NHS
The Walton Centre
NHS Foundation Trust

Public Trust Board Meeting

Thursday 3rd November 2022

Agenda and Papers

Excellence in Neuroscience

The Walton Centre NHS Foundation Trust

PUBLIC TRUST BOARD MEETING
Thursday 3rd November 2022
Boardroom
09:30 - 12.30

v = verbal d = document p = presentation

Item	Time	Item	Owner	Purpose
1	09.30	Patient Story (v)	Chief Nurse	N/A
2	09.50	Welcome and Apologies (v)	Chair	N/A
3	09.55	Declaration of Interests (v)	Chair	Decision
4	10.00	Minutes and actions of meeting held on 6th October 2022 (d)	Chair	Information
STRATEGIC CONTEXT				
5	10.05	Chair and Chief Executive's Update (d)	Chief Executive Officer	Information
CORPORATE TRUSTEE				
6	10.20	The Walton Centre Charity Annual Report and Accounts 2022/23 (d)	Chief Finance Officer	Approve
INTEGRATED PERFORMANCE REPORT				
7	10.30	Integrated Performance Report (d)	Chief Executive Officer	Assurance
8	10.35	Business Performance Committee: Chair's Assurance Report (d)	Committee Chair	Assurance
9	10.50	Quality Committee: Chair's Assurance Report (d)	Committee Chair	Assurance
11.05 BREAK				
QUALITY & SAFETY				
10	11.15	Mortality and Morbidity Report (d)	Medical Director	Assurance
11	11.25	Freedom to Speak Up Guardian Report – Q1 and Q2 (d)	Chief Nurse	Assurance
12	11.35	Nurse Staffing - Bi-Annual Acuity Review (d)	Chief Nurse	Assurance
WORKFORCE				
13	11.45	Guardian of Safe Working Annual Report 2021/22 (d)	Medical Director	Assurance
CHAIR'S ASSURANCE REPORTS FROM BOARD COMMITTEES				
14	11.55	Charity Committee - 21st October 2022: • Chair's Assurance Report (d) • Terms of Reference (d)	Committee Chair	Assurance

Item	Time	Item	Owner	Purpose
15	12.00	Audit Committee - 18th October 2022 (d)	Committee Chair	Assurance
CONSENT AGENDA				
Subject to Board agreement, the recommendations in the following reports will be adopted without debate: • Review of Standing Financial Instructions and Scheme of Reservation and Delegation (d) • Modern Slavery Act Statement (d) • Estates Return Information Collection (ERIC) Return (d)				
CONCLUDING BUSINESS				
16	12.05	Any Other Business (v)	Chair	Information
17	12.10	Review of Meeting (v)	Chair	Information

Date and Time of Next Meeting: 9.30am, 1st December 2022, Boardroom, The Walton Centre

UNCONFIRMED

Minutes of the Public Trust Board Meeting

Meeting held via Microsoft Teams

6th October 2022

Present:

Max Steinberg	Chair
Karen Heslop	Non-Executive Director (NED-KH)
Paul May	Non-Executive Director (NED-PM)
Su Rai	Senior Independent Director (SID)
David Topliffe	Non-Executive Director (NED-DT)
Ray Walker	Non-Executive Director (NED-RW)
Mike Burns	Chief Financial Officer (CFO)
Mike Gibney	Chief People Officer (CPO)
Andy Nicolson	Medical Director (MD)
Jan Ross	Chief Executive (CEO)
Lisa Salter	Chief Nurse (CN)
Lindsey Vlasman	Chief Operating Officer (COO)

In attendance:

Adam Barley	Specialist Nurse, Organ Donation (SNOD) (item 4)
John Baxter	Corporate Governance Officer (CGO) (minutes)
Katharine Dowson	Corporate Secretary (CS)
Mark Foy	Head of Information and Business Intelligence (HIBI) (item 12)
Lisa Judge	Head of Patient & Family Experience (HPFE) (items 4 and 13)
Gemma Nanson	Head of Neurosciences Research Centre (HNRC) (item 14)
Elaine Vaile	Communications and Marketing Manager (CMM) (item 4)

Observers:

Belinda Shaw	Public Governor – Merseyside

Apologies:

None received

1 Welcome and apologies

1.1 No apologies were received. The Chair welcomed everyone to the meeting.

2 Declarations of interest

2.1 No declarations of interest in relation to the agenda were made, no new declarations were recorded.

3 Minutes of the meeting held on 1st September 2022

3.1 Minor amendments were requested from NED-KH, NED-DT and CFO. Following completion of these amendments the minutes of the meeting held on 6th October 2022 were approved as an accurate record of the meeting.

Action tracker

3.2 There was one closed action which was agreed for removal from the tracker.

4 Patient Story

4.1 CMM, HPFE and SNOD joined the meeting and introduced the partner of a patient.

4.2 The patients partner shared their story with the Board and informed that the patient had collapsed while at work and had a suspected stroke on the way to the Liverpool University Hospital Foundation Trust (LUHFT). They were then transferred to the Walton Centre to undergo retrieval of the blood clot however while at the Trust it was discovered that the stroke was for more severe than originally realised and the patient was placed under sedation. The patient deteriorated when the sedation was withdrawn and was confirmed to be brain stem dead following completion of tests to confirm this. The partner reported that this took place during the early stages of the Covid pandemic and visiting restrictions were in place however arrangements were made for the patients partner and family members to visit while complying with national guidelines to say their final goodbyes. The partner also noted that a bed was set up next to the patient so they could be together one last time.

4.3 The organ donation team met with the partner to discuss the potential for organ donation and also confirm the required agreements. All of the detail and paperwork was completed by the organ donation team and the patients family were constantly kept informed of the process. A donation passport was compiled which provided details of the patients hobbies and their family and this was given to the organ retrieval team so that the patient became a bit more personal. The partner was able to take the patient to the theatre doors and say goodbye and was also able to say a final goodbye following surgery.

4.4 The partner reported that every member of staff encountered from the cleaners to staff in ICU were very respectful from the moment the patient came through the doors. Every member of staff introduced themselves when entering the room and informed the patient what they were going to do and talked to the patient throughout their time at the Trust.

4.5 The patient helped four other people through donation of organs and the partner had received a letter from one donor recipient to express their sympathy and thanks. The partner reported that they would be attending the Walton Willow event on 22nd June 2023 to hang a leaf on the Walton Willow tree in remembrance.

4.6 The Chair stated on behalf of the Board that they had not heard such a moving story expressed in such a dignified way. The patient had given life to four people and the Chair wished to record their pride in the partner and the care that the Trust had provided which provided confidence that the Trust was moving in the right direction.

4.7 SID questioned if there was anything that the Trust could have done differently to improve the patient and family experience and the partner stated that they understood the Covid restrictions that were in place however the Trust had embraced and included all family members to visit to say goodbye and also provided great support and care throughout their journey.

4.8 CEO thanked the partner for sharing their moving story and looked forward to meeting them at the Walton Willow remembrance event. The partner informed that they had presented their story regarding organ donation within their workplace and this had raised awareness

of the process and removed the taboo of talking about organ donation. This had resulted in a number of work colleagues registering as an organ donor.

4.9 CN also highlighted the support available for staff and recognised the emotional toll that caring for patients at the end of life could have.

4.10 The Chair also wished to record their thanks on behalf of the Board to the organ donation team.

The Board recorded thanks to the patient partner for sharing their story.

5 Chair & Chief Executive's Report

5.1 The Chair updated that the annual members meeting had been held on 8th September with attendance from SID, NED-DT and NED-PM. Feedback received following the meeting had been positive and the agenda had a good mix of business and clinical presentations.

5.2 The Metro Mayor of the Liverpool City Region, Steve Rotheram, recently visited the Trust and stated that he continued to be very impressed by the services delivered and would continue to support the Trust.

5.3 The Trust Strategy was launched on 29th September with staff engagement sessions held across all areas of the Trust. A short summary of the strategy had been produced and this would be published and distributed. Different options for the next steps of marketing the strategy were currently under review.

5.4 The Chief Executive presented their report detailing updates from a national, regional and Trust perspective and highlighted that the Trust had been awarded University Hospital status after being accepted as a member of the University Hospital Association. This had been very well received across the Trust and was recognised as a significant step for the Trust achieving its strategic ambitions.

5.5 It was stated that Covid infections were rising again and internal sickness absence had increased to approximately 7% with a number of Covid positive patients in the Trust. National discussions on how the current wave would be managed were ongoing and it was recognised that this would present different challenges for all organisations.

5.6 SID queried if any updates were available regarding potential industrial action. CEO clarified that trade unions were currently in the process of balloting members and the Trust recognised the impact the impact and link to in-work poverty and this would be discussed further under agenda item 16.

The Board noted the Chair and Chief Executive reports.

6 Trust Strategy 2022-25 Update

6.1 MD presented the Trust strategic priorities for quarter three (Q3) and informed that the enabling substrategies were currently in development. The Trust strategy contained five strategic ambitions and a number of objectives for each strategic ambition had been identified and an overview of each was provided. Work to progress each of these objectives was underway and quarterly update reports would be presented to Board and further

quarterly priorities developed. Project management tools were currently being evaluated prior to an agreement being made on how progress would be monitored and presented.

6.2 NED-PM informed that the Clinical Directorate at University of Liverpool were holding an away day on 12th October and suggested sharing the presentation with Research and Development Leads, MD stated that plans for this were already in place and discussions were underway with the Clinical Director of Medical Education and Research.

6.3 NED-DT questioned if metrics and Key Performance Indicators (KPIs) would be agreed for each milestone and it was confirmed that KPIs would be set however that level of detail had not yet been agreed and that some areas would not lend themselves to that approach. NED-DT also queried if ISO56001 accreditation was part of the Investors in People accreditation and it was clarified that this was a separate comprehensive framework regarding the creation of a culture of innovation, it was also highlighted that no other Trust had achieved this accreditation.

6.4 COO informed that work to implement a Project Management Office (PMO) to deliver the Trust strategy and other objectives was underway.

6.5 It was agreed that quarterly updates would be added to the cycle of business with a larger update on progress reported in April 2023.

The Board agreed the Trust strategic priorities for Q3.

7 University Hospital Status Update

7.1 CEO informed the Board that a lot of hard work had been undertaken to support the Trusts application for University Hospital status and while this had appeared unachievable at times work had continued to evidence academic outputs which had resulted in the Trust successfully achieving University Hospital status. This achievement would be used to support the strategy around research, development and innovation and raise the profile of the Trust regionally and nationally. Accreditation also demonstrated the Trusts commitment to increasing research capacity and capability and cemented the foundations for research, development and innovation.

7.2 A workshop would be held to consider a potential change of name for the Trust and this would be discussed further with the marketing team prior to discussion at a future Board meeting. CMM stated that NHS England have very strict naming conventions for Trusts and there were a number of factors to be considered around a potential name change.

The Board noted the Trusts membership to the University Hospital Association and agreed to review the Trust name.

8 Board Assurance Framework, Quarter 2 2022-23

8.1 CS presented the Board Assurance Framework (BAF) for quarter two and informed that the risks had been discussed by the Executive Leads at the Executive Directors team meeting, Business Performance Committee (BPC), Quality Committee (QC) and Research, Innovation and Medical Education (RIME) Committee.

8.2 A summary of amendments made following review at sub-committees was provided and all updates to each risk ID had been highlighted in red.

8.3 NED-RW highlighted Risk ID005 and queried what work would be required to improve the risk scoring in line with the target score. CS clarified that this risk was not necessarily related to workforce however focussed on leadership and development and work was ongoing in this area. CPO stated that the Trust was performing well in relation to vacancies however feedback received was that leadership values were not as high as they could be and had decreased in some areas. A number of programmes had been launched and would be reviewed to identify their impact going forward.

8.4 NED-DT suggested that there was a potentially significant new operational risk relating to the possibility of industrial action. This had been discussed at Business Performance Committee (BPC) however this risk was not related to BPC and this had not been included as a new risk due to the timing of the emergence of the risk. It was recognised that this would feature more during the Autumn period and there were gaps in assurance due to the balloting process currently underway however business continuity plans would provide mitigation.

The Board approved the revised description for BAF004 Operational Performance and the revised scoring for BAF011 Cyber Security.

9 Integrated Performance Report

9.1 The CEO informed that check and challenge of the Integrated Performance Report (IPR) had been undertaken at Board Committees and the Chairs of the relevant Committee would present this as part of their assurance reports.

9.2 NED-DT, as Chair of BPC, highlighted that all cancer wait and treatment targets and diagnostic targets continued to be met and all patient flow indicators remained strong with the exception of Did Not Attend (DNA) rates which continued to be a challenge. Significant progress against performance targets had been made since July which provided assurance that the Trust was performing well. It was recognised that a different approach regarding the delivery of mandatory training and PDRs was required and it was highlighted that there had been a step change in waiting lists since the transfer of spinal services to the Trust however system and process changes had been implemented with improvements being evidenced.

9.3 Staff turnover in back-office functions remained high however assurance was provided that vacancies were being filled. It was noted that the labour market was challenging in these areas and there may be difficulties in retaining staff going forward. CN highlighted that Nursing vacancies were at an all time low across the Trust.

9.4 NED-KH updated on discussions held at Quality Committee and reported that there had been no hospital acquired infections on Lipton Ward since April 2022. There had been no pressure ulcers on Lipton Ward for 280 days and no pressure ulcers on Chavasse Ward for 156 days. It was also highlighted that ITU had not recorded any incidents of E.Coli since March 2022 and no incidents of MSSA since April 2022. The work undertaken to achieve these reductions would be shared and implemented across all wards.

9.5 NED-RW requested additional data analysis and commentary for all areas of the IPR and queried how this data was triangulated with other data such as complaints and concerns received. CEO highlighted the need to consider the data and how this data demonstrated

safe staffing and other metrics. Some new tools had been implemented on wards and the data outputs from these would be considered to provide assurance.

The Board noted the Integrated Performance Report

10 Business Performance Committee Chair's Assurance Report

10.1 NED-DT presented the Chair's Assurance report from the BPC meeting held on 28th September 2022 and highlighted that the draft people substrategy had been reviewed with the extensive content commended. However, it was noted that an alternative format was suggested which was currently under consideration.

The Board noted the Business Performance Committee Chair's Assurance Report.

11 Quality Committee Chair's Assurance Report

11.1 NED-KH had deputised at the Quality Committee meeting in the absence of NED-RW and presented the Chair's Assurance report. It was highlighted that improvements to the format and content of the clinical audits report had been made.

11.2 NED-PM queried if there was an issue with supernumerary staff assisting with care leading to a risk of areas being unable to provide safe staffing. It was clarified that the data did not support this and extensive discussions around staffing were held at the meeting. CN highlighted that the bi-annual nurse staffing and acuity review was currently underway and this would be presented to the Executive Directors prior to the next Board meeting and staffing data was reviewed on a daily basis at the staff huddle.

11.3 SID noted that there had been three device related pressure ulcers recorded which had resulted in the Trust trialling a different device and queried if this risk was unknown when the original devices were procured. It was clarified that these related to nasogastric (NG) tubes and these were not defective however there was a known issue relating to the use of NG tubes as the skin around the area is so thin and very easy to break down. Alternative measures were being explored to try and reduce the number of pressure ulcers. Benchmarking data was due to be received shortly and this would be reviewed. It was recognised that this data was being reported to ensure that this could be investigated and improvement measures identified for implementation.

The Board noted the Quality Committee Chair's Assurance Report.

12 Health Inequalities Update

12.1 HIBI joined the meeting to present initial analysis undertaken on health inequalities to measure outcomes and the steps taken to understand the workforce in relation to inequality. The percentage of referrals from areas below the baseline highlighted questions regarding access to healthcare and it was noted that there were a high number of patients where ethnicity had not been recorded and work was underway to identify ways of improving data capture in this area.

12.2 Ten indices of deprivation were reviewed and it was confirmed that waiting lists were broadly the same across each decile. This was the same for all outcome measures apart from mortality and work was underway with NHS Special Commissioning to gain more understanding around this.

12.3 There was an obvious trend around Did Not Attend (DNA) rates identified and this was the same for face to face and virtual appointments and also for both new and follow up patients. This was an area of focus for the Trust in addressing inequalities.

12.4 A dashboard had been created detailing information relating to the ten indices of deprivation so this data was easily available to all areas.

12.5 Workforce data had been reviewed against the same criteria and it was reported that this was very similar to patient data however it was clarified that ISS staffing data was not available to the Trust so had not been included. This data provided a snapshot in time to identify areas of focus and linked in with work to respond to in-work poverty. It was recognised that there was a need for accurate data analysis prior to being able to move forward and agree responses. 40% of Trust staff lived within the top two areas with increased indices of deprivation.

12.6 NED-KH stated that it was good to have this data available and questioned where work to identify and progress improvements would be monitored. CEO clarified that this work would be monitored at the Strategic Black, Asian and Minority Ethnic Advisory Committee (SBAC) which would then report up to Trust Board.

12.7 SID recognised that patient access was a big challenge and there was a need to improve the recording of ethnicity data and a systemic approach was required to ensure the correct data was recorded for all patients.

12.8 MD reported that the Trust was participating in a pilot scheme with NHS Specialist Commissioning to review pathways for Neurology patients and improve access to care.

12.9 CEO summarised that a dashboard recording health inequality data had been introduced and this data was available across the Trust with work underway to identify ways of improving the data recorded. Work was ongoing to improve DNA rates and this would be monitored at SBAC and reported to Trust Board for assurance.

The Board noted the health inequalities update.

13 CQC Inpatient Survey

13.1 CN presented the results of the CQC Inpatient Survey for 2021 and reported that the CQC rated the Trust as 'Better than Expected' with the Trust scoring 'Much Better than Average' in one of the ten sections and 'Better than Average' in a further five sections. The Trust was ranked 8th for overall positive patient scores from 73 Trusts and was also ranked 11th out of 134 Trusts nationally. An overview of scoring on each metric was provided along with areas for improvement and it was noted that noise at night from other patients and staff had been highlighted in the responses along with requests for additional information on discharge regarding next steps and who patients and families could contact with any concerns.

13.2 An action plan had been compiled to address any issues highlighted with tight timescales in place. Work had begun to address these actions and this would be monitored at Quality Committee with a progress report submitted to Trust Board in February 2023.

13.3 NED-KH commended the results and comprehensive action plan and noted that some metrics had decreased since the previous survey results and it was questioned if this was

related to staff absence during the pandemic. CN clarified that these results were triangulated against other available data and highlighted the positive work from patient support assistants and work was ongoing collectively across all areas of the Trust to improve results further. Work was also underway to address concerns regarding noise at night and it was recognised that small actions could have a big impact on patient experience.

The Board noted the results of the CQC Inpatient Survey and the improvements required.

14 Research and Development Annual Report

14.1 HNRC joined the meeting to present the Research and Development annual report.

14.2 CPO introduced the annual report and highlighted that research and development was a key part of the Trust strategy and work was required to resolve the challenges facing the department which had been one of the areas most impacted by Covid.

14.3 HNRC reported that the Neuroscience Research Centre (NRC) had been operating at a sub-optimal level however had continued to recruit to trials and operate throughout the pandemic. Financial losses recorded in 2020 had plateaued in 2021 and there was a need to improve finances moving forward and work was underway with the regional Single Point of Access to Research and Knowledge (SPARK) joint service to ensure that research work was costed correctly and reconciled. It was recognised that if patients could be recruited and studies brought in then this area would improve.

14.4 It was stated that the majority of research undertaken nationally thorough 2021 was Covid focussed which had an impact on tertiary centres and there were challenges at a national level. This had resulted in a backlog of studies and patients and work to recover this would be ongoing for some time.

14.5 Research within the Trust was now in a different place and the new Trust strategy demonstrated the Trusts ambitions regarding research. HNRC invited all members of the Board to visit the NRC and see first-hand the work that is undertaken.

14.6 NED-PM wished to record thanks to HNRC and recognised the strong management, leadership and background in research and felt that the NRC was moving in the right direction.

14.7 NED-KH stated that the annual report was open regarding the challenges faced and queried if the report was submitted anywhere other than Trust Board. It was clarified that the report was not presented elsewhere however the approach to openness led the Trust to contact the wider system to request support where required.

14.8 SID highlighted inequality research regarding the Black, Asian and Minority Ethnic (BAME) community and HNRC stated that this was high on the National Institute for Health and Care Research (NIHR) agenda however the NRC needed to embed the correct processes first and ensure the structure was correct before aspirational work could be undertaken.

The Board noted the research and development annual report.

15 Staff Survey Update and Talk, Engage, Action (TEA) Feedback

15.1 CPO provided an update on actions taken in response to the 2021 annual staff survey and feedback received during the recent TEA engagement sessions. TEA sessions were held between July and September with all members of the Executive Directors team involved across a number of sessions. It was agreed that an additional session would be arranged for staff who work night shifts and from underrepresented areas and plans were also in place to continue these events moving forward. The main themes of feedback related to IT infrastructure and staff facilities.

15.2 An overview of staff survey outcomes was presented along with actions undertaken to address concerns and issues raised. The Trust Health and Wellbeing Hub was in the process of being implemented and health MOTs were available to staff. The national staff survey for 2022 had recently been published and all staff were encouraged to complete the survey. The survey would close in December 2022 with results available to Trusts in March 2023 however results would be embargoed for publication until April 2023.

15.3 NED-KH queried what the driver had been for the rebanding of Health Care Assistants (HCAs) and it was confirmed that this had been a national issue however the complexities of pay resulted in the unintended consequence of a number of HCA staff who had been rebanded to a higher pay band having their take home pay reduced. Work had been undertaken with all affected staff to identify a mutually agreed approach.

The Board noted the staff survey update and feedback received from TEA sessions.

16 Responding to In-Work Poverty

16.1 CPO presented an update detailing measures being taken across the Trust to respond to in-work poverty. The Joseph Rowntree Foundation (JRF) had identified four issues to be prioritised in healthcare organisations and the Walton Centre was the first Trust to begin addressing the issues identified by the JRF. The Trust had a responsibility as a fair employer to identify ways of providing support with sensitivity and it was recognised that in work poverty was a key issue on a national strategic level.

16.2 NED-RW questioned if the Trust expected ISS to sign up to the fair employment charter and it was confirmed that issues relating to fair pay were built into the contract with ISS however the Trust could not force ISS to sign up to the fair employment charter.

The Board noted the work undertaken by the Trust to respond to in-work poverty.

17 Cheshire and Merseyside Provider Collaborative (CMAST) Collaborative Agreement

17.1 and Committee in Common

CEO informed that there was a duty for Trusts to work collaboratively and terms of reference for a Committee in Common had been produced. Trust Chairs and Chief Executives across Cheshire and Merseyside had worked closely with Hill Dickinson and Mike Farrar and agreements had been made to work collaboratively wherever possible.

17.2 The Board were asked to endorse CEO being part of the CMAST Board and approve the joint working agreement and establishment of a Committee in Common bound by terms of reference. Decisions to be made by the CMAST Board would be presented to the Trust Board for agreement where required.

17.3 The Chair stated that progress reports would be presented to Board going forward as part of the Chief Executive update report and a formal report on how the Committee in Common was working in practice would be presented in April 2023.

The Board approved the CMAST joint working agreement to be signed by the Chief Executive on behalf of the Board, approved the establishment of a Committee in Common with terms of reference as proposed and also agreed to adopt and sponsor the approaches to collaborative working and decision making, as described, recognising the anticipated evolution and development of these proposals.

18 Research, Innovation and Medical Education (RIME) Committee Chairs Assurance
18.1 **Report and Terms of Reference**

NED-PM provided an update from the RIME Committee meeting held on 7th September 2022 and highlighted that an update on the funding position within the Research and Development function had been provided. A full review of the research portfolio was underway and further work was also required to ensure that the Neuroscience Research Centre was in a position to deliver on commercial contracts. This work would be undertaken by the Head of Neuroscience Research Centre and the Research Delivery and Quality Manager.

The Board noted the RIME Committee chairs assurance report and approved the terms of reference.

19 Remuneration Committee Chairs Assurance Report and Terms of Reference
19.1 The Chair provided an update from the Remuneration Committee meeting held on 1st September 2022 and informed that the annual review had been positive with improvements in year noted and the Pension Contribution Alternative Award Scheme Policy had been approved by the committee.

The Board noted the Remuneration Committee chairs assurance report and approved the terms of reference.

20 Consent Agenda
20.1 The Board agreed the following actions in relation to each Consent Agenda item:

- **Health Education England Self-Assessment** – The Board approved the Health Education England self-assessment and noted that the Patient Safety Group reported into Quality Committee and not Trust Board as a point of clarity.
- **Emergency Planning Resilience & Response (EPRR) Core Standards Self-Assessment** – The Board approved the EPRR core standards self-assessment.
- **NHS Prevention Pledge Progress Update** – The Board noted progress against the NHS Prevention Pledge action plan.

21 Any Other Business
21.1 NED-KH highlighted that Freedom to Speak Up month would be taking place throughout October and a number of events and promotional stands would be held.

21.2 The Chair wished to recognise on behalf of the Board the contribution of Dr Rhys Davies to the research agenda and also to the successful University Hospital accreditation for the Trust

22 Review of Meeting

22.1 Those present agreed the agenda covered a lot of ground, that the meeting was open, strategic and well chaired with a good level of debate. The relevant issues for Board had been discussed and there had been a good balance between the Executive Directors and Non-Executive Directors. NED-PM highlighted that the patient story had illustrated what the Trust was about and reflected the compassionate high level care delivered and noted the responsibility of the Board to challenge practice to ensure this continued.

There being no further business the meeting closed at 13.00

Date and time of next meeting - Thursday 3rd November 2022 at 09:30 Boardroom

Trust Board Attendance 2022-23										
Members:	Apr	May	Jun	Jul	Sept	Oct	Nov	Dec	Feb	Mar
Mr M Steinberg	✓	✓	✓	✓	✓	✓				
Ms K Bentley	✓	✓	✓	✓	✓	✓				
Mr P May	✓	✓	A	✓	✓	✓				
Ms S Rai	✓	✓	✓	✓	✓	✓				
Mr D Topliffe	✓	✓	✓	✓	✓	✓				
Mr R Walker	✓	✓	✓	✓	✓	✓				
Mr M Burns	A	✓	✓	✓	✓	✓				
Mr M Gibney	✓	✓	✓	✓	✓	✓				
Dr A Nicolson	✓	✓	A	✓	✓	✓				
Ms J Ross	✓	✓	✓	✓	✓	✓				
Ms L Salter	✓	✓	✓	A	✓	✓				
Ms L Vlasman	✓	✓	✓	A	A	✓				

TRUST BOARD
Matters Arising Action Log
October 2022

	Complete & for removal
	In progress
	Overdue

Actions for Completion

Date of Meeting	Item Ref	Agenda item & action	Lead	Update	Deadline	Status
6th October 2022	6	**Trust Strategy 2022-25 Update Report** CS to update the cycle of business to include quarterly progress reports and a larger update report to be presented in April 2023.	CS		3rd November 2022	
6th October 2022	17	**Cheshire and Merseyside Provider Collaborative (CMAST) Collaborative Agreement and Committee in Common** CS to update the cycle of business to include a formal report on how the CMAST Committee in Common was working in practice to be presented in April 2023.	CS		3rd November 2022	

The Walton Centre NHS Foundation Trust

Report to Trust Board
3 November 2022

Report Title	Chief Executive's Report
Executive Lead	Jan Ross, Chief Executive
Author (s)	Jan Ross, Chief Executive
Action Required	To note

Level of Assurance Provided

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

Key Messages

- National Politics remain unsettled with another new Conservative prime minister, Rishi Sunak and subsequently a new Secretary of State for Health and Social Care, Stephen Barclay. The priorities and challenges at present remain unchanged.

- Operational pressures continue, both nationally and regionally, with Accident & Emergency Department performance at lowest ever levels. The Walton Centre has seen high levels of occupancy, causing operational pressures internally. The National flu vaccination campaign is in full flow as well as covid boosters for those who are eligible.

- The national pay offer remains a concern and trade unions are currently in the process of balloting their members. The Trust has developed a draft business continuity plan and a regional response to potential action is being coordinated through the Cheshire & Merseyside (C&M) Integrated Care Board (ICB).

- The Jan Fairclough charity ball is scheduled for Friday 25th November 2022 with a focus upon the Trust's rehabilitation service.

- The staff annual awards and party takes place in November.

- NHS England published a new operating framework on 12 October 2022 which sets out how the NHS will operate in the new structure created by the 2022 Health and Care Act. The new operating framework sets out the roles that NHS England, Integrated Care Systems and providers will now play in the new structure. It describes how the NHS will work together and shows how accountabilities and responsibilities will work for all organisations.

Next Steps

- This paper is intended for information purposes.

Related Trust Strategic Ambitions and Themes	**Impact**		
All Applicable	Not Applicable	Not Applicable	Not Applicable

Strategic Risks		
All Risks	Choose an item.	Choose an item.
Equality Impact Assessment Completed		
Strategy ☐	Policy ☐	Service Change ☐

Report Development			
Committee/ Group Name	**Date**	**Lead Officer (name and title)**	**Brief Summary of issues raised and actions agreed**
n/a			

Chief Executive's Report

National Update

1. Since the last Trust Board, the political environment has seen further changes, with the appointment of another new Conservative prime minister, Rishi Sunak and subsequently Secretary of State for Health, Stephen Barclay. It is again too early to understand the potential expectation and impact.

2. The NHS pay offer continues to cause unrest nationally. All major unions are currently balloting staff on strike action. As reported in last month's report The Trust has worked up robust business continuity plans to support with industrial action if required.

3. Operational pressures nationally have remained high demand on urgent care. The Royal Liverpool Hospital moved into its new building over the month of October. The Walton Centre supported with mutual aid as required, however this has impacted on high occupancy levels, causing operational pressures.

4. NHS England (NHS) winter planning continues with additional meetings taking place across the system. Elective recovery remains a key national focus.

5. The Trust continues to perform well and has made significant improvements in seeing and treating patients in a timely manner. An amber alert for blood products has been officially declared by NHS Blood and Transplant, the Walton Centre has a working group to manage the alert, a daily sitrep has been implemented for any patients who have their surgery cancelled due to lack of blood products.

6. In February 2020, NHS England and NHS Improvement (NHSE/I) commissioned Dr Bill Kirkup to undertake an independent review into maternity and neonatal services at East Kent Hospitals University NHS Foundation Trust. This followed concerns raised about the quality and outcomes of maternity and neonatal care. The report, Reading the signals: Maternity and neonatal services in East Kent was published in October with several key action areas for all Trusts to review. The Walton Centre will review and bring a report to a future board meeting.

Cheshire & Merseyside Integrated Care System (ICS)

7. At a C&M level the pay deal and cost of living crisis remains a key concern, particularly as we move into the winter months, we also need to consider this with regards to potential industrial action.

8. The Liverpool Clinical Services Review continues, the workshops have now commenced with the agreed priorities as Women's Health and the Urgent and Emergency Care pathways, executive representation has been provided for the focus groups.

9. Following a rigorous judging process, The Walton Centre in collaboration with St Helens and Knowsley NHS trust won the Nursing Times 'Cancer Nursing award' for their work on Introduction of a brain cancer optimisation pathway.The judges said the idea for this brain tumour optimisation pathway was conceived by nurses who then innovated, with courage, commitment and collaboration, a sustainable nurse led service. In doing so, they are

addressing the needs of patients in a previously unrepresented group who without this support may have been left with unmet needs. This is a fantastic example of collaboration.

Covid-19

10. The current Covid-19 wave appears, based on the national data, to be on a downward trend. The key focus is on booster vaccinations for those eligible. The Walton Centre is supporting staff to get their vaccinations through the Hub at Aintree Hospital.

Trust Update

11. A location has now been agreed for the staff Health and Wellbeing hub at the front of the hospital and is scheduled to open in December 2022. This represents a step change in our health and well being offer to staff and will provide a dedicated area with an increased offer of support.

12. The annual staff survey has now gone live and is open for all staff to complete. As of the 26th October, 25% of staff have completed the survey.

13. We have now circulated the Trust strategy to all key stakeholders we have received a lot of positive feedback on style and content.

Branding and Marketing

14. The Board brand workshop is planned for the 29th November, this will further support the agency in their vision for The Walton Centre.

15. There have been several media opportunities throughout the month of October and into early November listed below:
    - Nick Carleton-Bland and Farouk Olubajo are featuring in a documentary on Channel Five, 'Cause of Death: The Coroner's Office'.
    - Neuropsychiatric Specialist Nurse Lindsay Cleary has written a profile for the Nursing Standard.
    - Principle Speech and Language Therapist Mel Taylor is being interviewed by BBC Radio Merseyside next week, covering the new saliva management clinic for Motor Neurone Disease patients.
    - Patient Support Assistant Rachel Chadwick is being interviewed by Tony Snell from BBC Radio Merseyside about the role and also her experience as a patient
    - When we have identified a spinal patient case study, ITV Granada have already expressed an interest in shadowing Ms Maggie Lee in using the new spinal robot.

Estates & Facilities

16. The Heating and Pipework project remains on track and we have now commenced phase 5 of the project, this phase includes the old Lipton ward, Neurophysiology, Therapies and Radiology and any issues or concerns will be picked up as part of the Heating and Pipework group which is chaired by the Chief Operating Officer.

17. The Bed Repurposing project has now moved into the next phase, the new Lipton and Caton short stay unit is now complete and open for patients, and the new Rapid Access Neurology Assessment (RANA) work has been commenced and is due to open end of November 2022.

18. There are three planned Estates capital projects for this year which include the air handling units, the CCTV and security upgrade and the Critical Care ponta systems (the structures behind the beds that hold the monitors and electrical supply). A working group has been set up to plan for these three projects and will be chaired by the Chief Operating Officer. The capital funding and business cases have been approved for all these projects to commence.

Business as Usual

Quality

19. Both the Complex Rehabilitation Unit (CRU) and Chavasse wards have achieved Gold in their ward accreditation.

20. Patient and family centred care 6 steps has been re-launched and work is ongoing.

21. A review of Healthcare Assistant establishments has been undertaken and resulted in a redistribution of resource. A review of shift patterns has also been undertaken to release funds to reinvest sum of £430k.

Finance

22. The Trust is delivering above plan for its Income & Expenditure (I&E) financial plan year to date by £0.2m after performance in Month 6. Some of this has been driven by the assumed recovery of the Elective Recovery Fund (ERF) to plan for reporting purposes though this has yet to be confirmed formally by NHSE. There has also been increased activity relating to the IOM. The Trust will continue its efforts to deliver challenging ERF and Cost Improvement Programme (CIP) targets across the rest of the financial year in order to deliver its full year forecast of a £3.1m surplus, which is £0.2m above plan.

23. Unidentified CIP has reduced from £1m to £0.4m and work continues to identify the full year CIP. Capital expenditure remains behind plan (£0.9m) with the Heating and Pipework and Digital Aspirant schemes forming the majority of spend. and the Trust is still forecasting that it will manage to its Capital Resource Limit (CRL) by the end of the year.

24. The C&M ICB deficit at Month 6 stands at £55m (providers £57.4m deficit) against a plan of £30.2m deficit (providers £40.1m deficit plan). Providers are therefore currently £17.3m worse than plan at Month 6, with pay being the key driver of the variance (£104.0m) and non-pay representing a £5.0m pressure offset by over-performance on income (£91.7m). CIP is being delivered but this is heavily dependent on non-recurrent schemes. Forecast outturn is still showing delivery of a £30.4m deficit which is in line with the agreed plan. Capital spend in C&M is £60.1m YTD against a plan of £92.6m with full year forecast of £233.7m being c£9m above plan.

25. ERF performance continues to be awaited and specialised commissioners are awaiting up to date information from the national team to understand year to date performance. As noted, it is not expected that clawback will take place for Quarter 1 and Quarter 2 although formal

confirmation is awaited. There are potential changes to ERF in Quarter 3 and Quarter 4 that the national team are considering. Given the recent news regarding the gap in public finances it has been reported the NHS budget is likely to face real term cuts over the next 2 years given the projected level of inflation, so finance delivery will continue to be a major challenge going forward.

Performance/ Operations

26. The Trust is in a good position for performance, all diagnostic and cancer targets have been achieved continuously throughout the Covid-19 pandemic and 104-week waits have now been eradicated. The focus is now on patients who have waited 78 weeks and we currently have four patients to be listed and approximately 152 patients waiting 52 weeks.

27. Additional spinal referrals are now being received from Liverpool Universities University Hospitals Trust – there are 79 outstanding which include several long waits that need clinical validation.

28. Winter pressures and patients requiring community services has increased there are currently 36 patients in the trust requiring external care resulting in delayed discharges and cancelled operations.

29. The Walton Centre's key areas of focus for areas of improvement will be DNA (Did Not Attend) and this will be completed as part of the Outpatient Transformation work.

Recommendation

To note

Author: Jan Ross, Chief Executive Officer

Date: 1 November 22

The Walton Centre NHS Foundation Trust

Report to Trust Board
3 November 2022

Report Title	The Walton Centre Charity Annual Reports & Accounts 2021/2022
Executive Lead	Mike Burns Chief Financial Officer
Author (s)	Zoe Stevenson, Financial Accountant Madeleine Fletcher, Head of Fundraising
Action Required	To approve

Level of Assurance Provided

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

Key Messages

- The Annual Report & Accounts were considered and agreed by the Charity Committee on October 21, 2022.
- No errors were identified during the independent examination by BWM.
- The 2021/2022 Annual Report & Accounts for The Walton Centre Charity are presented for approval by the Board in its capacity as Corporate Trustee.

Next Steps

- Chair to sign Annual Report & Accounts, and Letter of Representation and return to BWM for their records.
- Update the final print version of the report with the electronic signatures of the Chair and the independent examiner.
- Submit Annual Report & Accounts to the Charity Commission by 31 December 2022.

Related Trust Strategic Ambitions and Themes	**Impact**		
Choose an item	Not Applicable	Not Applicable	Not Applicable

Strategic Risks

Choose an item.	Choose an item.	Choose an item.

Equality Impact Assessment Completed

Strategy ☐	Policy ☐	Service Change ☐

Report Development

Committee/ Group Name	**Date**	**Lead Officer (name and title)**	**Brief Summary of issues raised and actions agreed**
The Walton Centre Charity Committee	22 July 2022	Zoe Stevenson Financial Manager	Draft version considered by the WCCC – no issues raised.
The Walton Centre Charity Committee	21 October 2022	Zoe Stevenson Financial Manager	Final version presented to the WCCC by the independent examiner BWM. No issues raised. WCCC approved report & accounts.

The Walton Centre Charity Annual Report & Accounts 2021/2022

Introduction

1. The 2021/2022 Annual Report and Accounts for The Walton Centre Charity are presented to the Board for approval in its capacity as Corporate Trustee.

Background and Analysis

2. The Annual Report and Accounts were considered in draft format at the Walton Centre Charity Committee meeting on 22 July.

3. Final version of the report and accounts were presented by the independent examiner BWM at the October meeting of the Walton Centre Charity Committee (21st October). No issues were reported and the report/accounts were approved by the Committee.

Conclusion

4. An independent examination of The Walton Centre Charity's Annual Report and Accounts raised no issues – the final version, already approved by the Walton Centre Charity Committee on 21 October, is presented to the Board for final approval in its capacity as Corporate Trustee of the Charity.

Recommendation

Approve

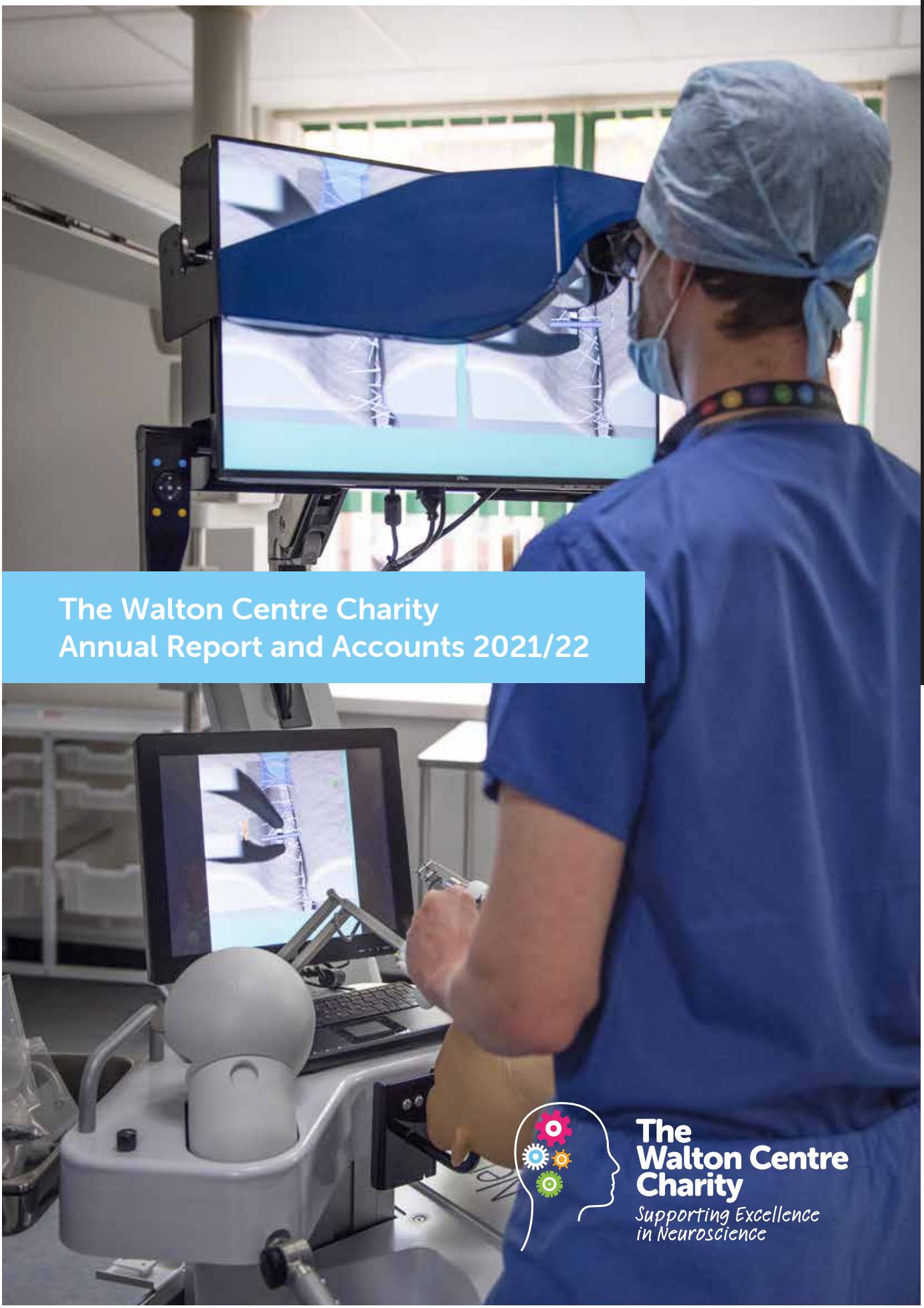
Author: **Madeleine Fletcher, Head of Fundraising**
Date: **27 October 2022**

Appendix 1

The Walton Centre Charity Annual Report & Accounts

Appendix 2

Letter of Representation



The Walton Centre Charity Annual Report and Accounts 2021/22

The Walton Centre Charity
Supporting Excellence in Neuroscience

Physiothapist Maya in one of the patient gyms

Welcome to The Walton Centre Charity Annual Report for 2021/22

Once again, the past year has brought considerable challenges across so many areas, including the charity sector, due to the Covid-19 pandemic.

However, we have continued to support the work of The Walton Centre and have been delighted to return to some of our face-to-face fundraising, as well as innovate and develop some new fundraising opportunities.

Our supporters have been incredible throughout the hard time of the pandemic, and as the cost-of-living crisis begins to really impact homes across the region, and the country. We appreciate this support more than we can say, it means a huge amount to our patients, their families and our staff and for that, I'd like to say a big thank you to everyone who has donated or raised money for us over the past year.

Although the 2021 Hope Mountain Hike and Golf Day were both unfortunately cancelled, we were able to proceed with a virtual hike and a cathedral abseil which raised over £10,000 between them. We were also delighted to have a team taking part in both the Virtual London Marathon and the in-person event, raising an amazing £14,000.

The 10th anniversary Jan Fairclough Ball was also able to go ahead, raising £72,000 towards the appeal for the Neuro VR simulator, a training tool for neurosurgeons. Due to the continued success of this appeal, we were able to fully fund the equipment, and The Walton Centre is the only centre in the UK to offer this innovative training tool.

We also continued to support the Home from Home relatives' accommodation which provides an enormous benefit to the families of patients who value enormously the ability to stay close to their loved ones at such a difficult time.

Our support for research at The Walton Centre increased, including funding for research posts, equipment and training. This is a key strategic focus for the Trust and we're pleased to support it and enable the advancement of treatment and care for patients.

We're looking forward to the next year and hopefully continuing to open up our in-person fundraising whilst also putting an increased focus on new methods of digital fundraising, but we recognise it may be a difficult time for many of our supporters. We value however and whenever people support us, the kindness and generosity means so much to everyone at The Walton Centre and makes an enormous difference. Thank you.

Su Rai
Chair, The Walton Centre Charity Committee
and Non-Executive Director, The Walton Centre
NHS Foundation Trust
3 November 2022

Cover image
Surgeons using the new charitably acquired Neuro VR, which simulates complex neurosurgical procedures, to train.

Objective

For any charitable purpose or purposes relating to The Walton Centre NHS Foundation Trust and such other places as the Trustee shall from time to time determine.

The Charity includes 27 earmarked funds which have been set up to enable the Trustee to meet the wishes of donors who have indicated that they would wish to have their money spent to benefit a specific ward/ department or area of research. A full list of the funds is provided on page 26 of this report. Details of the fund managers and aims and objectives for each fund are provided on page 27.

A patient receives rehabilitative therapy

Public benefit statement

The Walton Centre NHS Foundation Trust is the main beneficiary of the Charity and is a related party by virtue of being Corporate Trustee of the Charity. By working in partnership with the Trust, the charitable funds are used to best effect for the benefit of the public served by the Trust.

When deciding on the most beneficial way to use charitable funds, the Corporate Trustee has regard to the main objective, strategies, and plans of the Trust, whilst ensuring that the grants reflect the wishes of the donors, patients and staff.

The focus of the Charity's activities is to benefit the public who utilise the services of The Walton Centre NHS Foundation Trust. The hospital mainly services the community of Cheshire, Merseyside, North Wales and the Isle of Man, all of whom have equal access to its facilities. Charitable expenditure is made by way of direct grants to The Walton Centre NHS Foundation Trust, to enhance the patient care already provided.

The agents of the Corporate Trustee have complied with their duty to have due regard to the guidance on the public benefit published by the Charity Commission in exercising their powers of duty.

Fundraising regulation

The Charity strives to give the best possible donor care to ensure supporters are treated fairly and with respect. The Charity is regulated by the Charity Commission and Fundraising Regulator, the self-regulatory scheme for fundraising in the UK. In addition to this, the Charity is a member of NHS Charities Together and the Chartered Institute of Fundraising.

Fundraising activities, donations and legacies

During the year the total donations, legacies and income from fundraising events (shown as 'Other Trading Activities' in the Statement of Financial Activities) came to £350,000 (total income including return on investments £380,000).

Despite the continued challenges of this year there were still amazing fundraising efforts made by supporters of the Charity. Individuals took up their own personal challenges to fundraise - whether that was running, cycling or walking - and there were a number of 'virtual' events using social media and other online platforms.

The Charity website and other digital platforms played a particularly significant role during this year, to help facilitate fundraising in different ways.

Fundraisers welcomed back to the Trust after running the Virtual London Marathon

Examples of activities carried out to raise funds during the year under review include:

Fundraising activities and donations

- Virtual Hope Mountain Hike - £5,700
- Abseil from the Anglican Cathedral - £6,000
- The Virtual London Marathon – £14,000
- Christmas Appeal - £7,000

Grant making trusts and foundations

- NHS Charities Together - £16,500
- Hemby Trust - £20,000

Legacies

During the year under review the Charity received a total of £18,000 in legacy income.

To facilitate supporters wishing to leave gifts in their wills, the Charity also continued their partnership with an on-line will writing service, to support legacy marketing and giving.

The Charity is grateful to all our donors and supporters for all they do to raise funds and awareness for The Walton Centre Charity, to help us make a difference to patients and their families both now and in the future.

Review of the year

During the year the Charity received a total income of £380,000 (2020/21: £529,000) which is a decrease of £149,000. The overall decrease can in the main be attributed to the drop of £77,000 in legacy income from £319,000 in 2020/21. The year under review did also see a decrease in donations from £409,000 in 2020/21 to £239,000 in 2021. Although the Charity received a £16,500 grant from NHS Charities Together this was £130,100 less than what was received during the 'emergency phase' of the national covid appeal in 2020/21.

The loss of income during the year under review was expected considering the very different landscape which has emerged following the pandemic. The new environment includes a shift in how people work and socialise, and many aspects of the economy has been severely affected. The direct impact on the Charity was the cancellation early in the year of the Golf Day and Hope Mountain Hike due to covid restrictions in place. However, in November, the 10th Anniversary Jan Fairclough Ball was able to go ahead, and the Charity used the opportunity to launch an appeal for a Neuro VR Simulator (a training tool for neurosurgeons). The appeal was successfully completed by the end of March 2022 and the Trust is now the only centre in the UK, and one of only three in Europe, to offer this innovative training tool.

During the year under review, the Charity spent £638,000 in 2021/22 (2020/21: £685,000). The Charity's expenditure covers its charitable objectives, fundraising and governance support costs.

In 2021/22 expenditure on charitable activities was £394,000 (2020/2021 £491,000) covering three main areas:

— Patient welfare and amenities: £169,000 (2020/21: £199,000) – this included the Home from Home relatives' accommodation; cutting edge medical equipment including a Neuro VR Simulator and Music Therapy.

— Staff welfare and amenities: £50,000 (2020/21: £158,000) – expenditure on staff welfare and amenities decreased. In addition to welfare and amenities, funding was also made available for professional development, such as enhanced study courses, training and conferences, to ensure staff remain at the forefront of clinical, research and personal developments. Expenditure also included enhanced study courses and training and conferences for staff, which will enable them to provide a better service to patients of the Trust, £4,265 was provided for this purpose (20/21 £6,905).

— Research: £127,000 (2020/21: £95,000) – this included funding for research posts, equipment, training, books and journals.

Including the £86,000 net gain on investments, (which is treated as a component of net income), the total expenditure for the Charity exceeded income by £172,000 for the year.

Young fundraiser Archie with dad Adam and mum Sam after completing his own Hope Mountain Hike challenge

Volunteers

The Trust currently has approximately 59 registered Volunteers working in various departments throughout the Trust.

The volunteers provide a much-needed trolley service for the inpatients and staff. Other volunteer activity covers the Meet and Greet; Infection Control; Neuro Buddies; Gardening; Pain Management Programme and Neurophysiology Outpatient services. The Volunteer service is supported by the Charity.

During much of the year under review, all the above-mentioned roles were suspended as the volunteers were not able to come to site due to health and safety and infection control restrictions.

Staff and volunteers working together to welcome patients

Forward look

The Charity aims to continue its work to fund a variety of projects which will help improve patient care and services. These include new technology and innovations; research; as well as improved facilities for our patients and families.

The Charity will also continue to support staff with health and wellbeing initiatives, as well as enhanced training opportunities to ensure they can remain at the forefront of clinical and research developments to the benefit of patients today and in the future.

The Charity will develop a new three-year Fundraising Strategy for 2022- 2025 which will explore options to adapt the fundraising business model and strategy to support income generation in the post pandemic environment. This will include restarting annual events in person, but with a more hybrid approach to the delivery in order to enable virtual/online participation if necessary.

Focus will also be to increase individual giving through regular patterns, such as monthly direct debit donations; lottery scheme; and Facebook fundraising events as well as a more proactive legacy marketing campaign. This will all be underpinned by digital fundraising, and the Charity is exploring options to strengthen its fundraising team in this area.

Work will also continue to implement and promote the process through which future fundraising projects can be identified. The process ensures that wider engagement with clinical staff occurs and includes relevant levels of approval to make sure that any potential major charitable investments are in-line with and support the overall corporate strategic direction of the organisation

Structure, governance and management

The Charity was established in 1992 using the model declaration of trust for NHS charities and all of the funds held on trust at the date of registration were registered under the umbrella Charity.

Following discussions with the Charity Commission it was determined that ward and departmental funds should be registered as part of the General Purpose fund as would any monies received for purposes which had a finite life. This is on the basis that hospitals are continually evolving organisations and the bureaucratic impact on the Charity and the Charity Commission would be significant if the ward funds were registered as separate charities. This is because of the legal requirements surrounding changing fund objectives or the winding up of funds. Subsequent donations and gifts are added to the appropriate earmarked fund balance within the existing Charity or a new earmarked fund is created.

The Charity has procedures in place to ensure that it fulfils its legal duty of ensuring that funds are spent in accordance with the objects of each fund. The use of earmarked funds also allows the Charity to respect the wishes of donors in indicating how they would like their donation spent without imposing a material administrative burden. A full list of the funds, fund advisors and objectives for each fund are provided in Appendix 2 on page 27.

All expenditure is recorded as grant expenditure as the recipient organisation (normally The Walton Centre NHS Foundation Trust) requires beneficial ownership of any assets. Applications for expenditure are submitted to the Charitable Funds Administrator who ensures that they are properly authorised and in accordance with the relevant fund's objectives.

Each separate fund has a fund advisor who is an authorised signatory and has delegated authority to approve expenditure in line with the objective of the fund up to £1,000. Items of expenditure between £1,000 and £5,000 must also be authorised by the Director of Finance. Any expenditure in excess of £5,000 is approved by the Committee.

Non-Executive members of the Trust Board are appointed by the Foundation Trust Governors and Executive members of the Board are subject to recruitment by the NHS Foundation Trust. Members of the Trust Board and the Committee are not individual trustees under charity law but act as agents on behalf of the Trustee.

Day-to-day administration of the funds is dealt with by the Financial Accounts section of the Finance Department.

Specialist Nurses reviewing notes for a Subarachnoid Haemorrhage clinic

Reference and administration details

Name

The Walton Centre Charity

Charity Commission number

1050050

HM Revenue and Customs number

XR4801

The principal contact of the Charity

Mike Burns
Chief Finance Officer
The Walton Centre Charity
The Walton Centre NHS Foundation Trust
Lower Lane, Fazakerley
Liverpool L9 7LJ

T 0151 556 3482
E mike.burns3@nhs.net

Bankers

Royal Bank of Scotland
Liverpool Group of Branches
1 Dale Street
Liverpool L2 2PP

Independent examiner

Anita Mason BA(Hons) BFP FCA
BWM Chartered Accountants
Tempest, Suite 5.1, 12 Tithebarn Street,
Liverpool, L2 2DT.

Investment advisors

CCLA
Senator House
85 Queen Victoria Street
London EC4V 4ET

Ruffer LLP
80 Victoria Street
London SW1E 5JL

Head of Fundraising Madeleine Fletcher with Charity Patron David Fairclough and Charles Hanson at the annual Jan Fairclough Ball

Trustee

The Walton Centre NHS Foundation Trust is the sole corporate trustee of the Charity. For the purpose of this annual report and these accounts the sole corporate trustee is referred to as The Walton Centre NHS Foundation Trust ("the Trust").

The Board of the aforementioned Trust has delegated responsibility for the ongoing management of funds to The Walton Centre Charity Committee ("the Committee") which administers the funding on behalf of the Trustee. In the year ended 31 March 22 the following people served as directors of the Trustee:

Janet Rosser
Chair (to 31/10/21)

Hayley Citirine
Chief Executive (to 31/03/21)

Janet Ross
Chief Executive (to 01/04/22)

Dr Andrew Nicolson
Medical Director

Seth Crofts
Non-Executive Director (to 31/03/22)

Ray Walker
Non-Executive Director (from 01/01/22)

Prof Nalin Thakkar
Non-Executive Director (to 31/12/21)

Prof Paul May
Non-Executive Director (from 01/01/22)

Su Rai
Non-Executive Director

Karen Bentley
Non-Executive Director

David Topliffe
Non-Executive Director

Mike Burns
Chief Finance Officer

Mike Gibney
Chief People Officer

Lisa Salter
Chief Nurse

Lindsey Vlasman
Acting Chief Operating Officer

In the year ended 31 March 2022 the following people served on the Committee as agents for the Trustee, as permitted under Regulation 16 of the NHS Trust's (Membership and Procedures) Regulations 1990:

Su Rai
Non-Executive Director (Chair)

Prof Nalin Thakkar
Non-Executive Director (to 31/12/21)

Prof Paul May
Non-Executive Director (from 1/1/22)

Mike Burns:
Chief Finance Officer

Lisa Salter
Chief Nurse

Dr Sacha Niven
Consultant Neuroradiologist and Deputy Medical Director

Mr Neil Buxton
Consultant Neurosurgeon

Dr Peter Moore
Consultant Neurologist

Risk management

The Committee has examined the major risks affecting the Charity and identified the system and mechanisms in place to mitigate these risks.

The most significant risk identified is the potential loss incurred by a fall in the value of the Charity's investments. The Committee believe that the higher returns available from the stock market over the longer-term means that this is an acceptable risk, and the Charity has balanced its investment portfolio to safeguard against a material loss in value and has concluded that there is no material risk to the fund at present.

The close relationship between the Charity and the Trust means that the Charity benefits from the same controls designed to manage risk as the Trust. The Trust has developed various controls designed to mitigate the risk of loss through fraud or maladministration which have been applied to the Charity. Mersey Internal Audit Agency has developed a risk-based approach which reviews the operation and effectiveness of these controls. The various controls are examined on a cyclical basis and the frequency is determined by the level of risk relating to that area of control.

Reserves

The Charity has a reserves policy that is reviewed every year. Reserves are part of the Charity's funds that are available for its general purpose after meeting its commitments and other planned expenditure. Reserves include unrestricted funds or income that can be expended at the Trustee's discretion in furtherance of the Charity's aims and objectives.

Such funds can be earmarked for a particular project, but such a designation has an administration purpose only and does not legally restrict the Trustee's discretion to apply the fund. The Trustee has adopted a policy which states that reserves will not be permitted to fall below the total available of unrestricted funds for the General Purpose Fund at March 2022 less approved committed expenditure and running costs of the charity it is recommended that reserves of £300,000 be held in light of the Reserves Policy. .

At 31 March 2022 the Charity held £1,689,000 in reserves, all of which related to unrestricted funds.

An Intensive Care Nurse preparing to receive a patient in ICU

Investments

The Walton Centre NHS Foundation Trust is the sole corporate trustee of the Charity. The Trust Board therefore has overall responsibility for the investment of the Charity's funds.

The Board has delegated responsibility for the ongoing management of funds to The Walton Centre Charity Committee. In turn, full discretion has been given to external investment managers in the day-to-day management of the assets. The Trustee believes that the investment strategy inherent in the investment managers' discretionary actions is appropriate for controlling risk.

The main assets of the Charity were previously held in a segregated portfolio of investments managed by Investec Wealth and Investment Ltd. The Charity Committee, supported by the Trust Board, transferred the Charity's investments to two multi-asset pooled charity funds in July 2018: CCLA Ethical Investment Fund (50%) and Ruffer LLP Charity Assets Trust (50%).

The aim was to create greater diversification (minimising risk) and improved performance over the longer-term, as well as generating potentially lower fees.

Ethical investment describes a way of making financial investments which reflects the Charity's values and ethos and does not run counter to its aims. A Charity can decide to invest ethically, even if the investment might provide a lower rate of return than an alternative investment. The law permits the following reasons:

— A particular investment conflicts with the aims of the Charity,

— The Charity might lose supporters or beneficiaries if it does not invest ethically, and

— There is no significant financial detriment.

As an NHS Charity, The Walton Centre Charity has determined that it should not invest in tobacco companies because of the proven link between smoking and poor health which would make such investments contrary to its charitable aims.

The pooled funds operated by CCLA and Ruffer LLP satisfy this requirement. Any other restrictions applied by the investment managers should not limit the operations of the Charity.

During the year ending the 31 March 2022 the stock market continued the fairly volatile trend of the past few years. The market value of the funds at the 31 March 2022 was £1,248,000 which is £86,000 higher than the market value at the 31 March 2021. The Charity benefited from dividends and interest of £30,000 which represents a positive result, given the low risk nature of the investment portfolio.

Statement of Trustee responsibilities

It is a pleasure to present the Annual Report for The Walton Centre Charity ("the Charity"), together with the financial statements for the year ended 31 March 2022 which have been subject to an independent examination.

The annual report and accounts have been prepared in accordance with Part 8 of the Charities Act 2011 and Accounting and Reporting by Charities: Statement of Recommended Practice (SORP) applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) (effective 1 January 2015) as updated by the Charities SORP (FRS 102) Update Bulletin 1 (as amended for accounting periods commencing from 1 January 2019). The Charity's report and accounts include all of the separate funds for which The Walton Centre NHS Foundation Trust is the sole corporate trustee (the "Trustee").

All of the separate funds are designated parts of the Charity registered with the Charity Commission under the umbrella of The Walton Centre Charity with the registered Charity Number 1050050 in accordance with the Charities Act 2011.

The law applicable to charities in England and Wales requires the Trustee to prepare financial statements for each financial year which give a true and fair view of the charity's financial activities during the year and of its financial position at the end of the year. In preparing financial statements giving a true and fair view, the Trustee should follow best practice and:

- Select suitable accounting policies and then apply them consistently,
- Make judgements and estimates that are reasonable and prudent,
- State whether applicable accounting standards and statements of recommended practice have been followed, subject to any departures disclosed and explained in the financial statements, and
- Prepare the financial statements on the going concern basis unless it is inappropriate to presume that the charity will continue in operation.

The Trustee is responsible for keeping accounting records which disclose with reasonable accuracy the financial position of the charity and which enable them to ascertain the financial position of the charity and which enable them to ensure that the financial statements comply with the Charities Act 2011, the Charity (Accounts and Reports) Regulations and the provisions of the trust deed. The Trustee is responsible for safeguarding the assets of the Charity and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The Trustee confirms that it has met the responsibilities set out above and complied with the requirements for preparing the accounts. The financial statements and notes set out on pages 16 to 25 have been compiled from and are in accordance with the financial records maintained by the Trustee.

Signed on behalf of the Trustee

Su Rai
Chair of the Charity Committee
3 November 2022

A Healthcare Assistant preparing a monitor to use with a patient on Chavasse Ward.

Neurosurgeon Mr Farouk Olubajo in theatre

Independent examiner's report to the corporate trustee of The Walton Centre Charity

I report to the Trustees on my examination of the accounts of The Walton Centre Charity (the charity) for the year ended 31 March 2022.

This report is made solely to the charity's trustees, as a body, in accordance with Section 145 of the Charities Act 2011. My examination has been undertaken so that I might state to the charity's trustees those matters I am required to state to them in an Independent Examiner's report and for no other purpose. To the fullest extent permitted by law, I do not accept or assume responsibility to anyone other than the charity and the charity's trustees as a body, for my examination, for this report, or for the opinions I have formed.

Responsibilities and basis of report

As the Trustees of the charity you are responsible for the preparation of the accounts in accordance with the requirements of the Charities Act 2011 ('the Act').

I report in respect of my examination of the Trust's accounts as carried out under section 145 of the 2011 Act and in carrying out my examination I have followed all the applicable Directions given by the Charity Commission under section 145(5) (b) of the Act.

Independent examiner's statement

Since the charity's gross income exceeded £250,000 your examiner must be a member of a body listed in section 145 of the 2011 Act. I confirm that I am qualified to undertake the examination because I am a member of the ICAEW, which is one of the listed bodies.

Your attention is drawn to the fact that the charity has prepared financial statements in accordance with Accounting and Reporting by Charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) in preference to the Accounting and Reporting by Charities: Statement of Recommended Practice issued on 1 April 2005 which is referred to in the extant regulations but has now been withdrawn.

I understand that this has been done in order for the financial statements to provide a true and fair view in accordance with Generally Accepted Accounting Practice effective for reporting periods beginning on or after 1 January 2015.

I have completed my examination. I confirm that no matters have come to my attention in connection with the examination giving me cause to believe that in any material respect:

1. accounting records were not kept in respect of the charity as required by section 130 of the Act; or

2. the accounts do not accord with those records; or

3. the accounts do not comply with the accounting requirements concerning the form and content of accounts set out in the Charities (Accounts and Reports) Regulations 2008 other than any requirement that the accounts give a 'true and fair' view which is not a matter considered as part of an independent examination.

I have no concerns and have come across no other matters in connection with the examination to which attention should be drawn in this report in order to enable a proper understanding of the accounts to be reached.

Anita Mason BA(Hons) FCA BFP
Independent Examiner
BWM Chartered Accountants
Date TBC

Statement of financial activities

For the year ended 31 March 2022

	Note	2021/22	2020/21
		Total Funds (Unrestricted)	Total Funds (Unrestricted)
		£000	£000
Income and endowments from:			
Donations and legacies		257	504
Other trading activities		93	4
Investments		30	21
Total income and endowments	3	**380**	**529**
Expenditure on:			
Raising funds		244	194
Charitable activities		394	491
Total expenditure	4	**638**	**685**
Net gains/(losses) on investments		86	168
Net income/(expenditure) and net movement in funds	6	**(172)**	**12**
Reconciliation of funds:			
Fund balances brought forward		1,861	1,850
Fund balances carried forward		**1,689**	**1,861**

All of the Charity's funds are unrestricted. The net expenditure for the year arises from the Charity's continuing operations. The notes on pages 19 to 25 form part of these accounts.

Balance Sheet

As at 31 March 2022

	Note	2021/22	2020/21
		Total Funds (Unrestricted)	Total Funds (Unrestricted)
		£000	£000
Fixed assets			
Investments	6	1,248	1,162
Total fixed assets		**1,248**	**1,162**
Current assets			
Debtors	7	3	80
Cash at bank and in hand	8	650	680
Total current assets		**653**	**760**
Creditors: amounts falling due within one year	9	212	61
Net current assets/(liabilities)		**441**	**699**
Total assets less current liabilities		**1,689**	**1,861**
Total net assets		**1,689**	**1,861**
Funds of the Charity			
Unrestricted	10	1,689	1,861
Total funds		**1,689**	**1,861**

The notes on pages 19 to 25 form part of these accounts.

Signed on behalf of the Trustee

Su Rai
Chair
3 November 2022

Statement of cash flows

For the year ended 31 March 2022

	Note	2021/22	2020/21
		Total Funds (Unrestricted)	Total Funds (Unrestricted)
		£000	£000
Cash flows from operating activities:			
Net cash provided by (used in) operating activities		**(60)**	**(265)**
Cash flows from investing activities:			
Dividends and interest from investments		30	21
Proceeds from sale of investments		0	0
Purchase of investments		0	(27)
Net cash provided by (used in) investing activities		**30**	**(6)**
Change in cash and cash equivalents in the reporting period		(30)	(271)
Cash and cash equivalents at the beginning of the reporting period		680	951
Cash and cash equivalents at the end of the reporting period	8	**650**	**680**
Reconciliation of net income/(expenditure) to net cash flow from operating activities:			
Net income/(expenditure) for the reporting period (as per the statement of financial activities)		(172)	12
Adjustments for:			
(Gains)/losses on investments		(86)	(168)
Dividends and interest from investments		(30)	(21)
(Increase)/decrease in debtors		77	(75)
Increase/(decrease) in creditors		151	(14)
Net cash provided by (used in) operating activities		**(60)**	**(265)**

Notes to the financial statements

For the year ended 31 March 2022

1. Accounting Policies

1a. Accounting Convention

The financial statements have been prepared under the historic cost convention, as modified for the revaluation of certain investments. The financial statements have also been prepared in accordance with Accounting and Reporting by Charities: Statement of Recommended Practice applicable to charities preparing their accounts in accordance with the Financial Reporting Standard (FRS 102) (effective 1 January 2015) as updated by the Charities SORP (FRS 102) Update Bulletin 1 (as amended for accounting periods commencing from 1 January 2019) and applicable UK Accounting Standards and the Charities Act 2011.

This is the seventh year that financial statements have been prepared in compliance with the Charities Statement of Recommended Practice (FRS 102). A Statement of Cash Flows has also been included.

1b. Incoming Resources

a. All incoming resources are included in full in the Statement of Financial Activities as soon as the following three factors can be met:

   i. Entitlement – arises when control over the rights or other access to the economic benefit has passed to the Charity;

   ii. Probable – when it is more likely than not that the economic benefits associated with the transaction or gift will flow to the Charity; and

   iii. Measurement – when the monetary value or amount of the income can be measured reliably and the costs incurred for the transaction and the costs to complete the transaction can be measured reliably.

b. Legacies are accounted for as incoming resources when it is probable that they will be received. Receipt is normally probable when:

   i. There has been grant of probate;

   ii. The executors have established that there are sufficient assets in the estate, after settling any liabilities, to pay the legacy; and

   iii. Any conditions attached to the legacy are either within the control of the Charity or have been met.

1c. Resource Expended

a. The funds held on Trust accounts are prepared in accordance with the accruals concept. All expenditure is recognised when all of the following criteria are met:

   i. Obligation – a present legal or constructive obligation exists at the reporting date as a result of a past event;

   ii. Probable – it is more likely than not that a transfer of economic benefits, often cash, will be required in settlement; and

   iii. Measurement – the amount of the obligation can be measured or estimated reliably.

b. Cost of generating funds comprises the costs associated with attracting voluntary income.

c. Charitable expenditure comprises those costs incurred by the Charity in the delivery of its activities and services for its beneficiaries. It includes both costs that can be allocated directly to such activities and any costs of an indirect nature necessary to support them.

d. Governance costs include those costs associated with meeting the constitutional and statutory requirements of the Charity and include accountancy fees and costs linked to the strategic management of the Charity.

1d. Structure of Funds

Where there is a legal restriction on the purpose to which a fund may be put, the fund is classified in the accounts as a restricted fund. Other funds are classified as unrestricted funds. These are funds which are not legally restricted but which the Trustee has chosen to earmark for set purposes as classified funds. The major funds held within these categories are disclosed in note 10.

1e. Investment Fixed Assets

Stocks and shares are shown at market value.

1f. Realised Gains and Losses

All gains and losses are taken to the Statement of Financial Activities as they arise. Realised gains and losses on investments are calculated as the difference between sales proceeds and opening market value (or date of purchase if later). Unrealised gains and losses are calculated as the difference between marked value at the year-end and opening market value or date of purchase if later.

1g. Foreign Currency transactions

All expenditure and income arising from transactions denominated in a foreign currency are translated into sterling at the exchange rate in operation on the date on which the transactions occurred.

1h. Change in the Basis of Accounting

This is the seventh year that financial statements have been prepared in compliance with the Charities SORP (FRS 102). There has been no material change in the basis of accounting during the year.

1i. Prior Year Adjustments

There has been no change to the accounts of prior years.

1j. Going Concern Assumption

The accounts have been prepared on a going concern basis and the Trustee has no plans to wind up the Charity, or concerns that it cannot continue as a viable entity.

2. Dividends and interests

Dividends are received for all stocks and shares in beneficial ownership of the Charity and are shown after recovery of tax where allowed. Interest is recorded for all bank accounts and short-term deposits made by the Charity.

3. Details of Income

	2021/22	2020/21
	Total Funds (Unrestricted)	Total Funds (Unrestricted)
	£000	£000
Income and endowments		
Donations	239	409
Legacies	18	95
Fundraising activities and events	93	4
Investment income	30	21
Total income and endowments	**380**	**529**

4. Details of Expenditure

	2021/22	2020/21
	Total Funds (Unrestricted)	Total Funds (Unrestricted)
	£000	£000
Raising Funds:		
Fundraising staff costs	176	169
Fundraising activities and events	68	25
	244	**194**
Charitable Activities:		
Patients welfare and amenities	169	199
Staff welfare and amenities	50	158
Research	127	95
Independent examination	3	1
Administrative support	45	38
	394	**491**
Total	**638**	**685**

All of the expenditure is accounted for as grants to benefit the staff and patients of The Walton Centre in line with the Charity's objectives.

5. Analysis of Staff Costs

	2021/22	2020/21
	Total Funds (Unrestricted)	Total Funds (Unrestricted)
	£000	£000
Fundraising Staff Costs		
Salaries and wages	142	136
Social security costs	15	15
Employers pension contribution	19	19
Total Fundraising Staff Costs	**176**	**170**

The average number of full-time equivalent employees during the year was 3.3 (2020/21: 3.3). One employee received emoluments in excess of £60,000 in the current year in the salary band £60,000 - £70,000 (2020/21: one).

No Trustee remuneration or any other benefits have been paid from an employment with the Charity and no Trustee expenses have been incurred.

6. Analysis of Fixed Asset Investments

The investment portfolio is managed by CCLA and Ruffer LLP and the total amount invested with each manager was £500,000. The movement in the portfolio can be analysed as follows:

	2021/22	2020/21
	£000	£000
Market value at the beginning of the reporting period	1,162	967
Less Disposals at carrying value	0	0
Aquisitions at cost	0	27
Unrealised gains/(losses)	86	168
Market value at the end of the reporting period	**1,248**	**1,162**
Book cost at the end of the reporting period	1,000	1,000

All investments are held in the UK and the market value can be analysed as follows:

	2021/22	2020/21
	£000	£000
Listed investments	1,248	1,162
Total	**1,248**	**1,162**

7. Debtors

Debtors in respect of the following are represented in the accounts:

	2021/22	2020/21
	£000	£000
Prepayments and accrued income	3	80
Total	**3**	**80**

There were no debtors falling due over one year.

8. Cash and Cash Equivalents

Cash at bank and in hand is held to meet the day-to-day running costs of the Charity as they fall due. Cash equivalents are short-term, highly liquid investments, usually in 90 day notice interest bearing savings accounts:

	2021/22	2020/21
	£000	£000
Cash at bank and in hand	650	680
Total cash and cash equivalents	**650**	**680**

9. Creditors

The creditor position can be summarised as follows:

	2021/22	2020/21
	£000	£000
Amounts due to NHS Foundation Trust	23	0
Accruals	189	61
Total	**212**	**61**

There were no creditors falling due over one year.

10. Analysis of Funds

The movement in the funds during the year can be analysed as follows

	Balance as at 1 April 2021	Income	Expenditure	Revaluation of investments	Balance as at 31 March 2022
	£000	£000	£000	£000	£000
Unrestricted Funds	1,693	380	(638)	0	1,435
Revaluation Reserve	168	0	0	86	254
Total	**1,861**	**380**	**(638)**	**86**	**1,689**

A list of the unrestricted funds and their balances as at 31 March 2022 is shown in Appendix 1.

11. Related Party Transactions

During the year the Trustee, members of The Walton Centre Charity Committee and the key management staff, and parties related to them, had no personal interest in any contract, nor undertook any material transactions with The Walton Centre Charity.

The Charity delivers its charitable objectives by making grants to The Walton Centre NHS Foundation Trust. Grants made amounted to £346,000 (2020/21: £453,000). This included £87,000 for cutting edge technology which included a Neuro VR Simulator, also an individual grant of £39,000 from the Home from Home appeal to cover the running costs of the relatives' accommodation in the Trust's Sid Watkins Building.

The Walton Centre NHS Foundation Trust provides administrative support to the Charity and in 2021/22 charged a fee of £45,000 at arm's length (2020/21: £36,000).

12. Events after the Reporting Date

The Trustee is not aware of any events after 31 March 2022 and up to the date the financial statements have been approved which will affect the accounts.

Appendix 1

List of Funds and Fund Balances as at 31 March 2022

Fund Name		Fund Balance	
		2021/22	2020/21
		£000	£000
4009	General Fund	804	818
4010	NRU Fund	17	20
4015	Wards Fund	17	18
4017	Roy Ferguson Compassionate Care Fund	70	71
4019	Headache and Neurology Fund	1	1
4422	Pain Relief Research Fund	4	4
4442	Neuro General Research Fund	8	8
4457	Neuro Muscular Diseases Fund	1	1
4464	Cerebro Vascular Fund	27	28
4465	Home From Home	11	35
4481	Neurosurgical General Fund	28	32
4487	Horsley ITU Fund	76	76
4499	Epilepsy Fund	27	27
4527	R&D & Higher Study	7	20
4528	Neurophysiology Train. & Educ.	0	1
4530	Neurological Disability Fund	65	95
4532	L Loudrey Mvmt Disorders Fund	9	0
4533	Alan Sutcliffe Kerr Lecture Fund	1	11
4537	Cognitive Research Fund	0	3
4538	Stereotactic Fund	9	10
4541	Neurobiochemistry Fund	6	7
4543	Disorders Of Movement Gen Fund	59	60
4550	Research Fellowship	1	1
4552	Parkinsons Disease	8	9
4900	Neuro X-Ray Research	16	21
4905	Neurosurgical Neuro-Oncology	21	30
4910	Brain Infections Research	6	7
4911	Nmo And Atypical Disorders	18	18
4915	The Sid Watkins Innovation Fund	122	261
		1,438	**1,693**

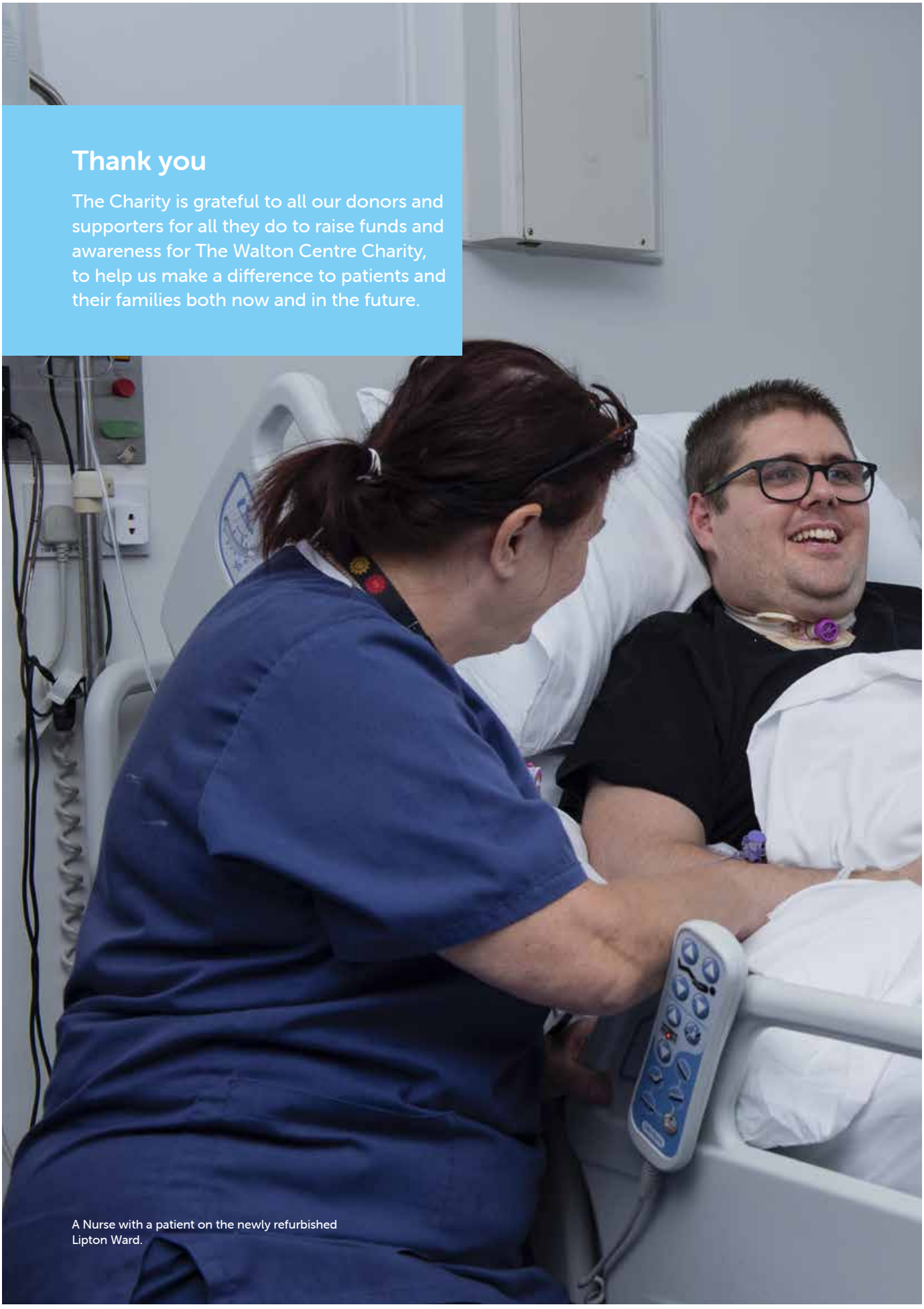
Appendix 2

List of Funds, Fund Managers and Objectives

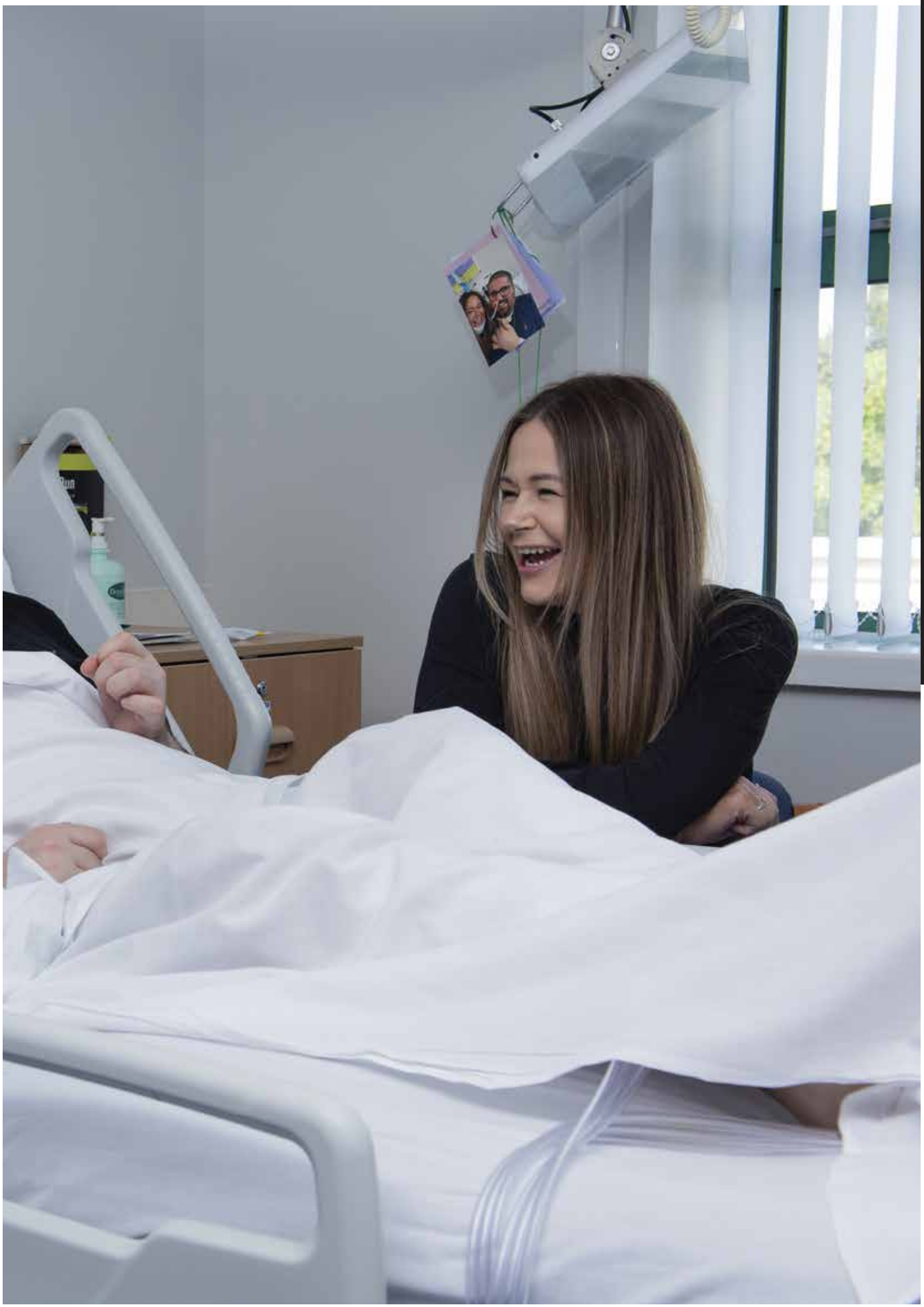
Fund	Fund Name	Fund Manager	Aims and Objectives
4009	General Fund	Chief Finance Officer/Quorum of Panel	Any charitable purpose relating to The Walton Centre
4010	NRU	E Cottier/R Moreton	Social and recreational facilities for inpatients, improving quality of life
4015	Wards Fund	L Salter /N Martin	Items for wards to benefit patients, carers and staff; staff study support
4017	Roy Ferguson Comp Care Award	L Salter	Annual compassionate care project
4019	Headache And Neurology Fund	Dr Silver	Research into headache and allied disorders; support presentations
4422	Pain Relief Research Fund	Dr M Gupta/J Tetlow	Research and education
4442	Neuro General Research Fund	Dr Nicolson	Research projects relating to any aspect of clinical science
4457	Neuro Muscular Diseases Fund	Dr C Dougan	Research and teaching in the field of neuromuscular diseases
4464	Cerebro Vascular Fund	Dr Nicolson	Research, education, training and equipment
4465	Home From Home	Chief Finance Officer/Quorum of Panel	Maintain the relatives' accommodation
4481	Neurosurgical General Fund	Dr S Niven	Research, education, training and equipment
4487	Horsley ITU Fund	Dr Lakhani/M Rackham	Improve standard of care to patients and their relatives; study support
4499	Epilepsy Fund	Dr T Marson	Research
4527	R&D & Higher Study	C Chadwick	Research, education, training and equipment
4528	Neurophysiology Train. & Educ.	C Finnegan	Training/education for Neurophysiology staff
4530	Neurological Disability Fund	Prof C Young	Research/service development activities in disabling conditions
4533	Alan Sutcliffe Kerr Lecture Fund	Chief Finance Officer	Specialist research and education
4537	Cognitive Research Fund	Dr M Doran	Research and development
4538	Stereotactic Fund	Mr J Farah	Research and training
4541	Neurobiochemistry Fund	C Chadwick/N Moxham	Research, education, training and equipment
4543	Disorders Of Movement Gen Fund	Dr AP Moore	Research, education, development of new service initiatives
4550	Neuropsychology Fund	J Martlew	Research, patient education and equipment to benefit patients
4552	Parkinson's Disease	Dr M Steiger	Research, education and training
4900	Neuro X-Ray Research	Dr S Niven	Advancement of Neuroradiology
4905	Neurosurgical Neuro-Oncology	Mr A Brodbelt/ Mr M Jenkinson	Research, education, training and equipment
4910	Brain Infections Research	Prof T Solomon	Research
4911	Nmo and Atypical Disorders	Dr A Jacob	Research and patient care
4915	The Sid Watkins Innovation Fund	Chief Finance Officer/Quorum of Panel	Support innovation through The Walton Centre in research, prevention, diagnosis, treatment and the overall care of people with diseases or injury of the nervous system

Thank you

The Charity is grateful to all our donors and supporters for all they do to raise funds and awareness for The Walton Centre Charity, to help us make a difference to patients and their families both now and in the future.



A Nurse with a patient on the newly refurbished Lipton Ward.



Contact us

If you would like to contact us about fundraising, events or volunteering please get in touch.

Call
0151 556 3466

Write
The Walton Centre Charity
The Walton Centre NHS Foundation Trust
Lower Lane, Fazakerley
Liverpool L9 7LJ

Visit
thewaltoncentrecharity.org

The Walton Centre Charity
Supporting Excellence in Neuroscience

20 October 2022

AM/TP/WA034/552162

The Trustees
The Walton Centre Charity
The Walton Centre NHS Foundation Trust
The Walton Centre
Lower Lane
Liverpool
L9 7LJ

Dear Trustees

During the course of the independent examination of the accounts for the year ended 31 March 2022, the following representations were made to us by management and trustees. Please read these representations carefully and if you agree with our understanding please sign and return a copy of this letter to us as confirmation of this.

1 You acknowledge as trustees that you have fulfilled your responsibilities under the Charities Act 2011 for making accurate representations to us and you confirm that the accounts for the charity are in accordance with the applicable financial reporting framework FRS 102.

You confirm that in your opinion the financial statements give a true and fair view and in particular that where any additional information must be disclosed in order to give a true and fair view that information has in fact been disclosed.

2 You confirm that all accounting records have been made available to us for the purposes of our independent examination and that all transactions undertaken by the charity have been properly reflected and recorded in the accounting records. All other records and related information, including minutes of all management and trustees' meetings, have been made available to us.

3 You confirm that significant assumptions used by you in making accounting estimates, including those measured at fair value, are reasonable, as set out in the attached list.

4 You confirm that all known actual or possible litigation and claims whose effects should be considered when preparing the accounts have been accounted for and disclosed in accordance with the applicable financial reporting framework FRS 102.

5 You confirm that there have been no events since the balance sheet date which require disclosing or which would materially affect the amounts in the accounts, other than those already disclosed or included in the accounts.

6 You confirm that you are aware that a related party of the charity is a person or organisation which either (directly or indirectly) controls, has joint control of, or significantly influences the charity or vice versa and as a result will include shareholders (as a guide with more than 20% of the voting rights), directors, trustees, other key management, close family and other business interests of the previous. You confirm that the related party relationships and transactions set out as

Tempest, Suite 5.1, 12 Tithebarn Street, Liverpool, L2 2DT
t: 0151 236 1494 e: mail@bwm.co.uk w: www.bwm.co.uk

attached are a complete list of such relationships and transactions and that you are not aware of any further related parties or transactions.

7 You confirm that all related party relationships and transactions have been accounted for and disclosed in accordance with the applicable financial reporting framework FRS 102.

8 You confirm that the charity has not contracted for any capital expenditure other than as disclosed in the accounts.

9 You have no plans or intentions that may materially alter the carrying value and where relevant the fair value measurements or classification of assets and liabilities reflected in the accounts.

10 The charity has satisfactory title to all assets, and there are no liens or encumbrances on the assets except for those disclosed in the accounts.

11 There are no liabilities or provisions other than those recognised and no contingent liabilities or guarantees to third parties other than those disclosed in the accounts.

12 You confirm that you are not aware of any possible or actual instance of non-compliance with those laws and regulations which provide a legal framework within which the charity conducts its business, and which are central to the charity's ability to conduct its business (as set out in the attached list) except as explained to us and as disclosed in the accounts. The charity has complied with all aspects of contractual agreements that could have a material effect on the accounts in the event of non-compliance.

13 You acknowledge your responsibility for the design, implementation and maintenance of controls to prevent and detect fraud. You confirm that you have disclosed to us the results of your assessment of the risk that the financial statements may be materially misstated as a result of fraud.

14 You confirm that there have been no actual or suspected instances of fraud involving management or employees who have a significant role in internal control or that could have a material effect on the accounts. You also confirm that you are not aware of any allegations of fraud by employees, former employees, regulators or others.

15 You confirm that, having considered your expectations and intentions for the next twelve months, and the availability of unrestricted reserves, the charity is a going concern. You also confirm that the period that you have considered covers a minimum of twelve months from the date of this letter.

16 You confirm the accounts are free of material misstatements, including omissions. In your opinion, the effects of unadjusted misstatements are immaterial, both individually and in aggregate, to the accounts as a whole.

17 You confirm the following specific representations made to us during the course of preparing your accounts:

You confirm that you make use of internet banking and that adequate and appropriate controls over your internet banking facility/access were operational and effective throughout the year.

You confirm that your IT back up procedures and off-site cyber security are adequate, regularly tested, current and appropriate and that an up to date back up is available. You confirm that disaster recovery planning is conducted and reviewed periodically, and that adequate and appropriate insurance is carried.

You confirm that historic records are maintained for the minimum required (that is for the current and previous six years) to ensure, for example, that any future HMRC gift aid audit will proceed without irregularity.

You confirm that all grants, donations and other income, including any subject to special terms or conditions or received for restricted purposes, have been notified to us. There have been no breaches of terms or conditions regarding the application of such income.

You confirm that you are not aware of any matters of material significance that should be reported to the Charity Commission.

You confirm that all donated funds are correctly classified as unrestricted funds within the accounts and are correctly recorded within their separate funds.

Yours faithfully

BWM

The Walton Centre Charity

I confirm that the above representations are made on the basis of enquiries of management and staff with relevant knowledge and expertise (and, where appropriate of supporting documentation) sufficient to satisfy myself that I can properly make these representations to you and that to the best of my knowledge and belief they accurately reflect the representations made to you by the trustees during the course of your work.

Signed on behalf of the Board of Trustees.

..... Date .....

Su Rai

Chair of The Walton Centre Charity Committee

The Walton Centre Charity
Year ended 31 March 2022

Related party details

	Related party	Transactions
Corporate Trustee	The Walton Centre NHS Foundation Trust	Grants made to the Trust amounting to £346,000 Admin support provided by the Trust - £45,000

Directors of the Corporate Trustee:

Type	Name of party	Transaction type (please state if none)
Chair	Ms J Rosser (*Resigned 31 October 2021*)	None
Chief Executive	Ms H Citirine (*Resigned 31 March 2021)*	None
Chief Executive	Ms J Ross (*Appointed 25 June 2022, Acting from 1 April 2022)*	None
Medical Director	Mr A Nicolson	None
Non-Executive Director	Mr S Crofts (*Resigned 31 March 2022*)	None
Non-Executive Director	Mr N Thakkar (*Resigned 31 December 2021*)	None
Non-Executive Director	Ms Su Rai (Chair of TWCCC)	None
Non-Executive Director	Ms K Bentley	None
Non-Executive Director	Mr D Topliffe	None
Non-Executive Director	Mr R Walker (*Appointed 1 January 2022*)	None
Non-Executive Director	Mr P May (*Appointed 1 January 2022*)	None
Director of Finance and Information Technology	Mr M Burns	None
Director of Workforce and Innovation	Mr M Gibney	None
Director of Operations and Strategy and Deputy Chief Executive	Ms J Ross (*Resigned 25 June 2021)*	None
Acting Director of Operations and Strategy	Ms L Vlasman (*Appointed 10 November 2021)*	None
Director of Nursing and Governance	Ms L Salter	None

Management of the Corporate Trustee:

Key Management	Dr S Niven - Consultant Neuroradiologist and Deputy Medical Director	None
Key Management	Dr N Buxton - Consultant Neurosurgeon	None
Key Management	Dr P Moore - Consultant Neurologist	None
Key Management	Ms Z Stevenson – Financial Accountant	None
Other	The Walton Centre Charity Committee	None

And their close families

The Walton Centre Charity
Year ended 31 March 2022

Laws and regulations

Charities Act 2011
Charities SORP
General Data Protection Regulations - GDPR
Money Laundering Regulations

Accounting estimates

Estimate	How identified	Estimation method	Level of uncertainty
Year end accruals	Review invoices and payments after the year end	A provision is made in the year end accounts for any goods / service received in the year where the invoices / payments are not processed until after the year end date.	Low
Accrued income	Review of past income remittances received	Review post year end invoices for goods/ services provided pre year end and adjust accordingly.	Low
Year end prepayments	Review invoices and payments around the year end	Review invoices for goods / services provided post year end and adjust accordingly	Low

The Walton Centre NHS Foundation Trust

Report to Trust Board
3rd November 2022

Report Title	Integrated Performance Report
Executive Lead	Lindsey Vlasman - Chief Operating Officer
Author (s)	Rebecca Sillitoe – Senior Information Analyst
Action Required	To note

Level of Assurance Provided

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

Key Messages

- See summary for performance overview

Next Steps

- Ongoing

Related Trust Strategic Ambitions and Themes	**Impact**		
All Applicable	Not Applicable	Not Applicable	Not Applicable

Strategic Risks

001 Quality Patient Care	004 Operational Performance	003 System Finance

Equality Impact Assessment Completed

Strategy ☐	Policy ☐	Service Change ☐

Report Development

Committee/ Group Name	**Date**	**Lead Officer (name and title)**	**Brief Summary of issues raised and actions agreed**
n/a			

Integrated Performance Report

Executive Summary

1. This report provides assurance on all Integrated Performance Report measures aligned to the Business & Performance and Quality Committee's. Performance is based on four aspects; performance in month, trend/variation, whether the target is within variation and external benchmarking. The below table highlights indicators by those which are High Performing (achieving target or improvement), Opportunity for Improvement (improving but not hitting target, or underperforming compared to peers, and Underperforming (not hitting target consistently or performance significantly decreasing).

Operations & Performance Indicators

High Performing
Cancer Standards
Diagnostics
Referral to Treatment Long Waits
28 Day Emergency Readmissions
% of Patients on a PIFU

Opportunity for improvement
Theatres
Activity Restoration

Underperforming

Workforce Indicators

High Performing
Vacancies

Opportunity for improvement
Mandatory Training
Turnover

Underperforming
Appraisal Compliance
Sickness/Absence

Quality Indicators

High Performing
Complaints
Hospital Acquired Pressure Ulcers
Risk Adjusted Mortality
Friends and Family Test
Infection Control

Opportunity for improvement
Moderate Harm Falls
CAUTI
VTE

Underperforming
N/A

Finance Indicators

Key Performance Indicators	July	August	September
% variance from plan - Year to date	3.9%	18.2%	19.5%
% variance from plan - Forecast	0.0%	0.0%	7.3%
% variance from efficiency plan - Year to date	6.3%	5.3%	3.0%
% variance from efficiency plan - Forecast	-21.1%	-21.0%	-8.3%
Capital % variance from plan - Year to date	56.0%	51.6%	35.9%
Capital % variance from plan - Forecast	0.0%	0.0%	0.0%
Capital Service Cover *	2.5	2.9	3.2
Liquidity **	33.1	34.6	35.0
Cash days operating expenditure ***	91.6	93.1	91.3
BPPC - Number	84.4%	85.5%	86.3%
BPPC - Value	82.6%	83.8%	83.2%

* Capital service cover - the level of income available to fund the Trust's capital commitments
** Liquidity - the level of cash available to fund the Trust's activities
*** Number of days cash available to cover operating expenditure

Conclusion

2. As listed above many of the indicators are high performing either against a set target, local improvement or external benchmarking, with only a few indicators underperforming.

Recommendation

3. To note the compliance against key performance indicators and the assurance or mitigations in place

Author: Rebecca Sillitoe – Senior Information Analyst
Date: 25/10/2022

The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience

Board KPI Report
November 2022

Data for September 2022 unless indicated

Explanation of SPC Charts and Assurance Icons

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SPC charts are widely used in this report int order to provide increased assurance, insight and an indication of future performance. However SPC charts are not relevant for every indicator. Where there are not enough data points, numbers too small or very unstable, or the indicator is to provide knowledge rather than show an improvement then an alternative visualisation will be used.

To maximise insight the charts will also include any targets and benchmarking where applicable.

All SPC charts will follow the below Key unless indicated

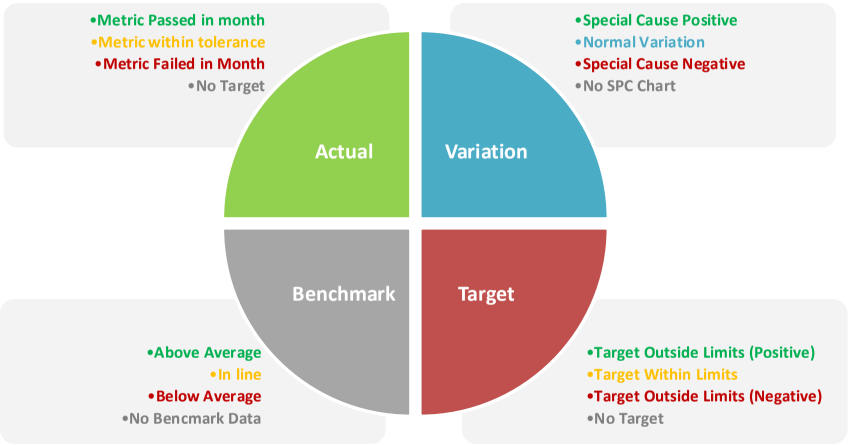
Actual — UCL — Average — LCL — National Average — Target

= Part of Single Oversight Framework

= Mandatory Key Performance Indicator

Assurance Icons (Colour Key)

All metrics now have an Assurance Icon consisting of 4 components. These give assurance on; in month performance against target, whether any SPC variation rules have been triggered, whether the target is achievable, and how the organisation compares to benchmarked data.



SPC Chart Rules

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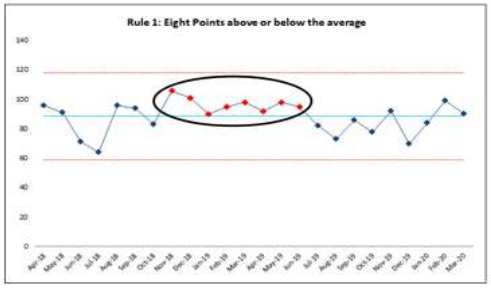
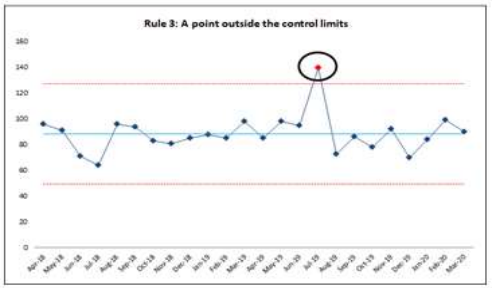
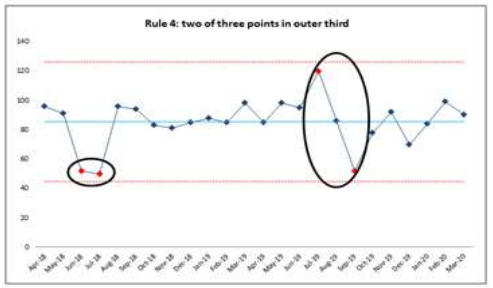
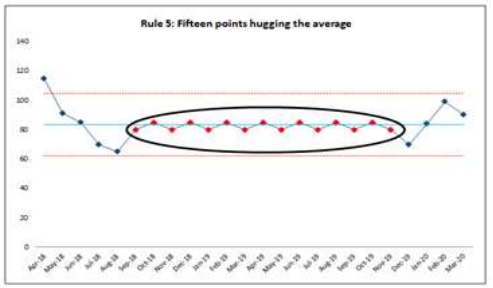
When using SPC Charts we are looking for unexpected variation. Variation occurs naturally in most systems, numbers fluctuate between typical points (control limits) the below rules are to assist in separating normal variation (expected performance) from special cause variation (unexpected performance).









Operations & Performance Indicators

Operational

Responsive - Referral to Treatment

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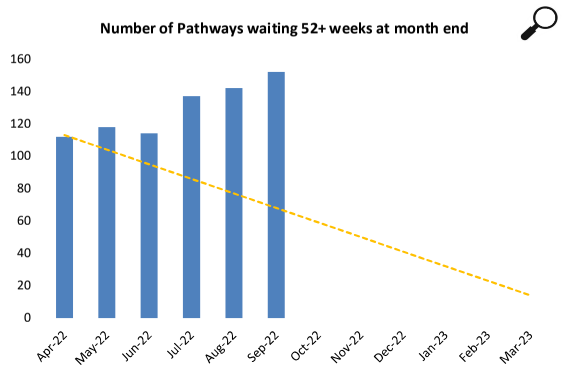
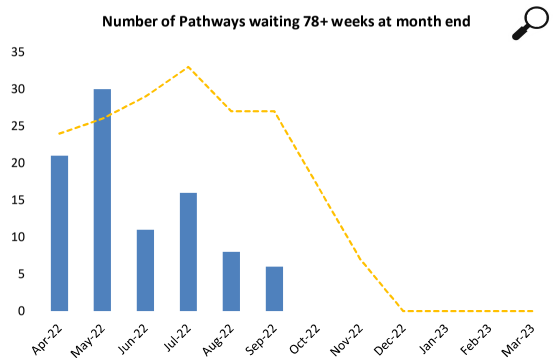
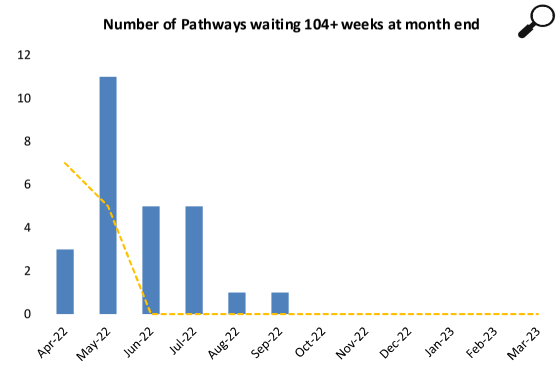
The one 104 week waiter that remained at the end of September had their clock stopped on 05/10/2022 so as at 24/10/2022 there are zero patients waiting more than 104 weeks.

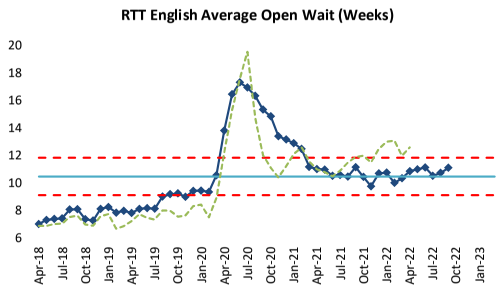
As part of plans to restore services to pre-COVID levels, each Trust was required to submit a trajectory along with timescales for reducing long waits. This includes having zero patients waiting longer than 104 weeks by July due to capacity issues.

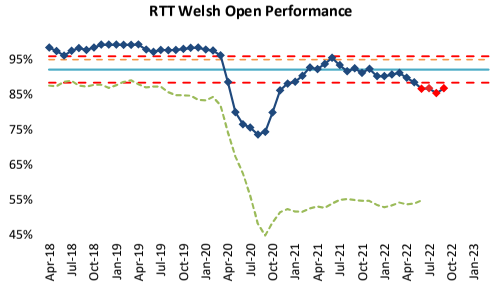
During May the Trust received a further waiting list of over 200 patients as part of the Spinal Service Transfer. This has resulted in the total open pathways increasing significantly. There was a significant number of long waiters included in these which were not included in our long waiter reduction trajectory who are still contributing to the under performance.











Operational

Responsive - Cancer Standards

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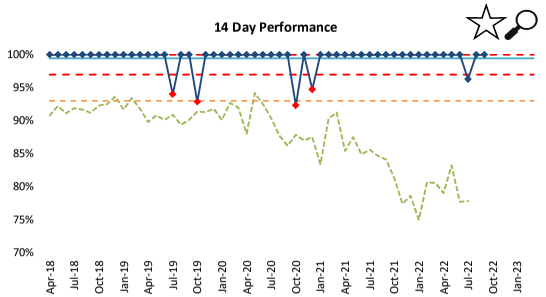
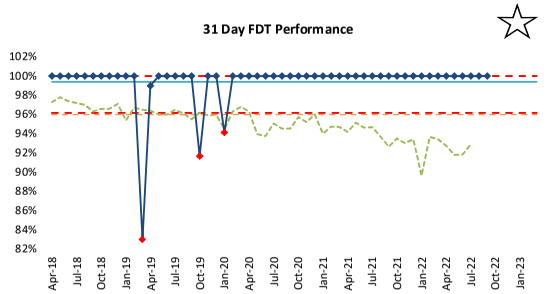
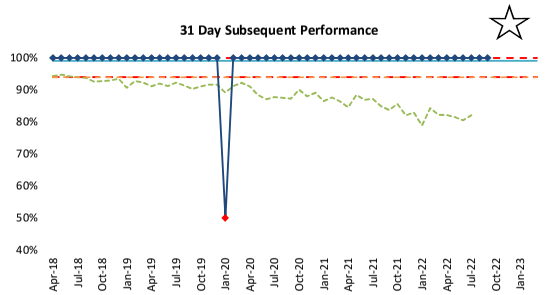
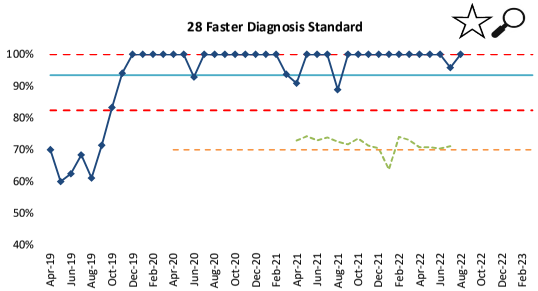
Responsive - Access Standards	Target	Actual	Assurance
Cancer TWW	93%	100%	
Cancer 31 Day FDT	96%	100%	
Cancer 31 Day Sub	94%	100%	
Cancer 62 Day Standard	85%	100%	
28 Day Faster Diagnosis Standard	70%	100%	

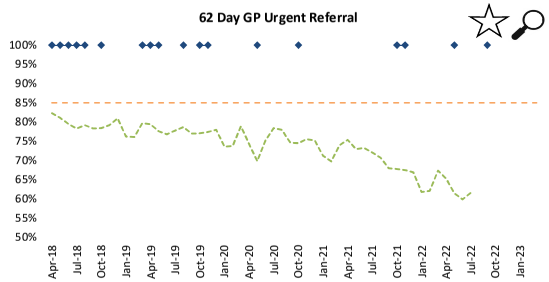
The Trust has continued to see and treat all cancer patients as these patients are designated as urgent, this is inline with NHSE requirements.

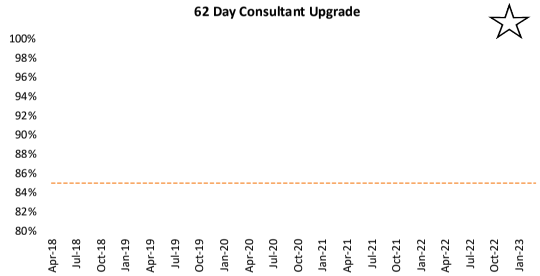












Operational

Responsive - Diagnostics

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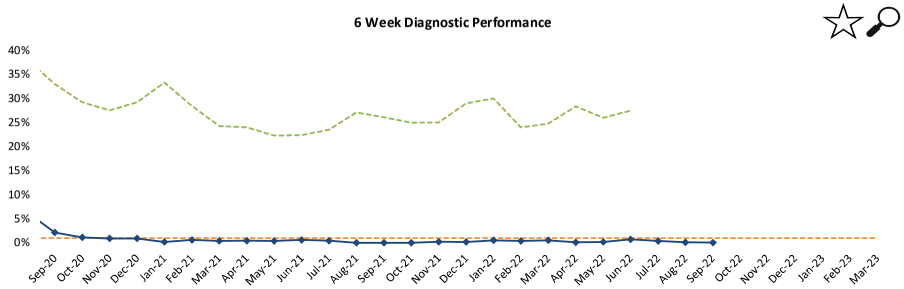
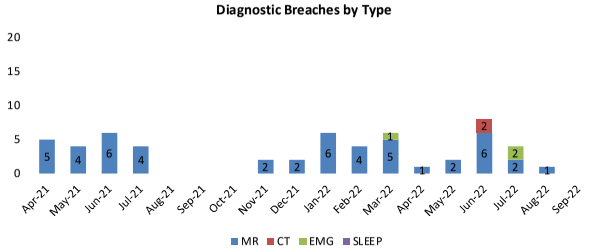
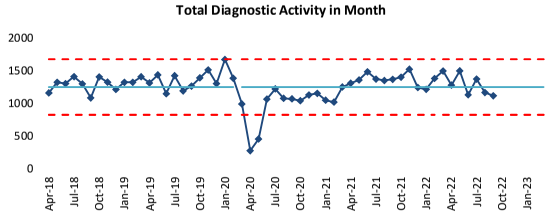
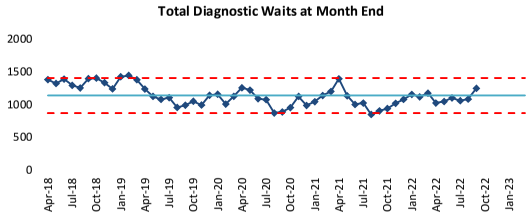
Responsive - Access Standards	Target	Actual	Assurance
Diagnostic 6 Week Performance	1%	0.07%	

Achievement against the Diagnostic 6 week standard has been met in month. There were no six week breaches in month.









Operational
Effective - Theatres

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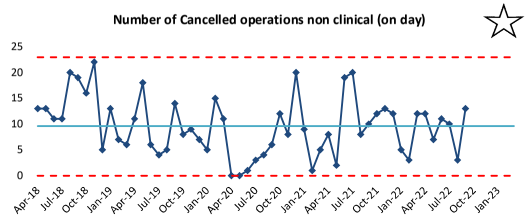
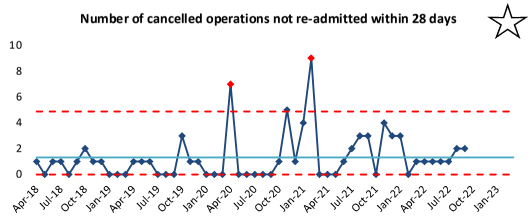
Effective - Theatres	Target	Actual	Assurance
No. Non Clinical Cancelled Operations	-	13	
% Cancelled operations non clinical on day	0.80%	1.23%	
28 Day Breaches in month	0	2	

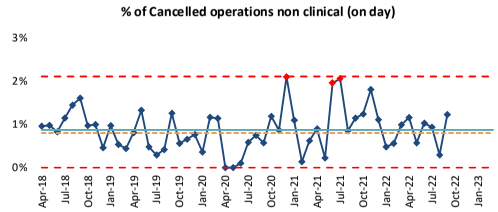
Non Clinical Cancellations

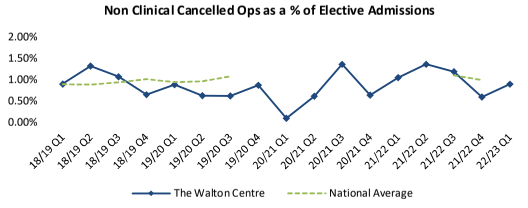
There were 13 patients cancelled at last minute for non-clinical reasons, the reasons for the cancellations were: list overrun (5), theatre staff unavailable (4), surgeon/anaesthetist/consultant unavailable (3) and other (1).

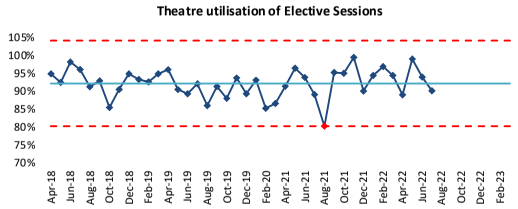
The Trust is in line with the national average for the percentage of non clinical cancelled operations based off latest published data.

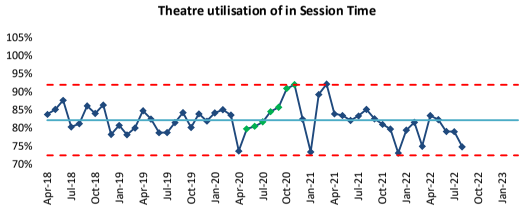












Operational

Effective - Activity Recovery Plan

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September 22 Overall Activity Performance

POD	Actual 22/23	Plan 22/23	Actual (% of 19/20)	Target* (% of 19/20)	YTD (% of 19/20)
Daycase	788	849	102.1%	104%	102.53%
Elective	269	282	98.9%	104%	85.04%
Elective & Daycase Total	**1057**	**1131**	101.2%	**104%**	98.17%
Non Elective	161	-	111.0%	-	95.83%
New Outpatients	4995	4572	113.6%	104%	107.05%
Follow Up Outpatients	7867	7869	100.0%	100%	98.82%
English Admitted Stops	227	240	98.3%	110%	82.85%
English Non Admitted Stops	2130	2234	99.2%	110%	105.72%
Total English Stops	**2357**	**2474**	**99.1%**	**110%**	**102.85%**

***Target a guide for ERF purposes**

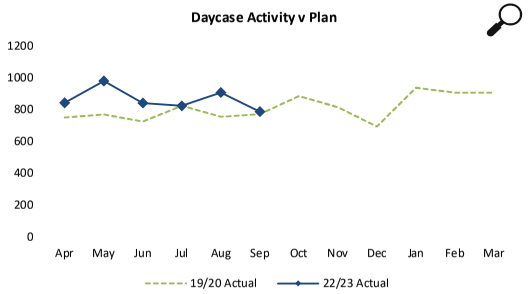
Operational planning for 2022/23 set Trusts the ambition to increase new outpatient appointments, Elective and Daycase activity to 110% of 19/20 level by March 2023 which is measured using RTT Stops.

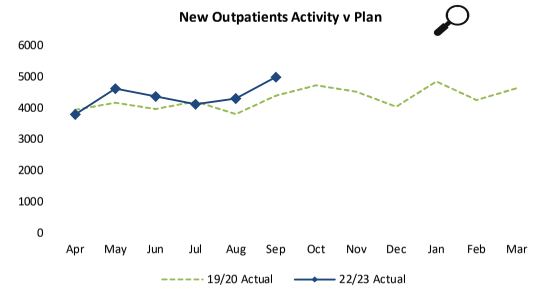
ERF is calculated using Value Weighted Activity and is set 104% of 2019/20 levels.

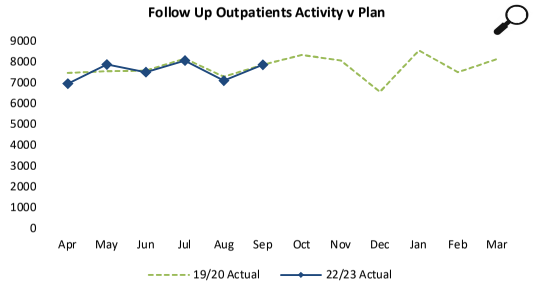
Trusts are also asked to achieve the ambition of reducing follow up outpatient appointments compared to 2019/20.

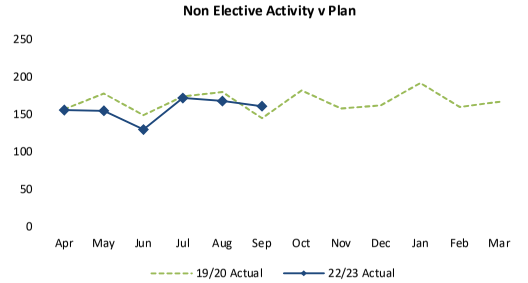
There is no target set against Non Elective activty.

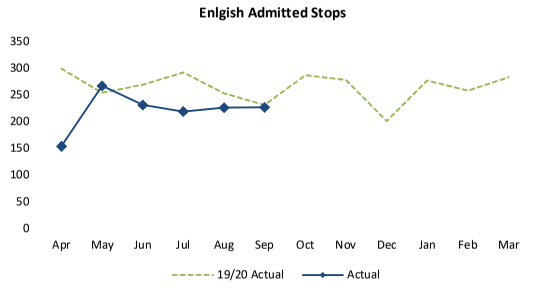
The information on this slide is raw activity for all Walton Centre patients and is unweighted.

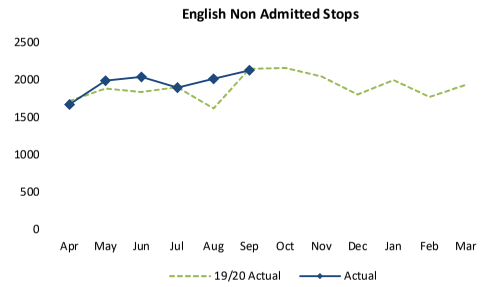












Operational

Effective - Activity (Leading Indicators)

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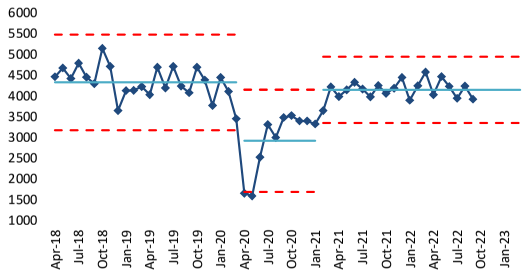
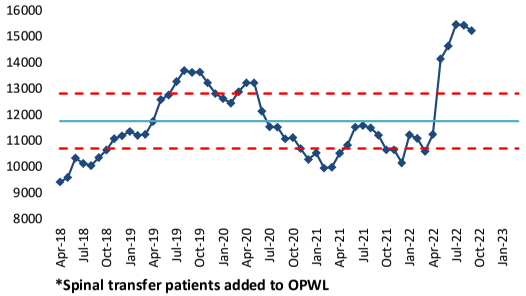
Total New Referrals Received

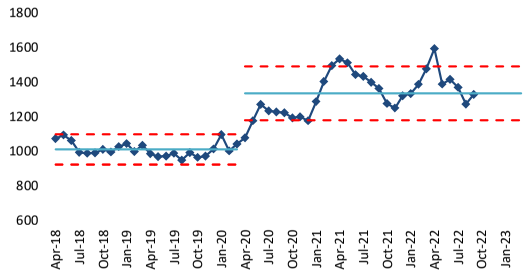


New Outpatient Waiting List

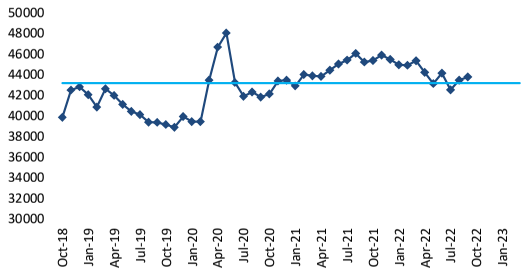


*Spinal transfer patients added to OPWL

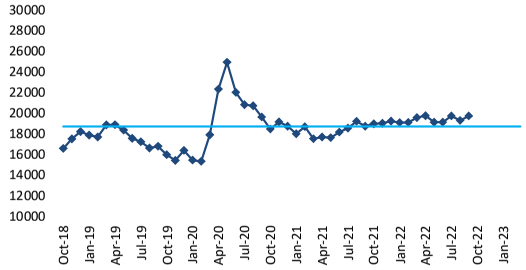
Inpatient Waiting List



Follow Up Outpatient Waiting List



Follow Up Outpatient Waiting List (Overdue)



Operational
Effective - Flow

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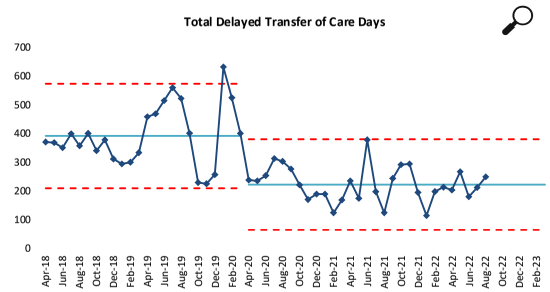
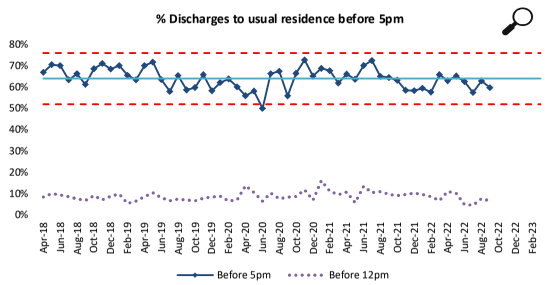
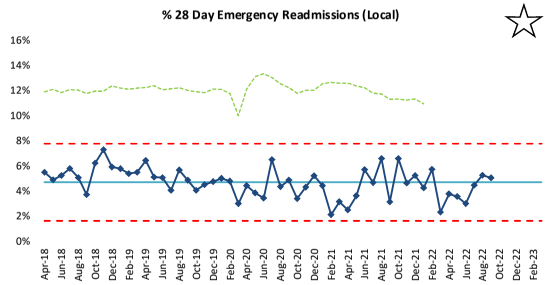
Excellence in Neuroscience

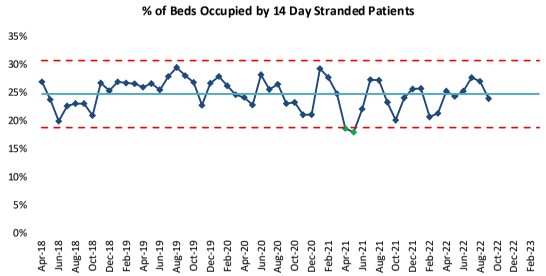
Effective - Flow	Target	Actual	Assurance
% 28 Day Emergency Readmissions (Local)	-	5.07%	
Total Delayed Discharge Days	-	250	
% Discharges by 5pm	-	59.73%	
% 14 Day Stranded Patients	-	23.95%	

All indicators are stable and within normal variation. These indicators form part of Patient Flow Transformation and are monitored through that workstream.









Operational

Effective - Outpatient Transformation

NHS
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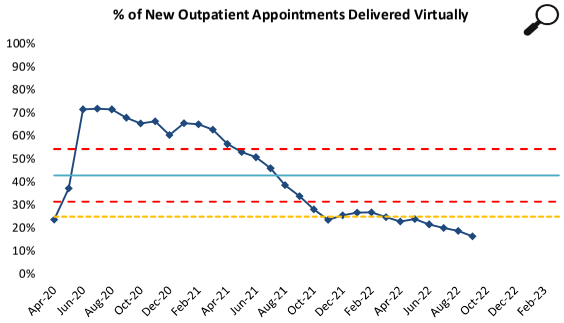
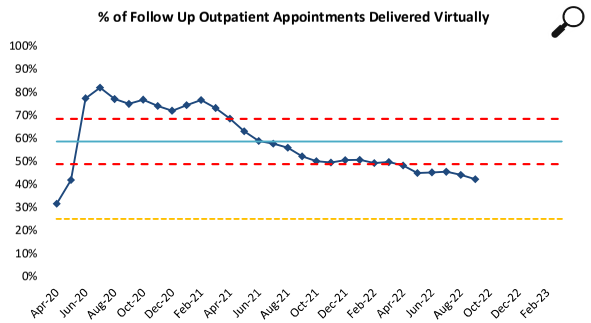
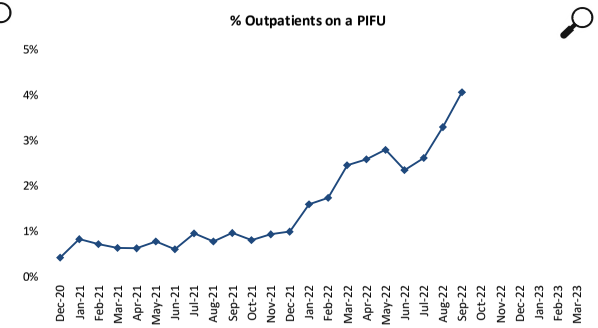
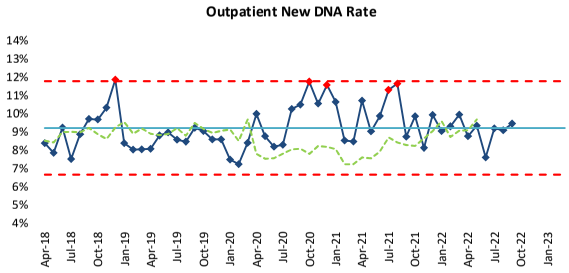
Virtual Appointments
The Trust is required to deliver a minimum of 25% of its total outpatient appointments virtually. We are currently above this target. Following a switch to deliver mainly virtual appointments during Covid-19 the Trust is reverting appropriate clinics back to face to face where clinically necessary but is expected to remain above the target.

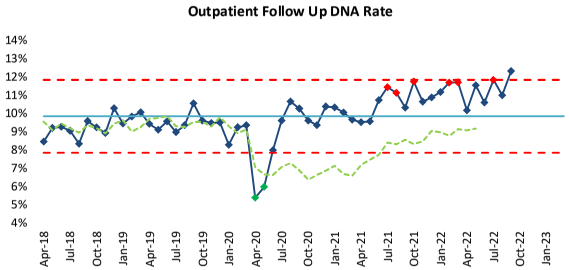
Patient Initiated Follow Up (PIFU)
As part of national Outpatient Transformation schemes the guidance is to work towards 5% of our total outpatients on a Patient Initiated Follow Up by March 2023. In September 4.07% of total outpatient appoitments had a PIFU outcome.

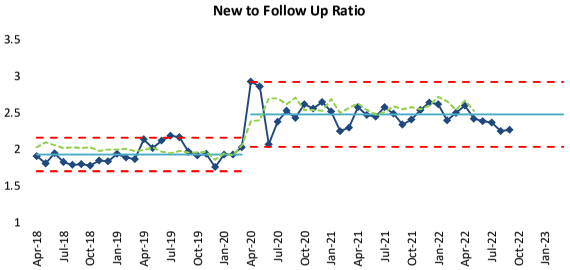












Workforce Indicators

Workforce

Well Led - Workforce KPIs

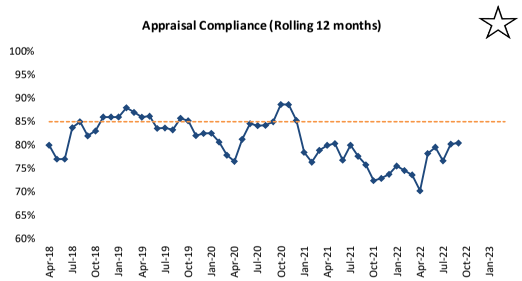
The Walton Centre NHS Foundation Trust

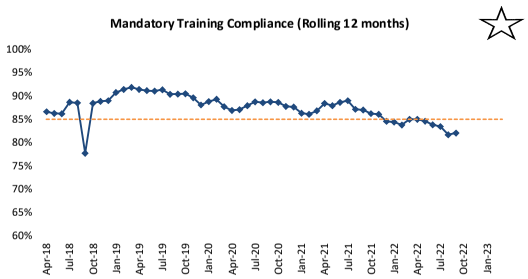
Excellence in Neuroscience

Well Led - Workforce	Target	Actual	Assurance
Appraisal Compliance	85%	80.44%	
Mandatory Training Compliance	85%	82.06%	

Appraisal Compliance

The Walton Centre PDR target has been set at 85%. Targeted chasing and the offer of further support with appraisals will continue. Following feedback from managers regarding the appraisal process, the paperwork is due to undergo review, however, this is on pause awaiting the outcome from the recommended standardised appraisal system outlined in the Messenger report, "Leadership for a collaborative and inclusive future".





Workforce

Well Led - Workforce KPIs

The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

Well Led - Workforce	Target	Actual	Assurance
Sickness / Absence	4.75%	6.89%	
Trust Turnover	-	16.33%	
Nursing Turnover	-	11.39%	
Other Staff Turnover	-	17.83%	

Sickness/Absence

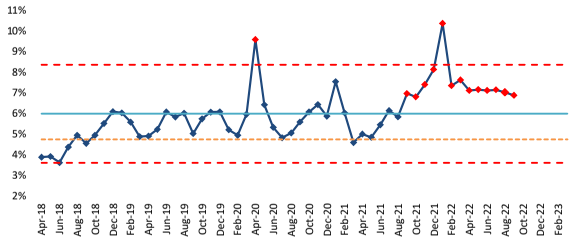
The Trust has seen a significant increase in Sickness/Absence levels which is above the 4.75% target. Sickness continues to be managed and sickness reports are shared monthly with managers and support is provided by HR advisors, who have monthly meetings with ward managers in place. Themes and trends are discussed at People Group with no outlying themes noted.

Turnover

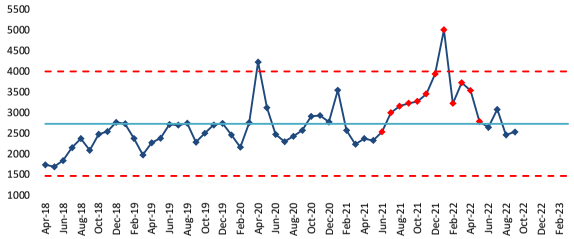
Overall Turnover for the Trust has significantly increased recently, largely driven by Corporate Services and Non Nursing Staff within Divisions. Nursing turnover is within normal variation and the trust is fully established in this area.

Other staff turnover has increased steadily and reflects the pressures within the wider labour market. This is exacerbated by other NHS providers not adhering to principles of agenda for change.

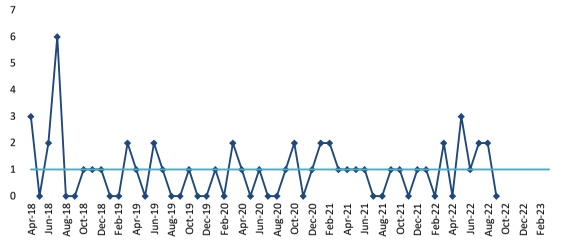
Sickness/Absence (Monthly)



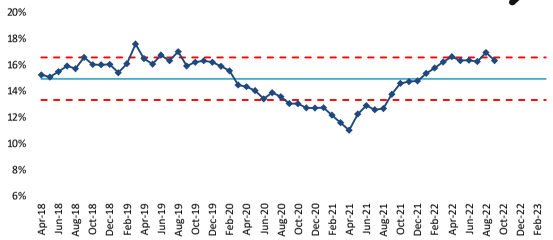
Lost Days due to Sickness/Absence (Monthly)



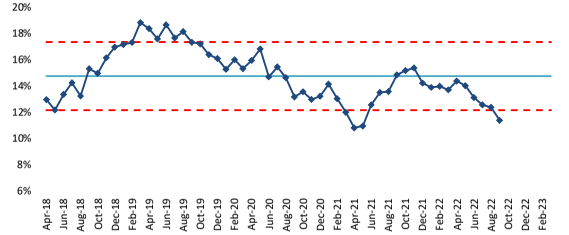
Medical Leavers



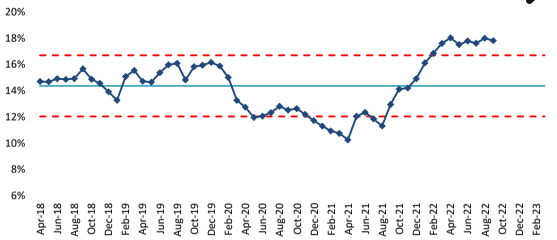
Trust Turnover (Rolling 12 months) - All Staff Groups



Nursing Turnover (Rolling 12 months)



Other Staff Turnover (Rolling 12 months)



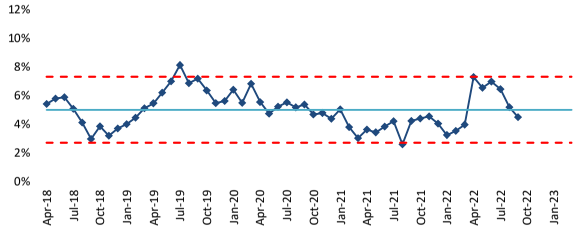
Quality of Care

Well Led - Workforce KPIs

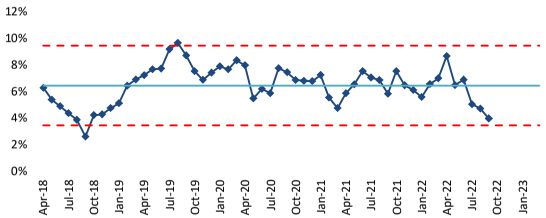
The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

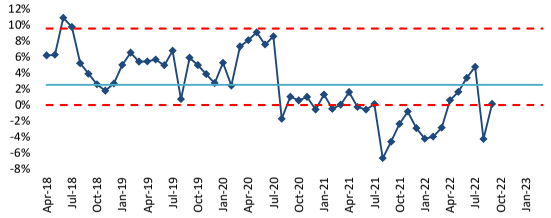
Overall Vacancy Level %



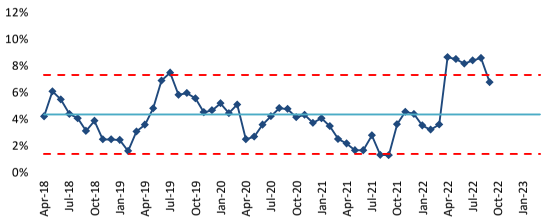
Nursing Vacancy Level %



Medical Vacancy Level %



Other Staff Vacancy Level %



Vacancy Rates

New budgets have been set for 2022/23 which reflect several ongoing restructures across the organisation, this has impacted the vacancy rate this month.

Vacancy rates include posts that have been recruited to but the post holder has not commenced employment yet.

Quality Indicators

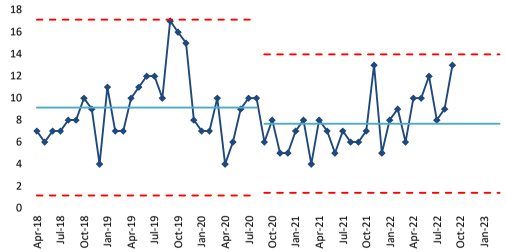
Quality of Care

Caring - Complaints

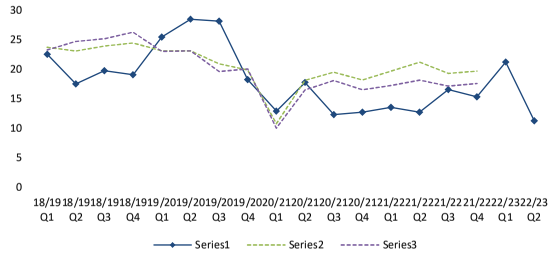
The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience

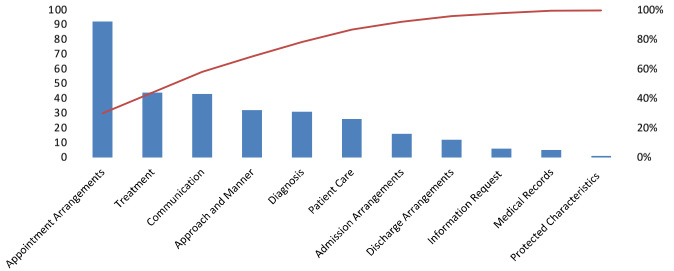
Total New Complaints Received in month



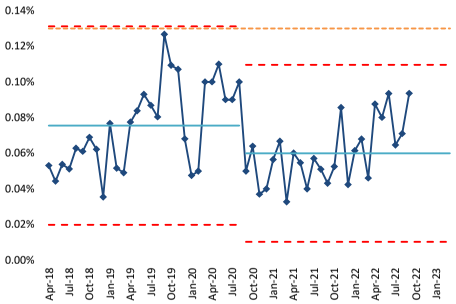
Quarterly Complaints per 1000 WTE



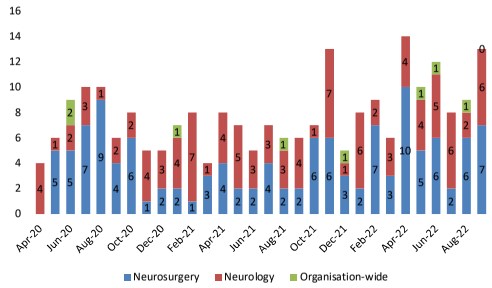
Complaints by Subject Apr 19 to present



% New Complaints Received against Activity



Total New Complaints Received



Complaints by Outcome

	Not Upheld	Partial Upheld	Upheld
19/20	66	32	24
20/21	42	23	6
21/22	45	19	11
22/23	20	13	10

In September 2022 the Trust received 13 new complaints; 6 Neurology and 7 Surgery. Of the 13 complaints received; 4 related to admission, discharge or appointment arrangements and 6 related to treatment, care or diagnosis, 2 related to communcation and 1 to medical records.

Due to the reduction seen the Trust is now below both the national and peer average up to the latest published period of benchmarking data (Q4 2021/22). Locally there was an increase in complaints in Q1 of 2022/2023 which has dropped again in Q2 of this year.

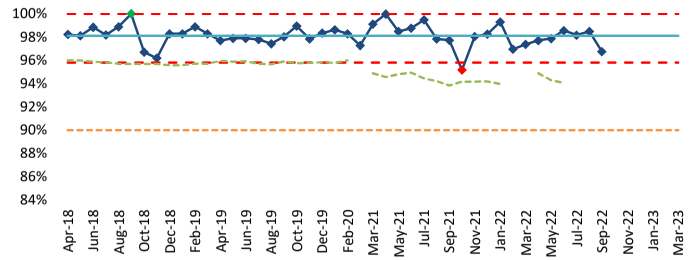
Quality of Care

Caring - Friends & Family Test

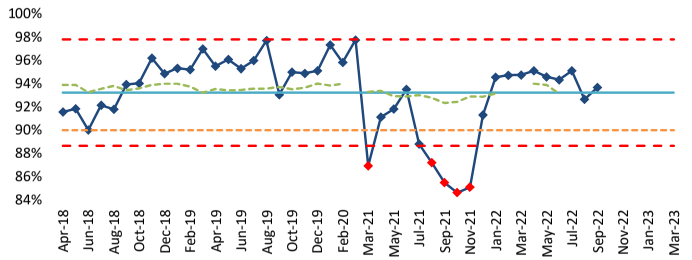
The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

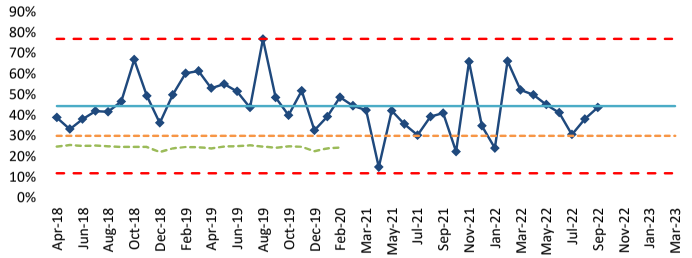
Inpatient FFT % Likely to Recommend



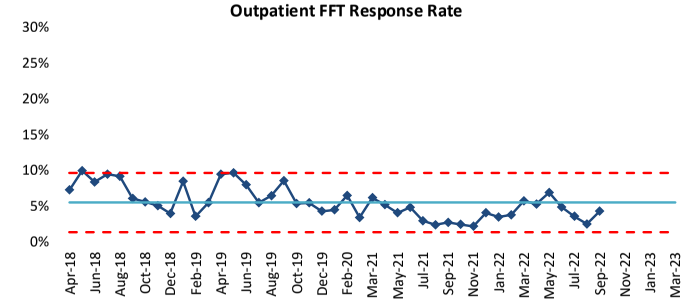
Outpatient FFT % Likely to Recommend



Inpatient FFT Response Rate



Outpatient FFT Response Rate

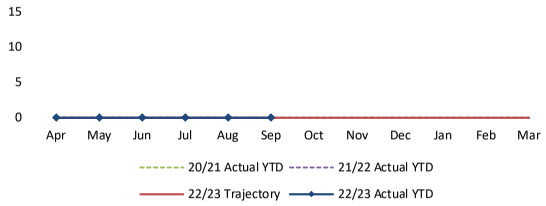


Quality of Care

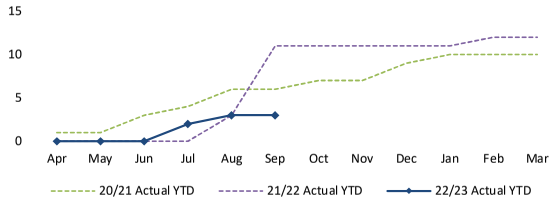
Safe - Infection Control

The Walton Centre
NHS Foundation Trust
Excellence in Neuroscience

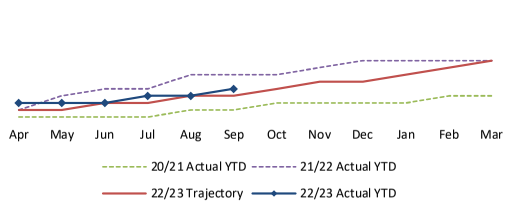
MRSA Bacteraemia



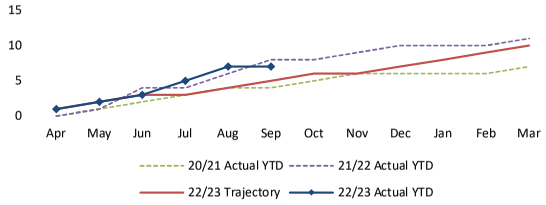
CPE



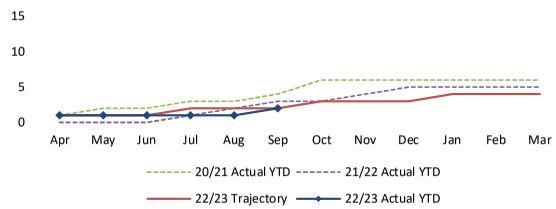
C.Diff



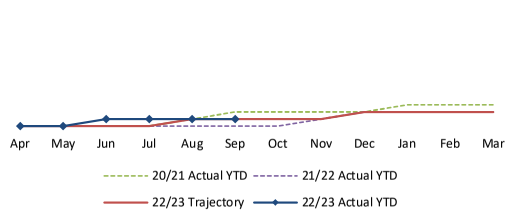
E.Coli



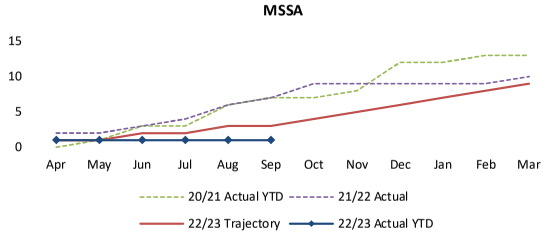
Klebsiella Bacteraemia



Pseudomonas Bacteraemia



MSSA



Total Healthcare Acquired Infections 2022/23

	MRSA B	CPE	C.Diff	E.Coli	KB	PB	MSSA	Total
Cairns		1		2				**3**
Caton		2				1		**3**
Chavasse			1	4				**5**
CRU			1		1			**2**
Dott				1				**1**
Horsley			2		1		1	**4**
Lipton								**0**
Sherrington								**0**
Total	**0**	**3**	**4**	**7**	**2**	**1**	**1**	**18**

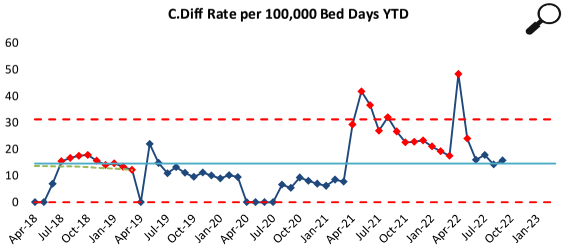
September Breakdown by Ward
1 x Klebsiella and 1 X Clostridium Difficile both on Horsley.

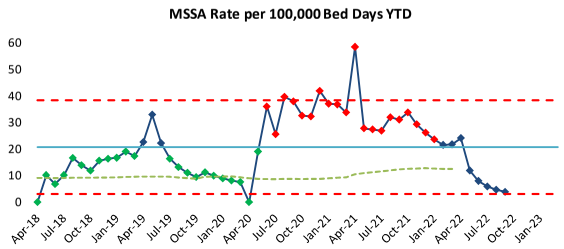
Quality of Care

Safe - Infection Control

The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience





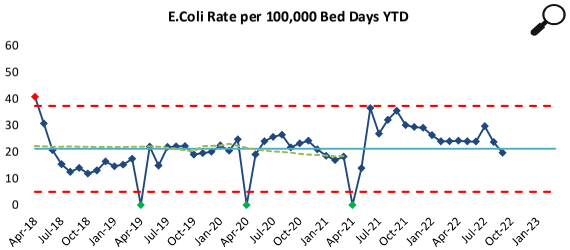
There have been four C.Diff year to date at a rate of 14.6 per 100,000 bed days.

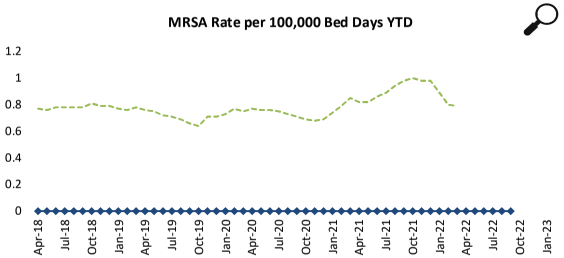
E. Coli cases are at seven during 22/23 at a rate of 21.91 per 100,000 bed days.

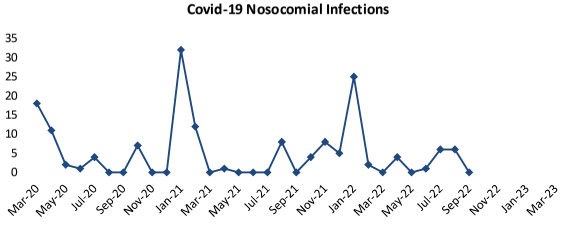
Two Klebsiella cases YTD give a rate of 9.70 per 100,000 bed days.

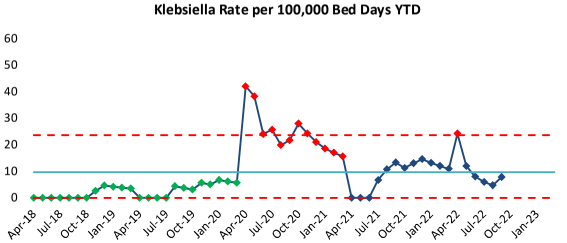
There has been one MSSA and one Pseudomonas YTD each at a rate of 2.43 per 100,000 bed days. The MSSA rate reamins below the last updated national average.

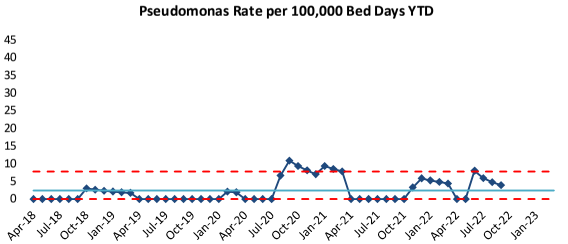
Covid-19 Nosocomial infections are lab confirmed PCR results only. There were six in August and none in September.











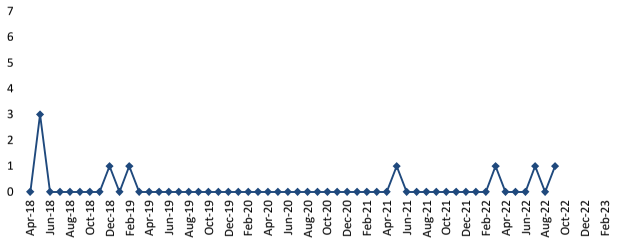
Quality of Care

Safe - Harm Free Care

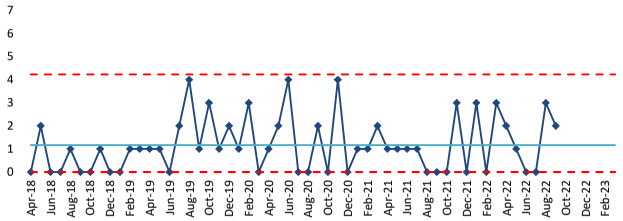
The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience

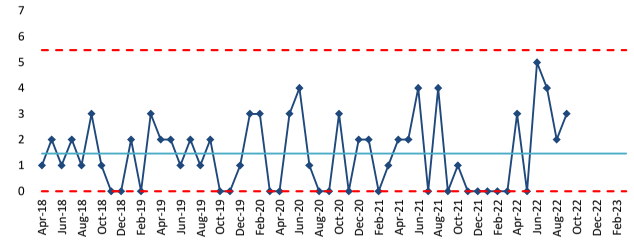
Total Moderate or Above Harm Inpatient Falls



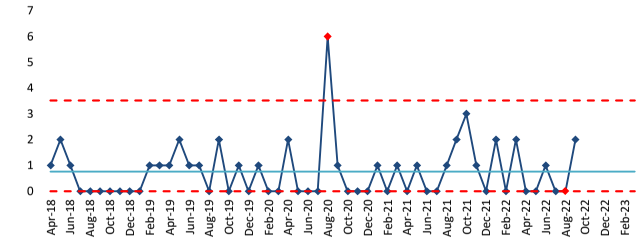
Total Hospital Acquired Pressure Ulcers (Category 2, 3, 4, Unstageable & Mucosal)



CAUTI Incidences



VTE Incidences



Falls
There was one fall which resulted in moderate or above harm in month.

Pressure Ulcers
There were two Hospital Acquired Pressure Ulcers in month

CAUTI
There were three CAUTI incidents this month.

VTE
There were two VTE incidences in month

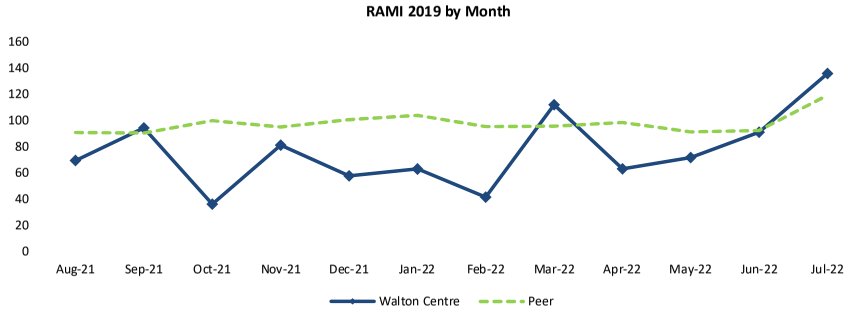
All harm measures are within normal variation.

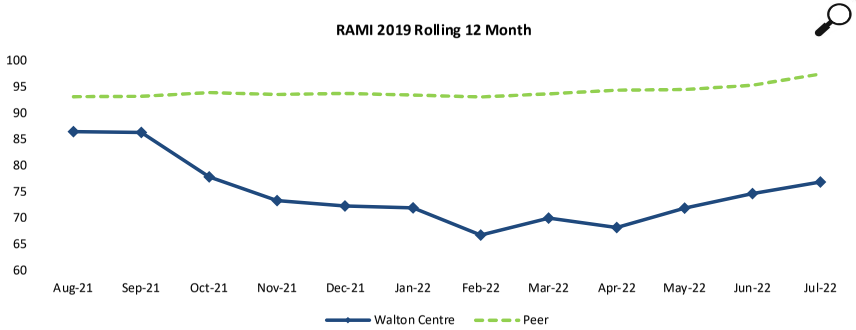
Quality of Care

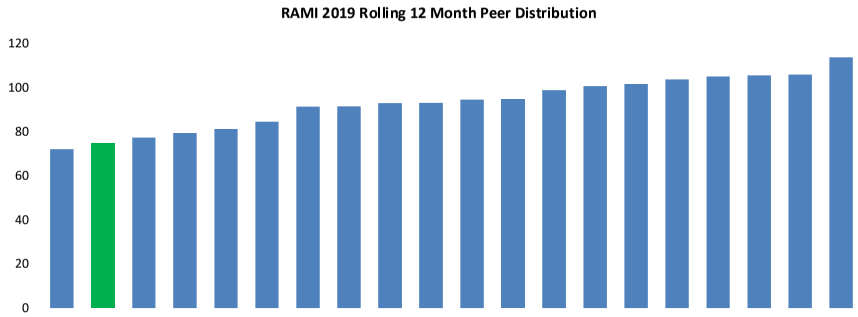
Safe - Mortality

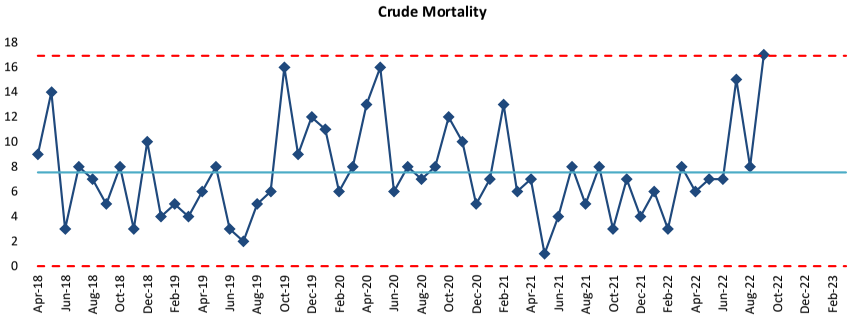
The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience









As at July 2022 the rolling 12 month RAMI19 figure is 76.86. During the period there were a total of 71 observed deaths against 92 expected deaths. Compared to peers The Walton Centre has performed 71significantly better during the period.

RAMI19 excludes deaths following a positive covid-19 result. During the rolling 12 month period there have been 3 deaths following a positive covid-19 result. In the most recent two months there has been two.

Crude mortality is within normal variation

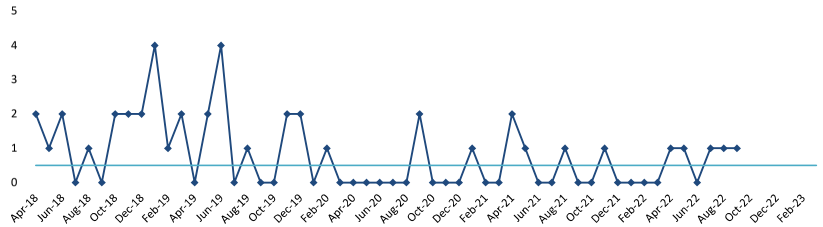
Quality of Care

Safe - Governance

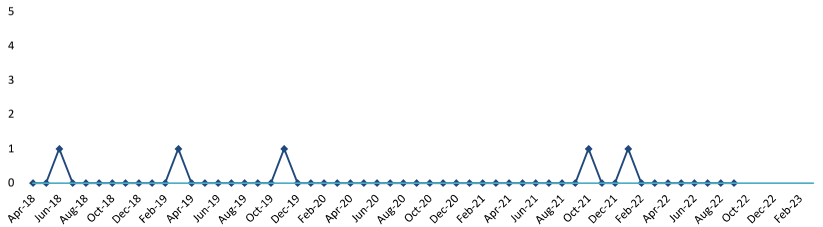
The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

Total SIs Reported



Total Never Events Reported



Ward Scorecard

September 2022

The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience

Number of shifts judged in each of the four categories and number flagged overall	Safe Staffing						Harms				Infection Control			
	Green	Grey	Amber	Red	Flagged	Walton Cares	Pressure Ulcers	Falls (Mod+)	UTI	VTE	MRSA	MSSA	E Coli	C Diff
Cairns	6	50	29	5	1	Gold	0	1	0	0	0	0	0	0
Caton	46	74	31	0		Silver	0	0	0	2	0	0	0	0
Chavasse	18	50	23	1		Gold	1	0	0	0	0	0	0	0
CRU	12	53	23	3			0	0	0	0	0	0	0	0
Dott	10	48	25	7	1	Gold	0	0	0	0	0	0	0	0
Horsley ITU	53	34	3				0	0	0	0	0	0	0	1
Lipton	8	39	40	3	2	Silver	0	0	0	0	0	0	0	0

Safe staffing now reflects the utilisation statuses which are managed through SafeCare. Green shifts are those where staff were underutilised, Grey are fully utilised and Amber and Red indicate where staff have been utilised at more than their capacity. These values are initially calculated based on the staff assigned to a shift and the acuity of inpatients. This initial calcualtion can be overwridden by the professional judgement of the nursing team. The figures here incorporate those professional judgements.

WELL LED

Finance

Key Performance Indicators	July	August	September
% variance from plan - Year to date	3.9%	18.2%	19.5%
% variance from plan - Forecast	0.0%	0.0%	7.3%
% variance from efficiency plan - Year to date	6.3%	5.3%	3.0%
% variance from efficiency plan - Forecast	-21.1%	-21.0%	-8.3%
Capital % variance from plan - Year to date	56.0%	51.6%	35.9%
Capital % variance from plan - Forecast	0.0%	0.0%	0.0%
Capital Service Cover *	2.5	2.9	3.2
Liquidity **	33.1	34.6	35.0
Cash days operating expenditure ***	91.6	93.1	91.3
BPPC - Number	84.4%	85.5%	86.3%
BPPC - Value	82.6%	83.8%	83.2%

* Capital service cover - the level of income available to fund the Trust's capital commitments
** Liquidity - the level of cash available to fund the Trust's activities
*** Number of days cash available to cover operating expenditure

Please see glossary at end of the finance IPR for an explanation of key performance indicators.

THE WALTON CENTRE NHS FOUNDATION TRUST
SUMMARY FINANCIAL INFORMATION

Trust I&E	In month			Year to Date			Full Year		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Forecast £'000	Variance £'000
Operating income from patient care activities	13,247	15,004	1,757	79,289	80,594	1,305	158,610	161,156	2,546
Other operating income	641	734	93	3,858	3,593	(265)	7,728	7,804	76
Donated Income	0	0	0	0	0	0	0	0	0
Total Operating Income	**13,888**	**15,738**	**1,850**	**83,147**	**84,187**	**1,040**	**166,338**	**168,960**	**2,622**
Employee expenses	(7,013)	(7,163)	(150)	(42,665)	(41,513)	1,152	(84,722)	(84,428)	294
Operating expenses excluding employee expenses	(6,407)	(8,065)	(1,658)	(38,560)	(40,603)	(2,043)	(77,030)	(79,860)	(2,830)
Total Operating Expenditure	**(13,420)**	**(15,228)**	**(1,808)**	**(81,225)**	**(82,116)**	**(891)**	**(161,752)**	**(164,288)**	**(2,536)**
EBITDA	**468**	**510**	**42**	**1,922**	**2,071**	**149**	**4,586**	**4,672**	**86**
Finance income	20	55	35	120	201	81	240	398	158
Finance expense	(49)	(48)	1	(290)	(289)	1	(583)	(577)	6
PDC dividends payable/refundable	(137)	(139)	(2)	(819)	(832)	(13)	(1,639)	(1,666)	(27)
Other gains/(losses) including disposal of assets	0	0	0	0	(7)	(7)	0	(8)	(8)
Financial performance surplus/(deficit)	**302**	**378**	**76**	**933**	**1,144**	**211**	**2,604**	**2,819**	**215**
I&E impact capital donations and profit on asset disposals	22	19	(3)	132	129	(3)	264	257	(7)
Adjusted financial performance surplus/(deficit)	**324**	**397**	**73**	**1,065**	**1,273**	**208**	**2,868**	**3,076**	**208**

Month 6 – in month £397k surplus compared to £324k planned surplus – an in month favourable variance of £73k.

Year to Date - £1,273k surplus compared to £1,065k planned surplus, a YTD favourable variance of £208k.

Income - YTD overperformance of £1,040k, due to:

- Increased NHS England funding relating to 6 months of 2022/23 pay award.
- Increased reimbursement for High-Cost Drugs and Devices due to higher volumes being used.
- Increased Isle of Man activity.
- Offset by risk around coiling consumables and Spinal ERF activity.
- Lower than anticipated salary recharges due to delayed transfer of Health Procurement Liverpool staff (offset in expenditure).

ERF income has been reported to plan YTD and forecast in line with reporting guidance issued by NHS England. ERF Income is reported under patient related income.

Expenditure (inc. Financing Costs) - YTD over-spend of £829k due to:

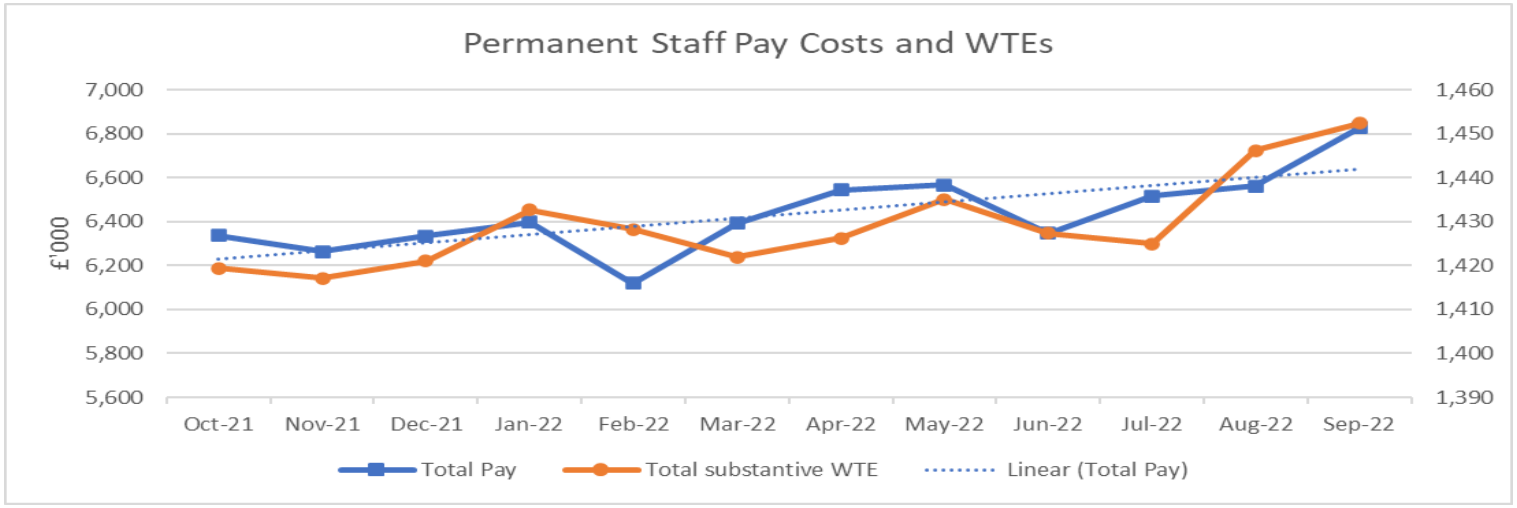
- Increased spend on High-Cost Drugs and Devices including spend on Botox that is no longer reimbursed as it is no longer classed as an excluded drug.
- Increased pay costs due to 2022/23 pay award being higher than was assumed by NHSE at budget setting.
- Offset by Non-recurrent vacancy savings.
- Delays in TUPE of Health Procurement Liverpool staff.
- Reduction in nursing bank spend.

STATEMENT OF FINANCIAL POSITION - 2022/23	Plan Sep-22	Actual Sep-22	Variance
	£'000	£'000	£'000
Intangible Assets	657	902	245
Tangible Assets	94,112	93,011	(1,101)
Right of use assets - leased assets	78	77	(1)
Receivables	428	434	6
TOTAL NON CURRENT ASSETS	**95,275**	**94,424**	**(851)**
Inventories	1,841	1,635	(206)
Receivables	6,315	8,346	2,031
Cash at bank and in hand	34,592	39,592	5,000
TOTAL CURRENT ASSETS	**42,748**	**49,573**	**6,825**
Payables	(24,185)	(31,258)	(7,073)
Borrowings	(1,624)	(1,632)	(8)
Provisions	(55)	(66)	(11)
TOTAL CURRENT LIABILITIES	**(25,864)**	**(32,956)**	**(7,092)**
TOTAL ASSETS LESS CURRENT LIABILITIES	**112,159**	**111,041**	**(1,118)**
Borrowings	(21,565)	(21,550)	15
Provisions	(693)	(684)	9
TOTAL ASSETS EMPLOYED	**89,901**	**88,807**	**(1,094)**
Public Dividend Capital	35,954	34,617	(1,337)
Revaluation Reserve	7,377	7,377	0
Income and Expenditure Reserve	46,570	46,813	243
TOTAL TAXPAYERS EQUITY AND RESERVES	**89,901**	**88,807**	**(1,094)**

STATEMENT OF CASH FLOW - 2022/23	Plan Sep-22	Actual Sep-22	Variance
	£'000	£'000	£'000
Cash flows from operating activities			
Operating surplus/(deficit)	**1,922**	**2,075**	**153**
Non-cash income and expense:	3,480	3,673	193
Working Capital	(701)	1,283	1,984
Net cash generated from/(used in) operations	**4,701**	**7,031**	**2,330**
Cash flows from investing activities	(8,578)	(6,123)	2,455
Cash flows from financing activities	(603)	(2,039)	(1,436)
Increase/(decrease) in cash and cash equivalents	**(4,480)**	**(1,131)**	**3,349**
OPENING CASH	**39,072**	**40,723**	**1,651**
CLOSING CASH	**34,592**	**39,592**	**5,000**

Year to Date - £39,592k cash balance compared to £34,592k plan, a YTD favourable variance of £5,000k:

- Opening cash balance against plan: £1,651k
- Operating surplus above plan: £346k
- Movement in payables/receivables: £1,998k
- Capital programme: £2,375k
- Public dividend capital drawdown below plan: (£1,337k)
- Other balance sheet movements: (£33k)
- **Total** **£5,000k**



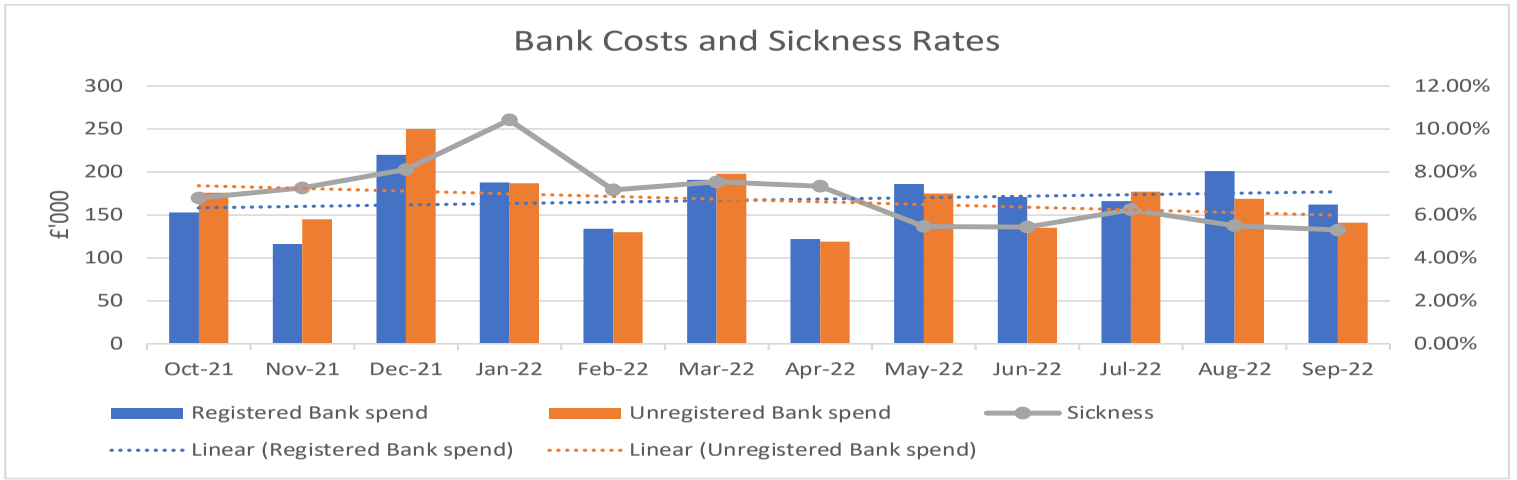
September 2021 and 2022 increase caused by six months backpay being paid relating to that year's pay award. August 2022 WTE increase due to the change in Junior Doctor rota (and more junior doctors than in the previous rotation).

Pay costs:

- Jul: £6,517k
- Aug: £6,563k
- Sep: £6,827k

WTE:

- Jul: 1,425 WTE
- Aug: 1,446 WTE
- Sep: 1,452 WTE



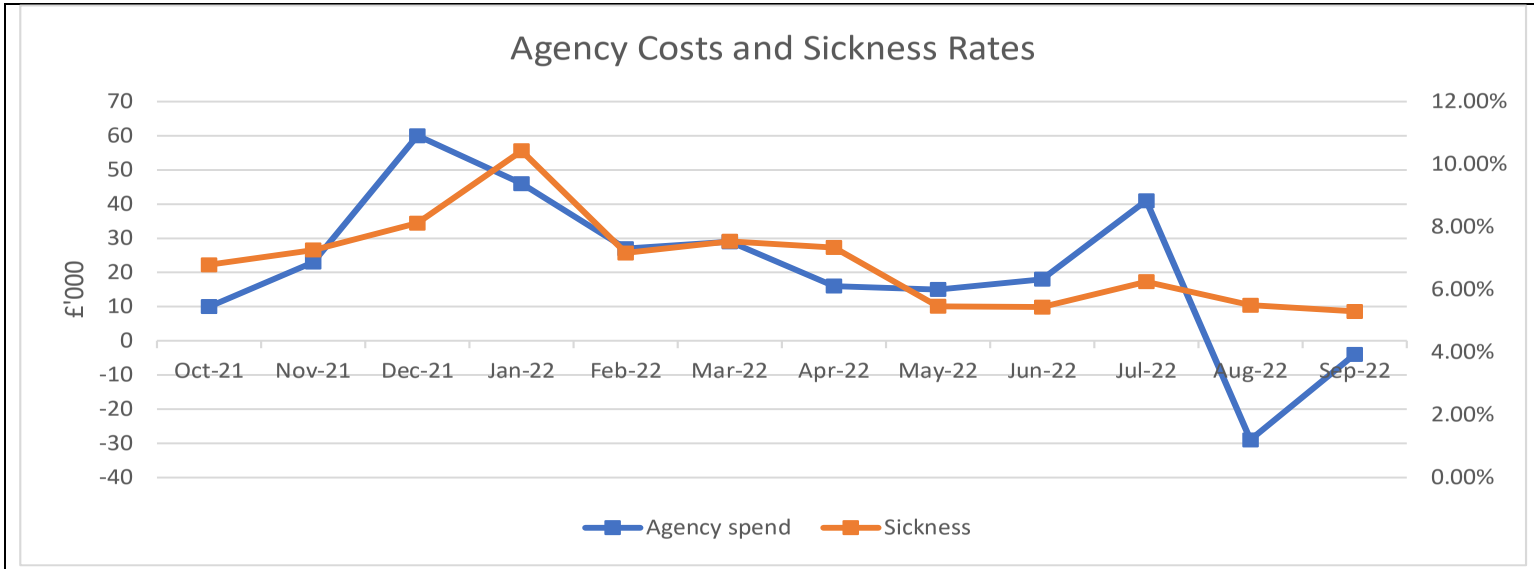
This is a key area of focus for NHSE/I.

Nursing Bank costs:

- Jul: £343k
- Aug: £370k
- Sep: £303k

Sickness rate:

- Jul: 6.3%
- Aug: 5.5%
- Sep: 5.3%



This is a key area of focus for NHSE/I.

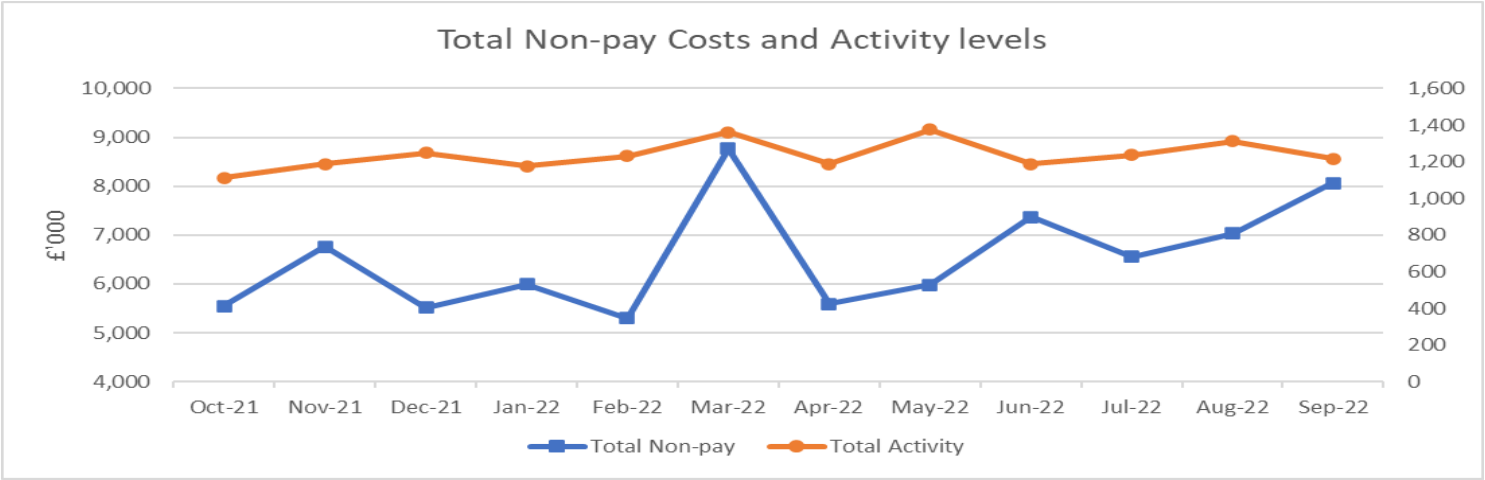
Prior year accrual released in August and September, as all invoices have been received, with actual costs being lower than anticipated at the end of the year

Agency costs:

- Jul: £41k
- Aug: (£29k)
- Sep: (£4k)

Sickness rate:

- Jul: 6.3%
- Aug: 5.5%
- Sep: 5.3%



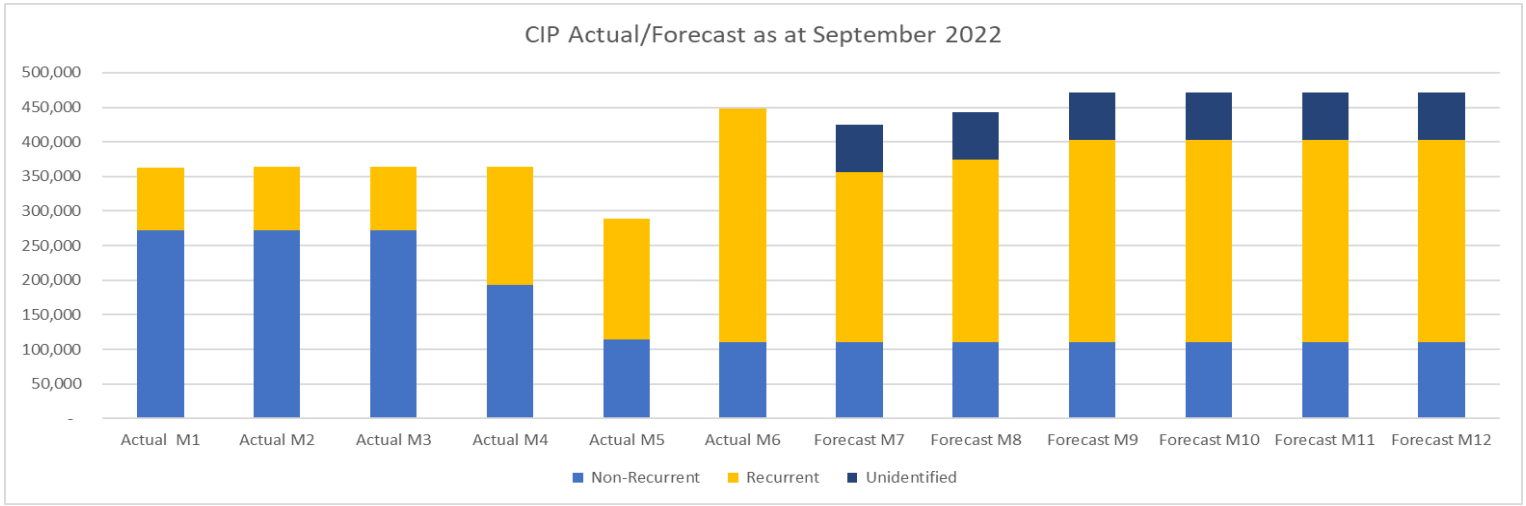
Increased costs in March 2022 are caused by increased consumable spend at the financial year end.

Non-pay costs:

- Jul: £6,557k
- Aug: £7,038k
- Sep: £8,063k

Inpatient activity:

- Jul: 1,236 spells
- Aug: 1,313 spells
- Sep: 1,216 spells



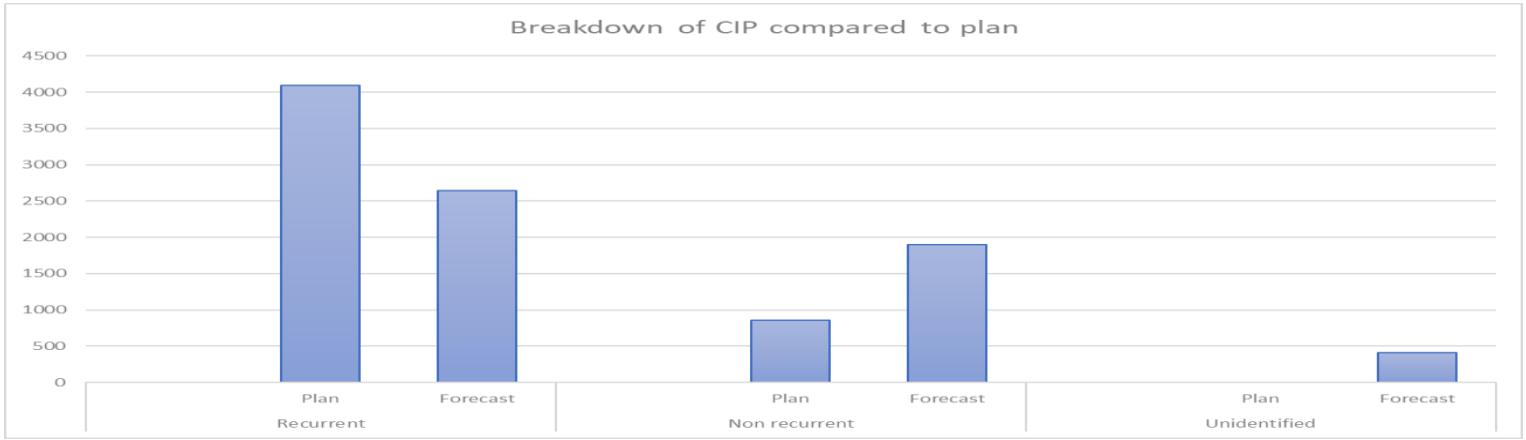
- £0.4m CIP remains unidentified.
- Further work to be undertaken with clinical and operational teams to identify schemes to achieve this amount.

Recurrent CIP:

- Jul: £445k
- Aug: £620k
- Sep: £957k

Non-recurrent CIP:

- Jul: £1,009k
- Aug: £1,124k
- Sep: £1,235k



- £4.1m (82.7%) of the CIP plan was required to be delivered recurrently.
- Currently anticipating that £2.6m (53.3%) will be delivered recurrently with the remainder either non-recurrent (£1.9m/38.3%) or unidentified (£0.4m/8.4%).

PATIENT RELATED INCOME

	In month			Year to Date			Full Year		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Forecast	Variance
Patient Related	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
NHS England	9,230	10,963	1,733	55,206	57,324	2,118	110,426	114,764	4,338
Clinical Commissioning Groups	2,112	2,347	235	12,651	12,907	256	25,323	25,683	360
Wales	1,705	1,858	153	10,232	10,331	99	20,464	20,662	198
Isle of Man	140	166	26	839	1,086	247	1,677	2,151	474
Other Patient Related Income	60	(330)	(390)	361	(1,054)	(1,415)	720	(2,104)	(2,824)
Total Patient Related Income	**13,247**	**15,004**	**1,757**	**79,289**	**80,594**	**1,305**	**158,610**	**161,156**	**2,546**

To note that patient related income includes ERF income

NON-PATIENT RELATED INCOME

	In month			Year to Date			Full Year		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Forecast	Variance
Non-patient Related	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Research & Development Income	65	144	79	391	542	151	783	1,033	250
Education And Training	269	355	86	1,612	1,753	141	3,223	3,706	483
Employee Benefits Income	217	139	(78)	1,313	722	(591)	2,635	1,946	(689)
Other Non-patient Related Income	90	96	6	542	576	34	1,087	1,119	32
Total Patient Related Income	**641**	**734**	**93**	**3,858**	**3,593**	**(265)**	**7,728**	**7,804**	**76**

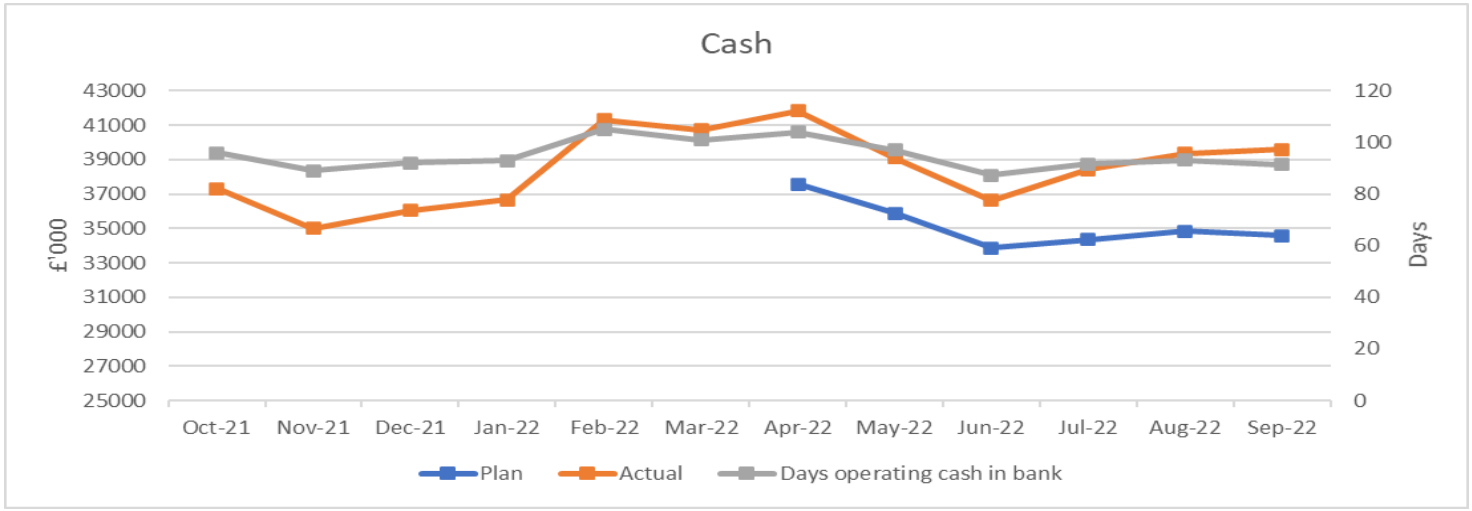
ERF

	In month			Year to Date			Full Year		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Forecast £'000	Variance £'000
Elective Recovery Funding	358	376	18	1,956	1,973	17	3,947	3,947	0

To note: for reporting purposes, Trusts have been asked to include all planned ERF up to month 6. The in month variance is due to the difference in phasing of ERF payments compared to plan.

CAPITAL	In month			Year to date			Forecast		
	Plan £'000	Actual £'000	Var £'000	Plan £'000	Actual £'000	Var £'000	Plan £'000	Actual £'000	Var £'000
Division									
Heating & Pipework	100	145	(45)	600	650	(50)	1,200	1,200	0
Estates	70	0	70	416	13	403	836	1,281	(445)
IM&T	0	20	(20)	0	87	(87)	593	608	(15)
Neurology	0	18	(18)	0	43	(43)	0	43	(43)
Neurosurgery	0	327	(327)	0	324	(324)	3,109	2,526	583
Corporate	0	0	0	0	0	0	0	80	(80)
TOTAL (excl. external funding)	**170**	**510**	**(340)**	**1,016**	**1,117**	**(101)**	**5,738**	**5,738**	**0**
Donated Assets	0	0	0	0	0	0	0	0	0
Digital Aspirant	223	46	177	1,337	391	946	2,675	2,675	0
Diagnostics Digital Capability (PDC)	0	0	0	0	0	0	208	208	0
TOTAL (incl. external funding)	**223**	**46**	**177**	**1,337**	**391**	**946**	**2,883**	**2,883**	**0**
TOTAL	**393**	**556**	**(163)**	**2,353**	**1,508**	**845**	**8,621**	**8,621**	**0**

- Capital expenditure in month of £556k.
- Year to date Capital spend of £1,508k, £391k of which is Digital Aspirant
- Year to date spend on divisional schemes includes
  - Heating and pipework replacement
  - Bed repurposing
  - IT staffing
  - Radiology Syngo equipment
  - Theatres Brain lab and S7 equipment
- Further work has been undertaken by the divisions on forecasting anticipated capital spend meaning that the 22/23 capital demands is now roughly in line with plan and all schemes are in the process of being mobilised.

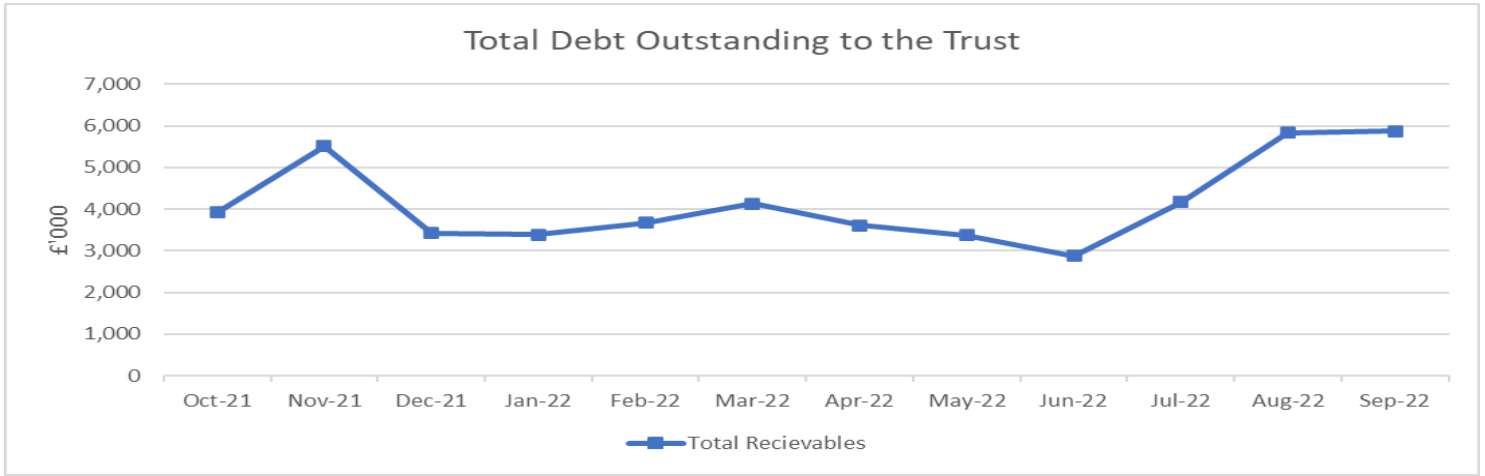


Cash:

- Jul: £38,413k
- Aug: £39,367k
- Sep: £39,592k

Operating expenditure days cover:

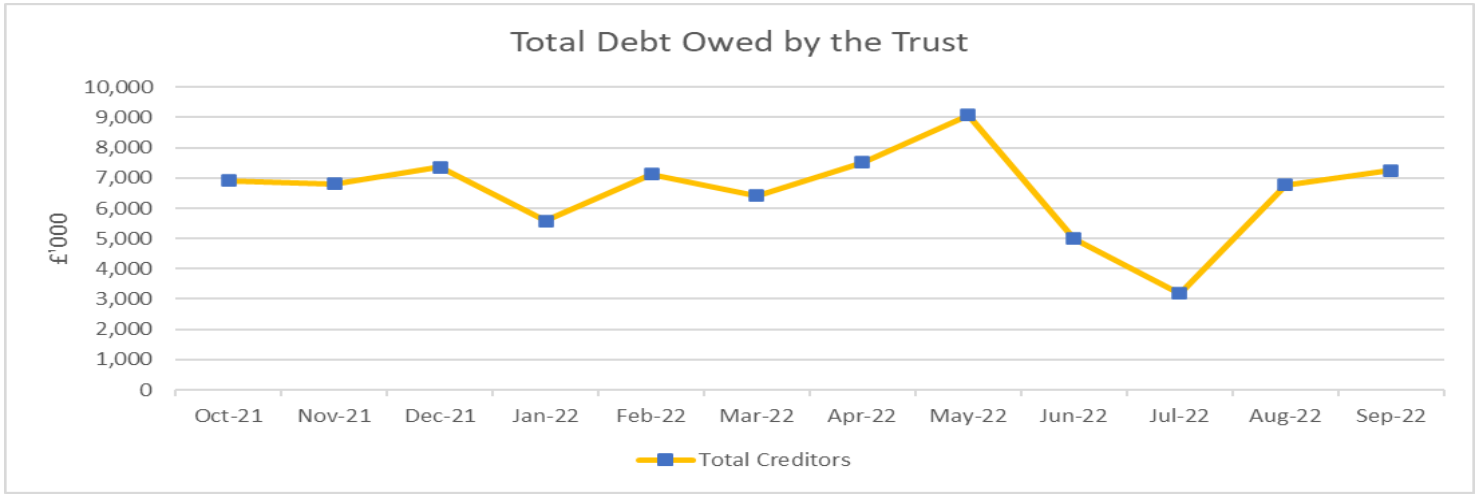
- Jul: 91.6 days
- Aug: 93.1 days
- Sep: 91.3 days



- November 2021 increase due to two large value invoices to Isle of Man and Health Education England raised in month.
- August 2022 increase due to WHSSC year-end settlement invoice, Isle of Man M1-4 invoice and M4-6 Health Education England invoice that all fall in the 0-61 days outstanding position. These are expected to be settled over the coming months as the Finance team return to full capacity.

Debt outstanding to Trust:

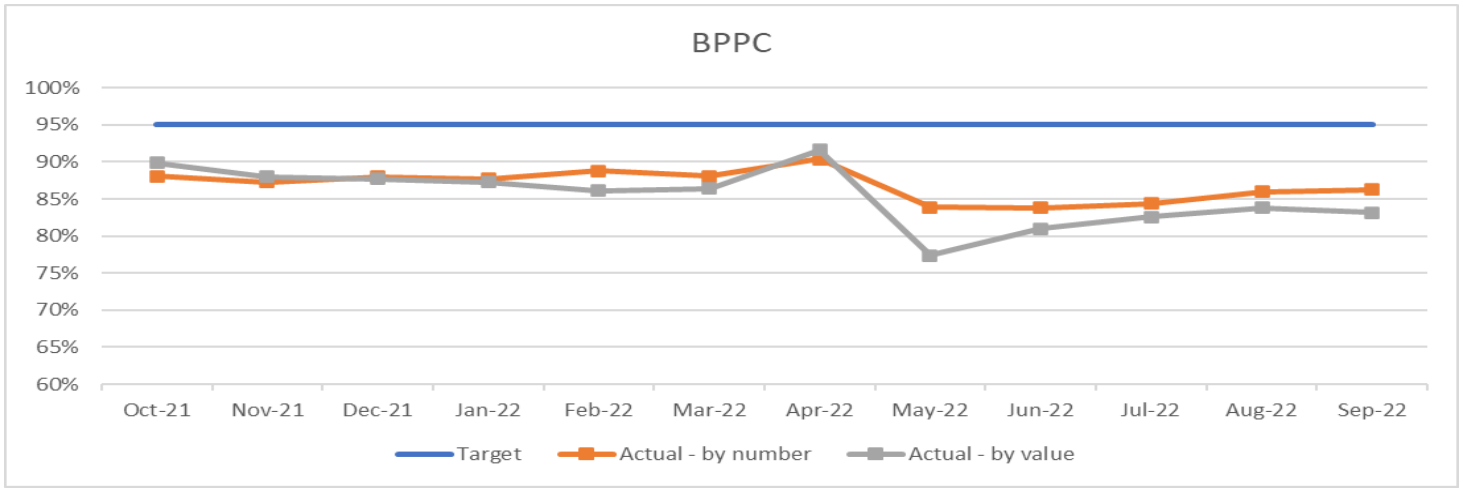
- Jul: £4,174k
- Aug: £5,830k
- Sep: £5,866k



Debt owed by the Trust:

Increase in M5 and M6 due to the level of outstanding LUHFT invoices awaiting payment that had been received in month.

- Jul: £3,185k
- Aug: £6,777k
- Sep: £7,249k



This is a key area of focus for NHSE/I.

- The Trust BPPC percentage (by number of invoices paid) at the end of September is 86.3%. This has improved from 86.0% at the end of August.
- The Trust BPPC percentage (by value of invoices paid) at the end of September is 83.2%. This has deteriorated from 83.8% at the end of August.
- Action plan now in place to improve BPPC performance.
- This involves collaborative working across the whole finance team, procurement, and the divisions to ensure that invoices are approved in a timely manner. and analysed prior to breaching the 30-day limit.

EXPENDITURE - NEUROLOGY

	In month			Year to Date			Full Year		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Forecast £'000	Variance £'000
Registered nursing, midwifery and health visiting staff	(549)	(487)	62	(2,781)	(2,493)	288	(5,706)	(4,987)	719
Allied health professionals	(595)	(582)	13	(3,033)	(2,953)	80	(6,072)	(5,907)	165
Other scientific, therapeutic and technical staff	(125)	(99)	26	(660)	(541)	119	(1,319)	(1,083)	236
Health care scientists	(74)	(81)	(7)	(377)	(376)	1	(754)	(751)	3
Support to nursing staff	(330)	(322)	8	(1,532)	(1,508)	24	(3,097)	(3,017)	80
Support to allied health professionals	(101)	(103)	(2)	(466)	(462)	4	(921)	(924)	(3)
Support to other clinical staff	(1)	(1)	0	(11)	(11)	0	(15)	(23)	(8)
Medical - Consultants	(993)	(939)	54	(4,957)	(4,732)	225	(9,891)	(9,549)	342
Medical - Junior	(265)	(193)	72	(1,449)	(1,329)	120	(2,895)	(2,711)	184
NHS infrastructure support	(252)	(245)	7	(1,193)	(1,123)	70	(2,391)	(2,245)	146
Bank/Agency	(144)	(148)	(4)	(480)	(1,032)	(552)	(480)	(2,068)	(1,588)
Total Pay Expenditure	**(3,429)**	**(3,200)**	**229**	**(16,939)**	**(16,560)**	**379**	**(33,541)**	**(33,265)**	**276**
Supplies and services – clinical (excluding drugs costs)	(677)	(676)	1	(4,065)	(4,362)	(297)	(8,130)	(8,734)	(604)
Supplies and services - general	(17)	(25)	(8)	(105)	(101)	4	(209)	(202)	7
Drugs costs	(1,736)	(3,079)	(1,343)	(10,415)	(12,846)	(2,431)	(20,830)	(25,692)	(4,862)
Establishment	(2)	(3)	(1)	(12)	(16)	(4)	(23)	(31)	(8)
Premises - other	(111)	(100)	11	(667)	(545)	122	(1,334)	(1,128)	206
Transport	(5)	(5)	0	(31)	(33)	(2)	(63)	(66)	(3)
Education and training - non-staff	(1)	(1)	0	(7)	(11)	(4)	(13)	(22)	(9)
Lease expenditure	(5)	(2)	3	(32)	(25)	7	(64)	(50)	14
Other	(5)	(8)	(3)	(28)	(47)	(19)	(57)	(94)	(37)
Total Non-pay Expenditure	**(2,559)**	**(3,899)**	**(1,340)**	**(15,362)**	**(17,986)**	**(2,624)**	**(30,723)**	**(36,019)**	**(5,296)**

EXPENDITURE - NEUROSURGERY

	In month			Year to Date			Full Year		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Forecast £'000	Variance £'000
Registered nursing, midwifery and health visiting staff	(1,412)	(1,331)	81	(7,405)	(6,775)	630	(14,619)	(13,553)	1,066
Allied health professionals	(218)	(217)	1	(1,118)	(1,100)	18	(2,235)	(1,634)	601
Other scientific, therapeutic and technical staff	(58)	(54)	4	(314)	(307)	7	(627)	(1,180)	(553)
Health care scientists	(89)	(88)	1	(469)	(449)	20	(938)	(899)	39
Support to nursing staff	(359)	(390)	(31)	(1,852)	(1,692)	160	(3,489)	(3,385)	104
Support to allied health professionals	(16)	(17)	(1)	(75)	(75)	0	(151)	(151)	0
Support to other clinical staff	(2)	(2)	0	(4)	(4)	0	(14)	(7)	7
Medical - Consultants	(891)	(916)	(25)	(4,521)	(4,542)	(21)	(8,961)	(9,280)	(319)
Medical - Junior	(400)	(343)	57	(2,238)	(2,233)	5	(4,419)	(4,475)	(56)
NHS infrastructure support	(275)	(246)	29	(1,280)	(1,154)	126	(2,564)	(2,309)	255
Bank/Agency	(79)	(184)	(105)	(310)	(1,102)	(792)	(310)	(2,203)	(1,893)
Total Pay Expenditure	**(3,799)**	**(3,788)**	**11**	**(19,586)**	**(19,433)**	**153**	**(38,327)**	**(39,076)**	**(749)**
Supplies and services – clinical (excluding drugs costs)	(1,378)	(1,481)	(103)	(8,268)	(7,665)	603	(16,536)	(15,336)	1,200
Supplies and services - general	(21)	(24)	(3)	(129)	(143)	(14)	(258)	(285)	(27)
Drugs costs	(71)	(72)	(1)	(429)	(446)	(17)	(858)	(893)	(35)
Consultancy	0	0	0	0	0	0	0	0	0
Establishment	(9)	(14)	(5)	(54)	(66)	(12)	(109)	(131)	(22)
Premises - other	(50)	(49)	1	(297)	(228)	69	(595)	(457)	138
Transport	(2)	(10)	(8)	(13)	(34)	(21)	(27)	(69)	(42)
Education and training - non-staff	(5)	(6)	(1)	(27)	(21)	6	(54)	(42)	12
Lease expenditure	(6)	(13)	(7)	(35)	(47)	(12)	(69)	(94)	(25)
Other	(21)	(11)	10	(124)	(98)	26	(249)	(196)	53
Total Non-pay Expenditure	**(1,563)**	**(1,680)**	**(117)**	**(9,376)**	**(8,748)**	**628**	**(18,755)**	**(17,503)**	**1,252**
Total Divisional Operating Expenditure	**(5,362)**	**(5,468)**	**(106)**	**(28,962)**	**(28,181)**	**781**	**(57,082)**	**(56,579)**	**503**

EXPENDITURE - CORPORATE

	In month			Year to Date			Full Year		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Forecast £'000	Variance £'000
Registered nursing, midwifery and health visiting staff	(170)	(183)	(13)	(677)	(643)	34	(1,353)	(1,404)	(51)
Other scientific, therapeutic and technical staff	0	17	17	0	0	0	0	0	0
Support to nursing staff	(1)	(1)	0	(5)	(6)	(1)	(11)	(12)	(1)
Medical - Consultants	(8)	(7)	1	(38)	(47)	(9)	(77)	(88)	(11)
NHS infrastructure support	(1,072)	(976)	96	(5,417)	(4,787)	630	(10,827)	(10,134)	693
Apprenticeship Levy	(24)	(30)	(6)	(143)	(153)	(10)	(287)	(306)	(19)
Bank/Agency	(18)	(33)	(15)	(82)	(158)	(76)	(164)	(279)	(115)
Total Pay Expenditure	**(1,293)**	**(1,213)**	**80**	**(6,362)**	**(5,794)**	**568**	**(12,719)**	**(12,223)**	**496**
Non-executive directors	(12)	(10)	2	(75)	(62)	13	(150)	(123)	27
Supplies and services – clinical (excluding drugs costs)	46	(13)	(59)	(180)	(158)	22	(311)	(353)	(42)
Supplies and services - general	(294)	(233)	61	(1,762)	(1,586)	176	(3,523)	(3,189)	334
Consultancy	(6)	(8)	(2)	(34)	(12)	22	(68)	(27)	41
Establishment	(111)	(128)	(17)	(529)	(561)	(32)	(1,032)	(991)	41
Premises - business rates payable to local authorities	(65)	(71)	(6)	(389)	(428)	(39)	(778)	(856)	(78)
Premises - other	(480)	(489)	(9)	(2,881)	(2,045)	836	(5,762)	(4,697)	1,065
Transport	(6)	(46)	(40)	(34)	(224)	(190)	(68)	(415)	(347)
Audit fees and other auditor remuneration	(12)	(17)	(5)	(71)	(56)	15	(141)	(113)	28
Clinical negligence	(475)	(475)	0	(2,852)	(2,852)	0	(5,704)	(5,704)	0
Education and training - non-staff	(16)	(103)	(87)	(98)	(230)	(132)	(197)	(290)	(93)
Lease expenditure	0	0	0	0	(1)	(1)	0	(1)	(1)
Other	(97)	(123)	(26)	(585)	(649)	(64)	(1,169)	(1,352)	(183)
Total Non-pay Expenditure	**(1,528)**	**(1,716)**	**(188)**	**(9,490)**	**(8,864)**	**626**	**(18,903)**	**(18,111)**	**792**
Total Divisional Operating Expenditure	**(2,821)**	**(2,929)**	**(108)**	**(15,852)**	**(14,658)**	**1,194**	**(31,622)**	**(30,334)**	**1,288**

KPI Glossary	Green	Amber	Red
% variance from plan - Year to date	value > 0%	0% > value > -5%	value < -5%
% variance from plan - Forecast	value > 0%	0% > value > -5%	value < -5%
% variance from efficiency plan - Year to date	value > 0%	0% > value > -5%	value < -5%
% variance from efficiency plan - Forecast	value > 0%	0% > value > -5%	value < -5%
Capital % variance from plan - Year to date	value > 0%	0% > value > -5%	value < -5%
Capital % variance from plan - Forecast	value > 0%	0% > value > -5%	value < -5%
Capital Service Cover	value > 2.5	2.5 > value > 1.25	value < 1.25
Liquidity	value > 0	0 > value > -14	value < -14
Cash days operating expenditure	value > 60 days	30 days < value < 60 days	value < 30 days
BPPC - Number	value > 95%	95% > value > 90%	value < 90%
BPPC - Value	value > 95%	95% > value > 90%	value < 90%

Board of Directors Key Issues Report

The Walton Centre NHS Foundation Trust

Report Date: 26/10/22		**Report of:** Business Performance Committee (BPC)
Date of last meeting: 25/10/22		**Membership Numbers:** Quorate
1	**Agenda**	The Committee considered an agenda which included the following: • Integrated Performance Report • Deep Dive – Cost Improvement Plan • Review of Digital Aspirant Funding Spend • Digital Transformation Monthly Update • Consolidated Estates Report • Business Case for HITU Ponta Beam replacement • Health and Wellbeing Strategic Implementation Plan Update • Trustwide Risk Register (BPC risks) • People Group Terms of Reference • Key Issues Reports from 7 sub-groups
2	**Alert**	• A further tranche of 80 spinal patients have come to light which are currently undergoing clinical validation as/when information is passed on by LUHFT. This is highly likely to include a number of >104 week and other long waiters. • Winter pressures and patients requiring community services has increased there are currently 36 patients in the trust requiring external care resulting in delayed discharges and cancelled operations.
3	**Assurance**	*Integrated Performance Report* • All cancer wait/treatment and diagnostic targets continue to be achieved. • Patient flow and outpatient transformation indicators remain strong, with the exception of Did Not Attends (DNAs) which remains challenging, especially for virtual appointments. • With regards to activity recovery – (ahead of any further transferred spinal patients as per the alert above) >104 week waiters have been eliminated and 78 week waiters are down to 5. New outpatient activity exceeded target in September. Day cases were slightly below plan as was elective activity – although the latter was the highest month YTD. • Sickness fell to 5.7% (1% of which is Covid related) giving 6.9% rolling 12-month average. Appraisal completion and mandatory training compliance remain below target. Face to face training modules have the lowest compliance and capacity issues are being addressed. • The reported Income and Expenditure position was £73k better than plan in September; both income and expenditure were above plan in the month, largely because of back-dating the pay award to April. Latest estimate forecast for the full

		year is to maintain the current £200k YTD favourable variance (i.e a surplus of £3.1m v plan of £2.9m), notwithstanding threats from inflation. A review of the cost improvement plan was made: now only £0.4m of the £4.1m full year plan has yet to be identified. £2.2m was delivered in the first half year. • Capital spend remains behind plan but is starting to pick up. • BPPC performance (paying creditors on time) remains behind target and as yet is only improving slowly. Creditors (debt owed) has risen to £7.2m and debtors has increased to £5.9m. Both have been affected by vacancies in finance which are now being filled. *Other matters* • The Digital Aspirant project continues to make good progress; a review of the project to date was made including elements completed, scope still to complete and financials. • Estates related information included in 4 different data-collection and benchmarking tools was reviewed. Further work will now be done to follow-up on insights relating, in particular, to energy usage/costs and some soft-FM services where the Trust appears as outliers. The Trust maintenance backlog cost benchmarks high relative to other specialist trusts in the region; assurance was given that the Trust has a comprehensive inventory and provision to address this backlog over the coming years in the medium-term capital plan. • Progress in implementing the Health & Wellbeing strategic plan, together with emerging Cost of Living support programmes, were reviewed. A steering group is in place and a wellbeing hub is being set up. A dashboard to track progress is being developed. • The Trustwide Risk Register was reviewed; continued work improving documenting mitigating actions and target dates was noted.		
4.	**Advise**	• A business case to replace end-of-life HITU Ponta Beams was approved. At £450k, this is less than the provision made in the capital plan. • The Terms of Reference of the People Group was updated with only minor changes. Ways to improve the assurance given to BPC from the group were discussed. • 7 Key issues reports from sub-groups were received and noted. • The Information Governance Security Forum reported another externally reportable incident (patient receiving another patient's letter mixed up with their own) which is brought to the attention of the Audit Committee.		
5.	**Risks Identified**	None		
6.	**Report Compiled**	David Topliffe, Non-Executive Director	Minutes available from:	Corporate Secretary

Board of Directors' Key Issues Report

The Walton Centre NHS Foundation Trust

Report Date: 03/11/22		**Report of: Quality Committee**
Date of last meeting: 20/10/22		**Membership Numbers:** 18
1.	**Agenda**	The considered an agenda which included the following: • Patient Story • Quality Presentation from Advanced Critical Care Practitioner • Integrated Performance Report & Divisional KPI Reports • Mortality & Learning from Deaths Report • Infection Prevention Quarterly Report • Tissue Viability Quarterly Report • Governance & Risk Quarterly Report • Patient Experience Quarterly Report • National In-patient Survey Update • Subcommittees Chair's Reports
2.	**Alert**	• None raised
	Assurance	**Infection Control Q2 Report** The report noted improvements with regards to the number of infections reported. A return to the fundamentals of infection prevention and the embedding of ANTT (Anti-septic Non-Touch Technique) within nursing teams has contributed to the reduction. It was noted that flu vaccination is available both in-house and at the Aintree Hub (if received with covid booster). Clarification was sought of how and where the flu CQUIN was monitored and how this was shared with the divisional teams **Tissue Viability Report** The report noted continued good performance on Lipton ward with regards to pressure ulcer free days following targeted intervention by the Tissue Viability Nurse (TVN). The chair requested feedback of the plan for TV education across the Trust together with an update with regards to the possible business case for either further TVN support within the team or for TV training on the wards once the divisions and IPC team have discussed this **External Visits to the Trust** Following the Anaesthesia Clinical Services Accreditation review which took place earlier in the year, it was noted that an email had been received advising that the anaesthetic services within the Walton Centre were excellent. Following receipt of the full report, a presentation will be delivered to Quality Committee The major trauma peer review is due to take place on 17/11/22. Trauma Audit and Research Network (TARN) data is to be added to the Quality Committee work cycle

		Quality Presentation – Mike Jennings presented on behalf of the Advanced Critical Care Practitioner's (ACCP) team. The presentation demonstrated how the team has grown, not only in numbers (currently 7 WTE) but also with regards to greater responsibilities, qualifications and support provided the highly skilled ACCP team within critical care. The chair enquired about succession planning for this role and requested that it forms part of the workforce or quality substrategy. **NICE Guidance** Dr Silver (Trust Clinical Lead for NICE, Clinical Audit & NCEPOD) delivered a comprehensive presentation which provided clear steps of how the backlog of NICE guidance is being managed. The presentation also provided assurances that significant progress has been made to reduce the backlog and processes are now in place for the most relevant guidance to be prioritised. Updates will be presented to the Quality Committee on a quarterly basis.		
	Advise	**Integrated Performance report:-.** There was a drop in responses to Friends and Family Tests (FFT) due to a number of factors, namely another survey was being undertaken and staff absence. Focus is back onto FFT within OPD. It was noted that the Executive Team have agreed that OPD will be a focus for the Transformation Team working cross divisionally. It was agreed that following the CARES assessment in OPD, a paper will be presented to Quality Committee in March detailing progress within OPD Safe staffing data is now included in the IPR which provides more focus and identifies red flags which all agreed is helpful. However, it was noted that there is more work to be completed with regards to health rosters and safe care. DCN advised that staffing establishments in some areas have been uplifted. A suggestion was made that safe staffing could be audited and that this will be raised with audit committee. **Mortality & Learning from Deaths Q2 Report** The number of deaths reported in July and August was higher than usual. All rapid reviews have been completed. No themes were noted. The number of deaths within critical care did have an impact on staff and extra support has been made available to staff. An Update with regards to the adoption of the Swan Model for End-of-Life Care (ELOC) is to be provided to Quality Committee in November. **Governance & Risk Quarterly Report** The committee welcomed the proposals and progression being made with regards to the presentation of data with regards to risk. The Governance Assurance Framework was discussed with the chair noting need for themes to be identified via the risk register for risks of scores 12 and above or overdue risks to be presented to Quality Committee. **Patient Experience Quarterly Report** The report noted a return to pre-covid levels of complaints which could possibly be due to increased activity. The committee discussed themes arising with regards to outpatients and the need for a plan for staffing as the Patient Support Assistant contracts come to an end in March.		
2.	Risks Identified	• No new risks identified		
3.	Report by	Ray Walker	Minutes available from:	Corporate Secretary

The Walton Centre NHS Foundation Trust

Mortality report (Q4 21/22 and Q1-2 22/23) to Trust Board
3rd November 2022

Report Title	Mortality Report (Combined) Quarter 4 2021/22, Quarters 1 and 2 2022/23
Executive Lead	Dr A Nicolson, Medical Director
Author (s)	Mrs P Crofton, Governance Lead for Mortality
Action Required	To note

Level of Assurance Provided

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

Key Messages

- There has been an increase in the number of inpatient deaths in Quarter 2 2022 when compared with previous quarters. Review of the cause of death has not identified any trends, and initial rapid reviews no areas of concern. RAMI19 (Risk Adjusted Mortality Index) remains well below expected level of deaths for the year when compared to peers.
- The Trust wide approach to Learning from Deaths is continuing with the review of the format and processes involved with retrospective case record reviews following an inpatient death.
- The divisions have appointed medical and nursing leads for mortality who will form part of a multidisciplinary mortality surveillance group (MSG) chaired by the Deputy Medical Director.

Next Steps

- The revised Learning from Deaths Policy is to be presented at Clinical Effectiveness group October 2022.
- The Deputy Chief Nurse and members of the Senior Nursing Team have met with the End of Life (EOL) team at Liverpool University Foundation Trust (LUFT) regarding the implementation of the Swan Model of EOL and bereavement care.
- The mortality surveillance group has been formed and will meet monthly to provide additional internal scrutiny of the mortality review process.

Related Trust Strategic Ambitions and Themes	**Impact**		
Quality of Care	Quality	Not Applicable	Not Applicable

Strategic Risks		
001 Quality Patient Care	Choose an item.	Choose an item.

Equality Impact Assessment Completed		
Strategy ☐	Policy ☐	Service Change ☐

Report Development

Committee/ Group Name	**Date**	**Lead Officer (name and title)**	**Brief Summary of issues raised and actions agreed**
Quality Committee	19th May 22 21st July 22 20th October 22	Dr Nicolson	

Mortality report for Trust Board Q4 2021/22, Q1-2 2022/23

Executive Summary

1. This report is a review of Mortality from Quarter 4 2021/22 and Quarters 1 and 2 of 2022/23 in The Walton Centre NHS Foundation Trust. A summary of deaths is presented in the report, including number and location of deaths and subspecialty the patients were admitted under.
2. All deaths are reported through Datix and are scrutinised by clinical leads and the governance department who liaise directly with the Medical Director, Chief Nurse and Divisional Clinical Leads, any concerns are escalated to the serious incident group.
3. Following the initial review the case may be investigated further to determine if the death was associated with problems in the care provided and the degree of avoidability (using the Royal College of Physicians guidance) determined. Of those deaths that have been reviewed by the mortality review groups one patient death was considered to have some degree of avoidability.
4. There was an increase in the number of deaths in Q2 22/23 (40, compared with 17 in Q4 21/22 and 19 in Q1 22/23). All cases have been referred either to HM coroner or the Medical Examiner, with no concerns raised. Initial rapid reviews have not revealed any pattern in the increase in mortality or areas of concern. Risk adjusted mortality index (RAMI19) (see appendix 1) remains well below average for peers up to and including July 2022, data beyond this is not yet available.
5. The report also provides an update on a number of actions being taking to improve our learning from deaths processes.

Background and Analysis

6. In Quarter 4 21/22 and Q1 22/23 there were 17 and 19 inpatient deaths in the Trust respectively. There was a significant increase in deaths of 40 in Q2 22/23.
7. Over these three quarters there was one death judged to have had a degree of avoidability, according to the Royal College of Physicians guidance.
8. All inpatient deaths were subject to external scrutiny, either through referrals made to HM Coroner, or using the Medical Examiner (ME) process.
9. Number of deaths and location by quarter:

Quarter	Q4 2021/22	Q1 2022/23	Q2 2022/23
Total	17	19	40
Ward Areas	8	8	12
Critical Care	8	11	28
Theatre	1	0	0

10. Subspecialty the patient was admitted under:

Quarter	Q4 2021/22	Q1 2022/23	Q2 2022/23
Total	17	19	40
Vascular	3	5	15
Trauma	6	9	12
Oncology	4	3	5
Infection	2	0	4
Neurology	2	2	4

11. Review of the causes of death in Q2 and rapid review of cases has not identified any trends, most patients were admitted to critical care as emergencies following traumatic or vascular events.
12. There were 3 unexpected deaths due to cardiac arrests in Q2, all have been subject to rapid review and discussed at the Trust Serious Incident Group. Two were due to thromboembolic events and the coroner concluded both deaths were due to pulmonary embolism with no further action. These deaths will be subject to internal review including scrutiny of the thromboprophylaxis plan of care.
13. The majority of deaths were anticipated, and following discussion with patients' families do not attempt cardiorespiratory resuscitation were completed (DNARCPR). Review of the inpatient deaths during this period has shown that clinical teams are making appropriate and timely decisions regarding DNACPR decisions referrals for specialist advice, and there is evidence of good communication with families and carers.
14. Where possible the patients were referred to Specialist Palliative Care Services. All families of patients who die in critical care are approached regarding organ donation. All patients and families are seen and supported by the Specialist Nurses for organ donation.
15. The RAMI19 (appendix 1) is a measure of actual versus expected deaths, taking into account the severity of underlying condition and associated co-morbidities. The Trust has consistently had a RAMI19 score well below peers, which has continued up to the most recently available data (July 2022).
16. There has been an increase in the number of patients dying in critical care during Q2. Care of the dying and deceased patient and their family is an integral part of critical care. Contextual issues such as the pace and complexity of critical care, the severity of patient illness, unpredictable dying trajectories and the interprofessional teams' frequent exposure to death that might be sudden in nature, all give rise to concerns regarding the emotional burden of caring and the importance of support for staff after death of a critically ill patient and their family.
17. Senior critical care staff recognise the importance of workplace support for the multidisciplinary teams and besides debriefings and peer support have arranged staff support from the Trust psychology team (either group or individual support). Staff can also access support from external Agency Network of Staff Supporters (NOSS).
18. All inpatients who die following an initial presentation of trauma require referral to HM Coroner. Referrals are now made via an electronic portal. Although this improves the initial referral process, there can be some delays at the coroners' office causing distress to several bereaved families. The Governance lead for Mortality and Patient Experience Team are providing support for families where possible.

Progress with the Implementation of the Medical Examiner Services

19. The procedural changes required to ensure compliance with the introduction of the Medical Examiner Service have been implemented successfully.
20. The referral process is now via an electronic portal in EP2, and the information is uploaded to the patient's case records. The Medical Examiner team have access to records within EP2.
21. The medical staff have been extremely supportive of the changes required ensuring there are no unnecessary delays for bereaved families.
22. Initial feedback from the lead Medical Examiner is positive, the quality of the medical information was highlighted. There have been no unnecessary delays for bereaved relatives. The administration team in critical care now provide administrative support for the mortality processes, this has improved the completion of medical certificate of cause of death (MCCD) and cremation forms as they are all in one area with an experienced team. Despite this being

an increase in workload they have been a been supportive resource for clinical colleagues and a supportive point of contact for bereaved families.

23. One of the tasks of the medical examiner team is to contact the patient's family and ask if there are any concerns regarding the deceased patients care, which may have contributed to the patient's death. Family feedback via the medical examiner has been regarding family satisfaction has been positive.

Mortality Surveillance Group

24. The Deputy Medical Director has identified a suitable group of senior clinicians who will meet monthly as the Mortality Surveillance Group (MSG). The group will provide an extra level of mortality scrutiny and support for divisional groups.
    The MRG will:
    - Receive and review assurance reports from Divisional mortality representatives, considering any cases where suboptimal care has been identified or concerns have been raised by bereaved relatives or staff. Areas of good practice and compliments will also be monitored.
    - Assign clinical leads to address key trends/ issues and monitor actions.
    - Support cross divisional sharing and learning from death.
    - Ensure any patient deaths graded as having a degree of avoidability have resulted in a Patient safety Investigation.
    - Provide assurance to Quality Committee by a monthly report.
    - The Deputy Medical Director as chair of the Mortality Surveillance Group may also act on urgent matters arising between meetings of the Group.

SWAN model of care

25. Members of the Senior Nursing and Patient Experience team have met with the Director of Corporate Nursing Services at LUFT who spearheaded the SWAN model at Salford Royal hospital and has been replicated across the UK.
26. The SWAN model supports and guides the care of patients and their loved ones at the end of life and after they have died, from handprints, memory boxes and support for those who are bereaved.
27. Clinical staff at the Trust provide elements of the model at present, however it is not recognised as the SWAN model of care. The team at LUFT have committed to sharing their experience and expertise with staff at the WCFT to safely provide care that is patient and family focused.

Conclusion

28. There has been an increase in mortality in Q2 2022/23, but with no trends apparent on initial review of each case. All cases will be subject to a more detailed review in the relevant mortality review group. The majority of deaths occur in critical care in patients presenting with acute vascular pathology or following traumatic injury.
29. The RAMI19 up to July 2022 remains well below the expected level of deaths when the Trust is compared to peers.
30. The Medical Examiner service (provided by LUFT) is now well embedded and provides an additional and independent layer of scrutiny over deaths, with all cases either referred to HM Coroner or the Medical Examiner.
31. A mortality surveillance group has been developed and will be chaired by the Deputy Medical Director.

Recommendation

The Board is asked to note.

Author: Dr A Nicolson
Date: 19/10/22

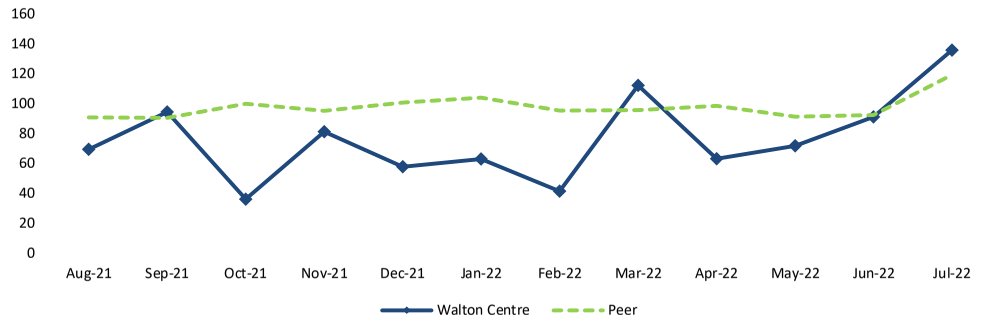
Quality of Care

Safe - Mortality

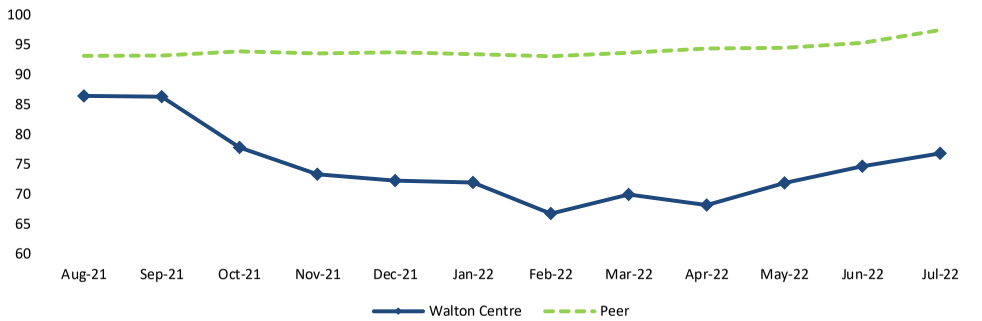
The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

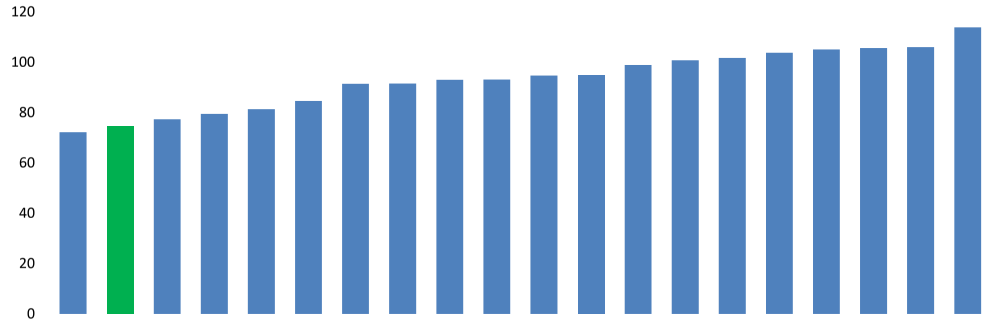
RAMI 2019 by Month



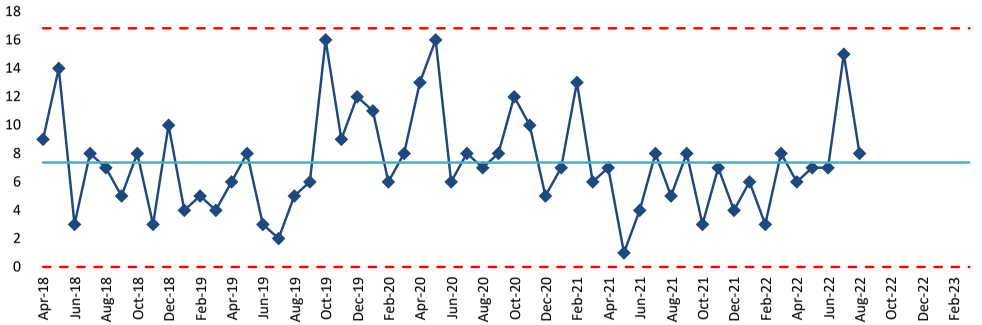
RAMI 2019 Rolling 12 Month



RAMI 2019 Rolling 12 Month Peer Distribution



Crude Mortality



As at July 2022 the rolling 12 month RAMI19 figure is 76.86. During the period there were a total of 69 observed deaths against 92 expected deaths. Compared to peers The Walton Centre has performed significantly better during the period.

RAMI19 excludes deaths following a positive covid-19 result. During the rolling 12 month period there have been six deaths following a positive covid-19 result. In the most recent two months there has been two.

Crude mortality is within normal variation

The Walton Centre NHS Foundation Trust

Report to Trust Board
3rd November 2022

Report Title	Freedom to Speak Up Report – Quarters One and Two 2022/23
Executive Lead	Lisa Salter, Chief Nurse & Executive Lead for Raising Concerns
Author (s)	Julie Kane, Quality Manager & Freedom to Speak Up Guardian
Action Required	To note

Level of Assurance Provided

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

Key Messages

- The purpose of this report is to provide the Board with an overview of the Freedom to Speak Up (FTSU) process and activity during quarters one and two 2022/23
- The report provides information relating to the requirements of the National Guardians Office (NGO) and the Trust processes

Next Steps

- The NGO Freedom to Speak Up Reflection Tool will be completed in line with national guidance. The tool will help identify strengths/gaps in individuals, the leadership team and the organisation
- The Trust will further promote speaking up during the 'speak up' month in October and will launch the role of the Freedom to Speak Up Champions
- All staff to complete the mandatory first module of the Speak Up e-learning

Related Trust Strategic Ambitions and Themes	**Impact**		
Leadership	Quality	Equality	Workforce

Strategic Risks		
001 Quality Patient Care	004 Leadership Development	004 Operational Performance

Equality Impact Assessment Completed		
Strategy ☐	Policy ☐	Service Change ☐

Report Development

Committee/ Group Name	**Date**	**Lead Officer (name and title)**	**Brief Summary of issues raised and actions agreed**
n/a			

Freedom to Speak Up Board Report
Quarters One and Two 2022/23

Executive Summary

1. This report provides data, information and updates on the activities undertaken by the Freedom to Speak Up Guardian (FTSUG) during quarters one and two 2022/23. It includes data with regards to the numbers and types of concerns raised within divisions and by which professional groups.

2. The FTSUG plays an important role in supporting an open and transparent 'speak up' culture of improvement and learning where speaking up and raising concerns are welcomed. A positive speak up culture is essential to ensuring the organisation is well led.

3. The FTSUG operates independently, impartially, and objectively whilst working in partnership with individuals and groups throughout the organisation. The Trust have numerous Speak Up Champions. The Guardian and Champions support the organisation to be open, responsive, and compassionate to staff members when they speak up.

4. All staff are encouraged and supported to raise concerns and know their concerns will be acted upon will have a positive impact on patient safety, promote good practice and ensure lessons are learnt.

Background and Analysis

5. Following the Mid-Staffordshire inquiry and the Freedom to Speak Up review, Sir Robert Francis QC stated "Poor standards of care can proliferate unless both patients and staff are listened to by the leaders of our health services and their concerns welcomed and acted upon. Speaking up should be the norm, not a dangerous exception to a general practice of keeping one's head down. Every healthcare leader from ward to board level must promote a culture where speaking up about legitimate concerns can occur without fear of harassment, bullying or discrimination". The full review and executive summary are available on via the following link http://freedomtospeakup.org.uk/the-report

6. The Trust's Raising Concerns Policy is currently being updated following the publication of the revised policy by the National Guardians Office (NGO).

7. The NGO have published a FTSU Reflection and Planning Tool which all organisations are required to complete by January 2024. The Executive Lead for Raising Concerns is responsible for completing the tool.

8. The tool is set out in three stages, as per below:
   - Stage 1 - Sets out statements for reflection under the eight principles of speaking up
   - Stage 2 - Involves summarising high level actions to be taken over the next 6-24 months to develop speak up arrangements. This will help the FTSUG and Executive Lead for Raising Concern carry out more detailed planning
   - Stage 3 - Summarises high level actions the Trust need to take to share and promote strengths. This will enable other within the Trust and the wider system to learn

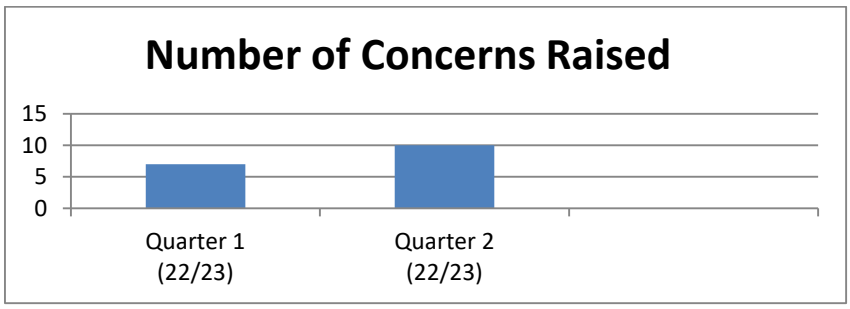
9. An initial meeting with the FTSU Guardian, Executive Lead and Non- Executive Lead for Raising Concerns and Deputy Chief People Officer took place in September 2022 to review the tool. A further meeting has been scheduled to review the tool in greater detail as there is a lot of work to be undertaken during its completion.

Local Activity – Quarters One and Two 2022/23

10. The FTSUG has recorded 17 cases that were raised during this period of reporting. Some cases were resolved quickly and some remain open and are being following up by the FTSUG. A concern was raised anonymously and following this the FTSUG and HR have attended the area where the concern was raised and further work is being undertaken.

    The concerns raised were from all divisions and those raising concerns include administrative staff, clinicians, nurses, allied health professionals and corporate staff, and

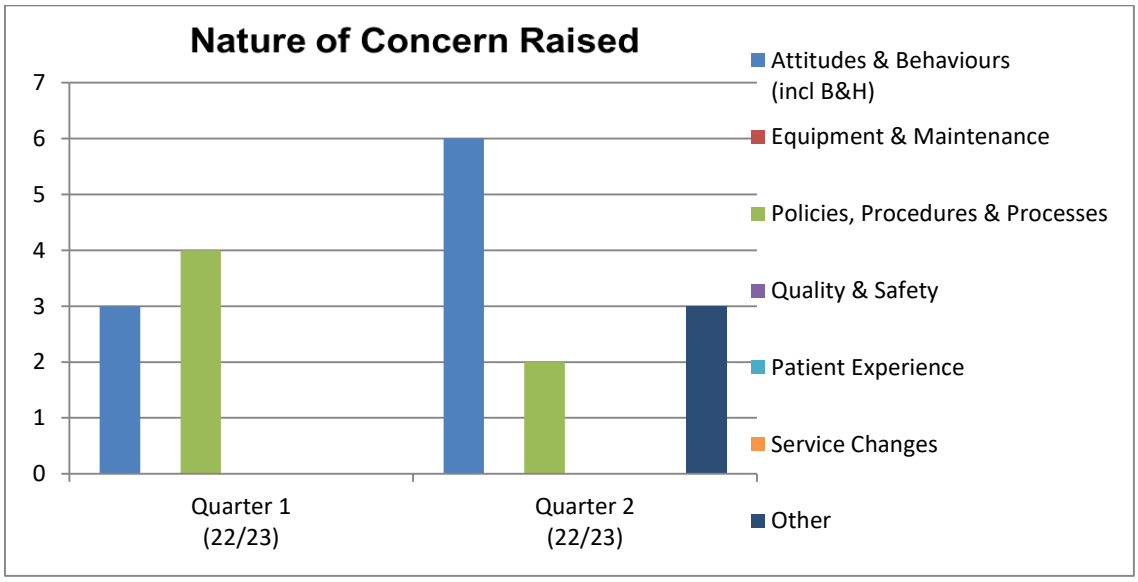
    The graph below indicates how many concerns were raised during quarters one and two.



The number of people speaking up to the FTSUG has increased from the same quarters in the previous year, 2021/22 (Q1 = 5 cases and Q2 = 3 cases).

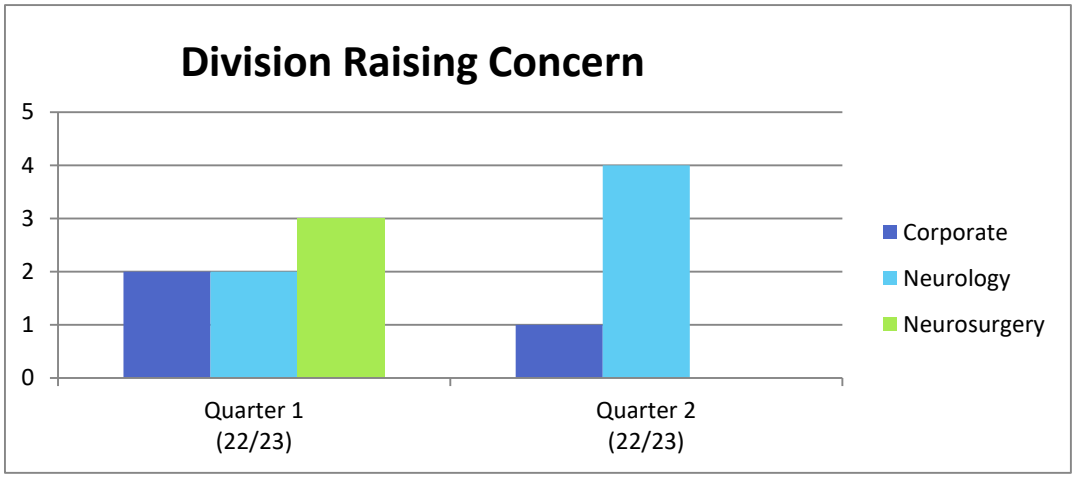
Several staff within the same team spoke with the FTSUG which are counted as individual concerns and in turn increases the figures.

The graph below indicates the nature of the concerns raised during quarters one and two.



Note: Some concerns raised have more than one element and are displayed across several categories.

The graph below indicates the division raising the concerns during quarters one and two.



11. The themes of those individuals or teams speaking up is mainly around the following:
    - Lack of visibility of line managers
    - Recruitment processes
    - Communication being undertaken via e-mail rather than face-to-face
    - Team/Departmental meetings paused during COVID not being reintroduced

    These themes echoed the feedback from the NHS Staff Survey, Pulse Survey and the TEA sessions which were held over the last couple of months. The Executive Team met to discuss the feedback and are taking the appropriate action.

Submission to the National Guardian Office (NGO)

12. The NGO issued a minimum dataset for Trust's to assist with internal and external reporting.

    Each quarter the FTSUG submits a return to the NGO to enable benchmarking to be undertaken.

    The information required is listed below:
    - Number of cases raised within the quarter
    - Number of cases including an element of patient safety/quality of care
    - Number of cases including elements of bullying and harassment
    - Number of incidents where the person speaking up may have suffered detriment
    - Number of anonymised cases received

    The Trust's FTSUG collects information from those who have raised concerns by asking the following questions:
    - Given your experience, would you speak up again
    - Please explain your above response

    Respondents have confirmed they would speak up again and have given positive feedback.

    Once a case in closed, with the agreement of the individual raising the concern, they are asked to make contact if they feel they are being treated differently following them raising a concern. Nobody should fear or suffer detriment as a result of speaking up and they are encouraged to speak up if they do.

FTSU Activities in the Trust

13. Various activities have taken place during the reporting period which include:
    - A refresh of the Speak Up section on the Trust Intranet to provide more detail around speaking up, 'drop in sessions' calendar, what the role of the FTSUG/Champion is and information on who to contact to raise a concern
    - Additional 'Drop In' Sessions have been scheduled throughout the year
    - 'Walkabouts' have been diarised which will take place throughout the day, evening, and weekends to ensure those hard to reach groups have the opportunity to meet the team and raise a concern they may have
    - Expressions of interest have been asked of staff if they wish to promote speaking up by becoming a Speak Up Champion. There are currently 12 Champions to date
    - Plans are afoot to promote October Speak Up month which will include stands, raffles, questionnaires, and lots more

14. The FTSUG meets monthly with the Non-Executive/Executive Leads for Raising Concerns to discuss concerns raised and review progress. She meets with the Head of Business HR and HR Manager for Neurology monthly to discuss concerns, review themes, and provide progress updates as appropriate. Meetings are also scheduled quarterly with the Chair and Chief Executive to keep them appraised of activity.

15. The FTSUG continues to attend virtual regional meetings throughout the year to keep appraised of national guidance, plans going forward and to share views and learn from peers.

16. The first module of the Speak Up e-learning has been launched which is mandatory for all staff to complete. There has been a glitch with the system which FTSU Guardians in other NHS Trusts have confirmed are experiencing the same issues. The Trusts IT Team are currently testing the system in order to resolve the issue.

17. The Trust will not be launching the other modules until the above issue is resolved. There are a further two e-learning modules; the second is for all line managers to complete and the third is for senior leader, such as the Executive team, to complete.

18. The FTSUG has completed the annual refresher training in line with the NGO requirements.

19. The FTSUG presented an Assurance Report to the Audit Committee, in accordance with the NHS Audit Committee Handbook, which is to review the Trusts processes in relation to raising concerns to ensure there is a system of internal control. The FTSUG will present an annual assurance report to the Audit Committee going forward.

Conclusion

20. The Raising Concerns Policy is currently being updated as per NGO publication.

21. The Trust has a designated Freedom to Speak up Guardian and an Executive and Non-Executive Lead for Raising Concerns in accordance with Trust policy.

22. FTSU e-learning module one has been launched, IT are currently testing the module as there is a glitch. The launch of the second and third module has been paused until the issue with the first module has been rectified.

23. Freedom to Speak Up Champions have taken on the role of promoting speaking up and are visible across the Trust.

24. The FTSU Reflection and Planning Tool is being reviewed and is to be completed by January 2024.

25. The FTSUG has completed the refresher training as per NGO requirement.

Recommendation

26. To note the content of this report for the purposes of assurance.

27. To continue to promote and support the role of the FTSU Guardian at the Trust.

Author: **Julie Kane**
Date: **18th October 2022**

The Walton Centre NHS Foundation Trust

Report to Trust Board Report
3 November 2022

Report Title	Nurse Staffing - Bi-Annual Acuity Review
Executive Lead	Lisa Salter, Chief Nurse
Author (s)	Nicola Martin, Deputy Chief Nurse
Action Required	To note

Level of Assurance Provided

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

Key Messages

- Acuity and Dependency review has taken place with a focus on professional judgement
- A review of shift patterns has been undertaken to release funds to reinvest at a sum of £430k
- Health Care Assistant (HCA) Pool staff has been redistributed, total of 17 WTE
- The implementation of Safe care has provided richer detail to gain a full understanding of acuity and dependency vs established staffing levels now that wards are back to their own specialties.
- Increase in the number of red flags following education and training

Next Steps

- Continue to educate and embed the safe care system
- 6-monthth acuity and dependency review May 2023

Related Trust Strategic Ambitions	**Impact**		
Leadership	Quality	Workforce	Choose an item.

Strategic Risks

004 Patient Care and Experience	005 Recruitment and Retention of Staff	

Equality Impact Assessment Completed

Strategy ☐	Policy ☐	Service Change ☐

Report Development

Committee/ Group Name	**Date**	**Lead Officer (name and title)**	**Brief Summary of issues raised and actions agreed**
NA			

Nurse Staffing - Bi-Annual Acuity Review

Executive Summary

1. The purpose of this report is to provide the Board of Directors with assurance regarding the nursing staffing levels during the months of April to October 2022. The Trust has a duty to ensure nursing staffing levels are sufficient to maintain safety and provide quality care. It forms part of the expectation set out in the National Quality Board (NQB) guidance published in 2016 and in their recommendations in 2018, that Boards take full responsibility for the quality of care provided to patients, and as a key determinant of quality, take full responsibility for nursing and care staffing capacity and capability.
2. This paper provides assurance that shortfalls on each shift are reviewed and addressed, with actions to ensure safe staffing levels are provided and reviewed at the daily staffing meeting.
3. Substantial evidence exists that demonstrates nurse staffing levels significantly contribute to patient outcomes (mortality and adverse events, including levels of harm), patient experience, quality of care, and the efficiency of care delivery and therefore essential that the Trust delivers the right staff, with the right skills, in the right place at the right time.

Background and Analysis

4. At The Walton Centre, we aim to provide excellent, efficient safe care for our patients every day and our nursing staffing levels are continually assessed to ensure that we achieve this.
5. All Trusts are required to submit staffing data to NHS England via the Unify Safe Staffing return, which is a national requirement for all hospitals to publish information about staffing levels on wards, including the percentage of shifts meeting their agreed staffing levels. In addition, assurance is provided to the Trust Board of Directors via the Chief Nurse.
6. During the months of April 2022 to October 2022 staffing data continued to be systematically reviewed to ensure we safely staff our wards and provide mitigation and action when a ward falls below 90% of planned staffing levels. The safer staffing data consists of the ‘actual’ numbers of hours worked by registered nursing and health care support staff on a shift-by-shift basis, measured against the numbers of ‘planned’ hours to calculate a monthly fill rate for nights and days by each ward. A monthly fill rate of 90% and over is considered acceptable nationally and within the Trust, when fill rates are below 90%, the ward staffing is reviewed at the daily staffing meeting and the late and night shift, considering acuity and dependency via the safe care tool, and where necessary staff are redeployed from other areas to support.

7. Care Hours Per Patient Day (CHPPD)

8. Care Hours Per Patient Day (CHPPD) was developed, tested, and adopted to provide a single, consistent, and nationally comparable way of recording and reporting staff

redeployment on all inpatient wards across all healthcare settings. CHPPD is the total time spent on direct patient care based on the number of occupied beds at midnight.

9. The senior nursing team currently collects and reports CHPPD data monthly. The April to October 2022 Trust wide staffing data was analysed and cross-referenced, with ward level data for validation by the Lead Nurses.

Year 2022	Month	Cumulative count over the month of patients at 23:59 each day	CHPPD Registered	CHPPD Care staff	CHPPD All
	April	4137	6.7	6.5	13.5
	May	4212	6.6	5.7	12.3
	June	4221	6.6	5.9	12.6
	July	4379	5.7	5.5	11.3
	August	4283	6.1	5.4	11.7
	Sept	5784	4.2	3.9	8.2

Table 1 illustrates the monthly CHPPD data.

10. Table 2 illustrates the number of areas per month that didn't achieve their planned 90% target for registered nurses. To ensure safe staffing levels, mitigation and responsive plans were implemented by the senior nursing tam based on acuity and dependency for areas that did not meet their 90% threshold.

Month	Area
April 2022	1 area
May 2022	nil
June 2022	3 areas
July 2022	2 areas
August 2022	1 area
September 2022	4 areas

Table 2: Number of areas that didn't achieve their 90% Registered Nurse Target.

11. An acuity and Dependency review has taken place with the Deputy Chief Nurse, Lead Nurse, Matron, and Ward managers with a focus on professional judgment due to the new launch of safe care and wards have been functioning previously as covid wards and not as specialty levels.
12. Following the Acuity and dependency review an uplift of HCAs was provided on the Complex Rehab unit, Lipton, Chavasse, and Cairns but it is noted a further 6-month acuity and dependency review is required in May 2023 when safe care will be embedded, and wards will have been functioning as surgical and neurology wards more than 6 months.
13. This uplift has been provided by the Health Care Assistant (HCA) Pool staff being redistributed, A total of 17 WTE, and A review of current shift patterns has been undertaken to release funds to reinvest the sum of £430k to support the uplift.

14. Red Flags Staffing levels are reviewed three times a day with safe care and in the staffing meeting with all areas. A process has been put in place where red flags are reviewed, and resolved at the staffing meetings, if possible, to do so to ensure appropriate action has been taken to ensure staff and patients are safe.
15. During the rollout of safe care has enabled further education and training re the reporting of red flags and the trust has seen an increase following this. The trust has noted 4 red flags from April 2022 to October 2022 which were due to delay in care, lack of break for a member of staff, 1 missed intentional rounding, and staff shortage. All the red flags were datixed and reviewed, and no patient harm was noted as a result.
16. Trust-wide staffing data for April 2022 to October 2022 was analysed and cross-referenced, with ward-level data for validation by the Lead Nurses. The senior nursing team currently collects and reports CHPPD data monthly and data via safe care.
17. Staffing Data and patient harms are presented Monthly to the Quality committee as part of the Integrated Performance Report.
    - Falls – There has been 1 serious harm falls during April-October.
    - Pressure ulcers – The trust has reported 9 category 2 pressure ulcers in April to date which is an increase from 21/22 where there were 3 category Two pressure ulcers, 1 category One, and 3 Deep Tissue Injuries. This is also an increase from pre covid levels. The Tissue viability lead is providing the Quality committee with a work plan and the Deputy Chief Nurse is ensuring a robust education plan is in place and discussed with both divisions.
    - Infection prevention and control- The trust is currently below all the allocated trajectories for Hospital Acquired infections.
    - The Trust continues to see an increase in incidents relating to violence and aggression, from 14 incidents in August 2022 to 48 in September 2022 with an increased need of patients requiring 1-1 care
    - RED Flag system in place to escalate staffing concerns
    - RAG status in place to record the level of staffing
    - Three times a day acuity and dependency review by a senior nurse of RAG status and red flags
    - 4 red flags unresolved from April 2022 to October 2022
    - Unresolved red flags are monitored during the day and evening by senior nursing teams.

18. Sickness

19. Sickness does remain above 5% but is continuing to decrease, both divisions hold monthly sickness meetings to ensure a plan is in place for each individual and the trust sickness policy is followed and required individualised support is provided as necessary.

	2022 / 04	2022 / 05	2022 / 06	2022 / 07	2022 / 08	2022 / 09
Healthcare Assistant	15.58%	11.56%	11.21%	12.84%	9.89%	8.31%
Nursing and Midwifery Registered	7.98%	6.38%	6.01%	6.33%	6.46%	5.80%

Table 3:RN and HCA sickness

20. Vacancies

21. Tables 4 and 5 indicate the number of RN and HCA vacancies as of October 2022 and this is a reduction in comparison to 20/21 where there were 55 RN Vacancies. Staff have been recruited into these posts within the clinical areas and are currently being processed via recruitment, there are also several international recruitment nurses waiting for their pin numbers. HCA vacancies will now increase due to the uplift in establishments, and advertisements are already in process. Recruitment is no longer carried out by the corporate team this is completed by each individual area and it is thought that this is having a positive impact on the Nursing turnover (Graph 1).

October 22 Registered nurse vacancies

Period	6
7AN - Level 7 Account Name	Nursing & Midwifery

Row Labels	Budget WTE	Actual WTE	Vacancy	Percentage
Corporate Services	32.94	33.85	-0.91	-2.76%
Neurology & Long Term Care	113.74	98.80	14.94	13.14%
Surgery & Critical Care	299.15	283.91	15.24	5.09%
Grand Total	**445.83**	**416.56**	**29.27**	**6.57%**

Table 4: RN Vacancies October 2022

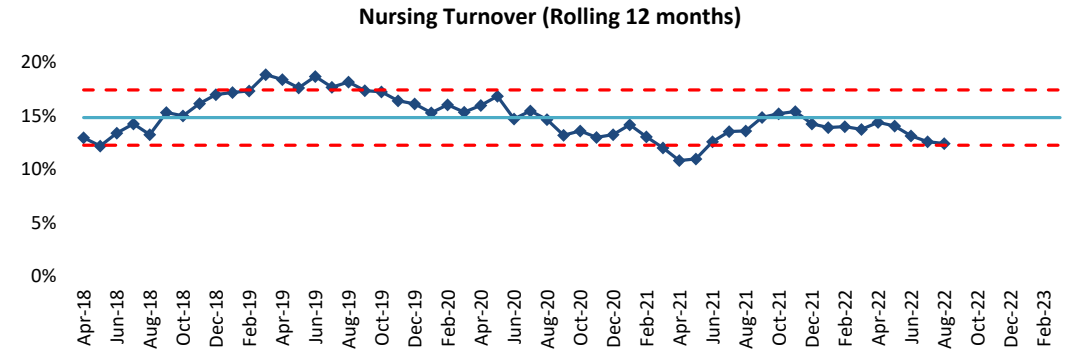
October 22 HCA Vacancies

Period	6
7AN - Level 7 Account Name	(Multiple Items)

Row Labels	Budget WTE	Actual WTE	Vacancy	Percentage
Corporate Services	0.40	0.40	0.00	0.00%
Neurology & Long Term Care	98.62	95.06	3.56	3.61%
Surgery & Critical Care	107.38	114.27	-6.89	-6.42%
Grand Total	**206.40**	**209.73**	**-3.33**	**-1.61%**

Table 5: HCA Vacancies 2022

22. Turnover



Graph 1: Nursing Turnover

23. Overseas recruitment

24. The Trust successfully participated in a Pan-Mersey international recruitment project and recruited a total of 61 Internationally Educated Nurses across all areas.

8 nurses are due to sit their OSCE exam during November and December. The Trust is not taking part in the next cohort of recruitment due to lack of vacancies and turnover on a downward trajectory.

25. Temporary Staffing

26. The Trust utilises NHS Professionals (NHSP) for temporary staffing with a current fill rate of 79% in comparison with 20/21 of 81.3%. The Deputy Chief Nurse is working with NHSP to recruit 12 CSWD to support training and in return aims to achieve an increased fill rate for HCA shifts.

27. Theatres

28. Theatre pathways have resumed back to pre-covid pathways and work is underway to increase theatre utilisation. There is currently just one ODP vacancy that is out to advert, and the department is currently not experiencing any issues with recruitment. The division is in the process of completing a business case proposal to bring ODP apprenticeships to The Walton Centre to support their recruitment and retention plan.

29. Daily meetings are in place across the division to review daily activity versus nurse staffing for theatres for assurance safe staffing is in place.

30. Therapies

31. The Walton Centre Therapies service consists of 5 AHP disciplines with valid HCPC registration: Occupational Therapy, Physiotherapy, Speech & Language Therapy, Dietetics, and Orthoptists. Together these teams provide specialist therapy intervention to acute wards, ITU, rehabilitation units CRU & Lipton Hyperacute, community rehab, outpatients, Pain Management, Trauma, and Spinal services.

32. The biggest challenge in 2022 (to date) has been in continuing to provide safe and effective patient care during periods of high staff absence and maternity leave which requires backfill. Despite this staff have gone above and beyond to deliver high-quality patient care.

33. Recruitment for vacant posts has mostly been successful, although there remains a national shortage of Occupational therapists and speech and language therapists. To develop our future workforce therapies are currently supporting the new Degree Apprenticeship route for one occupational therapist and one physiotherapist on a three year program.

	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Maternity	6	4	3	3	3	2
Turnover Rate (FTE)	1.05%	1.20%	1.20%	0.00%	3.59%	2.40%
Turnover Rate FTE (12m)	19.92%	21.41%	19.94%	17.44%	20.42%	19.53%
Absence FTE %	9.00%	3.40%	3.61%	3.97%	4.58%	5.40%

Table 6: Illustrates Therapy sickness, maternity leave, and turnover.

Conclusion

34. The Walton Centre has a series of robust systems in place to consistently monitor safe staffing and utilise the nationally recommended tools to support the setting of establishments in line with the expectation set out in the National Quality Board (NQB) guidance published in 2016 and in their recommendations in 2018.
35. It is acknowledged due to the new launch of safe care further work is required with support and education to line managers to ensure this data remains correct and consistent moving forward from November 2022 and support the next acuity and dependency review.
36. Violence and aggression continue to be a theme in incidents and patients requiring 1-1 care remain a pressure
37. It has been difficult to complete a full acuity and dependency review due to wards previously functioning as covid wards rather than their neurological and surgical specialties and covid cohort ward in place. A further full acuity and dependency review will take place in May 2023 utilising the care hours data and safe care data.
38. 4 wards have received an increase in their HCA establishments

39. There were 4 Red flags during the months of April 2022 and October 2022, none of which resulted in patient harm.

Recommendation

40. The Trust Board is asked to note the contents of the report.

Author: **Nicola Martin, Deputy Chief Nurse**
Date: **26/10/2022**

The Walton Centre NHS Foundation Trust

Report to Trust Board
3rd November 2022

Report Title	Guardian of Safe Working Annual Report
Executive Lead	Dr Andrew Nicolson, Medical Director
Author (s)	Dr Chrissie Burness, Guardian of Safe Working
Action Required	To note

Level of Assurance Provided

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

Key Messages

- Thrombectomy has significantly impacted Neurology Registrars out of hours working pattern
- In response, changes made during the report period seem to have had a positive effect

Next Steps

- Neurology Registrar working hours and rest will be monitored in October and November 2022
- Further alterations to roles and responsibilities out of hours will be considered accordingly

Related Trust Strategic Ambitions and Themes	**Impact**		
Education, Teaching & Learning	Workforce	Finance	Not Applicable

Strategic Risks

008 Medical Education Strategy	001 Quality Patient Care	Choose an item.

Equality Impact Assessment Completed

Strategy ☐	Policy ☐	Service Change ☐

Report Development

Committee/ Group Name	**Date**	**Lead Officer (name and title)**	**Brief Summary of issues raised and actions agreed**
n/a			

Guardian of Junior Doctor's Safe Working Annual Report

Executive Summary

1. This report provides the Trust Board with information around contractually defined safe working hours for junior doctors in training August 2021 to end July 2022.
2. All exception reports during this period have been from Neurology Registrars. The majority are related to additional hours worked associated thrombectomy cases.
3. Breeches to the minimum rest regulation during a 24 hour shift have lead to all of the Guardian levied fines during this period.
4. In response to these breeches, timely changes have been made and this seems to have lead to a significant reduction in exception reports with no safety breeches during the last quarter.

Background

5. The 2016 Junior Doctors Contract has been phased in since August 2016. The Trust does not directly employ junior doctors in training, they are however, seconded to work at the Trust via a Lead Employer model. The Lead Employer is St Helens and Knowsley Hospitals NHS Trust. The junior doctors in training have various rotation dates, the main rotations take place on the 1st Wednesday in August, December, February, and April each year. The Anaesthetic trainees rotate every 3 months. We currently have 52 junior doctors placed in the Trust on the new 2016 terms and conditions of service.

6. In June 2019, amendments to the 2016 contract were agreed as follows:
   - Changes to rest requirements during a 24 hour shift (minimum of 8 hours rest to include 5 hours between 7pm and 7am)
   - Maximum of 72 hours to be worked within any 7 day period.
   - Increased pay for weekend a night shifts (shifts ending between midnight and 4am)
   - £1000 per year extra for LTFT trainees
   - A fifth nodal point on the payscale when doctors reach ST6
   - Transitional pay protection extended until 2015
   - Improvements in rest and stay entitlements (no more 'pay to stay' when too tired to drive)
   - Exception reporting for all ARCP/ portfolio requirements
   - Guaranteed annual pay uplift of 2% per year for the next 4 years
   - Fines to be levied by the GoSW for any breach of safe working hours

7. The purpose of exception reports is to ensure prompt resolution and/or remedial action to ensure that safe working hours are maintained. The purpose of work schedule reviews is to ensure that a work schedule for a doctor remains fit for purpose, in circumstances where earlier discussions have failed to resolve an issue.

8. Exception reporting is the mechanism used by doctors to inform the employer (or Host Organisation in our case) when their day to day work varies significantly and/or regularly from the agreed work schedule. Primarily these variations will be;
   - Differences in the total hours of work (including opportunities for rest breaks)
   - Differences in the pattern of hours worked
   - Differences in the educational opportunities and support available to the doctor
   - Differences in the support available to the doctor during service commitments

9. We use an electronic system from Skills for Health to manage the exception reporting process allowing for any variations from the trainees to be resolved in a timely manner.

10. Exception reports can be resolved in consultation with the trainee. The Terms and Conditions allow for time off in lieu (TOIL) or additional pay and depending on the breach, the Guardian may also fine the Trust.

11. Exception reports may also trigger work schedule reviews and if necessary, fines can be raised against the directorates by the Guardian.

12. The Guardian of Safe working and the Director of Medical Education (DME) hold a joint junior doctor's forum alternating with to the forum held by the junior doctors and the GoSW each month. The Guardians meet locally and nationally and share a NHS network hosted forum to discuss progress and issues related to the new contract.

Analysis

High Level Data (requested by NHS Employers)

Number of doctors in training (total)	52
Number of doctors on 2016 T&C (total)	52
Amount of time in job plan for guardian to fulfil the role	1PA
Admin support provided to the guardian Support provided by Heather Doyle	0
Amount of job-planned time for educational supervisors	0.25 (for education and training)

Annual expenditure to cover junior doctor rota gaps (see Appendix 1 for breakdown by month)

Neurology	2,000
Neurosurgery	0
Total	**2,000**

a) Exception reports

There have been 51 exception reports during this period (and none during the last quarter). Of these, 29 have been due to breaches in the minimum rest requirements for doctors working a 24 hour on call shift.

b) Work schedule reviews

We have not had to undertake any work schedule reviews. The neurology registrars working hours were monitored in October 2021 and this exercise is to be repeated in October 2022.

c) Vacancies

The Trust has 52 established training posts, currently none are unfilled.

d) Fines

On 29 occasions, fines have been required from the neurology division due to breeches to the regulation regarding minimum rest during an on call shift for neurology registrars.

Qualitative Information

13. All exception reports have been submitted by registrars in Neurology and all have been resolved with time of in lieu plus payment when minimum rest requirements have not been met.

14. The majority of the exception reports have been due to Neurology Registrar working hours during out of hours thrombectomy cases. This was escalated after the hours monitoring exercise in October 2021 and changes were made to the work and responsibilities of neurology registrars during the thrombectomy treatments. This lead to a reduction in exception reports in the latter half of the year.

15. There were 16 reports with 10 breaching safe rest requirements between August and October, 32 with 18 breeches from November to January, 2 with 1 breech from February to April and then only one report between May and July and this did not breech safety requirements.

16. This trend is encouraging, and the neurology registrars are to monitor their hours and work for 2 months from October 2022 in order to formally reassess.

17. The exception reports during this period have all been resolved by offering time of in lieu and payment where minimum rest hours have not been possible during a shift.

18. The hours monitoring exercise is to be repeated annually for the Neurology Specialist Trainees in order to ensure that the rota accurately represents the hours worked. The senior neurosurgical registrar rota is also to be monitored if exception reports are received.

19. Trainees are aware that they can request a work schedule review or hours monitoring exercise at any time of they have concerned. Potential rota changes to resolve any issues are reviewed in anticipation.

Conclusion

20. There have been 51 exception reports this year, mainly related to the impact of out of hours thrombectomy on neurology registrars. Changes have been implemented which seem to have lead to a prompt improvement. A formal hours monitoring exercise in the autumn will provide further data.

21. No concerns regarding safe working have been raised from any other groups of junior doctors during the report period.

Recommendation

22. The Annual Board report from the Guardian will be considered by the CQC, GMC and NHS employers during any review.

23. The Board is asked to receive, review and comment upon the Guardian’s annual report.

Author: Dr Chrissie Burness
Date: 18.10.2022

Appendix 1

Junior Medic Agency	Aug 2021	Sept 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	June 2022	July 2022	Total
Neurology	0	0	0	0	0	0	0	0	0	0	2000	0	**2000**
Neurosurgery	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Grand Total	0	0	0	0	0	0	0	0	0	0	2000	0	**2000**

Board of Directors' Key Issues Report

The Walton Centre NHS Foundation Trust

Report Date: 24/10//22		**Report of:** The Walton Centre Charity Committee Meeting
Date of last meeting: 21/10/22		**Membership Numbers:** Quorate
1	**Agenda**	The Committee considered an agenda which included the following: • Impact Presentation – Chatbot • Finance Report to 31 August 2022 • Annual Investment Performance Analysis • Fundraising Activity Update • Charity Risk Register • Training & Development Department applications for part funding towards professional development • Application for Personal Kinetic Graph (PKG) movement recording reports • Annual Report and Accounts and Independent Review Statement from BWM Accountants • Grant Making Policy Update • Fundraising Substrategy • The Walton Centre Charity Committee Terms of Reference
2	**Alert**	• The Committee received quarterly statements from Fund Managers CCLA and Ruffer noting investment balances had reduced from £1.2m in June 2021 to £1.18m in June 2022. The annual investment report from Jagger & Associates (independent advisors) provided analysis on the Charity's investments and the Committee were assured the two investment managers (CCLA and Ruffer) were the best performing on 5-year risk-return outputs. Given the volatility of the markets the Committee would receive an additional independent investment report from Jaggers at the meeting in January 2023.
3	**Assurance**	• The Committee received The Walton Centre Charity Annual Report and Accounts 2021/22. Subject to a couple of minor amendments the Accounts would be presented to Trust Board in November 2022. An independent examiner's report was provided by BWM Chartered Accountants who joined the meeting and reported no concerns and no matters in connection with the examination of the accounts. • The final Fundraising Substrategy and Delivery Plan was agreed by the Committee. The Substrategy detailed the Charity's vision, mission and strategic objectives with specific focus on individual / committed legacy giving as well as digital fundraising. It would be presented to Trust Board for approval in its capacity of Corporate Trustee of the Charity. • The Committee approved four study leave applications from staff for part funding (25%) towards professional development. The Committee were assured on the governance arrangements and the guidelines in place for staff prior to making an application.

4	**Advise**	• The Committee received an Impact Presentation on the Walton Headache Chatbot project that had received £29k + VAT from the Charity to implement the project in July 2021. A lot of progress had been made to get the initiative off the ground and there had been interest from NHS Digital. The Committee were fully supportive of the initiative and thanked Drs Krishnan and Davies for the update. • The Committee approved an application for £5k from the Movement Disorders fund for the purchase of 20 Personal KineticGraph (PKG) movement recording reports. The Committee said they would fully support a further £5k, from this fund or the Parkinsons Disease fund, to increase the purchase to 40 PKGs (subject to fund manger agreement). • The Fundraising Activity Update was received noting the Jan Fairclough Ball would go ahead on 25 November 2022 as planned. • The Charity Risk Register detailing the top five risks was presented. It was agreed the risks relating to investments (risk 5) and unsatisfactory income generation (risk 9) would be reviewed and the risk levels increased. • The finance position to 31 August 2022 was presented and it was noted that fund balances had reduced by £125,409. This figure was likely to increase when funding received in August/September had transferred to the finance system from the Harlequin charity accounting system. • The Committee were updated on plans in place to encourage spending / plans by the fund managers particularly relating to slow moving funds. • Simon Jagger (Jagger & Associates) independent advisor provided some options on the cash reserves currently held by the Trust's bank. A focus group would be set up to discuss the options and make a decision on the £600k cash. • The Walton Centre Charity Committee Terms of Reference had been updated by the Corporate Secretary and the tenure / voting members / core membership had been reviewed. The Committee agreed the Terms of Reference with one amendment relating to nursing representation. They would be presented for approval by Trust Board in November 2022. • Following the agreement of the Fundraising Substrategy and Delivery Plan a Grant Making Policy would now be written for approval by the Committee. This would be presented by the Head of Fundraising at the meeting in April 2023. • The Committee were concerned about the difficulties that many staff members would be facing over the winter period and agreed to explore options the charity might be able to support, within its objectives. A Health and Wellbeing fund should be set up from which specific staff initiatives could be funded. • The Committee approved the establishment of a new staff and wellbeing fund. • The Committee were informed that a revised financial forecast would be produced.		
5	Risks Identified	• None		
6	Report Compiled by	Su Rai Non-Executive Director	Minutes available from:	Corporate Secretary

The Walton Centre NHS Foundation Trust

Report to Board of Directors
3 November 2022

Report Title	The Walton Centre Charity Committee Terms of Reference (ToR)
Executive Lead	Mike Burns, Chief Finance Officer
Author (s)	Katharine Dowson, Corporate Secretary
Action Required	To decide

Level of Assurance Provided

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

Key Messages

- Terms of Reference (ToR) have been refreshed with a new format in line with the Board Committees
- Deputy Chief Nurse to replace Chief Nurse to ensure Non-Executive Directors remain in majority
- 3 year tenure for Clinical Representatives introduced
- No changes to duties of Committee

Next Steps

- Adoption of ToR

Related Trust Strategic Ambitions and Themes	**Impact**		
All Applicable	Not Applicable	Not Applicable	Not Applicable

Strategic Risks

009 Research & Development Ambition	Choose an item.	Choose an item.

Equality Impact Assessment Completed

Strategy ☐	Policy ☐	Service Change ☐

Report Development

Committee/ Group Name	**Date**	**Lead Officer (name and title)**	**Brief Summary of issues raised and actions agreed**
WCC	July 2022	Katharine Dowson, Corporate Secretary	Effectiveness Review agreed and discussion on required changes to ToR
WCC	21 October 2022	Katharine Dowson, Corporate Secretary	Draft ToR agreed

Terms of Reference (ToR) Walton Centre Charity Committee (WCC)

Background and Analysis

1. The Committee reviewed its annual effectiveness report in July and discussed a number of potential changes to the ToR which were subsequently redrafted and presented to the Committee in October.

2. There were no changes proposed to the duties of the Committee.

Changes

3. A number of changes have been made to the ToR including the refresh of format. Key changes are highlighted in red tracked changes.

Membership

4. As the Chief People Officer is now a full voting member of the Board it is appropriate for him, as Executive Lead for the Charity, to become a full voting member of the Committee. However, this creates a majority of Executive Directors which is not good practice. The Chief Finance Officer remains the lead for financial and governance oversight of the Charity and is therefore require.

5. It is proposed to remove the Chief Nurse but add the Deputy Chief Nurse as a non-voting member to ensure that the voice of the nursing and allied health professional workforce remains at Committee.

6. Representation from each division by a clinician remains, although this has been amended to clinical representative rather than consultant, to be open to a wider group of clinical staff members. The additional 'named consultant' on the ToR has been updated to the Deputy Medical Director which would not impact current membership.

Tenure

7. Consideration of tenure of appointments for consultant members was proposed by the Committee in order to allow for a variety of views and input from the clinical workforce at periodic intervals and this has been added in paragraph 13.

> 13. Clinical divisional representatives are invited on to the Committee for a period of three years at which point other clinical staff members will be invited to submit submissions of interest. If there is no further interest, then the divisional representative can be asked to serve a further three years.

Quoracy

8. Quoracy of the Committee has been kept at two, which is the same as all Board Committees, except Remuneration Committee. At the meeting the Committee requested the addition of two non-voting members to the quoracy as well.

Conclusion

9. The ToR have been updated to ensure they remain fit for purpose and reflect the requirements of the Trust as the Corporate Trustee. The changes proposed are in regard to the function of the Committee rather than to its duties and purpose.

Recommendation

To approve.

Author: Katharine Dowson, Corporate Secretary
Date: October 2022

Appendix 1 – Terms of Reference

Appendix 1

THE WALTON CENTRE CHARITY COMMITTEE
TERMS OF REFERENCE

Authority/Constitution

1. The Walton Centre Charity Committee (WCC) (the Committee) is authorised by the Board of Directors of The Walton Centre NHS Foundation Trust, to exercise the Trust's functions as sole corporate trustee of The Walton Centre Charity, registered charity number 1050050.

2. The Committee has no executive powers other than those specifically delegated in these Terms of Reference.

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

4. The Committee is authorised to request specific reports from individual functions within the organisation and to seek any information it requires from any member of staff in order to perform its duties.

5. The Committee is authorised to create operational sub-groups, forum, advisory or working groups as are necessary to fulfil its responsibilities within its terms of reference. The Committee may not delegate executive powers and remains accountable for the work of any such group.

6. In discharging its role members must act solely in the best interests of The Walton Centre Charity and in a manner consistent with the Charity Commission's requirements and expectations of Charity Trustees.

Purpose

7. The purpose of the Committee is to discharge the Trust's responsibility as Corporate Trustee in the effective management of the Charity, including compliance with statutory and regulatory requirements and in accordance with the guidance on NHS Charities set out by the Charity Commission.

Membership

8. The Committee shall be comprised of the following voting members:
   - Two Non-executive Directors, one of whom will be the Committee Chair
   - Chief People Officer
   - Chief Finance Officer

9. The following are required to attend in a non-voting capacity:
   - Clinical Representative from the Division of Neurosurgery
   - Clinical Representative from the Division of Neurology
   -
   - Deputy Medical Director
   - Deputy Chief Nurse or Deputy
   - Head of Fundraising

10. The Committee will be deemed quorate when two voting and two non-voting members are present, including at least one Executive and one Non-Executive Director.

11. In the event that the Chair of the Committee is unable to attend a meeting, the other Non-Executive Director shall be Chair for that meeting. The Chair shall have a casting vote in the event of a vote.

12. Members may only nominate a deputy to attend on their behalf if they have sufficient understanding of the area they are representing to be able to contribute effectively to the Committee/Group's business; however, this should only be in exceptional circumstances. There is no provision for deputies to represent voting members at meetings of the Committee unless they are formally acting-up in accordance with the Trust's Constitution.

13. Clinical Divisional representatives are invited on to the Committee for a period of three years at which point other clinical staff members will be invited to submit submissions of interest. If there is no further interest, then the divisional representative can be asked to serve a further three years.

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

15. An open invitation exists for all members of the Board of Directors to attend the Committee.

Requirements of Membership

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

17. Conflicts of Interest – the Companies Act 2006 defines a conflict of interest as arising when the interests of directors or 'connected persons' are incompatible or in competition with the interests of the organisation. Committee/Group members are required to exercise judgement and to declare such interests as there is a risk of implied improper conduct. The relevant interest, once declared, will be recorded in a register of interests, maintained by the Company Secretary.

Duties

18. In order to fulfil its role and obtain the necessary assurance, the Committee will:
    - inform the development of the Charity and Fundraising Substrategy and objectives for the Charity's work for consideration by the Board and oversee their delivery
    - monitor the performance of the fundraising and marketing activity, ensuring that the return on investment is satisfactory and that income targets are met
    - receive reports detailing balances of the Charity's Funds
    - receive reports on all individual charitable non-pay transactions in excess of £1,000
    - approve expenditure of all individual charitable non-pay transactions valued from £5,000 up to £100k
    - in line with charity law establish the strategy, policies, budget, spending priorities and criteria for spending decisions for each fund
    - appoint appropriate Investment Managers to provide investment advice and manage the Charity's investment portfolio
    - in conjunction with the investment managers, agree an investment policy which lays down guidelines in respect of:
        - the balance required between income and capital growth
        - the balance of risk within the portfolio

- any categories of investment which the Trust does not wish to include in the portfolio on ethical grounds.

i) keep investment performance under review
j) review the impact on the Charity of changes in legislation both of a charitable and non-charitable nature and make appropriate recommendations to the Trust Board, as Corporate Trustee, as to how any new requirements will be met
k) ensure compliance with the Trust's Standing Financial Instructions, Financial Control Procedures and Scheme of Delegation
l) receive audit reports on the charity controls
m) approve new fundraising appeals and monitor fundraising targets
n) consider the Charity's annual report and accounts prior to approval by Trust Board.

19. Policies – consider and approve all policies relevant to the Committee's remit including the Investment Policy, the Fundraising Policy and the Ethical Donations Policy

20. The Committee will also keep under review any risks relevant to its remit in order to provide assurance to the Board that risks are being effectively controlled and managed.

Data Privacy

21. The Committee is committed to protecting and respecting data privacy. The RIME Committee will have regard to the EU General Data Protection Regulation (Regulation (EU) 2016/679) (GDPR) and demonstrate, where applicable, compliance with data protection legislation, in particular the Data Protection Act 1998 (DPA).

Equality, Diversity & Inclusion

22. In conducting its business, the Committee will at all times seek to meet its obligations under the Equality Act 2010 and promote its commitment to equality and diversity by the creation of an environment that is inclusive for both our workforce, patients and service users, including those who have protected characteristics and vulnerable members of our community.

Reporting

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

24. The Committee will agree a cycle of business which will be reviewed at each meeting to ensure the Committee is meeting its duties.

25. The Committee will annually assess its performance against the Charity and Fundraising Substrategy.

26. Reports including regular assurance reports will be received from any subgroups established by the Committee and the Committee will approve their Terms of Reference and annual work programme and keep their effectiveness under review.

Administration of Meetings

27. Meetings shall be held quarterly with additional meetings held on an exception basis at the request of the Chair or any three voting members of the Committee. There shall be a minimum of four meetings per year.

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

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

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

31. An annual workplan will be agreed which will be reviewed at least quarterly by the Committee to ensure it is meeting its duties.

Review

32. The Terms of Reference shall be reviewed annually and approved by the Board of Directors.

33. The Committee will undertake an annual review of its performance and effectiveness against its work plan and the Trust Strategy in order to evaluate the achievement of its duties.

Approved by WCC: October 2022
Ratified by Board of Directors: November 2022
Review Date: April 2023

Board of Directors' Key Issues Report

The Walton Centre NHS Foundation Trust

Report Date: 18/10/22		**Report of:** Audit Committee
Date of last meeting: 18/10/22		**Membership Numbers:** Quorate
1.	**Agenda**	The Committee considered an agenda which included the following: • Internal Audit Progress Report Q2 • Internal Audit Recommendation Report • External Audit Update and Progress Report 2022/23 • Credit Card Fraud Update • Tender Waivers Q2 • Financial Compliance Report • Review and Explanation of the 2020/21 National Cost Collection Index (NCCI) • Review of Standing Financial Instructions and Scheme of Reservation and Delegation • HFMA Improving NHS Financial Sustainability Checklist • Senior Information Risk Officer Annual Report • Externally Reportable Incidents Update • Clinical Audit Update • Raising Concerns and Freedom to Speak Up • Review of Board Committees • Annual Cycle of Business
2.	**Alert**	• The Trust had been made aware of a payment made via the Trust credit card for services not received to a value of £1500. Processes for using the credit card were reviewed and gaps in control identified. A number of actions had been implemented to close these gaps and am updated process put in place. • The National Cost Collection Index (NCCI) for 2020/21 was published by NHS England in July 2022 which rated the Walton Centre as having a cost index of 117 after market forces factor adjustment. This indicated that the Trust has a more expensive cost base than average however represented a marginal reduction from the previous years cost base. Steps to be taken to improve the cost base were presented to the Committee.
	Assurance	• The Committee considered the Internal Audit Progress Report and noted that a number of Audit Reports were in progress since the meeting on 19th July 2022. The following audits were underway: o Management of Controlled Drugs (reporting stage) o Data Quality (fieldwork stage) o HFMA Checklist (fieldwork stage)

		○ Health Procurement Liverpool (scoping stage) • The Internal Audit Progress Report also informed that the following audits had been finalised: ○ Data Protection and Security Toolkit (substantial / moderate assurance) ○ IT Infrastructure Housekeeping (moderate assurance) ○ Risk Management Core Controls (high assurance) ○ Conflicts of Interest (substantial assurance) ○ Quality Account (substantial assurance) • The committee reviewed the updated Standing Financial Instructions and Scheme of Reservation and Delegation to ensure they were up to date and comply with current financial regulations.		
	Advise	• The Committee reviewed the outstanding internal audit recommendations report and noted that there had been a further decrease in the number of outstanding recommendations. Work was ongoing to close all remaining open recommendations. • The Committee received the financial compliance report and noted that compliance with the Better Payment Practice Code remained below target. Updated processes had been implemented and an action plan embedded into practice with improvements not expected to be recorded from April 2023 due to the rolling monthly recording of compliance. • The Committee received the Clinical Audit Progress Report and noted clinical audit activity during Q1 along with details of audits that had passed the anticipated date for completion. Details of all completed audits were also provided to provide assurance. • The Committee received a report on the self-assessment undertaken by the Trust against the Healthcare Financial Management Association (HFMA) checklist relating to their briefing titled “Improving NHS financial sustainability: are you getting the basics right?”. The self assessment is currently under review from internal auditors with a deadline for completion of 30th November. • The Committee noted the Senior Information Risk Officer annual report which was a positive report highlighting that the Trust self-assessment rating of the Data Security and Protection Toolkit had gained substantial assurance for the 12thyear in succession. The Trust also successfully obtained the full ISO27001:20013 accreditation with no major, minor or observations noted. • The Committee were informed that there had been four incidents externally reportable to the Information Commissioners Office (ICO) since April 2022 and an overview of each incident was provided. Three of the incidents have been closed down by the ICO with no further action required and there was still one incident awaiting a response from the ICO. • The Committee received an overview report of committee effectiveness reviews that had been undertaken. It was highlighted that there had been a number of mixed responses to the RIME committee effectiveness review which had led to a deep dive review being undertaken. The terms of reference for RIME committee had been revisited in light of this and membership was reviewed.		
2.	Risks Identified	• None		
3.	Report Compiled by	Su Rai, Non-Executive Director	Minutes available from:	Corporate Secretary

The Walton Centre NHS Foundation Trust

Report to Trust Board
3rd November 2022

Report Title	Review of Standing Financial Instructions (SFIs) and Scheme of Reservation and Delegation (SORD)
Executive Lead	Mike Burns – Chief Finance Officer
Author (s)	Helen Wells – Deputy Chief Finance Officer
Action Required	To note

Level of Assurance Provided

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

Key Messages/ Summary

- Both the SFI and SORD have been reviewed to ensure that they remain up to date and in line with current financial regulations
- There have been no amendments required to the SFI
- A number of minor amendments have been made to the SORD, primarily to reflect changes in job titles and amending EU threshold tender values to reflect the latest limits. A summary of the changes is shown in section 21 of the record of amendments

Change to Chief Executive approval limits within e-procurement

- There are a number of situations where a requisition is required to be approved that exceed the e-procurement system approval limits for the Chief Executive (e.g. drugs SLA)
- All the correct governance processes are completed for approval of the spend (e.g. Board approval) but the Chief Executive is still unable to approve the requisition within the system. This means that a system 'super user' within procurement has to authorise any requisitions in excess of the Chief Executive limits
- After discussion with Internal audit, it has been agreed that there is no change required to the SFI or SORD and that an internal form can be completed to increase the chief executive's approval limit within the e-procurement system. The form will be countersigned by the Trust Chair and is being highlighted to Audit Committee for transparency. This will enable the chief executive to approve all high value requisitions within the system (but they will all have gone through the correct governance process as per SFI and SORD).

Next Steps

- Ensure updated SORD is put on Trust intranet
- Submit to Board for approval

Related Trust Strategic Ambitions and Themes	**Impact**		
Value for Money	Finance	Not Applicable	Not Applicable

Strategic Risks

Not Applicable	Not Applicable	Choose an item.

Equality Impact Assessment Completed

Strategy ☐	Policy ☐	Service Change ☐

Report Development

Committee/ Group Name	Date	Lead Officer (name and title)	Brief Summary of issues raised and actions agreed
Audit Committee	18th October 2022	Helen Wells, Deputy Chief Finance Officer	

The Walton Centre NHS
NHS Foundation Trust

STANDING FINANCIAL INSTRUCTIONS

Reviewed by:

Zoe Stevenson, Financial Accountant

October 2022

Authorised by:

Mike Burns, Chief Financial Officer

CONTENTS

SECTION

RECORD OF AMENDMENTS

SECTION	AMENDMENT	DATE
5	Replacement of OPG by GBS and electronic banking	25/03/2010
11	Replace references to Capital Accounting Manual with Reporting Manual	25/03/2010
16	Remove section on charitable funds and renumber	25/03/2010
16 (Formerly section 17)	Remove references to PASA which no longer exists	25/03/2010
12.8 and 16.7 (Formerly section 17.7)	Change name of NHS Logistics to NHS Supply Chain	25/03/2010
All sections	General review and updating re: legislative updates	01/12/2011
Section 16	Revised for introduction of electronic tendering	July 2012
All sections	General review and updating re: legislative updates (e.g. NHS Act 2012)	June 2013
11	Revised for Monitors amended Risk Assurance Framework	Oct 2014
16	Revised for electronic tendering	Oct 2014
All sections	General review for titles and legislative changes	Oct 2014
All sections	General review for typos and legislative changes	Nov 2015
All sections	General review for typos and legislative changes – including change from Monitor to NHS Improvement and the introduction of the Single Oversight Framework.	Oct 2016
1	Add in comments on Chair's actions, as requested by Nov 16 Board.	Jan 2017
All sections	Updated Director of Nursing, Operations and Quality job title	
All sections	General review for errors and legislative changes	Oct 2017
9	Details added regarding the Zero Cost Model ordering process (the ZCM process flow document is currently under review)	Oct 2017
All sections	General review for errors, names and legislative changes	Oct 2018
12	Details added regarding the authorisation of NHS Supply Chain Weekly Sales invoices	Oct 2018
9	Details added regarding travel for Executives	Oct 2018
All sections	General review for errors, names and legislative changes	Oct 2019
16	Exclude Liverpool Health Partners subscription from formal tendering procedures	Oct 2019
All sections	NHS Protect to NHS Counter fraud Authority	Oct 2020
All sections	NHS Improvement to NHS England/Improvement	Jan 2021
Section 13	Update responsibility from Medical Director to Board of Directors	Jan 2021
All sections	Changes to job titles as follows: Director of Finance and IT amended to Chief Financial Officer Deputy Director of Finance amended to Deputy Chief Financial Officer Director of Nursing and Governance amended to Chief Nurse Deputy Director of Nursing and Governance amended to Deputy Chief Nurse Director of Operations and Strategy amended to Chief Operating Officer Director of Workforce and Innovation amended to Chief People Officer	Oct 2021
Section 14	Responsibility OF the Trusts IT compatibility, compliance and risk changed from Director of Finance and IT to Chief People Officer	Oct 2021
All sections	NHSI to NHSE/I	Oct 2021

General

NHS England/Improvement (NHSE/I) sets the Terms and Authorisation for the Foundation Trust that require compliance with the principles of best practice applicable to corporate governance within the NHS / Health Sector and with any relevant code of practice and guidance issued by NHSE/I. 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 (SFIs) for the regulation of the conduct of its employees in relation to all financial matters with which they are concerned. These SFIs are issued in accordance with the Code and detail the financial responsibilities, policies and procedures to be adopted by the Foundation Trust. They are designed to ensure that its financial transactions are carried out in accordance with law and government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Scheme of Reservation and Delegation (SoRD) adopted by the Foundation Trust and identify the financial responsibilities, which apply to everyone working for the Foundation Trust and its constituent organisations including hosted arrangements. They do not provide detailed procedural advice and should therefore be read in conjunction with the detailed departmental and financial procedure notes.

The Chief Financial Officer must approve all financial procedures and should any difficulties arise regarding the interpretation or application of any SFIs then the advice of the Chief Financial Officer **MUST BE SOUGHT BEFORE ACTING.** The user of these SFIs should also be familiar with and comply with the provisions of the Foundation Trust's Governance Manual.

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

Overriding SFIs:

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 reported to the next 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 SFIs to the Chief Financial Officer as soon as possible.

In the Standing Financial Instructions the following definitions apply:

Term	Definition
The 2006 NHS Act	Means the 2006 National Health Service (NHS) Act as amended.
The Health and Social Care Act 2012	Means the Health and Social Care Act 2012.
Accounting Officer	Shall be the Officer responsible and accountable for funds entrusted to the Foundation Trust in accordance with the NHS Foundation Trust Accounting Officer Memorandum. They shall be responsible for ensuring the proper stewardship of public funds and assets. The 2006 NHS Act designates the Chief Executive of the NHS Foundation Trust as the Accounting Officer.
Board of Directors	The Board of Directors of the Foundation Trust, as constituted in accordance with the Foundations Trust's constitution.
Budget	A plan, expressed in financial or workforce terms, proposed by the Board of Directors for the purpose of carrying out, for a specific period, any or all of the functions of the Foundation Trust.
Budget Holder	The Director or employee with delegated authority to manage finances (income and expenditure) for a specific area of the organisation.
The Chair	Means the Chair of the Foundation Trust, or such person, in relation to the function of presiding at or chairing a meeting where another person is carrying out that role as required by the Constitution.
Chief Executive	The Chief Officer (and Accounting Officer) of the Foundation Trust.
Committee	A Committee or Sub-Committee created and appointed by the Foundation Trust.
Constitution	The Constitution of The Walton Centre NHS Foundation Trust.
Contracting and Procuring	The systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets.
Director	Means a member of the Board of Directors.
Auditor	Any auditor other than the external auditor appointed under the Constitution to review and report upon other aspects of the Foundation Trust's performance.
External Auditor	The independent organisation appointed to audit the accounts of the Foundation Trust, who is called the auditor in the 2006 NHS Act.
Financial Year	The period beginning with the date on which the Foundation Trust is authorised and ending with the next 31 March and each successive period of twelve months beginning with 1 April.
The Foundation Trust	The Walton Centre NHS Foundation Trust
Foundation Trust Contract	Agreement between the Foundation Trust and Commissioners for the provision and commissioning of health services.
Funds held on trust	Those funds which the Foundation Trust holds as its date of incorporation, receives on distribution by statutory instrument, or chooses subsequently to accept under powers derived under 2006 NHS Act. Such funds may or may not be charitable.
Monitor	Means the Independent Regulator of NHS Foundation Trusts until 1 April 2016 when Monitor became part of NHS Improvement. Guidance provided by Monitor remains valid until superseded by new publications from NHS Improvement.
Fraud	Reference to 'fraud' shall be used as an umbrella term to include financial crime, including bribery and other corruption offences.
Member	A member of the Foundation Trust.
NHS Improvement	Means the Independent Regulator of NHS Foundation Trusts. From 1 April 2016 Monitor, the former regulator, became part of NHS Improvement.

NHS Provider License	The Health and Social Care Act (2012) requires everyone who provides an NHS health care service to hold a license unless they are exempt under regulations made by the Department of Health and Social Care. Foundation Trusts are licensed from 1 April 2013. All other providers will be required to apply for a licence from April 2014. The Walton Centre NHS Foundation Trust license number is 130132.
Nominated Officer	An officer charged with the responsibility for discharging specific tasks within Standing Orders and SFIs.
Officer	An employee of the Foundation Trust with specific nominated delegated powers.
Partner	In relation to another person, a member of the same household living together as a family unit.
Secretary	Means the Corporate Secretary of the Foundation Trust.
Scheme of Reservation and Delegation (SoRD)	The SoRD sets out the powers which the Board of Directors has reserved and those which have been delegated to committees, sub-committees, individual directors or officers.
Standing Financial Instructions (SFIs)	SFIs regulate the conduct of the Foundation Trust's financial matters.

Wherever the title Chief Executive, Chief Financial Officer, 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 Foundation Trust when acting on behalf of the Foundation Trust.

Responsibilities and Delegation

The Foundation Trust shall at all times remain as a going concern as defined by the relevant accounting standards in force. The Board of Directors exercises financial supervision and control by:

1. Formulating the financial strategy;

2. Requiring the submission and approval of budgets within overall income;

3. 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

4. Defining specific responsibilities placed on directors and employees as indicated in the Scheme of Delegation document.

The Constitution dictates that the Council of Governors may not delegate any of its powers to a committee or sub-committee. 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 Trust's SoRD.

The Board of Directors will delegate responsibility for the performance of its functions in accordance with the Scheme of Delegation adopted by the Foundation 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 Foundation 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 Foundation Trust's system of internal control.

The Chief Executive and Chief Financial Officer 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 appointees are notified of and understand their responsibilities within these instructions. All staff shall be responsible for ensuring conformity with the Standing Orders, SFIs and financial procedures of the Foundation Trust.

There may be occasions when Chair's Action needs to be taken due to the nature or timing of business i.e. the Chair of the meeting can make a decision that would have normally been done within the relevant committee but due to timing, this has had to be done on an individual basis. All instances will be recorded at the subsequent associated meeting as a formal record.

The Chief Financial Officer is responsible for:

1. Implementing the Foundation 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;

2. 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;

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

4. Without prejudice to any other functions of directors and employees of the Foundation Trust, the duties of the Chief Financial Officer include:

    - the provision of financial advice to other members of the Board of Directors, Council of Governors and employees;

    - the design, implementation and supervision of systems of internal financial control;

    - the preparation and maintenance of such accounts, certificates, estimates, records and financial reports as the Foundation Trust may require for the purpose of carrying out its statutory duties.

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

1. The security of the property of the Foundation Trust;

2. Avoiding loss;

3. Exercising economy and efficiency in the use of resources;

4. Conforming with the requirements of the Governance Manual, SFIs, financial procedures, Monitor/NHSE/I procedures/directives and the SoRD.

Any contractor or employee of a contractor who is empowered by the Foundation Trust to commit the Foundation 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 any and all directors and 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 Chief Financial Officer.

2. AUDIT

Audit Committee

The Board of Directors shall formally establish an Audit Committee, with clearly defined terms of reference and following guidance from the NHS Audit Committee Handbook and Foundation Trust governance requirements, which will provide an independent and objective view of internal control by:

1. Overseeing Internal and External Audit Services:

   (i) Internal Audit – to monitor and review the effectiveness of the internal audit function and to undertake a market testing exercise for the appointment of the auditor at least once every five years;

   (ii) External Audit:

   - to assess the external auditor's work and fees on an annual basis to ensure that the work is of sufficiently high standard and that the fees are reasonable;
   - to undertake a market testing exercise for the appointment of the auditor at least once every five years;
   - to make recommendations to the Council of Governors in relation to the appointment, re-appointment and removal of the external auditor and to approve the remuneration and terms of engagement of the external auditor;
   - to review and monitor the external auditor's independence and objectivity and the effectiveness of the audit process, taking into account relevant UK professional and regulatory requirements;
   - to develop and implement a policy on the engagement of the external auditor to supply non-audit services, taking into account relevant ethical guidance

2. Reviewing financial and information systems and monitoring the integrity of the financial statements, any formal announcements relating to the Foundation Trust's financial performance and reviewing significant financial reporting judgements;

3. The monitoring of compliance with the SoRD and SFIs;

4. Reviewing schedules of losses and compensation and ratifying on behalf of the Board of Directors;

5. Reviewing the effective implementation of corporate governance measures to enable the Foundation 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;

6. Review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (clinical, operational, compliance controls and risk management systems) that supports achievement of the organisation's objectives.

The Audit Committee may also review arrangements by which staff of the Trust may raise concerns about possible improprieties in matters of financial reporting and control, clinical quality and patient safety. All such concerns are to be treated in confidence and the Committee should ensure that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow up action.

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 feel 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 Chief Financial Officer in the first instance).

Chief Financial Officer

The Chief Financial Officer is responsible for:

1. Ensuring adequate internal and external audit services are provided;

2. Ensuring there are arrangements to review, evaluate and report on the effectiveness of internal control including the establishment and maintenance of an effective internal audit function and the coordination of other assurance arrangements;

3. Ensuring that the internal audit is effective and meets all relevant professional standards;

4. Deciding at what stage to involve the police in cases of fraud, misappropriation, and other irregularities not involving fraud or corruption;

5. Ensuring that a quarterly and annual internal audit report is prepared for the consideration of the Audit Committee. The report must cover:

    - 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;
    - major internal financial control weaknesses discovered;
    - progress on the implementation of internal audit recommendations;
    - progress against plan over the previous year;
    - the forward plan;
    - any updates / requirements as determined by NHSE/I or other regulators.

The Chief Financial Officer or designated auditors are entitled, without necessarily giving prior notice, to require and receive:

1. Access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of confidential nature;

2. Access at all reasonable times to any land, premises, members of the Board of Directors and Council of Governors or employees of the Foundation Trust;

3. The production of any cash, stores or other property of the Foundation Trust under a member of the Board of Directors or an employee's control;

4. Explanations concerning any matter under investigation.

Internal Audit

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

The role of internal audit embraces two key areas:

1. 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;

2. 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 produce a strategic audit plan and a detailed plan for the coming year and 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; and
- the extent to which the Foundation Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:
  i) fraud and other offences; and
  ii) waste, extravagance, inefficient administration, poor value for money or other causes.

Internal Audit shall also independently verify the Assurance Statements in accordance with guidance from NHSE/I.

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 Chief Financial Officer 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 Foundation Trust. The Head of Internal Audit shall be accountable to the Chief Financial Officer. The reporting system for Internal Audit shall be agreed between the Chief Financial Officer, 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 systems 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 Foundation 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 Chief Financial Officer 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 Chief Financial Officer.

External Audit

The 2006 NHS Act states that the Foundation Trust is to have an External Auditor (defined in the Act as the Financial Auditor) and is to provide the External Auditor with every facility and all information which they may reasonably require for the purpose of their functions. The External Auditor is to carry out their duties in accordance with Schedule 10 to the 2006 Act and in accordance with any directions given by NHSE/I on standards, procedures and techniques to be adopted. In auditing the accounts, the External Auditor must, by examination of the accounts and otherwise, satisfy themselves that the Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The Foundation Trust is required to include an Annual Governance Statement within the financial statements. The financial auditors have a responsibility to:

- consider the completeness of the disclosures in meeting the relevant requirements; and
- identify any inconsistencies between the disclosures and the information that they are aware of from their work on the financial statements and other work.

Appointment of the External Auditor

The External Auditor is appointed by the Council of Governors. The *Audit Code for NHS Foundation Trusts* has been produced by the regulator under its powers under paragraph 24(5) of Schedule 7 of the 2008 Act which states that in auditing the accounts the External Auditor is to comply with any directions given by NHSE/I (formerly Monitor) as to the 'standards, procedures and techniques' to be adopted.

The Council of Governors of the Trust is responsible for appointing an External Auditor. NHS foundation trusts must ensure that the appointed External Auditor meets the following criteria, at the date of appointment and on an on-going basis throughout the term of their appointment:

1. The External Auditor must satisfy the criteria for appointment as an auditor of an NHS foundation trust, as set out in paragraph 23(4) of Schedule 7 of the 2006 Act;

2. The External Auditor must have an established and demonstrable standing within the healthcare sector and be able to show a high level of experience and expertise. The work is of a specialised nature, and so general audit experience is not sufficient;

3. The External Auditor must comply with the *Audit Code for NHS Foundation Trust;* and

4. The External Auditor must subject the audit to internal quality control procedures which are sufficiently robust to monitor the compliance of the audit work with the *Audit Code for NHS Foundation Trusts.*

The Council of Governors shall appoint or remove the External Auditor at a general meeting of the Council of Governors. NHSE/I may require External Auditors to undertake work on its behalf at the Foundation Trust. In this situation, a tripartite agreement between NHSE/I, the External Auditor and the Foundation Trust will be agreed. This agreement, which will include details of the subsequent work and reporting arrangements, will be in accordance with the principles established in the guidance issued by the Institute of Chartered Accountants in England and Wales in audit 05/03: Reporting to Regulators and Regulated Entities.

The External Auditor may, with the approval of the Council of Governors, provide the Foundation Trust with services which are outside of the scope as defined in the code (additional services). The Foundation Trust shall adopt and implement a policy for considering and approving any additional services to be provided by the External Auditor.

Liaison with Internal Auditors

It is expected that the External Auditors will liaise with the internal audit function in order to obtain a sufficient understanding of internal audit activities to assist in planning the audit and developing an effective audit approach. The External Auditors may also wish to place reliance upon certain aspects of the work of internal audit in satisfying their statutory responsibilities as set out in the 2006 Act and the *Audit Code for NHS Foundation Trusts.* In particular the External Auditors may wish to consider the work of internal audit when undertaking their procedures in relation to the Annual Governance Statement.

Access to Documents

External Auditors of NHS Foundation Trusts have a right of access at all reasonable times to every document relating to the NHS Foundation Trust

which appears to them necessary for the purposes of their functions under Chapter 5 of Part 2 of the 2006 Act.

Public Interest Report

In the event of the External Auditor issuing a Public Interest report the Foundation Trust shall send the public interest report to the Council of Governors, the Board of Directors and NHSE/I, at once if it is an immediate report; or not later than 14 days after conclusion of the audit, forward a report to NHSE/I within 30 days (or such shorted period as NHSE/I may specify) of the report being issued. The report shall include details of the Foundation Trust's response to the issues raised within the Public Interest report.

Fraud, Bribery and Corruption

The Foundation Trust shall take all necessary steps to counter fraud and corruption relating to its functions and in accordance with the 'Foundation Trust Contract' and have regard to any reasonable guidance or advice from NHS Counter Fraud Authority. The Foundation Trust shall act in accordance with:

- the NHS Anti-Fraud, Bribery and Corruption policy; and
- the policy statement '*Applying appropriate sanctions consistently'* published by NHS Counter Fraud Authority.

The Chief Executive and Chief Financial Officer shall monitor and ensure compliance with Fraud and Corruption elements of the Foundation Trust Contract.

The Foundation Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist.

Manual and Guidance

The Local Counter Fraud Specialist shall report to the Foundation Trust's Chief Financial Officer and shall work with the staff in NHS Counter Fraud Authority in accordance with the requirements set out in the NHS Anti-Fraud, Bribery and Corruption policy. The Local Counter Fraud Specialist will provide a written plan and report, at least annually on counter fraud work within the Foundation Trust.

Security Management

The Foundation Trust shall promote and protect the security of people engaged in activities for the purposes of the health service functions of that body, its property and its information in accordance with the requirements of the Foundation Trust Contract, having regard to any other reasonable guidance or advice issued by NHS Counter Fraud Authority, or previously by the CFSMS. The Foundation Trust shall nominate and appoint a Local Security Management Specialist as per the Foundation Trust Contract. The Chief Executive has overall responsibility for controlling and coordinating security, however, key tasks are delegated to the Security Management Director (SMD) (the Trust's Chief Operating Officer) and the appointed Local Security Management Specialist (LSMS).

3. BUSINESS PLANNING, BUDGETS, BUDGETARY CONTROL, AND MONITORING

Preparation and approval of operational plan and budgets

Operational planning

In accordance with the annual planning cycle, the Chief Executive will compile and submit to the Board of Directors and to the Council of Governors the annual Operational Plan which takes into account financial targets and forecast limits of available resources, The Trust Operational 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;
- The Financial Plan for the year;
- Such other contents as may be determined by the Integrated Care System (ICS) / NHSE/I.

The annual Operational Plan must be submitted to NHSE/I in accordance with NHSE/I requirements.

Budgets

Prior to the start of the financial year, the Chief Financial Officer 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 Foundation Trust's operational plan;
- accord with workload and workforce plans;
- be produced following discussion with appropriate budget holders;
- be prepared within the limits of available funds;
- identify potential risks and mitigations;
- be based on reasonable and realistic assumptions;
- be prepared on a basis to maximise value for money; and
- enable the Foundation Trust to comply with the requirements of the Single Oversight Framework set by NHSE/I.

The Chief Financial Officer shall monitor the financial performance against budgets, periodically review it and report to the Board of Directors. Any significant variance should be reported by the Chief Financial Officer 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 Chief Financial Officer to enable budgets to be compiled.

All budget holders will be provided with delegated budgets which they will assess, review with their Divisional Accountant, suggest changes and then agree at the commencement of each financial year.

The Chief Financial Officer has a responsibility to ensure that adequate financial training is delivered on an on-going basis to all budget holders to help them manage budgets effectively.

Budget 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. 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 Chief Financial Officer.

Budgetary Control and Reporting

The Chief Financial Officer 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:

1. Statement of Comprehensive Income to date showing trends and forecast year-end position;

2. Statement of Financial Position including movement in working capital;

3. Cash flow;

4. Capital project spend and projected out-turn against plan;

5. Explanations of any material variances from plan / budget;

6. Details of any corrective action where necessary and the Chief Executive's and / or Chief Financial Officer's view of whether such actions are sufficient to correct the situation;

7. The issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

8. Investigation and reporting of variances from financial, and workload budgets;

9. The monitoring of management action to correct variances;

10. Arrangements for the authorisation of budget transfers;

11. 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 provide advice on the economic and financial impact of future plans and projects;

12. Review of the bases and assumptions used to prepare the budgets.

In the performance of these duties the Chief Financial Officer 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:

1. Any planned or known overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the Board of Directors;

2. Officers shall not exceed the budget limit set;

3. The amount provided in the approval budget is not used in whole or in part for any purpose other than specifically authorised subject to the rules of virement;

4. Capital project spend and projected out-turn are managed against plan;

5. They can provide explanations of any material variances from plan / budget;

6. Details are provided of any corrective action where necessary and the Chief Executive's and / or Chief Financial Officer's view of whether such actions are sufficient to correct the situation;

7. The issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

8. Investigation and reporting of variances is undertaken for financial and workforce budgets;

9. They monitor management action to correct variances;
10. Arrangements for the authorisation of budget transfers are followed;

11. They advise 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 provide advice on the economic and financial impact of future plans and projects;

12. They review the bases and assumptions used to prepare the budgets; and

13. No permanent employees are appointed without the approval of the Chief Executive or Chief Financial Officer other than those provided for in the budgeted establishment as approved by the Board of Directors.

The Chief Operating Officer and the Chief Financial Officer are responsible for ensuring delivery of the Trust's long-term savings programme in line with agreed schemes and with appropriate quality impact assessment in accordance with the requirements of the operational and strategic plans.

Capital Expenditure

The general rules applying to delegation and reporting shall also apply to capital expenditure. A project sponsor will be identified who will assume responsibility for the budget relating to each scheme.

Quarterly or Monthly Performance Returns

The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to NHSE/I within the specified time-scales.

4. ANNUAL ACCOUNTS AND REPORTS

Accounts

The Foundation Trust shall prepare accounts in respect of each financial year in such form as NHSE/I may, with the approval of HM Treasury, direct. The accounts are to be audited by the Foundation Trust's External Auditor. The following documents will be made available to the Comptroller and Auditor General for examination at his request:

- the accounts;
- any records relating to them;
- any report of the External Auditor on them.

The functions of the Foundation Trust with respect to the preparation of the annual accounts shall be delegated to the Accounting Officer. The Accounting Officer shall cause the Foundation Trust to prepare in respect of each financial year annual accounts in such form as NHSE/I may, with the approval of the HM Treasury, direct. The Accounting Officer will comply in preparing accounts with HM Treasury guidance as to:

- the methods and principles according to which the accounts are to be prepared;
- the information to be given in the accounts; and
- shall be responsible for the functions of the Foundation Trust as set out in the 2006 NHS Act.

The following documents are to be presented to the Council of Governors at a general meeting of the Council of Governors:

- the annual report including the annual accounts; and

- any report of the External Auditor on them;

The Accounting Officer shall cause the Foundation Trust to lay a copy of the annual accounts, and any report of the External Auditor on them, before Parliament and once it has done so, send copies of those documents to NHSE/I.

Responsibility for complying with the requirements relating to the form, preparation and presentation of the accounts shall be delegated to the Accounting Officer.

Annual Reports

The Foundation Trust shall prepare an Annual Report and send it to NHSE/I. The reports are to give information on any steps taken by the Foundation Trust to secure that (taken as a whole) the actual membership of the Public Constituency and of the classes of the Staff Constituency is representative of those eligible for such membership; and any other information NHSE/I requires.

The Foundation Trust is to comply with any decision NHSE/I makes as to the form of the reports; when the reports are to be sent to them; and the periods to which the reports are to relate.

The Financial Auditors of the Foundation Trust have a responsibility to read the information contained within the Annual Report and consider the implications for the External Audit opinion and/or certificate if there are apparent misstatements or material inconsistencies with the financial statements.

Annual Plans

The Foundation Trust shall provide information as to its forward planning in respect of each financial year to NHSE/I. The Foundation Trust must make clear which elements of the Annual Plan do not constitute forward planning information. The document containing the information with respect to forward planning (referred to above) shall be prepared by the directors. The forward plan must be prepared with reference to documents published by NHSE/I which aid planning. In preparing the document, the directors shall have regard to the views of the Council of Governors.

The Annual Plan must be approved by the Board of Directors. The Foundation Trust is required to provide three types of in-year reports:

1. Regular reports on a quarterly basis;

2. Exception reports, which may relate to any in-year issue affecting compliance with the Authorisation, such as performance against core national healthcare targets and standards;

3. Ad-hoc reports, following up specific issues identified either in the Annual Plan or in-year Eg. Monthly update of forecast annual outturn.

5. BANK AND GOVERNMENT BANKING SERVICE (GBS) ACCOUNTS

General

The Chief Financial Officer is responsible for managing the Foundation Trust banking arrangements and for advising the Foundation Trust on the provision of banking services and operation of accounts. The Board of Directors shall approve the banking arrangements.

Bank and GBS Accounts

The Chief Financial Officer is responsible for:

1. Bank accounts and GBS accounts; and other forms of working capital financing that may be available from the Department of Health and Social Care or commercial entity;

2. Establishing separate bank accounts for the Foundation Trust's non-exchequer funds;

3. Ensuring payments made from bank or GBS accounts do not exceed the amount credited to the accounts except where arrangements have been made;

4. Reporting to the Board of Directors all arrangements made with the Foundation Trust's bankers for accounts to be overdrawn.

All accounts should be held in the name of the Foundation Trust. No officer other than the Chief Financial Officer shall open any account in the name of the Foundation Trust or for the purpose of furthering Foundation Trust activities.

Banking Procedures

The Chief Financial Officer will prepare detailed instructions on the operation of bank and GBS accounts, which must include:

1. The conditions under which each bank and GBS accounts are to be operated;

2. The limit to be applied to any overdraft;

3. Those authorised to make payments drawn on the Foundation Trust's accounts.

The Chief Financial Officer must ensure the accounts are operated in accordance with the conditions agreed with the Trust's bankers and shall approve security procedures for payments made without a hand-written signature. 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.

Trust Credit Cards

The Chief Financial Officer is responsible for the authorising of Trust Corporate Credit Cards to named individuals. Expenditure will only be made on these credit cards as a payment of last resort or where a financial saving can be obtained by usage.

Tendering and Review

The Chief Financial Officer will review the banking arrangements of the Foundation Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Foundation Trust's business banking. Competitive tenders should be sought at least every 5 years and the results of the tendering exercise should be reported to the Board of Directors. This review is not applicable to GBS accounts.

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

Income Systems

The Chief Financial Officer 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 Chief Financial Officer is also responsible for the prompt banking of all monies received.

Fees and Charges other than Foundation Trust Contract

The Chief Financial Officer 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, NHSE/I 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. All employees must inform the Chief Financial Officer promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

Debt Recovery

The Chief Financial Officer 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.

Security of cash, cheques and other negotiable instruments

The Chief Financial Officer is responsible for:

1. 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 Chief Financial Officer should be issued;

2. Ordering and securely controlling any such stationery;

3. 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;

4. Prescribing systems and procedures for handling cash and negotiable securities on behalf of the Foundation Trust.

Officially 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 Chief Financial Officer. 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 Foundation Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Foundation Trust from responsibility for any loss. Any loss or shortfall of cash, cheques or other negotiable instruments, however occasioned, shall be monitored and recorded within the Finance Department. Any significant trends should be reported to the Chief Financial Officer 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 Foundation Trust's Anti-Fraud, Bribery and Corruption Policy/Response Plan and guidance provided by NHS Counter Fraud Authority. Where there is no evidence of fraud, bribery or corruption the loss should be dealt with in line with the Foundation Trust's Losses and Compensations Procedures.

7. FOUNDATION TRUST CONTRACTS

Provision of Services

The Board of Directors of the Foundation Trust shall regularly review and shall at all times maintain and ensure the capacity and capability of the Foundation Trust to provide the services referred to in the Trust's contracts.

Foundation Trust Contracts

The Chief Executive, as the Accounting Officer, is responsible for ensuring the Foundation Trust enters into suitable Foundation Trust Contracts (FTC) with commissioners for the provision of NHS services. The Foundation Trust will follow the priorities contained within the schedules of the contract, 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 performance metrics;
- the provision of reliable information on cost and volume of activity;
- ability to provide timely and accurate information / reports relating to agreed CQUIN targets;
- the provision of agreed information regarding outcome measures.

A good FTC 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 Foundation Trust works with all partner agencies involved in both the delivery and the commissioning of the service required.

The Chief Executive, as the Accounting Officer, will need to ensure that regular reports are provided to the Board of Directors detailing actual and forecast income from the FTC. This will include appropriate payment by results performance information.

Non-Commercial Contract

Where the Foundation 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 arrangements; and
- Exit provisions.

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

8. TERMS OF SERVICE, ALLOWANCES AND PAYMENT OF MEMBERS OF THE BOARD OF DIRECTORS AND EMPLOYEES

Remuneration Committee

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

The Committee will advise the Board of Directors about appropriate remuneration and terms of service for the Chief Executive and other Executive and Corporate Directors (and other senior employees), including:

- all aspects of salary (including any performance-related elements and bonuses);
- provisions for other benefits, including pensions and cars, arrangements for termination of employment and other contractual terms;
- review recommendations to the Board of Directors on the remuneration and terms of service of Executive and Corporate Directors (and other senior employees) to ensure they are fairly rewarded for their individual contribution to the Foundation Trust – having proper regard to the Foundation Trust's circumstances and performance and to the provisions of any national arrangements for such staff where appropriate;

- 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 Committee shall report in writing to the Board of Directors the basis for its recommendations. The Board of Directors shall use the report as the basis for their decisions, but remain accountable for taking decisions on the remuneration and terms of service of Executive Directors. Minutes of the Board of Directors meetings should record such decisions.

The Council of Governors, at a general meeting will decide the remuneration and allowances, and the other terms and conditions of office of the Non-Executive Directors.

Funded Establishment

The workforce plans incorporated within the annual budget will form the funded establishment. The staffing establishment of the Foundation Trust will be identified and monitored by the Chief People Officer under delegation from the Chief Executive. 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 SoRD. The Divisional Accountant is responsible for verifying that funding is available.

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;

1. Unless authorised to do so by the Chief Executive; and

2. Within the limit of their approved budget and funded establishment as defined in the SoRD.

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.

Processing of the payroll

The processing of the Foundation Trust's payroll is a contracted-out service. The Chief Financial Officer remains responsible for:

- specifying timetables for submission of properly authorised time records and other notifications;
- the financial 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 Chief Financial Officer will issue instructions regarding:

1. verification and documentation of data;

2. the timetable for receipt and preparation of payroll data and the payment of employees and allowances;

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

4. security and confidentiality of payroll information;

5. checks to be applied to completed payroll before and after payment;

6. authority to release payroll data under the provisions of the Data Protection Act;

7. methods of payment available to various categories of employee;

8. procedures for payment by cheque, bank credit, or cash to employees; procedures for the recall of cheques and bank credits;

9. pay advances and their recovery;

10. maintenance of regular and independent reconciliation of pay control accounts;

11. separation of duties of preparing records and handling cash; and

12. a system to ensure the recovery from leavers of sums of money and property due by them to the Foundation Trust.

Appropriately nominated managers have delegated responsibility for:

1. processing a signed copy of the contract / appointment form and such other documentation as may be required immediately upon an employee commencing duty;
2. submitting time records, and other notifications in accordance with agreed timetables;

3. completing time records and other notifications in accordance with the Chief Financial Officer's Instructions and in the form prescribed by the Chief Financial Officer; and

4. 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 Chief Financial Officer must be informed immediately. In circumstances where fraud might be expected this must be reported to the Chief Financial Officer.

The Chief Financial Officer shall ensure that the chosen method of providing the payroll service 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.

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 and Safety legislation; and
- dealing with variations to, or termination of, contracts of employment.

9. 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 which should be updated and reviewed on an on-going basis and annually by the Finance and Procurement Departments;
- 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.

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 Foundation Trust. In so doing, the advice of the Foundation Trust's advisor shall be sought. Where this advice is not acceptable to the requisitioner, the Chief Financial Officer (and/or the Chief Executive) shall be consulted. The Chief Financial Officer 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 Chief Financial Officer 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 SoRD and regularly reviewed;
- prepare procedural instructions where not already provided in the SoRD 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:

1. 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;

2. 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 standards 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 and examined;
- the account is arithmetically correct; and
- the account is in order for payment.

3. A timetable and system for submission to the Chief Financial Officer of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment;

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

5. Responsibility 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. cash flows 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 Foundation Trust if the supplier is at some time during the course of the prepayment agreement unable to meet their commitments;
- the Chief Financial Officer 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); and
- 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 Chief Financial Officer;
- State the Foundation 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 with the guidance and limits specified by the Chief Financial Officer and that:

1. All contracts other than for a simple purchase permitted within the SoRD or delegated budget, leases, tenancy agreements and other commitments which may result in a liability are notified to the Chief Financial Officer in advance of any commitment being made;

2. Contracts above specified thresholds are advertised and awarded in accordance with EU rules on public procurement;

3. 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;

4. 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;

5. No order shall knowingly be issued for any item or items to any firm which has provided/offered/promised gifts, rewards, benefits or inducements to either 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.

6. No requisition / order is placed for any item or items for which there is no budget provision unless authorised by the Chief Financial Officer on behalf of the Chief Executive;

7. 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;

8. 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'*;

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

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

11. Changes to the list of directors / employees authorised to certify invoices are notified to the Chief Financial Officer;

12. Purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Chief Financial Officer;

13. Petty cash records are maintained in a form as determined by the Chief Financial Officer; and

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

15. Online orders for Executives' travel ordered by Personal Assistants due to system time constraints are later checked and approved by the Chief Executive or Chief Financial Officer/Deputy Chief Financial Officer*.

The Chief Executive and Chief Financial Officer shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with relevant EU and IFRS accounting guidance.

Under no circumstances should goods be ordered through the Foundation Trust for personal or private use with the exception of permitted schemes such as lease cars or the cycle to work initiative.

Joint finance arrangements with local authorities and voluntary bodies

Payments to local authorities and voluntary organisations made under statutory powers shall comply with procedures laid down by the Chief Financial Officer.

*The Chief Executive to authorise travel for the Chief Financial Officer; the Chief Financial Officer to authorise travel for the Chief Executive; the Chief Executive/ Chief Financial Officer/Deputy Chief Financial Officer to authorise travel for all other Executives.

10. EXTERNAL BORROWING AND INVESTMENTS

Temporary cash surpluses must be held only in such public and private sector investments as authorised by the Board of Directors (delegated to the Trust's Business Performance Committee).

The Business Performance Committee is responsible for establishing and monitoring an appropriate investment strategy. The Chief Financial Officer is responsible for advising the Board of Directors on investments and shall report periodically to the Board of Directors concerning the performance of investments held and will prepare detailed procedural instructions on investment operations and on the records to be maintained. The Foundation Trust's Treasury Management Policy will incorporate guidance from NHSE/I as appropriate.

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

Capital Investment

The Chief Executive:

1. 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;

2. Shall ensure that the capital investment is not undertaken without the availability of resources to finance all revenue consequences, including capital charges and other recurrent costs;

3. Is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost;

4. That NHSE/I is notified if the Foundation Trust has plans for material transactions in accordance with the thresholds defined in NHSE/I's Single Oversight Framework. NHSE/I will determine whether they class the transaction as material or significant. Material investments can, under specific conditions set out in NHSE/I's Compliance Framework, be approved by the Foundation Trust's Board of Directors. Significant investments must be assessed by NHSE/I before the Foundation Trust can proceed. In addition, all transactions which potentially impact the Financial Sustainability Risk Rating must also be notified to NHSE/I. All PFI transactions require NHSE/I assessment. All decisions to borrow money, from any source, will be rigorously reviewed by the Board of Directors and the Foundation Trust will undertake its own financial due diligence using independent financial experts prior to making any decision.

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

1. That a business case 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;
    - appropriate project management and control arrangements; and

- the involvement of appropriate Foundation Trust personnel and external agencies.

2. That the Chief Financial Officer has sought professional advice and assurance regarding the capital costs and has assessed and verified the 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. The Chief Financial Officer 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; and
- approval to accept a successful tender.

The Chief Executive will issue a scheme of delegation for capital investment management which will be detailed in the Foundation Trust's Governance Manual.

The Chief Financial Officer shall issue procedures governing the financial management, including variations to contract of capital investment projects and valuation for accounting purposes.

Private Finance

The Foundation 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:

- The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers an appropriate proportion of risk to the private sector;
- A business case must be referred to the appropriate DH and NHSE/I for approval or treated as per current guidelines;
- The proposal must be specifically agreed by the Foundation Trust in the light of such professional advice as should reasonably be sought in particular with regard to vires; and

- The selection of a contractor / finance company must be on the basis of competitive tendering or quotations.

Asset Registers

The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Chief Financial Officer 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 once a year. The Foundation trust shall maintain an Asset Register recording fixed assets and 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;
- lease agreements in respect of assets held under a finance lease and capitalised; and
- independent valuation of assets.

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 Chief Financial Officer 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 the principles outlined in the Group Accounting Manual issued by the Department of Health and Social Care and the value of each asset shall be depreciated also using with the principles outlined in the Annual Reporting Manual.

Any disposal of fixed assets must be in a compliance with the Terms of the Trust Licence specifically section 5 condition COS2 – restriction on the disposal of assets.

Security of Assets

The overall control of fixed assets is the responsibility of the Chief Executive advised by the Chief Financial Officer. Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including

donated assets) must be approved by the Chief Financial Officer. 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 the Fixed Asset Register shall be notified to the Chief Financial Officer. Whilst each employee has a responsibility for the security of property of the Foundation Trust, it is the responsibility of directors and senior employees in all departments to apply appropriate routine security practices in relation to NHS property as determined by the Board of Directors. Any breach of agreed security practices must be reported in accordance with instructions. Any damage to the Foundation 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 and where practical, assets should be marked as Foundation Trust property.

12. 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:

1. controlled stores – specific areas designated for the holding and control of goods;

2. wards and departments – goods required for immediate usage to support operational services; and

3. 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 Chief Financial Officer) 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 Chief Financial Officer 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 Chief Financial Officer. The control of any Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer. 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 practical, stocks should be marked as NHS property. The Chief Financial Officer shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, returns to stores and losses.

Stocktaking arrangements shall be agreed with the Chief Financial Officer 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 Chief Financial Officer. The designated manager shall be responsible for a system approved by the Chief Financial Officer for a review of slow moving and obsolete items and for condemnation, disposable, and replacement of all unserviceable articles. The designated Officer shall report to the Chief Financial Officer any evidence of significant overstocking and of any negligence or malpractice (see also section 13 – Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

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 Head/Deputy Head of Procurement shall check receipt against delivery to satisfy themselves that the goods have been received and will then authorise payment of NHS Supply Chain weekly sales invoices. The Finance Department will make payment on receipt of an invoice. This may also apply for high volume low value items such as stationery.

Issue of Stocks

The issue of stocks shall be supplied by an authorised requisition note and a receipt for the stock issued shall be returned to the designated officer. Where a 'topping up' system is used, a record shall be maintained as approved by the Chief Financial Officer. 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 Chief Financial Officer.

13. DISPOSALS AND CONDEMNATIONS, INSURANCE, LOSSES AND SPECIAL PAYMENTS

Disposals and Condemnations

The Chief Financial Officer must prepare detailed procedures for the disposal of assets including condemnations and ensure that these are notified to managers. When it is decided to dispose of a Foundation Trust asset, the head of department or authorised deputy will determine and advise the Chief Financial Officer of the estimated market value of the item, taking account of professional advice where appropriate. For protected assets see Section 11 of these SFIs. All unserviceable articles shall be:

- condemned or otherwise disposed of by an employee authorised for that purpose by the Chief Financial Officer; and
- recorded by the condemning officer in a form approved by the Chief Financial Officer which will indicate whether 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 Chief Financial Officer.

The condemning officer shall satisfy themselves as to whether or not there is evidence of negligence in use and shall report any such evidence to the Chief Financial Officer who will take the appropriate action.

Losses and Special Payments

Losses

The Chief Financial Officer must prepare procedural instructions on the recording of and accounting for condemnations, and losses. The Chief Financial Officer 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 Chief Financial Officer 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 Chief Financial Officer who will liaise with the Chief Executive. Where a criminal offence is suspected, the Chief Financial Officer must immediately inform the police if theft or arson is involved. In cases of fraud or corruption or of anomalies which may indicate fraud, bribery or corruption, the Chief Financial Officer must inform their Local Counter Fraud Specialist who will inform the relevant NHS Counter
Fraud Authority regional team **before** any action is taken and reach agreement as to how the case is to be handled. For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Chief Financial Officer must immediately notify:

- The Board of Directors;
- The External Auditor; and
- NHS Counter Fraud Authority (through the Local Counter Fraud Specialist).

The Chief Financial Officer shall be authorised to take any necessary steps to safeguard the Foundation Trust's interests in bankruptcies and company liquidations. For any loss, the Chief Financial Officer should consider whether any insurance claim can be made.

Write-Offs and Special Payments

The writing-off of debts, the abandonment of claims and the making of any kind of special or ex-gratia payments will be approved in accordance with the scheme of delegation. In approving the write-off of debts consideration will be

made of the nature of the monies owed and the likelihood of the receipt of monies against any costs which may be incurred in attempting to recover the debt. In approving special payments account will be taken of national guidance, any precedents and any potential for admitting liability for further claims.
The Chief Financial Officer shall maintain a Losses and Payments Register in which write-off action is recorded. All losses and special payments must be reported to the Audit Committee.

Compensation Claims

The Foundation 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 Foundation 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 Foundation 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 Standards for Care Quality Commission essential standards of quality and safety; and
- Implementing an effective system of Clinical Governance.

The Board of Directors are collectively responsible for ensuring the proper reporting, recording, and management of all claims. The Board of Directors delegates responsibility for receiving, assessing and acting upon claims in two key Board sub-committees, namely the Quality Committee and the Business and Performance Committee.

14. INFORMATION TECHNOLOGY

Responsibilities and Duties of the Chief Financial Officer

The Chief Financial Officer, who is responsible for the accuracy and security of the computerised financial data of the Foundation Trust, shall:

- devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Foundation 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 (update 2000) and the Computer Misuse Act 1990;

- ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

- ensure that adequate controls exist to maintain the security, privacy, accuracy and completeness of financial data sent via transmission networks;

- 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 Chief Financial Officer shall satisfy them self 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.

Freedom of Information

The Chief Financial Officer shall also 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 described that classes or types of information about our Foundation Trust that we make publicly available.

Responsibilities and Duties of other Directors and Officers in relation to IM&T and Information Governance

General

In order to ensure compatibility and compliance with the Trust's IM&T Strategy, no computer hardware, software or facility will be procured without authorisation of the Chief People Officer and Head of IM&T.

Information Governance

The Head of Information Governance together with the Head of Procurement are to ensure that all Trust contracts and SLAs have appropriate clauses to protect the Trust and its staff, patients and other stakeholders from any risk of breach of confidentiality of breach of Information Governance standards.

Risk Assessment

The Chief People Officer shall ensure that risks to the Foundation 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. The Foundation Trust shall disclose to NHSE/I and directly to any third parties, as may be specified by the Secretary of State, the information, if any, specified in the Terms of Authorisation, Schedule 6. Other information, as requested, shall be provided to NHSE/I.

15. PATIENT'S PROPERTY

The Foundation 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 Nurse is responsible for ensuring that patients or their guardians, as appropriate, are informed of appropriate procedures for storing such items before or at admission by:

- notices and information booklets;
- hospital admission documentation and property records; and
- the advice of administrative and nursing staff responsible for admissions.

The Foundation 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 Chief Financial Officer must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patient's 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. These instructions shall cover the necessary arrangements for withdrawal of cash or disbursements 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 Chief Financial Officer shall be completed in respect of the following:

1. Property handed in for safe custody by any patient (or guardian as appropriate); and

2. Property taken into safe custody having been found in the possession of:

- mentally disordered patients;
- confused and/or disorientated patients;
- unconscious patients;
- patients dying in hospital; and
- patients found dead on arrival at hospital (property removed by police).

A record shall be completed in respect of all persons in category (2) 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 Chief Financial Officer. Patients' income, including pensions and allowances, shall be dealt with in accordance with current Department for Work and Pension 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 for Work 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.

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 Chief Financial Officer, 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 Chief Financial Officer. 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 a total of 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 Grant of Representation 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 appropriate administration 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 Foundation Trust are a first charge on a deceased person's estate. Where arrangements for burial or cremation are not made privately, any element of the estate held by the Foundation Trust may be appropriated towards funeral expenses, upon authorisation of the Chief Financial Officer. 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.

16. TENDERING AND CONTRACT PROCEDURE

Duty to comply with Standing Orders and SFIs

The procedure for making all contracts by or on behalf of the Foundation Trust shall comply with the Standing Orders and SFIs (except where Suspension of Standing Orders is applied).

EU Directives Governing Public Procurement

Directives by the Council of the European Union promulgated by the Department of Health and Social Care (DHSC) prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in the Standing Orders and SFIs. Procedure notes detailing EU thresholds and the differing procedures to be adopted must be maintained within the Foundation Trust.

Formal Competitive Tendering

The Foundation Trust shall ensure that competitive tenders are invited for:

- the supply of goods, materials and manufactured articles;
- 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); and
- for the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); and for disposals.

Where the Foundation Trust elects to invite tenders for the supply of healthcare these SFIs 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 SoRD, (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
- the expenditure relates to the annual member subscription of Liverpool Health Partners, which the Foundation Trust must incur as a founding partner of this limited company; or
- regarding disposals as set out in SFIs 'Disposals and Condemnations.'

Formal tendering procedures **may be waived** in the following circumstances:

1. 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 Foundation Trust record;

2. Where the requirement is covered by an existing contract;

3. Where public sector agreements are in place and have been approved by the Board of Directors;

4. 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;

5. Where the timescale genuinely precludes competitive tendering. However, failure to plan the work properly would not be regarded as a justification for a single tender;

6. Where specialist expertise is required and is available from only one source;

7. 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;

8. 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; and

9. For the provision of legal advice and services providing that any legal firm or partnership commissioned by the Foundation 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 all generally recognised as having sufficient expertise in the area of work for which they are commissioned.

The Chief Financial Officer will ensure that any fees paid are reasonable and within commonly accepted rates for the costing of such work. 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 Foundation Trust and reported to the Audit Committee at each meeting.

Fair and Adequate Competition

Where applicable the Foundation 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 three firms / individuals, having regard to their capacity to supply the goods or materials or to undertake the services or works required.

Building and Engineering Construction Works

Competitive Tendering cannot be waived for building and engineering construction works and maintenance (other than in accordance with EU regulations) without Department of Health and Social Care approval.

Items which subsequently breach thresholds after original approval

Items estimated to be below the limits set in this SFIs for which formal tendering procedures are not used which subsequently prove to have a value above such limits shall be reported to the Audit Committee and be recorded in an appropriate Foundation Trust record.

Contracting / Tendering Procedure

All tenders for services with a value greater than £50,000 (inc VAT) must be published on the national contracts' finder website.

Invitation to tender

1. all invitations to tender shall state the date and time as being the latest time for the receipt of tenders;

2. all invitations to tender shall state the procedures to be followed in submitting the tender;

3. every tender for goods, materials, services or disposals shall embody such of the NHS Standard Contract Conditions as are applicable;

4. every tender for building or engineering works should be subject to the appropriate form of contract.

Receipt and Safe custody of Tenders

The Chief Executive or their nominated representative will be responsible for the system to track the receipt, endorsement and safe custody of tenders received until the time appointed for their opening. The date and time of receipt of each tender shall be recorded. Tenders will be carried out using an electronic tendering system. Access to the electronic tendering system will be by username and password and a full audit trail will be maintained. The system will ensure that submitted tenders, apart from in-house bids, cannot be accessed by any member of the Trust until after the closing date.

Opening Tenders and Register of Tenders

1. As soon as possible after the date and time stated as being the latest time for the receipt of tenders, they shall be opened by the manager designated by the Chief Executive and not from the originating department;

2. The 'originating' Department will be taken to mean the department sponsoring or commissioning the tender. The involvement of Finance Department staff in the preparation of a tender proposal will not preclude the Chief Financial Officer or any approved Senior Manager from the Finance Department from serving as one of the managers to open tenders;

3. The date and person opening every tender should be recorded;

4. 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 tenders were opened;
    - the person opening the tenders;
    - the price shown on each tender; and
    - a note where price alterations have been made on the tender;

5. 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 below).

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 Chief Financial Officer shall, as far practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Foundation Trust.

Late Tenders

Tenders received after the due time and date, but prior to the opening of the other tenders, may be considered only if the Chief Executive or their nominated officer decided that there are exceptional circumstances i.e. despatched in good time but delayed through no fault of the tenderer. Only in the most exceptional circumstances will a tender be considered which is received after the opening of the other tenders and only then if the tenders that have been duly opened have not left the custody of the Chief Executive or their nominated officer or if the process of evaluation and adjudication has not started. While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential, recorded, and held in safe custody by the Chief Executive or their nominated officer.

Acceptance of formal tenders

Any discussions with a tenderer which are deemed necessary to clarify technical aspects of their tender before the award of contract will not disqualify the tender. The tender which is the most economically advantageous to the Trust will be accepted. The weighting of finance, quality and other measures in determining the most economically advantageous tender will be consistent with the invitation to tender.

No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Foundation Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.

All tenders should be treated as confidential and should be retained for inspection.

Tender reports to the Board of Directors

Reports to the Board of Directors will be made on an exceptional circumstance basis only.

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 SoRD.

Competitive Quotations

Quotations should be obtained from at least three firms / individuals based on specifications or terms of reference prepared by, or on behalf of, the Foundation Trust. Quotations should be in writing unless the Chief Executive or their nominated officer determines that it is impractical to do so in which case quotations may be obtained by telephone. For the avoidance of doubt, writing includes electronic means which can be permanently recorded. 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. All quotations should be treated as confidential and should be retained for inspection. The Chief Executive or their nominated officer should evaluate the quotation and select the quote which is the most economically advantageous to the Trust. The factors used to determine economic advantage should be recorded in a permanent record.

Non-Competitive Quotations

Non-competitive quotations in writing may be obtained in the following circumstances:

- 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;
- the supply of goods or manufactured articles of any kind which are required quickly and are not obtainable under existing contracts; and
- 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.: (1) and (2) 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 Foundation trust and which is not accordance with SFIs except with the authorisation of either the Chief Executive or Chief Financial Officer.

Authorisation of Tenders and Competitive Quotations

Providing all the conditions and circumstances set out in these SFIs have been fully complied with, formal authorisation and awarding of a contract may be decided by the staff as defined in the SoRD. 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.

Instances where formal competitive tendering or competitive quotation is not required

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

- the Foundation Trust shall use the NHS Supply Chain or other national contracts/frameworks for procurement of all goods and services unless the Chief Executive or nominated officer deems it inappropriate. The decision to use alternative sources must be documented; and
- If the Foundation Trust does not use the NHS Supply Chain or other national contracts/frameworks – where tenders or quotations are not required, because expenditure is below the levels defined in the SoRD, the Foundation Trust shall procure goods and services in accordance with procurement procedures approved by the Chief Financial Officer.

Private Finance for Capital Procurement

The Foundation 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:

- The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers an appropriate proportion of risk to the private sector;

- Where the sum exceeds delegated limits, a business case must be referred to NHSE/I in accordance with guidelines in the Single Oversight Framework;
- The proposal must be specifically agreed by the Board of the Foundation Trust; and
- The selection of a contractor / finance company must be on the basis of competitive tendering or quotations.

Compliance requirement for all contracts

The Board may only enter into contracts on behalf of the Foundation Trust within the statutory powers delegated to it by the Secretary of State and shall comply with:

- The Foundation Trust's SOs and SFIs;
- EU Directives and other statutory provisions;
- Such clauses of the NHS Standard Contract Conditions as are applicable;
- Contracts with Foundation Trusts must be in a form compliant with appropriate NHS guidance;
- Where appropriate contracts shall be in or embody the same terms of conditions of contract as was the basis on which tenders or quotations were invited; and
- NHSE/I principles / regulations.

In all contracts made by the Foundation 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 Foundation Trust.

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. All contracts should be compliant with DHSC / HMRC tax rules and mitigate the Trust's liability for individual non-compliance accordingly.

Foundation Trust Contracts / Healthcare Service Agreements

Service agreements with NHS providers for the supply of healthcare services 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 SoRD).

Disposals

Competitive Tendering or Quotation procedures shall not apply to the disposal of:

- 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;
- obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Foundation Trust;
- 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;
- items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract; and
- land or buildings connected with DHSC guidance that has been issued but subject to compliance with such guidance.

All contractors should be compliant with DHSC / HMRC tax rules and mitigate to Trust's liability for individual non-compliance accordingly;

For any of the conditions noted above, check with the financial accountant prior to progressing.
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 Foundation 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:

- Specification Group, comprising the Chief Executive or nominated officer/s and a Specialist Officer;

- In-house tender group, compromising a nominee of the Chief Executive and technical support; and
- Evaluation team, comprising normally a specialist officer, a supplier's officer and a Chief Financial Officer 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 and the Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Foundation Trust.

Where the Trust is considering providing a service in-house which is currently contracted-out the same groups should be set up to evaluate the service and make recommendations to the Board of Directors.

Applicability of SFIs on Tendering and Contracting to funds held in trust

These instructions shall not only apply to expenditure from Exchequer funds but also to works, services and goods purchased from the Foundation Trust's Charity and private resources. There may be times when instructions may be waived e.g. when there is an opportunity to purchase an asset of strategic importance / benefit to the Trust.

17. ACCEPTANCE OF GIFTS AND HOSPITALITY BY STAFF

The Chief Financial Officer shall ensure that all staff and any other interested and applicable parties are made aware of the Foundation Trust policy – Standards of Business and Personal Conduct. This policy makes due provision to the Bribery Act 2010. The policy is deemed to be an integral part of the Trust's Governance Manual and SFIs.

18. RETENTION OF DOCUMENTS

Context

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.

Accountability

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 record legacy of predecessor organisations and / or obsolete services. Under the Public Records Act all NHS employees are responsible 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 compliant-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).

Documents held in archives shall be capable of retrieval by authorised persons and 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.

19. RISK MANAGEMENT

Programme of Risk Management

The Chief Executive shall ensure that the Foundation Trust has a programme of risk management, which must be approved and monitored by the Board of Directors. The programme of risk management shall include:

- a process for identifying and quantifying risks and potential liabilities;
- engendering among all levels of staff a positive attitude towards the control of risk;
- 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;
- contingency plans to offset the impact of adverse events;
- audit arrangements including; Internal Audit, clinical audit, health and safety review;
- a clear indication of which risks shall be insured; and
- arrangements to review the Risk Management Programme.

The existence, integration and evaluation of the above elements will assist in providing a basis to make an annual Governance Statement within the Annual Report and Accounts as required by current Department of Health and Social Care guidance.

Insurance Arrangements

The Board shall decide if the Foundation Trust will insure through the risk pooling schemes administered by NHS Resolution, use commercial insurance or self-insure for some or all of the risks to which the Trust is exposed. A combination of the three options may be used. If the Board decides not to use the NHS Resolution 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.

In addition, the Board of Directors will need to consider the implications of leaving the NHS Resolution scheme upon its quality profile as determined by Monitor / NHS England/Improvement and the CQC.

Arrangements to be followed by the Board of Directors in agreeing Insurance Cover

The Chief Financial Officer shall examine the options in regard to insurance cover and make a recommendation to the Board on which arrangements, or combination of arrangements, represent the best value for money for the Trust. In coming to their decision, the Board will take account of the impact of a major incident / loss on the operation and reputation of the Trust.

Where the Board decides to use commercial insurance the insurance contract will be let subject to the normal procurement rules set out in Section 16. The Chief Financial Officer should ensure documented procedures also cover the management of claims and payments behind the deductions in each case and will maintain records of the policies and insurance certificates in line with the retention of records policy.

Areas not covered by the NHS Resolution schemes

The following areas are not covered by the NHS Resolution schemes and therefore need to be covered by commercial insurance or self-insurance:

- Motor vehicles owned by the Foundation Trust including insuring third party liability arising from their use;
- Where the Foundation Trust is involved with a consortium in a Private Finance Initiative (PFI) contract and the other consortium members require that commercial insurance arrangements are entered into; and
- Income generation schemes are not covered by the NHS Resolution schemes. If the income generation activity is also an activity normally carried out by the Foundation Trust for an NHS purpose the activity may be covered in the risk pool. Confirmation of coverage in the risk pool must be obtained from NHS Resolution.

The Walton Centre NHS
NHS Foundation Trust

SCHEME OF RESERVATION AND DELEGATION

Reviewed by:

Zoe Stevenson, Head of Financial Services
October 2022

Authorised by:

Mike Burns, Chief Financial Officer

CONTENTS

RECORD OF AMENDMENTS

NO	SECTION	DATE
1	Updated document issues for implementation	
2	3.9 adjusted to reflect Walton Neurosciences responsibility for charity accounts	25/03/2010
3	4.1.2 Walton Neurosciences funds committee's role as Trustee of Walton Neurosciences Fund	25/03/2010
4	Table A section 20 relating to charitable funds removed and remainder renumbered	25/03/2010
5	Table B section 1 relating to charitable funds removed and remainder renumbered	25/03/2010
6	Table A section 39 add in tariff setting responsibility for Bistro	25/03/2010
7	General update throughout document	01/12/2011
8	General update throughout document	08/01/2013
9	Annual review and amendment following	23/05/2013
10	Amend to reflect change in executive team duties, amend expenditure limits for Chief Executive and Director of Finance and IT and give Other Executive Directors authority to spend up to £50K and update for changes in EU limits	Oct 2014
11	Amend to amend Chief Executive expenditure approval lower level from £70,000 to £75,000 and general review for consistency, changes to titles and Director responsibilities	Nov 2015
12	Amend references to Monitor to reflect NHS Improvement as the new regulator. Amend values given on p7 regarding proposals on individual contracts to reflect expenditure limits in table B. Update table A and B for minor typos and job title changes. Include in table B a threshold of £500 for Deputy Director of Finance and IT to approve ex gratia payments.	Oct 2016
13	Amend references to Director of Nursing and Modernisation to cover revised job title: Director of Nursing, Operations and Quality. Include paragraph on Chair's action as requested at November 2016 Board meeting.	Jan 2017
14	Update tables A and B for the authorisation of credit notes. Update the financial limits in table B to exclude VAT where appropriate. Update tables A and B – quotations and tenders to reflect Trust procurement and tendering policy.	Apr 2017
15	Minor corrections and job title changes; update table B to include £15k (excl VAT) threshold for Deputy Director of Nursing and Lead Nurse for Neurosurgery to approve other expenditure; updated table B to include Zero Cost Model (ZCM) expenditure.	Oct 2017
16	Minor corrections and job title changes (Director of Nursing and Governance); over EU threshold tender limits updated in table B; consignment stock added to table B; authorisation limits for NHS Supply Chain weekly sales invoices added; details regarding travel for Executives added.	Oct 2018
17	Changes to job titles as follows: Director of Finance amended to Director of Finance & IT Director of Strategy and Operations now included Deputy Director of Governance duties now covered by Director of Nursing & Governance Inclusion of the Corporate Secretary title Removal of a section from the Code of Accountability Formatting amended to include numbered paragraphs throughout Approval of polies reserved to the Board as per national guidance. Specifically • approval of the Trust's *Freedom to Speak Up Policy*; • approval of the Trust's *Risk Management Strategy*; • approval of the Trust's *Health, Safety and Welfare Policy*; • approval of the Trust's *Major Incident Plan*; • approval of the Trust's *Learning from Deaths Policy*;	Oct 2019

	• approval of the Trust's *Fit and Proper Persons Policy*.	
18	Over EU threshold tender limits updated in table B Amend reference to NHS Protect to NHS Counter Fraud Authority	Oct 2020
19	Table B – Delegated Financial Limits – Updated following benchmarking exercise. Amend reference to NHS Improvement to reflect name change to NHS England/Improvement	Jan 2021
20	**Changes to job titles as follows:** Director of Finance and IT amended to Chief Financial Officer Deputy Director of Finance amended to Deputy Chief Financial Officer Director of Nursing and Governance amended to Chief Nurse Deputy Director of Nursing and Governance amended to Deputy Chief Nurse Director of Operations and Strategy amended to Chief Operating Officer Director of Workforce and Innovation amended to Chief People Officer Head of Procurement amended to Associate Director of Procurement Deputy Head of Procurement amended to Head of Procurement Deputy Director of Human Resources amended to Deputy Chief People Officer Head of Finance, Income and Contracting amended to Head of Financial Services, Income and Planning Deputy Director of Nursing and lead nurse for Neurosurgery amended to Divisional Nurse Director for Neurosurgery Table A section 36 Risk Management responsibility amended from Director of Nursing and Governance to Chief Operating Officer Table B section 6 EU threshold updated Table B section 9 updated for new consignment contracts to go to BPC and Board of Directors NHSI to NHSE/I Added Deputy CEO and CFO to requisition limit £25k - £35k	Oct 2021
21	Amend approval limits for Board for strategy and business plans (section 3.6) to previously agreed levels (£500k) Remove reference to Monitor requirements and replace with NHSE/I (monitoring of financial planning/ budgetary responsibility) Putting risk manager as having operational responsibility for developing systems for the management of risk (previously Deputy Chief Operating Officer) Amending EU threshold tender values to reflect latest limits **Changes to job titles as follows:** Financial Accountant to Head of Financial Services Head of IM&T to Chief Digital Information Officer Head of Financial Services, income and planning for Head of Income, costing, strategic and commercial planning	Oct 2022

1.0 INTRODUCTION

1.1 Background

1.1.1 This Scheme of Reservation and Delegation of Powers details administrative practice and procedure and records the delegations and reservations of powers and functions adopted by the Walton Centre NHS Foundation Trust (referred to as the "Trust"). They should be used in conjunction with the *Constitution* and the *Standing Financial Instructions* which have been adopted by the Trust. The Trust's *Constitution* and the *Foundation Trust Code of Governance* from Monitor/ NHS England/Improvement.

1.1.2 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 Foundation 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.

1.2 Role of the Chief Executive

1.2.1 All powers of the Foundation Trust which have not been retained as reserved by the Council of Governors, 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 (SoRD) identifying which functions they shall perform personally and which functions have been delegated to other directors and officers for operational responsibility.

1.2.2 All powers delegated by the Chief Executive can be re-assumed by them should the need arise.

2.3 Caution over the Use of Delegated Powers

2.31 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.

2.4 Absence of Directors or Officer to Whom Powers have been Delegated

2.4.1 In the absence of a director or officer to whom powers have been delegated, those powers shall be exercised by that director or officer's superior unless 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(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.

2.4.2 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 Deputy Chief Executive, 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.

3.0 RESERVATION OF POWERS TO THE BOARD OF DIRECTORS

3.1. Accountability

3.1.1 The Code of Accountability which has been adopted by the Trust requires the Board of Directors to determine those matters on which decisions are reserved unto itself. These reserved matters are set out in paragraphs 3.2 to 3.9 below:

3.2 General Enabling Provision

3.2.1 The Board of Directors may determine any matter it wishes in full session within its statutory powers and taking account of the Trust's Constitution and any guidance issued by NHS England/Improvement.

3.3 Regulations and Control

The Board of Directors remains accountable for all of its functions; even those delegated to individual committees, sub-committees, directors or officers and would therefore expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

The Board of Directors exercises this delegation of regulation and control by the:

a) approval of *Standing Orders for the Board of Directors* which form Annex 8 of the Trust's Constitution;

b) a schedule of matters reserved to the Board of Directors and *Standing Financial Instructions* (SFIs) for the regulation of its proceedings and business;

c) approval of a *Scheme of Reservation and Delegation of Powers* (SoRD) of powers from the Board of Directors to managers;

d) requirement to receive the declaration of directors' 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;

e) requirement to receive the declaration of interests from officers which may conflict with those of the Trust;

f) disciplining of Directors who are in breach of Statutory Requirements or the Trust's Constitution and governance documents;

g) adoption of the organisational structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications there to;

h) requirement to receive reports from committees including those which the Trust is required by the Secretary of State or other regulation to establish and to take appropriate action thereon;

i) confirmation of the recommendations of the Foundation Trust's committees

j) where the committees do not have executive powers;
    a. requirement to establish terms of reference and reporting arrangements of all committees;

k) ratification of any urgent decisions through use of emergency powers in accordance with paragraph 5.2 (Emergency Powers) of the *Standing Orders for the Board of Directors* as described in Annex 8 of the Trust's *Constitution*;

l) approval of arrangements relating to the discharge of the Trust's responsibilities

as a corporate Trustee for funds held on Trust by The Walton Centre Charity;

m) approval of arrangements for dealing with complaints;
n) approval of arrangements relating to the discharge of the Trust's responsibilities as a bailee for patients' property;
o) authorisation of use of the seal;
p) ratification or otherwise, instances of failure to comply with SOs brought to the Chief Executive's attention; and
q) approval and monitoring of the Foundation Trust's policies and procedures for the management of risk;
r) approval of the Trust's *Freedom to Speak Up Policy*;
s) approval of the Trust's *Health, Safety and Welfare Policy*;
t) approval of the Trust's *Major Incident Plan*;
u) with the Council of Governors, and in accorda*nce with the* Trust's *Constitution,* approve changes to the Trust's *Constitution*;
v) approval of the Trust's *Learning from Deaths Policy*;
w) approval of the Trust's *Fit and Proper Persons Policy*.

3.4 Appointments/Remuneration and Dismissals

3.4.1 The Board of Directors exercises this delegation of appointments by:

a) the appointment and dismissal of committees;
b) the appointment, appraisal, disciplining and dismissal of Executive Directors;
c) approval of proposals received from the Remuneration Committee regarding the remuneration of the Chief Executive, Executive Directors and senior employees.

3.4.2 In accordance with the Trust's *Constitution*, the Council of Governors will appoint the Chairman, the Non-Executive Directors and approve the appointment of the Chief Executive.

3.5 Policy determination

3.5.1 The Board of Directors exercises this delegation of policy determination by: (a) the approval of Trust management policies where not specifically delegated to Committee(s) to approve.

3.6 Strategy and Business Plans and Budgets

3.6.1 The Board of Directors exercises this delegation of strategy, business plans and budgets by:

a) defining the strategic aims and objectives of the Foundation Trust;
b) approval annually of the Foundation Trust's proposed business plan / service development strategy;
c) approval of the Trust's annual budget and long-term financial plans;

d) approval of Outline and Final Business Cases for capital investment for values greater than £500,000;
e) approval annually of the Foundation Trust's proposed business plan / service development strategy;
f) ratification of proposals for acquisition, disposal or change of use of land and/or buildings;
g) approval of PFI proposals;
h) approval of the creation of corporate bodies by the Trust;
i) approval of the participation in joint ventures and the creation of joint entities;
j) approval of proposals on individual contracts, including purchase orders (other than NHS contracts) of a capital level above £500,000 or revenue amounting to, or likely to amount to over £500,000 over the life of the contract;
k) approval of proposals in individual cases for the write-off of debt or making of special payments above the limits of delegation to the Chief Executive and Chief Financial Officer;
l) approval of proposals for action on litigation against or on behalf of the Foundation 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;
m) review of the use of NHS risk pooling schemes;
n) approval of the opening of bank accounts; and
o) approval of individual compensation payments.

3.8 Financial and Performance Reporting Arrangements

3.8.1 The Board of Directors exercises this delegation of financial and performance reporting arrangements by:

a) continuous appraisal of the affairs of the Foundation Trust through receipt of management reports and policy statements;

b) receiving reports from committees in respect of their exercise of powers delegated;

c) receive reports from Chief Financial Officer on financial performance against budget and business plan / service development strategy;

d) receive reports from the Chief Financial Officer on actual and forecast income from service level agreements and contracts.

e) receive and approve of the Foundation Trust's Annual Report and Annual Accounts prior to:
   - being laid before Parliament; and
   - presentation to the Council of Governors at the Annual Members Meeting.

f) the receipt and approval of a schedule of NHS contracts signed in accordance with arrangements approved by the Chief Executive;

g) the receipt and approval of the Annual Report(s) for funds held on Trust.

3.9 Audit Arrangements

3.9.1 The Board of Directors exercises this delegation of audit arrangements by:

a) approving audit arrangements (including arrangements for the separate audit of funds held on Trust) and to receive reports of the Audit Committee meetings and take appropriate action;
b) the receipt of the annual management letter received from the external auditor and agreement of action on the recommendation where appropriate of the Audit Committee;
c) the receipt of the Annual Internal Audit Report from the internal auditor and the agreement of action on the recommendation where appropriate of the Audit Committee.

d) The Board of Directors note, in accordance with the Trust's *Constitution*, that the Council of Governors is responsible for the appointment, re-appointment and removal of the External Auditor, advised by the Board of Directors' Audit Committee.

4.0 DELEGATION OF POWERS

4.1 Delegation to Committees

4.1.1 The Board of Directors may determine that certain of its powers shall be exercised by committees. The composition and terms of reference of such committees shall be that determined by the Board of Directors who shall also determine the committee's reporting requirements. Committees may not delegate executive powers to sub-committees.

4.2 Delegation to Officers
(From the Accounting Officer Memorandum for Foundation Trusts 2015)

4.2.1 **The general responsibilities of an NHS foundation trust accounting officer**

The Accounting Officer has responsibility for the overall organisation, management and staffing of the NHS Foundation Trust and for its procedures in financial and other matters. The Accounting Officer must ensure that:

- there is a high standard of financial management in the NHS Foundation Trust as a whole;
- financial systems and procedures promote the efficient and economical conduct of business and safeguard financial propriety and regularity throughout the NHS Foundation Trust; and
- financial considerations are fully taken into account in decisions on NHS Foundation Trust policy proposals.

4.2.2 **The specific responsibilities of an NHS Foundation Trust Accounting Officer**

The essence of the Accounting Officer's role is personal responsibility for:

- the propriety and regularity of the public finances for which he or she is answerable;
- the keeping of proper accounts;
- prudent and economical administration; and
- the avoidance of waste and extravagance; and the efficient and effective use of all the resources in their charge.

4.2.3. The Accounting Officer must:

- personally sign the accounts and, in doing so, accept personal responsibility for ensuring their proper form and content as prescribed by NHS England/ Improvement in accordance with the Act;
- comply with the financial requirements of the terms of authorisation;
- ensure that proper financial procedures are followed and that accounting records are maintained in a form suited to the requirements of management, as well as in the form prescribed for published accounts (so that they disclose with reasonably accuracy, at any time, the financial position of the NHS Foundation Trust);
- ensure that the resources for which they are responsible as Accounting Officer are properly and well managed and safeguarded, with independent and effective checks of cash balances in the hands of any official;
- ensure that assets for which they are responsible such as land, buildings or other property, including stores and equipment, are controlled and safeguarded with similar care, and with checks as appropriate; and
- ensure that conflicts of interest are avoided, whether in the proceedings of the Board of Directors, Board of Governors or in the actions or advice of the NHS Foundation Trust's staff and ensure that, in the consideration of policy proposals relating to the expenditure for which the Accounting Officer is responsible, all relevant financial considerations, including any issues of propriety, regularity or value for money, are taken into account, and brought to the attention of the Board of Directors.

4.2.4 The Accounting Officer should ensure that effective management systems are appropriate for the achievement of the NHS Foundation Trust's objectives, including financial monitoring and control systems have been put in place. An Accounting Officer should also ensure that managers at all levels:

- have a clear view of their objectives, and the means to assess and, wherever possible, measure outputs or performance in relation to those objectives;
- are assigned well-defined responsibilities for making the best use of resources (both those consumed by their own commands and any made available to organisations or individuals outside the NHS Foundation Trust), including a critical scrutiny of output and value for money; and

- have the information (particularly about costs), training and access to the expert advice which they need to exercise their responsibilities effectively.

4.2.5 Accounting Officers must make sure that their arrangements for delegation promotes good management and that they are supported by the necessary staff with an appropriate balance of skills. Arrangements for internal audit should accord with the objectives, standards and practices set out in NHS Internal Audit Standards.

4.3

Chairs Actions

There may be occasions when Chair's Action needs to be taken due to the nature or timing of business i.e. the Chair of the meeting can make a decision that would have normally been done within the relevant committee but due to timing, this has had to be done on an individual basis. All instances will be recorded at the subsequent associated meeting as a formal record.

TABLE A - DELEGATED AUTHORITY

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
1. Standing Orders (SOs) / Standing Financial Instructions (SFIs)		
a) Final authority in interpretation of SOs.	Chair	Chief Executive
b) Notifying Directors and employees of their responsibilities within the SOs and SFIs and ensuring that they understand the responsibilities.	Chief Executive	Deputy Chief Financial Officer and Budget Managers
c) Responsibility for security of the Foundation Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming with SOs, Standing Financial Instructions and financial procedures.	Chief Executive	All Directors and Employees
d) Suspension of SOs	Board of Directors	Board of Directors
e) Review suspension of SOs	Audit Committee	Audit Committee
f) Variation or amendment to SOs	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-Executive Directors	Chair and Chief Executive with two Non-Executive Directors
h) Disclosure of non-compliance with SOs to the Chief Executive (report to the Board of Directors).	All Staff	All Staff
i) Disclosure of non-compliance with SFIs to the Chief Financial Officer(report to the Audit Committee).	All Staff	All Staff
j) Advice on interpretation or application of SFIs and this Scheme of Delegation.	Chief Financial Officer	Deputy Chief Financial Officer

TABLE A – DELEGATED MATTERS

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
1. Audit Arrangements		
a) To make recommendations to the Council of Governors in respect of the appointment, re-appointment and removal of the External Auditor and to approve the remuneration in respect of the External Auditor.	Audit Committee (for recommendation to the Council of Governors for approval).	Chief Financial Officer
b) Monitor and review the effectiveness of the internal audit function.	Audit Committee	Director of Internal Audit / Chief Financial Officer
c) Review, appraise and report in accordance with international Internal Audit Standards and best practice.	Audit Committee	Director 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.	Audit Committee	Chief Financial Officer
f) Implement recommendations.	Chief Executive	Relevant Officers
2. Clinical Trials and Research Projects		
a) Authorisation of Clinical Trials and Research Projects.	Chief Executive	Research, Development and Innovation (RDI) Operations Group
b) Financial Management of Clinical Trials and Research Projects in accordance with all Trust financial policies and procedures.	Chief Financial Officer	Deputy Chief Financial Officer with Chief Operating Officer
3. Authorisation of New Drugs		
4. Bank / GBS Accounts / Cash		
a) **Operation** • Managing banking arrangements and operation of bank accounts (Board of Directors approves arrangements).	Chief Financial Officer	Head of Financial Services
• Opening bank accounts.	Chief Financial Officer	Deputy Chief Financial Officer
• Authorisation of transfers between the Foundation Trust's bank accounts.	Chief Financial Officer	In accordance with the bank mandate

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
• Approve and apply arrangements for the electronic transfer of funds.	Chief Financial Officer	To be completed in accordance with bank mandate / internal procedures.
• Authorisation of: – GBS schedules; – BACS schedules; – Automated cheque schedules; – Manual cheques.	Chief Financial Officer	To be completed in accordance with bank mandate / internal procedures.
b) **Investments** • Investment of surplus funds in accordance with the Foundation Trusts Treasury Management policy (based on NHSE/I requirements / guidance). • Preparation of investment procedures.	Chief Financial Officer	Head of Financial Services
c) **Petty Cash**	Chief Financial Officer	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 impact on business plans / service development strategy.	Chief Executive	Chief Financial Officer
• Preparation of Capital Investment Programme.	Chief Executive	Chief Financial Officer/ Chief Operating Officer
• Preparation of a business case.	Chief Financial Officer/ Chief Operating Officer	Relevant operational manager – Refer to Table B
• Financial monitoring and reporting on all capital scheme expenditure including variations to contract.	Chief Financial Officer	Deputy Chief Financial Officer
• Contracting: Selection of architects, quantity surveyors, consultant engineers and other professional advisors within the EU regulations and Trust tender procedures.	Chief Executive	Chief Financial Officer/ Chief Operating Officer with external advice as required
• Authorisation of capital requisitions.	Chief Executive	Refer to Table B Delegated Limits
• Responsible for the management of capital schemes and for ensuring that they are	Chief Executive	Chief Financial Officer/Chief

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
delivered on time and within cost.		Operating Officer.
• Ensure that capital investment is not undertaken without availability of resources to finance all revenue consequences.	Chief Executive	Chief Financial Officer/ Chief Operating Officer
• Issue procedures to support: (i) capital investment; (ii) staged payments.	Chief Financial Officer/ Chief Operating Officer	Deputy Chief Financial Officer
• Issue procedures governing financial management, including variation to contract, of capital investment projects and valuation for accounting purposes.	Chief Financial Officer	Deputy Chief Financial Officer
• 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	Chief Financial Officer
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	Chief Financial Officer
c) **Leases (property and equipment):**		
• Review of type of lease to determine whether an operating lease or finance lease implication on the Financial Sustainability Rating prior to being signed	Chief Financial Officer	Head of Financial Services
• Granting and termination of leases with Annual rent < £50k.	Chief Financial Officer	Head of Financial Services
• Granting and termination of leases with Annual rent of £50k - £100k.	Chief Executive	Chief Financial Officer
• Granting and termination of leases with Annual rent > £100k.	Board of Directors	Chief Executive
6. Clinical Audit	Chief Executive	Medical Director / Chief Nurse
7. Commercial Sponsorship		
Agreement to proposal.	Chief Executive	Chief Financial Officer with reference to the Standards of Business and

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
		Personal Conduct Policy
8. Complaints (Patients & Relatives)		
a) Overall responsibility for ensuring that all complaints are dealt with effectively.	Chief Executive	Chief Nurse
b) Responsibility for ensuring complaints relating to a division / department are investigated thoroughly.	Chief Executive	Chief Nurse
9. Confidential Information		
• Review of the Foundation Trust's compliance with the Caldicott report on protecting patients' confidentiality in the NHS; • Freedom of Information Act compliance code; • Data Security Arrangements.	Chief Executive Chief Executive Chief Executive	Medical Director Chief Financial Officer Chief Financial Officer
10. Data Protection Act		
Assurance of the Foundation Trust's Compliance.	Chief Executive	Chief Financial Officer
11. Declaration of Interest		
Maintaining a register of interests of the Board of Directors.	Chair	Corporate Secretary
To ensure Senior Managers / Senior Clinicians / Department Heads / all Senior Staff have declared relevant and material interest.	Chief Executive	Chief Financial Officer
12. Disposal and Condemnations		
• Items obsolete, redundant, irreparable or cannot be repaired cost effectively. • Develop arrangements for the sale of assets.	Chief Financial Officer Chief Financial Officer	Head of Department in accordance with agreed policy Deputy Chief Financial Officer
13. Environmental Regulations		
Review of compliance with environmental regulations, for example those relating to clean air and waste disposal.	Chief Executive	Chief Operating Officer
14. External Borrowing		

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
a) Advise Trust Board of the requirements to repay / draw down Public Dividend Capital.	Chief Financial Officer	Deputy Chief Financial Officer
b) Approve a list of employees authorised to make short term borrowings on behalf of the Foundation Trust.	Board of Directors	In accordance with relevant mandate
c) Application for draw down of Public Dividend Capital, overdrafts and other forms of external borrowing.	Chief Executive	Chief Financial Officer
d) Preparation of procedural instructions concerning applications for loans and overdrafts.	Chief Financial Officer	Head of Financial Services
15. Financial Planning / Budgetary Responsibility		
a) **Setting:**		
• Submit budgets to the Trust Board	Chief Executive	Chief Financial Officer
• Submit to Board financial estimates and forecasts	Chief Executive	Chief Financial Officer
• Compile and submit to the Board operational and strategic plans which take into account financial targets, forecast limits and available resources.	Chief Executive	Chief Operating Officer
b) **Monitoring:**		
• Devise and maintain systems of budgetary control.	Chief Financial Officer	Deputy Chief Financial Officer
• Monitor performance against budget.	Chief Financial Officer	Divisional Accountant / Budget Holders
• Delegate budgets to budget holders	Chief Executive	Chief Financial Officer
• Ensuring adequate training is delivered to budget holders to facilitate their management of the allocated budget.	Chief Financial Officer	Deputy Chief Financial Officer
• Submit in accordance with the NSHE/I ~~Monitor's~~ requirements for financial monitoring returns.	Chief Executive	Chief Financial Officer
• Identify and implement cost improvements and income generation activities in line with the Business Plan.	Chief Executive	Executive Team/Divisional Management Teams

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
Preparation of: • Annual Accounts • Annual Reports	Chief Financial Officer Chief Executive	Deputy Chief Financial Officer Corporate Secretary
c) Budget Responsibilities: Ensure that: • no overspend or reduction of income (that cannot be met from virement) should be incurred without authorisation from the Divisional Manager or lead Executive in the case of corporate budgets. All overspending budgets or unfavourable variances are reported to the Board on a monthly basis. • 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.	Chief Financial Officer	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 / Chief Financial Officer	Refer to Table B Delegated Limits
16. Financial Procedures and Systems		
a) Maintenance and update on Foundation Trust Financial Procedures	Chief Financial Officer	Deputy Chief Financial Officer
b) Responsibilities:- • Implement Foundation Trust's financial policies and co-ordinate corrective action; • Ensure that adequate records are maintained to explain Foundation 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; and • Designing and maintaining compliance with all financial systems.	Chief Financial Officer	Deputy Chief Financial Officer
17. Fire Precautions		

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
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	Chief Operating Officer
18. Fixed Assets		
a) Maintenance of asset register including asset identification and monitoring	Chief Executive	Chief Financial Officer
b) Ensuring arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with current accounting requirements.	Chief Financial Officer	Deputy Chief Financial Officer
c) Responsibility for security of Foundation Trust's assets including notifying discrepancies to the Chief Financial Officer and reporting losses in accordance with Foundation Trust's procedures.	Chief Executive	All Staff
19. Fraud (See also 25,35)		
a) Monitor and ensure compliance with Secretary of State Directions on fraud and corruption including the appointment of the Local Counter Fraud Specialist.	Chief Executive	Local Counter Fraud Specialist
b) Notify NHS Counter Fraud Authority and External Audit of all suspected Frauds.	Chief Financial Officer	Local Counter Fraud Specialist
20. Health and Safety		
Review of all statutory compliance with legislation and Health and Safety requirements.	Chief Executive	Chief Operating Officer
21. Hospitality / Gifts		
Keeping of hospitality register.	Chief Executive	Corporate Secretary
22. Infectious Diseases & Notifiable Outbreaks		
	Chief Executive	Chief Nurse
23. Information Management & Technology		
Financial Systems • Developing financial systems in accordance with the Foundation Trust's IM&T strategy; • Implementing new systems and ensure they are developed in a controlled manner and thoroughly tested; • Seeking third party assurances regarding financial systems operated externally; and • Ensure that contracts for computer services for financial applications define responsibility for:	Chief Financial Officer	Deputy Chief Financial Officer

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
security; privacy; accuracy; completeness and timeliness of data during processing and storage.		
IT Systems • Developing IT systems in accordance with the Foundation Trust's IM&T Strategy and Trust objectives; • Implementing new systems and ensure they are developed in a controlled manner and thoroughly tested; • Seeking third party assurances regarding IT systems operated externally; • Ensure that contracts for computer services for IT applications define responsibility re security, privacy, accuracy, completeness and timeliness of data during processing and storage; • Ensure that risks to the Trust from use of IT are identified and considered and that disaster recovery plans are in place.	Chief People Officer	Chief Digital Information Officer
24. Legal Proceedings		
• Engagement of Foundation Trust's Solicitors / Legal Advisors • Approve and sign all documents which will be necessary in legal proceedings i.e. executed as a deed; • Sign on behalf of the Foundation Trust any agreement or document not requested to be executive as a deed.	Chief Executive Chief Executive Chief Executive	All Executive and Corporate Directors Chief Financial Officer Chief Financial Officer
25. Losses, Write-off & Compensation		
a) Prepare procedures for recording and accounting for losses and special payments including preparation of a Fraud Response Plan and informing NHS Counter Fraud Authority of fraud / alleged fraud. **Losses:** – Losses of cash due to theft, fraud, overpayment & others; – Fruitless payments (including abandoned Capital Schemes); – Bad debts and claims abandoned; and – Damage to buildings, fittings, furniture and equipment and loss of equipment and property in stores and in use due to culpable causes (e.g.	Chief Executive	Chief Financial Officer Refer to Table B Delegated Limits

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
fraud, theft, arson).		
b) Reviewing appropriate requirement for insurance claims.	Chief Financial Officer	Deputy Chief Financial Officer
c) A register of all of the payments should be maintained by the Finance Department and made available for inspection / audit.	Chief Financial Officer	Deputy Chief Financial Officer / Head of Financial Services ~~Financial Accountant~~
d) A report of all of the above payments should be presented to the Audit Committee on an annual basis.	Chief Financial Officer	Deputy Chief Financial Officer/ Head of Financial Services ~~Financial Accountant~~
Special Payments: Compensation payments by Court order **Exgratia Payments:** • To patients/staff for loss of personal effects; • For clinical negligence after legal advice; • For personal injury after legal Advice; • Other clinical negligence and personal injury; • Other ex-gratia payments.	Chief Executive Chief Executive	Refer to Table B Delegated Limits Refer to Table B Delegated Limits
Write-offs: • Write-off of Debtors. • Report all bad debt write-offs to the Audit Committee at least annually	Chief Executive	Deputy Chief Financial Officer(Refer to Table B Delegated Limits)
26. Meetings		
a) Calling meetings of the Foundation Trust Board.	Chair	Corporate Secretary
b) Chair all Foundation Trust Board meetings and associated responsibilities.	Chair	Chair
27. Medical		
• Clinical Governance arrangements	Medical Director / Chief Nurse	Chief Nurse
• Medical Leadership	Medical Director	Medical Director / Divisional Clinical Directors
• Programmes of medical education	Medical Director	Director of Medical Education
• Medical staffing plans	Medical Director	Divisional Clinical Directors /

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
		Divisional General Managers
• Medical Research	Medical Director	Clinical Director of Research /
28. 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	Chief Financial Officer
b) Obtain the best value for money when requisitioning goods / services	Chief Executive	Associate Director of Procurement
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	Chief Financial Officer
d) Develop systems for the payment of accounts.	Chief Financial Officer	Deputy Chief Financial Officer
e) Prompt payment of accounts.	Chief Financial Officer	Head of Financial Services ~~Financial Accountant~~
f) Financial Limits for ordering / requisitioning goods and services	Chief Financial Officer	Refer to Table B Delegated Limits
g) Approve prepayment arrangements	Chief Financial Officer	Head of Financial Services ~~Financial Accountant~~
h) Financial limits for authorising internal credit notes	Chief Financial Officer	Refer to Table B Delegated Limits
i) Financial limits for authorising NHS Supply Chain weekly sales invoices	Chief Financial Officer	Refer to Table B Delegated Limits
29. Nursing		
• Compliance with statutory and regulatory arrangements relating to professional nursing practice.	Chief Nurse	Deputy Chief Nurse
• Matters involving individual professional competence of nursing staff.	Chief Nurse	Deputy Chief Nurse
• Compliance with professional training and development of nursing staff.	Chief Nurse	Deputy Chief Nurse
• Quality assessment of nursing processes.	Chief Nurse	Deputy Chief Nurse
30. Patient Services Agreements		
a) Negotiation of Foundation Trust Contract and Non-Commercial Contracts.	Chief Executive	Chief Financial Officer

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
b) Quantifying and monitoring non-contract activity.	Chief Financial Officer	Deputy Chief Financial Officer / Head of Income, costing, strategic and commercial planning ~~Head of Financial Services, Income and Planning~~
c) Reporting actual and forecast income.	Chief Financial Officer	Deputy Chief Financial Officer / Head of Income, costing, strategic and commercial planning ~~Head of Financial Services, Income and Planning~~
d) Costing Foundation Trust Contract and Non-Commercial Contracts.	Chief Financial Officer	Deputy Chief Financial Officer / Head of Income, costing, strategic and commercial planning ~~Head of Financial Services, Income and Planning~~
e) Reference costing / Payment by Results. • Production of annual reference costs in accordance with national guidance and best practice.	Chief Financial Officer	Deputy Chief Financial Officer / Head of Income, costing, strategic and commercial planning ~~Head of Financial Management.~~
f) Ad hoc costing relating to changes in activity, developments, business cases and bids for funding.	Chief Financial Officer	Senior Finance Team Members
31. Patients' Property		
a) Ensuring patients and guardians are informed about patients' monies and property procedures on admission.	Chief Financial Officer	Ward Managers
b) Prepare detailed written instructions for the administration of patients' property.	Chief Financial Officer	Deputy Chief Financial Officer / Divisional Nurse Director for Neurosurgery
c) Informing staff of their duties in respect of patients' property.	Chief Financial Officer	Divisional General Manager /

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
		Department Manager / Clinical Managers / Ward Manager
d) Issuing property of deceased patients • <£4,999 in accordance with agreed Foundation Trust policies; • >£5,000 only on production of a probate letter of administration.	Chief Financial Officer Chief Financial Officer	Head of Financial Services ~~Financial Accountant~~ Head of Financial Services ~~Financial Accountant~~
32. Personnel & Pay		
a) Nomination of officers to enter into contracts of employment regarding staff, agency staff or consultancy service contracts.	Chief Executive	Chief People Officer
b) Develop Human Resource policies and strategies for approval by the Board including training, industrial relations.	Chief People Officer	Deputy Chief People Officer
c) Authority to fill funded post on the establishment with permanent staff.	Chief People Officer	Budget Managers and Divisional Accountants
d) The granting of additional increments to staff within budget.	Chief People Officer	Budget Managers and Deputy Chief Financial Officer
e) The granting of additional increments to staff outside of budget limits.	Chief Executive	Budget Managers and Divisional Accountants with Executive Team Approval
f) All requests for re-grading shall be dealt with in accordance with Foundation Trust Procedure	Chief People Officer	Deputy Chief People Officer
g) Establishments • Additional staff to the agreed establishment with specifically allocated finance; • Additional staff to the agreed establishment without specifically allocated finance. • Self-financing changes to an establishment	 Chief Financial Officer Chief Executive Chief Financial Officer	 Budget Managers and Divisional Accountants with Executive Team Approval Budget Managers and Divisional Accountants with Executive Team Approval Budget Managers / Divisional Accountant
h) Pay		

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
• Presentation of proposals to the Foundation Trust Board for the setting of remuneration and conditions of service for those staff not covered by the Remuneration Committee.	Chief Executive	Chief People Officer
• Authority to complete standing data forms effecting pay, new starters, variations and leavers	Chief People Officer	Budget Managers
• Authority to complete and authorise Staff Variation Lists (SVLS) • Authority to authorise overtime • Authority to authorise travel and subsistence expenses • Authority to authorise travel orders for Executives	Chief Financial Officer Chief People Officer/ Chief Financial Officer Chief Financial Officer Chief Executive/ Chief Financial Officer/ Deputy Chief Financial Officer	Budget Managers or authorised deputy Budget Managers Budget Managers Personal Assistants
i) Leave *(note entitlement may be taken in hours)*	Chief People Officer	Refer to Annual Leave Policy / Divisional Manager / Head of Department
<u>Annual Leave</u> • Approval of annual leave	Chief People Officer	Line / Departmental Manager (as per departmental procedure)
• Annual leave – approval of carry forward (up to maximum of 5 days)	Chief People Officer	Line/Departmental Manager
• Annual leave – approval of carry forward over 5 days (to occur in exceptional circumstances only).	Chief People Officer	Clinical Directors / Departmental Manager / Department Heads
<u>Special Leave (paid and unpaid)</u> For example • Parental Leave ▪ Leave for Family Emergencies ▪ Bereavement Leave ▪ IVF and other fertility treatments ▪ Domestic Emergencies ▪ Participation in Elections ▪ Public Duties ▪ Jury Service	Chief People Officer	Departmental Manager / Head of Service / Clinical Managers

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
▪ Appearance as a Witness/Expert Witness ▪ Special Forces ▪ Additional Professional Duties ▪ Participation in Sporting Events ▪ Adverse Weather Conditions ▪ Travel Delays following Annual Leave ▪ Time off for Job Interviews To be applied in accordance with Foundation Trust Policy.		
• Leave without pay.	Chief People Officer	Clinical Director / Directorate
• Medical Staff Leave of Absence – paid and unpaid.	Chief People Officer	Clinical Director with advice from the Medical Director
• Time off in lieu.	Chief People Officer	Line / Departmental Manager
• Maternity Leave - paid and unpaid.	Chief People Officer	Automatic approval with guidance
<u>Sick Leave</u> j) Extension of sick leave and pay.	Chief People Officer	Clinical Director / Directorate Manager / Department Heads in conjunction with the Chief People Officer
ii) Return to work part-time on full pay to assist recovery.	Chief People Officer	Clinical Director / Directorate Manager / Department Heads in conjunction with the Chief People Officer
<u>Study Leave</u> • Study leave outside the UK.	Chief Executive	Relevant Executive Director
• Medical staff study leave (UK) – Consultant / Non-Career Guide – Career Guide	 Medical Director Medical Director	 Medical Director / Clinical Directors Post Graduate Tutor

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
• All other study leave (UK)	Chief People Officer	Budget Manager (in budget) and Training and Development Manager
k) Grievance Procedure All grievances cases must be dealt with strictly in accordance with the Grievance Procedure and the advice of the Chief People Officer must be sought when the grievance reaches the level of Divisional General Managers / Heads of Department.	Chief People Officer	Departmental Manager / Line Manager / Appeals Committee
l) Authorised – Car Users • Regular users allowance.	Chief Financial Officer	To be applied as per Trust Policy
m) Mobile Phone Users / Blackberry's / iPad's/laptops	Chief Financial Officer	To be applied as per local Trust policy
n) Renewal of Fixed Term Contract.	Chief People Officer	Budget Holder / Finance Approval plus relevant Executive Director
o) Redundancy.	Chief Executive	Chief People Officer/ Chief Financial Officer
p) Ill Health Retirement Decision to pursue retirement on the grounds of ill-health following advice from the Occupational Health Department.	Chief People Officer	Deputy Chief People Officer
q) Early retirement.	Chief Executive	Chief People Officer/ Chief Financial Officer
r) Disciplinary Procedure (excluding Executive Directors).	Chief People Officer	To be applied in accordance with the Foundation Trust's Disciplinary Procedure
s) 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.	Chief People Officer	Deputy Chief People Officer
t) Engagement of staff not on the establishment: • Authorisation of bank staff and temporary nursing staff, including agency	Chief Nurse	Refer to Table B In Hours – Budget Manager Out of Hours – On Call Manager

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
• Management Consultants and Other	Executive Team	(silver) Budget Manager Refer to Table B Delegated Limits
33. Quotation, Tendering & Contract Procedures		
a) Services:		
• Best value for money is demonstrated for all services provided under contract or in-house;	Chief Executive	Chief Financial Officer/ Deputy Chief Financial Officer/ Associate Director of Procurement
• Nominate officers to oversee and manage the contract on behalf of the Foundation Trust.	Chief Executive	Chief Financial Officer/ Deputy Chief Financial Officer/ Associate Director of Procurement / Divisional Director / Head of Department
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	Associate Director of Procurement
• Receipt and custody of tenders prior to opening	Chief Executive	Associate Director of Procurement
• Opening Tenders	Chief Executive	Corporate Secretary
• Decide if late tenders should be considered	Chief Executive	Associate Director of Procurement
• Ensure that appropriate checks are carried out as to the technical and financial capability of the firms invited to tender or quote.	Chief Executive	Associate Director of Procurement

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
c) Quotations / Authorisation Limits:	Chief Executive	Refer to Table B Delegated Limits
d) Waiving the requirement to request: • Tenders; • Quotes.	Chief Executive	Chief Financial Officer Refer to Table B Delegated Limits
34. Records		
a) Review Foundation Trust's compliance with the Records Management Code of Practice.	Chief Executive	Chief Nurse
b) Ensuring the form and adequacy of the financial records of all departments.	Chief Financial Officer	Deputy Chief Financial Officer
35. 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	Senior Manager On-Call Directorate Manager / Department Heads / Security with reference to Chief Operating Officer
b) Where a fraud is suspected (reporting to NHS Counter Fraud Authority).	Chief Financial Officer	Local Counter Fraud Specialist
c) Deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption.	Chief Financial Officer	Executive Director / Senior Manager On Call (silver)
36. Risk Management		
• Ensuring the Foundation Trust has a Risk Management Strategy and a programme of risk management.	Chief Executive	Chief Operating Officer
• Developing systems for the management of risk.	Chief Operating Officer	Risk Manager
• Developing incident and accident reporting systems • Compliance with the reporting of incidents and accidents	Chief Nurse	Deputy Chief Nurse All Staff
37. Seal		
a) The keeping of a register of seal and safekeeping of the seal	Chief Executive	Corporate Secretary
b) Attestation of seal in accordance with SOs	Chair / Chief Executive	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

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
		nominated Director
38. Security Management		
a) Monitor and ensure compliance with Clause 43 and Schedule 13 of the standard NHS contract (which mirror Secretary of State Directions) on fraud and corruption including the appointment of the Local Counter Fraud Specialist.	Chief Executive	Chief Financial Officer
39. Setting of Fees and Charges (Income)		
a) Private Patient, Overseas Visitors, Income Generation and other patient related services.	Chief Financial Officer	Head of Income, costing, strategic and commercial planning ~~Head of Financial Services, Income and Planning~~
b) Non-patient care income	Chief Financial Officer	Head of Income, costing, strategic and commercial planning ~~Head of Financial Services, Income and Planning~~
c) Information to the Board of Directors of monies due to the Foundation Trust	Chief Financial Officer	Head of Income, costing, strategic and commercial planning ~~Head of Financial Services, Income and Planning~~
d) Recovery of debt	Chief Financial Officer	Head of Financial Services ~~Financial Accountant~~
e) Security of cash and other negotiable instruments	Chief Financial Officer	Head of Financial Services ~~Financial Accountant~~
f) Financial limits for authorising credit notes	Chief Financial Officer	Refer to Table B Delegated Limits
40. Stores and Receipt of Goods		
a) Responsibility for systems of control over stores and receipt of goods, issues and returns	Chief Financial Officer	Associate Director of Procurement
b) Stocktaking arrangements	Chief Financial Officer	Heads of Departments and Divisional

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
		Accountants
c) Responsibility for controls of pharmaceutical stock.	Designated Pharmaceutical officer	Under SLA – senior designated Pharmaceutical Officer
41. Medicines Inspectorate Regulations		
Review Regulations.	Chief Executive	Medical Director (with operational support from Divisional General Manager) and contractor under SLA
42. Consignment Stock		
Responsibility for approving consignment stock agreements.	Chief Executive/ Chief Financial Officer/ Deputy Chief Financial Officer	Associate Director of Procurement/ Head of Procurement

TABLE B – DELEGATED FINANCIAL LIMITS

Unless otherwise stated, all thresholds are inclusive of VAT irrespective of recovery arrangements.

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 Executives thresholds.

Financial Limits (subject to funding available in budget)		
	Value	**Delegated to:-**
1. GIFTS AND HOSPITALITY		
Any gifts or hospitality or offers of gifts or hospitality which exceed the £50 threshold must be declared.	£50	Chief Financial Officer in line with hospitality policy.
2. LITIGATION CLAIMS		
Payments made on advice of NHS Resolution, insurance company.	<excess on policy	Chief Financial Officer/ Chief Nurse - Report to Audit Committee
Payments made on advice of legal advisor	>excess	Chief Financial Officer/ Chief Nurse - Report to Board of Directors
Decision to contest/initiate other litigation claims	>£10k or contentious case <£10k and not contentious	Board of Directors Chief Financial Officer
3. LOSSES AND SPECIAL PAYMENTS – Reported to Audit Committee		
<u>Losses</u> Fruitless payments (including abandoned capital schemes)	>£10,000 <£10,000 <£5,000	Chief Executive (reported to audit committee) Chief Executive Chief Financial Officer
<u>Other Losses</u> Losses of cash due to theft, fraud, overpayment and others	>£10,000 <£10,000 <£5,000	Chief Executive (reported to the Board of Directors) Chief Executive Chief Financial Officer
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 etc.).	> £10,000 <£10,000	Chief Executive Chief Financial Officer
Exgratia Payments	>£10,000 £5,000 to £10,000	Chief Executive (reported to the Board of Directors) Chief Executive

Financial Limits (subject to funding available in budget)		
	<£5,000	Chief Financial Officer
Write-offs, Bad debts and claims abandoned. Private patients, overseas visitors & other.	>£50,000 <£50,000 <£1,000	Board of Directors Chief Executive/ Chief Financial Officer (reported to the Board of Directors) Deputy Chief Financial Officer
Compensation Payments		Deputy Chief Financial Officer in accordance with NHS Resolution/ legal advice
4. PETTY CASH DISBURSEMENTS (authority to pay)		
Small incidental items of expenditure.	< £100	Budget Holder / Financial Accountant
5. REQUISITIONING GOODS AND SERVICES AND APPROVING PAYMENTS		
5.1 Agency Staff: Any individual booking of agency staff, including medical locums, subject to NHSE/I guidelines	>£100,000 <£100,000 <£10,000 <£5,000	Board of Directors Chief Executive Executive Directors Divisional General Managers / Senior Manager On Call / Deputy Chief People Officer/ Medical Staffing Manager *No other managers can authorise the use of agency staff*
5.2 Removal Expenses	<£8,000	Chief People Officer/ Chief Financial Officer
5.3 All Other Expenditure All pay and non-pay expenditure including software and IT equipment, maintenance contracts, goods and services contracts, management consultants and call off orders. The limit is the total value over the life of the contract. (Please see below for NHS Supply Chain weekly sales invoices).	All figures excl, VAT >£500k £150k - £500k £100k-£150k £60,000 to £100k £35k to £60k	 Board of Directors Business Performance Committee Chief Executive (EMT) Chief Financial Officer Other Executive Directors

Financial Limits (subject to funding available in budget)		
	£25k to £35k <£25k <£5k	Deputy Chief Financial Officer Divisional Directors/Deputy Chief Nursing Officer Other Managers
5.4 NHS Supply Chain Expenditure Authorisation of weekly sales invoices	>£25,000 (excl VAT) <£25,000 (excl VAT)	Associate Director of Procurement Head of Procurement
5.5 Zero Cost Model Expenditure	£0	Chief Financial Officer/ Deputy Chief Financial Officer/Associate Director of Procurement
5.6 Capital Expenditure • General • Strategic Investment Plan	>£500k £150k-£500k £50k-£150k <£50k	Board of Directors Business performance Committee EMT Capital Management Group
6. QUOTATIONS AND TENDERS		
Obtain competitive price for goods/services	<£9,999 (Inc. VAT)	Budget Managers in conjunction with Procurement Team
Quotations: Obtain a minimum of 3 written competitive quotations for goods/services.	£10,000 to £49,999 (Inc. VAT)	Budget Manager in conjunction with Procurement Team To note that regular reviews of cumulative expenditure for individual suppliers (on the same project) will be undertaken to ensure that SoRD limits are adhered to.
Under Threshold Tenders: Undertake a competitive tendering exercise for goods/services. Over EU Threshold Tenders: Undertake a competitive tendering exercise for goods/services.	>£50,000 (Inc. VAT) (Local tendering procedures) £138,760 (incl. VAT) ~~£122,976 (excl VAT)~~ Goods/Services Contracts £5,336,937 (incl. VAT) ~~£4,733,252 (excl VAT)~~ Works Contracts £663,540 (incl. VAT) Social & other specific	Associate Director of Procurement evaluated by a member of the procurement team and at least three stakeholders from the evaluation panel

Financial Limits (subject to funding available in budget)		
	services (Light Touch)	
7. VIREMENT		**Conditions:-**
Chief Executive Chief Financial OfficerBudget Holder and Deputy Chief Financial Officer	 >£50,000 p.a. < £50,000 p.a. <£25,000 p.a.	Trust must still meet Financial Targets Total Trust budget remains underspent Chief Executive Chief Financial Officer Budget Holder & Deputy Chief Financial Officer
8. CREDIT NOTES		
Authorisation of credit notes, including internal credit notes used to adjust expenditure	>£25,000 (excl VAT) <£25,000 (excl VAT)	Chief Financial Officer Deputy Chief Financial Officer
9. CONSIGNMENT STOCK		
Responsibility for approving consignment stock agreements. Associate Director of Procurement/ Head of Procurement to review terms and conditions prior to financial approval. Any existing contracts that increase in value to the next threshold need relevant approval	 >£500k (new consignment contracts) £150k-£500k(new consignment contracts) £100k- £150k £60k -£100k £35k-£60k £25k - £35k <£25k	All figures excl.VAT Board of Directors Business & Performance Committee Chief Executive (EMT) Chief Financial Officer Other Executive Directors Deputy Chief Financial Officer Divisional Directors/Deputy Chief Nurse

The Walton Centre NHS Foundation Trust

Report to Trust Board
3 November 2022

Report Title	**Modern Slavery Act Statement 2022**
Executive Lead	Mike Gibney, Chief People Officer
Author (s)	Mike Gibney, Chief People Officer Katie Tootill, Associate Director of Procurement
Action Required	To approve

Level of Assurance Provided

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

Key Messages

- The updated statement meets the requirement of the Modern Slavery Act 2015.
- Consideration at Board and the subsequent publishing online, will constitute full compliance with the Trust's duties.

Next Steps

- Following Board approval statement to be published online.

Related Trust Strategic Ambitions and Themes	**Impact**		
All Applicable	Not Applicable	Not Applicable	Not Applicable

Strategic Risks

Not Applicable	Choose an item.	Choose an item.

Equality Impact Assessment Completed

Strategy ☐	Policy ☐	Service Change ☐

Report Development

Committee/ Group Name	**Date**	**Lead Officer (name and title)**	**Brief Summary of issues raised and actions agreed**
n/a			

Modern Slavery Act Statement 2022

Executive Summary

1. This statement constitutes the Walton Centre's annual response to the requirements of the Modern Slavery Act 2015. The Trust is required to publish the statement online in accordance with the public sector duties under this Act.

2. There has only been one slight addition to the statement in relation to procurement arrangements to include framework Terms & Conditions.

Modern Slavery Statement November 2022

3. **The Walton Centre's Response to the Requirements of the Modern Slavery Act 2015**

This Act was brought about to make provision about slavery, servitude and forced or compulsory labour and about human trafficking; including provision for the protection of victims; to make provision for an Independent Anti-Slavery Commissioner; and for connected purposes.

Slavery is not an issue confined to history or an issue that only exists in certain countries – it is something that is still happening today. It is a global problem and the UK is no exception.

Modern slavery is part of the safeguarding agenda for children and adults.

All staff at the Walton Centre, be they in clinical or non-clinical roles, have a responsibility to consider issues regarding modern slavery, and incorporate their understanding of these issues into their day to day practice. Front line NHS staff are well placed to be able to identify and report any concerns they may have about individual patients who present for treatment.

Modern slavery is a real issue.

It is also a serious concern for public services.

As a Trust we are committed to working in partnership with local authorities to identify cases of modern day slavery and to intervene to protect vulnerable adults and children when they are identified.

Who is affected?

Victims found in the United Kingdom come from many different countries, including Romania, Albania, Nigeria, Vietnam and the United Kingdom itself.

Social and economic deprivation, limited opportunities at home, lack of education, unstable social and political conditions, economic imbalances and war are some of the key drivers that contribute to the trafficking of victims.

Victims can also face more than one type of abuse and slavery, for example if they are sold to another trafficker and then forced into another form of exploitation.

The Walton Centre is committed to ensuring that no modern slavery or human trafficking takes place in any part of our business or our supply chain and has taken steps to ensure that all staff are aware of the issue of Modern Slavery and what they can do to prevent it by

including information in the Safeguarding Adult and Children Policies. Any concerns are raised with the Safeguarding Matron who will escalate accordingly.

Modern Slavery

Starting in 1 November 2015, specified public authorities have been given a duty to notify the Home Office of any individual encountered in England and Wales who they believe is a suspected victim of slavery or human trafficking.

The 'duty to notify' provision is set out in the Modern Slavery Act 2015 and applies to all police forces and local authorities in England and Wales, the Gang masters Licensing Authority and the National Crime Agency.

Procurement arrangements:

Contracts established by The Walton Centre use the NHS Terms and Conditions for Supply of Goods or framework terms and conditions, which contains Anti-Slavery clauses that require providers/contractors to comply with Law and Guidance, use Industry Good Practice and to notify the authorities if they become aware of any actual or suspected incident of slavery or human trafficking. The Walton Centre Procurement team issued Modern Slavery Act 2015 compliance letters to our supply chain and keeps a database of responses. Also, the Trust's purchase orders to suppliers now set out the Trusts expectations in terms of compliance with the Act.

In addition to the above The Walton Centre will investigate any concern raised with the service. This could be by national or local media publicity, through supply chain contacts or by individuals.

Employment arrangements: As an NHS Employer we are required to comply with the NHS employment check standard for all directly recruited staff.

The six checks which make up the NHS Employment Check Standards are:

- Verification of identity checks
- Right to work checks
- Professional registration and qualification checks
- Employment history and reference checks
- Criminal record checks
- Occupational health checks

No individual is permitted to commence employment with the Trust without these checks having been completed. The checks are carried out centrally by the recruitment team and recorded on the Trust workforce information system (ESR). These measures ensure that the Trust does not unwittingly employ people subjected to modern slavery.

If staff have concerns about the supply chain or any other suspicions related to modern slavery they will be encouraged to raise these concerns through line management and report the issues to appropriate agencies. This will be raised particularly with clinical staff that may be in contact with vulnerable people.

Conclusion

4. The updated statement meets the requirement of the Modern Slavery Act 2015. Consideration at Board and the subsequent publishing online, will constitute full compliance with the Trust's duties.

Recommendation

5. Board is requested to approve the Modern Slavery Act Statement.

Author: Mike Gibney & Katie Tootill
Date: 26 October 2022

The Walton Centre NHS Foundation Trust

Report to Trust Board
3rd November 2022

Report Title	Estates Consolidated Report
Executive Lead	Lindsey Vlasman, Chief Operating Officer
Author (s)	Stephen Holland, Head of Estates
Action Required	To note

Level of Assurance Provided

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

Key Messages

- Information relating to Estates Returns Information Collection (ERIC), Premises Assurance Model (PAM), Six-Facet Survey and NHS Model Health System detailed
- Appendices added providing relevant, up-to-date, supporting evidence

Next Steps

Related Trust Strategic Ambitions and Themes	**Impact**		
All Applicable	Compliance	Finance	Estates & Facilities

Strategic Risks

004 Operational Performance	007 Capital Investment	003 System Finance

Equality Impact Assessment Completed

Strategy ✓	Policy ☐	Service Change ☐

Report Development

Committee/ Group Name	**Date**	**Lead Officer (name and title)**	**Brief Summary of issues raised and actions agreed**
Business Performance Committee	25th October 2022	Stephen Holland, Head of Estates	

Estates Consolidated Report

Executive Summary

1. The purpose of this report is to inform the reader of the use of the various data reporting and analytical tools used to measure the estate (hard, soft and other), ERIC, PAM, Six-Facet and Model Health System.

2. The report also offers evidence, via the appendices, of the various systems both submitted and/or updated

Analysis

3. Estates Returns Information Collection (ERIC)

4. The Trust must submit ERIC return data on an annual basis which covers areas which covers and array of items, including, finance, floor areas, backlog maintenance, energy, water, waste, food, linen, cleanliness and portering.

5. The data can be used to cross reference against both, other, similar, NHS Trusts and also against national indices, e.g. upper and lower quartile data.

6. Due to the specialist nature of the Trust, some of the collated data shows as being above median and, in some cases, in the upper quartile.

7. Due to regular inaccuracies and subjectivity within the various data submissions, it is often difficult to undertaken exact comparisons. The most obvious quantitative comparisons are with other, local, specialist Trusts. However, this data needs to be read in the knowledge that, other Trust's estates (size and age) will not offer a direct comparison to that within The Walton Centre.

8. Appendix 1 shows a comparative spreadsheet showing the Walton Centre data against the region's other specialist Trusts.

9. Appendix 2 shows the Walton Centre data against lower, median and upper quartile data for all specialist Trusts nationally.

10. Premises Assurance Model (PAM)

11. Until recently, PAM was an optional tool. However, in 2021, it became compulsory that all Trusts must complete the software on an annual basis. PAM focuses on more strategic items, such as, policies, strategies, regulations and technology in order to demonstrate a safe, high quality and efficient estate.

12. It is a multi-disciplinary tool designed to give assurance to the Trust and covers; safety (both hard and soft FM), patient experience, efficiency, effectiveness and organisational governance.

13. The data submission from The Walton Centre offers assurance that the majority of the subjects are either outstanding or good, however, there are areas identified, that required improvement. These are largely around the need for additional policies and training. These are the areas now being focused upon for improvement.

14. Appendix 3 details the most recent data submission for the Trust Premises Assurance Model

15. Six Facet Survey

16. The Department of Health document, "A risk-based methodology for establishing and managing backlog" describes the steps involved in undertaking a detailed survey for the purpose of establishing backlog; that is, assessing the physical condition of your estate assets and their compliance with mandatory fire safety requirements and statutory safety legislation.

17. This survey includes six specific facets:

    - physical condition
    - functional suitability
    - space utilisation
    - quality
    - fire and health & safety requirements
    - environmental management

18. The final document is used to inform both forward capital planning and ERIC return data. The document is updated, internally, on an annual basis, to reflect investment since previous iteration and possible additional items that may have come to light.

19. The six-facet survey is formally updated, externally, on a 5 yearly basis with the next one due before end of financial year 23-24.

20. Appendix 4 shows the latest iteration of the Trust six-facet backlog figures.

21. Model Health System (formerly Model Hospital)

22. The Model Health System (MHS) is a digital tool provided by NHS England includes a suite of tools developed to support NHS providers. It can be used by anyone in the NHS from Trust Boards to Ward staff and provides the following:

    - understanding how you are performing in comparison to your peers
    - relevant information at board, specialty, functional and workforce levels
    - themed compartments, presenting key performance metrics within these specialties of areas
    - user-selectable peer groups alongside pre-defined recommended peers

23. Whilst the Trust have no direct input into the MHS, the system collates information from various other data input sources and produces various statistical and analytical data that allows the user to peer review any Trust against other (or group) and offers areas where improvement opportunities exist.

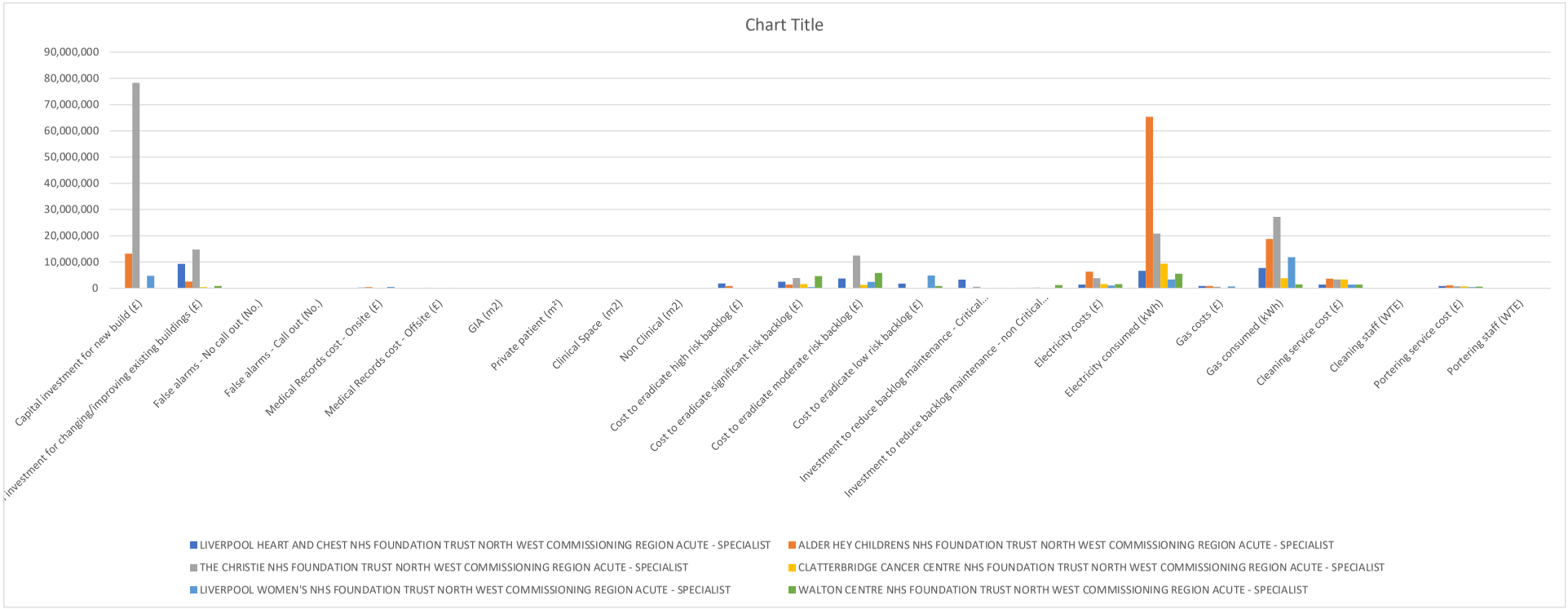
Conclusion

24. The report outlines the various analytical tools available within the NHS to measure Estates and Facilities against other, similar, Trusts, notwithstanding accuracy issues. Additionally, it details how other tools are developed and utilised for similar goals.

Recommendation

- Note this report
- Highlight any areas where further information is required

Trust Name	Trust Type	Capital investment for new build (£)	Capital investment for changing/improving existing buildings (£)	False alarms - No call out (No.)	False alarms - Call out (No.)	Medical Records cost - Onsite (£)	Medical Records cost - Offsite (£)	GIA (m^2)
LIVERPOOL HEART AND CHEST NHS FOUNDATION TRUST	ACUTE - SPECIALIST	6,149	9,285,457	51	2	257,870	35,960	31,062
ALDER HEY CHILDRENS NHS FOUNDATION TRUST	ACUTE - SPECIALIST	13,160,191	2,548,354	38	0	405,918	187,744	104,000
THE CHRISTIE NHS FOUNDATION TRUST	ACUTE - SPECIALIST	78,271,108	14,750,114	0	51	135,901	55,074	102,475
CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	ACUTE - SPECIALIST	173,000	457,000	14	2	24,448	58,080	43,081
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	ACUTE - SPECIALIST	4,730,842	198,226	8	2	479,000	197,000	32,736
WALTON CENTRE NHS FOUNDATION TRUST	ACUTE - SPECIALIST	0	850,198	11	9	71,697	11,636	28,595



Private patient (m^2)	Clinical Space (m2)	Non Clinical (m^2)	Cost to eradicate high risk backlog (£)	Cost to eradicate significant risk backlog (£)	Cost to eradicate moderate risk backlog (£)	Cost to eradicate low risk backlog (£)	Investment to reduce backlog maintenance - Critical Infrastructure Risk (£)	Investment to reduce backlog maintenance - non Critical Infrastructure Risk (£)	Electricity costs (£)	Electricity consumed (kWh)	Gas costs (£)	Gas consumed (kWh)	Cleaning service cost (£)	Cleaning staff (WTE)	Portering service cost (£)	Portering staff (WTE)
454	20,237	4,331	1,830,730	2,479,732	3,694,224	1,744,933	3,295,530	187,547	1,411,736	6,616,102	839,133	7,724,570	1,417,045	47.91	883,552	30.5
1,382	53,299	40,200	884,500	1405030	154200	91,500	0	197500	6,353,485	65,348,353	880,085	18,785,404	3,628,718	111	1,122,407	35
62	42,522	37,208	17,050	3,878,070	12,481,090	6,450	561,400	240,600	3,823,120	20,836,718	553,127	27,188,907	3,372,022	104.88	750,177	24
0	29,243	5,894	48,629	1,556,985	1,290,253	185,339	51,540	22,756	1,580,215	9,368,452	113,125	3,836,144	3,372,022	104.88	676,862	28.85
63	23,280	4,240	0	423,000	2,460,275	4,881,436	0	0	1,025,989	3,347,589	654,313	11,821,542	1,407,099	50.39	429,134	11.06
0	18,417	5,902	0	4,650,000	5,837,891	883,256	176,000	1,236,000	1,560,959	5,524,716	73,403	1,490,152	1,396,135	35.48	633,172	19.48

Trust Median Report 2021/2022
showing WALTON CENTRE NHS FOUNDATION TRUST
filtered by ACUTE - SPECIALIST

Finance	Unit	Value	Lower Q	Median	Upper Q	No In Sample
Capital investment for new build per occupied floor area	£/m²	0.00	1.27	64.68	140.21	6
Capital investment for improving existing buildings per occupied floor area	£/m²	31.21	14.88	27.70	129.06	6
Capital investment for maintaining (lifecycle) existing buildings per occupied floor area	£/m²	44.51	0.00	0.77	12.28	4
Total capital investment per occupied floor area	£/m²	75.73	94.07	151.09	263.93	6
Fire Safety	**Unit**	**Value**	**Lower Q**	**Median**	**Upper Q**	**No In Sample**
False alarms per number of fires reported	No.					1
Fires reported per 1,000m of occupied floor area	No/1,000m²	0.00	0.00	0.00	0.01	4
Facilities Management (FM) Services	**Unit**	**Value**	**Lower Q**	**Median**	**Upper Q**	**No In Sample**
Estates and facilities finance costs per occupied floor area	£/m²	176.94	150.77	162.08	173.30	6
Hard FM costs per occupied floor area	£/m²	133.11	115.78	137.03	171.54	6
Soft FM costs per occupied floor area	£/m²	142.36	103.86	115.74	138.51	6
Hard and Soft FM costs per occupied floor area	£/m²	275.47	227.21	271.70	283.54	6
Management (Hard and Soft FM) costs per occupied floor area	£/m²	3.00	4.50	6.92	9.27	6
Facilities management costs per occupied floor area	£/m²	455.40	377.64	429.17	494.17	6
Areas	**Unit**	**Value**	**Lower Q**	**Median**	**Upper Q**	**No In Sample**
Occupied floor area per gross internal floor area	%	95.26	91.33	95.97	98.76	6

Clinical space per occupied floor area	%	70.04	57.11	69.28	71.54	6
Non-clinical space area per occupied floor area	%	29.96	28.46	30.73	42.89	6
Heated volume per gross internal floor area	m	2.391	2.082	2.444	2.650	6
Quality of Buildings	**Unit**	**Value**	**Lower Q**	**Median**	**Upper Q**	**No In Sample**
Cost to eradicate backlog per occupied floor area	£/m²	417.44	106.46	213.00	295.20	6
Cost to eradicate Critical Infastructure Risk per occupied floor area	£/m²	170.70	26.86	42.99	115.30	6
Energy	**Unit**	**Value**	**Lower Q**	**Median**	**Upper Q**	**No In Sample**
Site energy consumed per occupied floor area	kWh/m²	258.97	462.99	507.83	612.65	6
Site energy consumed per heated volume	kWh/100m³	10,317.35	17,141.08	20,099.76	23,209.92	6
Electrical energy consumed per occupied floor area	kWh/m²	202.82	205.40	225.81	240.79	6
Fossil and renewable non-fossil energy consumed per occupied floor area	kWh/m²	56.16	204.54	280.06	350.15	6
Energy cost per occupied floor area	£/m²	63.64	51.39	57.77	68.38	6
Average cost per unit of energy consumed	Pence/kWh	24.58	8.74	10.23	14.56	6
Renewable energy consumed per occupied floor area	kWh/m²	0.00	0.00	0.00	0.00	6
Percentage of renewable energy per total energy consumed	%	0.00	0.00	8.73	17.70	6
Water Services	**Unit**	**Value**	**Lower Q**	**Median**	**Upper Q**	**No In Sample**
Water and sewage cost per total water volume	£/m³	3.18	3.21	3.82	4.48	6
Water and sewage cost per occupied floor area	£/m²	3.19	3.31	3.99	5.12	6
Water volume per occupied floor area	m³/m²	1.00	1.00	1.02	1.20	6
Waste	**Unit**	**Value**	**Lower Q**	**Median**	**Upper Q**	**No In Sample**
Waste cost per waste volume	£/tonne	198.40	108.75	228.53	282.80	6

Waste cost per occupied floor area	£/m²	3.86	3.45	3.84	5.52	6
Car Parking	**Unit**	**Value**	**Lower Q**	**Median**	**Upper Q**	**No In Sample**
Disabled car parking per total car parking	%	28.30	5.06	6.27	7.54	6
Cleanliness	**Unit**	**Value**	**Lower Q**	**Median**	**Upper Q**	**No In Sample**
Cleaning service cost per occupied floor area	£/m²	51.25	39.46	42.65	45.04	6
Cleaning service cost per WTE	£/WTE	39,349.92	28,337.44	30,864.24	32,556.17	6
Food Services	**Unit**	**Value**	**Lower Q**	**Median**	**Upper Q**	**No In Sample**
In-patient food services cost per main meals requested (cost per in-patient meal)	£/meal	6.68	6.08	6.89	7.98	6
Laundry & Linen	**Unit**	**Value**	**Lower Q**	**Median**	**Upper Q**	**No In Sample**
Laundry and linen cost per occupied floor area	£/m²	7.50	4.33	5.30	7.03	6
Laundry and linen service cost per item	£/item	0.37	0.35	0.36	0.41	4
Laundry service cost per item	£/item		1.04	1.69	2.35	2
Portering Services	**Unit**	**Value**	**Lower Q**	**Median**	**Upper Q**	**No In Sample**
Portering service cost per occupied floor area	£/m²	23.24	11.57	15.44	21.79	6
Portering service cost per WTE	£/WTE	32,503.70	29,541.04	31,663.08	32,394.97	6
Occupied floor area per WTE	m²/WTE	1,398.36	1,295.42	2,138.77	2,886.72	6

NHS Premises Assurance Model: Safety Domain (Combined and Hard FM)

The organisation provides assurance for Estates, Facilities and its support services that the design, layout, build, engineering, operation and maintenance of the estate meet appropriate levels of safety to provide premises that supports the delivery of improved clinical outcomes.

The SAQs collectively provide assurance that the ***design, maintenance and use of facilities, premises and equipment that keeps people safe.***

SAQ/Prompt Questions

SAQs at the top of each block can be rated 'Not applicable', in which case the prompt questions are disabled and the scores are ignored.

Refer to 'prompt guidance sheet' and NHS PAM Guidance Document for further guidance.

SH1 - Estates and Facilities Operational Management

2020-2021

SH1: With regard to the Estates and Facilities Operational Management can the organisation evidence the following?

Applicable

1: Policy & Procedures

Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?

Requires Minimal Improvement

2: Roles and Responsibilities

Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?

Outstanding

3: Risk Assessment
Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed? (Note 1)

Outstanding

4: Maintenance
Are assets, equipment and plant adequately maintained? (Note 1)

Good

5. Training and Development
Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?

Good

6: Resilience, Emergency & Business Continuity Planning
Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?

Outstanding

7: Review Process
Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?

Good

8: Costed Action Plans
If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**

No

Capital cost to achieve compliance (£000s)

£

Revenue consequences of achieving compliance (£000s)

£

Comments

Estates Strategy being updated

SH2 - Design, Layout and Use of Premises

2020-2021

SH2: With regard to the Design, Layout and Use of Premises [Functional suitability/Fitness for Purpose] can the organisation evidence the following in relation to functional suitability?

Applicable

1: Policy & Procedures

Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?

Good

2: Roles and Responsibilities

Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?

Outstanding

3: Risk Assessment

Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?

Good

4: Maintenance
Are relevant assets, equipment and plant adequately maintained? (Note 1)

Requires Minimal Improvement

5. Training and Development
Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?

Good

6: Resilience, Emergency & Business Continuity Planning
Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?

Outstanding

7: Review Process
Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?

Good

8: Costed Action Plans
If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**

No

Capital cost to achieve compliance (£000s)

£

Revenue consequences of achieving compliance (£000s)

£

Comments

SH3 - Estates and Facilities Document Management

2020-2021

SH3: With regard to Estates and Facilities Document Management can the organisation evidence the following?

Applicable

1: Document Management System in Place

Does the Organisation have an effective and efficient document management system in place proportional to the level of complexity, hazards and risks concerned?

Outstanding

2: Approval of documents

Are documents approved for adequacy prior to issue?

Outstanding

3: Review of documents

Are documents reviewed and updated as necessary with changes identified?

Outstanding

4: Availability of documents

Are all relevant versions of applicable documents available at points of use?

Outstanding

5. Legibility of Documents

Are all relevant documents legible and readily identifiable?

Outstanding

6: Document Control
Are all internal and external documents identified and their distribution controlled?

Outstanding

7: Obsolescence
Is there a process to prevent the unintended use of obsolete documents and apply suitable identification to them if they are retained for any purpose?

Outstanding

8: Costed Action Plans
If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**

No

Capital cost to achieve compliance (£000s)

£

Revenue consequences of achieving compliance (£000s)

£

Comments

SH04 - Health & Safety at work

2020-2021

SH4: With regard to Health & Safety at Work can the organisation evidence the following?

Applicable

1: Policy & Procedures
Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?

Outstanding

2: Roles and Responsibilities
Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood? (Note 1)

Good

3: Risk Assessment
Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed? (Note 1)

Outstanding

4. Training and Development
Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements? (Note 1)

Good

5: Resilience, Emergency & Business Continuity Planning
Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?

Good

6: Review Process
Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?

Good

7: Costed Action Plans
If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**

No

Capital cost to achieve compliance (£000s)

£

Revenue consequences of achieving compliance (£000s)

£

Comments

SH5 - Asbestos

2020-2021

SH5: With regard to Asbestos can the organisation evidence the following?

Applicable

1: Policy & Procedures
Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?

Outstanding

2: Roles and Responsibilities
Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?

Outstanding

3: Risk Assessment
Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed? (Note 1)

Outstanding

4. Training and Development
Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?

Outstanding

5: Resilience, Emergency & Business Continuity Planning
Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?

Good

6: Review Process
Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?

Outstanding

7: Costed Action Plans
If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**

No

Capital cost to achieve compliance (£000s)

£

Revenue consequences of achieving compliance (£000s)

£

Comments

SH6 - Medical Gas Systems

2020-2021

SH6: With regard to Medical Gas Systems can the organisation evidence the following?

Applicable

1: Policy & Procedures

Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?

Requires Minimal Improvement

2: Roles and Responsibilities

Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?

Good

3: Risk Assessment

Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?

Requires Minimal Improvement

4: Maintenance

Are assets, equipment and plant adequately maintained?

Outstanding

5. Training and Development

Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?

Requires Minimal Improvement

6: Resilience, Emergency & Business Continuity Planning

Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?

Requires Minimal Improvement

7: Review Process

Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?

Requires Minimal Improvement

8: Costed Action Plans

If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**

No

Capital cost to achieve compliance (£000s)

£

Revenue consequences of achieving compliance (£000s)

£

Comments

No medical Gas policy in place at present

SH7 - Natural Gas and specialist piped systems

2020-2021

SH7: With regard to Natural Gas and specialist piped systems can the organisation evidence the following?

Applicable

1: Policy & Procedures
Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?

Requires Minimal Improvement

2: Roles and Responsibilities
Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?

Requires Minimal Improvement

3: Risk Assessment
Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?

Requires Minimal Improvement

4: Maintenance
Are assets, equipment and plant adequately maintained?

Outstanding

5. Training and Development
Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?

Not applicable

6: Resilience, Emergency & Business Continuity Planning
Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?

Outstanding

7: Review Process
Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?

Good

8: Costed Action Plans
If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**

No

Capital cost to achieve compliance (£000s)

£

Revenue consequences of achieving compliance (£000s)

£

Comments

SH8 - Water Safety Systems

2020-2021

SH8: With regard to Water Safety Systems can the organisation evidence the following?

Applicable

1: Policy & Procedures
Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?

Outstanding

2: Roles and Responsibilities
Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?

Outstanding

3: Risk Assessment
Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?

Outstanding

4: Maintenance
Are assets, equipment and plant adequately maintained?

Outstanding

5. Training and Development
Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?

Good

6: Resilience, Emergency & Business Continuity Planning
Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?

Good

7: Review Process
Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?

Good

8: Costed Action Plans
If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**

No

Capital cost to achieve compliance (£000s)

£

Revenue consequences of achieving compliance (£000s)

£

Comments

SH9 - Electrical Systems

2020-2021

SH9: With regard to Electrical Systems can the organisation evidence the following?

Applicable

1: Policy & Procedures
Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?

Outstanding

2: Roles and Responsibilities
Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?

Outstanding

3: Risk Assessment
Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?

Outstanding

4: Maintenance
Are assets, equipment and plant adequately maintained?

Good

5. Training and Development
Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?

Good

6: Resilience, Emergency & Business Continuity Planning
Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?

Good

7: Review Process
Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?

Good

8: Costed Action Plans
If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**

No

Capital cost to achieve compliance (£000s)

£

Revenue consequences of achieving compliance (£000s)

£

Comments

SH10 - Mechanical Systems and Equipment e.g. Lifting Equipment

2020-2021

SH10: With regard to Mechanical Systems and Equipment e.g. Lifting Equipment can the organisation evidence the following?

Applicable

1: Policy & Procedures

Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?

Requires Minimal Improvement

2: Roles and Responsibilities

Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?

Good

3: Risk Assessment

Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed? (Note 1)

Good

4: Maintenance

Are assets, equipment and plant adequately maintained? (Note 1)

Outstanding

5. Training and Development

Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?

Good

6: Resilience, Emergency & Business Continuity Planning

Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?

Good

7: Review Process

Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?

Good

8: Costed Action Plans

If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**

No

Capital cost to achieve compliance (£000s)

£

Revenue consequences of achieving compliance (£000s)

£

Comments

SH11 - Ventilation, Air Conditioning and Refrigeration Systems

2020-2021

SH11: With regard to Ventilation, Air Conditioning and Refrigeration Systems can the organisation evidence the following?

Applicable

1: Policy & Procedures

Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?

Requires Minimal Improvement

2: Roles and Responsibilities

Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?

Good

3: Risk Assessment

Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?

Good

4: Maintenance

Are assets, equipment and plant adequately maintained?

Outstanding

5. Training and Development

Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?

Good

6: Resilience, Emergency & Business Continuity Planning

Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?

Good

7: Review Process

Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?

Good

8: Costed Action Plans

If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**

No

Capital cost to achieve compliance (£000s)

£

Revenue consequences of achieving compliance (£000s)

£

Comments

SH12 - Lifts, Hoists and Conveyance Systems

2020-2021

SH12: With regard to Lifts, Hoists and Conveyance Systems can the organisation evidence the following?

Applicable

1: Policy & Procedures
Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?

Requires Minimal Improvement

2: Roles and Responsibilities
Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?

Good

3: Risk Assessment
Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?

Good

4: Maintenance
Are assets, equipment and plant adequately maintained?

Outstanding

5. Training and Development
Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?

Good

6: Resilience, Emergency & Business Continuity Planning
Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?

Good

7: Review Process
Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?

Good

8: Costed Action Plans
If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**

No

Capital cost to achieve compliance (£000s)

£

Revenue consequences of achieving compliance (£000s)

£

Comments

SH13 - Pressure Systems

2020-2021

SH13: With regard to Pressure Systems can the organisation evidence the following?

Applicable

1: Policy & Procedures
Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?

Requires Minimal Improvement

2: Roles and Responsibilities
Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?

Good

3: Risk Assessment
Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed? (Note 1)

Requires Minimal Improvement

4: Maintenance
Are assets, equipment and plant adequately maintained? (Note 1)

Outstanding

5. Training and Development
Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements? (Note 1)

Good

6: Resilience, Emergency & Business Continuity Planning
Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?

Good

7: Review Process
Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?

Good

8: Costed Action Plans
If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**

No

Capital cost to achieve compliance (£000s)

£

Revenue consequences of achieving compliance (£000s)

£

Comments

SH14 - Fire Safety

2020-2021

SH14: With regard to Fire Safety can the organisation evidence the following?

Applicable

1: Policy & Procedures
Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?

Outstanding

2: Roles and Responsibilities
Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?

Outstanding

3: Risk Assessment
Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed? (Note 1)

Outstanding

4: Maintenance
Are assets, equipment and plant adequately maintained? (Note 1)

Outstanding

5. Training and Development
Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements? (Note 1)

Outstanding

6: Resilience, Emergency & Business Continuity Planning
Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?

Outstanding

7: Review Process
Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?

Outstanding

8: Costed Action Plans
If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**

No

Capital cost to achieve compliance (£000s)

£

Revenue consequences of achieving compliance (£000s)

£

Comments

SH15 - Medical Devices and Equipment

2020-2021

SH15: With regard to Medical Devices and Equipment can the organisation evidence the following?

Applicable

1: Policy & Procedures

Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?

Outstanding

2: Roles and Responsibilities

Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?

Outstanding

3: Risk Assessment

Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?

Outstanding

4: Maintenance

Are assets, equipment and plant adequately maintained?

Outstanding

5. Training and Development

Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?

Outstanding

6: Resilience, Emergency & Business Continuity Planning

Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?

Good

7: Review Process

Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?

Good

8: Costed Action Plans

If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**

No

Capital cost to achieve compliance (£000s)

£

Revenue consequences of achieving compliance (£000s)

£

Comments

SH16 - Resilience, Emergency and Business Continuity Planning

2020-2021

SH16: With regard to Resilience, Emergency and Business Continuity Planning can the organisation evidence the following?

Applicable

1: Policy & Procedures

Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?

Outstanding

2: Roles and Responsibilities

Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?

Outstanding

3: Risk Assessment

Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?

Outstanding

4: Maintenance

Are assets, equipment and plant adequately maintained?

Outstanding

5. Training and Development

Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?

Good

6: Review Process
Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?

Good

7: Costed Action Plans
If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**

No

Capital cost to achieve compliance (£000s)

£

Revenue consequences of achieving compliance (£000s)

£

Comments

SH17 - Reporting of safety related issues and actioning of safety related alerts for estates and facilities issues

2020-2021

SH17: With regard to the reporting of safety related issues and actioning of safety related alerts for estates and facilities issues can the organisation evidence the following?

Applicable

1: Policy & Procedures
Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?

Outstanding

2: Roles and Responsibilities
Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?

Outstanding

3: Risk Assessment
Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?

Outstanding

4. Training and Development
Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?

Outstanding

5: Resilience, Emergency & Business Continuity Planning
Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?

Outstanding

6: Review Process
Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?

Good

7: Costed Action Plans
If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**

No

Capital cost to achieve compliance (£000s)

£

Revenue consequences of achieving compliance (£000s)

£

Comments

SH18 - Ensuring estates and facilities services are safe and suitable when the organisation is not directly responsible for providing these services

2020-2021

SH18: With regard to ensuring estates and facilities services are safe and suitable when the organisation is not directly responsible for providing these services can the organisation evidence the following?

Applicable

1: Policy & Procedures

Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?

Good

2: Roles and Responsibilities

Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?

Outstanding

3: Risk Assessment

Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?

Good

4: Maintenance
Are assets, equipment and plant adequately maintained?

Outstanding

5. Training and Development
Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?

Good

6: Resilience, Emergency & Business Continuity Planning
Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?

Outstanding

7: Review Process
Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?

Good

8: Costed Action Plans
If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**

No

Capital cost to achieve compliance (£000s)

£

Revenue consequences of achieving compliance (£000s)

£

Comments

SH19 - Contractor Management for Soft and Hard FM services

2020-2021

SH19: With regard to Contractor Management for Soft and Hard FM services can the organisation evidence the following?

Applicable

1: Policy

Does the organisation have a current and approved policy and if applicable, a set of underpinning set of procedures relating to contractor management.

Requires Minimal Improvement

2: Roles and Responsibilities

Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood who are responsible for the management of contractors?

Outstanding

3: Risk Assessment

Are contractors risk assessments and if applicable, method statements (RAMS) requested from the contractor(s) prior to works commencing and reviewed for their appropriateness?

Good

4: Maintenance

Does the organisation hold the necessary proof to demonstrate consistent contractor maintenance activities - for its contracted services?

Outstanding

5. Contractor Competence

With regards to the competence of the contractors - has the organisation checked that contractors are using suitably competent persons to carry out the contracted services?

Good

6: Resilience, Emergency & Business Continuity Planning

Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?

Good

7: Review Process

Is there a robust regular review process in place to manage the performance of contractors ensuring compliance to the agreed contract, relevant standards, policies and procedures?

Requires Minimal Improvement

8: Costed Action Plans

If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**

No

Capital cost to achieve compliance (£000s)

£

Revenue consequences of achieving compliance (£000s)

£

Comments

NHS Premises Assurance Model: Safety Domain (Soft FM)

The organisation provides assurance for Estates, Facilities and its support services that the design, layout, build, engineering, operation and maintenance of the estate meet appropriate levels of safety to provide premises that supports the delivery of improved clinical outcomes. The SAQs collectively provide assurance that the ***design, maintenance and use of facilities, premises and equipment keep people safe.***

The SAQs collectively provide assurance that the ***design, maintenance and use of facilities, premises and equipment that keeps people safe.***

SAQ/Prompt Questions

SAQs at the top of each block can be rated 'Not applicable', in which case the prompt questions are disabled and the scores are ignored.

Refer to 'prompt guidance sheet' and NHS PAM Guidance Document for further guidance.

SS1 - Catering Services

2020-2021

SS1: With regard to Catering Services can the organisation evidence the following?

Applicable

1: Policy & Procedures

Does the Organisation have a current, approved Policy, Food Safety Management System and an underpinning set of procedures that comply with relevant legislation and published guidance?

Good

2: Roles and Responsibilities

Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?

Outstanding

3: Risk Assessment

Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed? Has the organisation documented all processes and procedures in an approved HACCP document?

Outstanding

4: Maintenance

Are assets, equipment and plant adequately maintained, regularly and monitored to ensure equipment relating to temperature control is functioning correctly?

Outstanding

5. Training and Development

Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements including level 2 hygiene for all food handlers and HACCP at the appropriate level for supervisors and Managers?

Good

6: Resilience, Emergency & Business Continuity Planning

Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?

Outstanding

7: Review Process

Is there a robust regular review process to assure compliance and effectiveness of relevant standards, policies and procedures which includes sampling and testing where required?

Good

8: Costed Action Plans
If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**

No

Capital cost to achieve compliance (£000s)

£

Revenue consequences of achieving compliance (£000s)

£

Comments

SS2 - Decontamination Processes

2020-2021

SS2: With regard to Decontamination Processes can the organisation evidence the following?

Applicable

1: Policy & Procedures
Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?

Outstanding

2: Roles and Responsibilities
Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?

Outstanding

3: Risk Assessment
Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?

Good

4: Maintenance
Are assets, equipment and plant adequately maintained?

Outstanding

5. Training and Development
Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?

Requires Minimal Improvement

6: Resilience, Emergency & Business Continuity Planning
Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?

Good

7: Review Process
Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?

Good

8: Costed Action Plans
If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**

No

Capital cost to achieve compliance (£000s)

£

Revenue consequences of achieving compliance (£000s)

£

Comments

SS3 - Waste and Recycling Management

2020-2021

SS3: With regard to Waste and Recycling Management can the organisation evidence the following?

Applicable

1: Policy & Procedures

Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?

Outstanding

2: Roles and Responsibilities

Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?

Good

3: Risk Assessment

Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?

Requires Minimal Improvement

4: Maintenance

Are assets, equipment and plant adequately maintained?

Outstanding

5. Training and Development

Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?

Requires Minimal Improvement

6: Resilience, Emergency & Business Continuity Planning

Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?

Good

7: Review Process

Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?

Good

8: Costed Action Plans

If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**

No

Capital cost to achieve compliance (£000s)

£

Revenue consequences of achieving compliance (£000s)

£

Comments

SS4 - Cleanliness and Infection Control applying to Premises and Facilities

2020-2021

SS4: With regard to Cleanliness and Infection Control applying to Premises and Facilities can the organisation evidence the following?

Applicable

1: Policy & Procedures

Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?

Outstanding

2: Roles and Responsibilities

Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?

Outstanding

3: Risk Assessment

Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?

Good

4: Maintenance

Are assets, equipment and plant adequately maintained?

Outstanding

5. Training and Development

Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?

Good

6: Resilience, Emergency & Business Continuity Planning
Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?

Good

7: Review Process
Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?

Good

8: Costed Action Plans
If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**

No

Capital cost to achieve compliance (£000s)

£

Revenue consequences of achieving compliance (£000s)

£

Comments

SS5 - Laundry and Linen Services

2020-2021

SS5: With regard to Laundry and Linen Services can the organisation evidence the following?

Applicable

1: Policy & Procedures
Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?

Not applicable

2: Roles and Responsibilities
Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?

Outstanding

3: Risk Assessment
Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?

Good

4: Maintenance
Are assets, equipment and plant adequately maintained?

Not applicable

5. Training and Development
Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?

Good

6: Resilience, Emergency & Business Continuity Planning
Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?

Outstanding

7: Review Process
Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?

Good

8: Costed Action Plans
If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**

No

Capital cost to achieve compliance (£000s)

£

Revenue consequences of achieving compliance (£000s)

£

Comments
Completely outsourced service

SS6 - Security Management

2020-2021

SS6: With regard to Security Management can the organisation evidence the following?

Applicable

1: Policy & Procedures
Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?

Outstanding

2: Roles and Responsibilities
Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?

Outstanding

3: Risk Assessment
Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?

Outstanding

4: Maintenance
Are assets, equipment and plant adequately maintained?

Good

5. Training and Development
Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?

Good

6: Resilience, Emergency & Business Continuity Planning
Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?

Outstanding

7: Review Process
Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?

Good

8: Costed Action Plans
If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**

No

Capital cost to achieve compliance (£000s)

£

Revenue consequences of achieving compliance (£000s)

£

Comments

SS7 - Transport Services and access arrangements

2020-2021

SS7: With regard to Transport Services and access arrangements can the organisation evidence the following?

Applicable

1: Policy & Procedures
Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?

Requires Minimal Improvement

2: Roles and Responsibilities
Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?

Good

3: Risk Assessment
Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?

Requires Minimal Improvement

4: Maintenance
Are assets, equipment and plant adequately maintained?

Outstanding

5. Training and Development
Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?

Good

6: Resilience, Emergency & Business Continuity Planning
Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?

Requires Minimal Improvement

7: Review Process
Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?

Requires Minimal Improvement

8: Costed Action Plans
If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**

No

Capital cost to achieve compliance (£000s)

£

Revenue consequences of achieving compliance (£000s)

£

Comments

SS8 - Pest Control

2020-2021

SS8: With regard to Pest Control can the organisation evidence the following?

Applicable

1: Policy & Procedures

Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?

Not applicable

2: Roles and Responsibilities

Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?

Not applicable

3: Risk Assessment

Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?

Not applicable

4: Maintenance

Are assets, equipment and plant adequately maintained?

Not applicable

5. Training and Development

Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?

Not applicable

6: Resilience, Emergency & Business Continuity Planning

Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?

Not applicable

7: Review Process

Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?

Not applicable

8: Costed Action Plans

If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**

No

Capital cost to achieve compliance (£000s)

£

Revenue consequences of achieving compliance (£000s)

£

Comments

Completely outsourced service

SS9 - Portering Services

2020-2021

SS9: With regard to Portering Services can the organisation evidence the following?

Applicable

1: Policy & Procedures

Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?

Not applicable

2: Roles and Responsibilities

Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?

Outstanding

3: Risk Assessment

Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?

Not applicable

4: Maintenance

Are assets, equipment and plant adequately maintained?

Outstanding

5. Training and Development

Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?

Good

6: Resilience, Emergency & Business Continuity Planning
Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?

Outstanding

7: Review Process
Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?

Good

8: Costed Action Plans
If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**

No

Capital cost to achieve compliance (£000s)

£

Revenue consequences of achieving compliance (£000s)

£

Comments

Outsourced service

SS10 - Telephony and Switchboard

2020-2021

SS10: With regard to Telephony and Switchboard can the organisation evidence the following?

Not applicable

1: Policy & Procedures
Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?

2: Roles and Responsibilities
Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?

3: Risk Assessment
Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?

4: Maintenance
Are assets, equipment and plant adequately maintained?

5. Training and Development
Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?

6: Resilience, Emergency & Business Continuity Planning
Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?

7: Review Process
Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?

8: Costed Action Plans
If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**

Capital cost to achieve compliance (£000s)

£

Revenue consequences of achieving compliance (£000s)

£

Comments
Outsourced service

NHS Premises Assurance Model: Patient experience

The organisation ensures that patient experience is an integral part of service provision and is reflected in the way in which services are delivered. The organisation will involve patients and members of the public in the development of services and the monitoring of performance.

The SAQs collectively provide assurance that the ***design, maintenance and use of facilities, premises and equipment that keeps people safe.***

SAQ/Prompt Questions

SAQs at the top of each block can be rated 'Not applicable', in which case the prompt questions are disabled and the scores are ignored.

Refer to 'prompt guidance sheet' and NHS PAM Guidance Document for further guidance.

P1 - Ensuring engagement and involvement on estates and facilities services from people who use the services, public and staff

2020-2021

P1: With regards to ensuring engagement and involvement on estates and facilities services from people who use the services, public and staff can your organisation evidence the following?

Applicable

1. Views and Experiences

Are people's views and experiences gathered and acted on to shape and improve the services and culture?

Outstanding

2. Engagement

Are people who use services, those close to them and their representatives actively engaged and involved in decision making?

Good

3. Staff Engagement
Do staff feel actively engaged so that their views are reflected in the planning and delivery of services and in shaping the culture?

Good

4. Prioritisation
Do leaders prioritise the participation and involvement of people who use services and staff?

Outstanding

5. Value
Do both leaders and staff understand the value of staff raising concerns? Is appropriate action taken as a result of concerns raised?

Good

6: Costed Action Plans
If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**

No

Capital cost to achieve compliance (£000s)

£

Revenue consequences of achieving compliance (£000s)

£

Comments
P2 - Ensuring patients, staff and visitors perceive the condition, appearance, maintenance and privacy and dignity of the estate is satisfactory

2020-2021

P2: With regard to ensuring patients, staff and visitors perceive the condition, appearance, maintenance and privacy and dignity of the estate is satisfactory can your organisation evidence the following?

Applicable

1. PLACE Assessment

The organisation has completed the PLACE assessment relating to the care environment (estate) and estates related privacy and dignity issues, for all relevant sites and published a local improvement plan.

Not applicable

2. Other Assessments

Is there a system/process, additional to PLACE assessments, to measure patients and visitors satisfaction with the estate and related privacy and dignity issues and is action taken on the results?

Good

3: Costed Action Plans

If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**

No

Capital cost to achieve compliance (£000s)

£

Revenue consequences of achieving compliance (£000s)

£

Comments

No place assessment carried out this year, to do, due to COVID-19

P3 - Ensuring that patients, staff and visitors perceive cleanliness of the estate and facilities to be satisfactor

2020-2021

P3: With regard to ensuring that patients, staff and visitors perceive cleanliness of the estate and facilities to be satisfactory can your organisation evidence the following?

Applicable

1. PLACE Assessment

The organisation has completed the PLACE assessment relating to the care environment (estate) and estates related privacy and dignity issues, for all relevant sites and published a local improvement plan.

Not applicable

2. Other Assessments

Is there a system/process, additional to PLACE assessments, to measure patients and visitors satisfaction with the estate and related privacy and dignity issues and is action taken on the results?

Requires Minimal Improvement

3. Cleaning Schedules

Are Cleaning Schedules publicly available?

Outstanding

4: Costed Action Plans

If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**

No

Capital cost to achieve compliance (£000s)

£

Revenue consequences of achieving compliance (£000s)

£

Comments

No place assessment carried out this year, to do, due to COVID-19

P4 - Ensuring that access and car parking arrangements meet the reasonable needs of patients, staff and visitors

2020-2021

P4: with regard to ensuring that access and car parking arrangements meet the reasonable needs of patients, staff and visitors can your organisation evidence the following?

Applicable

1. PLACE Assessment

The organisation has completed the PLACE assessment relating to the care environment (estate) and estates related privacy and dignity issues, for all relevant sites and published a local improvement plan.

Not applicable

2. Other Assessments

Is there a system/process, additional to PLACE assessments, to measure patients and visitors satisfaction with the estate and related privacy and dignity issues and is action taken on the results?

Requires Minimal Improvement

3: Costed Action Plans

If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**

No

Capital cost to achieve compliance (£000s)

£

Revenue consequences of achieving compliance (£000s)

£

Comments

No place assessment carried out this year, to do, due to COVID-19

P5 - Providing a high quality and supportive environment for patients, visitors and staff in relation to Grounds and Gardens

2020-2021

P5: With regard to providing a high quality and supportive environment for patients, visitors and staff in relation to Grounds and Gardens can your organisation evidence the following?

Applicable

1. PLACE Assessment

The organisation has completed the PLACE assessment relating to the care environment (estate) and estates related privacy and dignity issues, for all relevant sites and published a local improvement plan.

Not applicable

2. Other Assessments

Is there a system/process, additional to PLACE assessments, to measure patients and visitors satisfaction with the estate and related privacy and dignity issues and is action taken on the results?

Requires Minimal Improvement

3: Costed Action Plans

If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**

No

Capital cost to achieve compliance (£000s)

£

Revenue consequences of achieving compliance (£000s)

£

Comments

No place assessment carried out this year, to do, due to COVID-19

P6 - Ensuring that NHS Catering Services provide adequate nutrition and hydration through the choice of food and drink for people to meet their diverse needs?

2020-2021

P6: How does your organisation/site ensure that NHS Catering Services provide adequate nutrition and hydration through the choice of food and drink for people to meet their diverse needs?

Applicable

1. Policy & Procedures

Does the organisation have in place a policy for Hydration and Nutrition which is aligned to current Food standards and link to sustainable procurement and food waste monitoring and reduction which has been reviewed via an Multi-Disciplinary Team process within the last 3 years?

Good

2. Regulation

Does the organisation have a food and drink strategy as defined in the NHS Standard Contract

Good

3. Choice

The organisation provides a choice of nutritious and appetising food and hydration, in sufficient quantities to meet patients needs

Requires Minimal Improvement

4. Equality issues
Food and hydration meets any reasonable requirements arising from Equality issues e.g. from a patients religious or cultural background

Requires Minimal Improvement

5. Information
Patients have accessible information about meals and the arrangements for mealtimes, access to snacks and drinks throughout the day and night and to have mealtimes that are reasonably spaced and at appropriate times.

Requires Minimal Improvement

6. PLACE Assessment
The organisation has completed the PLACE assessment relating to catering services for all relevant sites and published a local improvement plan.

Not applicable

7. Other Assessments
Is there a system/process in place, additional to PLACE assessments, to measure patients satisfaction with the service provided and is action taken on the results?

Requires Minimal Improvement

8. Legal Standards
Has the organisation complied with the estates related legally binding standards as detailed in the NHS Standard Contract

Requires Minimal Improvement

9: Costed Action Plans
If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**

No

Capital cost to achieve compliance (£000s)

£

Revenue consequences of achieving compliance (£000s)

£

Comments

No place assessment carried out this year, to do, due to COVID-19

NHS Premises Assurance Model: Efficiency Domain

The organisation provides assurance that space, activity, income and operational costs of the estates and facilities provide value for money, are economically sustainable and meet clinical and organisational requirements.

The SAQs collectively provide assurance that the ***design, maintenance and use of facilities, premises and equipment that keeps people safe.***

SAQ/Prompt Questions

SAQs at the top of each block can be rated 'Not applicable', in which case the prompt questions are disabled and the scores are ignored.

Refer to 'prompt guidance sheet' and NHS PAM Guidance Document for further guidance.

F1 - Having a well-managed approach to performance management of the estate and facilities operations

2020-2021

F1: With regard to having a well-managed approach to performance management of the estate and facilities operations can the organisation evidence the following?

Applicable

1: Analysing Performance

A process in place to analyse estates and facilities services and costs and if these continue to meet clinical and organisational needs?

Good

2: Benchmarking

A process in place to regularly benchmark estates and facilities costs?

Good

3: Costed Action Plans
If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**

No

Capital cost to achieve compliance (£000s)

£

Revenue consequences of achieving compliance (£000s)

£

Comments

F2 - Having a well-managed approach to improved efficiency in running estates and facilities services

2020-2021

F2: With regard to having a well-managed approach to improved efficiency in running estates and facilities services can the organisation evidence the following?

Applicable

1: Business Planning
An effective and efficient estate and facilities business planning process in place?

Outstanding

2: Estate Optimisation
An effective and efficient process in place to ensure estate optimisation and space utilisation?

Requires Minimal Improvement

3: Commercial Opportunities
An effective and efficient process in place to identify and maximise benefits from commercial opportunities from land and property that support the main business of the NHS ?

Requires Minimal Improvement

4: Partnership working
An effective and efficient process in place to investigate and implement improvements through partnership working?

Outstanding

5: New Technology
An effective and efficient process in place to maximise the benefits from new technologies?

Good

6: PFI and LIFT contracts
An effective and efficient process in place to achieve value for money from existing PFI and LIFT contracts?

Not applicable

7: Other contracts
An effective and efficient process in place to achieve value for money from existing other contracts?

Good

8. Property
An effective and efficient process in place to record and managing property interest and leases held

Requires Minimal Improvement

9. Cost Improvement plans
A robust methodology for identifying the delivery and implications of cost improvement plans

Requires Minimal Improvement

10: Costed Action Plans
If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**

No

Capital cost to achieve compliance (£000s)

£

Revenue consequences of achieving compliance (£000s)

£

Comments

F3 - Improved efficiencies in capital procurement, refurbishments and land management

2020-2021

F3: With regard to improved efficiencies in capital procurement, refurbishments and land management can the organisation evidence the following?

Applicable

1. Capital Procurement
Capital procurement and refurbishment projects progressed in line with local standing orders and financial instructions and relevant HM Treasury and DH guidance.

Outstanding

2. Capital Procurement Efficiencies
Capital procurement and refurbishment projects that actively seek efficiency such as through cost benchmarking, Building Information Modelling and repeatable designs?

Good

3. Flexibility
Capital procurement and refurbishment projects that actively seek flexible designs to accommodate changes in services?

Good

4. Identification and disposal of surplus land
An effective and efficient process for the identification and disposal of surplus land?

Not applicable

5: Costed Action Plans
If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**

No

Capital cost to achieve compliance (£000s)

£

Revenue consequences of achieving compliance (£000s)

£

Comments

F4 - Having well-managed and robust financial controls, procedures and reporting relating to estates and facilities services

2020-2021

F4: With regard to having well-managed and robust financial controls, procedures and reporting relating to estates and facilities services can the organisation evidence the following?

Applicable

1: Policy & Procedures
Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?

Outstanding

2: Review Process
Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?

Outstanding

3: Costed Action Plans
If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**

No

Capital cost to achieve compliance (£000s)

£

Revenue consequences of achieving compliance (£000s)

£

Comments

F5 - Ensuring Estates and Facilities services are continuously improved and sustainability ensure facilities services

2020-2021

F5: With regard to ensuring Estates and Facilities services are continuously improved and sustainability ensured can the organisation evidence the following?

Applicable

1. Quality and Sustainability
When considering developments to estates and facilities services or efficiency changes (including derogations from standards and guidance), is the impact on quality and sustainability assessed, understood and monitored, before, during and after the development?

Good

2. Financial Pressure
Are there examples of where financial pressures have negatively affected estates and facilities services?

Good

3. Continuous Improvement
Do leaders and staff strive for continuous learning, improvement and innovation?

Outstanding

4. Quality Improvements
Are staff focused on continually improving the quality of estates and facilities services?

Outstanding

5. Recognition
Are improvements to quality and innovation recognised and rewarded?

Outstanding

6. Use of Information
Is information used proactively to improve estates and facilities services?

Good

7: Costed Action Plans
If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**

No

Capital cost to achieve compliance (£000s)

£

Revenue consequences of achieving compliance (£000s)

£

NHS Premises Assurance Model: Effectiveness Domain

The organisation provides assurance that it's premises and facilities are functionally suitable, sustainable and effective in supporting the delivery of improved health outcomes.

The SAQs collectively provide assurance that the ***design, maintenance and use of facilities, premises and equipment that keeps people safe.***

SAQ/Prompt Questions

SAQs at the top of each block can be rated 'Not applicable', in which case the prompt questions are disabled and the scores are ignored.

Refer to 'prompt guidance sheet' and NHS PAM Guidance Document for further guidance.

E1 - Having a clear vision and a credible strategy to deliver good quality Estates and Facilities services

2020-2021

E1: With regard to having a clear vision and a credible strategy to deliver good quality Estates and Facilities services can the organisation evidence the following?

Applicable

1. Vision and Values

A clear vision and a set of values, with quality and safety the top priority?

Requires Minimal Improvement

2. Strategy

A robust, realistic strategy for achieving the priorities and delivering good quality estates and facilities services?

Requires Minimal Improvement

3. Development
The vision, values and strategy has been developed with staff and other stakeholders?

Requires Minimal Improvement

4. Vision and Values Understood
Staff know and understand what the vision and values are?

Requires Minimal Improvement

5. Strategy Understood
Staff know and understand the strategy and their role in achieving it?

Requires Minimal Improvement

6. Progress
Progress against delivering the strategy is monitored and reviewed?

Requires Minimal Improvement

7: Costed Action Plans
If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**

No

Capital cost to achieve compliance (£000s)

£

Revenue consequences of achieving compliance (£000s)

£

Comments

Updated Estates Strategy nearing completion

E2 - Having a well-managed approach to town planning

2020-2021

E2: With regard to having a well-managed approach to town planning can the organisation evidence the following?

Not applicable

1. Local Planning

An effective and efficient process to participate in Local Planning matters?

2. Neighbourhood Planning

An effective and efficient process to participate in Neighbourhood planning matter?

3. Planning Control

An effective and efficient process to participate in planning control process?

4. Special Interests

An effective and efficient process to manage special interests (e.g. conservation areas, listed buildings etc.) ?

5. Enforcement

An effective and efficient process to deal with any enforcement procedures served on the organisation?

6: Costed Action Plans
If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**

Capital cost to achieve compliance (£000s)

£

Revenue consequences of achieving compliance (£000s)

£

Comments

E3 - Having a well-managed robust approach to management of land and property

2020-2021

E3: with regard to having a well-managed robust approach to management of land and property can the organisation evidence the following?

Applicable

1: Disposal of land and property
An effective and efficient process for the disposal of freehold/leasehold land and property?

Not applicable

2: Granting of Leases
An effective and efficient process for the granting of leases?

Good

3: Acquisition of land and property
An effective and efficient process for the acquisition of freehold/leasehold land and property?

Not applicable

4: Costed Action Plans
If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**

No

Capital cost to achieve compliance (£000s)

£

Revenue consequences of achieving compliance (£000s)

£

Comments

E4 - Having a suitable Sustainability approach in place and being actioned

2020-2021

E4: With regard to having a suitable Sustainability approach in place and being actioned can the organisation evidence the following?

Applicable

1: Sustainable Development Management Plan (SDMP)
Is your SDMP complete, up-to-date and active?

Requires Minimal Improvement

2: Energy
Is your energy usage managed to fully delivery sustainability and effectiveness?

Good

3: Waste
Are effective systems in place to minimise waste production and effectively dispose of it?

Good

4: Air Pollution
Does your Trust have policies and procedures in place to control air pollution?

Inadequate

5: Water
Are water services efficiently and effectively delivered?

Requires Minimal Improvement

6: Climate Change Adaptation
Are risk assessments of the effects of climate change risk assessment and mitigation action implemented?

Requires Minimal Improvement

7: Procurement
Is all relevant procurement consistent with Government policy?

Good

8: Costed Action Plans
If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**

No

Capital cost to achieve compliance (£000s)

£

Revenue consequences of achieving compliance (£000s)

£

Comments

NHS Premises Assurance Model: Governance Domain

How the organisations board of directors deliver strategic leadership and effective scrutiny of the organisations estates and facilities operations. How the other four Domains are managed as part of the internal governance of the NHS organisation. Its objective is to ensure that the outcomes of the Domains are reported to the NHS Boards and embedded in internal governance and assurance processes to ensure actions are taken where required.

The SAQs collectively provide assurance that the ***design, maintenance and use of facilities, premises and equipment that keeps people safe.***

SAQ/Prompt Questions

SAQs at the top of each block can be rated 'Not applicable', in which case the prompt questions are disabled and the scores are ignored.

Refer to 'prompt guidance sheet' and NHS PAM Guidance Document for further guidance.

G1 - Ensuring the Estates and Facilities governance framework has clear responsibilities and that quality, performance and risks are understood and managed

2020-2021

G1. With regard to ensuring the Estates and Facilities governance framework has clear responsibilities and that quality, performance and risks are understood and managed, can the organisation evidence the following?

Applicable

1. Framework

There is an effective governance framework to support the delivery of the Estates and Facilities strategy and good quality services?

Good

2. Roles
Staff are clear about their roles and understand what they are accountable for?

Good

3. Partners
Working arrangements with partners and third party providers, e.g. PFI, are effectively managed?

Not applicable

4. Framework
The governance framework and management systems are regularly reviewed and improved?

5: Assurance
There are comprehensive assurance system and service performance measures, which are reported and monitored, and action taken to improve performance

Outstanding

6. Monitoring
There are effective arrangements in place to ensure that the information used to monitor, report (including regional and national data collections) and manage quality and performance is accurate, valid, reliable, timely and relevant (including PFI and non PFI costs).

Good

7. Audit
There is a systematic programme of internal audit, which is used to monitor quality and systems to identify where action should be taken?

Good

8. Mitigation
There are robust arrangements for identifying, recording and managing risks, issues and mitigating actions?

Good

9. Alignment

There is alignment between the recorded risks and what people say is ‘on their worry list’?

Good

10: Costed Action Plans

If the organisation/site has any inadequate or requires (moderate or minor) improvement ratings in this SAQ, are there risk assessed costed action plans in place to achieve compliance?

No

Capital cost to achieve compliance (£000s)

£

Revenue consequences of achieving compliance (£000s)

£

Comments

G2 - Ensuring the Estates and Facilities leadership and culture reflects the vision and values, encourages openness and transparency and promoting good quality estates and facilities services

2020-2021

G2: With regard to ensuring the Estates and Facilities leadership and culture reflects the vision and values, encourages openness and transparency and promoting good quality estates and facilities services can the organisation evidence the following?

Applicable

1. Effectiveness Leaders have the skills, knowledge, experience and integrity that they need and have the capacity, capability, and experience to lead effectively – both when they are appointed and on an ongoing basis.

Good

2. Challenges
Leaders understand the challenges to good quality estates and facilities services and can identify the actions needed to improve.

Outstanding

3. Visibility
Leaders are visible and approachable.

Good

4. Relationships
Leaders encourage appreciative, supportive relationships among staff.

Outstanding

5. Respect
Staff feel respected and valued.

Good

6. Behaviours
Action is taken to address behaviour and performance that is inconsistent with the vision and values, regardless of seniority.

Good

7. Culture
Is the culture centred on the needs and experience of people who use services?

Good

8. Honesty
The culture encourages candour, openness and honesty.

Good

9. Safety & Wellbeing

There is a strong emphasis on promoting the safety, health and wellbeing of staff.

Good

10. Healthier workplace

Promoting a healthier NHS workplace through cutting access to unhealthy products on NHS premises, implementing food standards, and providing healthy options for night staff.

Good

11. Collaboration

Staff and teams work collaboratively, resolve conflict quickly and constructively and share responsibility to deliver good quality estates and facilities services.

Good

12: Costed Action Plans

If the organisation/site has any inadequate or requires (moderate or minor) improvement ratings in this SAQ, are there risk assessed costed action plans in place to achieve compliance?

No

Capital cost to achieve compliance (£000s)

£

Revenue consequences of achieving compliance (£000s)

£

Comments

G3 - Ensuring that the Organisations Board has access to professional advice on all matters relating to Estates and Facilities services

2020-2021

G3: With regard to ensuring that the Organisations Board has access to professional advice on all matters relating to Estates and Facilities services can the organisation evidence the following?

Applicable

1. Professional advice

The organisation has adequately identified its requirements for Estates and Facilities related professional advice?

Outstanding

2. In-house advisors

Where Estates and Facilities related professional advice is provided in house mechanisms are in place to ensure the appointment of suitably qualified staff with the appropriate pre-employment checks?

Outstanding

3. External advisors

Where Estates and Facilities related professional advice is provided externally mechanisms are in place to ensure the appointment of suitably qualified staff with the appropriate skills and knowledge?

Good

4: Costed Action Plans

If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**

No

Capital cost to achieve compliance (£000s)

£

Revenue consequences of achieving compliance (£000s)

£

Comments

Project No.20626

The Walton Centre NHS Foundation Trust

Surveyed August 2019

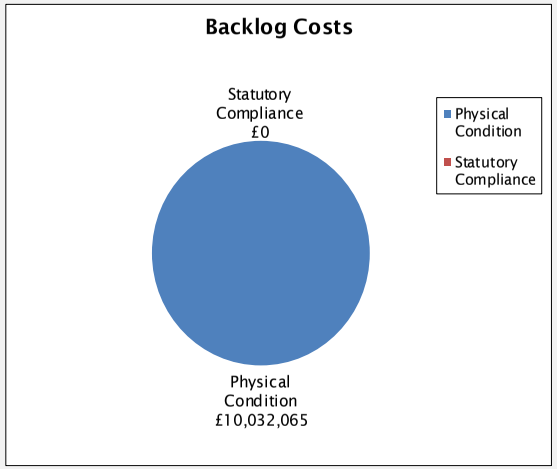
Reviewed May 2022

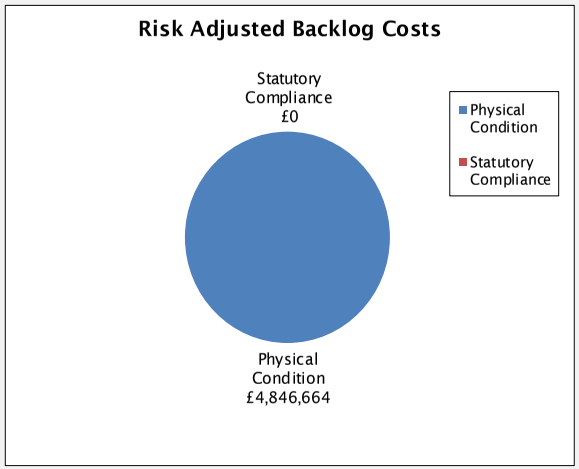
nifes Consulting Group

Property Appraisal Summary

Building Totals		% Uplift	0%	Building Life (Years)	20

Rank	B
Risk Rank (Elements below Condition B)	Significant
Total Backlog Costs (Incl. % Uplift)	£10,032,065
Total Risk Adjusted Backlog Costs (Incl. % Uplift)	£4,846,664





Facet	Overall Rank	Overall Risk Rank (Elements below Condition B)	Backlog Costs (Incl. % Uplift)	Backlog Risk Totals (Incl. % Uplift)				Risk Adjusted Backlog (Incl. % Uplift)
				Low	Moderate	Significant	High	
Physical Condition	B(C)	Significant	£10,032,065	£883,256	£5,837,891	£4,650,000	£0	£4,846,664
Statutory Compliance	B	-	£0	£0	£0	£0	£0	£0