Finance and Information /Assistant Director of Finance (Financial Services)
<u>Special Payments</u> Compensation payments by Court Order	Chief Executive	Above Excess – NHS Resolution Below Excess – Chief Executive
Ex-Gratia Payments:-		
• To patients/staff for loss of personal effects		Director of Finance and Information
• For clinical negligence after legal advice		Medical Director / Director of Finance and Information
• For personal injury after legal advice		Medical Director / Director of Finance and Information
• Other clinical negligence and personal injury		Medical Director / Director of Finance and Information
• Other ex-gratia payments		Director of Finance and Information
27. Meetings		
a) Calling meetings of the Trust Board	Chair	Chair
b) Chair all Trust Board meetings and associated responsibilities	Chair	Chair
28. Medical		
• Clinical Governance arrangements	Medical Director / Nursing Director	Medical Director / Nursing Director
• Medical Leadership	Medical Director	Medical Director
• Programmes of medical education	Medical Director	Medical Director
• Medical staffing plans	Medical Director	Medical Director
• Medical Research	Medical Director	Medical Director
29. Non Pay Expenditure		
a) Maintenance of a list of managers authorised to place requisitions/orders and accept goods in accordance with Table B	Chief Executive	Director of Finance and Information
b) Obtain the best value for money when requisitioning goods / services	Chief Executive	Deputy Director of Procurement / Director of Corporate Services/ Heads of Department
c) Non-Pay Expenditure for which no specific budget has been set up and which is not subject to funding under delegated powers of virement. (Subject to the limits specified above in (a)	Chief Executive	Director of Finance and Information

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
d) Develop systems for the payment of accounts	Director of Finance and Information	Deputy Director of Finance and Information / Assistant Director of Finance (Financial Services)
e) Prompt payment of accounts	Director of Finance and Information	Deputy Director of Finance and Information / Assistant Director of Finance (Financial Services)
f) Financial Limits for ordering / requisitioning goods and services	Director of Finance and Information	Refer To Table B Delegated Limits
g) Approve prepayment arrangements	Director of Finance and Information	Deputy Director of Finance and Information
30. Nursing		
▪ Compliance with statutory and regulatory arrangements relating to professional nursing and midwifery practice.	Director of Nursing, Midwifery & Governance	Deputy Director of Nursing & Governance
▪ Matters involving individual professional competence of nursing staff.	Director of Nursing, Midwifery & Governance	Deputy Director of Nursing & Governance
▪ Compliance with professional training an development of nursing staff.	Director of Nursing, Midwifery & Governance	Deputy Director of Nursing & Governance
▪ Quality assurance of nursing processes.	Director of Nursing, Midwifery & Governance	Deputy Director of Nursing & Governance
31. Patient Services Agreements		
a) Negotiation of Trust Contract and Non Commercial Contracts	Chief Executive	Director of Finance and Information
b) Quantifying and monitoring out of area treatments	Director of Finance and Information	Deputy Director of Finance and Information / Asst Director of Finance (Contracts & Commissioning)
c) Reporting actual and forecast income	Chief Executive	Deputy Director of Finance and Information / Asst Director of Finance (Contracts & Commissioning)
d) Costing Trust Contract and Non Commercial Contracts	Director of Finance and Information	Director of Finance and Information / Deputy Director of Finance and Information / Assistant Director of Finance (Financial Management)
e) Payment by Results	Director of Finance and Information	Deputy Director of Finance and Information / Asst Director of Finance (Contracts & Commissioning)
f) Reference Costing	Director of Finance and Information	Deputy Director of Finance and Information / Assistant Director of Finance (Financial Management)
g) Ad hoc costing relating to changes in activity, developments, business cases and bids for funding	Director of Finance and Information	Deputy Director of Finance and Information / Assistant Director of Finance (Financial Management)
32. Patients' Property (in conjunction with financial advice)		
a) Ensuring patients and guardians are informed about patients' monies and property procedures on admission	Chief Executive	Director of Finance and Information / Divisional Directors of Operations /Heads of Department
b) Prepare detailed written instructions for the administration of patients' property	Director of Finance and Information	Deputy Director of Finance and Information / Assistant Director of Finance (Financial Services)
c) Informing staff of their duties in respect of patients' property	Director of Finance and Information	Divisional Directors of Operations /Heads of Department
d) Issuing property of deceased patients (See SFI 6.15.9, 6.15.10) ▪ <£4,999 in accordance with agreed Trust policies. ▪ >£5,000 only on production of a probate letter of administration	Director of Finance and Information	General Office Staff Deputy Director of Finance and Information / Assistant Director of Finance (Financial Services)

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
33. Personnel & Pay		
a) Nomination of officers to enter into contracts of employment regarding staff, agency staff or consultancy service contracts	Chief Executive	Director of Human Resources / Divisional Directors of Operations /Heads of Department
b) Develop Human resource policies and strategies for approval by the board including training, industrial relations.	Director of Human Resources	Director of Human Resources
c) Authority to fill funded post on the establishment with permanent staff.	Director of Human Resources	Divisional Directors of Operations / Heads of Department in accordance with Trust policy
d) The granting of additional increments to staff within budget	Chief Executive	Director of Human Resources
e) All requests for re-grading shall be dealt with in accordance with Trust Procedure	Director of Human Resources	Deputy Director of Human Resources
f) Establishments • Additional staff to the agreed establishment with specifically allocated finance.	Director of Finance and Information	Deputy Director of Finance and Information
• Additional staff to the agreed establishment without specifically allocated finance.	Chief Executive	Director of Finance and Information
• Self financing changes to an establishment	Director of Finance and Information	Deputy Director of Finance and Information / Assistant Director of Finance (Financial Management)
g) Pay		
• Presentation of proposals to the Trust Board for the setting of remuneration and conditions of service for those staff not covered by the Remuneration Committee.	Chief Executive	Director of Human Resources
• Authority to complete standing data forms effecting pay, new starters, variations and leavers	Director of Human Resources	Divisional Directors of Operations /Heads of Department
• Authority to complete and authorise positive reporting forms (SVLS)	Director of Finance and Information	Divisional Directors of Operations /Heads of Department
• Authority to authorise overtime	Director of Human Resources/Director of Finance	Divisional Directors of Operations /Heads of Department
• Authority to authorise travel & subsistence expenses	Director of Finance and Information	Divisional Directors of Operations /Heads of Department
h) Leave *(Note entitlement may be taken in hours)*	Director of Human Resources	*Refer to Annual Leave Policy*
<u>Annual Leave</u>		
- Approval of annual leave		Line / Departmental Manager (as per departmental procedure)
- Annual leave - approval of carry forward (up to maximum of 5 days	Chief Executive	Director of Human Resources / Divisional Directors of Operations /Heads of Department
- Annual leave – approval of carry forward over 5 days (to occur in **<u>exceptional</u>** circumstances only)	Chief Executive	Director of Human Resources / Divisional Directors of Operations /Heads of Department Medical Staff – Medical Director
<u>Special Leave</u>	Director of Human Resources	
- Compassionate leave		Divisional Directors of Operations /Heads of Department

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
• Special leave arrangements for domestic/personal/family reasons • paternity leave • carers leave • adoption leave (to be applied in accordance with Trust Policy)		Divisional Directors of Operations /Heads of Department
• Special Leave – this includes Jury Service, Armed Services, School Governor (to be applied in accordance with Trust Policy)		Divisional Directors of Operations /Heads of Department
• Leave without pay		Executive Director / Heads of Department
• Medical Staff Leave of Absence – paid and unpaid		Clinical Director / Divisional Director of Operations
• Time off in lieu		Line /Departmental Manager
• Maternity Leave - paid and unpaid	Director of Human Resources	Automatic approval with guidance
<u>Sick Leave</u>	Director of Human Resources	
i) Extension of sick leave on pay		Director of Human Resources
ii) Return to work part-time on full pay to assist recovery		Director of Human Resources
<u>Study Leave</u>	Chief Executive	
• Study leave outside the UK		Relevant Executive Director
• Medical staff study leave (UK) - Consultant / Non Career Grade - Career Grade	Medical Director	 Medical Director Post Graduate Tutor
• All other study leave (UK)	Director of Human Resources	Executive Directors / Clinical Directors / Divisional Directors of Operations /Heads of Department (in accordance with agreed Trust policy)
i) Removal Expenses, Excess Rent and House Purchases All staff (agreed at interview) Maximum £6,000 Senior Medical Staff Maximum £8,000	Director of Human Resources	Relevant Executive Director
Authorisation of payment of removal expenses incurred by officers taking up new appointments (providing consideration was promised at interview)		Refer to Table B Delegated Limits
j) Grievance Procedure All grievances cases must be dealt with strictly in accordance with the Grievance Procedure and the advice of the Director of Human Resources must be sought when the grievance reaches the level of Divisional General Managers / Heads of Department	Director of Human Resources	As per procedure

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
k) Authorised - Car Users h) Leased car i) Regular user allowance	Chief Executive Director of Finance and Information	Director of Finance and Information Divisional Director / Divisional Manager /Head of Department
l) Mobile Phone Users / Blackberries	Director of Finance and Information	Divisional Directors / Heads of Department
m) Renewal of Fixed Term Contract	Director of Human Resources	Head of Department on advice from Human Resources and Management Accountant
n) Staff Retirement Policy		
▪ Authorisation of extensions of contract beyond normal retirement age in exceptional circumstances	Chief Executive	Director of Human Resources
▪ Authorisation of return to work in part time capacity under the flexible retirement scheme.	Chief Executive	Director of Human Resources
o) Redundancy	Chief Executive	Director of Human Resources/ Director of Finance and Information
p) Ill Health Retirement Decision to pursue retirement on the grounds of ill-health following advice from the Occupational Health Department.	Chief Executive	Director of Human Resources
q) Disciplinary Procedure (excluding Executive Directors)	Chief Executive	To be applied in accordance with the Trust's Disciplinary Procedure
r) Ensure that all employees are issued with a Contract of employment in a form approved by the Board of Directors and which complies with employment legislation.	Director of Human Resources	Deputy Director of Human Resources
s) Engagement of staff not on the establishment a. Management Consultants		Refer to Table B
▪ Booking of bank staff		
a. Nursing	Director of HR	Budget Holder/Line Manager
b. Other	Director of HR	Budget Holder/Line Manager
▪ Booking of agency staff		
a. Nursing	Director of HR	Budget Holder/Line Manager
b. Other	Director of HR	Budget Holder/Line Manager
34. Quotation, Tendering & Contract Procedures		
a) Services: • Best value for money is demonstrated for all services provided under contract or in-house	Chief Executive	Director of Finance and Information /Deputy Director of Procurement (via SLA)/ Director of Corporate Services
• Nominate officers to oversee and manage the contract on behalf of the Trust.	Chief Executive	Divisional Directors of Operations /Heads of Department/Procurement
b) Competitive Tenders: • Authorisation Limits	Chief Executive	Refer To Table B Delegated Limits
• Maintain a register to show each set of competitive tender invitations despatched.	Chief Executive	Director of Finance and Information
• Receipt and custody of tenders prior to opening	Chief Executive	Director of Finance and Information
• Opening Tenders	Chief Executive	Confirmed list of users to e-tendering system
•	Chief Executive	Director of Finance and Information
• Ensure that appropriate checks are carried out	Chief Executive	Director of Finance and Information

DELEGATED MATTER		DELEGATED TO	OPERATIONAL RESPONSIBILITY
	as to the technical and financial capability of the firms invited to tender or quote.		
c)	Quotations	Chief Executive	Refer To Table B Delegated Limits
d)	Waiving the requirement to request • tenders - subject to SOs (reporting to the Board)	Chief Executive	Refer To Table B Delegated Limits
	• quotes - subject to SOs	Chief Executive or Director of Finance and Information	Director of Finance and Information /Deputy Director of Finance and Information
35.	**Records**		
a)	Review Trust's compliance with the Records Management Code of Practice	Chief Executive	Executive Directors/ Divisional General Manager /Heads of Department
b)	Ensuring the form and adequacy of the financial records of all departments	Director of Finance and Information	Deputy Director of Finance and Information / Assistant Director of Finance (Financial Services)
36.	**Reporting of Incidents to the Police**		
a)	Where a criminal offence is suspected • criminal offence of a violent nature • arson or theft • other	Chief Executive	Manager On-call/ Head of Department/ Divisional Director of Operations
b)	Where a fraud is involved (reporting to the Directorate of Counter Fraud Services)	Director of Finance and Information	Chief Internal Auditor / Local Counter Fraud Officer (LCFO)
c)	Deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud, bribery or corruption.	Director of Finance and Information	Director of Finance and Information (with advice from LCFO)
37.	**Risk Management**		
	• Ensuring the Trust has a Risk Management Strategy and a programme of risk management	Chief Executive	Deputy Director of Nursing & Governance
	• Developing systems for the management of risk.	Governance Councils	Deputy Director of Nursing & Governance
	• Developing incident and accident reporting systems	Governance Councils	Deputy Director of Nursing & Governance
	• Compliance with the reporting of incidents and accidents	Governance Councils	Deputy Director of Nursing & Governance
38.	**Seal**		
a)	The keeping of a register of seal and safekeeping of the seal	Chief Executive	Chief Executive
b)	Attestation of seal in accordance with Standing Orders	Chair /Chief Executive	Chair / Chief Executive (report to Trust Board)
c)	Property transactions and any other legal requirement for the use of the seal.	Chair /Chief Executive	Chair or Non-Executive Director and the Chief Executive or their nominated Director
39.	**Setting of Fees and Charges (Income)**		
a)	Private Patient, Overseas Visitors, Income Generation and other patient related services.	Director of Finance and Information	Deputy Director of Finance and Information /Assistant Director of Finance
b)	Non patient care income	Director of Finance and Information	Deputy Director of Finance and Information / Assistant Director of Finance (Financial Management)
c)	Informing the Director of Finance and Information of monies due to the Trust	Director of Finance and Information	All Staff

DELEGATED MATTER		DELEGATED TO	OPERATIONAL RESPONSIBILITY
d)	Recovery of debt	Director of Finance and Information	Deputy Director of Finance and Information / Assistant Director of Finance (Financial Services)
e)	Security of cash and other negotiable instruments	Director of Finance and Information	Deputy Director of Finance and Information / Assistant Director of Finance (Financial Services)
40.	**Stores and Receipt of Goods**		
a)	Responsibility for systems of control over stores and receipt of goods, issues and returns	Director of Finance and Information	Deputy Director of Procurement (via SLA)/Head of Pharmacy/Director of Corporate Services and other Heads of Department as appropriate.
b)	Stocktaking arrangements	Director of Finance and Information	Assistant Director of Finance (Financial Services)
c)	Responsibility for controls of pharmaceutical stock.	Medical Director	Head of Pharmacy

Table B – Delegated Financial Limits

All thresholds are inclusive of VAT irrespective of recovery arrangements.

❶If the Chief Executive is absent powers delegated to them may be exercised by the nominated officer(s) acting in their absence after taking appropriate financial advice, two directors will be required to ratify any decisions within the Chief Executive's thresholds.

	Proposed Financial Limits (Subject to funding available in budget) ❶		**Includes:-**
1	**CHARITABLE FUNDS**		
	Charitable Funds Committee Chief Executive or Director of Finance and Information Both Fund holders One Fund holder	Over £15,000 £2,000 to £15,000 £1,000 to £2,000 Up to £1,000	*Note: Manual system, paper based approval*
2	**GIFTS AND HOSPITALITY**		Refer also to Trust's Anti-Fraud, Bribery and Corruption policy and Standards of Business Conduct policy
3.	**LITIGATION CLAIMS**		
	See 6.1 below for levels		Medical Negligence and other litigation payments made on the advice of NHS Resolution
4.	**LOSSES AND SPECIAL PAYMENTS**		
	See 6.1 below for levels		All losses, bad debts, damage to buildings, fittings, furniture and equipment and stock and loss of property due to culpable causes (eg. fraud, theft, arson etc) should be recorded and reported to the Audit Committee
5.	**PETTY CASH DISBURSEMENTS (authority to pay)**		
	Director of Finance and Information or Nominated Deputy Petty Cash Imprest Holder	Over £100 Up to £100	Sundry Exchequer Items, (ie. items where the use of the normal ordering system is inappropriate - refer to local operational procedures re petty cash), Patients' Monies
6.	**REQUISITIONING GOODS AND SERVICES, CONTRACT AWARDS AND INVOICE APPROVALS**		
6.1	**General points** 1. Contracts - The total value of the contract over the life of the contract should be used when determining the appropriate authorisation level required. The official documentation normally associated with initial approval of a contract includes purchase orders, tender documentation and contract awards. 2. Invoices received which relate to an approved purchase order will be paid subject to satisfactory receipting on the Trust's Oracle ordering system (or JAC system for Pharmacy drugs invoices). 3. Invoices received for certain types of expenditure which are NOT subject to an approved purchase order (ie. Non PO invoices), must be approved by a responsible manager with the appropriate approval limit. These invoices may relate to one-off or low value payments not previously approved or may be invoices relating to a pre-approved contract (see 1 above) 4. Payments made to HMRC and the NHS Business Services-Pensions Division relating to statutory issues (ie. income tax, national insurance and superannuation payments) are authorised by the Assistant Director of Finance (Financial Services) as delegated by the Director of Finance and Information based on information provided by the Trust's payroll department and reconciled to the financial ledger. . Other points to note: (i) Agency Staff subject to approval of Staffing Solutions Manager up to £5,000. (ii) For capital expenditure, see section 6.3 below. (iii) The annual contract value should apply to call-off orders when determining appropriate authorisation limits. (iv) IM&T equipment is normally subject to technical approval by the Informatics department before final approval by the budget holder.		

	Proposed Financial Limits (Subject to funding available in budget**)**		**Includes:-**
	Chief Executive	£1,0000,000 (see *)	(* Can authorise spend above £1,0000,000 providing pre-approved by Board, eg. via annual approved budget or capital programme) Each level requires approval by the manager i.e. level above. Note: it is possible for any of the above levels a manager at that level could be given a limit that is lower than the stated level here but not higher.
	Deputy Chief Executive or Director of Finance and Information	£1,0000,000	
	Executive Board Directors (other than above), Deputy Director of Finance and Information , Director of Corporate Services, Director of Informatics, Head of Pharmacy	£200,000	
	Divisional Directors/ Deputy Director of Estates	*£75,000*	
	Assistant Directors / Head of PFI and Facilities Management	£50,000	
	Pathology and Radiology Managers	£35,000	
	Directorate Managers	£25,000	
	Senior Manager Level 1	£10,000	
	Senior Manager Level 2	£5,000	
	Matron / Manager	£1,000	
	Ward and Other Managers	£500 or less	
6.2	**Agency Staff:-**		
	See 6.1 above for levels		Any agency staff, including medical locums. Nursing Agency staff to be hired via Staffing Solutions Manager (in accordance with relevant Trust policies on temporary staffing).
6.3	**Capital Expenditure (Subject to annual programme being approved by Trust Board)**		
	Director of Finance and Information	Capital Programme items Equipment Over £1,000	Requires completed 'Capital Sanction Form' authorised appropriately by Director of Finance and Information (or Deputy in his absence) before requisitoner proceeds (ie. authorisation follows levels 6.1 above **providing** expenditure is pre-approved in capital programme)
6.4	**Removal Expenses:-**		
	Director of Human Resources	Up to £8,000	
7.	**QUOTATIONS AND TENDERS**		
	Deputy Director of Procurement /Divisional Managers/Heads of Department/Head of PFI and Facilities Management e.g. SRP as appropriate	£30,000 to £50,000	Quotations: *Obtaining* a **minimum of 3 written quotations** for goods/services.
	Two officers as per the approved signatory list One of the two (Board Director and Board Secretary) + a senior manager	Over £50,000 (in compliance with EU Directives as appropriate – Please refer to the Head of Purchasing and Supply for the latest thresholds)	Competitive Tenders: *Obtaining* **a minimum of 3 written competitive tenders** for goods/services.
8.	**VIREMENT**		**Conditions:-**
	Trust Board	Over £40,000 p.a.	Trust must still meet Financial Targets
	Chief Executive	Up to £40,000 p.a.	Total Trust budget remains underspent
	Director of Finance and Information	Up to £25,000 p.a.	Total Trust budget remains underspent
	Director of Finance and Information	Up to £10,000 p.a.	Total Divisional / Departmental Budget remains underspent

9. Training

There is no formal training required to support this policy.

10. Monitoring Compliance

10.1 Key Performance Indicators of the Policy

Key Performance Indicators (KPI's) are not applicable in the management of this policy.

10.2 Performance Management of the Policy

Compliance will be periodically tested through internal audit. The results of internal audit reviews are routinely reported to the Trust's Audit Committee.

11. Related Policies and Procedures

Standards of Business Conduct
Anti-Fraud, Bribery and Corruption Policy Raising
Concerns Policy

12. Equality Impact Analysis

The screening assessment must be carried out on all policies, procedures, organisational changes, service changes, cost improvement programmes and transformation projects at the earliest stage in the planning process to ascertain whether a full equality analysis is required. This assessment must be attached to all procedural documents prior to their submission to the appropriate approving body. A separate copy of the assessment must be forwarded to the Head of Patient Inclusion and Experience for monitoring purposes via the following email, Cheryl.farmer@sthk.nhs.uk. If the assessment is related to workforce a copy should be sent to the workforce Head of Equality, Diversity and Inclusion darren.mooney@sthk.nhs.uk. If this screening assessment indicates that discrimination could potentially be introduced then seek advice from either the Head of Patient Inclusion and Experience or workforce Head of Equality, Diversity and Inclusion. A full equality analysis must be considered on any cost improvement schemes, organisational changes or service changes that could have an impact on patients or staff.

Equality Analysis			
Title of Document/proposal /service/cost improvement plan etc:	Trust Standards of Business Conduct Policy		
Date of Assessment	15/01/2024	**Name of Person completing assessment /job title:**	Kerry Jenkinson, Interim Assistant Director of Finance
Lead Executive Director	Director of Finance		January 2024
Does the proposal, service or document affect one group more or less favourably than other group(s) on the basis of their:		**Yes / No**	**Justification/evidence and data source**

1	Age	No	Click here to enter text.
2	Disability (including learning disability, physical, sensory or mental impairment)	No	Click here to enter text.
3	Gender reassignment	No	Click here to enter text.
4	Marriage or civil partnership	No	Click here to enter text.
5	Pregnancy or maternity	No	Click here to enter text.
6	Race	No	Click here to enter text.
7	Religion or belief	No	Click here to enter text.
8	Sex	No	Click here to enter text.
9	Sexual Orientation	No	Click here to enter text.
Human Rights – are there any issues which might affect a person's human rights?		**Yes / No**	**Justification/evidence and data source**
1	Right to life	No	Click here to enter text.
2	Right to freedom from degrading or humiliating treatment	No	Click here to enter text.
3	Right to privacy or family life	No	Click here to enter text.
4	Any other of the human rights?	No	Click here to enter text.
Lead of Service Review & Approval			
Service Manager completing review & approval Job Title:		Christine Oakely, Deputy Director of Finance	
		January 2024	

Data Protection Impact Assessment Screening Tool

If you answer **YES or UNSURE** to any of the questions below a full Data Protection Impact Assessment will need to be completed in line with Trust policy.

	Yes	No	Unsure	**Comments -** *Document initial comments on the issue and the privacy impacts or clarification why it is not an issue*
Is the information about individuals likely to raise privacy concerns or expectations e.g. health records, criminal records or other information people would consider particularly private?		X		
Will the procedural document lead to the collection of new information about individuals?		X		
Are you using information about individuals for a purpose it is not currently used for, or in a way it is not currently used?		X		
Will the implementation of the procedural document require you to contact individuals in ways which they may find		X		

intrusive?				
Will the information about individuals be disclosed to organisations or people who have not previously had routine access to the information?		X		
Does the procedural document involve you using new technology which might be perceived as being intrusive? e.g. biometrics or facial recognition		X		
Will the procedural document result in you making decisions or taking action against individuals in ways which can have a significant impact on them?		X		
Will the implementation of the procedural document compel individuals to provide information about themselves?		X		

Sign off if no requirement to continue with Data Protection Impact Assessment:
Confirmation that the responses to the above questions are all NO and therefore there is no requirement to continue with the Data Protection Impact Assessment

Policy author: Kerry Jenkinson, Interim Assistant Director of Finance – Financial Services
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