The Walton Centre
NHS Foundation Trust

TRUST BOARD MEETING

OPEN SESSION

Thursday 28th November 2019

09:30 – 12:15

Board Room

OPEN TRUST BOARD MEETING
AGENDA
The Boardroom, WCFT Thursday 28 November 2019
09:30 – 13.00pm

The Walton Centre NHS Foundation Trust

Agenda

V = verbal, d = document p = presentation

Item	Time	Item	Owner	Purpose	Reference
1	09.30	Welcome and Apologies	J Rosser	N/A	TB117/19(v)
2	09.30	Declaration of Interests	J Rosser	N/A	TB118/19(v)
3	09.30	Minutes and actions of meeting held on 26th Sept and 30th October 2019	J Rosser	Decision	TB119/19(d)
PATIENT STORY					
4	09.40	Patient Story	L Gurrell	Information	(p)
QUALITY					
5	10.25	Nurse Staffing Bi-annual Review	L Vlasman	Information	TB 120/19(d)
6	10.35	Quarterly Governance Report	L Vlasman	Assurance	TB 121/19(d)
BREAK					
PERFORMANCE					
7	10.45	Integrated Performance Report: August 2019	CEO/ NED Chairs	Assurance	TB 122/19(d)
GOVERNANCE					
8	11.00	Freedom to Speak UP Guardian's Report and Strategy	L Vlasman	Assurance	TB123 /19(d)
9	11.15	Walton Centre Charity Annual Report and Accounts	M Burns	Decision	TB124 /19(d)
10	11.25	Guardian of Safe Working Quarterly Report	C Burness	Deferred	
11	11.30	Standing Financial Instructions and Scheme of Reservation and Delegation	M Burns	Decision	TB125/19(d)
12	11.30	Committee Terms of Reference	J Hindle	Decision	TB126/19(d)
13	11.35	Fit and Proper Persons Policy	M Gibney	Decision	TB 127/19(d)
14	11.40	Board Assurance Framework	J Hindle	Assurance	TB 128 /19(d)
Chair's Assurance Reports					
15	12.00	BPC Chairs Report	S Samuels	Assurance	To follow
16	12.05	Quality Committee Chairs Report	S Crofts	Assurance	TB 129/19(d)
17	12.07	Trust Charity Committee Chairs Report	S Rai	Assurance	TB 130/19(d)
18	12.09	Audit Committee Chair's Report	S Rai	Assurance	TB 131/9(d)
Consent Agenda					
Consent Items Note – these items are provided for consideration by the Board . Members are asked to read the papers prior to the meeting and, unless the Chair / Trust Secretary receives notification before the meeting that a member wishes to debate the item or seek clarification on an issue, the items and recommendations will be accepted without debate at the meeting in line with the process for Consent Items. The recommendations will then be recorded in the minutes of the meeting					
19		Healthcare Worker Vaccination Self-Assessment	H Citrine	Information	TB132/19(d)
20		Modern Slavery Act Statement	H Citrine	Information	TB 133//19(d)
21		EPRR Annual Self-Assessment	J Ross	Information	TB 134/19(d)
CONCLUDING BUSINESS					
22	12:10	Seven Day Hospital Services – progress update	A Nicolson	Information	TB135/19 (v)
23	12.15	Any Other Business • Brexit Update	J Ross	Information	TB136/19 (v)
24	12.20	Meeting Review	J Rosser	Verbal	(v)

Exclusion of Press & Public
In accordance with the Public Bodies (Admission to Meetings) Act 1960 representatives of the press and other members of the public are excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest

UNCONFIRMED

MINUTES OF THE WALTON CENTRE NHS FOUNDATION TRUST OPENBOARD MEETING HELD ON THURSDAY 26th SEPTEMBER

Present

Ms J Rosser	Chair
Ms B Spicer	Non-Executive Director
Mr A Sharples	Non-Executive Director
Ms S Samuels	Non-Executive Director
Mr S Croft	Non-Executive Director
Ms H Citrine	Chief Executive
Mr M Burns	Director of Finance & Information Technology
Mr M Gibney	Director of Workforce & Innovation
Ms J Ross	Director of Operations & Strategy
Ms L Salter	Director of Nursing & Governance
Dr A Nicolson	Medical Director

In Attendance

Ms Suzanne Simpson	Occupational Therapist and MND Psychological Wellbeing & Social Support Advisor (Item 3)
Ms J Hindle	Company Secretary

Trust Board Attendance 2019-20

Members:	Apr	May	Ext May	Jun	Jul	Sept	Nov	Jan	Feb	Mar
Ms J Rosser	✓	✓	✓	✓	✓	✓				
Mr S Crofts	✓	✓	✓	✓	✓	✓				
Ms A McCraken	✓	✓								
Ms S Samuels	✓	✓	✓	✓	✓	✓				
Mr A Sharples	✓	✓	✓	✓						
Ms B Spicer				✓	✓	✓				
Ms S Rai						✓				
Prof N Thakkar	A	✓	✓	✓	✓	✓				
Ms H Citrine	✓	✓	✓	✓	✓	✓				
Mr M Burns	✓	✓	✓	✓	✓	✓				
Mr M Gibney	✓	A	✓	✓	✓	✓				
Dr A Nicolson	✓	✓	✓	✓	✓	✓				
Ms J Ross	A	✓	✓	✓	✓	✓				
Ms L Salter	✓	✓	✓	✓	✓	✓				

97/19 WELCOME AND INTRODUCTION

The Chair welcomed members to the meeting and introductions were made.

98/19 APOLOGIES FOR ABSENCE

Apologies were received from Sharon McLoughin, staff governor.

99/19 DECLARATION OF INTEREST

There were no declarations of interest made in relation to the agenda.

100/19 MINUTES OF THE LAST MEETING AND MATTERS ARISING

The minutes of the last meeting were reviewed and the following amendments requested;
Page 1 M Gibney to be recorded as attending in April and attendance for July to be completed for all members. There were no other amendments.

The following updates were provided against outstanding actions:

TB28/19: Staff Experience Action Plan
The plan had been presented to Business Performance Committee in July and would continue to be monitored by the Committee.

TB79/19 Equality and Diversity Report
The Trust had approached Gatenby Saunderson and was awaiting confirmation of the next programme.

TB97/19 Integrated Performance Report
The initial plan had been submitted and the final 5 Year Plan was due for submission on 15th November. Mr Burns suggested that this was circulated to Board members for commented and then presented to BPC for review.

TB97/19 Integrated Performance Report
Pensions/tax issue.
Currently the total figure is not known, until all medics receive independent financial advice, when they will know if they are affected or not. It is estimated to be around 75%.

TB99/19 RDI Chairs Report
To invite the Chair of LHP to present to Board. It was agreed that it was more appropriate to invite the CEO.

The remaining updates were due for review at future meetings.

101/19 PATIENT STORY - MOTOR NEURONE DISEASE, OCCUPATIONAL THERAPY AND SOCIAL PRESCRIBING

Suzanne Simpson, Occupational Therapist shared the story of a patient diagnosed with Motor Neurone Disease and the impact on his independence. Through access to the MND wellbeing project being piloted in the Liverpool and Sefton area, the patient was able to access community wellbeing activities suited to his needs and interests.

A national study examining the factors that influence quality of life in patients with neurological conditions had found that people living with MND feel psychological support and wellbeing is important in helping them manage their condition. Through involvement with communities groups the patient gained confidence and reported that he found the activities valuable in helping to maintain his wellbeing and provide structure to his life. The project also gave the patient the confidence to attend an MND support group and connect with other people living with MND.

(Professor Thakkar joined the meeting)

Ms Salter congratulated Ms Simpson on the presentation and her incredible work that makes a difference to the lives of patients.

A discussion took place regarding social prescribing and the benefits to patients living in social isolation with long term conditions. It was aimed at patients with diabetes, respiratory and cardiac issues and patients with neurological issues were omitted. Due to the complex needs of these patients it was recommended that they were supported by link workers and Occupational Therapists and this approach had been discussed with Commissioners. It was recognised that it would be of value to capture the efficiencies created through the use of social prescribing and therefore how this benefits the whole system. Mr Burns suggested that it would be possible to use counterfactual analysis to understand this although it would need to be based on a number of assumptions.

Mr Crofts queried if resources across the system were effectively aligned to support the complex nature of these patients and how this continued when they are no longer a patient of the Trust. Ms Simpson replied that this is a challenge for Community Teams as often caseloads dictate a task focussed approach to care that did not always consider the patients social wellbeing. It was suggested that there may be an opportunity to utilise the Integrated Nurses role in supporting these patients.

Ms Spicer asked if there was an opportunity for other parts of the system to provide support to these patients such as Mersey Travel or Social Housing. It was acknowledged that travel is often a problem for these patients due to the need to have access to vehicles adapted for wheel chair users. These patients would also benefit from having support from committed volunteers such as those who were involved with the Brain Charity.

The Chair thanked Ms Simpson for her presentation.

The Board:

- **noted the patient story**

102/19 PEOPLE STRATEGY

Mr Gibney presented the People Strategy which had been revised following comments received by the Business Performance Committee.

The Strategy had been developed in the context of a fragmented and complex system and would provide focus on:

- New recruitment methods
- The development of new roles
- Integration of roles with Social Care

Key to the success of the strategy would be strong staff engagement to ensure that staff felt empowered to deliver the required change. A further piece of work was required to identify the priorities for the next 6-12 months, 2 years and 5

years and this would be informed by the national workforce review and consultation and with staff via the Local Negotiating Committee.

At a system level the Trust was working closely with social care and Liverpool Council had established a Strategic Workforce Planning Group focussed on alternative models which would be less dependent on nursing roles.

Ms Spicer queried how the strategy would address some of the current issues facing the Trust such as sickness absence, recruitment etc. Mr Gibney advised members that this would require a focus on recruiting the right people, investing in their development and health and wellbeing. It would also require a commitment to innovation and workforce transformation on a large scale. Ms Citrine added that there was an opportunity to use advanced technology to reduce the demand on the workforce.

Ms Rosser queried if there was a means of quantifying the benefits of the Health and Wellbeing Programme as this was designed, in part, to support the Trust in managing sickness absence and turnover. Mr Gibney responded that it was not possible to demonstrate a direct causal link however the existence of a Health and Wellbeing Programme demonstrated a caring culture. A discussion took place regarding the ability to measure the benefit to the Trust, whether this could be benchmarked with other Trusts. Ms Spicer suggested that the Board focus on whether the investment was being targeted appropriately and if increased investment would ensure greater improvement in sickness absence etc.

Ms Citrine stated that the Executive Team had discussed how the Trust could use communications in a more strategic and meaningful way. Whilst there have been several Health and Wellbeing initiatives the reasons for offering them to staff may not have been made clear and this could be improved. A discussion took place around how the Trust celebrates the achievements of staff and the how the revised staff award process, publicised in Team Brief, had been well received. Ms Rosser commented that it was important the Trust established effective mechanisms to share success stories and the things that were done really well with staff and not just highlight the negative matters.

The Board:

- **approved the People Strategy**

103/19 QUALITY STRATEGY

Ms Salter introduced the Quality Strategy and advised members that it had been developed in consultation with staff including Surgeons, Nurses, AHP's and patients and set out what Quality means to them.

The strategy contains six ambitions and describes where the Trust wants to be and the actions required to achieve the future state. It would be monitored by the Quality Committee bi-annually with more frequent scrutiny provided by the Quality Assurance Group. The Quality Account would provide detail of the progress for the full year.

Professor Thakkar commented that it would be helpful for the strategy to contain clear targets to demonstrate the changes that would be measurable and the timeframe for these. Ms Salter stated that the KPI's for the next 12 months could be added into the strategy in line with the format of other strategies.

The Board:

- **approved the Quality Strategy**

CQC INSPECTION REPORT

104/19 Ms Salter presented the CQC Inspection Report, reminding members that this was the second time that the Trust had been rated as outstanding and was one of only six trusts in the country to achieve this.

The CQC had been particularly impressed by the compassionate, inclusive and effective leadership at all levels of the organisation and that innovation and research across the Trust was apparent.

In addition the CQC were also impressed by the resilience of staff and the support provided by the Health and Wellbeing Programme and the Shiny Minds app available to staff. Ms Salter added that the Shiny Minds app had received an award of highly commended from the Leading HealthCare awards.

Ms Salter went on to highlight the breakdown of the ratings contained within the report advising members that there had been an improvement from good to outstanding in 3 areas. Although there were no "Must do's" there were some areas to action and a plan had been developed to address these. The action plan would be monitored via the Quality Committee and the Quality Assurance Group.

Ms Citrine commented that no other trust had achieved outstanding overall within the "effective" domain and that this was a testament to the staff. Dr Nicholson added that the work of the Surgical Division should be recognised particularly as it was difficult to benchmark the service and provide meaningful data.

Ms Rosser stated that on receipt of the report both her and Ms Citrine had personally thanked staff as they felt it was important to acknowledge their achievements.

The Board:

- **noted the CQC Report**

105/19 MORBIDITY AND MORTALITY QUARTERLY REPORT

Dr Nicholson presented the quarterly report noting that this had previously been reviewed by the Quality Committee.

The report showed that re-admission rates, mortality rates and surgical site infection rates were all stable.

The report now contained an additional section regarding the process around Learning From Deaths and End of Life Care and highlighted ongoing work. In line with national guidance the Learning from Deaths dashboard included within the report was published on the Trust's website.

Ms Rai queried how the Trust identified and cascaded lessons from individual cases. Dr Nicholson explained the process of review by the Serious Incident Review Group which involved a review of all Root Cause Analysis (RCA's) completed. The relevant themes were shared with the Divisions via their risk and governance groups and fed into ward and consultants meetings. Dr Nicholson stated that the Trust had considered using a bulletin to communicate this information to staff but had thought that this would not be as effective as the current approach.

Ms Spicer queried if there was an opportunity to utilise the human factor training and feed this into the learning process. Dr Nicholson stated that the Trust had started to introduce this approach and that all RCA's were now reviewed by the Human Factors Group and this would apply to all incidents not just deaths.

The Board:

- **took assurance from the quarter 2 report**

106/19 FREEDOM TO SPEAK UP SELF ASSESSMENT TOOL

Ms Salter presented the report advising members that there was a requirement for the Trust to complete a self-assessment in relation to its process for raising concerns. The framework for self-assessment clearly highlighted that it was the responsibility of the Board to set the culture of the organisation in order to support people to speak up. This included ensuring that there was an Executive Lead to ensure that the Guardian was equipped to fulfil their role and a Non-Executive Lead to provide independent support and advice to staff if required.

The Trust's Guardian had worked closely with the HR Team to ensure that the assessment was appropriate and that the action plan reflected the work that needed to be undertaken. Ms Spicer stated that it was really important that staff coming into the organisation understood the role and culture as not all staff would have an NHS background.

Ms Salter described the process for induction and how the Trust Guardian engaged and supported staff. October was designated as national Freedom to Speak Up month and the Trust's Guardian planned to issue a questionnaire to staff to enable the Trust to understand if staff felt supported to raise concerns.

Ms Rosser commented that the Trust was incredibly fortunate to have such an engaging and committed Guardian however she was conscious that the role would continue to evolve based on national requirements. A new initiative tilted "Relay" had been introduced which required Guardians to work closely with the Guardians from other local trusts to share learning

Mr Gibney commented that other Trusts had experienced issues between the Guardian and the HR function but the relationship within the Trust was operating well.

Action: Members to feedback any comments to the Director of Nursing: Due: November 2019

107/19 INTEGRATED PERFORMANCE REPORT

Ms Citrine presented the Integrated Performance Report advising members that it had previously been reviewed by both Quality Committee and Business Performance Committee. August had been an incredibly difficult month and this was fundamentally due to the national issue around pensions which was beyond the Trust's control.

The Trust had seen lower than normal activity because of a reduction in Waiting List Initiatives. Ms Citrine commended the executive team for working together to resolve the issue which included the establishment of a weekly activity huddle brining staff from all disciplines together, discussions between the Medical Director and Consultants and consideration of alternative solutions such as the use of Time off In Lieu (TOIL).

Ms Citrine reported that the Trust expected to meet its financial plan in September however it may not meet its planned activity levels or waiting times. In terms of quality performance the Trust was doing well in relation to mixed sex accommodation which was particularly good given the closure of beds.

Ms Samuels updated members in relation to the areas of assurance gained by the Business Performance Committee. The committee had received a presentation in relation to the financial position activity challenges and had been assured by the planned mitigations. Whilst the pension issue had been acknowledged as an issue it had highlighted the need to better understand activity and flow.

The Committee had also raised concerns about the Trust's statutory responsibility regarding 18 week referral to treatment target but recognised that as the Trust was not currently being monitored against this target operational oversight had been devolved to one appropriate individual who would escalate issues if appropriate.

The Committee noted the increase in sickness absence but recognised key pieces of work that were focussed on trying to understand and improve that figure. The compliance with statutory and mandatory training had fluctuated however it was recognised that this was due to annual summer leave.

A discussion took place regarding winter planning recognising that the Trust had previously supported acute Trusts in the region via the provision of nursing staff. Ms Ross advised members that the Trust had received a request for mutual aid for the provision of therapists to support transitional care. The Trust was currently looking at whether this support was viable. Further information would be shared at a regional planning meeting on 4 October.

Mr Crofts highlighted the key matters from the Quality Committee.

The Trust was currently rated as green and amber across the Safe KPIs .There had been one Category 4 Pressure Sore recorded and a root cause analysis was underway. There had also been one case of C-Difficile which equated to 3 incidents against a trajectory of 8. Vacancies were also discussed and it was noted that the Director of Nursing was working closely with HR to address the issue. The Committee had noted an increase in complaints linked to appointments.

108/19 WORK RELATED EQUALITY STANDARD

Mr Gibney took members through the report explaining that it had taken some time for the standard to gain traction and be understood within the NHS. Once the information was published the Trust would be able to obtain comparative data across the region.

The tool was extremely useful and contained 4 indicators that were linked to the organisations culture and measured in the Trust's staff survey. Of the 9 indicators within the standard the Trust had seen improvement in 8.

Mr Gibney highlighted the following positive messages within the report:

- In Cheshire and Merseyside the Trust was the largest employer of BME staff.
- There were no BME staff entering into the formal disciplinary process in
- There were more BME staff accessing non-mandatory training than White staff
- The percentage of BME staff experiencing harassment, bullying or abuse from patients, relatives and members of the public had decreased by 16.99% since the last year

Ms Citrine stated that this was a positive position and a significant improvement from the original assessment. The Trust planned to include a feature in Team Brief to celebrate this and acknowledge the work around the Equality, Diversity and Inclusion 5 Year Vision which had supported this improvement.

The Board:

- **noted the report**

109/19 WORK RELATED DISABILITY STANDARD

Mr Gibney explained to members that this was the first year of collecting data and would therefore provide a baseline across the NHS. Learning from the work positive results of the WRES the Trust had developed its approach with Staff Side and set up a number of groups to understand how to move the agenda forward.

The greatest challenge was supporting staff to declare a disability and therefore

communication was key not only to clarify which health issues were classed as a disability and give reassurance that they would not experience any detriment.

It was important that staff understood that the purpose of making a declaration was to ensure that they received support and that reasonable adjustments would be put in place. The Trust had some really good examples of how it has provided support and made reasonable adjustments and these could be utilised in future communications.

Mr Gibney stated that whilst the Trust's position of 3.14% was marginally above the national average of 3%, it was believed that the real figures was somewhere between 15-18%.

Professor Thakkar observed that if the data was collected from staff at the point of application it would be natural that they would fear discrimination. A discussion took place around how the Trust could support staff to ensure that they would make a declaration, if appropriate and how this could be kept under review.

The Board:

- **noted report**

110/19 GOVERNORS ELECTION RESULTS

Ms Rosser advised members of the outcome of the recent governor elections. There had been 7 vacancies for public governors and 2 for staff governors. The results were as follows:

Merseyside	**Cheshire**	**North Wales**
Natalie Dill	Alison Astles	Nicola Brown
Linda Coles		
William Givens		

Rest of England
Cameron Hill
Chris Sutton

Staff Governors
Rhys Davies (re-elected)
Jan Harrison

There remain a number of vacancies amongst partnership governors including Sefton and Liverpool Local Authorities, North Wales Neurological Conditions Partnership and Liverpool CCG. This presented an opportunity to review the composition of the Council of Governors and the organisations best placed to engage with the membership of the communities that the Trust serves.

111/19 CHAIRS ASSURANCE REPORTS AND MINUTES

Ms Samuels presented the key issues from the meeting of the Business Performance Committee held on 24th September 2019.

Overdue Follow up Waiting List (FOWL)

- This had continued to reduce and the current total waiting was 13,000.
- No patients waiting over 2 years
- 600 waiting between 18 – 24 months

The waiting list had been fully validated and the committee were assured that no patients had suffered harm as a as a result of waiting for treatment. A further update would be provided at the next meeting.

Sickness Absence Management Audit.
Following recommendations by MIAA the HR team conducted an in house audit of sickness absence; using a small sample:

- Return to work interviews for short term absence were not always completed in a timely manner – e.g in excess of 20 days
- Poor record keeping around return to work interviews and discussion around reasonable adjustments

An action plan had been established to address the issues and it would be included within line manager training.

The Committee approved the extension of the contract for the Radiology Information System. Whilst the Trust may want to look at alternative systems it was currently in a consortium with 11 other trusts.

The Committee had received an update on the Digital Strategy and noted that further work with stakeholder groups would be undertaken before it was presented in its final form.

The Service Transformation team provided an update and the good start made by the team was noted. It was agreed that the Committee would receive regular summary reports on the progress of the Transformation Programme.

The following matters were escalated for the Board's attention:

- The Trust's financial position
- 2 Information Governance Breaches

Mr Burns reported that these had similar themes to other recent breaches and work was underway to raise awareness to staff regarding the importance of managing information. .

Mr Crofts updated members following the Quality Committee held on 19th September 2019:

- A presentation from the Dietetic Service demonstrated a commitment to service transformation, research and development
- Good progress was noted in the number of staff undertaking "Making

every contact count" training
- In order to meet the CQUIN target the Trust needed to engage an alcohol/substance misuse practitioner and was negotiations were taking place with other Trusts
- CQC Insight Report – some concerns regarding the currency of the information and how applicable it was for the trust. The Committee would keep this under review
- Pharmacy KPI Report - showed some amber indicators due to unavailability of staff to participate in MDT ward rounds
- Quality Surveillance report – Trust compliant with all relevant indicators

Professor Thakkar updated members following the meeting of the Research Development and Innovation Committee held on 11TH September 2019.

The key matter for consideration by the Committee was the Innovation Strategy which was agreed for approval by the Trust Board.

Ms Citrine presented the key issues from the Neurosciences Programme Board held on 13th June 2019. The Committee focussed on the use of data to inform decision making and how patients with neurological conditions were recorded when accessing A&E. The data demonstrated that the work underway was focussed on the right pathways and would support more targeted work.

112/19 ANY OTHER BUSINESS

Ms Ross updated members on recent national and regional discussions in relation to Brexit. The Board had received a report in March 2019 and was assured that the Trust had taken all prescribed steps in readiness and was continuing to be involved in all relevant planning exercises.

The Trust had reviewed its business continuity plans to ensure that they are up to date and robust. From 1st October there was a requirement for trusts to submit daily situation reports to NHSI highlighting the current position and any risks identified.

Across the system the focus is on a number of key areas:

- Income changes due to the requirement to charge EU Nationals for elective care
- Supplies of medicines/medical devices and sourcing additional stock and the logistical challenges of transporting stock had been managed at a national level
- Workforce – this had more significance for Birmingham and London but analysis showed this was a minor risk for Cheshire and Merseyside
- Traffic congestion – there was a possibility that this could be an issue on the days immediately following Brexit

Ms Rosser queried if the Trust planned to issue specific communications to staff in relation to Brexit. Ms Ross confirmed that the Trust was working on a series of staff bulletins on the implications of Brexit including potential transport difficulties. Professor Thakkar queried if the number of EU staff employed by the Trust was significant. Ms Ross stated analysis showed this not to be an issue for

the Trust.

DATE AND TIME OF NEXT MEETING
The next meeting of the Trust Board held in public is due to be held on Thursday 28 November 2019

TRUST BOARD
Matters arising Action Log:

	Complete & for removal
	In progress
	Overdue

Date of Meeting	Item Ref	Agenda item & action	Lead	Update	Deadline	Status
26.03.2019	TB28/19:	**National Staff Survey Results 2018** To present the updated staff engagement plan to a future Board meeting	M Gibney	Deferred until July The staff engagement plan has been reported to the Business, Performance Committee in August..	July 2019	
27.06.2019	TB79/19	**Equality, Diversity and Inclusion Report** To follow up the offer of the Trust supporting the Insight Programme	J Rosser	Contact has been made with Gatenby Sanderson who will advise when the next NW Insight Programme is being developed.	Sept 2019	
25.07.2019	TB97/19	**Integrated Performance Report** To provide an update in relation to the timeframe for submission of the 5 Year Plan and request the Board to delegate authority for approval if necessary	M Burns	Initial plan submitted 13th Sep.	Sept 2019	
25.07.2019	TB97/19	**Integrated Performance Report** To provide the total percentage of Medical staff who will be affected by the pension and tax issues relating to higher earners.	Dr A Nicolson	Verbal update to be provided.	Sept 2019	
25.07.2019	TB99/19	**RDI Chairs Report** To invite the Chair of LHP to present to Board	J Rosser		Sept 2019	
26.09.2019	TB106/19	**Freedom to Speak Guardian Report** Members to feedback any comments to the Director of Nursing:	L Salter		November 2019	

Actions for future meetings

27.06.2019	TB 78/19	**Annual Safeguarding Report** Director of Workforce & Innovation to provide an update on benchmarking with other organisations regarding DBS check approach/ funding	M Gibney		Oct 2019	
25.07.2019	TB 96/19	**Quality Committee Terms of Reference** To review the membership and Terms of Reference for all of the Board Committees	Co Sec		Nov 2019	

UNCONFIRMED

MINUTES OF THE WALTON CENTRE NHS FOUNDATION TRUST EXTRAORDINARY OPEN BOARD MEETING HELD ON WEDNESDAY 30th OCTOBER 2019

Present

Ms J Rosser	Chair
Ms S Samuels	Non-Executive Director
Mr S Croft	Non-Executive Director
Prof N Thakkar	Non-Executive Director (by phone)
Ms H Citrine	Chief Executive
Mr M Burns	Director of Finance & Information Technology
Mr M Gibney	Director of Workforce & Innovation
Ms L Salter	Director of Nursing & Governance

In Attendance

Ms Wells	Deputy Director of Finance
Ms J Hindle	Corporate Secretary

Apologies

Ms J Ross	Director of Operations & Strategy
Dr A Nicolson	Medical Director
Ms B Spicer	Non-Executive Director
Ms S Rai	Non-Executive Director

Trust Board Attendance 2019-20

Members:	Apr	May	Ext May	Jun	Jul	Sept	Ext Oct	Nov	Jan	Feb	Mar
Ms J Rosser	✓	✓	✓	✓	✓	✓	✓				
Mr S Crofts	✓	✓	✓	✓	✓	✓	✓				
Ms A McCraken	✓	✓									
Ms S Samuels	✓	✓	✓	✓	✓	✓	✓				
Mr A Sharples	✓	✓	✓	✓							
Ms B Spicer				✓	✓	✓	A				
Ms S Rai						✓	A				
Prof N Thakkar	A	✓	✓	✓	✓	✓	✓				
Ms H Citrine	✓	✓	✓	✓	✓	✓	✓				
Mr M Burns	✓	✓	✓	✓	✓	✓	✓				
Mr M Gibney	✓	A	✓	✓	✓	✓	✓				
Dr A Nicolson	✓	✓	✓	✓	✓	✓	A				
Ms J Ross	A	✓	✓	✓	✓	✓	A				
Ms L Salter	✓	✓	✓	✓	✓	✓	✓				

113/19 WELCOME AND INTRODUCTION

The Chair welcomed members to the meeting.

114/19 APOLOGIES FOR ABSENCE

Apologies were received from the above members.

115/19 DECLARATION OF INTEREST

There were no declarations of interest made in relation to the agenda.

116/19 PLANNING TIMEFRAME

Ms Wells outlined the timeframe for the Five Year Plan and the Trust's Operational Plan for 2020 as follows:

- STP's/ ICS's expected to create 5 year strategic plans;
- Covers period 2019/20 (year 1) to 2023/24;
- Initial submission made to STP – 13th September;
- 2nd submission due to STP 31st October;
- National LTP submission due to NHSI from STP 15th November;
- Further operational & technical guidance due to be issued from NHSI/E December 2019;
- 1st submission of draft 2020/21 operational plans due early Feb 2020;
- Final submission of operational plans due end of March 2020.

The Board:

- **noted the planning timetable**

117/19 AOB

There being no further business the meeting closed.

REPORT TO THE BOARD
Date November 2019

Title	**Staffing Paper – 6 monthly report**
Sponsoring Director	Name: Lisa Salter Title: Director of Nursing & Governance
Author (s)	Name: Lindsey Vlasman Title: Deputy Director of Nursing & Governance
Previously considered by:	Senior nursing team
Executive Summary The purpose of this paper is to provide assurance regarding nurse and other clinical staffing at The Walton Centre. This review is undertaken 6-monthly as per NICE guidance, with the last paper being presented in May 2019. The review is undertaken to ensure that all stakeholders including patients, families, staff and the Trust Board recognise and understand any risks and assurances associated with current staffing levels and the actions required to ensure quality care is delivered in a safe and cost effective manner. This paper identifies that staffing is safe within The Walton Centre and the Board are requested to receive a further report in 6 months, or sooner should this be required. During the last 6 months the main area of focus has been CRU due to concerns related to recruitment and retention. Within this paper the trust have also included the workforce safeguards working closely with NHSI looking at staffing in other clinical areas as well as nursing.	
Related Trust Strategic Objectives	Deliver best practice care Invest be financially strong Lead research, education and innovation Recognise as excellent in all we do
Risks associated with this paper	As contained within the paper
Related Assurance Framework entries	Related to BAF risk on national nurse shortages and ability to maintain safe staffing levels. Risk Number 0035
Equality Impact Assessment completed	N/A
Are there any associated legal implications / regulatory requirements?	• Yes – NHSE / NHSI and CQC requirements and regulations
Action required by the Board	• To acknowledge and support the requested changes • Receive a further report in 6 months

1. Executive Summary

The purpose of this paper is to provide assurance regarding nurse staffing at The Walton Centre. This review is undertaken 6-monthly as per NICE guidance, with the last paper being presented in May 2019. The review is undertaken to ensure that all stakeholders including patients, families, staff and the Trust Board recognise and understand any risks and assurances associated with current nurse staffing levels and the actions required to ensure quality care is delivered in a safe and cost effective manner. This paper identifies that staffing is safe within The Walton Centre and the Board are requested to receive a further report in 6 months.

Also included in this paper is an overview of staffing in other clinical areas in the trust, the paper has identified that staffing is safe for AHPs, Neurophysiology and Radiology.

2. Introduction and Background

This review is undertaken 6-monthly as per NICE guidance, with the last paper being presented in May 2019. Several national documents have been written about safe staffing in recent years including, “Safe and effective staffing: Nursing against the odds” (RCN, 2017), National Quality Board (2016), NICE safer staffing (2014), “The Francis review” (2013) and “The Berwick Review” (2013). The guidance from these documents has been considered when reviewing the staffing for nursing at WCFT. The Trust also acknowledges work undertaken by NHSE, CQC and NHS Improvement pertaining to safe staffing, efficiencies and the recent recruitment and retention work and this has also been referenced as part of the review.

NHSI released a new document in October (2018) entitled ‘Developing Workforce Safeguards’. The Trust have now changed the presentation of the staffing paper, to incorporate the wider workforce. A task and finish group was developed to look at how the Walton Centre will manage future staffing reviews for all staff groups, which can be seen in this paper.

3. Staffing situation since the presentation of the May 2019 nurse staffing review

- Lead Nurse for Neuro Surgery has commenced in post in October 2019.
- The Corporate Trust Secretary has now commenced in post in October 2019
- CRU Ward manager and Outpatients manager have now commenced in their role
- Diabetes Nurse Specialist commenced in post in July 2019
- 4 Trainee Nurse Associates have commenced in post in September 2019
- Tissue Viability Specialist Nurse post out to advert in October 2019

4. Methodology

Staffing data, Care Hours Per Patient Day (CHPPD) and actual against planned staffing is analysed monthly and is uploaded to the National Database (Unify), to the WCFT website for public access and reported to Trust Board. In addition to this a 6-monthly report is completed, the last one being in May 2019. Various tools were used to undertake the ward review, including the “safer nursing care tool” (SNCT also known as AUKUH) and the professional judgement model, as recommended by NICE (2014). The safer nursing care (SNCT-patient acuity tool) data has been collected Monday – Sunday for a three week period during October 2019 by the ward manager / designated nurse in charge. The data was collected for 21 days consecutively as activity can vary at weekends. The exception here is Horsley ITU and HDU as they utilise the Intensive Care Society (ICS) guidance. The data collation was overseen by the Matrons to ensure consistency.

The funded establishments were compared to actual establishments and this information was compared against nurse sensitive indicators. Nurse sensitive indicators include patient falls, infection rates, pressure ulcers, incidents, complaints, sickness, appraisal KPIs, staff turnover and

medication errors. These were reviewed to determine whether there were any concerns in any of the specific ward areas. No evidence was found that highlighted concerns. Previous reports to the Trust Board have described each element of the methodology in detail and it was agreed at a previous review this was not repeated in future reports. NHSI have suggested that planned versus actual staffing levels is no longer required but we have decided as a trust we will continue to undertake this as we felt it provides better assurance than CHPPD and other trusts have also decided to continue with this.

5. Benchmarking

In order to ensure that The Walton Centre are comparable with other neuroscience services across the UK, benchmarking data has been acquired, comparing registered nurses (RN) to patient ratios. Due to the acute specialty and acuity of the patients within Neurosciences across all areas, the ratios are better than the NICE guidance of 1 RN to 8 patients.

It should be noted that whilst 1:8 ratio is recognised by NICE, there are various concerns within the nursing arena that do not feel this can be aligned to all groups of patients as often a nurse to patient ratio needs to be lower due to patients requiring closer monitoring. A further benchmarking exercise will be undertaken in May 2020.

Wards and specialty (November 2019 Benchmarking)	**WCFT ratio**	**Trust 1 ratio**	**Trust 2 ratio**	**Trust 3 ratio**
Cairns: neurosurgery (hydrocephalus and neuro oncology)	1:6	1:5	1:6	N/A
Caton: neurosurgery (spinal and spinal trauma)	1:6	1:5	1:6	N/A
Chavasse: neurology (complex neurological conditions and telemetry)	1:5	1:4	N/A	N/A
CRU: complex rehabilitation unit	1:7	N/A	1:4	1:6
Dott: neurosurgery (vascular)	1:6	1:5	1:6	N/A
Lipton: Hyper acute rehabilitation	1:3	N/A	1:4	N/A
Sherrington: Neurosurgery (cranial trauma and spinal)	1:6	1:5	1:6	N/A

Whilst CRU has a ratio of 1:7 and this is higher than the other 2 Trusts, they do have a higher percentage of healthcare assistants in their area due to the highly complex needs of the patients. CRU have 6 HCA on day shifts and 5 HCA on night shifts, the 2 other trusts that the benchmarking exercise has been completed have 4 HCA and 3 HCA.

This has been discussed at ward and Divisional Risk and Governance level to confirm the appropriateness and further work is underway to confirm this. Adequate staffing numbers are required in order to provide a safe environment for the increasing number of high risk patients being admitted with several requiring 1-1 supervision. This allows the registered nurses to concentrate on the more acute aspects of care delivery in this area. Lipton ward has a higher ratio of RNs to patients due to the complex nature of the patients as many can be stepped down from Horsley ITU.

6. Care Hours Per patient Day (CHPPD)

As highlighted in the previous staffing report, care hours per patient day originated from guidance put forwards by the Carter review and NICE guidance to enable Trusts to have comparable data for staffing. CHPPD highlights both the staff required and actual in relation to the number of patients in the ward. This is calculated by adding the hours of RN to the hours of a HCA and dividing the total by 24 hours of every in-patient stay in the hospital. Comparisons of CHPPD data highlight wide variations from Trust to Trust, hence at WCFT the use of benchmarking data is also utilised. The Trust average of CHPPD from May 2019 to November 2019 is 13.07 (overall for RN and HCA staff) which is as expected. This data is captured monthly and reported to Trust Board and displayed to the public on the WCFT website.

7. Results

Overview compliance status of areas, following reviews of SNCT, professional judgement and indicators:

Cairns ward	*Compliant*
Caton ward	*Compliant*
CRU	*Compliant*
Dott ward	*Compliant*
Horsley ITU / HDU	*Compliant*
Jefferson ward	*Compliant*
Lipton ward	*Compliant*
Sherrington ward	*Compliant*
Theatres	*Compliant*

This confirms compliance with safe staffing across the Trust. As part of the process in reviewing the compliance status of all wards, a triangulation process has been used to look at and themes for the wards regarding complaints, any harm to patients, incidents, FFT and the Nursing Assessment and Accreditation System (CARES) assessments for all of the areas are currently being undertaken.

8. Quality & Safety

Each division is working to ensure safe staffing for every area on a shift by shift basis. The Matrons and Ward Managers work closely to ensure effective and efficient strategic monitoring and management of staffing with the principle aim to promote patient safety and optimise patient and staff experience.

Following the safety huddle an additional daily meeting is held to review safe staffing. All ward areas are reviewed and assessed to understand the staffing levels required for the shift and also reviewing the amount of patients who require an enhanced level of care. As part of this, the team also review ward capacity and acuity, to see if wards can be closed and also if staff can be redeployed to other areas to support with delivering safe patient care.

9. Challenges and Risks

Registered Nurse Recruitment: This has been a challenge for the Trust and this is a recognised national issue across the UK. There are currently just fewer than 19,000 vacancies in Cheshire and Merseyside and a third of the staff in post are over 50 years of age. The senior nursing team is currently undertaking a piece of work around age profiling of our staff and planning for the future, looking at retire and return initiatives. However The Walton Centre has lower vacancies than other trusts.

In addition, there has been lots of publicity regarding the future of the NHS and negativity regarding

the Nursing profession and how the role is tougher than ever, with a lack of financial support during training and the agency cap for registered nurses. Health Education England are reviewing how these messages are impacting on nurse recruitment and what actions need to be taken nationally. In recent months a national campaign has been launched to recruit more nursing staff.

As a consequence there are several actions that have been undertaken at WCFT to ensure that effective and timely recruitment is occurring. The Trust have reviewed their approach to recruitment of registered nursing staff, recruiting corporately rather than by ward to ensure that time is saved for ward managers and the HR recruitment team.

The Trust have organised recruitment open days with the ability to meet the nursing teams, have a tour of the hospital and be interviewed on the day; attended local and national recruitment fairs; attended university events and advertised locally and across social media. WCFT have also introduced a rotational programme to allow nurses the opportunity of moving between wards every 6 months. At present we have 4 RNs on the wards rotation. This provides the nurses with enhanced knowledge and skills whilst also enhancing the team working between areas and the ability to cross cover short termed sickness in a safe manner. Following feedback from the rotation we have also offered internal staff rotation opportunities. We are also considering looking at rotations between other specialist trusts.

The Trust has several initiatives in place to increase recruitment to the Trust, including return to practice (RTP) and trainee nurse associates (TNA). RTP allows for experienced registered nurses to return to the NHS who have allowed their PIN numbers to lapse. Such nurses attend a university course whilst also undertaking practical skills and care delivery within the hospital. We currently have 1 return to practice nurse on CRU.

TNA is an initiative to increase the skills and knowledge of staff enabling them to work at a band 4 position whilst enhancing the workforce. The Trust has 4 TNAs that completed their training course in April 2019 and are now in post as Nursing Associates the role has proved very successful. The Trust have now funded a further 4 places with Edge Hill University who commenced in September 2019. The WCFT would have a preference for band 5 Registered Nurses but due to the shortage in recruitment the (TNA) will replace these roles. If in the future if we can recruit more band 5 nurses we will undertake this method of recruitment.

Nursing retention:

The process for exit interviews has been reviewed by HR and the freedom to speak up guardian to support staff and have an understanding of why staff are leaving the Trust and understand what we can do to support and encourage staff to stay.

Work has been undertaken with the new starters to ensure they have been provided with enough support and have settled in their areas; meetings have been held on CRU where all staff were invited to attend and this was a successful session. The Deputy Director of Nursing and Governance has also attended the preceptorship days to meet staff and listen to their experience at The Walton Centre and will continue to do this on future preceptorship days.

The Trust are also encouraging retire and return programmes to support staff who want to reduce their hours and work in different areas throughout the Trust.

The Trust has recently introduced the resilience shiny minds app which will support staff to remain resilient, reduce sickness and reduce stress at all times of the day. Messages of positivity have been shared through the app between staff members.

Monthly staff listening walkabouts have been implemented in October 2019 with the Deputy Director of Nursing and Governance and The Deputy Director of Human Resources. To listen and support staff and try and understand what improvements can be made for retention.

10. Complex Rehabilitation Unit

The British Society of Rehabilitation Medicine (BSRM) provides guidelines on minimum staffing provision for specialist in-patient rehabilitation services. The guidance recommends a minimum 45% ratio of RN staff to 55% ratio Health Care Assistants (HCAs). With the additional posts invested from the nursing pool, CRU currently has a 43% ratio of RN staff to 57% ratio HCAs. The BSRM notes that specialised services such as CRU whom care for patients with highly complex needs require sufficient staffing levels to provide a safe environment for such high risk patients whom often require 1-1 supervision. The single side room layout of the ward creates a huge challenge to maintain patient safety with such a complex patient cohort. The unit has recently submitted a proposal for a video surveillance system to be installed to support monitoring of patients requiring increased levels of observation (level 2 and 3). This was approved and will reduce waiting times for admission and enhance throughput of patients through the Cheshire and Merseyside rehabilitation network. Whilst allowing us to monitor patient safety without a significant increase in staff resources. Patient numbers requiring level 4 observation (nurse within arms length) has proven to be consistently high therefore we are reviewing our existing establishment to ensure we can support maximum numbers safely.

In May 2019 a new Ward Manager commenced in post whom has previous experience of working on the CRU. All RN posts have now been successfully recruited to; with some pending starting in April 2020 on qualifying. We have reviewed ward establishments and identified a need for a senior nurse on each shift the establishment has been reconfigured to achieve this.

Due to previous numerous significant concerns being raised in recent years on CRU a Trust CRU action plan was developed which is regularly updated. Regular reports and updates have been provided to Trust Quality Committee on proposed and completed progress.

Turn Over for CRU

10/18	11/18	12/18	01/19	02/19	03/19	04/19	05/19	06/19	07/19	08/19	09/19
3.57%	**1.79%**	**5.64%**	**1.82%**	**3.77%**	**2.06%**	**0**	**4.51%**	**9.74%**	**4.87%**	**0**	**5.12%**

Quality Indicators for CRU (May 2019 - October 2019)

	Number	Action
Medication Errors:	0	
Moderate harm falls	0	
Pressure ulcers	2	CRU have had 2 pressure ulcers category 2 and above both of these have been investigated with management plans in place for patients.

Complaints	0	

Safe Staffing

Establishment	AUKUH Nursing Tool	Professional Judgement
58.23	**54.26**	**53.7**

ITU (Horsley)

ITU is a speciality service that is essential to the Trust for the delivery of the core services. In critical care we provide complex clinical care for level 2 and level 3 patients. In total we have 16 level 3 beds and 4 level

2 beds. Level 3 patients require 1:1 nursing care, while level 2 patients can be provided care on a 2:1 ratio. However, increased screening and development of multi drug resistant organisms, has seen an increase in the need of side rooms, which can be required by a level 2 patient but still require 1:1 nursing ratio. 1:1 nursing may also be required to safely meet the needs of a level 2 patient who has increased monitoring needs or delirium.

A Matron has also been recruited to support ITU to support the standardisation of practice across theatres and ITU alongside the lead nurse. This is working extremely well, across both areas. We have had a period of increased sickness on ITU, over the winter months and additional bank was booked to support this.

Turn Over ITU Horsley

10/18	11/18	12/18	01/19	02/19	03/19	04/19	05/19	06/19	07/19	08/19	09/19
0	**2.28%**	**0**	**2.94%**	**0**	**1.82%**	**0**	**0**	**3.82**	**0**	**0.97**	**0.96**

Quality Indicators ITU Horsley (May 2019-October 2019)

	Number	Action
Medication Errors:	1	A daily audit is undertaken for missed doses of medications and shared with the senior nursing team. Checks by matrons and pharmacy are undertaken Monitoring is undertaken in the safer medications group and D&T Group. There are no themes.
Moderate Harm Falls	0	
Pressure ulcers	0	

Complaints	0	

11. Theatres

There are 6 operational theatres within the department for elective lists, 1 emergency theatre running 24/7, and 1 fallow theatre. Each theatre (in hours), is staffed by a HCA, 2 scrub staff and an ODP, the co-ordination is overseen on a daily basis by a super numerary co-ordinator. The recovery area has 9 'bed areas' and is staffed on a 1:1 basis with a super numerary co-ordinator. Out of hours team consists of 1 HCA, 1 Scrub nurse, 1 ODP, 1 anaesthetist, 1 surgeon – with access to the SMART team if there are life threatening concurrent emergencies. Within the establishment we facilitate two late lists past 6pm and for a planned overrun on a three session day there is an on call agreement for scrub and ODP.

The Trust invested in an over establishment within theatres, acknowledging the requirement of scrub and ODP staff to facilitate running of an effective theatre schedule.

With the same day admission patients we have a same day admission unit which is staffed by a HCA – this enables the flow of patients and has facilitated increased utilisation of ward beds. The forward wait is also staffed by HCAs, which is an 8 bay area for patients waiting to go into the anaesthetic room.

The management structure for both theatres and ITU, has now changed to have 1 Lead Nurse who manages both areas. This has enabled the Trust to stream line services and support the teams in working together. The Divisional Nurse Director is also working closely within the AFPP(Association of Peri-Operative Practice) guidelines to ensure staffing remains safe between both areas.

A new role has been introduced in theatres in February 2019, the Surgical Theatre Assist role, the role assists the medical staff in theatres no additional funding has been given for these roles the competencies and training has been undertaken for the band 7 and band 6 roles in theatre. The governance processes around this role have been monitored via the Theatre User Group and feed into Divisional Governance.

Turn Over for Theatres

10/18	11/18	12/18	01/19	02/19	03/19	04/19	05/19	06/19	07/19	08/19	09/19
0	1.06%	0.39%	0	0	3.01%	0	0	0	0	2.28%	6.22%

12. Overview of the wards

Jefferson Ward

Jefferson ward is located next to the Theatre complex to allow for patients to be transferred for their surgery in a seamless manner. The team work alongside the Theatre surgical and recovery teams to ensure patient safety and experience is maximised. Patient care is supported in this area by Advanced Practitioners who provide hands on care and education to patients and staff alike. Since same day admission was commenced, Jefferson ward staff have adapted their hours to suit the newer requirements of the ward to support same day patients and processes whilst maintaining their day surgery activity successfully.

Jefferson ward is out to advert for their vacant Advanced Practitioner position.

There have been no quality indicators on Jefferson in the last 6 months.

Turn Over for Jefferson

10/18	11/18	12/18	01/19	02/19	03/19	04/19	05/19	06/19	07/19	08/19	09/19
0	0	0	0	0	0	0	0	0	0	0	0

Sherrington Ward

Quality Indicators (May 2019-October 2019)

	Number	Action
Medication Errors:	1	A daily audit is undertaken for missed doses of medications and shared with the senior nursing team. Checks by matrons and pharmacy are undertaken Monitoring is undertaken in the safer medications group and D&T Group. There are no themes.
Moderate harm falls	0	
Pressure ulcers category 2 and above	0	
Complaints	1	The complaint was regarding an issue about the patients discharge

Turn Over for Sherrington Ward

10/18	11/18	12/18	01/19	02/19	03/19	04/19	05/19	06/19	07/19	08/19	09/19
0	0	2.45%	2.46%	5.34%	0	0	0	0	0	0	4.72

Safe Staffing

Establishment	AUKUH Nursing Tool	Professional Judgement
42.23	37.44	34.7

Caton Ward

Quality Indicators (May 2019-October 2019)

	Number	Action
Medication Errors:	0	A daily audit is undertaken for missed doses of medications and shared with the senior nursing team. Checks by matrons and pharmacy are undertaken Monitoring is undertaken in the safer medications group and D&T Group.
Moderate harm falls	0	
Pressure ulcers category 2 and above	0	
Complaints	1	Medication delay and pain management

Turn Over for Caton Ward

10/18	11/18	12/18	01/19	02/19	03/19	04/19	05/19	06/19	07/19	08/19	09/19
2.73%	**0**	**2.56%**	**0**	**0**	**4.10%**	**0**	**0**	**0**	**0**	**0**	**0**

Safe Staffing

Establishment	AUKUH Nursing Tool	Professional Judgement
39.72	**35.66**	**34.7**

Cairns Ward

Quality Indicators (May 2019-October 2019)

	Number	Action
Medication Errors:	1	A daily audit is undertaken for missed doses of medications and shared with the senior nursing team. There are no themes Checks by matrons and pharmacy are undertaken Monitoring is undertaken in the safer medications group and D&T Group.
Moderate harm falls	0	

Pressure ulcers category 2 and above	0	
Complaints	1	Issues with nursing care and communication

Turn Over for Cairns Ward

10/18	11/18	12/18	01/19	02/19	03/19	04/19	05/19	06/19	07/19	08/19	09/19
0	**0**	**4.50%**	**4.12%**	**3.04%**	**1.67%**	**10.74%**	**3.33%**	**0**	**0**	**0**	**0**

Safe Staffing

Establishment	AUKUH Nursing Tool	Professional Judgement
41.22	**36.88**	**34.7**

Dott Ward

Quality Indicators (May 2019-October 2019)

	Number	Action
Medication Errors:	2	A daily audit is undertaken for missed doses of medications and shared with the senior nursing team. There are no themes. Checks by matrons and pharmacy are undertaken Monitoring is undertaken in the safer medications group and D&T Group.
Moderate harm falls	0	
Pressure ulcers category 2 and above	0	
Complaints	0	

Safe Staffing

Establishment	AUKUH Nursing Tool	Professional Judgement
39.11	**34.26**	**34.7**

Turn Over for Dott Ward

10/18	11/18	12/18	01/19	02/19	03/19	04/19	05/19	06/19	07/19	08/19	09/19
4.07%	**0**	**2.91%**	**3.49%**	**0**	**5.21%**	**0**	**0**	**0**	**0**	**0**	**0**

Chavasse

Quality Indicators (May 2019-October 2019)

	Number	Action
Medication Errors:	2	A daily audit is undertaken for missed doses of medications and shared with the senior nursing team. There are no themes. Checks by matrons and pharmacy are undertaken Monitoring is undertaken in the safer medications group and D&T Group.
Moderate harm falls	0	
Pressure ulcers category 2 and above	0	
Complaints	3	Attitude of the nursing staff these have been fully investigated.

Turn Over for Chavasse

10/18	11/18	12/18	01/19	02/19	03/19	04/19	05/19	06/19	07/19	08/19	09/19
0	**0**	**1.56%**	**0**	**0**	**1.98%**	**4.55%**	**0**	**10.04%**	**0**	**3.32%**	**0**

Safe Staffing

Establishment	AUKUH Nursing Tool	Professional Judgement
57.76	**45.80**	**53.4**

Lipton

Quality Indicators (May 2019-October2019)

	Number	Action

Medication Errors:	0	
Moderate harm falls	0	
Pressure ulcers category 2 and above	0	
Complaints	0	

Turn Over for Lipton

10/18	11/18	12/18	01/19	02/19	03/19	04/19	05/19	06/19	07/19	08/19	09/19
0	0	0	0	0	3.67%	7.49%	0	0	0	6.69%	0

Safe Staffing

Establishment	AUKUH Nursing Tool	Professional Judgement
31.76	25.34	25.8

Infection Rates for all clinical areas from May 2019-October 2019

Clinical Area	C Diff	CPE	E Coli	MSSA	MRSA
Sherrington	0	0	2	0	0
Caton	1	0	0	0	0
Cairns	1	0	0	0	0
Dott	0	0	1	0	0
Chavasse	0	0	1	0	0
Lipton	0	0	0	0	0
CRU	0	0	1	0	0
H/ITU	1	0	1	2	0

13. Uplift

The uplift of establishments is set at 21% RN and 19% HCA to ensure that staffing is appropriate and financially viable. The uplift whilst lower than the national average, accounts for the higher dependency on newly qualified staff who do not have the additional leave (week) that staff who

have worked for the NHS longer are entitled to, training requirements of each staff groups, as well as other leave arrangements.

Actions have been taken to improve fill rate of shifts with NHSP and the nurse bank has successfully been implemented across the Trust. This has been really positive and from September 2018 we have seen a reduction in agency and an increase in bank which was the pattern we wanted to see. The teams are currently reviewing how bank staff are requested to ensure that appropriate decision making is in place and staffing is safe. As part of this review overtime will be stopped, and a further review of pay rates will be undertaken as part of the collaboration work across Merseyside and Cheshire.

14. Revalidation

The implementation of the revalidation process by the Nursing and Midwifery Council in April 2016 has been supported within WCFT by a revalidation administration support who has worked with registered nurses Trust-wide to ensure that all revalidation requirements have been fulfilled. The Nursing Quality Lead also supports with the revalidation process. This has resulted in every RN revalidating and ensuring that all RNs could re-register and no PIN numbers have lapsed. All staff have been supported throughout this process.

15. Staffing Each Shift

Staffing has been reviewed by the senior nursing team alongside the finance team. Staffing has been altered and improved due to staff wanting to work long days which has allowed extra staffing on some shifts whilst being cost-neutral.

Meetings are held regularly with the budget holders, the Director of Nursing and Governance and the Deputy Director of Finance to work closely with the Ward Managers and ensure they are managing their budgets effectively.

16. Staffing in other Areas

Radiology

There is a national shortage of Consultant Radiologists (14%) and Radiographers (11%) .
We currently have 1.2 WTE Consultant vacancy, and a further 0.5wte post will be available from November, but we have 2 Clinical fellows in training who will be suitable for appointment in 2020. Utilising 'reporting from home' has increased reporting volumes and has removed the requirement for reporting WLI.

The Radiographer staffing group, remains relatively stable, but has been under pressure throughout 2019 due to several members of the team on Maternity leave and 1 member of the team on a long term career break. The vacancy rate is 2.23% , but recruitment to vacant posts has so far been successful, although non Neuro trained radiographers take approximately 18 months to train fully in the department.

The department places a high level of importance on the investment of training, together with in house professional development.

In addition, we have developed Advanced Practice to support different ways of working. There has been an appointment to 2 x Apprenticeship trainee Assistant Practitioners

Managing staffing

The Radiographer and Radiographic Department Assistants team staffing rotas are available 3 months in advance. Taken into account are also the minimum staffing levels (agreed locally in the

department) and clinical supervision requirements of trainee Assistant Practitioners. Any pressure areas are escalated to Service Manager / Principal Radiographers for action.

Neurophysiology

Historically, the main staffing issue for a significant number of years has been the Consultant Neurophysiologist staffing group, this is due to a national and international shortage of Consultants. Miraculously, whilst not fully staffed (and still relying considerably on WLI EMG to bridge the gap) we have recruited 1.4 WTE this year.

By contrast, the Clinical Physiologist staffing group, which was always been relatively stable, has been under pressure throughout 2019 due to unprecedented levels of maternity leave. The Clinical Physiologist is a small staffing group of 11 WTE and maternity leave reduced that by 2.6 WTE, then a further 1.0 WTE for a career break. In addition, further maternity leave 1.0 WTE of Neurophysiology Operations Manager.

The department places a high level of importance on the investment of training, together with in house professional development to retain as many staff as possible. In addition, we have created new Clinical Physiologist posts to support different ways of working.

Managing staffing

Due to the level of speciality and limited Clinical Physiologist's nationally of a suitable calibre, it is not possible to address this staffing pressure with locum cover. The Clinical Physiologist team work agree their staffing rota a month in advance based on staffing levels/demand and capacity across the Walton Centre department and the satellite department at Royal Liverpool. Taken into account are also the minimum staffing levels (agreed locally in the department as no national standards) and clinical supervision requirements of trainee Physiologists. The team will review urgent referrals daily and make appropriate changes to the workflow accordingly. Any pressure areas are escalated to Service Manager for discussion if clinic capacity needs to be adjusted.

Therapies

Background and current staffing

The Walton Centre Therapies service consists of 5 AHP disciplines who are required to hold valid HCPC registration: Occupational Therapy, Physiotherapy, Speech & Language therapy, Dietetics and Orthoptists. Together these teams provide specialised therapy intervention to acute wards, ITU, rehabilitation units CRU & Lipton Hyper acute, community rehab and out patients.

All therapy staff have delegated managerial and clinical responsibilities appropriate to grade and experience. Via a hierarchal approach, all qualified staff provides and receives clinical supervision and performance appraisal. Newly-qualified Band 5s joining the service complete a preceptorship process during the first six months of their employment to ensure competence to practice. All band 3 support staff undertakes a framework of clinical competencies. Each of the AHP disciplines is led by a band 8a Professional lead who is responsible for the clinical assurance and operational leadership of that team and reports directly to the Therapy Services Manager who is accountable to the Executive Director Nursing.

Undergraduate education: All qualified therapy staff of each discipline are accredited to provide pre-registration education and there is an identified Practice Placement Coordinator for each team responsible for organising all clinical education placements across the Centre for students from universities all over the country. All therapists' are actively involved in providing internal and external training and education and many participate in multiple external specialist clinical groups and profession-specific work for professional and clinical development.

Headcount for therapies sits at @ 92 headcount or 81.78 FTE with a turnover rate of @ 2.15% per month and this is balanced out with a new starters rate of 2.5% each month. Being a largely female workforce there is also consistently a minimum of 2.5 % of the workforce on maternity leave at any time.

The main body of the service remains at a consistent level which is fortunate as there is a regular stream of leavers and new starters, mostly of band 5 and band 6 level as these staff take up development opportunities. Despite this, the Walton Centre Therapy service has had no difficulty in attracting skilled staff from across the country.

The sickness absence rate for therapies across the past 6 months has ranged from 1.42% to 4.29 % .There is no provision for enhanced staffing to cover shifts or annual leave and the pressure falls to staff to maintain a safe level of service across the whole year and much of which is goodwill. Over the past 6 months the service has experienced a higher than average number of maternity leaves and mid-grade staff turnover resulting in widespread pressures. However, a reduced level of admissions across summer to acute and rehab beds has helped offset some of the problem.

17. Conclusion & Recommendations

Trust Board are asked to:

- Be assured that staffing is safe
- Receive the next 6-monthly staffing report in May 2020, unless further changes require reporting.

Appendix 1 **Ward Nurse Staffing Shift Patterns – May 2019**

	Beds	Early	Late	Night	RN to patient ratio (days)
Cairns	26	4RN* and 3 HCA	4RN and 3 HCA	3RN and 3 HCA (1 extra HCA)	1:6
Caton	25	4RN* and 3 HCA	4RN and 3 HCA	3RN and 3 HCA	1:6
Dott	27	4RN* and 3 HCA	4RN and 3 HCA	3RN and 3 HCA	1:6
Sherrington	25	4RN* and 3 HCA	4RN and 3 HCA	3RN and 3 HCA	1:6
Lipton	10	3RN* and 2 HCA	3RN and 2 HCA	2RN and 2 HCA	1:3
Chavasse	29	6RN* and 5 HCA (1 extra HCA)	5RN and 5 HCA (1 extra HCA)	4RN and 4 HCA	1:5
CRU	30	4RN* and 6 HCA (1 extra HCA)	4RN and 6 HCA (1 extra HCA)	4RN and 5HCA (1 extra RN)	1:7

* Ward Manager not included in establishments as they have supervisory status.

The Walton Centre NHS Foundation Trust

REPORT TO THE TRUST BOARD
Date 28TH November 2019

Title	**Quarter 2 Governance report**	
Sponsoring Director	**Name:** Lisa Salter **Title:** Director of Nursing and Governance	
Author (s)	**Name:** Kate Bailey **Title:** Clinical Governance Lead **Name:** Mark McKenna **Title:** Head of Patient Experience	**Name:** Tom Fitzpatrick **Title:** Head of Risk
Previously considered by:	• NA	

Executive Summary
The purpose of the report is to:

- Provide a quarterly summary of Governance activity across the Trust in Quarter 2 (19/20), comparing results of data over the past 3 months. Variance shown relates to a comparison with the previous Quarter.
- Provide assurance to the Trust Board that issues are being managed affectively, that robust actions are taken to mitigate risk and reduce harm and that we learn lessons from Incidents, complaints, concerns and claims.

The Report has been compiled using a collaborative approach with key services across the Trust, including Nursing, HR, Quality and Divisional Management to ensure those themes and trends identified are actioned appropriately.

Themes and Trends have been identified and agreed via a multidisciplinary approach, with input from the following colleagues: Matrons of Neurology and Neurosurgery, Deputy Director of Workforce, Neurosurgery Operational Services Manager, Neurology Operational Services Manager, Quality Manager and Freedom to speak guardian, Neuroscience Laboratories Quality and Governance Manager, Radiology Manager, Radiology Clinical Governance Lead, Estates Manager & Digital Health Records & IG Manager

If any queries are identified following the review of the report, please can you ensure they are directed to the Katie Bailey (Ext63083) prior to the meeting.

Related Trust Ambitions	• Best practice care • Be recognised as excellent in all we do
Risks associated with this paper	The risk of the failure to inform committee of the board of the risk profile of the organisation.
Related Assurance Framework entries	• None
Equality Impact Assessment completed	• No

Any associated legal implications / regulatory requirements?	• Yes – Failure to comply with CQC/HSE regulations
Action required by the Board	• To consider and note

Governance Quarter 2 Report

2019/20

"Governance is a framework to receive, assess and act upon information we know about the services that we provide. Good governance provides assurance about the key issues and themes relating to the safety and experience of patients and staff. Governance is the backbone of the organisation."

Contents

Purpose

This report represents the Quarterly Governance report for incidents, risks, resilience, safety, complaints, claims and volunteering.

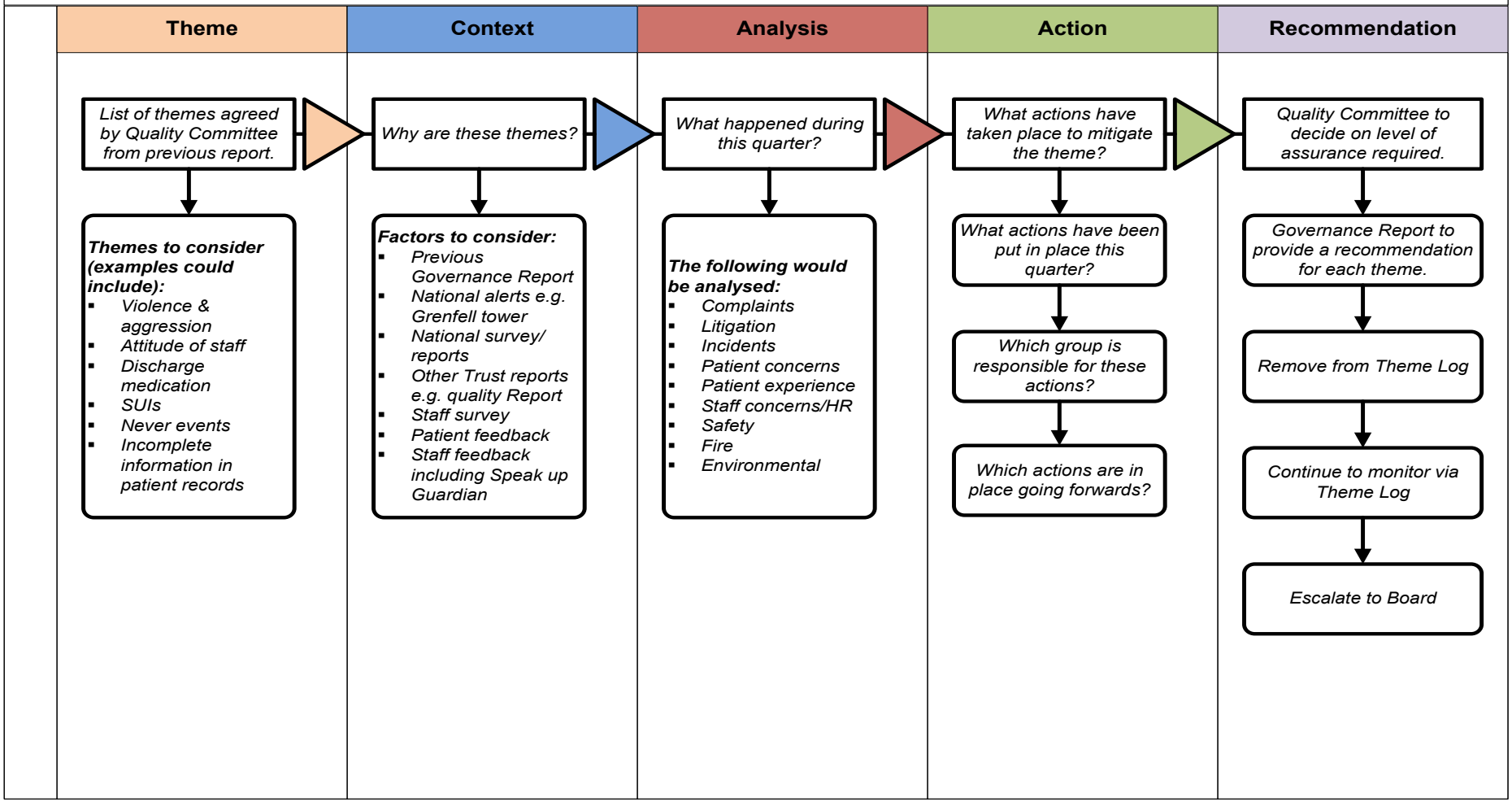
The report has been compiled using a collaborative approach with key services across the Trust, including Nursing, HR, Quality and Divisional Management to ensure those themes and trends identified are actioned appropriately.

The purpose of this report is to:

- Provide a quarterly summary of Governance activity across the Trust in Quarter 2 (2019/20), comparing results of data over the past 3 months. Variance shown relates to a comparison with the previous Quarter.
- Provide assurance to the Trust Board that issues are being managed affectively, that robust actions are taken to mitigate risk and reduce harm and that we learn lessons from Incidents, complaints, concerns and claims.

Please note that the data is accurate from the date the reports were generated for each financial year. There are occasions when incidents are retrospectively reported or complaints or claims withdrawn and those amended figures may appear in subsequent reports.

Governance Assurance Framework (overview)



Governance Assurance Framework Log - Quarter 2 (2019/20)

Theme	Context	Analysis	Action	Recommendation
REF287 Violence & Aggression 09.10.2017	Feedback from incidents continually highlight the issues of violence & aggression (V&A) against staff. This has also been highlighted in the 2018/19 staff survey. Issues of V&A are also identified and discussed at the daily Safety Huddle meeting. *This risk is on the Board Assurance Framework.*	During Q2 an increase of V&A incidents is evident. Physical assault incidents have increased, particularly against staff. Q2 data shows that 44 out of the 45 physical assaults against staff involved a patient that lacked capacity.	Continue to provide post incident support to wards in the development of risk assessments, solutions and to ensure most appropriate techniques are being used to manage the patient. Ensure V&A issues are Daily escalated to the Safety Huddle. V&A MDT working group continues to meet and identify new initiatives and work streams to help with the management of challenging patients. **LAST LAP** (Looking After Staff That Look After Patients) is being trialled in clinical areas. Review of V&A Risk assessments and alerting. Body worn cameras (BWC) – ISS Security Guards to commence use of BWC in Q3.	It is recommended that this remain on the Governance Assurance Framework to monitor. **Recommendation - Continue to monitor.**

Theme	Context	Analysis	Action	Recommendation
REF 286 Appointments Cancellations/Delays 16.01.2018	Poor patient and staff experience due to cancelled or delayed appointments. Problems with appointment letters and patients not being able to get through to PAC to book/cancel appointments. It is anticipated that there will be a significant increase in DNAs, complaints and this will affect staff/patient experience going forward.	There has been a significant increase in concerns received in Q2 regarding appointment issues with 66 concerns (36 in Q1). Increase in issues in Q2, relating to patients unable to get through or cancel appointments with PAC due to insufficient IT/Telephony infrastructure.	Service improvement work has been ongoing regarding outpatients/appointments. Data regarding concerns and complaints about appointments is feeding into service improvement work.	It is recommended that this remain on the Governance Assurance Framework to monitor whether improvements in patient and staff experience are sustained. **Recommendation - Continue to monitor**
REF 294 Patient Case Notes 04.01.2018	An increase in the number of incidents involving the misfiling of patients notes, which could have the potential to cause major harm to a patient.	A slight decrease can be noted on review of the Quarterly statistics from 36 Q1 to 15 Q2.	Incidents reviewed at Safety Huddle and monitored through the Monthly assurance reports. Incidents have decreased since staff have been spoken to in team meetings. All health records incidents are now reviewed at IGSF monthly. All incidents being reviewed and fed back to departments at the time. All user email, Walton Weekly, Team Brief, Clinical Safety Huddle and clerk team meetings have communicated this issue to all staff.	Improvement has been noted in figures in Q2 of patient case notes being incorrectly filed, however, due to 9 externally reportable incidents so far this year, suggestion is to continue to monitor. **Recommendation - Continue to monitor**

Theme	Context	Analysis	Action	Recommendation
REF 293 Patient Falls 04.01.2018	An increase in the number of falls is evident when reviewing quarterly and annual statistics.	There has been a decrease in falls from 76 in Q1 to 66 in Q2.	Incidents are reviewed at the Safety Huddle and monitored through the Monthly assurance reports. Falls incidents are discussed at Falls Prevention Steering group (FPSG). A high risk area for falls is patient bathrooms. Shelving is being built and installed to see if this has any impact. To consider if we need raised toilet seats in some areas. Trial of new falls equipment in CRU. Undertake a real time survey of patients with capacity who have fallen to see why they think they fell. (On FPSG action tracker). Shared with WNM monthly. Post fall compliance audit is on Falls prevention action tracker. 2019/2020. To complete gap analysis of falls versus datix. Annual health and safety is an opportunity to discuss with staff, falls incidents, RCA findings and falls prevention work plan.	It is recommended that this remain on the Governance Assurance Framework to monitor whether improvements in patient and staff experience are sustained. **Recommendation - Continue to monitor**

Theme	Context	Analysis	Action	Recommendation
			Real time questionnaire are continued post fall. Share ownership of falls with patients who have capacity and who choose to ignore advice. Falls leaflets for inpatients and have been reviewed are being updated. New falls leaflet for outpatients with long term conditions. Falls awareness event took place in July and was well attended. CQUIN is monitoring compliance against mobility assessments, drugs known to cause issues with balance and lying and standing blood pressure.	

Theme	Context	Analysis	Action	Recommendation
REF 296 Delayed clinic letters 08.01.2018	Increase in concerns and complaints relating to delayed clinic letters. Concerns raised that this has led to delayed scan results and medication changes.	There was an increase in complaints regarding issues with clinic letters. During Q2 there were 3 formal complaints regarding clinic letters.	Improvement work has been taking place, which may be linked to the decrease in concerns and complaints. However, we may wish to monitor this further to see sustained improvement. Full action plan in place since August 2019 to address the ongoing issues within the Neurology secretariat such as: communication, processes and system wide concerns. This action plan is monitored monthly with HR and the division. Neurology secretariat agreed to ad-hoc outsource typing when department is experiencing unforeseen workforce pressures e.g. sickness/absence, spikes in activity and peak holiday periods. Significant improvements identified, staff morale improving and genuine engagement with action plan.	It is recommended that this remain on the Governance Assurance Framework to monitor whether improvements in patient experience are sustained. **Recommendation - Continue to monitor**

Theme	Context	Analysis	Action	Recommendation
REF 300 Rejection Of Pathology samples by LCL 02.10.2018	Pathology samples may be rejected by Liverpool Clinical Laboratories (LCL) if request forms are incomplete and do not meet the acceptance criteria set out in both the Neuroscience Laboratories Specimen Acceptance Policy and LCL Minimum Data Standard Policy for Laboratory Investigations. This will lead to a delay in results and potential re-sampling requirements.	Rejection data now received monthly from LCL. In total, approx. 60 samples a month rejected across the trust. It is not possible to determine the number of tests this equates to or the percentage of requests affected. NOPD and HITU highest affected locations. Rejections may increase in the near future when samples will be rejected if time of collection is not included following a SUI.	Monthly rejection data now sent to Matrons and NOPD and HITU ward managers. NOPD now preparing samples from late clinics and retaining at WCFT until the following day. NOPD staff have received training on laboratory processes and specimen requirements. Addressograph labels to be used on microbiology samples. When applicable, comms to be given about rejections associated with lack of time on request. IT have prepared a prioritisation document for an order comms systems within pathology. This would ensure requests would be completed correctly and reduce number of rejections. Discussed regularly by Division.	Incidents to be monitored through Datix. **Recommendation - Continue to monitor**

Theme	Context	Analysis	Action	Recommendation
REF 301 Fire Safety Compliance 17.01.2018	Following the OPD/NRC fire, following Merseyside Fire Service investigation and inspection of the Walton Centre, the following legislative breaches were identified: - maintenance of fire compartmentation lines - access to records of maintenance information provided by Aintree Estates Department	The Fire Service identified serious breaches in the OPD/NRC fire compartment lines post fire. These gaps were as a result of the original building works not being inspected and signed off in as compliant as part of the schemes governance arrangements. These gaps were not fully identified in a subsequent survey by a competent contractor in 2015 post a DH Estates Alert.	A registered fire compartmentation contractor is currently on site undertaking reinstatement works. An action plan is monitored by the Head of Risk. A tender has gone out to the market for the remedial fire compartment works, this is currently under review.	Continue to monitor until remedial compartmentation works are complete. **Recommendation - Continue to monitor.**

Theme	Context	Analysis	Action	Recommendation
REF 302 Safeguarding 09.07.2019	Increase in safeguarding incidents reported to the commissioner in Quarter 1, as a result of the Implementation of new safeguarding section in DATIX it is anticipated that there will be a significant increase in incidents going forward.	Following the implementation of enhanced training for staff, there has been a significant increase in the identification of incidents of abuse/neglect. This increase in Datix reporting in Q2 is a positive indicator around staff knowledge and appropriate action in response to safeguarding concerns. There is also an increase in the reporting of Datix breaches due to untimely Local Authority assessment of the applications. This is in line with the revised Trust policy and processes for Deprivation of Liberty Safeguards (DoLS) applications.	The Datix reports will continue to be monitored with oversight from the Safeguarding Matron and Executive Safeguarding Lead to ensure that appropriate escalation/actions/referrals are addressed.	Continue to monitor this theme to ensure that staff continue to escalate safeguarding incidents. **Recommendation - Continue to monitor.**

Governance Log - Issues closed

Ref No	Theme	Date entered onto Log	Date Archived	Decision at QC	Escalated to Board?
REF 291	Major Incident Management	9th October 2018	21st June 2018	21st June 2018	N
REF 292	Incomplete Patient records	9th October 2018	21st June 2018	21st June 2018	N
REF 299	National Inpatient Survey	9th July 2018	18th October 2018	18th October 2018	N
REF 295	Fire Safety provisions	4th January 2019	23rd May 2019	23rd May 2019	N
REF 297	Lack of Neuropsychological	4th July 2019	23rd May 2019	23rd May 2019	N
REF 298	Failure of Carbon Steel	9th July 2019	23rd May 2019	23rd May 2019	N

Section 1 - incident Management (Governance Balanced Score Card)

This section provides a detailed report of the number and type of incidents reported during the Quarter 2 (2019/20), and how well we perform in relation to reporting those incidents against the relevant policy. The Walton Centre NHS Foundation Trust (WCFT) is committed to the Health, Safety and Welfare of patients, visitors, contractors and staff. Accurate reporting of incidents and near misses is essential in order to reduce risks and avoid untoward incidents. Incident reporting is a fundamental tool of risk management, the aim of which is to collect information about adverse incidents and near misses, ill health and hazards, which will help to facilitate wider organisational learning. If incidents are not properly managed, they may have a negative impact on the patient experience and result in a loss of public confidence in the organisation and a loss of assets.

TRUST WIDE	Quarterly trend	Q2 18/19	Q3 18/19	Q4 18/19	Q1 19/20	Q2 19/20	Quarterly variance (Q1 19/20 and Q2 19/20)
Incident							
Total number of Incidents		728	807	875	734	814	⇑
Neurosurgery		455	506	521	463	495	⇑
Neurology		236	256	307	230	281	⇑
Corporate		37	45	48	41	38	⇓
StEIS reported SUI's		1	5	7	6	1	⇓
Patient Safety Incidents reported to the NRLS		251	246	298	272	279	⇑
Accident		93	105	131	112	109	⇓
Communication		120	142	157	105	122	⇑
Death		21	22	13	14	14	⇨
Digital Systems		18	19	16	15	12	⇓
Environmental		26	37	37	31	38	⇑
Infection Control		31	34	33	22	21	⇓
Information Governance		49	53	68	55	53	⇓
Investigations, Images & Diagnosis		25	30	32	31	29	⇓
Medical Devices, Systems & Equipment		24	31	46	35	44	⇑
Medication		78	102	96	76	68	⇓
Nutritional and Hydration		13	12	9	10	9	⇓
Patient Care		115	96	127	108	92	⇓
Safeguarding (Safeguarding section added to DATIX June 2019)				1	13	72	⇑
Security		34	15	16	13	18	⇑
Treatment and procedure		18	27	28	31	32	⇑
Violence and aggression		63	82	65	62	81	⇑
RIDDOR		2	2	2	3	3	⇨
Percentage reported within 12 hours (as per Policy)		89%	90%	91%	88%	88%	⇨
% of level 2&3 incidents acknowledged in 24 hours (as per Policy)		92%	90%	89%	85%	75%	⇓
% of level 1 incidents acknowledged in 48 hours (as per Policy)		89%	90%	91%	94%	89%	⇓
% of level 0 incidents acknowledged in 48 hours (as per Policy)		91%	91%	90%	100%	87%	⇓
Rate of incidents per 100 admissions (excl Jef & OPD)		13.46%	13.67%	15.87%	13.87%	16.35%	⇑
Number where DOC (Duty of Candour) where patient/relative have been notified?		11	19	17	13	15	⇑

Incidents

High level incident overview – Quarterly data:

1. 1 Incident was reported to the Commissioner in Q2 (see below), which is a decrease of 5 in comparison with Q1 with 6 incidents reported.

Incident Date	Reported	Incident Type	Incident Summary	Root Cause
08.08.19	21.08.19	Cat 4 Pressure Damage	Patient has developed an unstageable pressure ulcer to LT buttock. Previously had moisture lesion which has deteriorated.	To be determined following investigation.

2. In Q2 there were 80 Incidents, which has increased from 734 in Q1 to 814 Q2. The main increase relates to incidents categorised as Safeguarding, increasing from 13 in Q1 to 72 Q2. A Breach in DOLs applications accounted for the main increase in incidents, increasing from 3 in Q1 to 37 Q2. Safeguarding has recently been added to the Governance Assurance Framework, **REF 302.**
3. Neurology had the highest increase in incidents, increasing from 230 in Q1 to 281 Q2. CRU incidents from 74 in Q1 to 95 Q2, with Safeguarding being the main reason of increase, increasing from 2 Q1 to 11 Q2. As noted above safeguarding will now be monitored via the Governance Assurance Framework (GAF).
4. Neurosurgery had an increase of 32 incidents from 463 in Q1 to 495 Q2. Dott Ward had 22 incidents, which was an increase of 45 in Q1 to 67 in Q2. The category with the highest increase was Violence and Aggression increasing from 4 in Q1 to 13 Q2. Violence and Aggression is currently a theme on the Governance Assurance Framework **REF 287.**
5. Corporate Division had a reduction of 3 incidents, decreasing from 41 Q1 to 38 Q2. On further review the area with the highest decrease in incidents was Human Resources decreasing from 3 in Q1 to 0 Q2. No partiulcar themes or trends where identified.

Incidents by Severity:

The table below provides an oveview of incidents reported by the severity of harm by Quarter.

Incidents by Severity	Q1 19/20	Q2 19/20
No obvious harm	628	669
Minor harm may require aid/support	84	120
Moderate harm requiring aid/support	13	14
Major permanent harm	0	1
Catastrophic	0	0
To be determined following investigation	9	10
Total	**734**	**814**

Duty of Candour (DoC):

Sub Category	Q1 19/20	Q2 19/20
DVT	0	1
Diagnosis test/images/specimens available but inaccurate	0	1
Device related pressure damage	0	1
Failure of device / equipment (not user error)	0	1
Delay in receiving test results	0	1
Burn or Scald	0	1
Administration - Allergic Reaction	0	0
Unexpected cardiac arrest	0	0
CDIF - WCFT acquired	2	1
CPE - WCFT acquired	0	0
E-Coli - WCFT acquired	2	3
FALL - Not witnessed / found on floor	1	0
Treatment/procedure - inappropriate/wrong	1	0
MSSA - WCFT acquired	3	0
NEVER EVENT- Wrong site surgery	0	0
Operation or procedure wrongly sited	1	0
Equipment out of date	1	0
Klebsiella pneumoniae - WCFT acquired	0	1
Pulmonary Embolism	1	2
Pressure Ulcer - WCFT acquired	1	2
Totals:	13	15

- Decrease in incidents of MSSA, decreasing from 3 in Q1 to 0 Q2
- Slight increase in E-Coli incidents, increasing from 2 in Q1 to 3 Q2
- All Incidents have been discussed with patient/relative/NOK within 10 working days of the incident occurring
- All Incidents have been followed up with a written notification

Quarterly themes:
Falls (All) In Q2 a total of 66 falls were reported, which is a decrease from Q1 of 10 were 76 Incidents were reported. On further review the main area of decrease relates to 'Fall – Assisted Fall,' decreasing from 13 in Q1 to 4 Q2. Please refer to GAF entry **293** for falls prevention.
Communication Communication incidents increased from 106 in Q1 to 122 Q2. On futher the scrutiny, the main area of increase relates to Communication Failure – Documentation, increasing from 4 in Q1 to 24 in Q2. On further investigation the main reason for increase relates to patients arriving in forward wait with incomplete or inaccurate documentation. These incidents will be reviewed and monitored via the appropriate assurance report.
Infection Control Infection control incidents decreased from 22 Q1 to 21 Q2. The main area of decrease relates to MSSA – WCFT Acquired, decreasing from 3 in Q1 to 0 Q2.
Violence and Aggression (All) Violence and Aggression incidents increased from 61 in Q1 to 80 Q2. 'Physical abuse – Patient on Staff,' increased from 27 in Q1 to 45 Q2. Please refer to section 2 for further information.
Information Governance Information Governance incidents decreased from 55 in Q1 to 53 Q2. 'Data protection,' decreased from 6 Q1 to 1 in Q2. All information Governance incidents are reviewed and monitored via the Information Governance and Security forum on a monthly basis.
Security Security incident increased from 11 in Q1 to 18 Q20. 'Accidental property damage//loss,' increased from 1 in Q1 to 4 Q2. Four of the five incidents related to patients personal property being reported as missing.
Safeguarding Safeguarding incidents have increased from 13 in Q1 to 72 in Q2. 'Breaches in DOLS applications,' increased from 3 in Q1 to 37 Q2. Please note Safeguading has been recently added to the Governance Assurance Framwork (GAF) **REF 302.**
Key actions to note from Q2:
1. The Clinical Governance lead has: • added Divisional Specialities to the incident reporting form to support the Divisions with better incident analysis and investigation • Undertook an audit of the Duty of Candour process was carried out which identified 100% of moderate harm patient safety incidents were verbally communicated to the patient/relative within 10 working days of the incident occurring

Section 2 - Violence and Aggression (Governance Balanced Score Card)

TRUST WIDE	Trend 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Q1 19/20	Q2 19/20	Quarterly variance (Q1 and Q2)
Incident							
Inappropriate Behaviour		10	8	8	5	5	→
Physical abuse/violence - other on patient		1	1	1	0	0	→
Physical abuse/violence - other on staff		0	0	1	0	0	→
Physical abuse/violence - patient on patient		0	0	1	0	0	→
Physical abuse/violence - patient on staff		34	50	18	27	45	↑
Physical abuse/violence - Visitor		0	0	2	0	2	↑
Racial abuse/violence - patient on staff		0	0	0	0	3	↑
Sexual abuse/violence - patient on staff		1	0	3	0	1	↑
Verbal abuse/Violence - other on staff		0	0	6	0	0	→
Verbal abuse/Violence - patient on staff		12	16	22	24	20	↓
Verbal abuse/Violence - patient on patient		0	0	0	0	2	↕
Verbal abuse/Violence - staff on staff		5	0	3	1	0	↕
Verbal abuse/violence - Visitor		0	7	0	4	2	↓
Total		63	82	65	61	80	↑

Violence & Aggression

Violence and Aggression Quarterly statistics

Key points to note:

1. Violence and aggression incidents have increased from 61 in Q1 to 80 in Q2.
2. The highest category of incidents continues to be physical assaults - patient on staff. There was an increase from 27 incidents in Q1 to 45 in Q2. This has also increased from the comparative Quarter of the previous year, Q2 of 19/20 in which there were 34 incidents.
3. 44 of the 45 physical assaults by patients on staff within Q2 involved patients who lacked capacity.
4. The location with the highest number of violent or aggressive incidents reported was Caton Ward with 21, followed by Dott Ward with 13 and then the CRU with 9. **NB** 27 of the incidents of violence on staff involved just 2 patients. Neither had capacity.
5. 1 patient that had previously been sanctioned was excluded from the Trust due to continued verbal abuse and threatening behaviour against staff, a police investigation is on-going.
6. Verbal abuse incidents – patient on staff, have reduced from the previous quarter with 24 incidents reported in Q1 compared with 20 in Q2.
7. **NB** 'Inappropriate behaviour incidents' do not meet the criteria of verbal or physical abuse, but still require reporting. Incidents include circumstances where a patient, relative or indeed a staff member have acted inappropriately or used inappropriate language but did fit within the verbal or physical abuse categories.

Governance Assurance Framework Log – REF 287:

Violence and aggression - During Q2 an increase across V&A incidents is evident. The majority of Trust patients involved in V&A incidents do not have capacity. 98% of patients that have physically assaulted staff did not have capacity at the time of the incident. Recommendation for this to say on the Governance Log for further monitoring.

Key Actions:

1. Development of Violence and Aggression working group to identify new initiatives and work streams, including but not limited to:
   - Introduction of electronic violence & aggression system which includes risk assessments and risk alerts.
   - Introduction of Body worn cameras for security staff.
   - Pilot Last Lap (Look after staff that look after patients) on Lipton ward
   - V&A survey using survey monkey and paper copies
2. LSMS/Personal Safety Trainer continue to:

- provide support for staff and patients
- deliver personal safety training and restraint reduction programme
- work with the Safeguarding Matron to ensure safeguarding/DOLS issues are included within the relevant training programme
- work in conjunction with medical staff to ensure MDT meetings occur when required following incidence of violence or aggression
- promote the use of sanctions available for staff when dealing with aggressive patients

3. Monitor Lone Worker Devices purchased and rolled out for staff working in the community.
4. Delivery of dynamic risk assessment training for lone workers in collaboration with WCFT Consultant Psychologist
5. Review of current CCTV and access control systems.

Section 3 - Clinical Quality Lead Update

Learning from Deaths

Learning from Deaths
Key points to note: Nearly half of deaths in the UK happen in hospital and quite rightly there has been growing political and professional focus in recent years on improving end-of-life care, support for the bereaved, and learning from and ultimately eliminating preventable deaths. Learning from deaths" (2017)' followed on from the Francis report and set out how organisations need to review deaths to ensure that any lessons learned are identified and acted upon to prevent reoccurrence. This has enabled hospitals to identify good practice and areas for improvement and develop stronger cultures of openness, learning and partnerships with families. The emphasis within the guidance is on having: • A robust learning from deaths processes so that we can capture as much learning as possible to enable us to ensure no patients experience harm leading to death whilst in our care • To provide answers for relatives and carers • To use this information to improve in areas such as EOL quality standards for those expected to die. Throughout 2018/19 we have concentrated on developing a mortality review policy in accordance with the guidance. Mortality meetings were standard practice in Neurosurgery and Neurology, however by implementing a validated, standardised way of reviewing the case records of in hospital deaths using the initial mortality review and Structured Judgement Review (SJR) processes we can maximise the potential for learning and improvement; and encourage the development of quality improvement initiatives when problems in care are identified. Importantly, the revised mortality review process includes the patient, family and carer experience at the End of life and helps identify good practice for sharing across disciplines. The End of Life (EOL) Care lead has reviewed the bereavement information given to families to explain the mortality review process and invite families and carers to share their experiences. This will enable us to reflect and improve the quality of care where necessary and feed back to staff when that care has been exceptional which is often the informal feedback from our bereaved families. Where there is evidence of avoidability this should be escalated to the Serious Incident Group, for further investigation. The Walton Centre undertakes such reviews and displays the information on our website, demonstrating a transparent culture. The standardised approach within the guidance has been adopted by most hospitals across the country and there is an enthusiasm

between Trusts to work collaboratively when a patient has been cared for in more than one organisation. The WCFT clinical and governance teams have been involved in cross organisational mortality reviews in acute trusts and Mersey Care Community Trust.

In 2018/19 100% of deaths were screened using the initial mortality review process. 97.4% of deaths were considered unavoidable. Two deaths remain under review, one patient death has required an external review and a further death is subject to coroner's inquest. The families are being supported by the patient experience team; the outcomes will be reported to Quality Committee when available.

In keeping with the "Ambitions" described within the Quality Strategy of no avoidable deaths.

The mortality committee will continue provide a summary of cases, together with any identified themes or trends to the Quality Committee and Trust Board. This will include details of any systems or processes which have been improved and describe any changes to practice and or policy.

Gap analysis.

- Mortality reviews should be fully embedded across all specialities; this will include pain and interventional radiology.
- We need to improve the Multidisciplinary (MDT) approach by including senior clinicians, senior and specialist nurses, therapy and palliative care specialists in the mortality review process.
- We need to improve MDT attendance at Mortality meetings, in order to identify any themes from the reviews, develop quality initiatives and evaluate the impact of any changes in practice, policy or education.
- We should triangulate information regarding mortality with incidents and complaints together with claims to improve opportunities for improvements in quality of care.

We need to understand is the emerging role of the Medical Examiner and its potential interaction with the Mortality Review process and wider bereavement services. This post is due to be operational in March 2020 (Liverpool).

Section 4 - Complaints and Concerns (Governance Balanced Score Card)

The Patient Experience Team receives a wealth of information surrounding the experience of our patients and their families. We use the positive information to share and promote good practice and this information can be found in below. This section concentrates on the areas of concern raised by patients and their families and occasionally by our wider community. This information helps us to improve services and learn lessons as well as modify behaviour where appropriate.

This section analysis the complaints and concerns raised with the Patient Experience Team.

TRUST WIDE	Quarterly trend	Q2 18/19	Q3 18/19	Q4 18/19	Q1 19/20	Q2 19/20	Quarterly variance (Q1 19/20 and Q2 19/20)
Complaints							
Coroner statement requests		1	2	5	6	3	↓
Police statement requests		7	12	12	5	9	↑
Total Number of Concerns		83	85	72	56	119	↑
Appointment arrangments		41	36	15	36	66	↑
Approach and manner		21	7	20	10	9	↓
Patient Care		4	9	4	9	10	↑
Communication		10	10	12	19	29	↑
Discharge Arrangements		3	5	3	5	5	→
Total Complaints received		23	24	27	36	42	↑
Approach and Manner		8	10	14	19	12	↓
Treatment		9	4	9	8	10	↑
Appointment Arrangements		11	8	9	13	12	↓
Patient Care		8	11	11	9	9	→
Communication		3	2	6	12	10	↓
% Acknowledged within 3 working days		100%	100%	100%	100%	100%	→
% responded to within agreed timescale		100%	100%	100%	100%	100%	→
Neurosurgery complaints		18	14	14	21	15	↓
Neurology complaints		7	11	13	11	19	↑
Neurosurgery/Neurology complaints		0	0	0	3	8	↑
Corporate		0	0	0	1	0	↓
% signed responses scanned on system		100%	100%	100%	100%	100%	→
Complaints to Ombudsman		1	0	0	1	0	↓

Complaints and concerns

Themes from concerns & complaints:

1. There was an increase in complaints in Q2. We received 42 complaints during Q2, compared to 36 complaints in Q1. While the quarter-on-quarter increase is not signifcant, it is noted that there has been a significant increase in the number of complaints to date during 2019/20 compared with 2018/19. At the end of Q2 in 2019/20 we have received 78 complaints, compared with 47 at the same stage last year. As we received 95 complaints in total for 2018/19, this indicates a likely considerable increase in complaints for 2019/20.
2. There was a reduction in Neurosurgery complaints from 21 in Q1 to 15 in Q2, however, the number of Neurology complaints increased from 11 in Q1 to 19 in Q2.
3. At the end of Q2 there were 33 ongoing complaint investigations, with 13 complaints that had exceeded the initial target timescale. There is ongoing work to improve the timeliness of complaint investigations.
4. The total number of complaints at the end of Q2 represented 0.08% of patient contacts. This is within the (internal) threshold set of 0.13%.
5. The key themes in complaints during Q2 were:
   - Appointment arrangements – 12 issues – These related to complaints about cancelled appointments, waiting times for follow-up appointments, referrals not received/actioned and no follow-up appointments arranged.
   - Approach and manner – 12 issues – These related to complaints about attitude of consultants, consultants being dismissive of patient symptoms or not listening to patients, appointments being rushed and the attitude of secretaries.
   - Communication – 10 issues – These related to complaints about incorrect/misdiagnosis and delay in diagnosis.
   - Treatment – 10 issues - These related to complaints about delay or failure to monitor patients' conditions, post-operative complications, inappropriate treatment/procedure and delay in treatment/procedure.
   - Patient care – 9 issues – These included failure to monitor patients, problems with medication, pain management, after care and privacy & dignity.
6. There was a significant increase in the number of informal concerns in Q2. We received 119 informal concerns in Q2, which was more than double the 56 informal concerns received in Q1. The overwhelming theme was appointment arrangements.
7. The key themes in informal concerns during Q2 were:
   - Appointment arrangements – 66 issues - These related to complaints about cancelled appointments, waiting times for follow-up appointments, referrals not received/actioned and no follow-up appointments arranged.
   - Communication – 29 issues - These related to complaints about incorrect/misdiagnosis and delay in diagnosis
   - Patient care – 10 issues - These related to complaints about delay or failure to monitor patients' conditions, post-operative complications, inappropriate treatment/procedure and delay in treatment/procedure.

- Approach and manner – 9 issues - These related to complaints about attitude of consultants, consultants being dismissive of patient symptoms or not listening to patients, appointments being rushed and the attitude of administrative staff.

8. The Trust has relatively low numbers of complaints referred to the Parliamentary and Health Service Ombudsman. There were no new or closed Ombudsman investigations during Q2.

Governance Log Theme Analysis

1. Appointments – There has been an increase in concerns received in Q2 regarding appointment issues with 66 concerns (36 in Q1). Increase in issues in Q2, relating to patients unable to get through or cancel appointments with PAC due to insufficient IT/Telephony infrastructure. This remains a key concern from patient feedback. Improvement work is commencing to improve outpatient efficiency and patient experience. It is recommended that this remain on the Governance Assurance Framework to monitor whether improvements in patient and staff experience are sustained.
2. Delays in clinic letters / Secretariat – There was an increase in complaints regarding issues with clinic letters. During Q2 there were 3 formal complaints regarding clinic letters. There is ongoing improvement work regarding this issue, however, it is recommended that this theme continue to be monitored until sustained improvement is evidenced.
3. Waiting times for Pain Clinic – This is a potential new theme. There have been complaints and concerns relating to waiting times for pain clinic. We are developing Datix to capture the specific concerns relating to Pain Clinic. Following discussion with the Neurosurgical Divisional Management team, this theme be monitored in the forthcoming monthly and quarterly governance reports as the waiting times are likely to have a negative impact on patient experience.

Key points to note

The aim of the Patient Experience Team (PET) is to support both staff and patients in resolving concerns and supporting the Trust to use patient feedback to enhance patient experience and drive improvements in care/service when required. During Q2 the following actions were taken to achieve this:

Support for Patients

1. Support to patients and families following incidents – In addition to formal complaints, there has been a focus on PET providing support to patients and families as part of the Duty of Candour and Learning from Deaths process. PET has acted as point of contact in providing support to patients and families and has coordinated meetings with clinical staff so that all concerns and questions about care are fully addressed. There has been repeated feedback that patients and families felt supported throughout the process by the personalised approach.
2. Engaging with patients and families – PET and Head of Patient Experience has sought to improve how we capture feedback from patients and families. This has included holding and attending engagement events at the Brain Charity, monthly listening events with Healthwatch Sefton in outpatient departments, inpatient listening event with Healthwatch Liverpool and Knowsley, and surveys carried out by volunteers (Neuro Buddies) on wards.
3. Home from Home Accommodation – PET have received extensive positive feedback from relatives about their experience in the Home from Home Accommodation. The consistent theme throughout this feedback is that relatives have felt supported by staff when they have

felt vulnerable and needed emotional support.

4. Development of WALTON Steps – as part of implementing Patient and Family Centred Care, the WALTON Steps initiative has been developed to monitor and improve different stages of the patient journey. This will be done through patient shadowing, walkabouts and triangulating patient feedback from other sources.

Support for Staff

1. Complaints can be very distressing for staff as well as patients. The Head of Patient Experience and members of the Patient Experience Team have regularly met with staff involved in complaints to provide support and advice on the complaints process.
2. Debrief sessions have been held with staff involved in sensitive complaints.

Volunteers

1. At the end of Q2 we had 71 volunteers. There are 16 further volunteers who have been recruited but awaiting induction training prior to starting their roles.
2. We appointed a Volunteer Coordinator during Q2 to cover maternity leave of the substantive post holder.
3. During Q2, volunteers provided a total of 1975 hours service to the Trust in a variety of roles across the organisation.
4. There has been widespread feedback from staff, patients and the volunteers themselves that they have improved both staff and patient experience.

Patient Stories

1. Patient stories have been widely used at Trust Board and Governors meetings as well as Patient Experience Group and Professional Nursing Forum. During Q2, patient story videos were captured focusing on the experiences of a patient with MND receiving support from OT and a patient who outlined their journey before and after a craniotomy and the impact this had on his life.
2. Stories have been developed to include insight from families as well as patients, with patients and relatives attending various groups to present their story in person.

Examples of lessons learnt from concerns and complaints

The aim of the Patient Experience Team is to support both staff and patients in resolving concerns and supporting the Trust to use patient feedback to enhance patient experience and drive improvements in care/service when required. Examples of lessons learnt during 2018/19 include:

Issue: *Patient returned home for overnight leave to be with their family, however, had to return to hospital as medication had been not been given to take home.*

Action: *Complaint was shared at Pharmacy team meeting and at Safety Huddle to stress the importance of checking appropriate medication is dispensed. Shadowing programme being undertaken of discharge process with specific emphasis on medication dispensing to ensure that staff are complying with our policies. Individual reflection for staff involved which forms part of their personal development plan.*

Issue: *Patient was given incorrect advice by PAC about their referral and appointment.*

Action: *Letters sent relating to appointments are being reviewed as part of ongoing service improvement work. Training given to staff to ensure that they understand referral pathways for different conditions to ensure that correct advice is given.*

Issue: *Patient (who is black) was distressed after her name was called in Outpatients Department and the member of staff asked if her husband was her translator and acted surprised that the patient had a western-sounding name.*

Action: *Head of Patient Experience and Equality and Inclusion Lead visited patient's house to discuss experience in detail. ED&I training has been updated to include this experience to educate staff on unconscious bias. The patient is sharing their experience by video for training programme and as a patient story.*

Issue: *Patient was distressed after attending to have a procedure but being informed on the day it would not take place due to an error. There was also a delay in sending the clinic letter.*

Action: *Clinican involved has changed their practice as a result of complaint to ensure that patients are followed up in clinic to provide clarity on next steps in their care. A report has been implemented to monitor timeliness of dictating and sending clinic letters.*

Patient Experience

Friends and Family Test (FFT)

1. The Trust results for FFT remained very positive during Q2, both in terms of recommend rate and response rate. The inpatient recommend rate was consistent at 96% to 98% each month. The recommend rate remains significantly above the national average (around 20%).
2. The FFT recommend rate was consistently high across all wards. It should be noted that the Inpatient FFT is reported nationally, however, there is no requirement for this to be done with Outpatient FFT. The Outpatient FFT response rate is significantly lower than the Inpatient FFT; however, this is consistent with practice across Trusts nationwide.

Overall Inpatient FFT

	July	August	September
Recommend rate	96%	97%	98%
Response rate	48%	76%	49%

Overall Outpatient FFT

	July	August	September
Recommend rate	96%	98%	93%
Response rate	6%	7%	8%

Recommend rate by Ward (total responses in brackets)

	July	August	September
Cairns	97%	100%	100%
Caton	99%	98%	100%
Chavasse	96%	97%	96%
CRU	100%	100%	100%
Dott	97%	99%	100%
Jefferson	97%	96%	97%
Lipton	N/A (0)	N/A (0)	N/A (0)
Sherrington	100%	99%	100%

Local Questionnaires

1. A key activity of our Neuro Buddy volunteer role is to conduct questionnaires with patients..
2. Overall, the results are positive, the comparitive data for Q1 is in brackets below.

	Did not need help	Yes	No
Were you given enough help from staff with your meals?	22% (Q1 14%)	76% (Q1 81%)	2% (Q1 5%)

	Had no worries/fears	Yes	No
Did you find someone to talk about any worries or fears?	42% (Q1 35%)	56% (Q1 56%)	2% (Q1 9%)

	Yes	No
Were you involved as much as you wanted in decisions abouy your care?	100% (Q1 92%)	0% (Q1 8%)

	Yes	No
Were you given enough privacy when discussing your condition and treatment?	95% (Q1 95%)	5% (Q1 5%)

	Yes	No
Did you feel you were treated with respect and dignity during your stay in hospital	100% (Q1 99%)	0% (Q1 1%)

	Excellent	Very good	Good	Fair	Poor
How would you rate the overall standard of care during your stay?	66% (Q1 60%)	25% (Q1 32%)	7% (Q1 7%)	2% (Q1 0%)	0% (Q1 1%)

Healthwatch Listening Events

Healthwatch Sefton conducted Listening Events every month in our Main Building and Sid Watkins Building reception areas. During Q2 Healthwatch Sefton shared their listening event report covering patients and families who had shared feedback between January and June 2019. 81 patients provided reviews during this period, with an average rating of 4.6 out of 5 stars. Quality of treatment, staff attitude, quality of food and drink and cleanliness scored an average of 5 out of 5 stars.

Section 6 - Compliments (Governance Balanced Score Card)

Compliments

The table above represents the numbers of compliments received centrally by the Patient Experience Team. However, it should be noted that this represents a very small reflection of the positive feedback received directly in wards or departments, and via social media. Below are examples of the compliments received by Wards and Departments during Quarter 2 (19/20).

TRUST WIDE	Quarterly trend	Q2 18/19	Q3 18/19	Q4 18/19	Q1 19/20	Q2 19/20	Quarterly variance (Q1 19/20 and Q2 19/20)
Compliments							
Total number of compliments		55	75	337	77	58	

Key points to note:

Examples of compliments received by Patient Experience Team

"I'd like to provide some really positive feedback on the staff in outpatients clinic this morning (6 August). The staff went out of their way to help me following confusion with a 'choose and book 'letter received. They managed to reschedule my appointment, were very helpful, patient and understanding and I am truly grateful to them for going that extra mile. Too many often complain but not many take the chance to provide positive feedback so thank you to everyone. You really do make a difference. Thank you!"

"Just wanted to say thanks so much for squeezing me in to yesterday's clinic. You are a shining example of the NHS going above and beyond. I don't know what I would have done without your help. Please also send on my thanks to Dr S, I cannot thank him enough. He always stretches himself so much to improve so many people's lives"

"My wife has just spent four weeks on the ward undergoing treatment for CRPS involving a number of plasma exchanges. You will be aware how challenging these procedures can be, balanced against the competing demands of the A&E and high-dependency wards where rightly patients have a greater priority. I really saw the words "the nursing profession" in action, every day at all hours for four weeks.

Your staff are, quite simply, amazing. Colleagues at all levels on the ward were so attentive and helpful, always ready to provide support, care and treatment even though they all work under incredible pressure with such long hours. I would like to emphasise the word all staff. Unlike many different professions, Chavasse has no distinction of 'rank' being felt. All staff were welcoming and helpful, at all levels. The chirpy

colleagues providing tea and coffee, the cleaning staff tirelessly keeping the ward spotless, the nursing and ancillary staff helping patients, students from Edge Hill starting out in the profession; there was no sense of hierarchy. Central to this was the sense of team, working for a common purpose and united in a vision to provide care and support to the patient. All staff said, quite unprompted, how proud they felt working on the ward.

Central to this is the work of the ward manager. Together with E, O was the visible presence on the ward, leading from the front. No job was too small or beneath her, she really does get stuck in to all jobs. She also provided amazing support, putting in plex lines, or using the ultra sound to place lines in veins, keeping her updated when there were delays, and breaking disappointing news with the compassion that is essential to maintain morale. Quiet, calm and authorative, O is a gem and deserves the highest praise. For my wife, this was quite an emotional time as certain parts of the procedure did not go easily. All staff were so helpful, and provided the reassurance, the hugs and understanding that was needed to help her through.

From my experience in my field, our customers & stakeholders are quick to complain, less so to pass on their grateful thanks. Hence this email. Quite simply, your staff are highly professional and dedicated, and I am sure you must feel very proud of them and their work".

NHS Choices

"So after possibly the scariest few days of our lives, I'm so pleased to say that our lovely mum is making an amazing recovery. We cannot thank our beautiful family, friends and the amazing staff of The Walton Centre enough for being there for us all. Thank you from the bottom of our hearts xxx"

"I visited WCNN for the second time in six weeks yesterday. This time I was bringing my father for his MRI scan. Unfortunately, the procedure was not carried out due to WCNN policies which are in place for a reason. I would just like to compliment and express my gratitude to ALL of the radiology team for the care and dignity showed toward my father who is currently under investigation for Alzheimer's. Your team are very dedicated and actually expedited xray for my dad even though it took them over their scheduled finish time. Once again 'Thank You'".

Twitter and Facebook

"To all therapists, Real heroes don't wear capes. They wear scrubs, work in hospital and are called therapists. Thank you for being my Batman."

"Today I've been on the other side of the bed! The Team on Jefferson Ward @WaltonCentre have been amazing, if I was a CQC assessor I would rate you as outstanding! Thank you for looking after me so efficiently & in such a caring way, you are assets to your profession! #teamCNO"

Section 7 - Claims (Governance Balanced Score Card)

The Trust has an agreed process in place for reporting, managing, analysing and learning from claims, in accordance with NHS guidance and Civil Procedure Rules. The Trust is a member of National Health Service Resolution (NHSR) Clinical Negligence Scheme for Trusts (CNST) and Existing Liabilities Scheme (ELS) for clinical claims. The Trust is committed to ensuring that claims are resolved in a professional, efficient and timely manner. The Trust aims to achieve an equitable outcome for all parties concerned, to take appropriate corrective action and to reduce the risk of future litigation.

This section describes the number of claims received and closed during the quarter. It should be noted that owing to the timeframe to settle a claim there can be a significant period of time to open and close a claim.

TRUST WIDE	Quarterly trend	Q2 18/19	Q3 18/19	Q4 18/19	Q1 19/20	Q2 19/20	Quarterly variance (Q1 19/20 and Q2 19/20)
Claims							
Total new claims received		9	12	4	8	4	↓
Neurosurgery claims		5	8	3	3	3	→
Neurology claims		1	1	1	3	1	↓
Corporate claims		3	3	0	2	0	↓
Total number of pre-action protocols in quarter		15	13	15	11	14	↑
Number of closed claims in quarter		3	7	8	4	5	↑
Value of closed claims - Public liability		£0	£1,286	£0	£5,427	£0	↓
Value of closed claims - Employer liability		£0	£0	£0	£0	£15,736	↑
Value of closed claims - Clinical Negligence		£8,540	£1,414,763	£1,134,580	£12,265	£447,102	↑

Claims / Legal

Key Points to note:

4 claims were received in Q2 of 19/20 compared to 8 received in Q1. See breakdown below:

1. GM (206) Neurosurgery Letter of Claim received.

Claimant had instrumented lumbar/fusion surgery from L4 to S1 on 26/09/2015 . It is alleged that the claimant suffered a bowel injury due to the length of the screw being used during the operation. It is further alleged that had a scan been performed earlier than 48 hours following surgery earlier intervention would have taken place and a better outcome would have been achieved. Claimant will say that they now suffer constant widespread pain, are unable to walk/stand for longer than 20 minutes, requires a crutch, suffers with anxiety, worsening of IBS amongst other things.

2. BMcD (207) Neurosurgery Letter of Notification received.

Claimant had degeneration scoliosis and underwent anterior and posterior correction surgery L2-5 OLIF. The surgery was complicated by break out of screws, implant failure and proximal junctional kyphosis. Further surgery was necessary. The claimant further suffered a haematoma. Still suffering with pain, low mood and isolation.

3. RP (208) Neurology Letter of Claim received.

Delay in diagnosing thoracic meningioma. Allegations are that the claimant saw consultant at CG but he did not check for plantar responses. Had they been checked it would have been found to be extensor which would prompt a search for a spinal cord lesion. An MRI of brain and cervical and thoracic spine would have been carried out. Had this been the case surgery would have been done by mid April 2012 although it wasn't carried out until Feb 2017. The claimant's date of knowledge regarding alleged negligence is September 2016.

4. SK (209) Neurosurgery Letter of Claim received.

Claimant had undergone cervical discectomy surgery in Nov 2011. The claimant started suffering with symptoms in May 2012. She was reviewed and managed by other specialty services until May 2015 when she was referred back to WCFT for review of symptoms affecting hands and legs with paraesthesia. She was admitted for ACDF surgery in September 2015. In recovery she had weakness to all 4 limbs and was returned to theatre where a small vein bleed was found. The cage was replaced and wound repaired. Following discharge in October 2015 she continued to suffer problems. Following further investigations the claimant was admitted in February 2017 for laminectomy but symptoms had resolved so the surgery did not take place.

It is alleged that the surgery carried out in September 2015 was not appropriate. It is alleged that had she been counselled properly and the MRI not been misinterpreted she would not had had surgery. As a result of the surgery and complications which followed the claimant requires medication to control her pain and symptoms of sensory loss below T12 level with mild weakness in lower limbs, impaired bowel and

bladder function when compared to her pre-op status.

Closed Claims

5 claims were closed in Q2 of 19/20. The total value of closed claims increased to £462,837.92 in Q2 of 19/20 compared to £17,692.00 in Q1 of 19/20 (one of the claims was an Employer Liability Claim with payments of £11,999.00 Damages, £3,737.00 Claimant costs, £0.00 Defence costs to pay. The claim was a V&A claim against a member of staff by a patient. The patient punched the member of staff in the face resulting in a swollen lip and front teeth loosened. The claimant had to have dental implants fitted.

- There were 4 new CNST claims in Q2 compared to 6 in Q1.
- There were no new corporate claims in Q2 compared to 2 in Q1.
- There were 2 re-opened claims in Q2.
- There were 14 pre-action requests for medical records in Q2 compared to 11 received in Q1. 5 claims were closed in Q2 compared to 4 being closed in Q1. We had to pay damages, claimant and defence costs for 2 of the closed claims. For the remaining 3 closed claims we paid defence costs only for 2 of them and no costs at all for the remaining 1. These claims may re-open if we receive any further correspondence from the claimants' solicitors at some point in the future. It should be noted that it may take over 5 years to settle an individual claim so any increase is not an indicator of any change in service between years.
- The Trust has served 5 Letters of Response of which 4 denied liability and 1 made a partial admission.
- The Trust has served 1 Defence denying liability.
- The Trust has settled 2 claims in Q2.

Following the introduction of Getting it Right First Time (GIRFT). All Letters of Claim/Notification are now discussed in the Serious Incident Group bi-weekly meetings. For Q2 none of the LOC/N discussed, which have not initially gone through the RCA process, have required an RCA to be carried out.

Coroners Inquests

We currently have 2 cases where the Coroner has requested that staff provide statements and attend Inquest.

1. DS.

The deceased's wife raised concerns with the Coroner regarding the tracheostomy and platelet care/treatment provided to her husband during his inpatient stay. She is of the opinion that the care/treatment provided contributed to his death. Directions were received from the Coroner for statements from staff involved in the patient's care which were provided. We have received inquest funding from NHSR and Hill Dickinson (HD) have been instructed to deal with this matter. The deceased's wife has also instructed solicitors. We have attended several Pre Inquest Review meetings to assist the Coroner with her investigations and an Inquest has now been confirmed to run for 3 days from 16/12/19 to18/12/19. Staff will be given the opportunity to attend an Inquest for observational purposes only before December. We will also arrange a meeting with staff and HD prior to the Inquest so that staff can discuss/raise any concerns/worries that they may have.

2. VH.

The deceased's husband raised concerns with the Coroner regarding a delay in diagnosing and treating his wife's brain tumour from December 2018 to May 2019. He is of the opinion that had she received an earlier diagnosis the treatment received would have been provided earlier giving a better outcome and therefore giving her more quality time to spend with her family before her death. The Trust attended two Inquest reviews. The first meeting focused on delay of diagnosis and treatment. The consultant who attended explained the reason behind the delay in diagnosis and further the reason for the delay in treatment – this explanation was accepted by the Coroner and the family. The second and final Inquest meeting focused on the consent form and whether the patient and family had been informed on the "risk to life" before undergoing the surgery to de bulk the tumour. Following the Registrar's evidence the Coroner was satisfied that the "risk to life" had been discussed. The Coroner recorded a verdict of misadventure. The Coroner further suggested that the consent forms should contain a section to confirm that "risk to life" had been discussed. Further discussed took place stating that patients/families who find themselves in the situation where they receive a life changing/limiting diagnosis should be given the opportunity and enough time to be able to take on board the seriousness of the diagnosis and therefore enable them to consider all treatment options and make a decision regarding treatment which is right for them. Following the Inquest the deceased's husband has been contacted and given the opportunity to attend a meeting at the Trust with the Head of Patient Experience, Lead Cancer Nurse and Claims Manager to discuss how the Trust can improve the service provided to support patients and families.

Staff Support

All staff involved in claims are fully supported regarding the process of clinical negligence claim

Section 8 - Risks (Governance Balanced Score Card)

Risk Management is a process of identifying, assessing, controlling and reducing risk across the whole organisation.

Risk is defined as a **hazard / exposure to danger which may lead to harm.** The consequence of risk can be damaging and consequently steps must be taken to eliminate or minimise risks and / or limit the impact / frequency of occurrence.

A risk will be deemed high if, the likely impact of the risk would lead to **major disability or death** of an individual or loss of service or reputation of the organisation or **prosecution.**

Clinical Risk Management focuses on the risks directly associated with patient care, whilst **Non Clinical Risk Management** is associated with all other Trust activities.

Risks							
Current Number of High Risks 15 and above		24	24	25	22	22	
Current Number of Medium Risks 6-12		142	145	154	147	150	
Current Number of Low Risks 1-5		48	46	53	53	43	
Number of new Risks opened in the Quarter		10	23	24	19	23	
Number of closed Risks in the Quarter		7	16	10	16	17	
Number of Risks increased in the Quarter		2	0	2	1	0	
Number of Risks decreased in the Quarter		6	2	7	4	6	

Risks

Key Points to note:

1. There are 22 risks rated at 15 and above remain at 22 for Q2.
2. There has been has been an increase in risks rated as 6 -12.
3. A total of 23 risks were reported in Q2, all of which were reviewed and approved at the appropriate Governance and Risk Group.
4. A total of 17 risks were closed in Q2.
5. No risks were increased and 6 risks were decreased in Q2.

Top 3 Board Assurance Framework Risks (BAF):

1. Failure to achieve the recurrent QIP financial plans in accordance with the Strategic Plan due to conflicting pressures/challenges without adequate mitigations – Risk Rating of 20.
2. Potential impact on business continuity due to an ageing estate – Risk Rating of 20.
3. Risk of physical harm to staff due to the complex clinical nature of the patient population – Risk Rating of 20.

Top 3 Operational/Divisional Risks:

1. Risk of not meeting the Activity Plan due to Consultants not undertaking WLI's – Risk Rating of 20 – Division: Neurosurgery.
2. Achievement of balanced budget – Risk Rating of 20 – Division: Neurosurgery.
3. Lack of Consultant Neuropsychiatrist review and intervention for Rehabilitation Network patients – Risk Rating of 15 – Division: Neurology.

Key Actions:

- The Trust recently received substantial assurance for Risk Management Arrangements, including a review of the BAF.
- Patient Safety Group scrutinises all Divisional risks on a bi-monthly rotational basis.
- The Divisional Governance and Risk Meetings review all new departmental risks providing approval onto the appropriate risk register.
- The Divisional Governance and Risk Meetings scrutinise Department risk registers on a rotational basis.
- Continue to ensure the Risk Register process is embedded in the Trust by providing continuous training and scrutiny of the risk registers at various groups and committees. Risk Register Training will continue to be provided throughout 2019/20.
- The Trust wide risk register is reviewed at Quality Committee, Trust Board and Executive Committee on a Quarterly basis.
- The Departmental Assurance reports were reviewed and Departmental Risk Activity included providing staff with an understanding of risk activity within their area.

Section 9 - Safety Section

Health and Safety Management is “The means by which an organisation controls risk through the management process”. The management of occupational health, safety and wellbeing is now central to the effective running of the NHS. There is strong evidence linking patient safety, patient experiences and the quality of care with the safety, health and wellbeing of the workforce.

The Walton Centre provides a commitment under its Health & Safety Policy to ensure the Health, Safety and Welfare of patients, visitors, contractors and staff. Accurate reporting of incidents and near misses is essential in order to reduce risks and avoid untoward incidents and near miss incidents.

Moving & Handling - The Manual Handling Operations Regulations 1992/2016 (MHOR) define manual handling as “any transporting or supporting of a load including the lifting, putting down, pushing, pulling, carrying or moving thereof) by hand or bodily force.”
Both animate and inanimate loads are included and therefore apply to all manual handling activity and assistance with movement for patients.

Fire Safety is the means by which all NHS organisations ensure the safety of patients, staff and visitors. For all premises under their control NHS organisations will need to select and effectively implement a series of measures to achieve an acceptable level of fire safety.

Emergency Preparedness, Resilience and Response (EPRR) is the means by which the NHS needs to plan for, and respond to, a wide range of incidents and emergencies that could affect health or patient care. These could be anything from extreme weather conditions to an outbreak of an infectious disease or a major transport or terrorist incident. The Civil Contingencies Act (2004) requires NHS organisations, and providers of NHS-funded care, to show that they can deal with such incidents while maintaining services.

Management of medical devices is the systematic approach to the acquisition, deployment, maintenance (preventive maintenance and performance assurance), repair and disposal of medical devices and medical device training, to ensure that medical devices are used safely, competently and effectively for the best care of patients and to comply with all relevant legislation and guidance.

Safety

Fire Safety

Fire alarms are Unwanted Fire Signals (UwFS) that cause disruption to the Trust and can affect service delivery. UwFS out of normal business hours attract the attendance of the Fire and Rescue Service (FRS), this can have a negative effect on how the FRS view and support the Trust in its Fire safety Policy. It is important that all trust employees apply common sense when carrying out simple activities, like preparing food or toasting bread within kitchens/pantry areas, using air freshener or deodorant sprays in the vicinity of Fire Detectors and when using the 'fogging' apparatus for deep cleaning. These activities are the most common causes of avoidable UwFS.

Key points to note:

1. Within Q2 there have been 7 (UwFS); one incident resulted in the attendance of the Fire Service at 02:00 hrs.

	Actual Fire	Manual Call Point	Toaster	Microwave	Fogging	Nebuliser/ aerosol	Smell of smoke	System fault	Fire service attendance
July	0	0	0	0	1	2	0	1	0
August	0	0	0	0	0	0	0	1	1
September	0	0	1	0	1	0	0	0	0
Total:	**0**	**0**	**1**	**0**	**2**	**2**	**0**	**2**	**1**

2. The Fire Safety Advisor (FSA) continues to work within wards and departments to increase fire safety awareness in order to reduce the number of UwFS. It is disappointing to note that during Q2, the use of the deep clean, 'fogging' apparatus has caused 2 UwFS and the over exuberant use of aerosols has caused 2 UwFS with 1 due to toasting, all of which are avoidable. If we take these from the total, we are looking at 2 UwFS which can be viewed as acceptable.
3. The FSA has delivered staff fire training at scheduled mandatory sessions (day and evening) however some staff members (particularly night staff) have struggled to attend these sessions. As a result training figures were falling below an acceptable level, the Director of Nursing & Governance has instructed managers to ensure all staff approaching date or indeed out of date, attend the mandatory sessions. FSA suggested via the 'Huddle' that training could be carried out on Ward/Depts, this will assist in capturing the aforementioned staff. The take up has been substantial and staff training compliance is now at 92%, which equates to 1236 of the 1343 staff within the trust being compliant. ITU/HDU and Theatres support in the delivery of FSA approved training via practice education leads which allows those areas to utilise availability of staff to the maximum.
4. Discussions have taken place and initial approval given to involve the SMART team as Fire Responders. The team already respond to an

area where a Fire Alarm has been actuated and it therefore makes sense that they take an active role in the response to fire alarms, especially outside of business hours, where attendance of the FRS would be expected, this would provide a clinical member of staff as liaison in addition to security/porters affording a greater level of 'responsible person' to deal with FRS Commanders. Some training will be involved and discussion is ongoing.

5. In relation to the post fire action plan, the work to rectify breeches In compartmentation is ongoing with slow but steady progress being made, FRS are kept up to date with progress and so far, are happy the Trust has taken steps to rectify.

GAF theme analysis

1. REF 301 Fire Safety Compliance - the work to rectify breeches In compartmentation is ongoing with slow but steady progress being made, FRS are kept up to date with progress and so far, are happy the Trust has taken steps to rectify.

Key actions:

1. The updated device addresses will now enable the Fire Response Team to promptly identify and respond to the exact location stated within the alarm panel.
2. Discussions with ISS are ongoing to improve Security Guard's knowledge of the fire alarm panels.
3. Continue to work with the SMART Team to integrate them as part of the Fire Response Team.
4. Continue to liaise with Estates with fire safety and on new projects.
5. Continue to monitor progress of post fire action plan (compartmentation upgrade and repair).
6. Continue to review Fire Risk Assessments ensure significant findings (works identified/required by the fire risk assessments) are actioned by the Estates dept. with suitable timelines taking account of budgetary constraints.

Medical Devices

Electrical & Biomedical Engineering (EBME)

1. Service support:
   - Engineers have attended training for Drager IACS monitoring equipment for Theatre/ITU equipment
2. Equipment issues identified:
   - Numerous faulty diagnostic sets on wards e.g. ophthalmoscopes
   - Bladder scanner - user negligence, excess damage due to poor care of equipment resulting in down time as numerous bladder scanners are away for 3rd party repair

Key actions:

1. EBME continue to:
   - Maintain and report against agreed trust KPI's
   - provide assurance that Walton Centre equipment is safe and available
   - monitor (applicable) third party contractor management
   - support evidence based procurement
2. EBME continue to identify cost savings e.g.:
   - Diagnostic sets
   - Bladder scanner - 3rd party contract arrangements
3. Equipment trials - provide support for:
   - Hamilton/Drager ventilator replacement

Moving and Handling

Key actions:

1. Education and Training:
   - Investigation into incorporating Moving and Handling elements into day 2 of Corporate induction to provide the foundation for clinical application of the personal safety training programme.
   - Moving and Handling training inputs delivered on site where appropriate; on receipt of new equipment, following incident or adverse event and on manager request.
2. Equipment: Medical Devices
   - awaiting third and final phase of replacement mobile hoists, familiarisation training to commence on receipt
3. Human Factors Ergonomics (HFE):
   - A review in relation to the Trusts' patient sling provision has been undertaken with audit and cost benefit analysis for alternatives completed and recommendations made
4. Bed Management:
   - Quarterly review meeting with Medstrom and monitoring against the performance indicators (KPI's) agreed. Real time audit against these expectations are performed regularly
5. DATIX:
   - 11 adverse events were reported through DATIX in Q2, 8 incidents were categorised as accidents and 3 related to the use of medical devices, systems and equipment. Support has been provided with advice and guidance and working with staff on alternative Moving and Handling approaches

- it is noted that of the 8 reports identified as an accident, 6 involved staff members being injured by an agitated, post anaesthetic patient or one who did not follow the requested movement plan
    - this highlights the importance of utilising safer Moving and Handling principles and supports the Trust approach of integrating Moving and Handling into the personal safety training on commencement of employment
- a total of five individual staff assessments have been completed in Q2 in relation to a diagnosed health condition or musculoskeletal concern, these were followed up with working with staff on the ward / departments concerned

Health and Safety

Key points to note:

1. The Trust reported 3 RIDDOR incidents to HSE in Q2, all 3 were staff related incidents occurring in August, these were:
    - staff member sustained a strain to their back and pain to their ankle following a slip and fall while responding to an emergency call buzzer
    - staff member was kicked in the back by a confused patient, causing the staff member to fall and injuring their back
    - staff member turned to walk into a clinical bay and tripped, falling to the floor injuring their right wrist (no fracture)
2. The Deputy Head of Risk has started in post and revised H&S training sessions and presentation, there has been positive feedback to date.

Key actions:

1. During Q3 the Deputy Head of Risk will be reviewing first aid provisions, department managers have been asked to complete first aid risk assessments to identify requirements.
2. Control of Substances Hazardous to Health (CoSHH) will also be reviewed during Q3 to ensure compliance with current legislation.
3. The online Health & Safety Environmental risk assessment tool is being tested by key members of staff with expected roll out and training to begin during October. The on-line tool will assist managers undertaking risk assessments and environmental issues (supported by the Risk Team).

Emergency Planning

Key points to note:

1. The completed the 2019-20 Emergency Preparedness Resilience & Response (EPRR) Core Standards; these standards are similar to the previous years, with a deep dive focus on adverse weather. The outcome of this self-assessment was that the Trust was complaint with the applicable standards. A report will be sent to Novembers BPC and Board and then submitted to Regional EPRR leads post Board approval.

2. The Trust participated in a regional emergency planning exercise, Exercise ELSA II, this exercise focussed on the lessons learnt from the MEN Arena incident, specifically on psychological support. A Consultant Neuropsychologist represented the Trust. The trust Major Incident Plan will be updated to include bespoke arrangements for dealing with psychological trauma.
3. Business Continuity Planning (BCP) - business impact analysis and risk identification is ongoing in line with the Trusts EPRR programme. A number of BCP exercises have been undertaken in Q2, in particular a regional EU EXIT workshop and exercises in Neuroscience Laboratories.
4. Following an alert from NHSI, the Trust has developed documented arrangements for casualty tracking with unknown patient status in the event of a mass casualty incident, which reduces the likelihood of harm e.g. incorrect transfusion.
5. Brexit preparations are ongoing are being overseen by the Director of Strategy & Planning and the Head of Risk. There has been a regular meeting of the Trusts EU EXIT task and finish group, SITREP reporting will commence to NHSI on 21st October 2019. The Trust is monitoring the situation and continues to implement bespoke arrangements for command & control, business continuity, procurement, pharmacy, medical devices and HR.

Integrated Performance Report – October 2019

Introduction

NHS Improvement is responsible for overseeing NHS trusts. NHS Improvement's strategic objectives set out overarching aims for trusts across five themes; Quality of Care, Finance and use of resources, Operation performance, Strategic change, and Leadership, improvement and capability. A Single Oversight Framework has been developed to provide a methodology to measure these themes (which replaced Monitor's Risk Assessment Framework and NHSTDA's Accountability Framework in September 2016). These measures are utilised by CQC when assessing the Trust's standards of quality and safety.

When assessing the Trust's performance the Single Oversight Framework (SOF) is the key measure used, as well as the CQC domains. There are also a number of internal measures used by the Trust that are not included within the SOF which is internally important when assessing the performance of the Trust. The Trust assesses and rates its overall performance against the 5 CQC standards and uses both SOF and internal measures to determine its performance against the CQC standards.

This documents sets out to provide evidence that the Walton Centre NHS Foundation Trust meets the required standards in a safe and sustainable way, and the overall objectives.

Executive Summary

Area	Rating	
Safe		Green
Caring		Green
Effective		Green/Amber
Responsive		Amber
Well Led		Amber

Domain RAG Rating Calculations

The table below explains the domain RAG Rating calculations.

	Measures		
	Green	Amber	Red
Green	90%	50%	25%
Green/Amber	75%	30%	30%
Amber	50%	25%	40%
Amber/Red	25%	10%	45%
Red	5%	5%	50%

Overview

Based on an overall assessment of the metrics across each domain, Safe and Caring are rated as Green, Effective as Green/Amber, Responsive and Well-Led are rated as Amber.

In summary, the Trust has successfully maintained all Cancer standards in the reporting month of October, with the exception of 2 week rule urgent GP referral and 31 Day Diagnosis to Treatment which is currently below target, although histology results are outstanding. The Diagnostic mandated standard was met for October.

The non-elective activity within the Trust was 1 spell above plan in month (0.56%). Inpatient elective activity in month was 8 spells below plan (-2.71%), whilst day cases were 72 spells above plan (-6.87%).

In month outpatient activity (excluding Procedures) was below plan for new outpatient attendances by 41 attendances (-1.01%); with follow ups above plan by 389 (5.85%).

The daily average delays fell from 13.4 days in September to 11.39 days in October, but remains above the 5.85 days target. There was a considerable fall in the number of delay days due to patients awaiting public funding (down from 188 in September to 66 in October) which was partially offset by small increases in patients awaiting care package in own home (94 days in October compared with 70 in September) and patients awaiting further NHS non-acute care (134 days in October as against 99 in September).

In terms of finance, the Trust delivered an in month surplus of £361k against a plan of £645k, a shortfall of £284k. As the Trust has not met the plan in month, Provider Sustainability Funding (PSF) for October is not assumed within the position (£135k in month). The overall Use of Resource Risk Rating is 1 (the lowest level of risk) compared to a plan of 1, although it should be noted that the I&E margin has reduced to a 2 due to not hitting the financial plan in month. The Trust will be doing as much as possible to deliver the 19/20 control total, although this has become an increased challenge given the reduction in activity (and associated income) caused by the pensions tax issue for clinicians. Discussions with NHSI/E are continuing around the protocol for changing the year end forecast, which involves development of a financial recovery plan and review of the NHSI 'grip and control' list.

In terms of Quality, C.Diff, MRSA, MSSA and E.Coli are below the YTD threshold. There were zero Grade 3 and 4 pressure ulcers in October and zero falls of moderate or above harm.

Safe		Green

For October 2019, Safe is RAG rated as Green, no change from the September rating.

Caring		Green

For October 2019 Caring is RAG rated as Green as there were no Red rated indicators this month.

Effective		Green/Amber

For October 2019 Effective was RAG rated as Amber/Green, this is an improvement from the Amber rating in September.

Responsive		Amber

For October 2019, Responsive was RAG rated as Amber. This is mainly related to Cancer 14 and 31 Day performance, Did Not Attend (DNA) rates and cancelled operations booked within 28 days.

Well Led		Amber

For October 2019, Well Led was RAG rated as Amber due to staff turnover, vacancies and sickness/absence being higher than internal targets. The level of statutory training compliance has also remained below agreed targets

The Single Oversight Framework

The Single Oversight Framework is used to oversee if trusts are meeting regulatory requirements, and looks at five themes, with metrics divided into four areas.

Quality of Care – Appendix 1 – Page 8
There are 15 metrics that demonstrate that care is safe, effective, caring and responsive. Of these 15 metrics, 13 have associated targets, with all achieving target compliance in month.

Finance score – Appendix 2 – Page 22

Operational Performance Metrics – Appendix 3 – Page 37
There are 8 metrics that demonstrate that core standards are being achieved. Of these 8 metrics, 7 metrics have associated targets, with all but 2 achieving target compliance; Cancer 31 Day Diagnosis to Treatment; Cancer 2 Week Rule Referrals.

Organisational Health Indicators – Appendix 4 – Page 40
There are 4 metrics that assess leadership. There is 1 target associated for these metrics, which is failing.

Additional Metrics

Additional metrics are detailed in the below appendices.

Balanced Scorecard – Appendix 5 – Page 48
These are metrics that measure performance across the 5 CQC domains.

Additional Indicators – Appendix 6 – Page 52
These are additional metrics that are not detailed above.

Safer Staffing – Appendix 6 – Page 56
These are additional metrics that are not detailed above.

Key Performance Indicators that were not achieved

Operational Performance Metrics – Appendix 3 – Page 37

Cancer 31 Day Diagnosis to Treatment

31 day diagnosis to treatment performance for October is currently at 93.75%, which is below the 96% target. This is due to one patient where we are yet to receive the final histology result. It is expected that this cancer will be low grade and removed from the performance figures once confirmed. Only malignant cancers (Grade III and IV) are including in reporting.

Cancer 2 Week Rule Urgent GP Referral

2 Week rule urgent GP referral performance for October is at 92.86%, which is below the 93% target. This is due to one patient who breached the 2 week rule target.

Organisational Health Indicators – Appendix 4 – Page 40

Staff Turnover

Nursing turnover for a rolling 12 month period is 17.22%, compared to 17.34% in September 2019. 3 registered Nurses left the Trust in October, compared to 6 in September. Other turnover for a rolling 12 month period is 15.85%, compared to 14.83% in September 2019. There were 15 leavers in October, as there were in September. Both groups continue to remain above the NW NHS profile of 10%. This target is currently under review.

Additional Indicators – Appendix 6 – Page 52

Delays

The daily average delays fell from 13.4 days in September to 11.39 days in October, but remains above the 5.85 days target. There was a considerable fall in the number of delay days due to patients awaiting public funding (down from 188 in September to 66 in October) which was partially offset by small increases in patients awaiting care package in own home (94 days in October compared with 70 in September) and patients awaiting further NHS non-acute care (134 days in October as against 99 in September).

Outpatient New DNA Rate

The outpatient new DNA rate has improved to 8.98% in October from 9.18% in September, but remains above the 8% threshold.

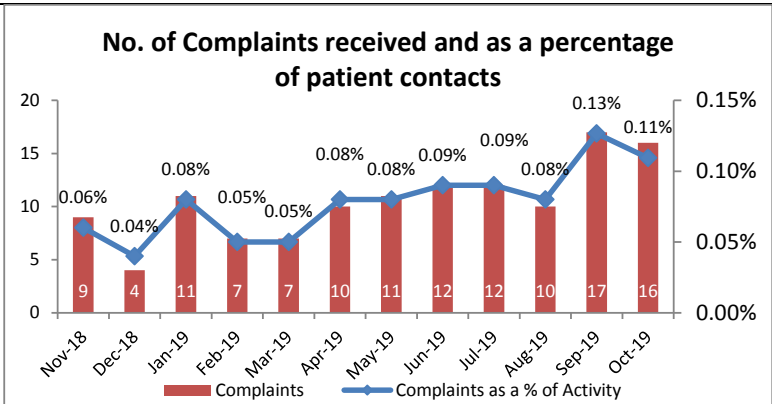
Follow up waiting list (FOWL)

The Neurology overdue follow-up waiting list is currently at 14,083 which is down by 736 from September. This reflects the increase in activity during October, which was above plan, even factoring in annual leave for half-term and lack of appetite for additional activity (WLIs). The recovery plan is well underway and all patients waiting 5 months or longer have been administratively validated. The validation exercise is due to be complete by December 2019. The train the trainer programme is being rolled out in November and will include the PAC team, secretaries and reception staff. This will provide refresher training to ensure PAS data is input correctly in relation to follow up patients. The clinical validation exercise is underway, ensuring clinical priority of patients and a weekly review of available appointments in order to maximise capacity for the backlog has also become business as usual.

Appendix 1: Quality of care metrics

CARING | Complaints

This is the number of complaints received as a percentage of patient contacts.

Trust Performance	Trend	Comments
October. 16 Complaints. **As % of activity. 0.11%.** **Target – 0.13%**		**There were a total of 16 complaints in October with 5 for the Neurology division, 7 for the Neurosurgery division, 1 for Corporate and 3 cross divisional.** **The overall level of complaints against volume of patient contacts within the Trust improved from 0.13% to 0.11%, below the 0.13% threshold.**

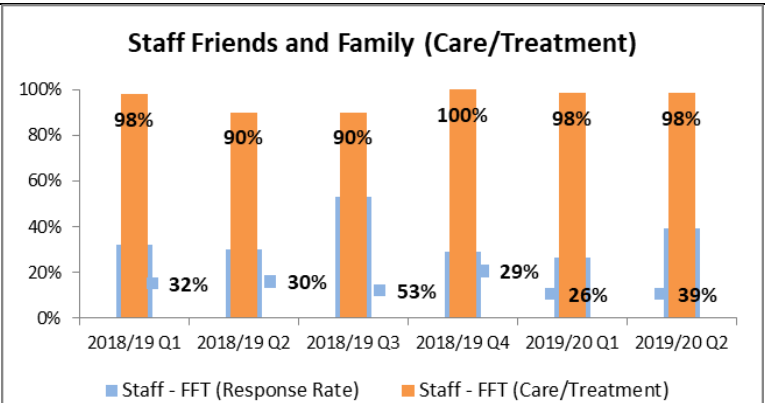
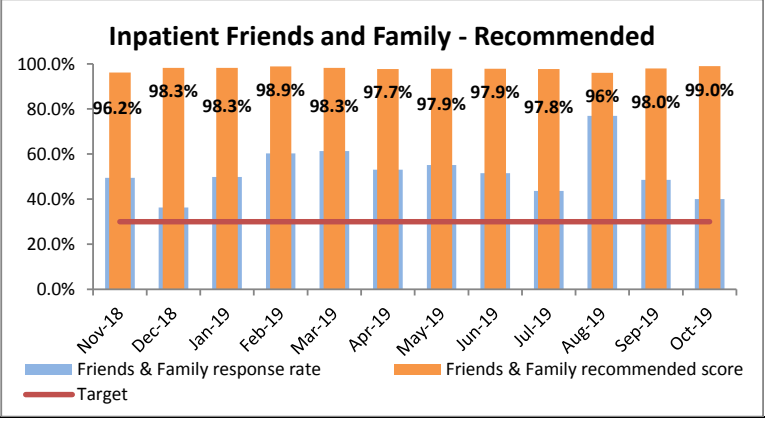
	Attitude Other staff	Communication failure outside of team	Communication breakdown with Consultant	Communication failure with patient/relative	Communication failure-within team	Consultant attitude	Consultant dismissive of patient symptoms	Delay in treatment/ procedure	Delay or failure to monitor	Incorrect / Misdiagnosis	Incorrect consent procedure	Incorrect information given to patients	Internal appointment error	Medication issues	Patient complains of inadequate pain management	Patient disputes urgency of referral	Patient felt Discriminated against	Patient unhappy with appointment and outcome	Post - operative complications	Treatment/procedure-inappropriate/wrong	Waiting times for follow up appointment	Total
Appointment Arrangements	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1	0	2	0	0	1	5
Approach and Manner	1	0	0	0	0	2	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4
Communication	0	1	1	2	1	0	0	0	0	0	0	1	0	0	0	0	2	0	0	0	0	8
Diagnosis	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1
Patient Care	0	0	0	0	0	0	0	0	0	0	1	0	0	1	2	0	0	0	0	0	0	4
Treatment	0	0	0	0	0	0	0	2	1	0	0	0	0	0	0	0	0	0	1	3	0	7

Each complaint can have multiple subjects and therefore the total is not a reflection on the number of complaints received.

The Walton Centre NHS Foundation Trust

CARING AND WELL-LED | Friends and Family

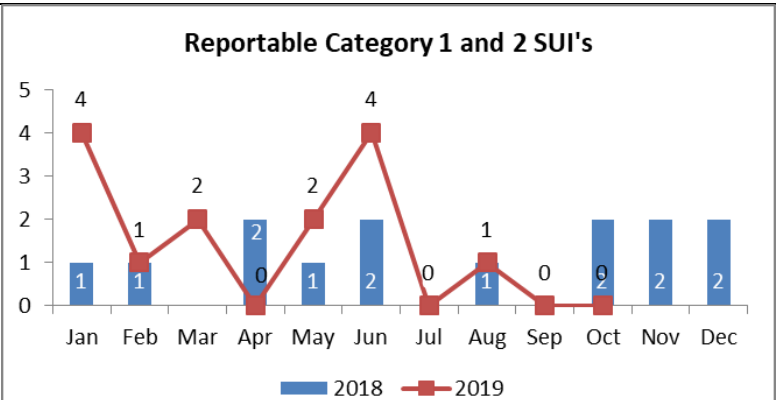
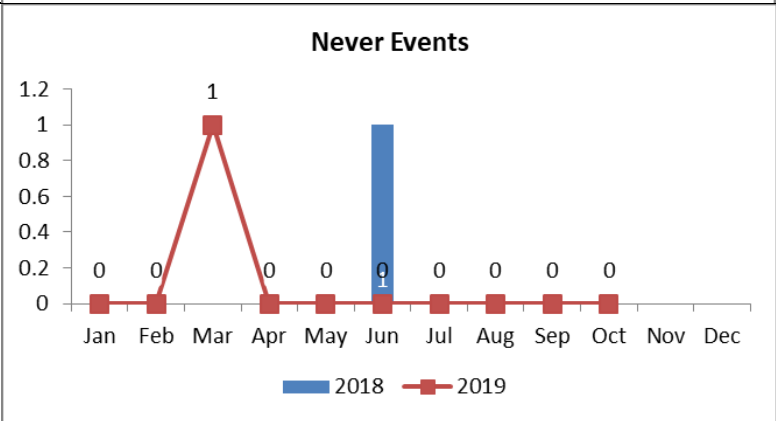
Count of those categorised as extremely likely or likely to recommend, against the total number of responders.

Trust Performance	Trend	Comments
Response rate was 39%. **Recommended score was 98%.**		**These figures are reported quarterly.** **The response rate in Quarter 2 was 39%.** **Recommended performance was 98%.**
Response rate was 40.0%. **Recommended score was 99.0%.**		**48.0% of Inpatients responded in October, compared to 48.60% in September. The response rate target is 30%.** **99% of Inpatients recommended the Trust, which is an increase compared to the 98% of Inpatients recommending the Trust in September.**

The Walton Centre NHS Foundation Trust

SAFE	Serious Untoward Incidents and Never Events

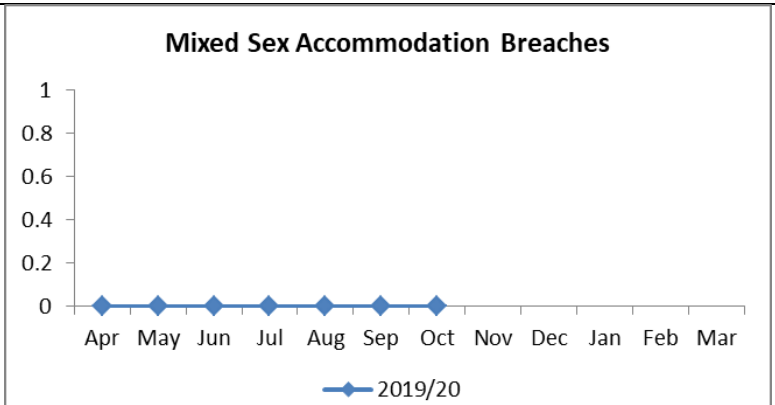
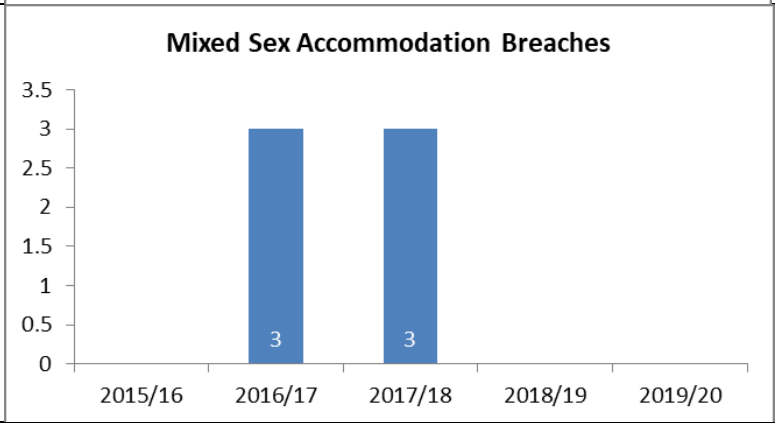
Number of Reportable Category 1 and 2 Serious Untoward Incidents (SUIs) and Never Events, reported on a monthly basis. This information is provided by the Risk department.

Trust Performance	Trend	Comments
0 SUIs in October 2019.		**There were 0 SUIs reported in October, which remains the same as September 2019.**
0 Never Events in October 2019.		**There were 0 Never Events in October 2019, which remains the same as September 2019.**

The Walton Centre NHS Foundation Trust

CARING	Mixed Sex Accommodation

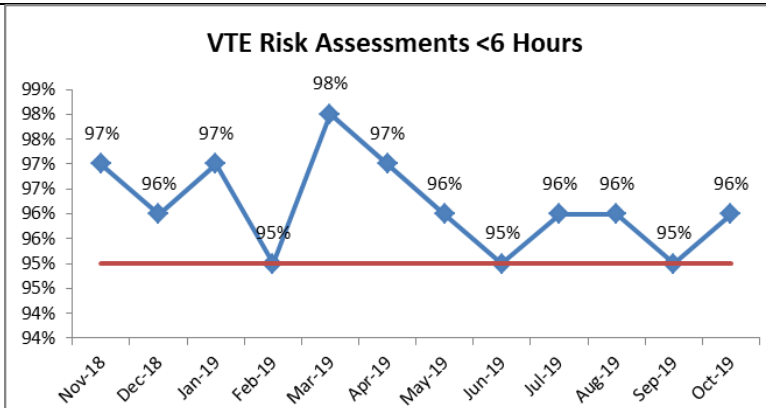
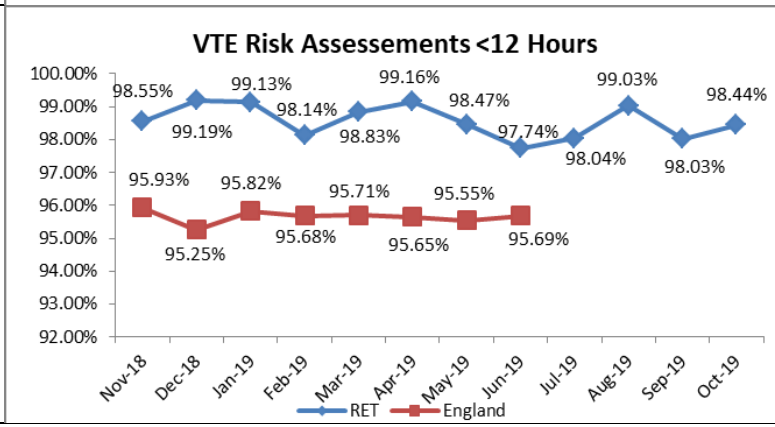
This is the number of occurrences of unjustified mixing of genders in sleeping accommodation.

Trust Performance	Trend	Comments
October is 0 **The target is 0**		**There were 0 breaches in October.**
YTD, there are 0 breaches in 2019/20. **There were 0 Breaches in 2018/19.**		

The Walton Centre NHS Foundation Trust

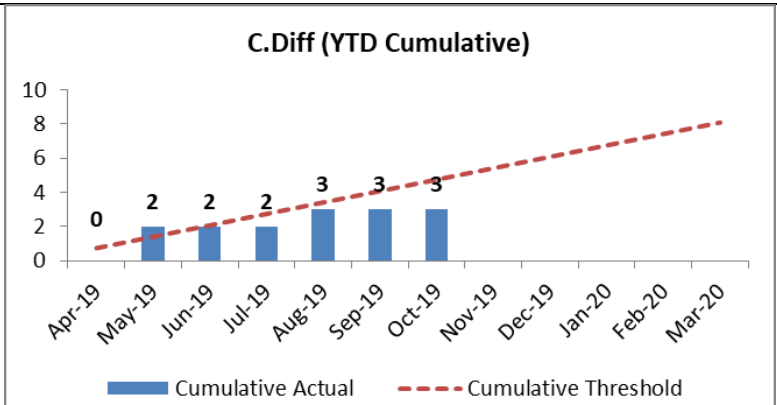
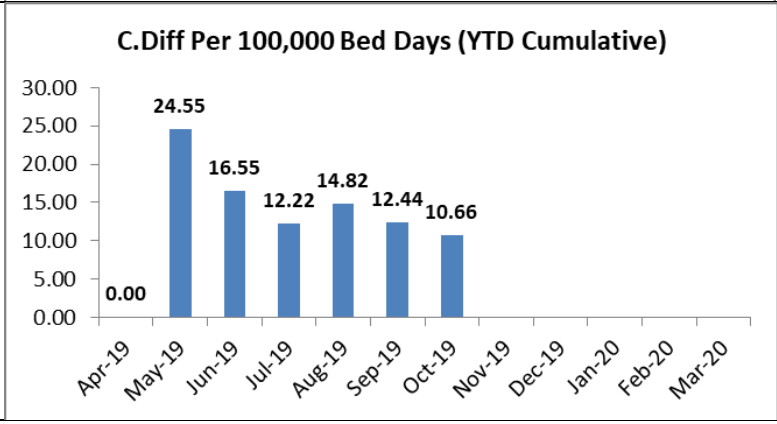
EFFECTIVE	VTE Risk Assessments

Number of patients admitted who have a VTE risk assessment/number of patients admitted. English national performance is published on a quarterly basis.

Trust Performance	Trend	Comments
6 Hour % - 96% **The target is >=95%**		**96% of patients were risk assessed for VTE within 6 hours of admission, which is an increase from 95% in September. The target is 95%.**
12 hour % - 98.44%		**98.44% of patients were risk assessed for VTE within 12 hours of admission, which is an increase from September (98.03%).** **English VTE Risk Assessment performance is published on a quarterly basis.**

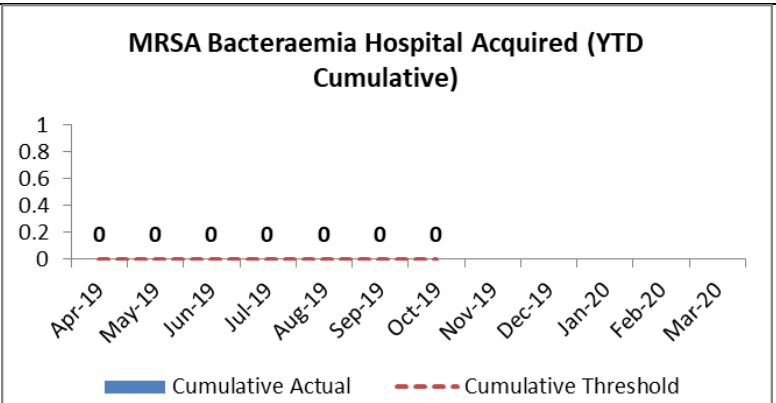
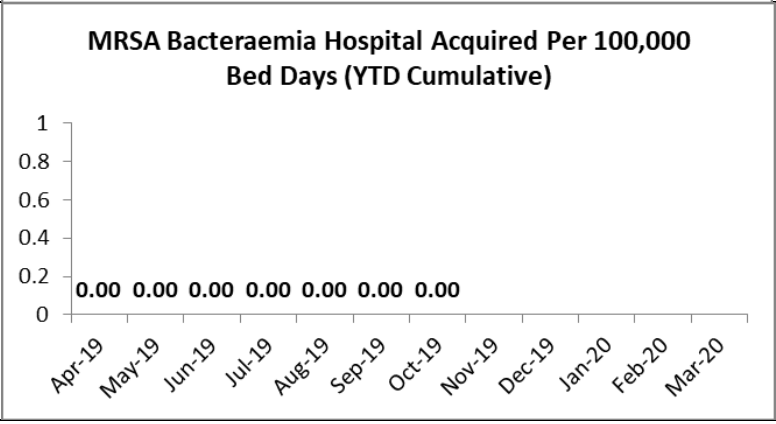
SAFE	Clostridium Difficile

Bacterium that's found in people's intestines. The metric measures instances of Clostridium Difficile counted cumulatively as an YTD figure. Information is provided by Infection Prevention and Control Team.

Trust Performance	Trend	Comments
Actual Month is 0. YTD is 3. Threshold is 8.		**There were 0 hospital acquired case of Clostridium Difficile in the Trust in October 2019.** **A root cause analysis will be undertaken for all infections and reported to the Infection Prevention & Control Committee.** **An RCA investigation for all cases is undertaken to identify any lapses in care and to determine themes and lessons to be learnt.**
YTD is 10.66		

SAFE | MRSA Bacteraemia (Hospital acquired)

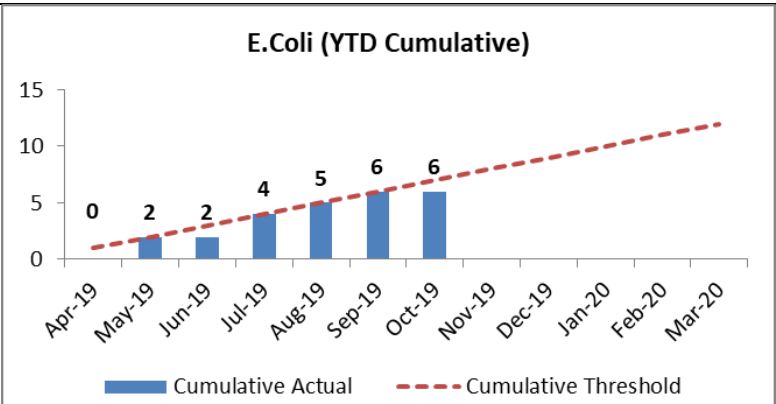
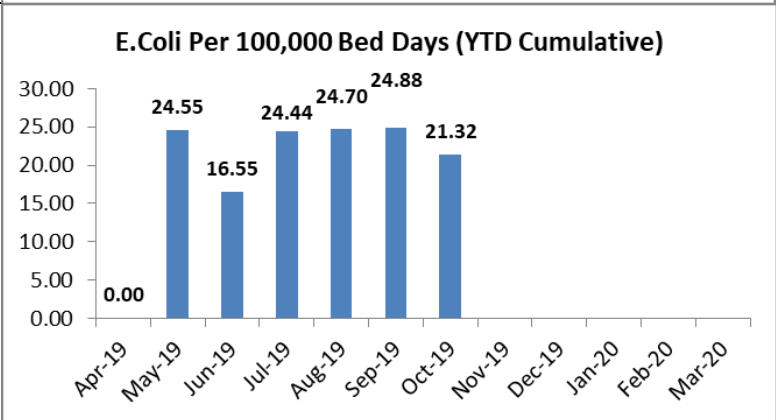
Staphylococcus aureus (S. aureus) is a bacterium that could enter the body. Illnesses ranging from mild to life threatening may develop. The metric measures instances of MRSA Bacteraemia (Hospital acquired) counted cumulatively as an YTD figure. Information is provided by Infection Prevention and Control Team.

Trust Performance	Trend	Comments
Actual Month is 0. YTD is 0. Threshold is 0.		**There were 0 hospital acquired cases of MRSA Bacteraemia in October 2019.** **The last case was November 2017.** **There were 0 cases of community acquired MRSA in October 2019.** **A root cause analysis will be undertaken for all infections and reported to the Infection Prevention & Control Committee.** **An RCA investigation for all cases is undertaken to identify any lapses in care and to determine themes and lessons to be learnt.**
YTD is 0.00		

SAFE

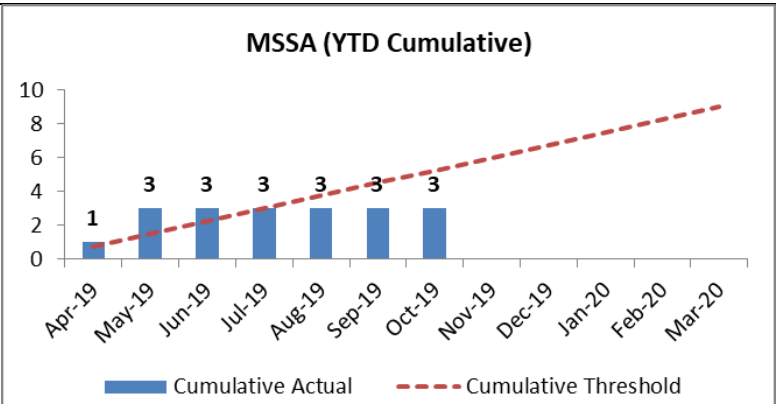
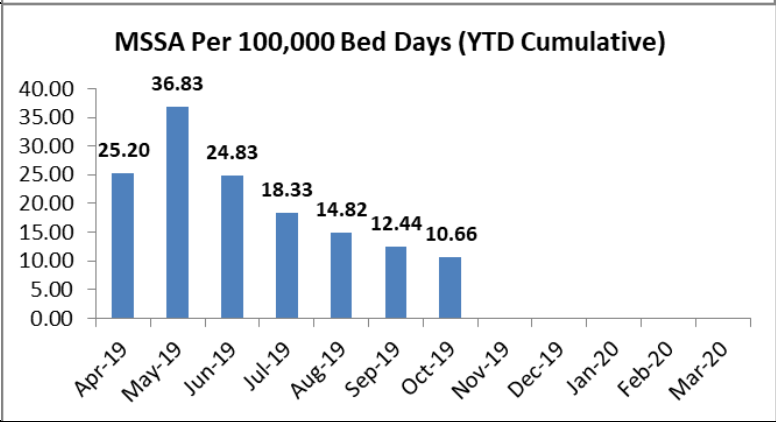
E Coli Bacteraemia

Cumulative YTD count of Escherichia coli (E. coli) bacteria. Information is provided by Infection Prevention and Control Team.

Trust Performance	Trend	Comments
Actual Month is 0. YTD is 6. Threshold is 12.		**There were 0 cases of E Coli Bacteraemia reported in October.** **There are 6 cases of E Coli for the current financial year, against a threshold of 12.**
YTD is 21.32		

SAFE	MSSA

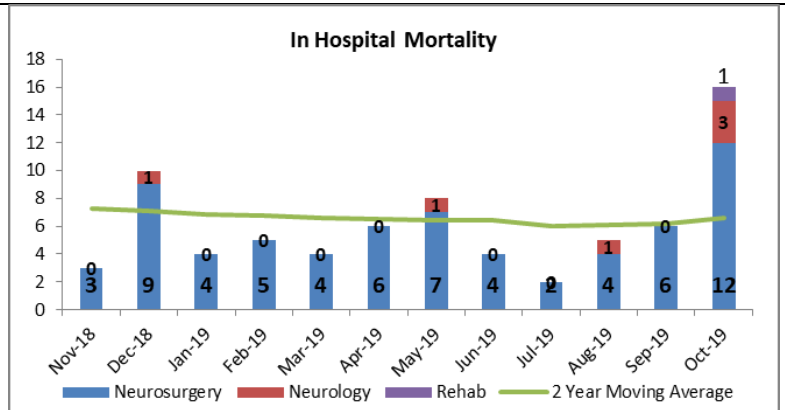
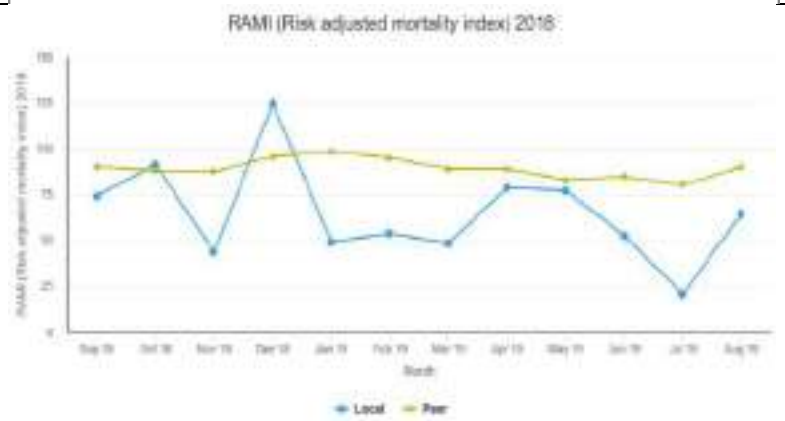
Cumulative YTD count of Methicillin-susceptible Staphylococcus aureus (MSSA) bacteria. Information is provided by Infection Prevention and Control Team.

Trust Performance	Trend	Comments
Actual Month is 0. **YTD is 3.** **Threshold is 9.**		**There were 0 cases of MSSA reported in October.** **There are 3 cases of MSSA for the current financial year, against a threshold of 9.**
YTD is 12.44		

EFFECTIVE

In Hospital Mortality

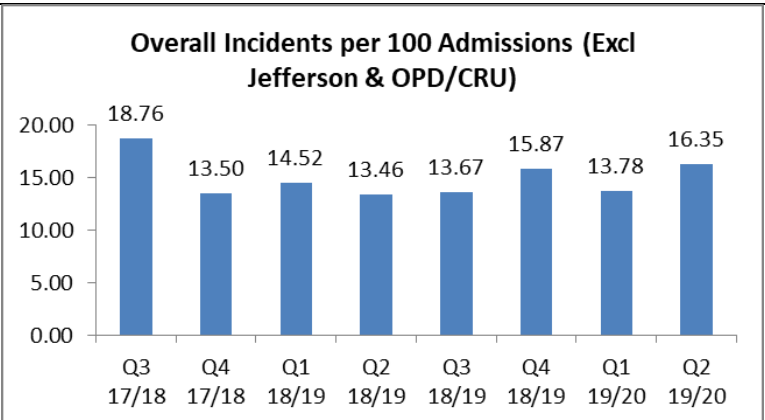
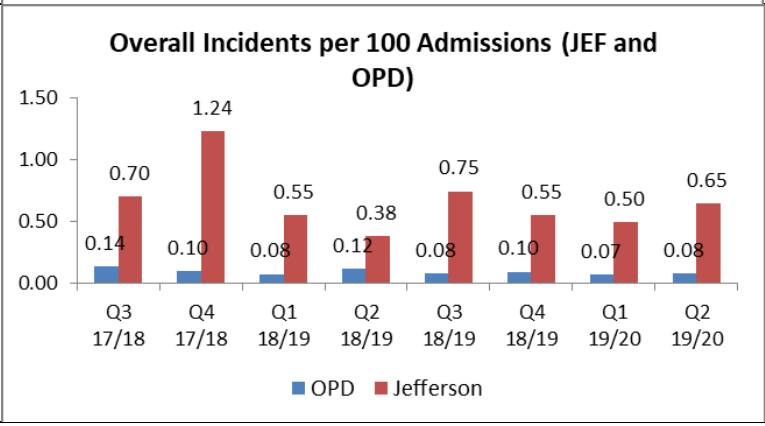
This is the number of instances of in-hospital mortality. Discharge method is 4.

Trust Performance	Trend	Comments
In-hospital mortality in October 2019 was 16. **NS = 12** **NEU = 3** **REHAB = 1.** **The In-Hospital annual target is 96.**	 	**Risk Adjusted Mortality Index (RAMI17) is now used as a replacement for Hospital Standardised Mortality Ratio (HSMR). The methodology behind RAMI17 is limited to just six factors, each of which is known to have a significant and demonstrable impact on risk of death. They are:** **1. Age - six groups** **2. Admission type - elective or non-elective** **3. Primary clinical classification - 260 CCS (Clinical Classifications Software) groups** **4. Sex - defaults to female if not known** **5. Length of stay - specific groups only** **6. Most significant secondary diagnosis - list covers 90% of all diagnoses mentioned in patients who died** **The first five of these as primary factors. Each is known with greater certainty and recorded with greater consistency than secondary diagnoses. The methodology uses these factors first, and then looks to see which secondary diagnoses most significantly and consistently increase risk of death.** **All cases are subject to detailed clinical review and discussion at Quality Committee, following review at Divisional mortality meetings. The longer term trend remains within the expected range for the case mix of patients treated.**

SAFE

Overall Incidents per 100 admissions

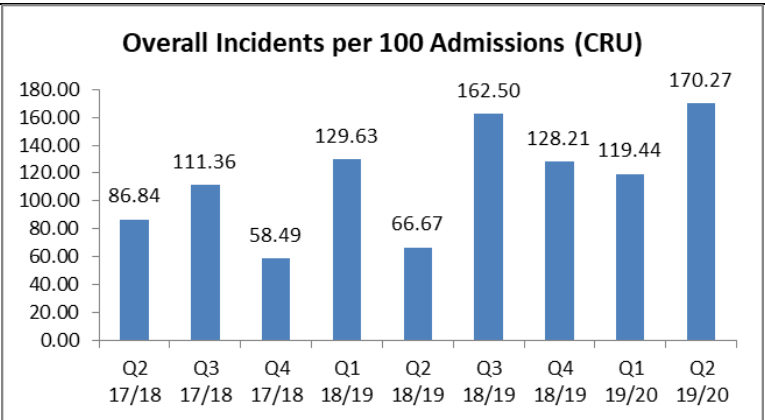
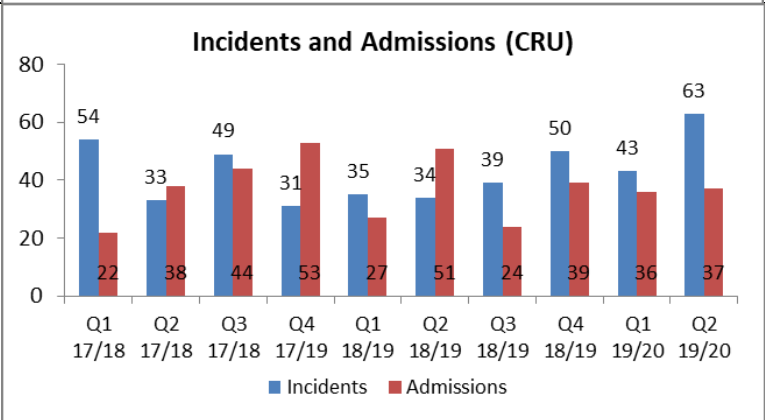
Number of Incidents reported on a quarterly basis, per 100 admissions. This information is provided by the Risk department on a quarterly basis.

Trust Performance	Trend	Comments
2019/20 Quarter 2 performance is 16.35% **OPD for Quarter 2 2019/20 is 0.08%** **Jefferson for Quarter 2 is 0.65%.**	 	**This information is produced on a quarterly basis.**

SAFE

Overall Incidents per 100 admissions

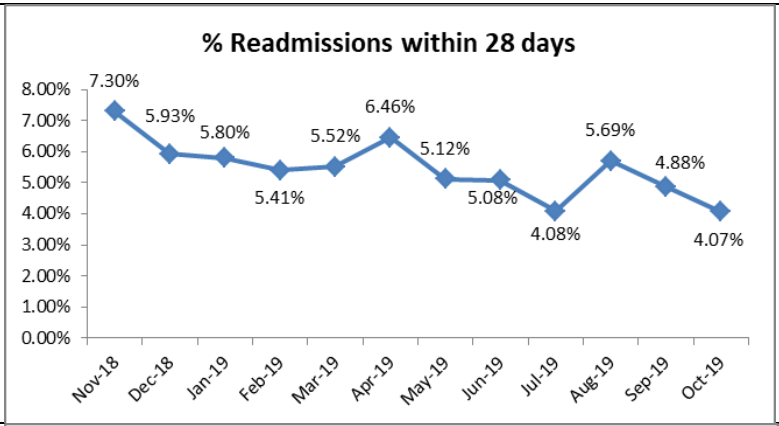
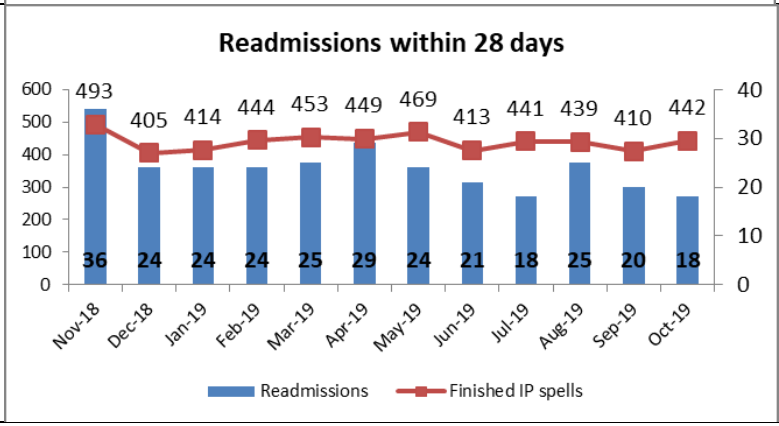
Number of Incidents reported on a quarterly basis, per 100 admissions. This information is provided by the Risk department.

Trust Performance	Trend	Comments
CRU for Quarter 1 is 170.27%	 	**The Complex Rehabilitation Unit (CRU) has a higher number of incidents per 100 admissions, as there are a smaller number of admissions who tend to have a longer inpatient stay. Due to the patients' complex rehabilitation needs, the number of incidents can be high.**

The Walton Centre NHS Foundation Trust

EFFECTIVE

Emergency Readmissions within 28 Days

Trust Performance	Trend	Comments
September - 18 **Performance – 4.07%** **Target – 6%**	 	**There were 18 emergency readmissions within 28 days in October 2019, with 442 inpatient discharges (excludes patients who were admitted for a planned sequence of admissions which do not involve an overnight stay and patients who died on discharge).** **Performance improved from 4.88% in September to 4.07% in October, but is under the 6% threshold.** **16 of the emergency readmissions were readmitted to Neurosurgery and 2 emergency readmissions were readmitted to Neurology.**

Appendix 2: Finance score

WELL LED | Finance

Finance Metrics used for finance risk rating

		Plan NHSI Risk Rating (1-4)	Actual NHSI Risk Rating (1-4)	RAG Rating
Financial sustainability	Capital service capacity	1	1	
Financial sustainability	Liquidity (days)	1	1	
Financial efficiency	I&E margin	1	2	
Financial controls	Distance from financial plan	1	1	
Financial controls	Agency spend	1	1	

THE WALTON CENTRE NHS FOUNDATION TRUST
SUMMARY FINANCIAL INFORMATION

Trust I&E	In month			Year to date			Forecast		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
Main Contract	9,055	8,918	(135)	61,552	59,172	(2,380)	105,787	105,030	(2,757)
Exclusions	1,540	1,819	279	10,775	11,478	703	18,471	19,675	1,204
Private Patient	17	(4)	(21)	116	65	(51)	198	112	(86)
Provider Sustainability Funding	135	0	(135)	647	619	(28)	1,582	1,489	107
Other Operating	548	586	38	3,835	3,836	101	6,578	6,577	(1)
Total Operating Income	**11,293**	**11,319**	**26**	**76,905**	**75,270**	**(1,635)**	**132,416**	**130,882**	**(1,533)**
Pay	(6,205)	(6,044)	161	(43,285)	(41,574)	1,695	(74,183)	(72,066)	2,117
Non-Pay	(2,493)	(2,527)	(34)	(17,445)	(17,244)	201	(29,884)	(29,607)	277
Exclusions	(1,591)	(1,909)	(270)	(10,710)	(11,415)	(705)	(18,360)	(19,570)	(1,210)
Reserves	158	(6)	(164)	757	583	186	1,528	1,581	453
Total Operating Expenditure	**(10,071)**	**(10,480)**	**(415)**	**(70,677)**	**(69,250)**	**1,377**	**(120,899)**	**(119,262)**	**1,047**
EBITDA	**1,222**	**955**	**(289)**	**6,278**	**6,020**	**(258)**	**11,517**	**11,621**	**104**
Depreciation	(401)	(400)	1	(2,806)	(2,746)	60	(4,810)	(4,810)	(0)
Profit / Loss On Disp of Asset	0	0	0	0	2	2	0	2	2
Interest Receivable	14	14	1	38	36	(2)	150	150	0
Financing Costs	(58)	(55)	2	(409)	(381)	28	(700)	(700)	0
Dividends on PDC	(151)	(151)	0	(920)	(919)	1	(1,577)	(1,577)	0
I & E Surplus / (Deficit)	**645**	**361**	**(284)**	**2,231**	**2,062**	**(169)**	**4,580**	**4,686**	**106**
Provider Sustainability Funding 2018/19	0	0	0	0	(106)	(106)	0	(106)	(106)
I & E Surplus / (Deficit) (CONTROL TOTAL)	**645**	**361**	**(284)**	**2,231**	**1,956**	**(275)**	**4,580**	**4,580**	**0**

STATEMENT OF FINANCIAL POSITION - 2019/20	Mar-19 £'000	Oct-19 £'000	Movement £'000
Intangible Assets	54	35	(11)
Tangible Assets	82,083	80,610	(1,473)
TOTAL NON CURRENT ASSETS	**82,137**	**80,633**	**(1,484)**
Inventories	985	1,112	127
Receivables	8,611	7,716	(895)
Cash at bank and in hand	31,733	33,435	1,750
TOTAL CURRENT ASSETS	**41,329**	**42,263**	**984**
Payables	(13,504)	(15,575)	1,609
Provisions	(312)	(318)	(6)
Finance Lease	(49)	(49)	0
Loans	(1,376)	(1,376)	0
TOTAL CURRENT LIABILITIES	**(17,241)**	**(15,738)**	**1,602**
NET CURRENT ASSETS/(LIABILITIES)	**13,988**	**16,516**	**2,586**
Provisions	(270)	7	277
Finance Lease	(168)	(144)	24
Loans	(26,427)	(25,729)	698
TOTAL ASSETS EMPLOYED	**69,220**	**71,283**	**2,063**
Public Dividend Capital	26,074	26,074	0
Revaluation Reserve	3,116	3,116	0
Income and Expenditure Reserve	39,430	41,492	2,062
TOTAL TAXPAYERS EQUITY AND RESERVES	**69,220**	**71,283**	**2,063**

STATEMENT OF CASH FLOW - 2019/20	Oct-19 Plan £'000	Oct-19 Actual £'000	Variance £'000
SURPLUS/(DEFICIT) AFTER TAX	2,231	2,062	(169)
Non-Cash Flows in Operating Surplus/(Deficit)	4,383	3,960	(423)
OPERATING CASH FLOWS BEFORE MOVEMENTS IN WORKING CAPITAL	6,614	6,022	(592)
Increase/(Decrease) in Working Capital	0	(772)	(772)
Increase/(Decrease) in Non-Current Provisions	(21)	(277)	(256)
Net Cash Inflow/(Outflow) From Investing Activities	(1,513)	(1,653)	(141)
NET CASH INFLOW/(OUTFLOW) FROM INVESTING ACTIVITIES	5,081	3,320	(1,761)
Net Cash Inflow/(Outflow) From Financing Activities	(1,720)	(1,612)	108
NET INCREASE/(DECREASE) IN CASH	3,361	1,708	(1,653)
OPENING CASH	20,439	21,713	1,274
CLOSING CASH	23,800	23,421	(379)

Trust Income and Expenditure (after adjustment for 2018/19 PSF allocation):

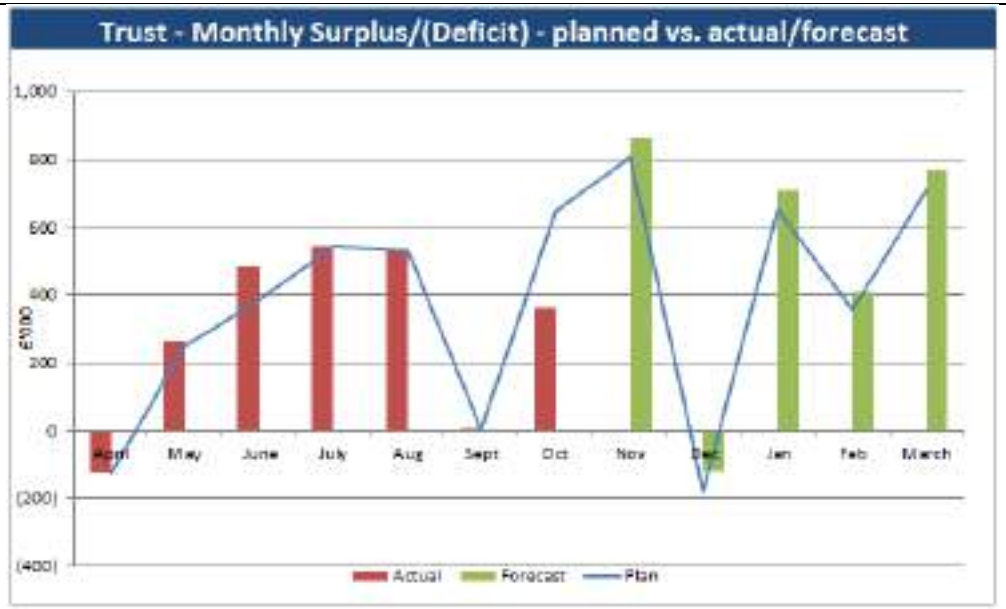
In month plan: £645k surplus

In month actual: £361k surplus

In month variance: £284k behind plan

Year to date variance: £275k behind plan

Currently forecasting to deliver control total of £4.6m (although this has become an increased challenge given the national pensions issue and under delivery of QIP).



Delivery of the year end control total is reliant on delivery of £2.9m QIP. There is also a risk around delivery of the activity and income plan, especially given the issues with regards to tax on pensions for consultants who perform additional work.

At month 7, 28% of the QIP target has been delivered recurrently. The trust delivered £195k below target in month.

In month patient related activity & income

	Activity			Income		
	Plan Spells	Actual Spells	Variance Spells	Plan £'000	Actual £'000	Variance £'000
Elective	296	291	(5)	1,833	1,961	128
Non-elective	180	176	(4)	1,661	1,695	34
Day case	1,052	1,120	68	728	792	64
OP First	4,024	4,147	123	1,011	1,040	29
OP Follow up	6,657	7,047	390	1,382	1,433	51
OP Procedure	748	601	(145)	167	129	(38)
Critical Care	642	565	(77)	944	833	(111)
Rehab	861	832	(29)	479	589	110
Other	0	0	0	2,405	2,261	(144)
TOTAL				10,610	10,733	123

Year to date patient related activity & income

	Activity			Income		
	Plan Spells	Actual Spells	Variance Spells	Plan £'000	Actual £'000	Variance £'000
Elective	2,065	1,973	(31)	12,438	12,424	(14)
Non-elective	1,158	1,157	(101)	11,565	11,193	(372)
Day case	7,291	6,995	(297)	5,026	4,842	(184)
OP First	26,942	25,025	(1,917)	6,782	6,307	(475)
OP Follow up	45,058	46,180	1,122	9,343	9,426	83
OP Procedure	4,787	4,209	(578)	1,078	913	(165)
Critical Care	4,249	3,938	(311)	6,248	5,744	(504)
Rehab	5,623	5,157	(466)	3,126	2,908	(218)
Other	0	0	0	16,817	16,958	141
TOTAL				72,423	70,715	(1,708)

Forecast patient related activity & income

	Activity			Income		
	Plan Spells	Actual Spells	Variance Spells	Plan £'000	Actual £'000	Variance £'000
Elective	3,467	3,411	(56)	21,579	21,792	213
Non-elective	2,111	1,943	(168)	19,398	19,030	(368)
Day case	12,580	12,069	(511)	8,680	8,363	(317)
OP First	46,703	43,371	(3,332)	11,758	11,369	(389)
OP Follow up	78,153	80,084	1,931	16,198	16,659	461
OP Procedure	8,328	7,296	(1,032)	1,878	1,584	(294)
Critical Care	7,225	6,857	(368)	10,624	9,713	(911)
Rehab	9,898	9,018	(880)	5,502	5,079	(423)
Other	0	0	0	28,839	29,228	389
TOTAL				124,456	122,817	(1,639)

Capital

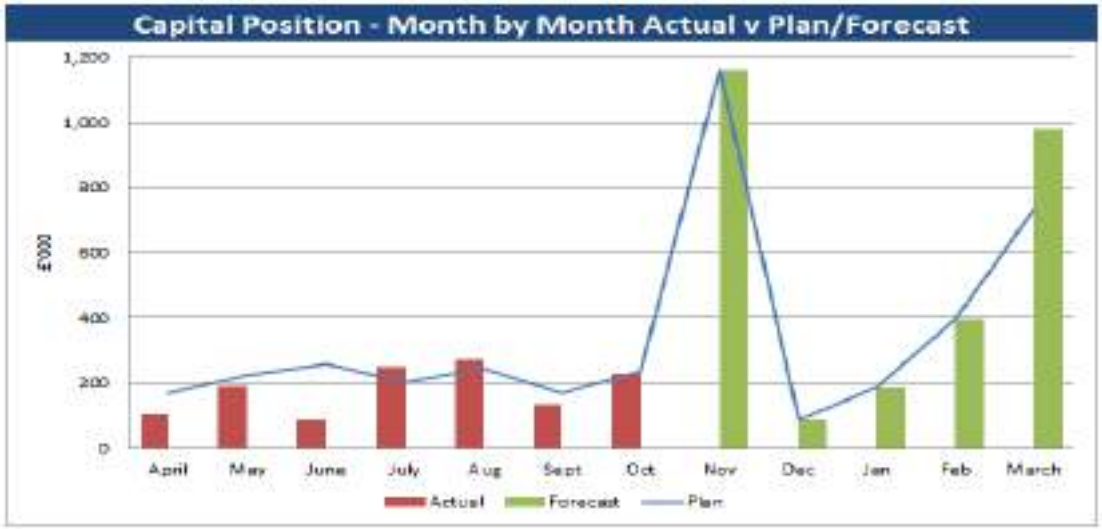
In month plan - £237k

In month actual - £230k

In month variance - £7k below plan.

Forecast - £4,075k in line with annual plan.

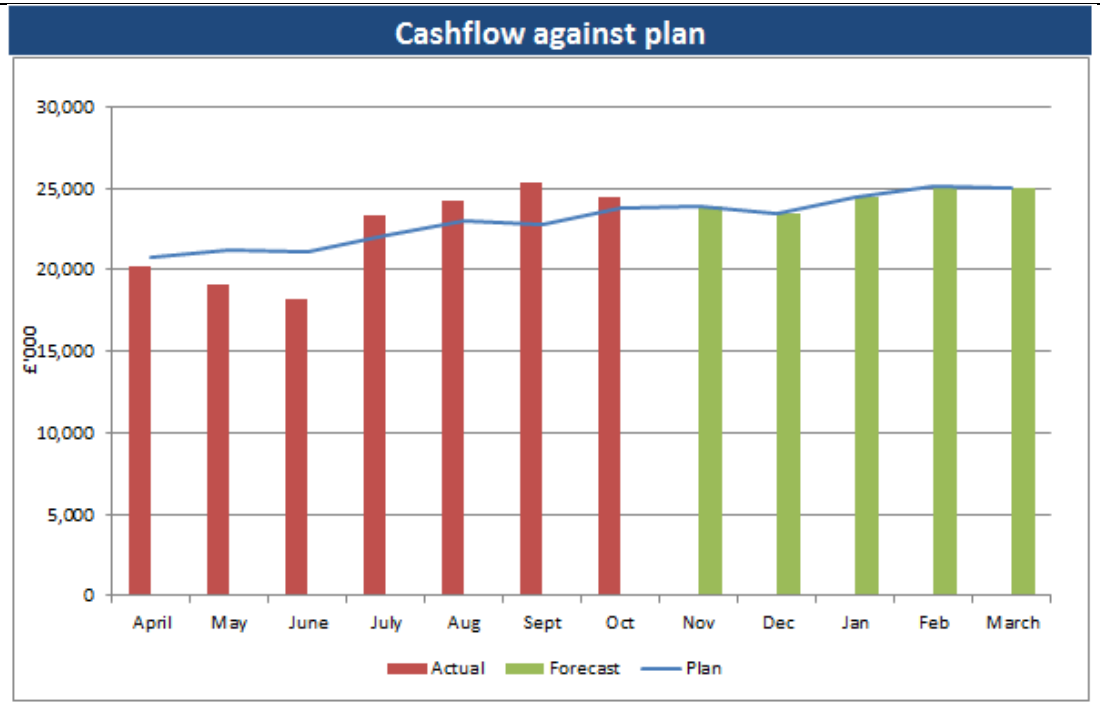
To note that work has been undertaken to prioritise capital as the commitments exceeded available capital limits.

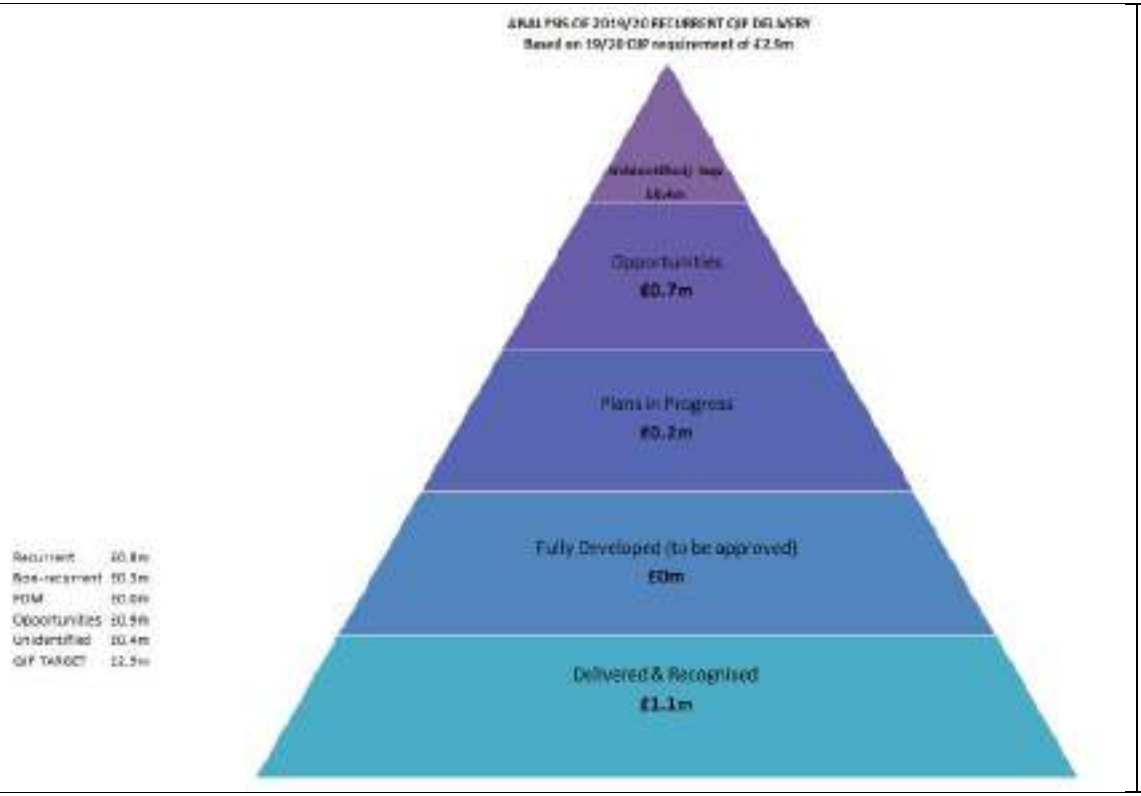


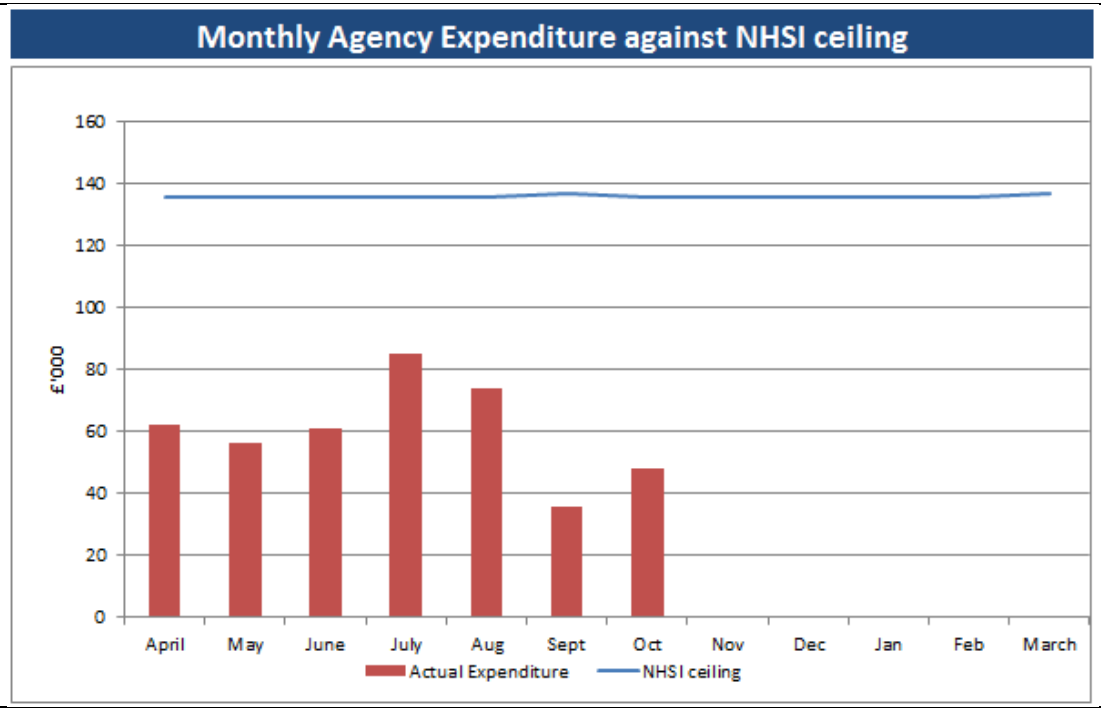
Capital is underspent against plan in month 7 by £7k. Neurosurgery has underspent in month due to not purchasing the Total Care Connect beds for Horsley which is planned for later in the year. Corporate is underspent due to the Financial Ledger System, which has been deferred into 20/21. The Phase 2 Heating Replacement Scheme is expected to come back into line with plan by the end of the year.

CAPITAL

	Annual	In month			Year to Date		
	Plan £'000	Plan £'000	Actual £'000	Var £'000	Plan £'000	Actual £'000	Var £'000
Division							
Estates	1,069	111	110	1	808	676	132
IM&T	649	45	120	(75)	386	472	(86)
Neurology	1,427	5	0	5	35	23	12
Neurosurgery	539	56	0	56	261	92	169
Corporate	391	20	0	20	20	0	20
TOTAL	**4,075**	**237**	**230**	**7**	**1,510**	**1,263**	**247**

As of the end of October: Planned Cash Balance: £23.8m Actual Cash Balance: £24.4m Variance: £0.6m above plan Number of days operating expenses = 74 days		The Trust cash balance at the end of October was £24.4m which is £0.6m ahead of plan. This is due to additional cash received for incentive, general distribution and bonus funding in relation to 18/19.

QIP In month Plan: £261k In month Actual: £66k In month variance: £195k below plan Year to date variance: £816k below plan Currently forecasting to deliver annual savings of £1.1m, a shortfall of £1.8m.		Trust delivered £66k of savings against planned savings of £261k in October, therefore £195k below the in month plan. Of the £66k, all of this was delivered on a recurrent basis. The service development team have been recruited to and it is hoped that further savings will be identified and delivered this financial year – work is ongoing with the team to identify potential opportunities.

Agency against NHSI ceiling: In month Plan: £136k In month Actual: £48k In month variance: £88k below plan. Year to date variance: £530k below plan (£423k expenditure against £953k ceiling)		Agency spend incurred in October was £48k, which is £88k below the NHSI monthly agency cap of £136k.

Key Risks and Actions for 2019/20

RISK	COMMENT/ ACTIONS
Risks to delivery of activity (and associated income) plan as a result of pension changes	The recent guidance from BMA to its members concerning potential tax liabilities on pensions linked to additional work is leading to less additional sessions being undertaken by consultants. The trust has proposed a Time off in Lieu (TOIL) scheme to clinicians as a local solution to the issue and will review the take up of this option to see if it provides a viable solution in the short term. It is also working up a policy of grossing up pay for pension contributions in line with BMA recommendations, however this awaits committee approval. Delivery of activity still remains a risk in achieving the 19/20 control total until an agreeable national solution is implemented.
Identification and delivery of recurrent efficiency savings	This remains a significant challenge and risk to the Trust. The Trust is progressing with 2 major transformation schemes in 2019/20 that will be resourced by a dedicated team. It is anticipated that these schemes will deliver savings and improved patient experience across the Trust. The Trust will also be using Model Hospital information to generate potential savings ideas for 2019/20.
Future Operating Model (FOM)	Delivery of recurrent savings through the central Future Operating Model (FOM). Tariffs were centrally top sliced to establish the FOM infrastructure with Supply Chain identifying the level of savings associated with the move to FOM which were assumed within Trust plans. To date the level of savings delivered through FOM have not materialised creating a pressure for the organisation.
Welsh Health Specialist Services Committee (WHSSC) income relating to HRG4+ tariff changes	It appears from recent discussions between NHSI/E, Welsh Government and DHSC that there is now an agreement that the Welsh Commissioners will pay at HRG4+ tariff less a 1.25% CQUIN element. The HRG4+ tariff will also form the basis of future tariff payments. The CQUIN element is to be funded by DHSC in 2019/20. The Trust is awaiting a final agreed contract from WHSSC and confirmation that DHSC will pay the 1.25% CQUIN element to completely mitigate the risk to the Trust. The DoF has contacted NHSI to ask them to confirm the DHSC position.
Capital Expenditure	The inflexibility on capital spend given the recent letter from NHSI/E is

	likely to cause the Trust some issues as there are some unplanned capital issues that have come to light that were not included in the plan. Given the recent communication, the capital plan will need to be reviewed and prioritised, however this could lead to impacts in other areas of planned investment.
Levels of nurse bank expenditure	Since the introduction of the internal nurse bank, levels of spend in this area have increased significantly. There has been a reduction in agency and overtime spend. However the levels of increase in bank spend (particularly registered nursing) is much higher than anticipated partly due to the levels of sickness and increase in fill rates. The bank expenditure is being continually monitored, and recently the NHSP pay rates have been reviewed with the aim of reducing rates in the near future. It should be noted that overall expenditure on bank, agency and substantive nursing is underspent against planned budget, largely due to the current level of nursing vacancies.

Neurosurgery financial position

Divisional contribution:

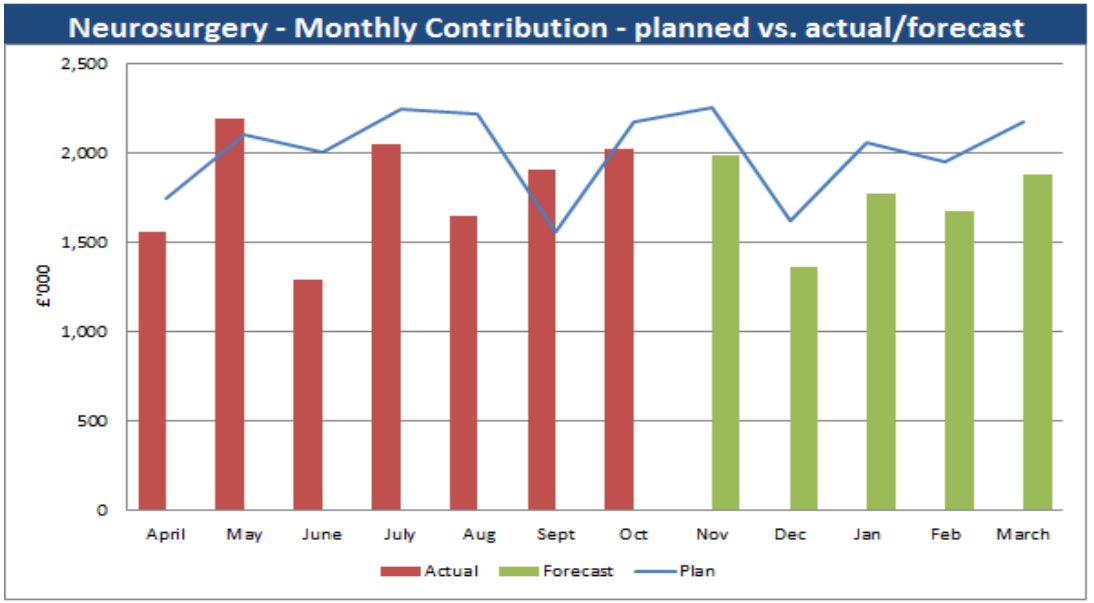
In month Plan: £2,176k surplus contribution

In month Actual: £2,019k surplus contribution

In month variance: £157k below plan.

Year to date variance: £1,399k below plan.

NOTE -The contribution excludes the QIP position which is reported centrally.



Key points:
- Income in month was below plan driven by below plan activity within critical care

- Pay expenditure is underspent against plan in month primarily due to vacancies.

To note that contribution measures the direct income less the direct costs of the service before overheads

Surgery in month patient related activity & income

	Activity			Income		
	Plan Spells	Actual Spells	Variance Spells	Plan £'000	Actual £'000	Variance £'000
Elective	270	270	0	1,779	1,898	119
Non-elective	156	151	(5)	1,507	1,528	21
Day case	705	692	(13)	524	509	(15)
OP First	1,300	1,411	111	375	400	25
OP Follow up	2,524	2,540	16	604	578	(26)
Critical Care	642	565	(77)	944	833	(111)
Other	0	0	0	296	89	(207)
TOTAL				6,029	5,835	(194)

Surgery YTD patient related activity & income

	Activity			Income		
	Plan Spells	Actual Spells	Variance Spells	Plan £'000	Actual £'000	Variance £'000
Elective	1,829	1,807	(22)	12,071	11,978	(93)
Non-elective	1,089	987	(102)	10,495	10,045	(450)
Day case	4,792	4,377	(415)	3,561	3,245	(316)
OP First	8,924	8,499	(425)	2,573	2,453	(120)
OP Follow up	16,857	16,574	(283)	4,034	3,844	(190)
Critical Care	4,249	3,938	(311)	6,248	5,744	(504)
Other	0	0	0	2,068	1,807	(261)
TOTAL				41,050	39,116	(1,934)

Surgery forecast patient related activity & income

	Activity			Income		
	Plan Spells	Actual Spells	Variance Spells	Plan £'000	Actual £'000	Variance £'000
Elective	3,179	3,141	(38)	20,979	20,816	(163)
Non-elective	1,821	1,651	(170)	17,557	16,806	(751)
Day case	8,323	7,610	(713)	6,185	5,641	(544)
OP First	15,559	14,806	(753)	4,486	4,274	(212)
OP Follow up	29,061	28,566	(495)	6,981	6,667	(314)
Critical Care	7,225	6,657	(568)	10,624	9,713	(911)
Other	0	0	0	3,519	3,054	(465)
TOTAL				70,331	66,971	(3,360)

Neurology financial position

Divisional contribution:

In month Plan: £48k surplus contribution

In month Actual: £217k surplus contribution

In month variance: £169k above plan.

Year to date variance: £594k above plan.

NOTE -The contribution excludes the QIP position which is reported centrally.

Key Points:

- Income in month was above plan. This was driven by higher than plan income in day cases, outpatient follow ups and rehab bed days.

- Pay expenditure is underspent against plan in month primarily due to vacancies across the division.

To note that contribution measures the direct income less the direct costs of the service before overheads

Neurology in month patient related activity & income

	Activity			Income		
	Plan Spells	Actual Spells	Variance Spells	Plan £'000	Actual £'000	Variance £'000
Elective	28	23	(5)	54	63	9
Non-elective	24	25	1	154	167	13
Day case	347	428	81	204	283	79
OP First	2,724	2,736	12	636	640	4
OP Follow up	4,133	4,507	374	778	855	77
OP Procedure	746	601	(145)	167	129	(38)
Rehab	861	832	(29)	479	589	110
Other	0	0	0	2,022	2,128	106
TOTAL				4,494	4,854	360

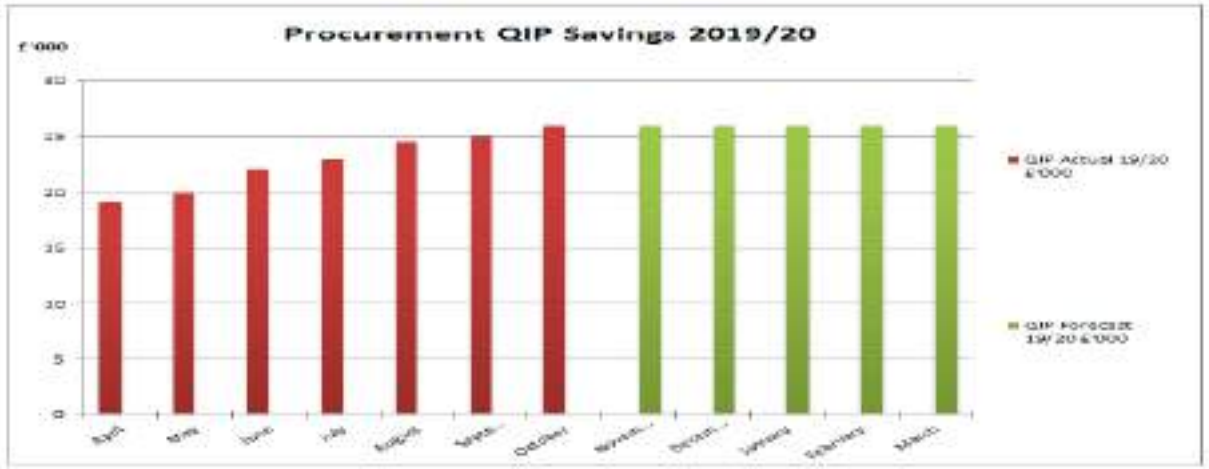
Neurology YTD patient related activity & income

	Activity			Income		
	Plan Spells	Actual Spells	Variance Spells	Plan £'000	Actual £'000	Variance £'000
Elective	170	160	(10)	367	446	79
Non-elective	169	170	1	1,070	1,148	78
Day case	2,500	2,618	118	1,465	1,598	133
OP First	18,018	16,526	(1,492)	4,209	3,854	(355)
OP Follow up	28,201	29,606	1,405	5,309	5,581	272
OP Procedure	4,787	4,209	(578)	1,078	913	(165)
Rehab	5,623	5,157	(466)	3,126	2,908	(218)
Other	0	0	0	14,153	14,576	423
TOTAL				30,777	31,024	247

Neurology forecast patient related activity & income

	Activity			Income		
	Plan Spells	Actual Spells	Variance Spells	Plan £'000	Actual £'000	Variance £'000
Elective	288	270	(18)	600	726	126
Non-elective	290	292	2	1,841	1,974	133
Day case	4,257	4,459	202	2,494	2,721	227
OP First	31,144	28,565	(2,579)	7,272	6,659	(613)
OP Follow up	49,092	51,518	2,426	9,244	9,714	470
OP Procedure	8,328	7,296	(1,032)	1,878	1,584	(294)
Rehab	9,898	9,018	(880)	5,503	5,080	(423)
Other	0	0	0	24,265	25,032	767
TOTAL				53,097	53,490	393

Procurement Performance (19/20) – Month 7

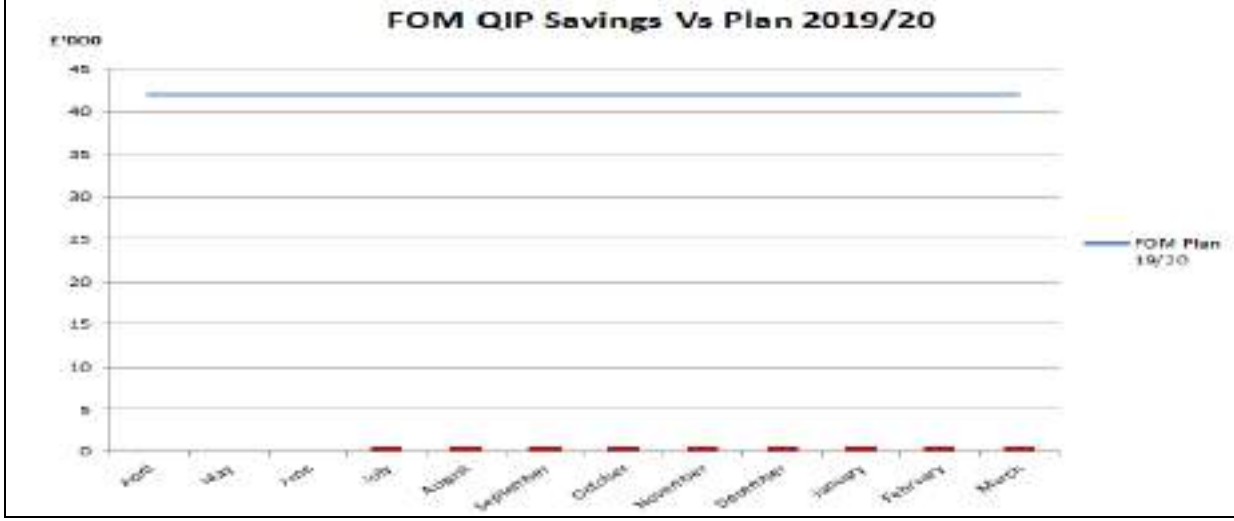


The graph to the left shows the total amount of Trust wide QIP savings the Procurement team has supported.

In month QIP delivered - £1k
FYE of delivered Schemes - £6k

In Month Savings Detail (FYE):

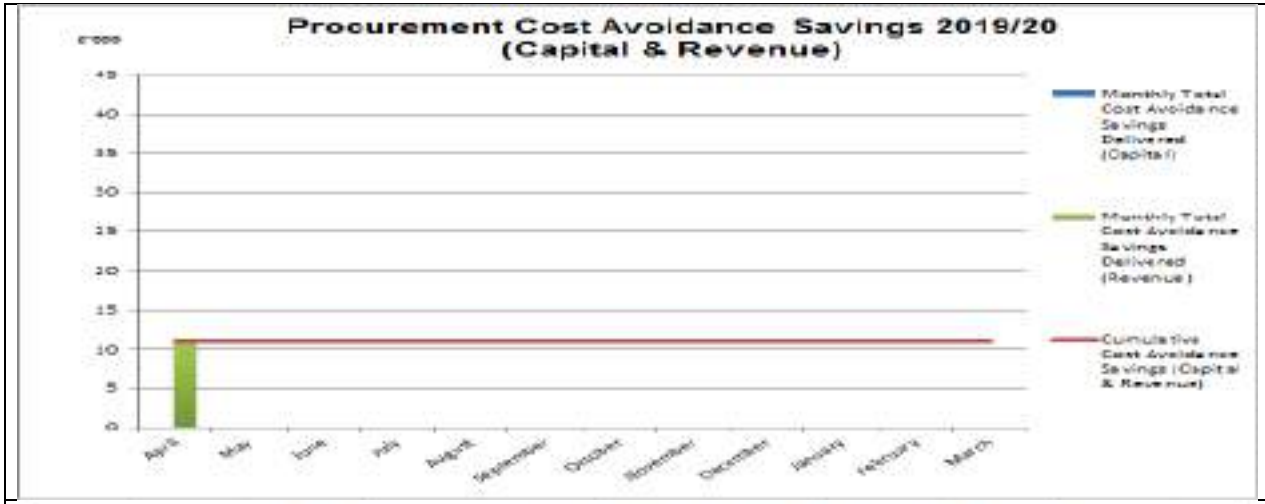
Cardinal Health IPC Sleeves (NHS SC Framework)- £13k



The graph to the left shows the total amount of QIP savings delivered against the Future Operating Model (FOM) projection.

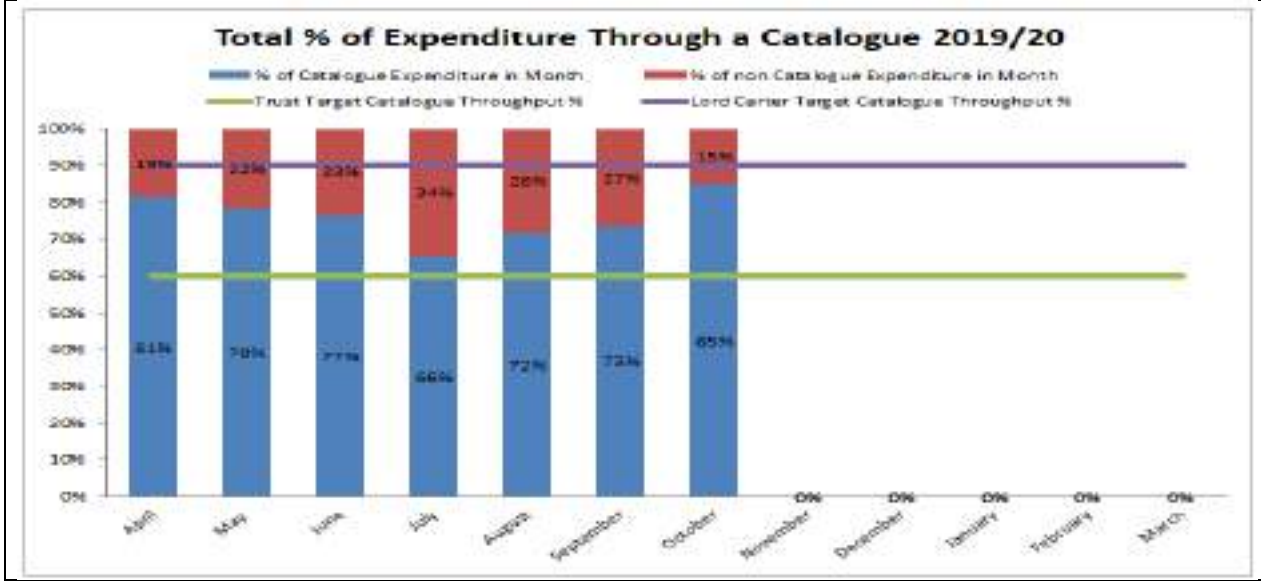
In month QIP delivered - £0
FYE of delivered Schemes - £4.5k

The DoF and Head of Procurement will meet with the regional FOM representatives in the near future to understand the current performance issues.



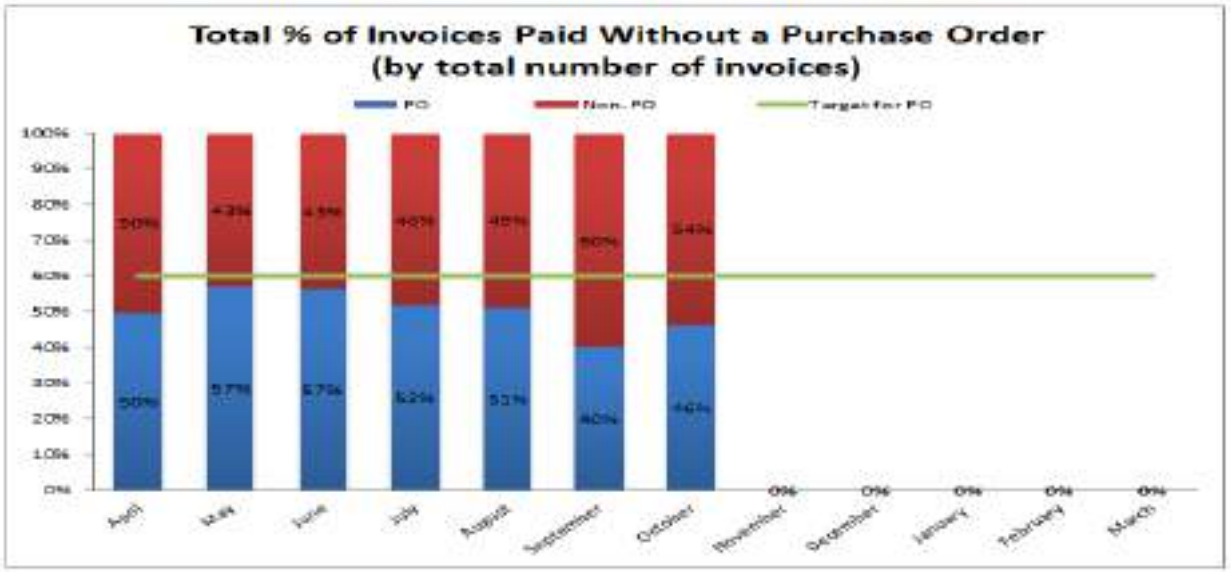
The graph to the left shows the savings delivered by the procurement team on cost avoidance (Capital and Revenue). Cost avoidance is recorded where the procurement team enable the trusts funds to be stretched further i.e. capital purchase costs vs budgeted, re-negotiating a price back from an inflationary increase, one off purchases where procurement obtain a better price.

In month cost avoidance delivered - £0k
FYE of delivered Schemes - £11k



The Trust target for purchase orders placed via a catalogue as detailed in the procurement strategy for 2018/19 (Y3) was 60%. However, since then the Lord Carter metric has been introduced at a target of 90%.

In month total orders placed via a catalogue - 85%
Average catalogue throughput YTD - 77%



The target identified within the 18/19 Procurement strategy for invoices paid with a valid purchase order is 60%; this is for all areas of non-pay expenditure. The Lord Carter target is 90%, based on number of line transactions and value, but only addresses the Clinical & General Supplies categories. When benchmarked against the Carter target the trust is at 92% for expenditure and 98% for transactions.

In month the total number of invoices paid was **2,522** of which **54%** were paid without a valid purchase order number.
Data includes all invoices paid in month including NHSLA, Rates, Utilities and SLA's etc. which may never be able to be paid via a PO.

Appendix 3: Operational performance metrics

The Walton Centre NHS Foundation Trust

RESPONSIVE	Cancer Waiting Times

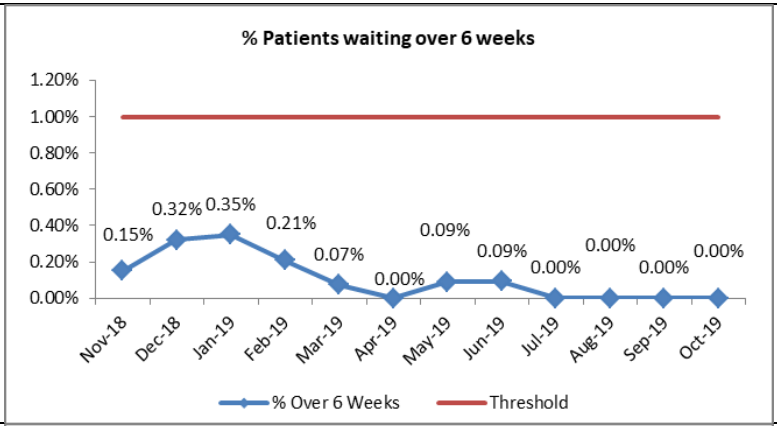
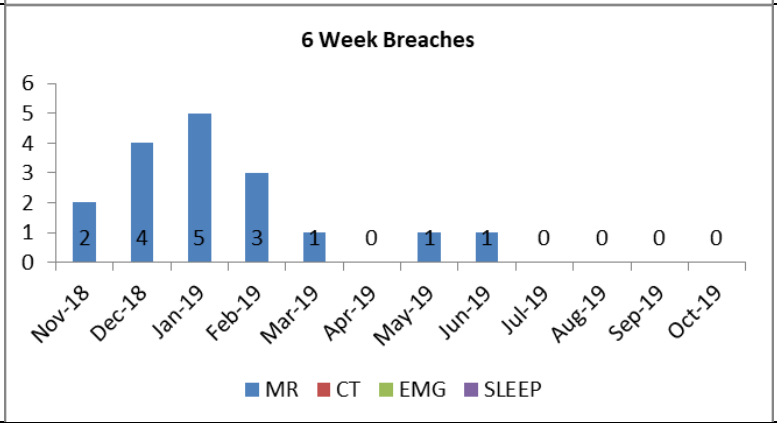
% of Cancer patients treated within target. There can be a delay in recording of cancers, as cancer may not be confirmed until receipt of the histology report.

Trust Performance	Comments
All standards achieved, except 31 day diagnosis to treatment – 93%.	**The Trust achieved all applicable cancer targets in October 2019, with the exception of Two Week Rule Urgent GP Referral and 31 day diagnosis to treatment target. Two week rule performance was 92.86%, below the 93% target. 31 day diagnosis to treatment performance is 93.75%. This is due to one patient where we are yet to receive the final histology result. It is expected that this cancer will be low grade and therefore removed from the performance figures once confirmed.** **Only malignant cancers (Grades III and IV) are included in SCR reporting. Grading is confirmed on receipt of histology reports, which may not be available at the time of reporting. Please note that performance will be retrospectively adjusted if necessary on receipt of formal histology.**

Measure	Target	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
31 day diagnosis to treatment	96%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	94%
31 day second or subsequent treatment	94%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
62 day GP urgent referral to treatment	85%	n/a	100%	n/a	n/a	100%	n/a	100%	n/a	n/a	100%	n/a	100%
62 day Consultant upgrade	85%	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
2 week rule urgent GP referral	93%	100%	100%	100%	100%	100%	100%	100%	100%	94%	100%	100%	93%

EFFECTIVE | Diagnostic Wait Performance (DM01)

English patients waiting over 6 weeks from date of referral to diagnostic test. Reported against MRI, CT, SLEEP and EMG.

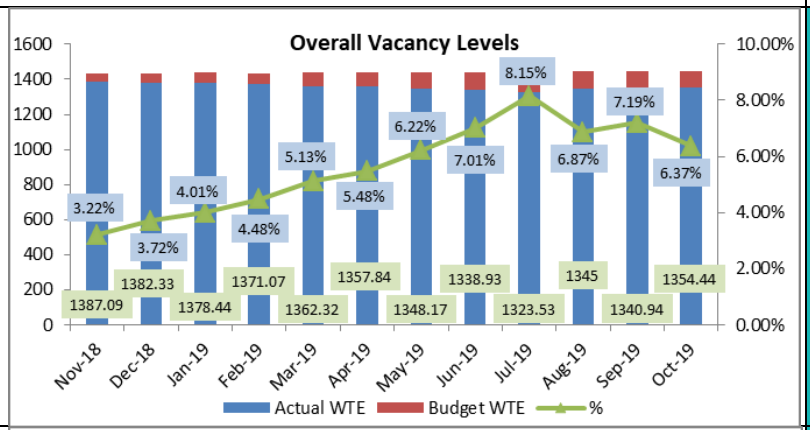
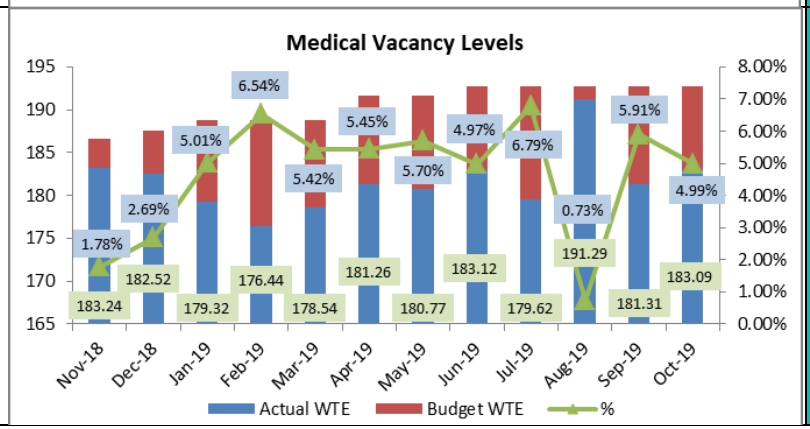
Trust Performance	Trend	Comments
October performance was 0.00%. **Target – 1%.**		**Performance in October 2019 was 0.00% with 0 patients breaching the 6 week target.**
0 breaches in October 2019		

Appendix 4: Organisational health indicators

WELL LED

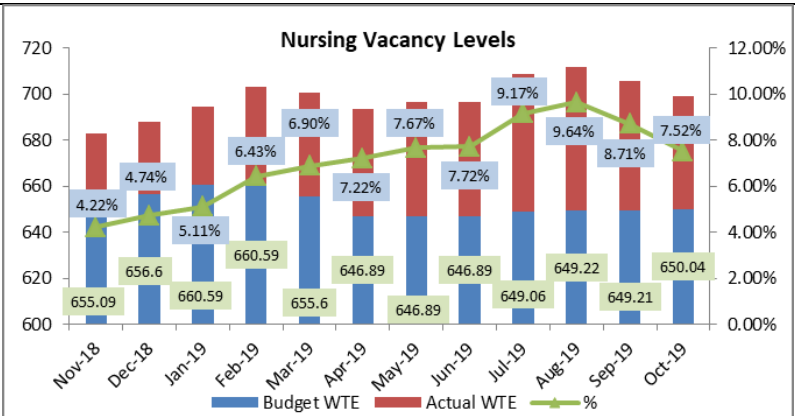
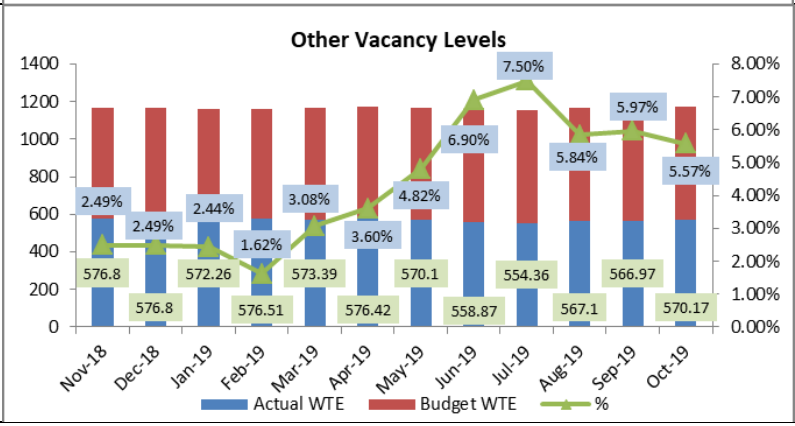
Vacancy Levels

% of vacancies by area. Data sourced from HR.

Trust Performance	Trend	Comments
Overall – 6.37%		**Overall vacancy levels are 6.37%, compared to 7.19% in September.** **Across the Trust there are 92.01 vacancies excluding bank and agency, -2.65 including bank and agency.**
Medical – 4.99%		**Medical vacancy levels are 4.99%, compared to 5.91% in September.** **For medical staff there are 9.61 vacancies excluding bank and agency, 8.61 including bank and agency.** • **Interview for Neurology Consultant at the end of November.** • **Going out to advert in November for Consultant Radiologist.** **Locum Consultant Neuropsychiatrist starting in post in November.**

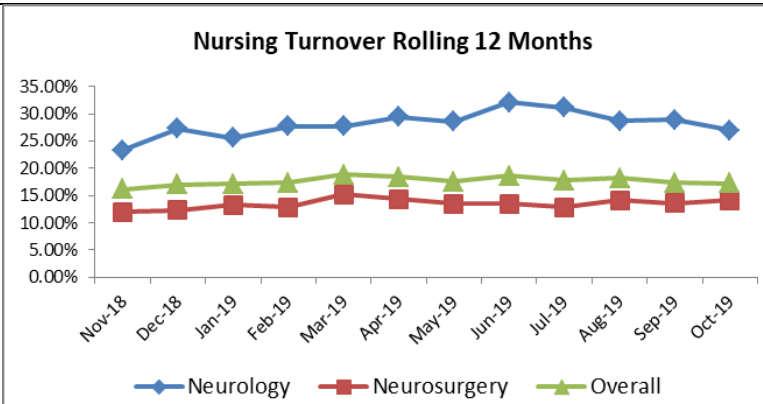
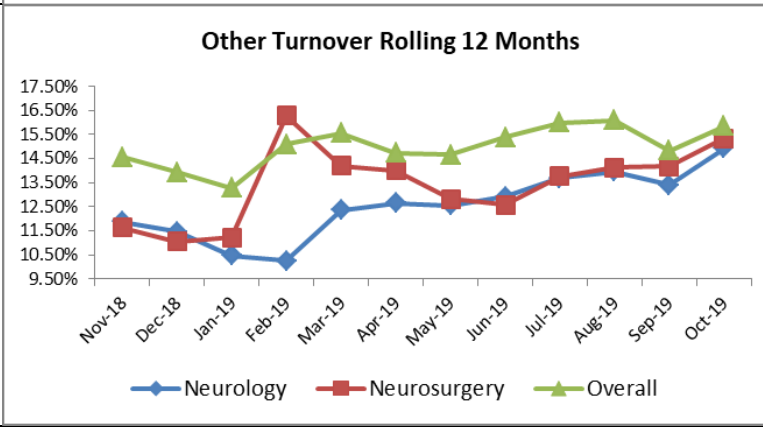
WELL LED	Vacancy Levels

% of vacancies by area. Data sourced from HR.

Trust Performance	Trend	Comments
Nursing – 7.52%		**Nursing vacancy levels are 7.52%, compared to 8.71% in September.** **For nursing staff there are 48.86 vacancies excluding bank and agency, -30.63 including bank and agency.** **Improvement Actions:** • **2 Staff nurses in recruitment and 9 started/due to start in October/November.** • **5 HCA's in recruitment and 7 started/due to start in October/November.**
Other – 5.57%		**Other vacancy levels are 5.57%, compared to 5.97% in September.** **For other staff there are 33.62 vacancies excluding bank and agency, 19.37 including bank and agency.**

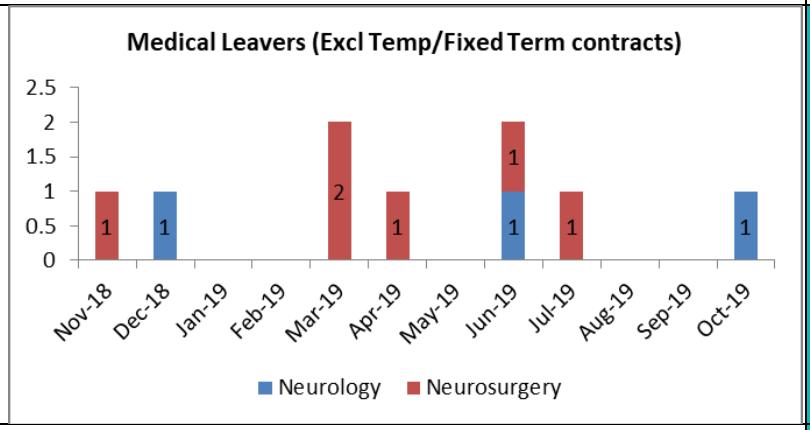
WELL LED	Staff Turnover Rolling 12 Months

% of staff leaving the Trust against number of staff. Information provided by HR.

Trust Performance	Trend	Comments
17.22% in October		**Nursing turnover for a rolling 12 month period is 17.22%, compared to 17.34% in September 2019. Neurology was 26.94% compared to 28.93% in September. Neurosurgery was 14.16% compared to 13.65% in September.** **3 Registered Nurse's left in October compared to 6 in September.**
15.85% in October.		**Other turnover for a rolling 12 month period is 15.85%, compared to 14.83% in September 2019.** **Neurology was 14.92% compared to 13.40% in September.** **Neurosurgery was 15.34% compared to 14.17% in September.** **There were 15 leavers in October, the same as in September.** **Both groups continue to remain above the NW NHS profile of 10%.**

WELL LED	Medical Leavers

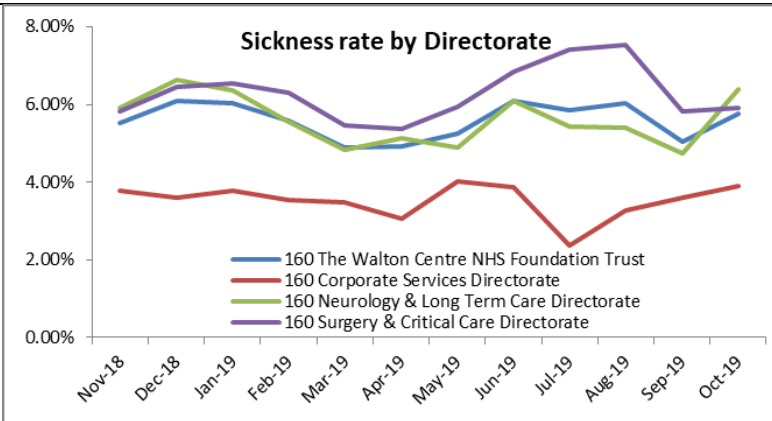
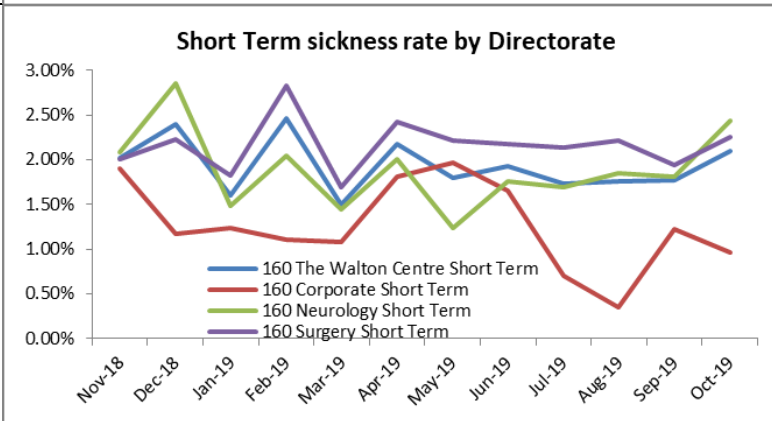
Number of medical leavers by Division. This excludes Temporary and Fixed Term contract leavers.

Trust Performance	Trend	Comments
1 in October		**There was 1 medical leaver in October 2019 which is an increase compared to September 2019 (0).**

The Walton Centre NHS Foundation Trust

WELL LED	Sickness

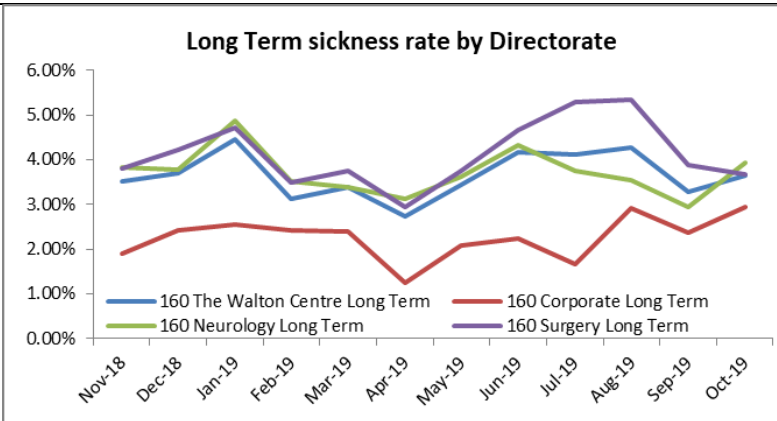
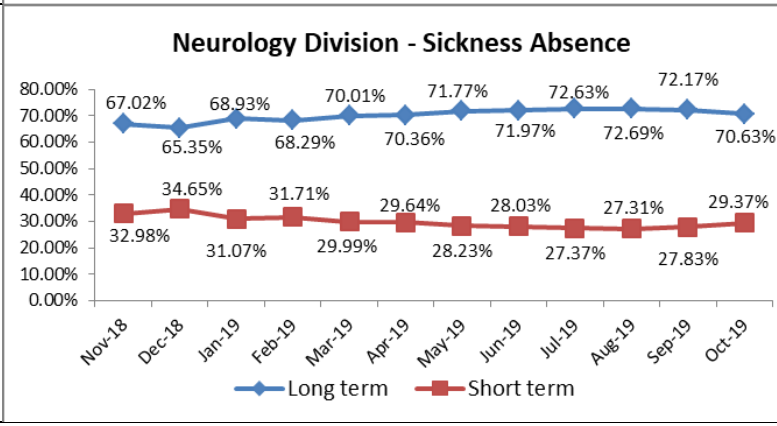
% of staff absent due to sickness. Long term sickness is defined as anything over 28 days.

Trust Performance	Trend	Comments
Trust – 5.75%. **Corporate – 3.90%.** **Neurology – 6.38%.** **Surgery – 5.90%**		**Sickness Improvement Actions:** **The HR team have completed a sickness absence audit of 16 departments that have been over the Trust target. This involved visiting the departments and looking at their records to obtain evidence of whether sickness is being managed appropriately or not. The HR team will be visiting the departments that were audited to give them feedback on any improvements that could be made.**
Trust – 2.10%. **Corporate – 0.96%.** **Neurology – 2.44%.** **Neurosurgery – 2.25%.**		

WELL LED

Sickness

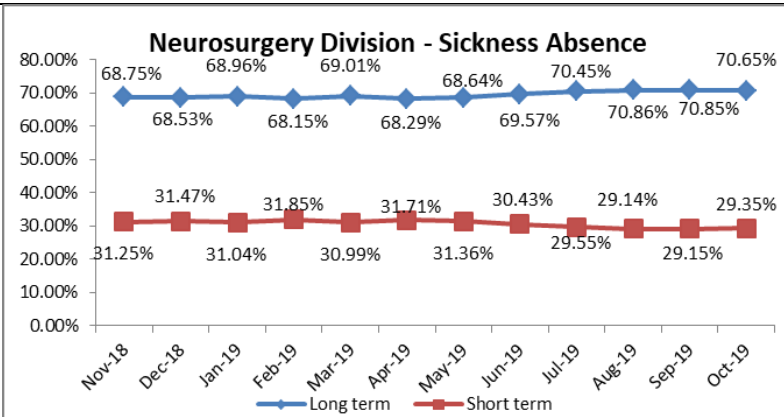
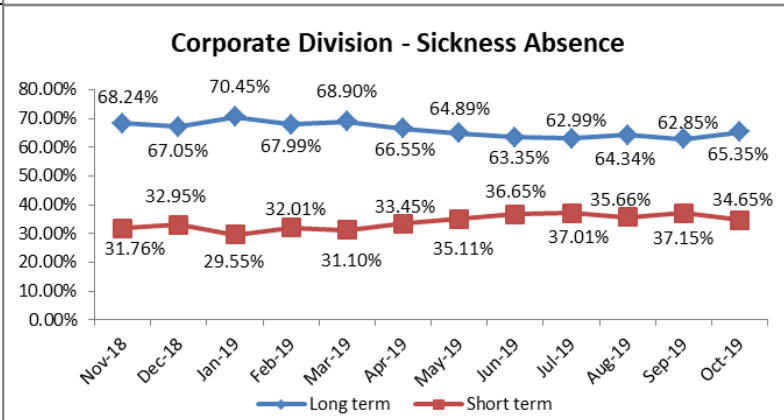
% of staff absent due to sickness. Long term sickness is defined as anything over 28 days.

Trust Performance	Trend	Comments
Trust – 3.64%. **Corporate – 2.94%.** **Neurology – 3.94%.** **Neurosurgery – 3.66%.**		
Long Term 70.63%. **Short term 29.37%.**		**Neurology long term sickness was 70.63% in October, compared to 72.17% in September.** **Neurology short term sickness was 29.37% in October, compared to 27.83% in September.** **1,075 calendar days were lost due to sickness in Neurology during October.**

The Walton Centre NHS Foundation Trust

WELL LED	Sickness

% of staff absent due to sickness. Long term sickness is defined as anything over 28 days.

Trust Performance	Trend	Comments
Long Term 70.65%. **Short Term 29.35%.**		**Neurosurgery long term sickness was 70.65% in October, compared to 70.85% in September.** **Neurosurgery short term sickness was 29.35% compared to 29.15% in September.** **1,191 calendar days were lost due to sickness in Neurosurgery during October.**
Long Term is 65.35%. **Short Term is 34.65%.**		**Corporate Division long term sickness was 65.35% in October, compared to 62.85% in September.** **Corporate Division short term sickness was 34.65% in October, compared to 37.15% in September.** **280 calendar days were lost due to sickness in Corporate during October.**

Appendix 5: Balanced Scorecard

TRUST WIDE.	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Annual Threshold (Trust) 19/20	2019/ 20 Year End
Safe														
MRSA Bacteraemia (Hospital acquired)	0	0	0	0	0	0	0						0	0
CPE (Hospital acquired)	0	0	0	0	0	0	1						0	1
CPE (Community acquired)	0	1	1	1	0	1	1						0	5
CDAD (Clostridium difficile) (Hospital acquired)	0	2	0	0	1	0	0						8	3
CDAD (Clostridium difficile) (Pre 48 Hours)	0	0	0	0	0	0	0							0
MSSA	1	2	0	0	0	0	0						9	3
E coli	0	2	0	2	1	1	0						12	6
Patient Falls with minor harm (cuts bruises)	3	4	6	5	1	3	2						23	24
Patient Falls Causing moderate, major or catastrophic	0	0	0	0	0	0	0						1	0
Pressure Ulcers (level 2 only)	1	0	0	0	0	1	0						15	2
Pressure Ulcers (level 3 only)	0	0	0	0	0	0	0						1	0
Pressure Ulcers (level 4 only)	0	0	0	0	1	0	0						0	1
Pressure Ulcers - Device Related (captured within figures above)	0	0	0	0	0	0	0						5	0
Pressure Ulcers (unstageable at present)							1							
Cardiac/Respiratory Arrest	0	1	1	0	2	4	1							9
VTE incidence (Hospital Acquired)	0	0	1	1	0	2	0						7	4
Catheter associated UTI	2	2	1	2	1	2	0						22	10
Klebsiella Bacteraemia	0	0	0	0	1	0	0							1
Pseudomonas Bacteraemia	0	0	0	0	0	0	0							0
Daily staffing -actual RN staff v planned (Days)	99%	100%	92%	98%	92%	92%	100.5%							96%
Daily staffing -actual RN staff v planned (Nights)	103%	108%	100%	106%	96%	95%	104.6%							102%
Daily staffing - actual HCA v planned (Days)	133%	142%	127%	130%	128%	134%	135.1%							133%
Daily staffing - actual HCA v planned (Nights)	136%	142%	130%	140%	134%	143%	139.9%							138%
Care Hours per Patient per Day (CHPPD)	14.0	14.5	13.5	14.2	13.8	12.6	13.9							13.8
Effective														
Slips, Trips and Falls (<6 hours) risk assessment*	98%	97%	95%	96%	96%	95%	96%						>=95%	96%
VTE (<6 hours) risk assessment*	97%	96%	95%	96%	96%	95%	96%						>=95%	96%
Nutrition (MUST) <6 hours risk assessment*	94%	94%	92%	94%	95%	91%	93%						>=95%	93%
Manual Handling <6 hours risk assessment*	97%	96%	95%	95%	95%	95%	96%						>=95%	96%
MRSA Screen	95%	96%	93%	92%	98%	96%	95%						>=95%	95%
Waterlow <6 hours risk assessment*	97%	96%	94%	96%	95%	93%	96%						>=95%	95%
Infection Control Risk Assessment (<6 hours)*	97%	97%	94%	96%	95%	95%	96%						>=95%	96%
Acquired Kidney Injury Risk Assessment (<6 hours)*	94%	92%	90%	91%	89%	89%	91%						>=90%	91%
Carbapenemase Producing Enterbacteriaceae (CPE) Risk Assess'	92%	84%	94%	89%	84%	84%	87%						>=85%	88%
The Deprivation of Liberty Safeguards (**DoLS**)	14	12	15	19	11	15	16							102
Mortality - HSMR (February 17)	n/a	n/a	n/a	n/a	n/a	n/a	n/a							
Mortality (deceased discharges)	6	8	4	2	5	6	16						96	47
Delayed Discharges - days lost	459	469	515	560	523	402	384							3,312
Delayed Transfers of Care - days lost	527	392	425	416	455	435	607							3,257
Diagnostic Waits	0.00%	0.09%	0.09%	0.00%	0.00%	0.00%	0.00%						1.00%	0.03%

TRUST WIDE.	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Annual Threshold (Trust) 19/20	2019/20 Year End
Caring														
New Complaints - Staff	9	11	12	11	10	16	14							83
Return complaint - Staff	0	0	0	0	0	1	2							3
Compliments - Staff	55	13	37	68	48	70	23							314
NHS Choices Patient Rating	4	4	4	4	4	4	4.5							4
Hand Hygiene Audit - Nursing	100%	99%	99%	99%	92%	100%	100%						>=99%	98%
Friend & Family response rate (Inpatients)	53%	55%	52%	44%	77%	49%	40%						>=30%	53%
Friend & Family response rate (Outpatients)	9.5%	9.7%	8.0%	5.5%	6.5%	8.6%	5.4%							
Friend and Family recommended score (inpatients)	98%	98%	98%	98%	98%	98%	99%						>90%	98%
Single sex breeches	0	0	0	0	0	0	0						0	0
Matron Round compliance 'putting patients first'		88.4%	92.2%	92.6%	93.9%	94.1%	95.3%						>=90%	93%
Matron Round compliance with quality care		83.4%	90.0%	89.3%	86.0%	89.8%	91.5%						>=90%	88%
Responsive														
2 week urgent GP referral	100%	100%	100%	94%	100%	100%	93%						93%	98%
31 day diagnsosis to treatment	100%	100%	100%	100%	100%	100%	94%						96%	99%
31 day second or subsequent treatment	100%	100%	100%	100%	100%	100%	100%						94%	100%
62 day urgent GP referral to treatment	N/A	100%	N/A	N/A	100%	N/A	N/A						100%	100%
Theatre utilisation of Elective Sessions	85%	83%	79%	79%	82%	84%	80%						90%	82%
Theatre utilisation of in Session Time	96%	91%	89%	92%	86%	91%	88%						90%	91%
Cancelled operations non clinical (last minute)	0.81%	1.33%	0.48%	0.29%	0.42%	1.26%	0.56%						<0.8%	0.74%
Cancelled operations not re-admitted within 28 days	9%	6%	17%	0%	0%	0%	38%						<=5%	10%
Median LoS Elective (excludes Rehab)	2	2	2	2	2	2	2						4	2
Median LoS Non-elective (excludes Rehab)	7	8	8	10	8	8	8						9	8
Outpatient DNA rate -New Attends	8.04%	8.88%	9.06%	8.53%	8.46%	9.18%	8.98%						<=8%	8.73%
Outpatient DNA rate - Follow-up Attends	9.35%	9.21%	9.63%	8.96%	9.33%	10.64%	9.67%						<=10%	9.54%

TRUST WIDE.	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Annual Threshold (Trust) 19/20	2019/20 Year End
Well led														
Staff - Friends and Family (Response Rate)														
Staff - Friends and Family (Care/Treatment)														
Staff - Friends and Family (Place to Work)														
Safeguarding Children Level 1 training (Trust)	92%	91%	90%	91%	90%	90%	92%						>=90%	91%
Safeguarding Children Level 2 training (Trust)	92%	92%	92%	93%	92%	93%	93%						>=90%	92%
Safeguarding Adults Level 1 Training (Trust)	98%	97%	98%	96%	94%	94%	95%						>=90%	96%
Safeguarding Adults Level 2 Training (Trust)	96%	95%	96%	96%	95%	95%	95%						>=90%	95%
Overall vacancy levels	5.48%	6.22%	7.01%	8.15%	6.87%	7.19%	6.37%						<10%	6.76%
Medical vacancy levels	5.45%	5.70%	4.97%	6.79%	0.73%	5.91%	4.99%						<6%	5%
Nursing vacancy levels	7.22%	7.67%	7.72%	9.17%	9.64%	8.71%	7.52%						<6%	8%
Other Staff vacancy levels	3.60%	4.82%	6.90%	7.50%	5.84%	5.97%	5.57%						<6%	6%
Medical Staff - No. of leavers	1	0	2	1	0	0	1						6	5
Nursing Staff Turnover (rolling 12 months)	18.37%	17.60%	18.66%	17.66%	18.15%	17.34%	17.22%						<10%	18%
Other Staff Turnover (rolling 12 months)	14.73%	14.66%	15.38%	15.99%	16.09%	14.83%	15.85%						<10%	15%
Agency Spend (£m)	0.063	0.057	0.061	0.085	0.074	0.038	0.048						£1.064m	0.426
Statutory Training Compliance	95%	95%	95%	96%	95%	96%	95%						98.80%	95%
Mandatory training compliance (rolling 12 months)	91%	91%	91%	91%	90%	90%	90%						85%	91%
Sickness Absence rolling 12 months	5%	5%	5%	5%	5%	6%	5%						4.20%	5%
Appraisals rolling 12 months	86%	86%	84%	84%	83%	86%	85%						85%	85%

Appendix 6: Additional Indicators

Metric	Target	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Safe																			
Surgical Site Infections (Quarterly)			18			29			22			16			19			24	
Surgical Site Infections Rate	6%		1.97%			3.12%			2.36%			1.76%			2.09%			2.69%	
Effective																			
Daily Patient Delayed Days	5.85	11.90	11.70	12.90	11.55	13.37	11.37	12.63	10.06	9.52	10.75	10.77	15.30	15.13	17.17	18.06	16.87	13.40	11.39
Non Reportable Transfer Delays - Patients		54	53	62	55	52	59	55	58	60	46	59	45	35	39	38	45	45	52
Non Reportable Transfer Days Delayed %	3.50%	16.6%	16.1%	17.2%	19.3%	15.7%	19.0%	23.8%	17.1%	23.7%	16.4%	19.6%	16.3%	11.5%	13.1%	11.5%	13.6%	13.5%	18.6%
Reportable Delayed Transfer of Care - Patients		24	29	40	27	26	25	29	28	24	23	27	29	30	36	31	34	35	24
Reportable Delayed Transfer Days Delayed %	5%	10.5%	10.2%	11.2%	11.7%	12.6%	9.4%	10.7%	9.8%	8.0%	8.6%	8.9%	14.8%	13.7%	15.9%	15.5%	15.7%	12.5%	10.8%
Responsive																			
GP Referrals - Neurology		1745	1688	1912	1912	1994	2195	1873	1397	1633	1,636	1,730	1,647	2,037	1,788	2,000	1,804	1,697	1,924
GP Referrals - Neurosurgery		414	392	602	404	295	306	330	236	327	304	292	315	321	328	364	333	282	319
GP Referrals - Other		189	166	152	104	105	144	178	180	135	147	165	157	221	191	195	149	221	255
GP Referrals - Total		2348	2246	2666	2420	2394	2645	2381	1813	2095	2087	2187	2119	2579	2307	2559	2286	2200	2498
GP Referrals Choose and Book - Neurology		1064	972	1330	1428	1530	1786	1452	1157	1297	1,297	1,372	1,371	1,621	1,441	1,624	1,459	1,374	1,513
GP Referrals Choose and Book - Neurosurgery		170	175	408	362	264	281	256	180	246	241	215	225	239	230	269	224	172	209
GP Referrals Choose and Book - Other		5	4	12	34	83	121	141	137	89	104	133	135	173	107	88	75	188	229
GP Referrals Choose and Book - Total		1239	1151	1750	1824	1877	2188	1849	1474	1632	1642	1720	1731	2033	1778	1981	1758	1734	1951
Tertiary Referrals - Neurology		847	752	855	750	734	971	953	752	776	799	771	806	823	716	881	778	799	895
Tertiary Referrals - Neurosurgery		777	722	642	634	624	709	679	525	611	592	565	512	607	572	605	542	567	614
Tertiary Referrals - Other		705	702	630	648	545	821	700	556	647	657	700	592	680	592	664	633	501	632
Tertiary Referrals - Total		2329	2176	2127	2032	1903	2501	2332	1833	2034	2048	2036	1910	2110	1880	2150	1953	1867	2141
Total Referrals - Neurology		2592	2440	2767	2662	2728	3166	2826	2149	2409	2435	2501	2453	2860	2504	2881	2582	2496	2819
Total Referrals - Neurosurgery		1191	1114	1244	1038	919	1015	1009	761	938	896	857	827	928	900	969	875	849	933
Total Referrals - Other		894	868	782	752	650	965	878	736	782	804	865	749	901	783	859	782	722	887
Total Referrals		4677	4422	4793	4452	4297	5146	4713	3646	4129	4135	4223	4029	4689	4187	4709	4239	4067	4639
IP Waiting List - Neurology		173	164	172	191	176	205	176	195	210	232	241	206	201	205	188	196	212	213
IP Waiting List - Neurosurgery		644	624	618	604	615	598	606	637	615	579	580	578	562	557	586	552	549	544
IP Waiting List Other		278	275	204	195	201	209	215	196	220	188	214	203	207	211	216	202	232	209
IP Waiting List Total		1095	1063	994	990	992	1012	997	1028	1045	999	1035	987	970	973	990	950	993	966
IP Waiting List Monthly % Growth		1.96%	-2.92%	-6.49%	-0.40%	0.20%	2.02%	-1.48%	3.11%	1.65%	-4.40%	3.60%	-4.64%	-1.72%	0.31%	1.75%	-4.04%	4.53%	-2.72%
OP Waiting List - Neurology		5604	6000	5894	6040	6028	6434	6761	6760	6760	6712	6723	7010	7366	7569	7889	8224	8079	8025
OP Waiting List - Neurosurgery		1800	1955	2040	1906	2100	1920	1894	1832	1753	1694	1599	1656	1799	1837	1939	1890	1842	1800
OP Waiting List - Other		2188	2387	2196	2105	2226	2293	2425	2601	2846	2801	2924	3081	3417	3346	3448	3583	3701	3817
OP Waiting List Total		9592	10342	10130	10051	10354	10647	11080	11193	11359	11207	11246	11747	12582	12752	13276	13697	13622	13642
OP Waiting List Monthly % Growth		1.80%	7.82%	-2.05%	-0.78%	3.01%	2.83%	4.07%	1.02%	1.48%	-1.34%	0.35%	4.45%	7.11%	1.35%	4.11%	3.17%	-0.55%	0.15%
Non clinical cancelled operations		13	11	11	20	19	16	22	5	13	7	6	11	18	6	4	5	14	8
First Finished Consultant Episodes		1427	1331	1302	1314	1178	1449	1499	1085	1343	1295	1370	1366	1351	1244	1366	1182	1111	1423
DoH Non clinical cancelled operations %	0.08%	0.91%	0.83%	0.84%	1.52%	1.61%	1.10%	1.47%	0.46%	0.97%	0.54%	0.44%	0.81%	1.33%	0.48%	0.29%	0.42%	1.26%	0.56%

Metric	Target	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Responsive																			
FOWL - Neurology							14656	15325	15716	15501	15460	16597	16723	16352	15773	15400	14793	14819	14083
FOWL - Overdue >12 Months - Neurology							1960	2226	2325	2418	2547	2847	2995	3024	2431	2093	2117	2177	2271
FOWL - % Overdue >12 Months - Neurology							13.37%	14.53%	14.79%	15.60%	16.47%	17.15%	17.91%	18.49%	15.41%	13.59%	14.31%	14.69%	16.13%
FOWL - Neurosurgery							984	1156	1356	1284	1198	1239	1132	1117	1038	1097	1203	1217	1196
FOWL - Overdue >12 Months - Neurosurgery							5	6	6	11	13	70	84	98	119	134	168	198	237
FOWL - % Overdue >12 Months - Neurosurgery							0.51%	0.52%	0.44%	0.86%	1.09%	5.65%	7.42%	8.77%	11.46%	12.22%	13.97%	16.27%	19.82%
FOWL - Other							956	1040	1148	1110	1043	1033	1043	904	767	741	637	764	707
FOWL - Overdue >12 Months - Other							138	155	180	217	229	258	261	284	257	275	268	283	306
FOWL - % Overdue >12 Months - Other							14.44%	14.90%	15.68%	19.55%	21.96%	24.98%	25.02%	31.42%	33.51%	37.11%	42.07%	37.04%	43.28%
FOWL - Total							16596	17521	18220	17895	17701	18869	18898	18373	17578	17238	16633	16800	15986
FOWL - Overdue >12 Months - Total							2103	2387	2511	2646	2789	3175	3340	3406	2807	2502	2553	2658	2814
FOWL - % Overdue >12 Months - Total							12.67%	13.62%	13.78%	14.79%	15.76%	16.83%	17.67%	18.54%	15.97%	14.51%	15.35%	15.82%	17.60%
Well Led																			
Non Elective Activity - Neurology		25	26	21	28	14	18	11	14	17	18	18	23	16	27	24	21	20	21
Non Elective Activity - Neurosurgery		164	155	145	145	140	165	161	136	145	151	152	134	157	118	143	156	123	155
Non Elective Activity - Other		5	0	9	7	2	3	4	9	3	2	2	0	5	3	7	3	2	5
Non Elective Activity - Total		194	181	175	180	156	186	176	159	165	171	172	157	178	148	174	180	145	181
Elective Activity - Neurology		22	30	27	17	19	27	23	28	18	34	23	26	28	27	24	17	19	19
Elective Activity - Neurosurgery		234	257	247	260	225	254	285	224	221	240	257	259	259	234	235	227	239	246
Elective Activity - Other		16	17	8	7	8	9	13	6	12	9	5	25	14	10	13	33	14	23
Elective Activity - Total		272	304	282	284	252	290	321	258	251	283	285	310	301	271	272	277	272	288
Day cases - Neurology		370	345	348	372	336	368	379	297	394	320	353	367	382	335	391	347	368	427
Day cases - Neurosurgery		104	85	86	83	78	88	78	69	75	67	79	84	78	72	97	80	68	102
Day cases - Other		673	547	548	505	467	683	662	436	584	573	611	592	589	546	601	470	392	597
Day cases - Total		1147	977	982	960	881	1139	1119	802	1053	960	1043	1043	1049	953	1089	897	828	1126
Total Inpatient Activity - Neurology		417	401	396	417	369	413	413	339	429	372	394	416	426	389	439	385	407	467
Total Inpatient Activity - Neurosurgery		502	497	478	488	443	507	524	429	441	458	488	477	494	424	475	463	430	503
Total Inpatient Activity - Other		694	564	565	519	477	695	679	451	599	584	618	617	608	559	621	506	408	625
Total Inpatient Activity		1613	1462	1439	1424	1289	1615	1616	1219	1469	1414	1500	1510	1528	1372	1535	1354	1245	1595
Elective Average Length of Stay		4.77	4.06	5.4	4.3	4.34	5.56	3.56	4.52	4.95	4.92	6.55	4.74	4.98	3.81	4.26	3.83	6.56	6.55
Non Elective Average Length of Stay		13.36	13.23	10.71	12.62	13.69	12.51	13.79	13.99	15.65	15.55	14.29	13.29	15.26	13.81	16.33	13.14	12.51	14.37
OP New Attends - Neurology		2232	2221	2538	2289	2509	2563	2597	1985	2407	2375	2516	2186	2263	2047	2248	2002	2288	2503
OP New Attends - Neurosurgery		1057	849	917	834	756	987	904	715	915	858	911	711	759	827	834	813	919	895
OP New Attends - Other		469	473	455	484	504	579	464	389	520	535	534	431	432	460	455	353	414	591
OP New Attends - Total		3758	3543	3910	3607	3769	4129	3965	3089	3842	3768	3961	3328	3454	3334	3537	3168	3621	3989
OP Follow Up Attends - Neurology		3771	3824	3783	3634	3828	3935	4164	3188	4193	3960	4214	3842	3988	4094	4080	3821	4195	4306
OP Follow Up Attends - Neurosurgery		1940	1995	2002	1653	1829	2041	1963	1681	2069	1896	1894	1829	1831	1637	1945	1629	1838	1897
OP Follow Up Attends - Other		713	674	762	664	647	804	729	588	764	718	745	706	694	667	884	661	659	839
OP Follow Up Attends - Total		6424	6493	6547	5951	6304	6780	6856	5457	7026	6574	6853	6377	6513	6398	699	6111	6692	7042

Metric	Target	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Well Led																			
OP Attends - Neurology		6003	6045	6321	5923	6337	6498	6761	5173	6600	6335	6730	6028	6251	6141	6328	5823	6483	6809
OP Attends - Neurosurgery		2997	2844	2919	2487	2585	3028	2867	2396	2984	2754	2805	2540	2590	2464	2779	2442	2757	2792
OP Attends - Other		1182	1147	1217	1148	1151	1383	1193	977	1284	1253	1279	1137	1126	1127	1339	1014	1073	1430
OP Attends - Total		10182	10036	10457	9558	10073	10909	10821	8546	10868	10342	10814	9705	9967	9732	10446	9279	10313	11031
Outpatient Procedures - Pain Relief		111	88	134	114	89	104	98	62	58	47	32	48	31	15	26	24	40	7
Outpatient Procedures - Neurology		621	603	570	637	617	655	694	542	567	527	654	597	673	485	560	501	599	593
Outpatient Procedures - Total		777	740	750	797	755	805	851	645	672	622	734	645	704	500	586	525	639	600
OP DNA Rate New	8%	7.87	9.18	7.49	8.89	9.71	9.63	10.21	11.74	8.3	8.05	8.06	8.04	8.88	9.06	8.53	8.46	9.18	8.98
OP DNA Rate Follow Up	10%	9.2	9.28	9.05	8.27	9.54	9.27	8.93	10.29	9.49	10	10.1	9.35	9.21	9.63	8.96	9.33	10.64	9.67
Occupancy at midnight - Main Wards		81.36%	81.63%	79.85%	78.87%	83.01%	86.99%	86.72%	82.69%	88.43%	88.86%	85.99%	75.57%	79.32%	78.54%	82.80%	78.21%	81.22%	74.53%
Occupancy at midnight - ITU		75.52%	80.20%	82.61%	81.45%	82.70%	85.32%	71.00%	73.23%	83.71%	80.18%	71.90%	73.17%	81.94%	75.42%	85.83%	78.32%	82.32%	78.06%
Occupancy at midnight - CRU		89.06%	91.67%	91.60%	92.86%	95.67%	95.62%	85.18%	76.64%	89.93%	91.70%	81.79%	83.01%	83.10%	77.90%	72.01%	57.63%	74.16%	82.46%
Occupancy at midnight - Lipton Acute Rehab		78.29%	83.67%	96.45%	91.61%	87.00%	89.68%	72.67%	73.87%	79.03%	83.57%	81.29%	87.24%	58.12%	48.33%	77.74%	79.68%	71.14%	75.16%
Rehab Complexity Score - Hyper Acute Unit	70.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	99.00%	100.00%	100.00%	100.00%	97.00%	99.00%	94.00%	100.00%	100.00%	100.00%	96.00%	100.00%
Rehab Complexity Score - Complex Unit	70.00%	99.00%	91.00%	91.00%	96.00%	96.00%	97.00%	96.00%	91.00%	95.00%	100.00%	97.00%	97.00%	98.00%	99.00%	99.61%	96.12%	96.00%	96.00%
Theatre Utilisation of in-session time	90%	85.16%	87.67%	80.34%	81.24%	86.18%	84.03%	86.40%	78.24%	80.75%	78.16%	80.10%	84.80%	82.90%	78.90%	78.90%	81.70%	84.40%	80.40%
Theatre Utilisation of sessions	90%	92.56%	98.25%	96.17%	91.37%	92.98%	85.56%	90.60%	94.90%	93.39%	92.69%	94.94%	96.09%	90.53%	89.38%	92.16%	86.10%	91.40%	88.06%
Appraisals Rolling 12 Months	85%	77.01%	76.51%	83.73%	84.97%	82.47%	82.84%	85.56%	85.74%	86.40%	88.46%	86.65%	85.96%	86.18%	83.58%	83.66%	83.28%	85.73%	85.17%
Appraisals - Corporate		69.39%	66.84%	79.38%	84.41%	78.38%	81.77%	86.59%	84.21%	86.93%	86.78%	90.06%	90.12%	89.88%	86.23%	86.06%	83.64%	89.16%	85.98%
Appraisals - Neurology		83.76%	83.03%	87.50%	87.34%	87.37%	82.31%	84.72%	82.98%	89.25%	89.90%	88.64%	89.95%	90.70%	88.37%	88.97%	88.05%	91.25%	92.08%
Appraisals - Surgery		74.70%	75.15%	82.47%	83.30%	80.25%	83.64%	85.83%	84.30%	83.76%	87.87%	83.73%	81.22%	80.93%	78.49%	78.24%	79.12%	79.87%	79.12%
Statutory % Trained	100%	91.70%	92.00%	92.04%	93.36%	93.36%	93.66%	95.18%	95.28%	95.70%	95.56%	95.17%	95.36%	94.94%	94.88%	95.55%	94.91%	95.64%	95.23%
Statutory Training - Neurology		92.23%	92.86%	92.55%	94.40%	93.72%	94.66%	96.08%	97.02%	97.32%	96.73%	96.89%	97.11%	96.73%	97.29%	97.21%	97.40%	97.97%	96.94%
Statutory Training - Neurosurgery		91.34%	91.85%	91.73%	92.61%	92.94%	92.56%	94.43%	94.20%	94.55%	94.00%	92.55%	92.58%	92.05%	92.13%	93.02%	92.84%	94.05%	94.08%
Statutory Training - Corporate		95.19%	95.02%	94.91%	95.99%	94.53%	96.47%	97.39%	97.28%	97.15%	97.42%	97.27%	97.34%	96.54%	95.16%	97.02%	95.17%	96.47%	96.23%
Statutory Training - Medical - Neurology		88.43%	88.43%	88.27%	91.12%	94.45%	94.40%	94.78%	95.24%	94.60%	96.19%	96.94%	97.89%	97.16%	96.99%	97.23%	96.11%	95.21%	84.80%
Statutory Training - Medical - Neurosurgery		83.79%	82.17%	85.55%	86.54%	88.40%	86.92%	89.92%	88.76%	91.22%	93.01%	93.50%	93.85%	95.22%	94.88%	95.40%	92.15%	92.11%	91.20%
Mandatory % Trained	85.00%	86.28%	86.21%	88.69%	88.51%	87.69%	88.44%	88.85%	89.00%	90.75%	91.42%	91.87%	91.41%	91.17%	91.08%	91.33%	90.38%	90.40%	90.49%
Mandatory Training - Neurology		90.70%	91.25%	93.47%	93.51%	93.29%	93.79%	94.32%	94.76%	95.31%	95.95%	95.54%	95.42%	95.76%	95.84%	95.85%	95.77%	96.21%	95.72%
Mandatory Training - Neurosurgery		85.90%	85.40%	87.53%	88.00%	87.03%	87.67%	87.91%	88.64%	89.81%	91.17%	92.08%	91.25%	90.62%	90.23%	90.27%	89.77%	88.86%	88.83%
Mandatory Training - Corporate		91.18%	90.77%	96.34%	91.84%	90.05%	93.12%	93.72%	94.01%	94.66%	95.01%	94.98%	94.75%	94.80%	93.15%	93.03%	91.68%	92.31%	93.28%
Mandatory Training - Medical - Neurology		79.28%	79.63%	79.02%	82.20%	80.59%	81.15%	80.90%	81.99%	86.54%	85.69%	85.09%	84.06%	84.21%	85.07%	86.79%	83.44%	84.95%	85.58%
Mandatory Training - Medical - Neurosurgery		67.50%	67.74%	70.04%	70.48%	70.79%	70.56%	69.83%	67.01%	72.57%	74.08%	76.56%	76.13%	76.18%	78.44%	79.93%	76.01%	77.08%	77.21%
Clinical Trials Recruitment - In month		156	311	219	193	235	187	96	44	93	130	173	68	57	41	102	89	95	144
Clinical Trials Recruitment - Cumulative Recruitment		284	595	814	1007	1242	1429	1525	1569	1662	1792	1965	68	125	166	268	357	452	596
Clinical Trials Recruitment - Cumulative Target		150	225	300	375	450	525	600	675	750	825	900	75	150	225	300	375	450	525

Safer Staffing

Oct-19
The Walton Centre

Date	Total Daily Staff Hours								Total Nightly Staff Hours				Day				Night	
	RN		Care Staff		NA		TNA		RN		Care Staff		RN	Care	NA	TNA	RN	Care
	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Average Fill	Average Fill	Average Fill	Average Fill	Average Fill	Average Fill
										NHS England :		Red Amber	75% 90%	50% 75%			75% 90%	50% 75%
Cairns	2,032.5	1,837.5	1,395.0	1,627.5	7.5	7.5	-	-	1,069.5	1,081.0	1,069.5	1,184.5	90.4%	116.7%	100.0%		101.1%	110.8%
Caton	1,230.0	1,365.0	877.5	960.0	94.5	94.5	45.0	45.0	874.0	966.0	1,069.5	1,173.0	111.0%	109.4%	100.0%	100.0%	110.5%	109.7%
Chavasse	1,470.1	2,002.5	1,371.8	2,550.0	127.5	127.5	30.0	30.0	841.3	1,334.0	1,051.7	1,782.5	136.2%	185.9%	100.0%	100.0%	158.6%	169.5%
Dott	1,852.5	1,672.5	1,395.0	2,317.5	7.5	7.5	-	-	1,069.5	1,035.0	1,069.5	1,817.0	90.3%	166.1%	100.0%		96.8%	169.9%
Lipton	1,395.0	1,327.5	1,380.0	1,552.5	-	-	-	-	713.0	736.0	1,069.5	1,230.5	95.2%	112.5%			103.2%	115.1%
Sherrington	1,432.5	1,380.0	1,672.5	1,672.5	172.5	172.5	112.5	112.5	966.0	966.0	1,391.5	1,426.0	96.3%	100.0%	100.0%	100.0%	100.0%	102.5%
CRU	1,395.0	1,942.5	2,790.0	4,237.5	22.5	22.5	22.5	22.5	1,069.5	1,391.5	1,426.0	3,208.5	139.2%	151.9%	100.0%	100.0%	130.1%	225.0%
Horsley ITU	8,835.0	8,212.5	1,162.5	1,357.5	-	-	-	-	6,773.5	6,486.0	1,069.5	1,069.5	93.0%	116.8%			95.8%	100.0%
Oct-19	**19,642.6**	**19,740.0**	**12,044.3**	**16,275.0**					**13,376.3**	**13,995.5**	**9,216.7**	**12,891.5**	100.5%	135.1%			104.6%	139.9%

Date	Bed Management			Registered Nurse to bed Ratio
	Empty	Total	%	
Cairns	101	780	12.9%	1:6
Caton	101	780	12.9%	1:7
Chavasse	168	870	19.3%	1:5
Dott	230	810	28.4%	1:5
Lipton	33	300	11.0%	1:3
Sherrington	268	750	35.7%	1:5
CRU	113	600	18.8%	1:4
Horsley ITU	92	600	15.3%	1:1
				Bed Occupancy
Oct-19	**1,106**	**5,490**	**20.1%**	**75.0%**

Date	Friends and Family Test Recommended Score	Falls (moderate and above)	CDIFF	CPE	MRSA Bacteraemia	Pressure Ulcers	Complaints	Red Flags
Cairns	99%	0	0	0	0	0	0	0
Caton	100%	0	0	1	0	0	0	0
Chavasse	100%	0	0	0	0	0	0	0
Dott	100%	0	0	0	0	0	0	0
Lipton	n/a	0	0	0	0	0	0	0
Sherrington	96%	0	0	0	0	0	0	0
CRU	100%	0	0	0	0	0	0	0
Horsley ITU	n/a	0	0	0	0	0	0	0

Date	Midnight Occupancy	CHPPD RN Day	CHPPD Care Staff Day	CHPPD NA Day	CHPPD TNA Day	CHPPD RN Night	CHPPD Care Staff Night	RN	Care Staff	Overall
Cairns	667	2.75	2.44	0.01	-	1.62	1.78	4.4	4.2	8.6
Caton	640	2.13	1.50	0.15	0.07	1.51	1.83	3.6	3.3	7.0
Chavasse	675	2.97	3.78	0.19	0.04	1.98	2.64	4.9	6.4	11.4
Dott	588	2.84	3.94	0.01	-	1.76	3.09	4.6	7.0	11.6
Lipton	233	5.70	6.66	-	-	3.16	5.28	8.9	11.9	20.8
Sherrington	468	2.95	3.57	0.37	0.24	2.06	3.05	5.0	6.6	11.6
CRU	757	2.57	5.60	0.03	0.03	1.84	4.24	4.4	9.8	14.2
Horsley ITU	484	16.97	2.80	-	-	13.40	2.21	30.4	5.0	35.4
Oct-19	**4512**	**4.38**	**3.61**	**-**	**-**	**3.10**	**2.86**	**7.5**	**6.5**	**13.9**

Overall Total Staffing	
Total Planned Hours	54,279.9
Total Actual Hours	62,902.0
%	115.88%

The Walton Centre NHS Foundation Trust

Doc Ref TBXX/XX

REPORT TO THE TRUST BOARD
Date: 28th November 2019

Title	**Freedom to Speak Up Guardian Report**
Sponsoring Director	Name: Lisa Salter Title: Director of Nursing and Governance
Author (s)	Name: Julie Kane Title: Quality Manager & Freedom to Speak Up Guardian
Previously considered by:	• Committee None • Group None • Other None
Executive Summary The report provides an update on the progress of the role and plans for strengthening current speak up arrangements. The report also highlights concerns raised with the Freedom to Speak Up Guardian.	
Related Trust Ambitions	Delete as appropriate: • Best practice care • Be recognised as excellent in all we do
Risks associated with this paper	The Freedom to Speak Up Report is a requirement of the National Guardian's Office and CQC regulations. There are a number of risks to having a culture where staff do not feel able to raise concerns. There are potential impacts on patient safety, clinical effectiveness and patient and staff experience, as well as reputational risk.
Related Assurance Framework entries	
Equality Impact Assessment completed	No
Any associated legal implications / regulatory requirements?	The Freedom to Speak Up Report is a requirement of the National Guardian's Office and CQC regulations.
Action required by the Board	Delete as Appropriate • To consider and note

Freedom to Speak Up Guardian Report – Quarter 2 2019/20

1. Introduction

The purpose of this paper is to provide the Board of Directors with assurance on the effective working of the Trust's Freedom to Speak Up arrangements.

Speaking up is about anything that gets in the way of providing good care. When things go wrong, we need to make sure that lessons are learnt and things are improved. If we think something might go wrong, it's important that all staff feel able to speak up so that potential harm is prevented. Even when things are good, but could be even better, we should feel able to say something and should expect that suggestions are listened to and used as an opportunity for improvement.

The Freedom to Speak Up Guardian (FTSUG), Julie Kane, has worked for the Trust for over twenty years in various roles and within different departments. Her substantive role as Quality Manager supports the Director of Nursing and Governance in the preparation and delivery of the Quality Accounts, CQUINs, CQC inspection, revalidation, KPIs, reporting and quality returns to Clinical Commissioning Groups, NHS England and NHS Improvement.

The Executive Lead for raising concerns is the Director of Nursing and Governance, Lisa Salter. The Non-Executive Lead for raising concerns is Seth Crofts who took on the role in June 2019. Prior to Seth the role was undertaken by Ann McCracken who had to step down as her term had come to an end.

The Trust's approach to developing and supporting a 'speak up' culture is essential to ensuring the organisation is well led. Staff who are encouraged and supported in raising 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.

2. Leading by Example

Following the Francis Report in February 2015, acute trusts were required to nominate a Freedom to Speak Up Guardian (FTSUG) by 1st October 2016 and the Trust has had a FTSUG in post since this time.

Following the 'Speak Up' month in 2018 the Trust now has three FTSU Champions to support the Guardian. The Champions have undertaken the National Guardian training and are embracing the Champion role.

The Trusts FTSU Champions are:

- Dr Martin Bamber - Consultant Anaesthetist
- Tina Hughes - Medical Secretary
- Andrew Sharrock - Senior Business Intelligence Developer

The Champions role has been promoted via the Walton Weekly, Team Brief and posters are displayed across the Trust which provides contact details for each of them.

The Trust are delighted to have been rated outstanding again following the Care Quality Commission (CQC) unannounced and announced inspections during March and April 2019. As part of the well led inspection the FTSUG was interviewed by two members of the CQC Inspection Team who asked questions relating to internal systems and processes and received positive feedback from the inspectors.

3. Awareness Raising:

- Walton Weekly/Articles in Team Brief
- Neuro Matters
- Separate email address freedomtospeakup@thewaltoncentre.nhs.uk
- Attendance at National Conferences
- Attendance and hosting Regional Meetings
- National Guardian Visit
- Presents monthly at Corporate and Medical Induction Days
- Attends team/departmental meetings
- Undertakes Surveys
- Presents at Berwick Session
- Undertakes ‘meet and greet’ sessions across the Trust
- Business cards attached to each payslip
- Drop-In Sessions scheduled throughout the year
- Holds ‘speak up’ events to promote the Guardian and Champions roles

The FTSUG attends team and departmental meetings across the Trust to ensure staff members are aware of the role, how to make contact and encourages staff to speak up.

During ‘Speak Up’ month in October 2019 there are plans afoot to undertake a relay with other local Trusts to share tips and best practice within the region. Speaking up will be promoted in various ways throughout the month and will continue throughout the year. Meet and greet sessions will be undertaken with clinical and non-clinical staff and contact details of the FTSUG, Champions, the Executive and Non- Executive Directors for Speaking Up will be provided. Information from those who have spoken up in the past will be shared including the learning/changes following concerns being raised. Staff will also be asked to complete an anonymous survey which could help identify any trends and inform future plans.

The National Guardian, Dr Henrietta Hughes, visited the Trust in September 2017. Following the visit the Trust received a letter from the National Guardian giving positive feedback stating "I think my abiding impression was that excellent practice was perceived as normal, and that makes The Walton Centre truly special. I hope what you have achieved can inspire other local organisations through partnership working."

NHS England asked the National Guardian's Office to support the implementation of the guardian role in primary care organisations and develop an integrated approach to speaking up across primary and secondary care boundaries. Since this request a Regional Liaison Lead (RLL) for the North West Region has been appointed and will be attending her first regional meeting in October 2019. The national conferences have been disbanded but the regional meetings will continue to ensure the RLL ensures the continued development of networks to support the expanding cohort of FTSUGs. The Trust's FTSUG attends the regional meetings throughout the year to keep appraised of national guidance, plans going forward and to meet with her peers.

The Trust were pleased to host the North West Regional Meeting in February 2019 and since then the FTSUG has met with guardians from other trusts to discuss speaking up and share best practice.

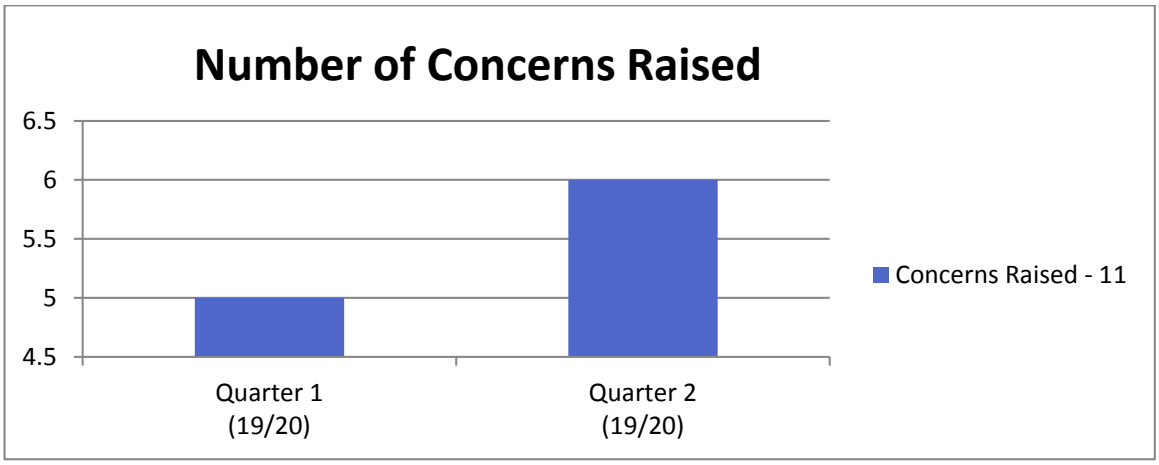
4. Monitoring

4.1 Culture

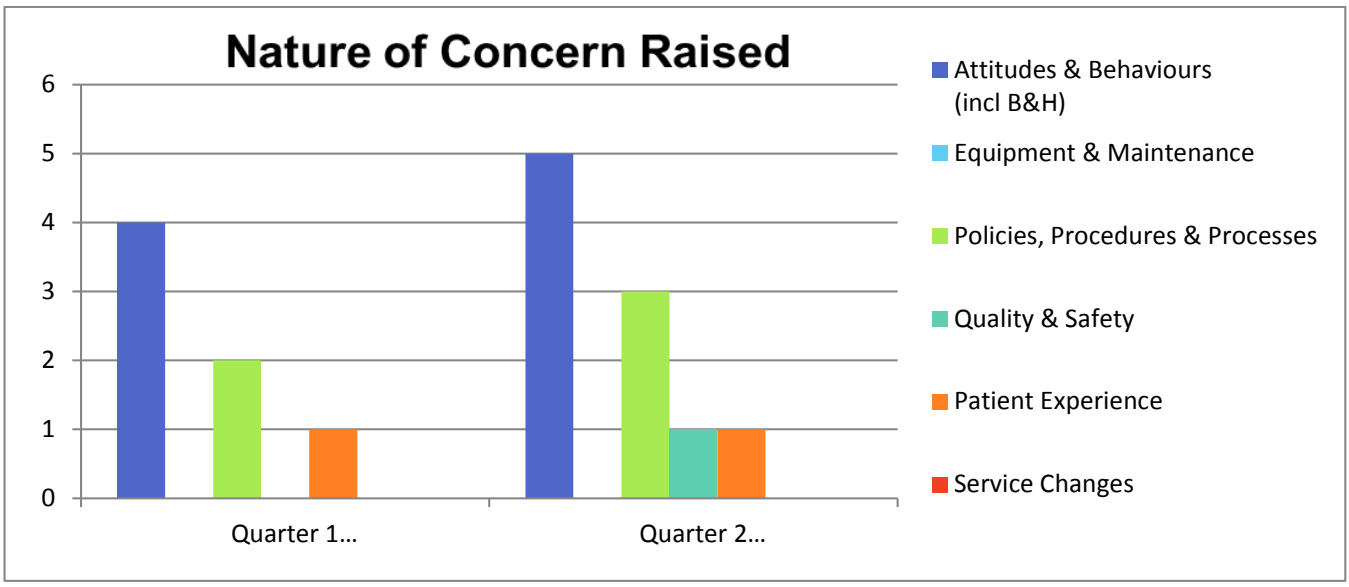
Following the publication of the Trust's 2018 NHS staff survey the FTSUG reviewed the results. Overall 758 staff members completed the questionnaire which gave a 53% response rate which is the same as the average response rate. There is currently a staff survey action plan in place and is being monitored via the Business and Performance Committee.

The NHS staff survey for 2019 is currently being undertaken. Once the results have been published the FTSUG will again review the findings and address any areas of improvement if there are any highlighted within the report.

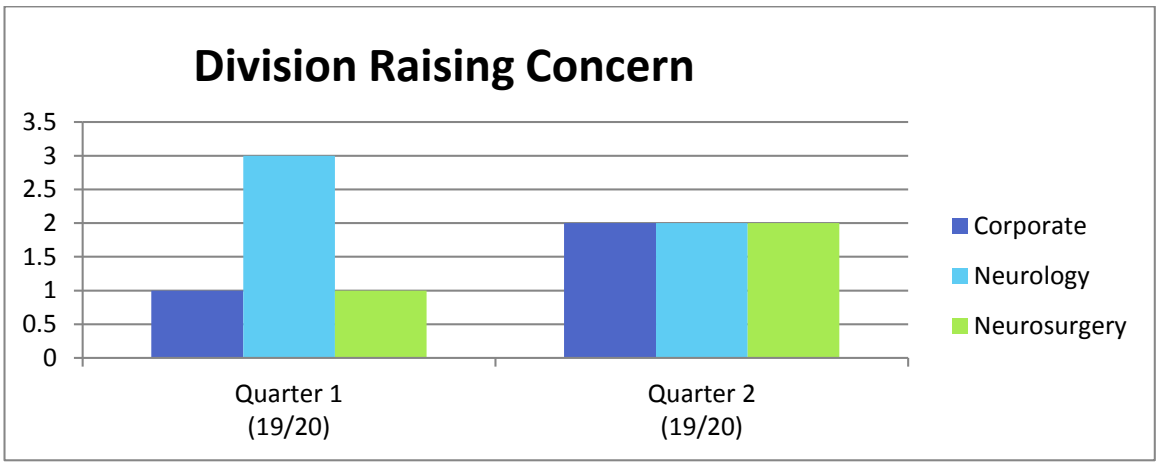
4.2 Local Activity – 2019/20



Note: Zero concerns were raised anonymously during Quarters 1 and 2 in 2019/20



Note: Some concerns raised have more than one element and are displayed across a number of categories



During the year staff have met with the FTSUG not only to raise concerns but to seek advice which they found beneficial as the Guardian is independent and impartial.

The role of the FTSUG/Champion is not to investigate a concern which has been raised or to mediate. Concerns are mostly resolved quickly by signposting individuals to appropriate personnel. However, further guidance regarding a specific issue is escalated immediately and links are made with the Executive/Non-Executive Leads for raising concerns and/or the Chief Executive.

The FTSUG meets monthly with the Non-Executive and Executive Lead for Raising Concerns to discuss concerns which have been raised and review progress made. Meetings also take place quarterly with the Chair and Chief Executive to keep them appraised of activity.

The FTSUG has access to all Board members and the 'open door' approach within the Trust is extremely positive and encouraging should a concern need immediate attention /action.

4.3 Submissions

National Guardians Office (NGO)

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 total number of cases raised, nationally, with Freedom to Speak Up Guardians within NHS Trusts are as follows:

	2017/18	2018/19
Quarter 1	1,447	2348
Quarter 2	1,515	2604
Quarter 3	1,939	3600
Quarter 4	2,186	3406
Total	**7,087**	**11958**

The figures above confirm more cases were raised during 2018/19 than in the previous year which is very encouraging.

The Trust's FTSUG collects information from staff members who have raised concerns by asking the following questions:

- Given your experience, would you speak up again
- Please explain your above response

To date all respondents have confirmed they would speak up again and have given positive feedback. Some of the feedback received is below:

- ❖ Thankful to you for giving a passionate ear to my vows and resolving them for me on a priority basis
- ❖ I would speak up again as I feel confident my concerns have been taken seriously
- ❖ I found the service very beneficial to have someone who listened, acted upon the information and gave feedback regularly. It was also good to be able to vent my feelings without judgement
- ❖ I am happy to say that there was a positive outcome and I would recommend that staff should feel able to speak up as it helped me
- ❖ I could feel the difference within days and things improved out of nowhere
- ❖ Thanks for taking the time to listen to me. I would speak up again as help was given to me and the monitoring has continued
- ❖ I would definitely speak up again as the experience I had I felt completely listened to, treated with respect, and you are so friendly and approachable

Inclusion of All Workers

In order to ensure monitoring takes place the FTSUG attends the Equality, Diversity and Inclusion (ED&I) Steering Group and works with the ED&I Lead for the Trust to review what information is currently being captured regarding BAME staff and make changes as necessary.

The Leavers Policy has been amended to include the Freedom to Speak Up Guardian undertaking exit interviews with staff members. This provides an opportunity for individuals who do not wish to have their exit interview with another member of staff. The FTSUG meets with staff members from the HR Team each month to discuss and review themes.

5. National Guardian's Office Update & Reporting

The NGO has undertaken seven case reviews looking into the handling of concerns and the treatment of people who have spoken up. These reviews have identified areas where the handling of NHS workers' concerns do not meet the standards of accepted good practice and have made recommendations to each of the organisations. Case reviews have been undertaken in the following trusts:

- Brighton and Sussex University Hospitals NHS Trust
- Derbyshire Community Health Services NHS Trust
- North West Ambulance Service NHS Trust
- Northern Lincolnshire and Goole NHS Foundation Trust
- Nottinghamshire Healthcare NHS Foundation Trust
- Royal Cornwall Hospitals NHS Trust
- Southport and Ormskirk Hospital NHS Trust

All reports and recommendations for the above trusts are accessible via the following link: https://www.nationalguardian.org.uk/case-reviews/

The FTSUG has reviewed six of the seven case reviews for the above trusts and noted each of the recommendations. The outstanding review (North West Ambulance Service NHS Trust) was recently published and a review of the recommendations will be undertaken during November. Overall most of the recommendations following each of the case reviews were specific to the individual trusts making it difficult to benchmark.

The FTSUG has looked at the Trust's position against each of the individual recommendations and will be presenting these to the Quality Assurance Group for review and discussion and agree any actions to be undertaken.

6. Next Steps and Actions

The Freedom to Speak Up Guardian, Champions, Executive and Non-Executive Leads will continue to promote the role, encourage speaking up and support staff engagement sessions.

Ensure future collaborative working takes place across the Trust.

Update the Trust's intranet site to ensure current information is readily available and accessible.

Continue to work with other organisations to review, discuss and support speaking up.

7. Recommendation

The Board are asked to receive and note the report and the Freedom to Speak Up arrangements in place within the Trust.

Excellence in Neuroscience

NHS
The Walton Centre
NHS Foundation Trust

Freedom to Speak Up

Our Vision and Strategy

Our Vision

- Staff to feel confident to speak up and raise any concerns
- Concerns to be welcomed, investigated and lessons learned will be shared
- Speaking up to make a difference to the quality of patient and family care and to staff experience

Leadership

- The Trust Board will drive the strategy and will be vital in promoting the ethos of a speak up culture
- Senior Leaders will support the Board in encouraging staff to feel confident in speaking up
- The Freedom to Speak Up Guardian will drive forward the ethos of ensuring staff who speak up are treated fairly, compassionately and quickly
- Collaborative working to ensure comparable data is reviewed across the Trust

How will we achieve this?

- Supporting individuals or areas that are presenting concerns, liaising with senior leaders to resolve any problems and maintaining appropriate levels of confidentiality
- Establishing an effective training programme
- Ensuring the Freedom to Speak Up Guardian has high levels of visibility
- Addressing any issues with relevant personnel/departments
- Providing regular updates on improvements made in response to concerns

How will we measure success?

- Feedback from staff regarding their knowledge or experience of the Freedom to Speak Up process
- Monitor the number of cases received by the Freedom to Speak Up Guardian

Su Rai
Chair of Walton Centre Charity Committee

Fazakerley
Liverpool
L9 7LJ

Tel: 0151 525 3611

28 November 2019

Grant Thornton UK LLP
Royal Liver Building
Liverpool
L3 1PS

Dear Robin

The Walton Centre Charity accounts for the year ended 31 March 2019

This representation letter is provided in connection with the independent examination of the accounts of The Walton Centre Charity for the year ended 31 March 2019 for the purpose of making of an independent examiner's report in accordance with Section 154 of the Charities Act 2011.

We confirm that to the best of our knowledge and belief having made such inquiries as we considered necessary for the purpose of appropriately informing ourselves:

Accounts

i We have fulfilled our responsibilities, as set out in the terms of our engagement letter dated 25 April 2017, for the preparation of accounts in accordance with section 132 of the Charities Act 2011 and comply with the Statement of Recommended Practice for accounting and reporting by Charities: Statement of Recommended Practice 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), in particular the accounts give a true and fair view in accordance therewith.

ii We acknowledge our responsibility for the design, implementation and maintenance of internal control to prevent and detect fraud.

iii Significant assumptions used by us in making accounting estimates, including those measured at fair value, are reasonable.

iv Except as stated in the accounts:

a. there are no unrecorded liabilities, actual or contingent;

b. none of the assets of the charity has been assigned, pledged or mortgaged;

c. there are no material prior year charges or credits, nor exceptional or non-recurring items requiring separate disclosure.

v Related party relationships and transactions have been appropriately accounted for and disclosed in accordance with the requirements of the Charities SORP (FRS 102) and any subsequent amendments or variations to this statement.

vi All events subsequent to the date of the accounts and for which the Charities SORP (FRS 102) and any subsequent amendments or variations to this statement require adjustment or disclosure have been adjusted or disclosed.

vii The accounts are free of material misstatements, including omissions.

viii We can confirm that:

a. all income has been recorded;

b. the restricted funds have been properly applied;

c. constructive obligations for grants have been recognised; and

d. we consider there to be appropriate controls in place to ensure overseas payments are applied for charitable purposes.

ix 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. There has been no non-compliance with requirements of regulatory authorities that could have a material effect on the accounts in the event of non-compliance.

x We have no plans or intentions that may materially alter the carrying value or classification of assets and liabilities reflected in the accounts.

xi Actual or possible litigation and claims have been accounted for and disclosed in accordance with the requirements of UK Generally Accepted Accounting Practice.

xii The charity meets the conditions for exemption from an audit of the accounts as set out in section 145 of the Charities Act 2011.

Information Provided

xiii We have provided you with:

a. access to all information of which we are aware that is relevant to the preparation of the accounts such as records, documentation and other matters;

b. additional information that you have requested from us for the purpose of your examination; and

c. unrestricted access to persons from whom you determine it necessary to obtain evidence.

xiv We have communicated to you all deficiencies in internal control of which we are aware.

xv We have disclosed to you the results of our assessment of the risk that the accounts may be materially misstated as a result of fraud.

xvi All transactions have been recorded in the accounting records and are reflected in the accounts.

xvii We have disclosed to you our knowledge of fraud or suspected fraud affecting the charity involving:

a. management;

b. employees who have significant roles in internal control; or

c. others where the fraud could have a material effect on the accounts.

xviii We have disclosed to you our knowledge of any allegations of fraud, or suspected fraud, affecting the charity's accounts communicated by employees, former employees, analysts, regulators or others.

xix We have disclosed to you all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing accounts.

xx We have disclosed to you the identity of the charity's related parties and all the related party relationships and transactions of which we are aware.

xxi We have disclosed to you all known actual or possible litigation and claims whose effects should be considered when preparing the accounts.

xxii We confirm that we have reviewed all correspondence with regulators, which has also been made available to you, including the guidance 'How to report a serious incident in your charity' issued by the Charity Commission (updated in October 2018). We also confirm that no serious incident reports have been submitted to the Charity Commission, nor any events considered for submission, during the year or in the period to the date of signing of the balance sheet.

Yours faithfully

Name……

Position……..…….

Date……..

Signed on behalf of The Walton Centre Charity

The Walton Centre Charity

Annual Report and Accounts for the Year Ending 31st March 2019

FOREWORD

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 2019 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 (effective 1 January 2016). The Charity's report and accounts include all the separate funds for which The Walton Centre NHS Foundation Trust is the sole corporate trustee (the "Trustee").

All 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.

Reference and Administration Details

Name:	The Walton Centre Charity
Charity Commission Number:	1050050
HM Revenue and Customs Number:	XR4801.

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 28 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 23 of this report. Details of the fund managers and aims and objectives for each fund are provided on pages 24 and 25.

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 2019 the following people served as directors of the Trustee:

Janet Rosser	:	Chair
Hayley Citrine	:	Chief Executive
Andrew Nicolson	:	Medical Director
Seth Crofts	:	Non-Executive Director
Peter Humphrey	:	Non-Executive Director (to 31/12/18)
Ann McCracken	:	Non-Executive Director
Sheila Samuels	:	Non-Executive Director
Alan Sharples	:	Non-Executive Director
Nalin Thakkar	:	Non-Executive Director (from 07/01/19)
Mike Burns	:	Director of Finance and Information Technology
Mike Gibney	:	Director of Workforce and Innovation
Stuart Moore	:	Director of Strategy and Planning (to 05/10/18)
Jan Ross	:	Acting Director of Operations and Strategy (from 26/11/18); Director of Operations and Strategy (from 01/01/19)
Lisa Salter	:	Acting Director of Nursing (to 23/05/18); Director of Nursing and Governance (from 24/05/18).

In the year ended 31 March 2019 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:

Alan Sharples	:	Non-Executive Director (Chair)
Peter Humphrey	:	Non-Executive Director (to 31/12/18)
Nalin Thakkar	:	Non-Executive Director (from 07/01/19)
Andrew Brodbelt	:	Consultant Neurosurgeon (to 18/01/19)
Mike Burns	:	Director of Finance and Information Technology
Peter Moore	:	Consultant Neurologist
Sacha Niven	:	Consultant Neuroradiologist/Deputy Medical Director
Lisa Salter	:	Acting Director of Nursing (to 23/05/18); Director of Nursing and Governance (from 24/05/18).

Other Administrative Details:

The principal contact of the Charity is:

Mike Burns
Director of Finance and Information Technology
The Walton Centre Charity
The Walton Centre NHS Foundation Trust
Lower Lane, Fazakerley
Liverpool L9 7LJ

Tel: (0151) 556 3482
E-mail: Mike.Burns@thewaltoncentre.nhs.uk

Bankers	Royal Bank of Scotland Liverpool Group of Branches 1 Dale Street Liverpool L2 2PP
External Auditors/ Independent Examiners	Grant Thornton UK LLP Royal Liver Building Liverpool L3 1PS
Investment Advisors	CCLA Senator House 85 Queen Victoria Street London EC4V 4ET Ruffer LLP 80 Victoria Street London SW1E 5JL.

Structure, Governance and Management

The Charity was established in 1992 using the model declaration of trust for NHS charities and all 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 24.

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.

Fundraising Regulation

The Charity has voluntarily subscribed to the Fundraising Regulator and, as such, is committed to the principles set out in the Fundraising Promise.

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 also 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 a level equivalent to 3 months unavoidable expenditure, currently estimated at £60,000.

At 31 March 2019 the Charity held £1,468,000 in reserves, all of which related to unrestricted funds.

Investments

Money which the Charity does not require in the immediate future is invested in two multi-asset pooled charity funds. The portfolio is managed to produce a balance between income return and capital appreciation. There is also an investment policy retained by the Trustee outlining the guidelines to be followed. The Charity does not invest in tobacco securities because of the proven link between smoking and poor health which would make such investments contrary to the charitable aims. The investment policy is reviewed every 12 months.

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.

During the year under review the stock market continued the fairly volatile trend of the past few years with a sharp decline in the equity markets at the end of December 2018. Despite a recovery in the early months of 2019, the market value of the funds at the 31 March 2019 was £971,000 which is £29,000 lower than the £1,000,000 transferred to the new managers in July 2018. The market value of the portfolio at the 31 March 2018 was £812,000. The Charity benefited from dividends and interest of £25,000 which represents a positive result, given the low risk nature of the investment portfolio.

Volunteers

The Trust currently has approximately 70 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.

In addition to the volunteers working in hospital, the Charity is grateful to all those people who freely give their time to arrange fundraising events to raise money for continuing the work of the Charity.

Review of the Year

During the year the Charity received total income of £697,000 (2017/18: £466,000) which is an overall increase of £231,000.

Total donations rose by £115,000 from £277,000 in 2017/18 to £392,000 in 2018/19. This growth was achieved despite not having the focus of a specific appeal to help drive fundraising, which is a positive reflection of the increased awareness the Charity is achieving. There were also some particular elements which directly contributed to this increase, including a number of legacies totalling more than £140,000.

The Charity continued to go from strength to strength during the year under review. Community support grew steadily, including the number of supporters using third party online fundraising platforms to facilitate their sponsored events and maximise gift aid opportunities. The Charity also secured two further ‘Charity of the Year’ partnerships with companies based in the region, strengthening our platform from which to build on our corporate partnership work with particular emphasis on employee fundraising. Also, fundraising income from managed events, including the Jan Fairclough Ball and the Golf Day, continued to provide a significant contribution to the Charity as well as providing opportunities to develop new and existing relationships in the corporate sectors.

In addition to raising awareness and unrestricted funds, the Charity also continued to raise funds for specific purposes such as the Home from Home Fund and the Sid Watkins Innovation Fund. Donations to the Home from Home Fund ensure that the Trust can provide the facility free of charge to relatives whose loved ones are receiving critical care at the hospital; and the Sid Watkins Innovation Fund supports innovation and research in the field of neurological health care.

During the year under review, the Charity also developed a dedicated website which will provide the functionality necessary for a fully integrated and fundraising focused digital platform to help the Charity raise awareness and funds. The website was launched in March 2019.

The Charity spent £538,000 in 2018/19 (2017/18: £545,000). The Charity's expenditure covers its charitable objectives, fundraising and governance costs.

In 2018/19, expenditure on charitable objectives included £46,000 for the construction of the ITU outside space and a £31,000 grant to the Trust to fund the running costs of the Home from Home relatives' accommodation in the Sid Watkins building.

Expenditure on charitable objectives of £277,000 covers three main areas:

- **Patient welfare and amenities:** £143,000 (2017/18: £222,000) – this included the ITU outside space (Garden Room); relatives' accommodation; other medical equipment; ward games and activities, including the art residency and the pet therapy programmes; as well as the volunteers service.

- **Staff welfare and amenities:** £21,000 (2017/18: £27,000) – this included areas such as enhanced study courses, training and conferences for staff, which will enable them to provide a better service to patients of the Trust. The Charity also supports some of the Trust's Health & Wellbeing programme.

- **Research:** £113,000 (2017/18: £47,000) – this included funding for research posts, equipment, training, books and journals.

Including the £17,000 net gain on investments (which is treated as a component of net income), the total income for the Charity exceeded expenditure by £176,000 for the year.

All charitable expenditure is for the public benefit through support of patients and staff at the Trust as well as the wider public through research investment, as noted above.

Fundraising

In 2018/19, the costs of fundraising increased by £17,000, which is due to the annual NHS salary increments and also the first payment for the website annual hosting/maintenance. The fundraising expenditure of £216,000 (2017/18: £199,000) also includes the costs directly related to the managed events (including the Jan Fairclough Ball, Hope Mountain Hike and the Golf Day). Over the same period, charitable donations and fundraising income increased in total by £231,000.

During the year under review, there was no specific fundraising appeal and so the main focus of fundraising activity, especially in the community, continued to be for the General Purpose Fund. In addition to raising unrestricted funds, the Charity also committed to raising funds designated for the Home from Home Fund to support the annual costs of the relatives' accommodation and the Sid Watkins Innovation Fund. The wider aims and objectives of the Sid Watkins Innovation Fund are to 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.

The links with the Justgiving and Virgin Money Giving websites continue to offer the Charity's supporters a vehicle to facilitate their fundraising efforts. It allows sponsorship to be collected in an efficient and timely manner, with the option to gift aid the donations. It also offers a route for online direct donations.

In addition to encouraging supporters to undertake fundraising activities on the Charity's behalf and supporting them in their efforts, the Fundraising team also organise and manage a number of events and initiatives. The following were examples of such activities during the year 2018/19:

Hope Mountain Hike (April)
Annual hiking event organised in conjunction with Liverpool Heart and Chest Hospital and volunteers in Wales. This year 200 people took part in support of The Walton Centre Charity and the income raised was allocated to the Home from Home Fund.

Abseil (May)
A second abseil event was held in Devils Gorge in Wales, raising money for the Home from Home fund.

The Walton Centre Golf Day (May)
The fourth event held at Formby Golf Club and hosted by Patron David Fairclough. 23 teams of 4, mainly corporates, took part in the tournament and enjoyed a dinner and prize presentation in the evening. The money raised from the event was allocated to the Sid Watkins Innovation Fund.

Jan Fairclough Ball (November)
Annual event now in its seventh year, held in memory of Charity Patron David Fairclough's wife. The event was held at the Hilton in Liverpool with

approximately 260 guests attending the black-tie dinner. The funds raised from the event were allocated to the Sid Watkins Innovation Fund.

Christmas Campaign (December)
A number of initiatives took place in the run up to the festive period, under the banner of The Walton Centre Charity Christmas Campaign. This included the sale of Christmas cards; the staff bake-off; and the Santa Dash.

In addition to the events organised by the Charity team, there were also two gala events organised by supporters which raised further funds for the Charity.

Forward Look

There are a range of initiatives for the next few years, which will continue to promote and support vital medical research and enhance the services and facilities that the Trust can offer to patients and their families or carers. These initiatives include the following:

- continue to develop the Sid Watkins Innovation Fund to support major Trust initiatives, projects or programmes, particularly in innovation and new technology;
- continue to fund and maintain the relatives' accommodation;
- support ongoing research into neurological and neurosurgical conditions; and
- support enhanced training and conference opportunities for staff to ensure that they remain at the forefront of clinical developments.

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.

Specific emphasis over the next year is likely to concern developments in complex rehabilitation, specifically movement and posture analysis, with a view to this becoming the focus of the Charity's next major fundraising appeal.

Statement of Trustee's Responsibilities

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 13 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) Date

Grant Thornton

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

I report on the accounts of The Walton Centre Charity (the "charity") for the year ended 31 March 2019, which are set out on pages 13 to 25.

Your attention is drawn to the fact that the charity's trustee has prepared the charity's accounts in accordance with the Statement of Recommended Practice 'Accounting and Reporting by Charities preparing the accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) (effective 1 January 2015)' issued in May 2014 in preference to the Statement of Recommended Practice 'Accounting and Reporting by Charities: Statement of Recommended Practice (revised 2005)' issued in April 2005 which is referred to in the Charities (Accounts and Reports) Regulations 2008 but has been withdrawn. I understand that the charity's trustee has done this in order for the charity's accounts to give a true and fair view in accordance with United Kingdom Generally Accepted Accounting Practice effective for reporting periods beginning on or after 1 January 2015.

This report is in respect of an examination carried out under section 145 of the Charities Act 2011. This report is made solely to the charity's trustee, as a body, in accordance with the regulations made under section 154 of the Charities Act 2011. My work 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 trustee, as a body, for my work, for this report or for the opinions I have formed.

Respective responsibilities of corporate trustee and examiner

The charity's corporate trustee is responsible for the preparation of the accounts. The charity's trustee considers that an audit is not required for this year under section 144(2) of the Charities Act 2011 and that an independent examination is needed. The charity's gross income exceeded £250,000 and I am qualified to undertake the examination by being a qualified member of the Chartered Institute of Public Finance and Accountancy.

It is my responsibility to:

- examine the accounts under section 145 of the Charities Act 2011;
- to follow the procedures laid down in the general Directions given by the Charity Commission under section 145(5)(b) of the Charities Act 2011; and
- to state whether particular matters have come to my attention.

Basis of independent examiner's report

My examination was carried out in accordance with the general Directions given by the Charity Commission. An examination includes a comparison of the accounts with the accounting records kept by the charity. It also includes consideration of any unusual items or disclosures in the accounts, and seeking explanations from you as trustee concerning any such matters. The procedures undertaken do not provide all the evidence that would be required in an audit, and consequently no opinion is given as to whether the accounts present a 'true and fair' view and the report is limited to those matters set out in the statement below.

Independent examiner's statement

In connection with my examination, no matter has come to my attention:

- which gives me reasonable cause to believe that in any material respect, the requirements:
  - to keep accounting records in accordance with section 130 of the Charities Act 2011; and
  - to prepare accounts which accord with the accounting records; and
  - to comply with the applicable requirements concerning the form and content of accounts set out in the Charities (Accounts and Reports) Regulations 2008

  have not been met, or
- to which, in my opinion, attention should be drawn in order to enable a proper understanding of the accounts to be reached.

To be signed

Robin Baker, CPFA

Grant Thornton UK LLP
Chartered Accountants

Liverpool

To be dated

Statement of Financial Activities for the Year Ended 31 March 2019

	Note	2018/19 Total Funds (Unrestricted)	2017/18 Total Funds (Unrestricted)
		£000	£000
Income and endowments from:			
Donations and legacies		**534**	283
Other trading activities		**138**	158
Investments		**25**	25
Total income and endowments	3	**697**	**466**
Expenditure on:			
Raising funds		**221**	210
Charitable activities		**317**	335
Total expenditure	4	**538**	**545**
Net gains/(losses) on investments		**17**	(15)
Net income/(expenditure) and net movement in funds		**176**	**(94)**
Reconciliation of funds:			
Fund balances brought forward		**1,292**	1,386
Fund balances carried forward		**1,468**	**1,292**

All the Charity's funds are unrestricted.

The net income for the year arises from the Charity's continuing operations.

The notes on pages 16 to 25 form part of these accounts.

Balance Sheet as at 31 March 2019

	Note	31-Mar-19 Total Funds (Unrestricted) £000	31-Mar-18 Total Funds (Unrestricted) £000
Fixed assets			
Investments	6	**971**	812
Total fixed assets		**971**	**812**
Current assets			
Debtors	7	**27**	14
Cash at bank and in hand	8	**545**	525
Total current assets		**572**	**539**
Creditors: amounts falling due within one year	9	**75**	59
Net current assets/(liabilities)		**497**	**480**
Total assets less current liabilities		**1,468**	**1,292**
Total net assets		**1,468**	**1,292**
Funds of the Charity			
Unrestricted	10	**1,468**	1,292
Total funds		**1,468**	**1,292**

The notes on pages 16 to 25 form part of these accounts.

Signed on behalf of the Trustee

Su Rai (Chair) Date

Statement of Cash Flows for the Year Ended 31 March 2019

	Note	2018/19 Total Funds (Unrestricted) £000	2017/18 Total Funds (Unrestricted) £000
Cash flows from operating activities:			
Net cash provided by (used in) operating activities		**137**	**(459)**
Cash flows from investing activities:			
Dividends and interest from investments		**25**	25
Proceeds from sale of investments		**921**	145
Purchase of investments		**(1,063)**	(136)
Net cash provided by (used in) investing activities		**(117)**	**34**
Change in cash and cash equivalents in the reporting period		**20**	(425)
Cash and cash equivalents at the beginning of the reporting period		**525**	950
Cash and cash equivalents at the end of the reporting period	8	**545**	**525**

Reconciliation of net income/(expenditure) to net cash flow from operating activities:

	2018/19 £000	2017/18 £000
Net income/(expenditure) for the reporting period (as per the statement of financial activities)	**176**	**(94)**
Adjustments for:		
(Gains)/losses on investments	**(17)**	15
Dividends and interest from investments	**(25)**	(25)
(Increase)/decrease in debtors	**(13)**	(14)
Increase/(decrease) in creditors	**16**	(341)
Net cash provided by (used in) operating activities	**137**	**(459)**

Notes to the Accounts

1 Accounting Policies

1 a) 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 (effective 1 January 2016) and applicable UK Accounting Standards and the Charities Act 2011.

This is the fourth 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.

1 b) 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.

1 c) Resources 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.

1 d) 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.

1 e) Investment Fixed Assets
Fixed asset investments are held to generate income or for their investment potential, or both. They exclude any investments held specifically for sale or those investments which the Charity expects to realise within 12 months of the reporting date. Fixed asset investments in quoted shares, traded bonds and similar investments are measured initially at cost and subsequently at fair value (their market value) at the reporting date.

1 f) Debtors
Debtors include amounts owed to the Charity for the provision of goods and services or amounts the Charity has paid in advance for the goods and services it will receive. They are measured on the basis of their recoverable amount, which is the amount the Charity anticipates it will receive from a debt or the amount it has paid in advance for goods or services.

1 g) 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.

1 h) Creditors
Creditors are amounts owed by the Charity. They are measured at the amount that the Charity anticipates it will pay to settle the debt or the amount it has received as an advance payment for goods or services it must provide.

1 i) 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 market value at the year-end and opening market value or date of purchase if later.

1 j) 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.

1 k) Change in the Basis of Accounting

This is the fourth 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.

1 l) Prior Year Adjustments

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

1 m) 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 Interest

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

	2018/19 Total Funds (Unrestricted) £000	2017/18 Total Funds (Unrestricted) £000
Income and endowments		
Donations	**392**	277
Legacies	**142**	6
Fundraising activities and events	**138**	158
Investment income	**25**	25
Total income and endowments	**697**	**466**

4. Details of Expenditure

	2018/19 Total Funds (Unrestricted) £000	2017/18 Total Funds (Unrestricted) £000
Raising Funds:		
Fundraising staff costs	**155**	147
Fundraising activities and events	**61**	52
Investment management costs	**5**	11
	221	**210**
Charitable Activities:		
Patients welfare and amenities	**143**	222
Staff welfare and amenities	**21**	27
Research	**113**	47
Independent examination	**1**	1
Administrative support	**39**	38
	317	**335**
Total	**538**	**545**

All 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

	2018/19 Total Funds (Unrestricted) £000	2017/18 Total Funds (Unrestricted) £000
Fundraising Staff Costs		
Salaries and wages	125	119
Social security costs	13	12
Employers pension contribution	17	16
Total Fundraising Staff Costs	**155**	**147**

The average number of full-time equivalent employees during the year was 3.5 (2017/18: 3.5). One employee received emoluments in excess of £60,000 in the current year in the salary band £60,000 - £70,000 (2017/18: none).

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 was previously managed by Investec Wealth and Investment Ltd in accordance with the guidance issued by The Walton Centre

Charity Committee. Following advice and a recruitment process, two new investment managers, CCLA and Ruffer LLP, were appointed. The transfer took place in July 2018 (the portfolio was valued at £856,000) with each manager receiving £428,000. Additional amounts were also transferred to both CCLA and Ruffer LLP taking the total amount invested with each manager to £500,000. The movement in the portfolio can be analysed as follows:

	31-Mar-19 £000	31-Mar-18 £000
Market value at the beginning of the reporting period	**812**	836
Less Disposals at carrying value	**(921)**	(145)
Acquisitions at cost	**1,063**	136
Unrealised gains/(losses)	**17**	(15)
Market value at the end of the reporting period	**971**	**812**
Book cost at the end of the reporting period	**1,000**	682

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

	31-Mar-19 £000	31-Mar-18 £000
Listed investments	**971**	775
Cash held as part of the investment portfolio	**0**	37
Total	**971**	**812**

7. Debtors

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

	31-Mar-19 £000	31-Mar-18 £000
Prepayments and accrued income	**27**	14
Total	**27**	**14**

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:

	31-Mar-19 £000	31-Mar-18 £000
Cash at bank and in hand	**545**	525
Total cash and cash equivalents	**545**	**525**

9. Creditors

The creditor position can be summarised as follows:

	31-Mar-19 £000	31-Mar-18 £000
Amounts due to NHS Foundation Trust	**31**	33
Accruals	**36**	14
Deferred income	**8**	12
Total	**75**	**59**

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 31-Mar-18 £000	Income £000	Expenditure £000	Revaluation of investments £000	Sale of investments £000	Balance 31-Mar-19 £000
Unrestricted Funds	858	697	(538)	(29)	480	**1,468**
Revaluation Reserve	434	0	0	46	(480)	**0**
Total	**1,292**	**697**	**(538)**	**17**	**0**	**1,468**

The change of investment managers during the year required the sale of the Charity's portfolio managed by Investec Wealth and Investment Ltd. At this point, the revaluation reserve was transferred to the unrestricted funds of the Charity based on average fund balances over a five-year period.

A list of the unrestricted funds and their balances as at 31 March 2019 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 £277,000 (2017/18: £296,000). This included £46,000 for the construction of the ITU outside space and an individual grant of £31,000 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 2018/19 charged a fee of £36,000 (2017/18: £36,000).

12. Events after the Reporting Date

The July 2019 Charity Committee meeting was the final meeting chaired by Alan Sharples. Su Rai, Non-Executive Director, became Chair of the Committee following Mr Sharples' departure from the Trust.

Neil Buxton, Consultant Neurosurgeon, joined the Committee in April 2019 as the replacement for Andrew Brodbelt, who stood down from the Committee in January 2019.

In May 2019 and June 2019, the Charity also received two significant legacies totalling £81,000 and £75,000 respectively.

Appendix 1

List of Funds and Fund Balances as at 31 March 2019

Fund	Name	Fund Balance	
		31-Mar-19	31-Mar-18
		£000	£000
4009	General Fund	**419**	153
4010	NRU Fund	**38**	11
4015	Wards Fund	**18**	9
4017	Roy Ferguson Compassionate Care Fund	**74**	47
4019	Headache and Neurology Fund	**2**	1
4422	Pain Relief Research Fund	**5**	3
4442	Neuro General Research Fund	**9**	5
4457	Neuro Muscular Diseases Fund	**2**	1
4464	Cerebro Vascular Fund	**29**	19
4465	Home From Home	**55**	20
4481	Neurosurgical General Fund	**55**	32
4487	Horsley ITU Fund	**88**	94
4499	Epilepsy Fund	**49**	58
4527	R & D & Higher Study	**21**	16
4528	Neurophysiology Train. & Educ.	**3**	2
4530	Neurological Disability Fund	**141**	86
4533	Alan Sutcliffe Kerr Lecture Fund	**12**	9
4537	Cognitive Research Fund	**4**	3
4538	Stereotactic Fund	**13**	8
4541	Neurobiochemistry Fund	**7**	6
4543	Disorders Of Movement Gen Fund	**62**	39
4550	Research Fellowship	**2**	3
4552	Parkinsons Disease	**17**	11
4900	Neuro X-Ray Research	**22**	12
4905	Neurosurgical Neuro-Oncology	**48**	32
4910	Brain Infections Research	**11**	5
4911	Nmo And Atypical Disorders	**13**	10
4915	The Sid Watkins Innovation Fund	**249**	163
		1,468	**858**

Appendix 2

List of Funds, Fund Managers and Objectives

	Fund Name	Fund Manager	Aims and Objectives
4009	General Fund	Finance Director/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/L Vlasman	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 Wiles	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	Finance Director/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	Dr C Dougan	Specialist research and education
4537	Cognitive Research Fund	Dr M Doran	Research and development
4538	Stereotactic Fund	Prof P Eldridge/ Mr J Farah	Research and training
4541	Neurobiochemistry Fund	C Chadwick/N Moxham	Research, education, training and equipment

	Fund Name	Fund Manager	Aims and Objectives
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	Parkinsons 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	Finance Director/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

The Walton Centre NHS Foundation Trust

REPORT TO THE TRUST BOARD
Date 28th November 2019

Title	**Scheme of Reservation and Delegation and Standing Financial Instructions**
Sponsoring Director	Name: Mike Burns Title: Director of Finance and IT
Author (s)	Name: Ian Benjamin -Financial Accountant , Jane Hindle - Corporate Secretary
Previously considered by:	Audit Committee – October 2019

Executive Summary

In line with best practice the Scheme of Reservation and Delegation and the Standing Financial Instructions should be reviewed on an annual basis.

The Audit Committee reviewed the documents at its meeting in October and supported their approval by Trust Board.

The following minor amendments should be noted and are highlighted throughout the document; 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 policies and key documents reserved to the Board as per national guidance. Specifically

  - approval of the Trust's Freedom to Speak Up Policy;
  - approval of the Trust's Health, Safety Policy;
  - approval of the Trust's Major Incident Plan;
  - approval of the Trust's Learning from Deaths Policy;

Related Trust Ambitions	Delete as appropriate: • Best practice care • More services closer to patients' homes • Be financially strong • Research, education and innovation • Advanced technology and treatments • Be recognised as excellent in all we do
Risks associated with this paper	None identified
Related Assurance Framework entries	None

Equality Impact Assessment completed	• Not applicable
Any associated legal implications / regulatory requirements?	
Action required by the Board :	• **The Board is requested to:** **a) Approve the revised Scheme of Reservation and Delegation and Standing Financial Instructions**

The Walton Centre NHS
NHS Foundation Trust

SCHEME OF RESERVATION AND DELEGATION

Reviewed by:

Ian Benjamin, Financial Accountant

October 2019

Authorised by:

Mike Burns, Director of Finance and IT

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*.	

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 NHS 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 Monitor / NHS 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;

k) k) requirement to establish terms of reference and reporting arrangements of all
   a. committees;

l) 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*;

m) 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;

n) approval of arrangements for dealing with complaints;
o) approval of arrangements relating to the discharge of the Trust's responsibilities as a bailee for patients' property;
p) authorisation of use of the seal;
q) ratification or otherwise, instances of failure to comply with SOs brought to the Chief Executive's attention; and
r) approval and monitoring of the Foundation Trust's policies and procedures for the management of risk;
s) approval of the Trust's *Freedom to Speak Up Policy*;
t) approval of the Trust's *Health, Safety and Welfare Policy*;
u) approval of the Trust's *Major Incident Plan*;
v) with the Council of Governors, and in accorda*nce with the* Trust's *Constitution,* approve changes to the Trust's *Constitution*;
w) approval of the Trust's *Learning from Deaths Policy*;
x) 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 £250,000; approval annually of the Foundation Trust's proposed

business plan / service development strategy;

e) ratification of proposals for acquisition, disposal or change of use of land and/or buildings;
f) approval of PFI proposals;
g) approval of the creation of corporate bodies by the Trust;
h) approval of the participation in joint ventures and the creation of joint entities;
i) approval of proposals on individual contracts, including purchase orders (other than NHS contracts) of a capital level above £250,000 or revenue amounting to, or likely to amount to over £250,000 over the life of the contract;
j) 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 Director of Finance and IT;
k) 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;
l) review of the use of NHS risk pooling schemes;
m) approval of the opening of bank accounts; and
n) 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 Director of Finance and IT on financial performance against budget and business plan / service development strategy;

d) receive reports from the Director of Finance and IT 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 unless expressly authorised by the Board of Directors.

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 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 Director of Finance 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 Director of Finance and IT (report to the Audit Committee).	All Staff	All Staff
j) Advice on interpretation or application of SFIs and this Scheme of Delegation.	Director of Finance and IT	Deputy Director of Finance

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).	Director of Finance and IT
b) Monitor and review the effectiveness of the internal audit function.	Audit Committee	Director of Internal Audit / Director of Finance and IT
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	Director of Finance and IT
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.	Director of Finance and IT	Deputy Director of Finance with Director of Operations and Strategy
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).	Director of Finance and IT	Financial Accountant
• Opening bank accounts.	Director of Finance and IT	Deputy Director of Finance
• Authorisation of transfers between the Foundation Trust's bank accounts.	Director of Finance and IT	In accordance with the bank mandate

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
• Approve and apply arrangements for the electronic transfer of funds.	Director of Finance and IT	To be completed in accordance with bank mandate / internal procedures.
• Authorisation of: – GBS schedules; – BACS schedules; – Automated cheque schedules; – Manual cheques.	Director of Finance and IT	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 NHSI requirements / guidance). • Preparation of investment procedures.	Director of Finance and IT	Financial Accountant
c) **Petty Cash**	Director of Finance and IT	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	Director of Finance and IT / Director of Operations and Strategy
• Preparation of Capital Investment Programme.	Chief Executive	Director of Finance and IT / Director of Operations and Strategy
• Preparation of a business case.	Director of Finance and IT / Director of Operations and Strategy	Relevant operational manager – Refer to Table B
• Financial monitoring and reporting on all capital scheme expenditure including variations to contract.	Director of Finance and IT	Deputy Director of Finance
• Contracting: Selection of architects, quantity surveyors, consultant engineers and other professional advisors within the EU regulations and Trust tender procedures.	Chief Executive	Director of Finance and IT / Director of Operations and Strategy with external advice as required
• Authorisation of capital requisitions.	Chief Executive	Refer to Table B Delegated Limits

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
• Responsible for the management of capital schemes and for ensuring that they are delivered on time and within cost.	Chief Executive	Director of Finance and IT / Director of Operations and Strategy.
• Ensure that capital investment is not undertaken without availability of resources to finance all revenue consequences.	Chief Executive	Director of Finance and IT / Director of Operations and Strategy
• Issue procedures to support: (i) capital investment; (ii) staged payments.	Director of Finance and IT / Director of Operations and Strategy	Deputy Director of Finance
• Issue procedures governing financial management, including variation to contract, of capital investment projects and valuation for accounting purposes.	Director of Finance and IT	Deputy Director of Finance
• Issuing the capital scheme project manager with specific authority to commit capital, proceed / accept tenders in accordance with the SO's and SFI's.	Chief Executive	Director of Finance and IT
b) **Private Finance:**		
• Demonstrate that the use of private finance represents best value for money and transfers risk to the private sector. Proposal to use PFI must be specifically agreed by the Board of Directors.	Chief Executive	Director of Finance and IT
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	Director of Finance and IT	Financial Accountant
• Granting and termination of leases with Annual rent < £50k.	Director of Finance and IT	Financial Accountant
• Granting and termination of leases with Annual rent of £50k - £100k.	Chief Executive	Director of Finance and IT
• Granting and termination of leases with Annual rent > £100k.	Board of Directors	Chief Executive
6. Clinical Audit	Chief Executive	Medical Director / Director of Nursing and Governance
7. Commercial Sponsorship		

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
Agreement to proposal.	Chief Executive	Director of Finance and IT with reference to the Standards of Business and Personal Conduct Policy
8. Complaints (Patients & Relatives)		
a) Overall responsibility for ensuring that all complaints are dealt with effectively.	Chief Executive	Director of Nursing and Governance
b) Responsibility for ensuring complaints relating to a division / department are investigated thoroughly.	Chief Executive	Director of Nursing and Governance
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 Director of Finance and IT Director of Finance and IT
10. Data Protection Act		
Assurance of the Foundation Trust's Compliance.	Chief Executive	Director of Finance and IT
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	Director of Finance and IT
12. Disposal and Condemnations		
• Items obsolete, redundant, irreparable or cannot be repaired cost effectively. • Develop arrangements for the sale of assets.	Director of Finance and IT Director of Finance and IT	Head of Department in accordance with agreed policy Deputy Director of Finance
13. Environmental Regulations		
Review of compliance with environmental regulations, for example those relating to clean air and waste disposal.	Chief Executive	Director of Operations and Strategy

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
14. External Borrowing		
a) Advise Trust Board of the requirements to repay / draw down Public Dividend Capital.	Director of Finance and IT	Deputy Director of Finance
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	Director of Finance and IT
d) Preparation of procedural instructions concerning applications for loans and overdrafts.	Director of Finance and IT	Financial Accountant
15. Financial Planning / Budgetary Responsibility		
a) **Setting:**		
• Submit budgets to the Trust Board	Chief Executive	Director of Finance and IT
• Submit to Board financial estimates and forecasts	Chief Executive	Director of Finance and IT
• Compile and submit to the Board operational and strategic plans which take into account financial targets, forecast limits and available resources.	Chief Executive	Director of Operations and Strategy
b) **Monitoring:**		
• Devise and maintain systems of budgetary control.	Director of Finance and IT	Deputy Director of Finance
• Monitor performance against budget.	Director of Finance and IT	Divisional Accountant / Budget Holders
• Delegate budgets to budget holders	Chief Executive	Director of Finance and IT
• Ensuring adequate training is delivered to budget holders to facilitate their management of the allocated budget.	Director of Finance and IT	Deputy Director of Finance
• Submit in accordance with the Monitor's requirements for financial monitoring returns.	Chief Executive	Director of Finance and IT
• 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	Director of Finance and IT Chief Executive	Deputy Director of Finance 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.	Director of Finance and IT	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 / Director of Finance and IT	Refer to Table B Delegated Limits
16. Financial Procedures and Systems		
a) Maintenance and update on Foundation Trust Financial Procedures	Director of Finance and IT	Deputy Director of Finance
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.	Director of Finance and IT	Deputy Director of Finance

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
17. Fire Precautions		
Ensure that the Fire Precautions and prevention policies and procedures are adequate and that fire safety and integrity of the estate is intact.	Chief Executive	Director of Operations and Strategy
18. Fixed Assets		
a) Maintenance of asset register including asset identification and monitoring	Chief Executive	Director of Finance and IT
b) Ensuring arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with current accounting requirements.	Director of Finance and IT	Deputy Director of Finance
c) Responsibility for security of Foundation Trust's assets including notifying discrepancies to the Director of Finance and IT 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 Protect and External Audit of all suspected Frauds.	Director of Finance and IT	Local Counter Fraud Specialist
20. Health and Safety		
Review of all statutory compliance with legislation and Health and Safety requirements.	Chief Executive	Director of Nursing & Governance
21. Hospitality / Gifts		
Keeping of hospitality register.	Chief Executive	Corporate Secretary
22. Infectious Diseases & Notifiable Outbreaks	Chief Executive	Director of Nursing and Governance
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:	Director of Finance and IT	Deputy Director of Finance

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.	Director of Finance and IT	Head of IM&T
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 Director of Finance and IT Director of Finance and IT
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 Protect 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	Director of Finance and IT Refer to Table B Delegated Limits

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
fraud, theft, arson).		
b) Reviewing appropriate requirement for insurance claims.	Director of Finance and IT	Deputy Director of Finance
c) A register of all of the payments should be maintained by the Finance Department and made available for inspection / audit.	Director of Finance and IT	Deputy Director of Finance / Financial Accountant
d) A report of all of the above payments should be presented to the Audit Committee on an annual basis.	Director of Finance and IT	Deputy Director of Finance / 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 Director of Finance (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 / Director of Nursing and Governance	Director of Nursing and Governance
• 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 / Divisional General Managers

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
• Medical Research	Medical Director	Clinical Director of Research / Director of Nursing and Governance
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	Director of Finance and IT
b) Obtain the best value for money when requisitioning goods / services	Chief Executive	Head 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	Director of Finance and IT
d) Develop systems for the payment of accounts.	Director of Finance and IT	Deputy Director of Finance
e) Prompt payment of accounts.	Director of Finance and IT	Financial Accountant
f) Financial Limits for ordering / requisitioning goods and services	Director of Finance and IT	Refer to Table B Delegated Limits
g) Approve prepayment arrangements	Director of Finance and IT	Financial Accountant
h) Financial limits for authorising internal credit notes	Director of Finance and IT	Refer to Table B Delegated Limits
i) Financial limits for authorising NHS Supply Chain weekly sales invoices	Director of Finance and IT	Refer to Table B Delegated Limits
29. Nursing		
• Compliance with statutory and regulatory arrangements relating to professional nursing practice.	Director of Nursing and Governance	Deputy Director of Nursing and Lead Nurse for Neurosurgery
• Matters involving individual professional competence of nursing staff.	Director of Nursing and Governance	Deputy Director of Nursing and Lead Nurse for Neurosurgery
• Compliance with professional training and development of nursing staff.	Director of Nursing and Governance	Deputy Director of Nursing and Lead Nurse for Neurosurgery
• Quality assessment of nursing processes.	Director of Nursing and Governance	Deputy Director of Nursing and Lead Nurse for Neurosurgery

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
30. Patient Services Agreements		
a) Negotiation of Foundation Trust Contract and Non-Commercial Contracts.	Chief Executive	Director of Finance and IT / Director of Nursing and Governance
b) Quantifying and monitoring non-contract activity.	Director of Finance and IT	Deputy Director of Finance / Head of Finance – Income & Contracting
c) Reporting actual and forecast income.	Director of Finance and IT	Director of Finance and IT / Head of Finance – Income & Contracting
d) Costing Foundation Trust Contract and Non-Commercial Contracts.	Director of Finance and IT	Deputy Director of Finance / Head of Finance – Income & Contracting
e) Reference costing / Payment by Results. • Production of annual reference costs in accordance with national guidance and best practice.	Director of Finance and IT	Deputy Director of Finance / Head of Costing.
f) Ad hoc costing relating to changes in activity, developments, business cases and bids for funding.	Director of Finance and IT	Senior Finance Team Members
31. Patients' Property		
a) Ensuring patients and guardians are informed about patients' monies and property procedures on admission.	Director of Finance and IT	Ward Managers
b) Prepare detailed written instructions for the administration of patients' property.	Director of Finance and IT	Deputy Director of Finance / Deputy Director of Nursing and Lead Nurse for Neurosurgery
c) Informing staff of their duties in respect of patients' property.	Director of Finance and IT	Divisional General Manager / 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.	Director of Finance and IT Director of Finance and IT	Financial Accountant Financial Accountant
32. Personnel & Pay		
a) Nomination of officers to enter into contracts of employment regarding staff, agency staff or	Chief Executive	Director of Workforce and

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
consultancy service contracts.		Innovation
b) Develop Human Resource policies and strategies for approval by the Board including training, industrial relations.	Director of Workforce and Innovation	Deputy Director of Human Resources
c) Authority to fill funded post on the establishment with permanent staff.	Director of Workforce and Innovation	Budget Managers and Divisional Accountants
d) The granting of additional increments to staff within budget.	Director of Workforce and Innovation	Budget Managers and Deputy Director of Finance
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	Director of Workforce and Innovation	Deputy Director of Human Resources
g) Establishments		
• Additional staff to the agreed establishment with specifically allocated finance;	Director of Finance and IT	Budget Managers and Divisional Accountants with Executive Team Approval
• Additional staff to the agreed establishment without specifically allocated finance.	Chief Executive	Budget Managers and Divisional Accountants with Executive Team Approval
• Self-financing changes to an establishment	Director of Finance and IT	Budget Managers / Divisional Accountant
h) Pay		
• 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	Director of Workforce and Innovation
• Authority to complete standing data forms effecting pay, new starters, variations and leavers	Director of Workforce and Innovation	Budget Managers
• Authority to complete and authorise Staff Variation Lists (SVLS)	Director of Finance and IT	Budget Managers or authorised deputy
• Authority to authorise overtime	Director of Workforce and Innovation / Director	Budget Managers

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
• Authority to authorise travel and subsistence expenses • Authority to authorise travel orders for Executives	of Finance and IT Director of Finance and IT Chief Executive/ Director of Finance and IT/ Deputy Director of Finance	Budget Managers Personal Assistants
i) Leave *(note entitlement may be taken in hours)*	Director of Workforce and Innovation	Refer to Annual Leave Policy / Divisional Manager / Head of Department
<u>Annual Leave</u> • Approval of annual leave	Director of Workforce and Innovation	Line / Departmental Manager (as per departmental procedure)
• Annual leave – approval of carry forward (up to maximum of 5 days)	Director of Workforce and Innovation	Line/Departmental Manager
• Annual leave – approval of carry forward over 5 days (to occur in exceptional circumstances only).	Director of Workforce and Innovation	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 ▪ 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.	Director of Workforce and Innovation	Departmental Manager / Head of Service / Clinical Managers
• Leave without pay.	Director of Workforce and Innovation	Clinical Director / Directorate

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
• Medical Staff Leave of Absence – paid and unpaid.	Director of Workforce and Innovation	Clinical Director with advice from the Medical Director
• Time off in lieu.	Director of Workforce and Innovation	Line / Departmental Manager
• Maternity Leave - paid and unpaid.	Director of Workforce and Innovation	Automatic approval with guidance
<u>Sick Leave</u> j) Extension of sick leave and pay.	Director of Workforce and Innovation	Clinical Director / Directorate Manager / Department Heads in conjunction with the Director of Workforce and Innovation
ii) Return to work part-time on full pay to assist recovery.	Director of Workforce and Innovation	Clinical Director / Directorate Manager / Department Heads in conjunction with the Director of Workforce and Innovation
<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
• All other study leave (UK)	Director of Workforce and Innovation	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 Director of Workforce must be sought when the grievance reaches the level of Divisional	Director of Workforce and Innovation	Departmental Manager / Line Manager / Appeals Committee

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
General Managers / Heads of Department.		
l) Authorised – Car Users • Regular users allowance.	Director of Finance and IT	To be applied as per Trust Policy
m) Mobile Phone Users / Blackberry's / iPad's.	Director of Finance and IT	To be applied as per local Trust policy
n) Renewal of Fixed Term Contract.	Director of Workforce and Innovation	Budget Holder / Finance Approval plus relevant Executive Director
o) Redundancy.	Chief Executive	Director of Workforce and Innovation/ Director of Finance and IT
p) Ill Health Retirement Decision to pursue retirement on the grounds of ill-health following advice from the Occupational Health Department.	Director of Workforce and Innovation	Deputy Director of Human Resources
q) Early retirement.	Chief Executive	Director of Workforce and Innovation/ Director of Finance and IT
r) Disciplinary Procedure (excluding Executive Directors).	Director of Workforce and Innovation	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.	Director of Workforce and Innovation	Deputy Director of Human Resources
t) Engagement of staff not on the establishment: • Authorisation of bank staff and temporary nursing staff, including agency • Management Consultants and Other	Director of Nursing and Governance Executive Team	Refer to Table B In Hours – Budget Manager Out of Hours – On Call Manager (bronze) Budget Manager Refer to Table B Delegated Limits
33. Quotation, Tendering & Contract Procedures		

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
a) Services:		
• Best value for money is demonstrated for all services provided under contract or in-house;	Chief Executive	Director of Finance and IT / Deputy Director of Finance / Head of Procurement
• Nominate officers to oversee and manage the contract on behalf of the Foundation Trust.	Chief Executive	Director of Finance and IT / Deputy Director of Finance / Head 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	Head of Procurement
• Receipt and custody of tenders prior to opening	Chief Executive	Head of Procurement
• Opening Tenders	Chief Executive	Corporate Secretary
• Decide if late tenders should be considered	Chief Executive	Head 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	Head of Procurement
c) Quotations / Authorisation Limits:	Chief Executive	Refer to Table B Delegated Limits
d) Waiving the requirement to request: • Tenders; • Quotes.	Chief Executive	Director of Finance and IT Refer to Table B Delegated Limits
34. Records		
a) Review Foundation Trust's compliance with the Records Management Code of Practice.	Chief Executive	Director of Nursing and Governance
b) Ensuring the form and adequacy of the financial	Director of Finance	Deputy Director of

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
records of all departments.	and IT	Finance
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 Director of Nursing and Governance
b) Where a fraud is suspected (reporting to NHS Protect).	Director of Finance and IT	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.	Director of Finance and IT	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	Director of Nursing and Governance
• Developing systems for the management of risk.	Director of Nursing and Governance	Deputy Director of Governance
• Developing incident and accident reporting systems • Compliance with the reporting of incidents and accidents	Director of Nursing and Governance	Deputy Director of Governance 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	Report to Audit Committee
c) Property transactions and any other legal requirement for the use of the seal.	Chair / Chief Executive	Chair or Non-Executive Director and the Chief Executive or their nominated Director
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	Director of Finance and IT

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
39. Setting of Fees and Charges (Income)		
a) Private Patient, Overseas Visitors, Income Generation and other patient related services.	Director of Finance and IT	Head of Finance – Income & Contracting
b) Non-patient care income	Director of Finance and IT	Head of Finance – Income & Contracting
c) Information to the Board of Directors of monies due to the Foundation Trust	Director of Finance and IT	Head of Financial Services, Income and Planning
d) Recovery of debt	Director of Finance and IT	Financial Accountant
e) Security of cash and other negotiable instruments	Director of Finance and IT	Financial Accountant
f) Financial limits for authorising credit notes	Director of Finance and IT	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	Director of Finance and IT	Head of Procurement
b) Stocktaking arrangements	Director of Finance and IT	Heads of Departments and Divisional 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/ Director of Finance and IT/ Deputy Director of Finance	Head of Procurement/ Deputy 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	Director of Finance and IT in line with hospitality policy.
2. LITIGATION CLAIMS		
Payments made on advice of NHS Resolution, insurance company.	Up to excess on policy	Director of Finance and IT / Director of Nursing and Governance - Report to Audit Committee
Payments made on advice of legal advisor	>excess	Director of Finance and IT / Director of Nursing and Governance - Report to Board of Directors
Decision to contest/initiate other litigation claims	Over £10,000 or contentious case Up to £10,000 and not contentious	Board of Directors Director of Finance and IT
3. LOSSES AND SPECIAL PAYMENTS – Reported to Audit Committee		
Losses Fruitless payments (including abandoned capital schemes)	 Over £5,000 Up to £5,000	 Chief Executive Director of Finance and IT
Other Losses Losses of cash due to theft, fraud, overpayment and others	 Over £1,000 Up to £1,000	 Chief Executive Director of Finance and IT
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.).	Over £10,000 Up to £10,000	Chief Executive Director of Finance and IT
Exgratia Payments	Up to £500 £500 to £5,000 £5,000 to £10,000 Over £10,000	Deputy Director of Finance Director of Finance and IT Chief Executive Chief Executive reported to the Board of Directors
Write-offs, Bad debts and claims abandoned. Private patients, overseas visitors & other.	Up to £1,000 Over £1,000	Deputy Director of Finance Director of Finance and IT

Financial Limits (subject to funding available in budget)		
Compensation Payments		Deputy Director of Finance in accordance with NHS Resolution/ legal advice
4. PETTY CASH DISBURSEMENTS (authority to pay)		
Small incidental items of expenditure.	Up to £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 NHSI guidelines	Over £100,000; Up to £100,000; Up to £10,000; Up to £5,000.	Board of Directors Chief Executive Executive Directors Divisional General Managers / Senior Manager On Call / Deputy Director of HR / Medical Staffing Manager *No other managers can authorise the use of agency staff*
5.2 Removal Expenses	Up to £8,000	Director of Workforce and Innovation / Director of Finance and IT
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).	>£250k (excl VAT) >£100k<£250k (excl VAT) £75,000 to £100k (excl VAT) £50,000 to £75,000 (excl VAT) £25,000 to £50,000 (excl VAT) Up to £25,000 (excl VAT) Up to £15,000 (excl VAT) Up to £5,000 (excl VAT)	Board of Directors Business & Performance Committee Chief Executive Director of Finance and IT Other Executive Directors Deputy Director of Finance Divisional Directors/Deputy Director of Nursing and Lead Nurse for Neurosurgery Other Managers
5.4 NHS Supply Chain Expenditure Authorisation of weekly sales invoices	Up to £25,000 (excl VAT) >£25,000 (excl VAT)	Deputy Head of Procurement Head of Procurement
5.5 Zero Cost Model Expenditure	£0	Director of Finance and IT/ Deputy Director of Finance/Head of Procurement

Financial Limits (subject to funding available in budget)		
5.6 Capital Expenditure • General • Strategic Investment Plan	Up to £50k £50k-£100k £100-£250k >£250k	Capital Management Group Executive Directors Team Business Performance Committee Board of Directors
6. QUOTATIONS AND TENDERS		
Obtain competitive price for goods/services	Up to £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
Under Threshold Tenders: Undertake a competitive tendering exercise for goods/services. Over EU Threshold Tenders: Undertake a competitive tendering exercise for goods/services.	Over £50,000 (Inc. VAT) (Local tendering procedures) £181,302 (excl VAT) Goods/Services Contracts £4,551,413 (excl VAT) Works Contracts £615,278 (excl VAT) Social & other specific services (Light Touch)	Head of Procurement evaluated by a member of the procurement team and at least three stakeholders from the evaluation panel
7. VIREMENT		**Conditions:-**
Chief Executive Director of Finance and IT Budget Holder and Deputy Director of Finance and IT	Over £50,000 p.a. Up to £50,000 p.a. Up to £25,000 p.a.	Trust must still meet Financial Targets Total Trust budget remains underspent Total Trust budget remains underspent
8. CREDIT NOTES		
Authorisation of credit notes, including internal credit notes used to adjust expenditure	Over £25,000 (excl VAT) Up to £25,000 (excl VAT)	Director of Finance and IT Deputy Director of Finance
9. CONSIGNMENT STOCK		

Financial Limits (subject to funding available in budget)		
Responsibility for approving consignment stock agreements. Head of Procurement/ Deputy Head of Procurement to review terms and conditions prior to financial approval	>£250k (excl VAT) >£100k<£250k (excl VAT) £75,000 to £100k (excl VAT) £50,000 to £75,000 (excl VAT) £25,000 to £50,000 (excl VAT) Up to £25,000 (excl VAT)	Board of Directors Business & Performance Committee Chief Executive Director of Finance and IT Other Executive Directors Deputy Director of Finance

The Walton Centre NHS
NHS Foundation Trust

STANDING FINANCIAL INSTRUCTIONS

Reviewed by:

Ian Benjamin, Financial Accountant

October 2019

Authorised by:

Mike Burns, Director of Finance and IT

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

General

NHS Improvement (NHSI) 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 NHSI. 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 Director of Finance and IT must approve all financial procedures and should any difficulties arise regarding the interpretation or application of any SFIs then the advice of the Director of Finance and IT **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 Director of Finance and IT 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.
Director of Finance and IT	Shall mean the Chief Finance Officer of the Foundation Trust.
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, Director of Finance and IT, 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 Director of Finance and IT 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 Director of Finance and IT 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 Director of Finance and IT 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/NHSI 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 Director of Finance and IT.

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 Director of Finance and IT in the first instance).

Director of Finance and IT

The Director of Finance and IT 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 NHSI or other regulators.

The Director of Finance and IT 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 NHSI.

Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Director of Finance and IT 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 Director of Finance and IT. The reporting system for Internal Audit shall be agreed between the Director of Finance and IT, 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 Director of Finance and IT shall identify a

formal review process to monitor the extent of compliance with audit recommendations. Where appropriate, remedial action has failed to take place within a reasonable period, the matter shall be reported to the Director of Finance and IT.

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 NHSI 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 NHSI (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. NHSI may require External Auditors to undertake work on its behalf at the Foundation Trust. In this situation, a tripartite agreement between NHSI, 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 NHSI, at once if it is an immediate report; or not later than 14 days after conclusion of the audit, forward a report to NHSI within 30 days (or such shorted period as NHSI 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 Protect. 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 Protect.

The Chief Executive and Director of Finance and IT 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 Director of Finance and IT and shall work with the staff in NHS Protect 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 Protect, 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 Director of Operations and Strategy) and the appointed Local Security Management Specialist (LSMS).

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

Preparation and approval of operational and strategic plans and budgets

Operational planning

The Chief Executive or nominated director will compile and submit to the Board of Directors annually an operational plan. This will reflect the longer-term strategic aims of the Trust and will be supported by detailed departmental budgets. The plan will include (but is not limited to):

- operational requirements and capacity;
- recurrent productivity, efficiency and cost improvement plans;
- service developments;
- activity and income plans;
- expenditure;
- capital programme;
- cashflow and liquidity;
- risk ratings; and
- quality plans.

Strategic Planning

The Chief Executive or nominated Director will compile and submit to the Board of Directors a strategic plan covering up to a five-year period. When requested, this will be provided to NHSI after it has been approved by the Trust Board. This will include:

- strategic plans;
- service strategies;
- capital plans and priorities;
- market analysis and growth; and

- risks to sustainability.

Budgets

Prior to the start of the financial year, the Director of Finance and IT 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 NHSI.

The Director of Finance and IT 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 Director of Finance and IT to the Board of Directors as soon as they come to light and the Board of Directors shall be advised of action to be taken in respect of such variances.

All budget holders must provide information as required by the Director of Finance and IT 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 Director of Finance and IT 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 Director of Finance and IT.

Budgetary Control and Reporting

The Director of Finance and IT 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 Director of Finance and IT'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 Director of Finance and IT 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 Director of Finance and IT'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 Director of Finance and IT other than those provided for in the budgeted establishment as approved by the Board of Directors.

The Director of Nursing and Governance and the Director of Finance and IT 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 NHSI 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 NHSI 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 NHSI 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 NHSI.

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 NHSI. 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 NHSI requires.

The Foundation Trust is to comply with any decision NHSI 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 NHSI. 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 NHSI 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 Director of Finance and IT 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 Director of Finance and IT 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 Director of Finance and IT shall open any account in the name of the Foundation Trust or for the purpose of furthering Foundation Trust activities.

Banking Procedures

The Director of Finance and IT 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 Director of Finance and IT 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 Director of Finance and IT 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 Director of Finance and IT 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 Director of Finance and IT is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due. All such systems shall incorporate, where practicable, in full the principles of internal check and separation of duties. The Director of Finance and IT is also responsible for the prompt banking of all monies received.

Fees and Charges other than Foundation Trust Contract

The Director of Finance and IT 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, NHSI 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 Director of Finance and IT 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 Director of Finance and IT 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 Director of Finance and IT 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 Director of Finance and IT 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 Director of Finance and IT. 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 Director of Finance and IT 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 Protect. 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 Director of Workforce 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 Director of Finance and IT 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 Director of Finance and IT 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 Director of Finance and IT's Instructions and in the form prescribed by the Director of Finance and IT; 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 Director of Finance and IT must be informed immediately. In circumstances where fraud might be expected this must be reported to the Director of Finance and IT.

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

The Director of Finance and IT 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 Director of Finance and IT 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 Director of Finance and IT 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 Director of Finance and IT;
- 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 Director of Finance and IT 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 Director of Finance and IT 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 Director of Finance and IT 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 Director of Finance and IT;

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

13. Petty cash records are maintained in a form as determined by the Director of Finance and IT; 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. All products and purchases that fall under the Zero Cost Model (ZCM) must follow the appropriate approval chain and checking mechanisms as detailed in the ZCM process flow document. All items covered under ZCM can only be approved by one of the following: Director of Finance and IT, Deputy Director of Finance, Head of Procurement. Staff involved in the ordering of ZCM items must ensure that the correct

processes are followed to allow reconciliation of devices to patients in order for the trust to comply with NHS England financial reporting requirements.

16. Online orders for Executives' travel ordered by Personal Assistants due to system time constraints are later checked and approved by the Chief Executive or Director/Deputy Director of Finance*.

The Chief Executive and Director of Finance and IT 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 Director of Finance and IT.

*The Chief Executive to authorise travel for the Director of Finance and IT; the Director of Finance and IT to authorise travel for the Chief Executive; the Chief Executive/Director of Finance and IT/Deputy Director of Finance 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 Director of Finance and IT 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 NHSI 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 NHSI is notified if the Foundation Trust has plans for material transactions in accordance with the thresholds defined in NHSI's Single Oversight Framework. NHSI will determine whether they class the transaction as material or significant. Material investments can, under specific conditions set out in NHSI's Compliance Framework, be approved by the Foundation Trust's Board of Directors. Significant investments must be assessed by NHSI before the Foundation Trust can proceed. In addition, all transactions which potentially impact the Financial Sustainability Risk Rating must also be notified to NHSI. All PFI transactions require NHSI 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 Director of Finance and IT 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 Director of Finance and IT 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 Director of Finance and IT 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 NHSI 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 Director of Finance and IT 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 Director of Finance and IT 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 Director of Finance and IT. Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Director of Finance and IT. 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 Director of Finance and IT. 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 Director of Finance and IT) should be subjected to an annual stocktake or perpetual inventory procedures; and

- valued at the lower of cost and net realisable value.

Subject to the responsibility of the Director of Finance and IT for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Chief Executive. The day-to-day responsibility may be delegated by them to departmental employees and stores managers / keepers, subject to such delegation being entered in a record available to the Director of Finance and IT. 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 Director of Finance and IT 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 Director of Finance and IT and there shall be a physical check covering all items in store at least once a year. Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Director of Finance and IT. The designated manager shall be responsible for a system approved by the Director of Finance and IT 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 Director of Finance and IT 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 Director of Finance and IT. Regular comparisons shall be made of the quantities issued to wards / departments etc. and explanations recorded of significant variations. All transfers and returns shall be recorded on forms / systems provided for the purpose and approved by the Director of Finance and IT.

13. DISPOSALS AND CONDEMNATIONS, INSURANCE, LOSSES AND SPECIAL PAYMENTS

Disposals and Condemnations

The Director of Finance and IT 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 Director of Finance and IT 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 Director of Finance and IT; and
- recorded by the condemning officer in a form approved by the Director of Finance and IT 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 Director of Finance and IT.

The condemning officer shall satisfy themselves as to whether or not there is evidence of negligence in use and shall report any such evidence to the Director of Finance and IT who will take the appropriate action.

Losses and Special Payments

Losses

The Director of Finance and IT must prepare procedural instructions on the recording of and accounting for condemnations, and losses. The Director of Finance and IT must also prepare a fraud response plan that sets out the action to be taken both by persons detecting a suspected fraud and those persons responsible for investigating it. Any employee or officer discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Director of Finance and IT who will liaise with the Chief Executive or inform an officer charged with responsibility for responding to concerns involving loss confidentially. This officer will then appropriately inform the Director of Finance and IT who will liaise with the Chief Executive. Where a criminal offence is suspected, the Director of Finance and IT 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 Director of Finance and IT must inform their Local Counter Fraud Specialist who will inform the relevant NHS Protect 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 Director of Finance and IT must immediately notify:

- The Board of Directors;
- The External Auditor; and
- NHS Protect (through the Local Counter Fraud Specialist).

The Director of Finance and IT shall be authorised to take any necessary steps to safeguard the Foundation Trust's interests in bankruptcies and company liquidations. For any loss, the Director of Finance and IT 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 Director of Finance and IT 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 Medical Director is responsible for clinical negligence for managing the claims process and informing the Board of Directors of any major developments on claims related issues.

14. INFORMATION TECHNOLOGY

Responsibilities and Duties of the Director of Finance and IT

The Director of Finance and IT, 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 Director of Finance and IT shall satisfy themself 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 Director of Finance and IT 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 Director of Finance and IT 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 Director of Finance and IT 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 NHSI 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 NHSI.

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 Director of Nursing and Governance 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 Director of Finance and IT 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 Director of Finance and IT 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 Director of Finance and IT. 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 Director of Finance and IT, in particular, where cash or valuables have been deposited for safe custody, they shall only be released after written authority has been given by the Director of Finance and IT. 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 Director of Finance and IT. 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 Director of Finance and IT 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 Director of Finance and IT 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 Director of Finance and IT 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 Director of Finance and IT.

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 Director of Finance and IT.

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 NHSI 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
- NHSI 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 Director of Finance and IT 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 Director of Finance and IT 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 and the CQC.

Arrangements to be followed by the Board of Directors in agreeing Insurance Cover

The Director of Finance and IT 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 Director of Finance and IT 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 Foundation Trust

REPORT TO THE TRUST BOARD
Date 28TH November 2019

Title	**Committee Terms of Reference**
Sponsoring Director	Janet Rosser Chair
Author (s)	Name: Jane Hindle Title: Corporate Secretary
Previously considered by:	• Audit Committee • Business Performance Committee • Quality Committee

Executive Summary

It is good practice to review terms of reference of groups at least annually to ensure they continue to meet the needs of the organisation. The Board last reviewed the terms of reference in October 2018 and a thorough review is currently underway to clarify the role of each committee and ensure there is no duplication of work between committees. The initial stage of this review has focussed on the following committees

- Audit Committee
- Business and Performance Committee
- Quality Committee.

The revised terms of reference are included at appendix A for approval.

Related Trust Ambitions	Delete as appropriate: • Best practice care • More services closer to patients' homes • Be financially strong • Research, education and innovation • Advanced technology and treatments • Be recognised as excellent in all we do
Risks associated with this paper	Not applicable
Related Assurance Framework entries	All BAF risks
Equality Impact Assessment completed	• Not applicable
Any associated legal implications / regulatory requirements?	It is a constitutional requirement for the Board to ensure any committees it appoints are formally established with terms of reference.
Action required by the Board	The Board is requested to: a) approve the membership of the committees b) approve the revised terms of reference

1.0 Introduction

1.1 It is good practice for the Board to review the terms of reference of committees at least annually to ensure they continue to meet the needs of the organisation. The Board last reviewed the terms of reference in October 2018 and a thorough review is currently underway to clarify the role of each committee and ensure there is no duplication of work between committees. The initial stage of this review has focussed on the following committees

- Audit Committee
- Business and Performance Committee
- Quality Committee.

1.2 Each of the above committees has reviewed and agreed its terms of reference and these are included at appendix A for approval by Trust Board.

1.3 Work will continue to ensure the remaining terms of reference are reviewed and available to the Board in early 2020.

2.0 Membership

2.1 In line with para 6.1 of the Trusts constitution the Board is required to approve the appointment of members to its committees. Recent changes in membership are shown below.

Audit Committee	Su Rai (Chair) Barbara Spicer Seth Crofts **Required attendance** Mike Burns Lisa Salter
Business, Performance Committee	Sheila Samuels (Chair) Barbara Spicer Su Rai Mike Burns Jan Ross **Required attendance** Mike Gibney
Quality Committee	Seth Crofts (Chair) Sheila Samuels Nalin Thakkar

3.0 Key Changes

In addition to changes in membership the following amendments should be noted:

- Approval of primary enabling strategies e.g People, Quality, Digital etc is reserved to the Trust Board with the committees providing oversight once approved

- The reporting requirements to the Board no longer includes the presentation of committee minutes at each meeting as a Chairs report is deemed sufficient to cover the business of the meeting. However minutes will be available to all members via the online reading room.

- The Terms of Reference for Quality Committee and Business Performance Committee now provide for all Board Directors to be able to attend the meetings

- The revised terms of reference for Business Performance Committee and Quality Committee

make explicit reference to their relationship with Audit Committee and the need to consider referring matters as appropriate for consideration

- The role of the Committees' in relation to their oversight of the Board Assurance Framework and operational risks is now explicit

- The Transformation Programme will be overseen by the Business Performance Committee

4.0 Recommendations

4.1 The Board of Directors is requested to:

a) approve the membership of the committees
b) approve the revised terms of reference

AUDIT COMMITTEE
Terms of Reference

1 AUTHORITY

1.1 The WCFT's Audit Committee is constituted as a standing committee of the Board of Directors. Its constitution and terms of reference shall be as set out below, subject to any future amendment(s) by the Board of Directors.

1.2 The Audit Committee is authorised by the Board of Directors to act within its terms of reference. All members of staff are directed to co-operate with any request made by the Audit Committee.

1.3 The Audit Committee is authorised by the Board of Directors to instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for, or expedient to, the exercise of its function.

1.4 The Audit Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions

2. PURPOSE

2.1 The Audit Committee provides an independent and objective view of the system of internal control. .

3. DUTIES AND REPSONSIBILITIES

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

Governance, Risk Management and Internal Control

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

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

- all risk and control related disclosure statements (in particular the Annual Governance Statement and declarations of compliance with the CQC outcomes) together with any accompanying Head of Internal Audit Statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board;

- the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;

3.4 In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

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

Internal Audit

3.6 The Committee will ensure that there is an effective internal audit function that meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board.

This will be achieved by:

- consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal;

- review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the Trust as identified in the Board Assurance Framework;

- consideration of the major findings of internal audit work (and management's response) and ensure co-ordination between Internal and External Auditors to optimise audit resources;

- ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the Trust, and

- an annual review of the effectiveness of internal audit.

External Audit

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

- Considering the appointment and performance of the external auditors as far as the rules governing the appointment permit (and make recommendations to the council of Governors when appropriate)

- discussing and agreeing with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan ensuring coordination, as appropriate, with other External Auditors in the local health economy;

- discussing with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee;

- reviewing all External Audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the Board and any work carried outside the annual audit plan, together with the appropriateness of management responses.

- Review and monitor the external auditor's independence and objectivity and the effectiveness of the audit process, taking into consideration relevant UK professional and regulatory requirements

- The Council of Governors should take the lead in agreeing with the Audit Committee the criteria for appointing, re-appointing and removing external auditors. To support them in the task, the Audit Committee should:

    - Provide information on the external auditor's performance, including details such as the quality and value of the work, the timeliness of reporting and fees;

    - Make recommendations to the Council of Governors in respect of the appointment, re-appointment and removal of an external auditor and related fees as applicable. To the extent that a recommendation is not adopted by the Council of Governors, this shall be included in the annual report, along with the reasons that the recommendation was not adopted.

- Ensure the Trust has effective arrangements for avoiding potential conflict of interest through the supply of non-audit services, by taking into account relevant ethical guidance regarding the provision of non-audit services by the external audit firm.

Other Assurance Functions

3.8 The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the Trust, and consider the implications to the governance of the Trust. These will include, but will not be limited to reviews and reports by, Department of Health, NHS England, CQC etc and professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies).

3.9 In addition, the Committee will review the work of other committees within the Trust that can provide relevant assurance to the Audit Committee's own scope of work. With regard to clinical governance and issues around clinical risk management, the Committee will wish to satisfy itself on the assurance that can be gained from the Trust's clinical audit system.

Counter Fraud and Whistleblowing

3.10 The Audit Committee will approve the appointment of the Local Counter Fraud Specialist and receive assurance that counter fraud polices are being developed within the Trust.

3.11 The Committee shall satisfy itself that the Trust has adequate arrangements in place countering fraud and shall review the outcomes of counter fraud work.

3.12 The Audit Committee shall review arrangements by which staff of the Trust and other individuals where relevant, may, in confidence, raise concerns about possible improprieties in matters of financial reporting or other matters.

Management

3.13 The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

3.14 The Committee may also request specific reports from individual functions within the Trust (e.g. clinical audit, information governance) as they may be appropriate to the overall arrangements.

Financial Reporting

3.15 The Audit Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance reviewing significant financial reporting judgements contained in them.

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

3.17 The Audit Committee shall review the Annual Report (including the Quality Account) and Annual Financial Statements before submission to the Board, focusing particularly on:

- the wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee;

- changes in, and compliance with, accounting policies and practices and estimation;
- unadjusted mis-statements in the financial statements;
- significant judgmental areas in the preparation of the financial statements;
- significant adjustments resulting from the audit;
- Letter of Representation, and
- Qualitative aspects of financial reporting.

4. MEMBERSHIP AND ATTENDANCE

4.1 The Committee will be appointed by the Board of Directors and shall comprise the following members:

- Chair – a Non-executive director who should have a financial qualification or recent and relevant financial experience (in the absence of the Chair another Non-executive director who is a member of the Committee will preside as chair).
- At least two other Non-executive directors.

4.2. **Attendees**

The following will be in attendance at each meeting:

- Director of Finance
- Director of Nursing and Governance
- A representative from Internal Audit
- A representative from External Audit
- Chief Executive as required. As a minimum this should be when the Committee considers the draft internal audit plan and the annual accounts and, at least annually, to discuss the process for assurance that supports the Annual Governance Statement.

4.3 All members are expected to attend a minimum of 75% of the meetings during the financial year and where they are unable to attend send a nominated deputy.

4.4 Other members of the Executive Team, Senior Management Team and or Professional Leads will be invited to attend by the Chair as appropriate to the Agenda.

4.5 **Quoracy**
The meeting will be deemed quorate if at least two members are in attendance.

5. RELATIONSHIP WITH THE BOARD OF DIRECTORS, COMMITTEES & OTHER GROUPS

5.1 The Committee Chair shall report in writing to the Board after each meeting through a Chair's assurance report which will incorporate matters for escalation to the Board where appropriate, or require executive action, a summary of the business transacted and the basis for any recommendations made.

5.2 The Committee will report to the Board annually on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the assurance framework, the completeness and embeddedness of risk management in the organisation, the integration of governance arrangements and the appropriateness of the self-assessment for the production of the Trust's Quality Account

5.3 The Audit Committee will report to the Council of Governors, where it has identified any matters which it considers that action or improvement is needed and make recommendations as to the steps to be taken.

6.0 PROCEDURAL ISSUES

6.1 **Frequency of meetings**
Meetings will be held at least four times a year, with additional meetings as required. Any member of the Committee, External Audit or Head of Internal Audit may request an extra ordinary meeting if they consider that one is necessary.

6.2 At least once a year the Committee will meet privately with the Internal and External Auditors.

6.4 **Minutes**
The minutes shall be formally recorded by the Corporate Secretariat, checked by the Chair and submitted for agreement at the next meeting.

6.5 **Annual Work Programme**
The Committee will agree an Annual Work Programme/Cycle of Business which will be reviewed at each meeting to ensure that the Committee is meeting its duties.

7. EQUALITY AND DIVERSITY

Ensure that equality and diversity and due consideration to the Human Rights Act are regarded in all aspects of the Audit Committee's work.

8. REVIEW

8.1 The Committee will evaluate its own membership and review the effectiveness and performance of the Committee on an annual basis. The Committee must review its terms of reference annually and make any changes to the Board of Directors for approval.

8.2 Compliance with the Terms of Reference will be monitored on an ongoing basis. In addition the Committee's effectiveness review will include a summary on compliance with the Terms of Reference.

BUSINESS PERFORMANCE COMMITTEE

Terms of Reference

1.0 CONSTIUTION

1.1 The WCFT's Business Performance Committee is constituted as a standing committee of the Board of Directors. Its constitution and terms of reference shall be as set out below, subject to any future amendment(s) by the Board of Directors.

1.2 The Business Performance Committee is authorised by the Board of Directors to act within its terms of reference. All members of staff are directed to co-operate with any request made by the Business Performance Committee.

1.3 The Business Performance Committee is authorised by the Board of Directors to instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its function.

1.4 The Business Performance Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

2.0 PURPOSE

2.1 The purpose of the Committee is to provide the Board with assurance that the trust's business, financial and workforce plans are viable and that risks have been identified and mitigated.

3.0 DUTIES AND RESPONSIBILITIES

3.1 The main functions of the Committee are to:
Inform the development and provide assurance against the following strategies, associated policies, action plans and annual reports:

- The Trusts Strategy 2018 – 2023
- People Strategy
- Finance and Procurement Strategy
- Financial Plan
- Long Term Financial Plan
- Digital Strategy
- Estate Strategy
- Transformation Strategy

3.2 Finance, Investment and Planning

a) Review the financial elements of the Trust's Operational Plan against the Long-Term Financial Plan and ensure that key assumptions are both realistic and deliverable (the Board of Directors will remain responsible for approval of the Operational Plan).

b) Monitor the financial performance of the Trust, the financial forecast and the key financial risks and mitigations or corrective plans

c) Monitor delivery of the Capital Expenditure Programmes and seek assurance on the preparation of comprehensive programmes for subsequent years.

d) Recommend the Capital Expenditure programme to the Board of Directors for approval and review Capital and Revenue investment proposals over £100k and less than £250k

e) Monitor delivery of the Cost Improvement Programme and seek assurance on the preparation of comprehensive programmes for subsequent years, recommend the Cost Improvement Programme to the Board of Directors for approval.

f) Review and assess the financial implications of performance against the Trust's principal contracts.

g) Review contract award proposals (in line with the Scheme of Delegation and Standing Financial Instructions) and make appropriate recommendations to the Board of Directors.

h) Review performance against CQUIN targets

i) Consider the financial impact of opportunities to grow new income streams and the market share of existing services.

j) Review the Digital and Information Management and Technology (IM&T) programme of work to ensure it aligns with the Trust's strategic plans and monitor progress on major schemes.

k) Review the Trust's Data Security and Protection arrangements and monitor the Trust's plans and Toolkit submission in relation to this.

l) Review the recommendations from any external reviews in relation to IM & T and monitor progress on major schemes.

3.3 Transformation and Efficiency

a) Review the process for developing the transformation programme and for the oversight and delivery of the programme within the Trust.

b) Consider and recommend any major transformation plans that the Trust should undertake.

3.4 Performance

a) Monitor the performance of clinical services in line with single oversight framework and contractual targets

b) Oversee the development and delivery of any corrective action plans and advise the Board of Directors accordingly

c) Review and support the development of appropriate performance measures, such as key performance indicators (KPIs), and associated reporting and escalation frameworks to inform the organisation and assure the Board of Directors.

3.5 Estates and facilities

a) Monitor the Trust's Sustainable Development Management Plan and ensure that the Trust meets its obligations under the Climate Change Act and that the Adaptation Reporting requirements are complied with.

3.5 Workforce

a) Seek assurance on the development and delivery of comprehensive workforce Plans

b) Monitor performance against key workforce indicators including sickness absence, appraisal review, mandatory training and turnover.

c) Monitor progress against equality and diversity goals arising from the Equality Delivery System, WRES, WDES, gender pay gap reporting and other regulatory requirements to ensure compliance with the Equality Act 2010.

d) Seek assurance that the essential standards of quality and safety in relation to staff (as determined by CQC's registration requirements) are being met by every service that the organisation delivers.

e) Ensure that there is a Training Needs Analysis process in place across the Trust and monitor its effectiveness.

f) Provide assurance to the Board on compliance with relevant HR legislation and best practice

g) Monitor any action plans relating to the staff survey and seek assurance that satisfaction levels are improving.

h) Monitor the implementation of the health and wellbeing programme, including the delivery of Occupational Health services.

3.5 Policies

To consider and approve relevant policies, procedures and guidelines in relation to workforce, finance, IM&T and estates and to escalate to the Trust Board, with an appropriate recommendation, any that may require approval at that level

3.6 Board Assurance Framework and Risk

Monitor the strategic risks within the Board Assurance Framework that are relevant to the Committee's remit, and provide assurance to the Board that such risks are being effectively controlled and managed.

3.7 Review operational risks with a score of 12 and above relevant to the Committee's remit.

4.0 MEMBERSHIP AND ATTENDANCE

4.1 The Committee will be appointed by the Board of Directors and shall comprise the following membership:

Voting members

- 3 Non-Executive Directors
- Director of Strategy and Operations
- Director of Finance and IT

4.2 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.

4.3 A Non-Executive Director will chair the Committee and in the event of a vote will have a second casting vote. Membership of the Committee will be disclosed in the annual report

Core attendees

4.4 The following non-voting members will be required to attend meetings of the committee:

- Director of Workforce and Innovation
- Deputy Director of Nursing and Governance
- Deputy Medical Director
- Deputy Director of Finance
- Divisional Director of Operations for Neurosurgery
- Divisional Director of Operations for Neurologyy
- Head of Commercial Engagement and Marketing

4.3 Members are expected to attend a minimum 75% of Committee meetings during each financial year.

4.4 In the event the Chair of the Committee is unable to attend a meeting, the Non-Executive Director members shall appoint one of their number to be Chair for that meeting

4.5 Other Officers of the Trust shall attend at the request of the Committee if it is considered appropriate due to the nature of the business being discussed.

4.6 Both voting and core members are expected to attend a minimum 75% of Committee meetings during each financial year.

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

4.8 **Quoracy**

The Committee will be deemed quorate provided 3 members are present including:

- At least two Non-Executive Directors
- At least one Executive Directors

5.0 RELATIONSHIP WITH THE BOARD OF DIRECTORS, COMMITTEES & MANAGEMENT GROUPS

5.1 The Committee will report in writing to the Board of Directors following each meeting and include a summary of the business that has been transacted and basis for any recommendations made.

5.2 The Chair of the Committee shall maintain an effective relationship with the Chair of the Audit Committee and may, from time to time, refer matters to the Audit Committee and / or other Board Committees as appropriate for consideration

5.4 The Committee has established the following management groups to support it in fulfilling its duties:

- Capital Management Group
- Digital Systems Programme Board
- Information Governance & Security Forum
- Local Negotiating Committee
- Staff Partnership Committee
- Medical Education Committee
- Resilience Planning Group
- Medical Devices, Estates and Facilities Group

The Committee will receive summary reports and consider the minutes following each meeting.

5.5 The Committee will approve the terms of reference and annual work programme of the above groups on an annual basis and keep their effectiveness under review.

6.0 PROCEDURAL ISSUES

6.1 **Frequency of meetings.**
The Committee will normally meet on a monthly basis and as a minimum ten times per year.

6.3 Additional meetings may be held on an exceptional basis at the request of the Chair or any three members of the Committee.

6.4 **Minutes.**
The minutes of meetings shall be formally recorded, checked by the Chair and submitted for agreement at the next meeting.

6.5 **Annual Work Programme**
The Committee will agree an Annual Work Programme/Cycle of Business, which will be reviewed at each meeting to ensure the Committee, is meeting its duties.

6.6 **Administration**
The Committee shall be supported administratively by the Corporate Secretariat, whose duties shall include: agreement of the agenda with the Chair and collation of papers; producing the minutes of the meeting for checking by the Chair, circulating draft minutes promptly to members once checked and advising the Committee on pertinent areas

7.0 EQUALITY ACT (2010)

7.1 The Committee will ensure the Trust meets its obligations under the Equality Act 2010 in relation to the remit of the Committee

8.0 REVIEW

8.1 The Committee will evaluate its own membership and review the effectiveness and performance of the Committee on an annual basis. The Committee must review its terms

of reference annually and recommend any changes to the Board of Directors for approval.

QUALITY COMMITTEE

Terms of Reference

1.0 CONSTITUTION

1.1 The Walton Centre Foundation Trust Quality Committee is constituted as a standing committee of the Board of Directors. Its constitution and terms of reference are set out below, subject to any future amendments by the Board of Directors
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1.2 The Quality Committee is authorised by the Board of Directors to act within its terms of reference. All members of staff are directed to cooperate with any request made by the Committee.

1.3 The Quality Committee is authorised by the Board of Directors to instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its function

1.4 The Quality Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

2.0 PURPOSE

2.1 The purpose of the Committee is to provide the Board with assurance there is a comprehensive and integrated approach to patient safety and quality throughout the organisation, that high standards of care are provided by the Trust and that risks to the safety of patient and staff, patient experience and clinical effectiveness have been identified and mitigated.

3.0 DUTIES AND RESPONSIBILITIES

3.1 The duties of the Committee can be categorised as follows:
To inform the development and provide assurance against the following strategies associated policies, action plans and annual reports:

- Quality Strategy
- Quality Account

3.2 To approve any clinical strategies underpinning the Quality Strategy such as Patient Experience, End of Life Care, Clinical Effectiveness and Audit.

3.3 Quality

a) To agree the Trust-wide clinical priorities and oversee the development and implementation of continuous improvements in the quality and outcomes of care for patients

b) Receive regular presentations defining “What Quality Looks Like to Me” at individual service level to enable the committee to understand operational challenges and opportunities to strengthen quality and share good practice

c) Oversee the Trusts arrangements for maintain compliance with the Care Quality Commissions essential standards and monitor any associated action plans

d) Monitor systems within the Trust for obtaining and maintaining any licences relevant to clinical activity in the Trust. For example registration with CQC, Human Tissue Authority, Radiation use and protection regulations (IR (ME) R and those associated with annual declarations of compliance

3.4 Safe

a) Monitor the Trust's arrangements for compliance with obligations for the protection of children and vulnerable adults (safeguarding); and the Trust's effective participation in partnership arrangements for these ends; (Mental Health Act 1983)

b) Monitor the Trust's systems in place to ensure compliance with statutory and regulatory requirements for infection prevention and control;

c) Monitor the Trust's arrangements to ensure compliance with statutory and regulatory requirements in relation to the Health and Safety of patients and staff (Health & Safety at Work Act 1974)

d) Receive and scrutinise annual reports in relation to the above prior to submission to the Board of Directors

e) Maintain oversight of the implementation of actions arising from internal or external reports, including inquiries and investigations that relate to services provided by the Trust

f) Monitor the arrangements for recognising, reporting and reviewing or investigating deaths where appropriate and ensure that lessons are learnt and implemented.

g) Ensuring the Trust acts on learning from HM Coroner's Inquests and specifically on Regulation 28 Reports

3.5 Effective

a) Monitor the Trust's arrangements for ensuring that care, treatment and support is delivered in line with legislation, standards and evidence based guidance, including NICE, GIRFT, radiation use and protection regulations (IR(ME)R) and other expert professional bodies, to achieve effective outcomes

b) Approve the annual Clinical Audit programme, and monitor progress on a regular basis providing assurance to the Audit Committee as necessary that the outputs and actions arising from clinical audit influence Trust wide quality improvements

3.6 Patient Experience

a) Monitor the Trust's arrangements for ensuring patients' views and feedback are captured and where relevant incorporated within service improvements.

b) Monitor and receive assurance on action plans and progress reports in response to serious incidents, near misses and other incidents and ensure that there are processes in place to enable lessons learnt to be cascaded and implemented

c) Monitor the effectiveness of the Trust's systems for complaints handling, and legal challenges ensuring that trends are identified, that the Trust takes appropriate action at the right time and that lessons are learnt and implemented.

d) Monitor levels of patient satisfaction via the 'Friends and Family' test and oversee the delivery of any associated action plans.

e) Consider the findings from national patient surveys and monitor the development of and implementation of appropriate action plans

f) Oversee the Trust's arrangements for maintaining compliance with the Equality Act 2010 requirements including:
    - Undertaking of Equality Impact Assessments
    - Monitoring of the Equality and Diversity Action Plan

3.7 Policies

To consider and approve relevant policies, procedures and guidelines in relation to Patient Safety, Patient Experience and Clinical Effectiveness and to escalate to the Trust Board, with an appropriate recommendation, any that may require approval at that level in line with the Scheme of Reservation and Delegation.

3.8 Board Assurance Framework and Risk

3.8.1 To monitor the strategic risks within the Board Assurance Framework that are relevant to the Committee's remit, and provide assurance to the Board that such risks are being effectively controlled and managed.

3.8.2 Review operational risks with a score of 12 and above relevant to the Committee's remit.

3.8.3 To ensure that any risks identified from quality impact assessments of cost improvement schemes or service changes are monitored appropriately

4.0 MEMBERSHIP AND ATTENDANCE

4.1 The Committee will be appointed by the Board of Directors and shall comprise the following membership:

Voting members

- 3 Non-Executives
- Director of Nursing & Governance
- Medical Director

4.2 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.

4.3 A Non-Executive Director will chair the Committee and in the event of a vote will have a second casting vote. Membership of the Committee will be disclosed in the annual report

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4.4 **Core members**

The following non-voting members will be required to attend meetings of the committee:

- Deputy Director of Nursing & Governance
- Director of Operations for Neurosurgery
- Director of Operations for Neurology

- Clinical Director Neurosurgery
- Clinical Director Neurology
- Divisional Nurse Director Neurology
- Divisional Nurse Director Neurosurgery
- Quality Manager / Speak up Guardian
- Head of Patient Experience
- Head of Risk
- Lead Nurse for Infection Control

4.5 Both voting and core members are expected to attend a minimum 75% of Committee meetings during each financial year.

4.6 In the event the Chair of the Committee is unable to attend a meeting, the Non-Executive Director members shall appoint one of their number to be Chair for that meeting.

4.7 Other Officers of the Trust shall attend at the request of the Committee if it is considered appropriate due to the nature of the business being discussed.

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

4.9 **Quoracy**
The Committee will be deemed quorate provided 3 members are present including:

- At least two Non-Executive Directors
- At least one Executive Directors

5.0 RELATIONSHIP WITH THE BOARD OF DIRECTORS, COMMITTEES & MANAGEMENT GROUPS

5.1 The Committee will report in writing to the Board of Directors following each meeting and include a summary of the business that has been transacted and basis for any recommendations made.

5.2 The Chair of the Committee shall maintain an effective relationship with the Chair of the Audit Committee and may, from time to time, refer matters to the Audit Committee and / or other Board Committees as appropriate for consideration

5.3 The Committee has established the following groups to support it in fulfilling its duties:

- Patient Safety Group
- Clinical Effectiveness and Services Group
- Safeguarding Group
- Health and Safety Group
- Patient Experience Group
- Infection Control Committee
- Quality Assurance Group
- Neurosurgery Divisional Governance Group
- Neurology Divisional Governance Group
- Corporate Division Governance Group
- Organ and Tissue Donation Committee

- Human Tissue Act Group

The Committee will receive summary reports and consider the minutes of the above groups following each meeting.

5.4 The Committee will approve the terms of reference and annual work programme of the above groups on an annual basis and keep their effectiveness under review.

6.0 PROCEDURAL ISSUES

6.1 **Frequency of meetings.** The Committee will meet at least 9 times per year.

6.2 Additional meetings may be held on an exceptional basis at the request of the Chair or any three members of the Committee.

6.4 **Minutes.**
The minutes of meetings shall be formally recorded, checked by the Chair and submitted for agreement at the next meeting.

6.5 **Annual Work Programme**
The Committee will agree an Annual Work Programme/Cycle of Business, which will be reviewed at each meeting to ensure the Committee, is meeting its duties.

6.6 **Administration**
The Committee shall be supported administratively by the Corporate Secretariat, whose duties shall include: agreement of the agenda with the Chair and collation of papers; producing the minutes of the meeting for checking by the Chair, circulating draft minutes promptly to members once checked and advising the Committee on pertinent areas

7.0 EQUALITY ACT (2010)

7.1 The Committee will ensure the Trust meets its obligations under the Equality Act 2010 in relation to the remit of the Committee

8.0 REVIEW

8.1 The Committee will evaluate its own membership and review the effectiveness and performance of the Committee on an annual basis. The Committee must review its terms of reference annually and recommend any changes to the Board of Directors for approval.

The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

FIT AND PROPER PERSON PROCEDURE

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Document Approval, History/Changes	See Appendices For further information contact the Governance Department on **Tel:** (0151) 529 5436	

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Executive Summary

The procedure outlines how the Trust will meet the requirements placed on NHS providers to meet the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulations 5: Fit and Proper Persons Requirement.

1. Introduction

1.1 The procedure outlines how the Trust will meet the requirements placed on NHS providers to meet the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulations 5: Fit and Proper Persons Requirement. The regulation sets out how to ensure that those individuals covered by the scope of the procedure are fit and proper to carry out their role.

1.2 The purpose of the Fit and Proper Persons Requirements (FPPR) is to ensure that NHS trusts are not managed or controlled by individuals who present an unacceptable risk either to the organisation or people receiving the service provided by the Trust. The regulation is about ensuring that directors are fit and proper to assume responsibility for the overall quality and safety of care delivered.

1.3 The aim of the process outlined in this document is to ensure that all members of the Board of Directors, the Executive Team and their direct reports, have been subject to the relevant Fit and Proper Persons Test on an annual basis.

2. Scope

2.1 The procedure applies to all Board appointments, both Executive and Non-executive Directors, Deputy Directors and Divisional Directors. This includes permanent and interim positions as well as acting up arrangements.

3. Definitions

3.1 Regulation 5 of The Health and Social Care Act 2008 (Regulated Activities) and Regulations 2014 (referred to as the 2014 Regulations) places a duty on NHS providers not to appoint a person or allow a person to continue to be, an Executive Director or equivalent or a Non-Executive Director under given circumstances. This means 'directors' should not be appointed / continue to hold office unless they meet the following criteria:

a) The Individual must be of good character

b) The individual must have the qualifications, competence, skills and experience which are necessary for the relevant office or position or the work for which they are employed

c) The individual must be able, by reason of health, after reasonable adjustments, to perform the tasks required

d) Must be able to supply information as set out in Schedule 3 of the 2014 Regulations when requested by the Care Quality Committee (see Appendix A).

3.2 When assessing a person being 'of good character' NHS providers are required to take account of Schedule 4 of the 2014 Regulations, namely:

a) Whether the person has been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence, and;

b) Whether the person has been erased, removed or struck off a register of professionals maintained by a regulator of health care or social work professionals.

3.3 The CQC's definition of good character is not the objective test of having no criminal convictions but instead rests upon a judgement as to whether the person's character is such that they can be relied upon to do the right thing under all circumstances. This implies discretion for Boards in reaching a decision and allows for the fact that people can and do change over time.

3.4. The regulations list categories of persons who are prevented from holding the office and for whom there is no discretion:

a) The person is an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged;

b) The person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland;

c) The person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986;

d) The person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it;

e) The person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland;

f) The person is prohibited from holding the relevant office or position, or in the case of an individual carrying on the regulated activity, by or under any enactment.

g) The person has been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity, or discharging any functions relating to any office or employment with a service provider.

4. Duties

4.1 The Chair has responsibility for:

a) Overseeing the outcome of Fit and Proper Person Tests where the individual is a Non-executive Director or a member of the Executive Team (i.e. the Chief Executive, Executive Directors, non-voting Directors who attend the Board;

If the outcome is the removal of a Non-executive Director, this will need to be referred to the Council of Governors.

b) With the support of the Corporate Secretary, undertaking investigations into any concerns raised about one of the above individuals, including where the individual has notified the Chair they may no longer comply with Fit and Proper Persons requirements.

4.2. The Senior Independent Director (a Non-executive Director) has responsibility for;

a) Overseeing the outcome of Fit and Proper Person Test for the Chair. If the outcome is the removal of the Chair, this will need to be referred to the Council of Governors;

b) With the support of the Corporate Secretary, undertaking investigations into any concerns raised about the Chair, including where the Chair has notified the Senior Independent Director they may no longer comply with Fit and Proper Persons requirements.

4.4 The Chief Executive has responsibility for:

a) Overseeing the outcome of Fit and Proper Person Tests where the individual is a Direct Report;

b) With the support of the Corporate Secretary, undertaking investigations into any concerns raised about one of the above individuals, including where the individual has notified the Chief Executive they may no longer comply with Fit and Proper Persons requirements.

4.5 The Director of Workforce and Innovation as the Lead Executive Director, has responsibility for:

a) Advising the Chair and Board of Directors on the process necessary to ensure the Trust has robust systems in place which comply with Regulation 5 of the 2014 Regulations (together with any guidance issued by the CQC);

b) Ensuring that any Fit and Proper Persons Tests undertaken comply with the process detailed in this policy, bringing non-compliance to the attention of the Chair, Senior Independent Director or Chief Executive (as relevant) and the Corporate Secretary.

4.6 The Human Resources Team has responsibility for:

a) Undertaking all recruitment checks for Executive Directors, Non-Executive Directors, Deputy Directors and Divisional Directors, including the pre-employment checks, and the checks under the regulations. These checks are undertaken for all permanent and interim positions as well as acting up arrangements;

b) Liaising with the recruiting manager and sending a copy of the following documents to the Corporate Secretary to retain:
- Fit and Proper Persons Requirement Personal Disclosure Form;
- Fit and Proper Person Test Checklist – New Applicants Check list;
- Signed and dates copies of documents to support the checks.

4.7 The Corporate Secretary has responsibility for:

a) Setting up files for all Executive, Non-Executive, Deputy Directors and Divisional Directors. The file will only contain copies of the recruitment documents as detailed in table 1;

b) Where an investigation is required, acting as the secretary to the chair of the investigation panel (i.e., the Chair, Senior Independent Director or Chief Executive as mandated in paragraphs 4.1 to 4.3 above) and appointing / liaising with legal advisors in respect of the advice for the chair of the panel, the arrangements for the panel to meet, the collation of any evidence requested and liaison with the individual under investigation).

4.8 Board of Directors / Direct Reports are responsible for:

a) Continuing to meet the requirements of being a Fit and Proper Person;

b) Immediately bringing to the attention of the relevant person (see below) any circumstances where they may not continue to meet the requirements of being a Fit and Proper Person:

i) If a Non-executive Director or a member of the Executive Team – to the Chair of the Trust;

ii) If the Chair – to the Senior Independent Director and the Chief Executive;

iii) If a Direct Report – to the Chief Executive and their line manager;

c) For maintaining their DBS checks and providing all information necessary to complete the Fit and Proper Persons Test, the annual signed update/DBS check to assist the Trust in undertaking an investigation (if required) in a timely manner.

5 New Appointments

5.1 Where a post is subject to the Fit and Proper Persons Test (as listed in paragraph 2.1) candidates will be notified as part of the Trust's normal recruitment processes. In addition to the other requirements of the NHS Safer Employment Check Standards and the Trust's Recruitment and Selection Policy and Procedure, candidates will be required to complete the Fit and Proper Persons Self Declaration Form (see Appendix A).

5.2 The Fit and Proper Persons Test for a new starter upon appointment will comprise of the following (including checking their Declaration Form against the information reviewed below):

Table 1 - Fit and Proper Persons Test for a New Starter

Element to test	Process
Good character	Pre-Employment checks – see Recruitment Policy and supporting procedures (e.g. references, identify checks, right to work, qualification checked)
Physically and mental fit	Occupational health screening process - see Occupational Health Procedure
Necessary qualifications	Certificates and professional registration checks - see Recruitment and Selection Policy and supporting procedures Self-declaration – see Appendix A
Skills and experience	Interview / assessment centre - see Recruitment Policy and supporting procedures Self-declaration – see Appendix A Criminal convictions Disclosure and Barring Service
Full employment history	Application form / CV - see Recruitment Policy and supporting procedures
Bankruptcy / insolvency	HR searches of relevant insolvency and bankruptcy register - see Recruitment Policy and supporting procedures Self-declaration – see Appendix A
Investigations / struck off / Barring Lists	HR searches of relevant professional registers and Companies House - see Recruitment Policy and supporting procedures Self-declaration – see Appendix A
Fitness to practice (including safeguarding / misconduct / mismanagement)	Professional registration - see Recruitment Policy Verification of Statutory Registration of Temporary and Permanent Colleagues Procedure Self-declaration – see Appendix A

Element to test	Process
Eligibility to hold office	HR searches of disqualified director register Self-declaration – see Appendix A

5.3 If a person meets the Fit and Proper Persons Test, then along with the satisfactory completion of the other required pre-employment checks, an offer of employment may be confirmed. If it is unlikely the person will meet the Fit and Proper Person Tests, please refer to section 6.3 below.

5.4 The Chair of the appointments panel will be responsible for ensuring compliance to the regulations and will sign off a checklist confirming the post holder meets the requirements. The checklist (Appendix B) will be retained on the post holder's personal file. For non-Board members (i.e. Deputy Director and those with 'Director' in their job title and who report to an Executive Director) covered by this policy, it will be the responsibility of HR to ensure that the appropriate checks are undertaken and that a completed checklist (Appendix B) is retained on the individual's personal file.

5.5 The HR Services Administrator will ensure that the Fit and Proper Person Test Checklist – New Applicants Check list (Appendix B) is completed. Once the recruitment checks have been completed, the Chair of the appointment panel will be asked to sign the checklist to confirm that they are satisfied that the checks meet the requirements. Following this, hard copies of the recruitment documents and the checklist will be given to the Chair to review and with a request to sign off confirming assurance that the checks are complete. All documentation will be handed to the Corporate Secretary Governance Team to retain place on the personal file.

5.6 Electronic copies of the checks will also be retained on the Trust's electronic personal files. This will ensure that a soft copy of the information is retained in the case of the files held at headquarters being destroyed e.g. through a fire or flood.

6 Formal Confirmation of Appointments

6.1 All appointments (excluding Non-executive appointments) including interim appointments, will be required to be approved by the Remuneration Committee in line with the Trust's scheme of delegation. All decisions on appointments will need to take account of the Trust's obligations under the regulations. The decision must be formally recorded in the minutes taken at the meeting.

6.2 Where the Trust deems that an applicant can be appointed, despite not meeting the characteristics outlined in Schedule 4, Part 2 of the Regulations (Good character), the reasons will be recorded in the minutes of the relevant meeting such as the Remuneration Committee.

6.3 Where the Trust considers that an individual can be appointed to a role based on their qualifications, skills and experience with the expectation that they will develop specific competence(s) to undertake the role within a specified timescale, any such discussions or recommendations will be recorded in the minutes of the Remuneration Committee. The expected competencies and the timescales for achievement will be agreed by the Committee and communicated to the individual. The Committee will then monitor progress at agreed intervals.

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

7 Annual Review and Ongoing Fitness

7.1 The Trust is responsible for ensuring the continued 'fitness' of those persons to whom the Fit and Proper Persons Test applies (as listed in paragraph 2.1). The Trust shall discharge this responsibility through an annual review process comprising of the following;

a) Completion of the Fit and Proper Persons Self Declaration Form annually by the persons covered by this policy ;

b) The HR Team undertaking annual checks against the relevant insolvency, bankruptcy and disqualified directors registers by the end of March each year;

c) The annual signed update/DBS check;

d) The formal annual appraisal process by the relevant line manager.

7.2 All individuals covered by the regulations are required to highlight to the Trust as soon as possible any reasons or changes in their circumstances that may mean they no longer meet the regulations. This requirement is also detailed in the contract of employment for the posts covered by the Regulations.

7.3 Where concerns are raised relating to an individual being fit and proper to carry out their role, the Chair will address this in the most appropriate, relevant and proportionate way on a case by case basis. Where it is necessary to investigate or take action, the appropriate HR policies and procedures will be utilised. For Non-executive Directors, the Council of Governors Remuneration and Nomination Committee will be notified.

7.4 Where an individual who is registered with a professional regulator (HCPC, GMC etc.) no longer meets the fit and proper person's requirement, the Trust must inform the regulator, and also take action to ensure the position is held by a person meeting the requirements. Directors may personally be accused and found guilty by a court of serious misconduct in respect of a range of already prescribed behaviours set out in legislation. Professional regulators may remove an individual from a register for breaches of codes of conduct.

7.5 The Director of Workforce and Innovation will ensure compliance through an annual audit of files and this will take place during Q4 of each year. The HR team will undertake the audit and report the findings to the Director of Workforce and Innovation and the Corporate Secretary for consideration.

7.6 Once the audit has been finalised, the Chair will make an annual statement of compliance on the Fit and Proper Persons Regulations in Q1 to the Board and Council of Governors.

8 Managing an Unfit Outcome - Failure to Confirm the Appointment

8.1 If during pre-employment screening it emerges that the individual appears unlikely to meet the requirements of the Fit and Proper Person Test, then consideration should be given to withdrawing the appointment / offer of employment. The Director of Workforce and Innovation, in conjunction with the recruiting manager and with the support of their team, in line with the legislation, CQC guidance and Trust policy, may consider if requests from the individual for further information may be necessary so as to make a fully informed decision.

8.2 However if the individual fails to meet the Fit and Proper Persons Test requirements, the offer for appointment / employment should be withdrawn.

9 Managing an Unfit Outcome – Annual Review Process

9.1 If during the annual review process aspects have not been completed or it has been found that the Trust had not complied with this policy, consideration should be given – based upon a risk assessment – as to whether or not the individual should be suspended and / or subject to any form of disciplinary action. For example, delays may occur in processing a DBS check which are beyond their control or paperwork has not been received by the HR Team in the requested timescales to triangulate aspects of the checks undertaken.

9.2 In these circumstances, the Director of Workforce and Innovation will bring this matter to the attention of the Chair, Senior Independent Director or Chief Executive (as relevant) and the Trust Corporate Secretary. The Director of Workforce and Innovation will then agree the necessary actions with the Chair, Senior Independent Director or Chief Executive (as relevant), which will then be communicated to the individual concerned and the Trust Corporate Secretary. The matter and outcome should also be reported to the Audit Committee by the Director of Workforce and Innovation and will also need to be reported as part of the annual report to the Board of Directors and / or the Council of Governors.

10 Monitoring

10.1 As can be seen from section 7 above, the Fit and Proper Persons status of the Board of Directors, the Executive Team and their Direct Reports is subject to review on appointment and on an annual and ongoing basis. The outcome of these reviews will be subject to:

a) In respect of the Chair and the Non-executive Directors, an annual report to the Council of Governors;

b) In respect of the Board of Directors, the Executive Team and their Direct Reports, an annual report to the Board of Directors; and

c) Where issues of concern are raised, an ad hoc report to either the Council of Governors or the Board of Directors (as appropriate) on the outcome of the review into the concern that had been raised.

10.2 Where necessary, reports on non-compliance with this policy will be taken to next Audit Committee.

Appendix A - Fit and Proper Person Declaration

In line with the requirements of (i) Regulation 5 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. I hereby declare:

Declaration	**Confirmed (Yes / No)**
I am of good character by virtue of the following:-	
• I have not been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence.	
• I have not been erased, removed or struck-off a register of professionals maintained by a regulator of health or social care.	
• I have not been sentenced to imprisonment for three months or more within the last five years.	
• I am not an undischarged bankrupt.	
• I am not the subject of a bankruptcy order or an interim bankruptcy order.	
• I do not have an undischarged arrangement with creditors.	
• I am not included on any barring list preventing me from working with children or vulnerable adults.	
I have the qualifications, skills and experience necessary for the position I hold on the Board.	
I am capable of undertaking the relevant position, after any reasonable adjustments under the Equality Act 2010.	
I have not been responsible for any misconduct or mismanagement in the course of any employment with a CQC registered provider.	
I am not prohibited from holding the relevant position under any other law e.g. under the Companies Act or the Charities Act.	

Signed:		Name:
Position:		Date:

Please answer **all of the above questions on this form**. If you answer 'yes' to any of the questions, please provide full details in the space below to provide any other information that may have a bearing on your suitability for the position for which you are applying. You may continue on a separate sheet if necessary, and you may attach supplementary comments should you wish to do so.

Appendix B - Fit and Proper Person Requirement Checklist – New Applicants Check list

First Name	
Surname	
Position Applied for	
Start date in post	

Identification Checks	**Received Y/N**	**Comments**
Verification of ID as per the right to work checklist NHS employment standards		
Confirmation of any restrictions on right to work in UK – *if applicable* Verification of Identification and Right to Work		
Confirm documents seen and that copies have been taken and Verified Please list documents seen:		
Employment history		
Confirmation of a full employment history, including a written explanation regarding any gaps in employment		
Two employment references (including one from most recent employer)		
Qualification checks		
Original certificates seen, copied and verified for mandatory qualifications Please list documents seen:		
Criminal Records Checks		
Is a DBS form applicable to the post?		
Standard *Date received*		
Enhanced *Date received*		
Professional registration		
Professional Body: Evidence of professional registration register checked		

Date checked		
Occupational Health check		
Confirmation that Occupational Health checks has been completed *Date received*		
Fit and Proper Persons Checks		
Declaration form fully completed and received *Date received*		
Confirmation that any areas of concern have been discussed with Chair		
Search of insolvency and bankruptcy register https://www.gov.uk/search-bankruptcy-insolvency-register Copy of web search results attached *Date accessed*		
Search of disqualified directors register https://www.insolvencydirect.bis.gov.uk/IESdatabase/viewdirectorsummary-new.asp Copy of web search results attached *Date accessed*		
Confirmation of checks		
Representative from HR Team: Name: Signature Date		
Chair of appointments panel; Name Signature Date		
Signature of Chair of the Trust: Name Signature		

Appendix C – CQC Regulations

1. The CQC has the right to require the provision of information set out in Schedule 3 of the 2014 Regulations and such other information as is kept by the organisation that is relevant to the individual as follows:

a) Proof of identity including a recent photograph

b) Where required for the purposes of an exempted question in accordance with section 113A(2)(b) of the Police Act 1997(38), a copy of a criminal record certificate issued under section 113A of that Act together with, after the appointed day and where applicable, the information mentioned in section 30A(3) of the Safeguarding Vulnerable Groups Act 2006 (provision of barring information on request)(39);

c) Where required for the purposes of an exempted question asked for a prescribed purpose under section 113B(2)(b) of the Police Act 1997, a copy of an enhanced criminal record certificate issued under section 113B of that Act together with, where applicable, suitability information relating to children or vulnerable adults;

d) Satisfactory evidence of conduct in previous employment concerned with the provision of services relating to:
    i. health or social care, or,
    ii. children or vulnerable adults;

e) Where a person (P) has been previously employed in a position whose duties involved work with children or vulnerable adults, satisfactory verification, so far as reasonably practicable, of the reason why P's employment in that position ended;

f) In so far as it is reasonably practicable to obtain, satisfactory documentary evidence of any qualification relevant to the duties for which the person is employed or appointed to perform;

g) A full employment history, together with a satisfactory written explanation of any gaps in employment;

h) Satisfactory information about any physical or mental health conditions which are relevant to the person's capability, after reasonable adjustments are made, to properly perform tasks which are intrinsic to their employment or appointment for the purposes of the regulated activity;

i) For the purposes of this Schedule:

    i. The appointed day' means the day on which section 30A of the Safeguarding Vulnerable Groups Act 2006 comes into force;
    ii. 'Satisfactory' means satisfactory in the opinion of the CQC;
    iii. Suitability information relating to children or vulnerable adults' means the information specified in sections 113BA and 113BB respectively of the Police Act 1997.

Appendix D - Version Control

Version	Section/Para/ Appendix	Version/description of amendments	Date	Author/Amended by
1.0	Whole Procedure	Initial draft of the procedure following in line with CQC recommendations	29.10.2019	J Hindle

Translation Service

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Gellir gofyn am gael cyfieithiad o'r deunydd hwn neu gellir trefnu cyfieithydd ar y pryd os yw hynny'n well gennych. I wybod rhagor am y gwasanaethau hyn cysylltwch â chanolfan Walton ar 0151 525 3611.

هذه المعلومات يمكن أن تُتَرْجَم عند الطلب أو إذا فضّل المترجم يمكن أن يُرَتَّب للمعلومة الإضافيّة بخصوص هذه الخدمات من فضلك اتّصل بالمركز ولتون على 0151 5253611

ئەم زانیاریە دەکرێت وەربگێڕدرێت کاتێك کە داواکرێت یان ئەگەر بەباش زاندرا دەکرێت وەرگێڕێك ئامادە بکرێت (ڕێك بخرێت) ، بۆ زانیاری زیاتر دەربارەی ئەم خزمەتگوزاریانە تکایە پەیوەندی بکە بە Walton Centre بە ژمارە تەلەفۆنی ١٥١٥٢٥٣٦١١ .

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The Walton Centre NHS Foundation Trust

REPORT TO THE TRUST BOARD
Date 28TH November 2019

Title	**Board Assurance Framework**
Sponsoring Director	Name: Lisa Salter Title: Director of Nursing and Governance
Author (s)	Name: Jane Hindle Title: Corporate Secretary
Previously considered by:	Quality Committee October 2019 Audit Committee October 2019 Business Performance Committee 2019

Executive Summary

The purpose of the paper is present the Board with the current Board Assurance Framework (BAF) and the position of risks at the end of October 2019.

New Risks
The BAF includes a new risk **ID 0041** in relation to Cyber Security as requested by the Board.

Risks for removal

Risk 0025
Compromising patient safety due to failure to prevent infection and breaching the annual NHS Improvement threshold for C-Difficile
This risk has achieved its target score and will now be monitored via the Infection Control Group.

Related Trust Ambitions	Delete as appropriate: • Best practice care • More services closer to patients' homes • Be financially strong • Research, education and innovation • Advanced technology and treatments • Be recognised as excellent in all we do
Risks associated with this paper	Not applicable
Related Assurance Framework entries	
Equality Impact Assessment completed	Not applicable
Any associated legal implications / regulatory requirements?	
Action required by the Board	The Board is requested to: a) approve the changes to the Board Assurance Framework b) discuss the new strategic risk in relation to cyber security for inclusion within the BAF

1.0 Introduction

1.1 The purpose of the paper is present the Board with the current Board Assurance Framework (BAF) and the position of risks at the end of October 2019.

2.0 Background

2.1 Board Assurance Framework is the key document that identifies the threats that could prevent the Trust from delivering its strategy. It brings together information from a number of sources including, the Board and its sub-committees and the internal/external auditors to provide evidence of delivery of the overarching strategy.

2.2 It provides direction to the Board's governance and assurance agendas and should also form the basis for the internal audit programme as it identifies the key controls in place to prevent and manage the strategic risks.

2.3 The Executive Directors have been consulted individually on the content and the details have been updated to reflect the changes.

2.4 The relevant committees have also reviewed the BAF and provided challenged to the proposed changes.

2.5 In order to identify strategic risks the Executive Team routinely advise the Board on the known external factors that may present threats or opportunities to the organisation. This horizon scanning combined with the internal knowledge of the operational forms the basis for the risk contained within the current BAF. The detail of all risks is shown at appendix A and key changes are highlighted in blue text.

3.0 Key Changes in the reporting period

3.1 New Risks

Since the last report to Board the following risks have been added to the BAF.

a) Risk ID 0041 Cyber Security: Current Score= 16
If methods of cyber-crime continue to evolve the Trust may receive a cyber-attack leading to service disruption, loss of data and financial penalties.

The following risk has been discussed at Quality Committee and will be further developed for inclusion within the next iteration of the BAF.

b) Risk ID 42 – Quality:
If the Trust does not deliver the benefits identified within the Quality Strategy, then patient and family centred care will not be sustained leading to poor patient experience and reputational damage

The key controls for this risk are the workstreams identified within the Quality Strategy e.g Infection Prevention Control, Patient & Family Experience, Training and Development, Technology etc and assurances will be provided to the Committee via the update reports.

3.2 Risks for removal

The following risks are proposed for removal from the BAF:

a) **Risk 0025 /Current score reduced to 9**
Compromising patient safety due to failure to prevent infection and breaching the annual

NHS Improvement threshold for C-Difficile

There is on-gong evidence that through the application of the controls the likelihood of the risk occurring has reduced to 3 and therefore the risk has achieved its target score. On-going monitoring will continue via the Infection Control Committee which reports by exception to Quality Committee

3.3 Changes in risk score during the reporting period

The following risks have reduced in score:

a) Risk ID 0031
Risk of breaching the NSHI Agency Cap
The year to date figure has shown that the controls are having a positive effect and therefore the score has reduced to 12.

b) Risk ID0037
Potential impact on business continuity due to an aging estate

The six facet survey completed in July 2019 has provided clarity on the severity of this risk and the score has reduced to 12.

c) Risk ID0 Data Quality
Lack of assurance on quality of data provided by the Informatics Department
The Data Quality action plan reviewed by the Business Performance Committee in Sept is nearly complete and there is evidence that internal timescales for the provision of data have been met. On this basis the score has reduced to 12.

4.0 Review of the BAF

4.1 In reviewing the BAF the Board is asked to focus on the gaps in controls and assurance and consider the following:

- Have all strategic risks been identified/captured?
- Are the controls in place current and sufficient to manage the risks?
- Is there sufficient assurance regarding the operation of the controls identified?
- Are there any concerns in respect of the assurances given?
- Is the progress on action plans sufficient to address gaps in controls and assurance?

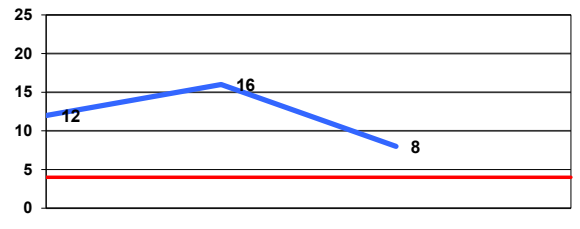
5.0 Recommendations

5.0 The Board is requested to:

a) approve the changes to the Board Assurance Framework
b) discuss the new strategic risk in relation to cyber security for inclusion within the BAF

Risk 024	Date risk identified October 2019	Date of last review:	Sept 2019
Risk Title: **Failure to see and treat patients in a timely manner**		Date of next review:	November 2019
		CQC Regulation:	Regulation 16- Assessing and monitoring Service Provision
		Ambition:	1 Deliver Best Practice in care and treatments
		Assurance Committee:	Business Performance Committee
		Lead Executive:	Director of Strategy and Operations

Risk Journey (Likelihood x Consequence)



Risk Appetite	Cautious

	Consequence	Likelihood	Rating
	Moderate	Likely	
Initial	4	4	16
	Major	Likely	
Current	4	4	16
	Major	Unlikely	
Target	4	2	8

Key Impact or Consequence	Performance: *What evidence do we have of the risk occurring i.e. likelihood?*
• Patients will wait longer for 1st and follow up appointments – which could result in harm. • Referral to treatment standard (RTT) will not be met. • Cancer standards will not be met. • Diagnostic standards will not be met.	Compliance for 'other' (Pain) Specialty below 92% standard Reliance on validation to continuing to meet RTT Overdue Follow up waiting list in Neurology 13,779 @ Aug 19. Capacity and demand modelling equates to a gap in capacity – Reduction in uptake of Waiting List initiatives (WLI).

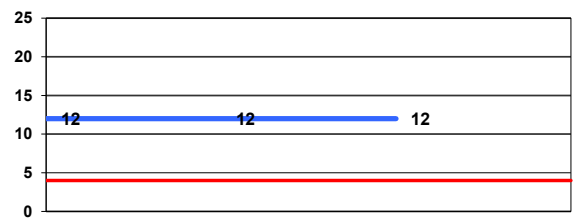
Key Controls or Mitigation: What are we currently doing to control the risks? Provide the date e.g. when the policy/procedure was last updated	Key Gaps in Control: Where we are failing to put controls/systems in place?
1. Operational Plan 209-20 Approved March 2019 2. Waiting list initiatives and overtime offered weekly to increase capacity and mitigate staff shortage to meet the demand of RTT targets - Implemented and ongoing 3. Demand management across all specialties and all activity gaps at point of delivery 2015 4. "New satellite Clinic at Aintree to provide T&E to Musculoskeletal Clinical Assessment Service and ensure only appropriate onward referrals" Jan-19 4. Workforce Plan 2018-2019 5. Job Planning for consultants Ongoing for 2019-20	1. Significant service provision changes impacting on demand not within our control and so lack of ability to plan 2. Nurse Staffing: to open bed capacity to deliver growth and respond to demand 3. Sustainability of WLI in pain and Neurosurgery 4. Business intelligence capacity to divisions to assist robust demand Management 5. Large overdue follow ups in Neurology 6. Reliance on WLI's to achieve performance 7. Participating in field testing of average wait vs 18 wks for RTT

Assurances: What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?	**Gaps in Assurance**: Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?
Level 1 Weekly monitoring of performance of RTT Performance Management Review Meetings – monthly **Level 2** Integrated Performance Report – reviewed by BPC monthly Operational Deep Dives via BPC - monthly Integrated Performance Report – review by Trust Board each meeting **Level 3** Meetings with Commissioners – bi-monthly	1. Visibility and accessibility of Information 2. Weekly RTT trend analysis

Corrective Actions: To address gaps in control and gaps in assurance		Action Owner	Forecast Completion Date	Action Status
1	Service Improvement focus agreed to cover flow and theatres and outpatient productivity	DoSO	March 2020	On track
2	Offer an Implement TOIL for consultants for the remainder of 2019	DoW	March 2020	On track
3	Full review of overdue follow ups and output reported to BPC	DoSO	Nov 2019	On track
4	Ongoing testing re average waits and discussion with NHSI.	DoSO		On track
5	Continued Job Planning for consultants for 2019-20	DoSO	End of Mar 2020	On track

Risk ID: 0030	Date risk identified May 2018	Date of last review:	Sept 2019
Risk Title: Failure to deliver the Trust Digital Strategy and business given the level of work required within the current resources and loss of experienced members of staff		Date of next review:	November 2019
		CQC Regulation:	Regulation 17 Good Governance
		Ambition:5	Adapt advanced technology and treatments enabling our teams to deliver excellent patient and family centered care.
		Assurance Committee:	Business Performance Committee
		Lead Executive:	Director of Finance and IT

Risk Journey (Likelihood x Consequence)



	Consequence	Likelihood	Rating
	Major	Possible	
Initial	4	3	12
	Major	Possible	
Current	4	3	12
	Minor	Unlikely	
Target	2	2	4

Risk Appetite — **Moderate**

Key Impact or Consequence	Performance: *What evidence do we have of the risk occurring i.e. likelihood?*
Impact on the delivery of key hospital services; Loss of clinical buy in for Digital Developments by key staff members. This will make progress difficult; - Scarcity of staff in IT, software development, SQL and business intelligence; - Potential cyber-security issues	Most NM trusts have / are purchasing 'off the shelf' solutions to EPR which leaves the Trust as an outlier in terms of its plan.

Key Controls or Mitigation: What are we currently doing to control the risks? Provide the date e.g. when the policy/procedure was last updated	Key Gaps in Control: Where we are failing to put controls/systems in place?
1. Trust has developed several operational digital groups regarding prioritisation of digital developments by area. 2. Good engagement around training on new system developments e.g. Order Comms 3. The Trust is developing with a key priority being interoperability with external partners which is key given the direction of travel in terms of collaboration across integrated health care and the wider health care partnership (STP) aspirations etc. 4. Digital developments are all 'wiki'd' so that system developments are recorded and we are not reliant on key individuals which would leave the Trust vulnerable to staff turnover. 5. Independent review of previous digital strategy carried out in 2018/19 by NHS Digital. Feedback to be used in development of strategy update 6. Member of North Mersey / C&M H&C Partnership 7. Collaboration with other Specialist Trusts regarding IT/Digital to review opportunities to work together / standardise approaches. 8. System development not overly complex so that new staff are able to understand and build on current infrastructure	1. Given linkage with Aintree University Hospitals the Trust will need to be able to integrate with the Aintree / Royal EPR Intersystems for services such as EPMA or ensure it has independent structures e.g. EPMA / Pharmacy. 2. Data Warehouse requirements / PAS replacement 3. Difficulties in recruiting due to source skills shortage in area

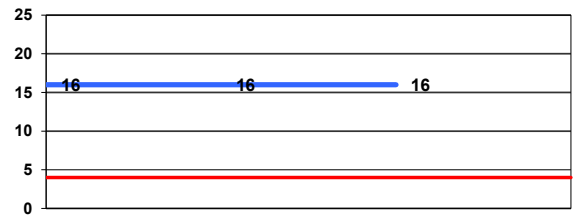
Assurances: What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?	Gaps in Assurance: Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?
Level 1 Digital Programme Board chaired by MD Care Cert Dashboard reviewed by SIRO **Level 2** Quarterly updates on digital strategy progress **Level 3** Digital Matrix Index score Cyber security CertCare progress Independent review of Digital Strategy by NHS Digital 2018/19 Acceptance of approach and contribution to STP by DigitALL	1. Directions of C&M Health and Social Care Digital Strategy may be different to Trust's internal digital strategy

	Corrective Actions: To address gaps in control and gaps in assurance	Action Owner	Forecast Completion Date	Action Status
1	Review of management arrangements for Corporate Information/Digital Intelligence. Corporate information is now being managed via the Deputy Director of Finance to ensure it aligns with the finance timetable and has the appropriate quality assurance undertaken for the	MB	Nov 2018	Complete

	work produced.			
2	Recruitment to new Head of Corporate Information, Business Intelligence and Performance will enable better collaboration between IT and Corporate Information around developments.	MB	Nov 2018	Complete

Risk ID:	Date risk identified Sept 2018	Date of last review:	September 2019
Risk Title: Lack of assurance on quality of data provided by the Informatics Department and, at times, difficulty in meeting deadlines. There is also a risk around the level of experience of senior managers within the department which further impacts on the ability to provide high quality and timely information.		Date of next review:	November 2019
		CQC Regulation:	Regulation 17 Good Governance
		Ambition:	5 Adapt advanced technology and treatments
		Assurance Committee:	Quality Committee
		Lead Executive:	Director of Nursing and Governance

Risk Journey (Likelihood x Consequence)



Risk Appetite: **Cautious**

	Consequence	Likelihood	Rating
Initial	Major: 4	Possible: 3	12
Current	Major: 4	Likely: 2	8
Target	Moderate: 2	Possible: 2	4

Key Impact or Consequence	Performance: *What evidence do we have of the risk occurring i.e. likelihood?*
- impact on mandatory and regulatory performance returns that have to be submitted - (additional workload for operational and management staff - adversely impact on Trusts income - reputational damage with Commissioners	It is recognised that the Trust has an under developed business intelligence function compared to other organisations and In terms of Digital Intelligence it is acknowledged that the Trust has come late into this area.

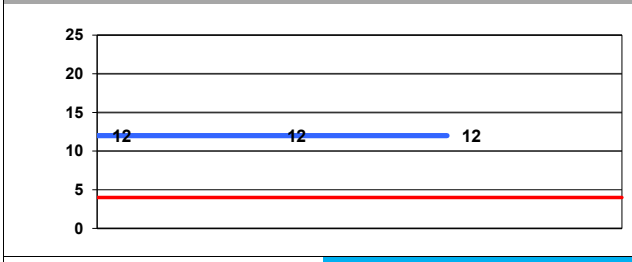
Key Controls or Mitigation: What are we currently doing to control the risks? Provide the date e.g. when the policy/procedure was last updated	Key Gaps in Control: Where we are failing to put controls/systems in place or where are we failing to make them effective?
1. Action Plan developed following independent, external review - approved by Trust Board 2. Team reporting line now moved to the Deputy Director of Finance to ensure that it aligns with the finance timetable and has the appropriate quality assurance undertaken for the work produced. Completed 3. 2 members of staff who used to work for the Trust have returned to the organisation which provides experience and knowledge around systems and processes and Corporate Informatics function. Completed 4. Monthly meetings with divisions held to understand key issues Outstanding - .Ongoing 5. Monthly timetable for production of Integrated Performance Report including meetings between Informatics, Finance, HR and Divisions to validate information. 6 Working closely with other organisations (e.g. other provider organisations and NHSE) to learn from their experiences and find areas of good practice as well as trying to resolve some longstanding issues with information submissions (SUS). Ongoing 7. Mapping' of patient coding from PAS to contract monitoring report and SUS submission to understand all adjustments made to data and as such where improvements can be made. Completed	1. The age of several informatics systems means that production of information can be more problematic and support available for the systems is limited. 2. Relative inexperience of the Corporate Information team. 3. Lack of Data Quality Policy/Strategy identifying a consistent approach to coding/validation

Assurances: What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?	**Gaps in Assurance**: Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?
Level 1 Data Quality Group monitoring or action plan IGSF review of Data Quality Group **Level 2** Monitoring of Data Quality Action Plan via BPC **Level 3** External Review of Data Quality – Sept 2018	

Corrective Actions: To address gaps in control and gaps in assurance		Action Owner	Forecast Completion Date	Action Status
1	Continued progress on Data Quality Action Plan and report updates to BPC	MB	Ongoing	On track
2	Close working with other organisations to learn from their experience and identify areas of best practice	MB	Ongoing	On track
4	Development of a Coding SOP to ensure clarity of escalation process for coders	MB	Dec 2019	On track

Risk ID: 0035	Date risk identified June 2018	Date of last review:	Sept 2019
Risk Title: **A risk of not having the required staffing resource to deliver the services the Trust is commissioned to provide**		Date of next review:	November 2019
		CQC Regulation:	Regulation 18 Staffing
		Ambition:	3 – Financially Strong
		Assurance Committee:	Business Performance Committee
		Lead Executive:	Director of Workforce

Risk Journey (Likelihood x Consequence)



	Consequence	Likelihood	Rating
	Moderate	Likely	
Initial	4	4	16
	Major		
Current	4	3	12
	Moderate	Possible	
Target	4	3	12

Risk Appetite	Cautious

Key Impact or Consequence	Performance: *What evidence do we have of the risk occurring i.e. likelihood?*
"- Patient safety - Business continuity - Compromised quality of care/ - Poor patient experience" - Reputational damage - Inadequate staff experience - Sickness increases - Staff Turnover increases"	The labour market for health care is at the point of full employment with significant skill shortages across a number of professions. This risk reflects the fact that there is a strong likelihood of a pressure in staffing numbers but it is not possible to identify the individual service or profession affected.

Key Controls or Mitigation: What are we currently doing to control the risks? Provide the date e.g. when the policy/procedure was last updated	Key Gaps in Control: Where we are failing to put controls/systems in place?
1. Annual Operational Plan and workforce plan - March 2019 2. Annual succession planning 2019 3. Five year education plan to ensure supply 2017 4. Quality Strategy Sept 2019 5. People Strategy Sept 19 6. Staff Experience Action Plan Aug 19 7. Escalation SOP 2015 8. Joint Nursing and HR initiative on Nursing turnover levels including regional best practice Jul-19 9. Partnership working with universities to recruit newly qualified staff 10. Extension of apprentice roles July 2019 11. Involvement with Regional Talent Management Board 12. Health and Wellbeing Programme 13. NHSP Bank 14. Collaborative Bank within NWest	1 Implications of Brexit i.e. Visas 2 National nursing workforce 3 Changes to pension arrangements and implications for recruitment and retention.

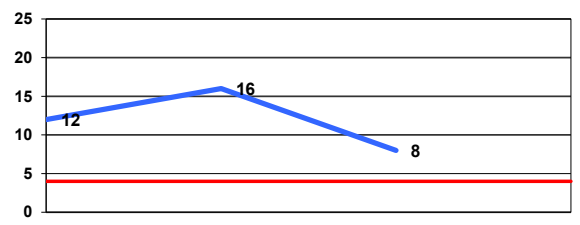
Assurances: What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?	**Gaps in Assurance**: Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?
Level 1 Vacancy monitoring – weekly Daily escalation undertaken and all outcomes are reported to Senior Nursing Team. Review of ward staffing pressures by ward manager and DDON - monthly **Level 2** Staff Listening Events – quarterly Actual and Planned staff via IPR t – monthly review by Business Performance Committee Integrated Performance Report – review by Trust Board each meeting Review of sickness absence management to BPC – Sept 2019 **Level 3** Internal Audit review of Sickness Absence Management - Jan 2019 Limited Assurance	1. Outcome of Shiny Minds App to be evaluated

Corrective Actions: To address gaps in control and gaps in assurance		**Action Owner**	**Forecast Completion Date**	**Action Status**
1	Outcome of Brexit and implications for recruitment and retention not fully understood. Ongoing involvement and discussion with NHS Employers, NW Staff Partnership Forums and Brexit	DoW	Ongoing Mar 2020	On track

	Council for Liverpool.			
2	Continued progress to develop a C&M Nursing Workforce and progress recommendations	DoW	End of March 2020	On track
3	Ongoing involvement with C&M Nursing Workforce Planning Initiative to progress recommendations	DoW	End of Dec 2019	On track
4	Implementation of time limited arrangements to bridge through to the end of the financial year e.g TOIL	DoW	End of March 2020	On track

Risk ID: 0037	Date risk identified October 2019	Date of last review:	Not applicable
Potential impact on business continuity due to an ageing estate		Date of next review:	November 2019
		CQC Regulation:	Regulation 17 Good Governance
		Ambition:	3 – Financially Strong
		Assurance Committee:	Business Performance Committee
		Lead Executive:	Director of Finance and IT

Risk Journey (Likelihood x Consequence)



	Consequence	Likelihood	Rating
Initial	Moderate 4	Almost Certain 5	20
Current	Major 4	Likely 4	12
Target	Moderate 4	Possible 2	8

Risk Appetite **Cautious**

Key Impact or Consequence *What are we currently doing to control the risks? Provide the date e.g. when the policy/procedure was last updated*	**Performance:** *What evidence do we have of the risk occurring i.e. likelihood?*
- Unsafe environment for staff - Patient safety/ - Compromised quality of care" - Poor patient experience - Business continuity - Reputational damage - Financial impact - Legal Compliance	The Trust currently has a costed backlog maintenance schedule which is updated annually for the purpose of the ERIC return submission. This schedule highlights high, significant, medium and low level backlog maintenance requirements.

Key Controls or Mitigation: What are we currently doing to control the risks? Provide the date e.g. when the policy/procedure was last updated	**Key Gaps in Control:** Where we are failing to put controls/systems in place?
1. Estates Strategy – approved 2015 2. Operational Plan 2019-20 3. Revenue and Capital budgets Ongoing 4. Backlog Maintenance Register June 2018 **5.** Maintenance Programme **6. Estates related policies** Electrical Safety Policy - Water Management Policy - 2014 Control and management of Contractors 2018 Fire Safety Policy - 2010 7. Specialist contracts Ongoing 8. Site based partnership/SLA with Aintree Hospital - 2016 9. Contractual agreement with specialist contractors Ongoing	1. Estates Strategy requires review and refresh to ensure it is aligned to the overarching Trust Strategy and future need 2. Under resourced Estates function 3. Limited access to certain areas prevents visual inspection 4. 20% reduction required for 2019-20 Capital Programme 5. Lack of a Sustainability Development Management Plan 6. Policies require review to ensure that they are reflective of current legislation

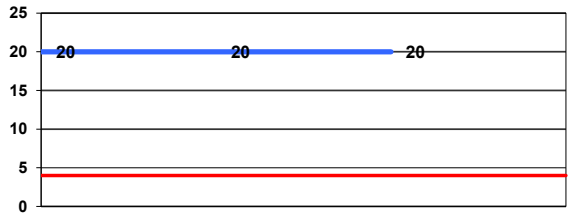
Assurances: What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?	**Gaps in Assurance**: Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?
Level 1 Daily Safety Huddle Water Safety Group Health & Safety Group Contract review meetings with AUH – monthly **Level 2** Capital Programme approved by Trust Board – March 2019 Monthly reporting to BPC via **Level 3** 6 Facet Survey – Jul 2019 CQC Inspection Report Aug 2019 NHS Digital acceptance of ERIC return 2018 Fire Brigade post-incident review of Fire Processes - 2019	1. Limited AUH planned maintenance/KPI reporting in place 2. Lack of reporting of sustainability data 3. Programme for Pipework replacement incomplete

Corrective Actions: To address gaps in control and gaps in assurance		Action Owner	Forecast Completion Date	Action Status
1	Work with NW specialist trusts North West QIP for specialist trusts to consider wider solutions for hard and soft FM . .	J Ross	March 2020	On track
2	Develop an in house out of hours Estates Service to provide sufficient cover and continue contract monitoring of AUH via monthly meetings	J Ross	March 2020	On track
3	Complete the recommendations within the Six facet survey	J Ross	End of Dec 2019	On track
4	Develop a Sustainability Development Management Plan as part of Estates Strategy review and establish sustainability reporting to BPC	J Ross	Jan 2020	On track

5	Ongoing monitoring of pipework replacement programme	J Ross	March 2020	On track

Risk ID: 0038	Date risk identified 08 February 2013	Date of last review:	September 2019
Risk Title: Risk of physical harm to staff due to the complex clinical nature of the patient population		Date of next review:	November 2019
		CQC Regulation:	Regulation 17 Good Governance
		Ambition:	3 – Financially Strong
		Assurance Committee:	Quality Committee
		Lead Executive:	Director of Nursing and Governance

Risk Journey (Likelihood x Consequence)



Risk Appetite: **Cautious**

	Consequence	Likelihood	Rating
Initial	Major	Almost Certain	
	4	5	20
Current	Major	Almost Certain	
	4	5	20
Target	Moderate	Possible	
	2	2	4

Key Impact or Consequence

"- Physical Injury /- Emotional/psychological impact on staff and other patients
- Low morale"
- Increased sickness levels
- Litigation
- Involvement with Regulators e.g. HSE, CQC, NHSI
- Increase in staff turnover

Performance:
What evidence do we have of the risk occurring i.e. likelihood?

Physical Assaults on staff
18/19 **19/20**
Q1 = 45 Q2 = 34 Q3 = 50 Q4 = 18 **Q1 =** 27 **Q2 =** 45
Related Claims
1 claim received in 2019/20

Staff Survey (relating to staff reporting physical harm)
2019 22.9% (15.25% higher than acute specialist sector average of 7%)
2018 – 21.9% (National average 2018 over 6.7%, compared to best performing Trust at 1.8%)
Trust Sickness absence – 6.02%

Key Controls or Mitigation:
What are we currently doing to control the risks? Provide the date e.g. when the policy/procedure was last updated

1. Violence and Aggression Policy - approved Feb 2018
2. Lone Worker Policy - approved Feb 2018
3. Liaison with Police (DOLs) - Safeguarding Intervention and advice Best Interest Meeting (MDT approach)
4., Security Function (ISS)
5. ED&I Lead attending ward areas to support staff where racist comments are made by patients
6. Personal Safety Trainer Programme of work Apr-2019
7. Safeguarding Matron in place working with Personal Safety Trainer and LSMS to agree plans for patients who are aggressive
7. Reviewed training in line with national guidance Jan-19
8. Health and Wellbeing programme (includes Shiny Minds Resilience Training) Approved 2018

Key Gaps in Control:
Where we are failing to put controls/systems in place or where are we failing to make them effective?

1. Lack of agreed KPI's within the Security Contract
2. Compliance with statutory and mandatory training

Assurances:
What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?

Level 1
Safety Huddle – daily
Health, Safety and Security Group – quarterly review of V&A data and monitoring of annual risk assessments
Safeguarding Group review of escalation concerns – bi monthly

Level 2
Violence & Aggression Data reviewed by Quality Committee – May Oct
Sickness absence data reviewed by BPC & Board – monthly
Annual Security Management Report – reviewed by BPC – June 2019

Level 3
Staff Survey 2019
Internal Audit review of Deprivation of Liberties (DOLS) Limited Assurance Oct 2018
Quarterly review meetings with commissioners
CQC Inspection 2019
Investors in People Health & Wellbeing Gold – re-accredited May 2019

Gaps in Assurance:
Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?

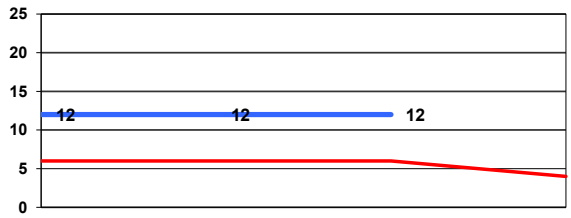
1. Outcome of Shiny Minds App to be evaluated

Corrective Actions: To address gaps in control and gaps in assurance		Action Owner	Forecast Completion Date	Action Status
1	KPI's for the Security Contract to be developed and monitored by the Health Safety and Security Group	JR	End of Nov	On track
2	Development of Violence and Aggression working group to identify new initiatives and work streams	LS	End of Nov	On track

3	Continued focus on statutory and mandatory training compliance Trust Wide	MG	End of March	On track
5	Pilot of Shiny Minds App to be evaluated	MG	End of March	On track

Risk ID: 0043	Date risk identified March 2018	Date of last review:	August 2019
Risk Title: **Risk to patient safety and service delivery due to failure of heating pipework due to age and corrosion**		Date of next review:	November 2019
		CQC Regulation:	Regulation 17 Good Governance
		Ambition:	3 – Financially Strong
		Assurance Committee:	Business Performance Committee
		Lead Executive:	Director of Finance and IT

Risk Journey (Likelihood x Consequence)



	Consequence	Likelihood	Rating
	Major	Likely	
Initial	4	4	16
	Major	Likely	
Current	4	3	12
	Major	Unlikely	
Target	4	2	6

Risk Appetite	Cautious

Key Impact or Consequence	Performance: *What evidence do we have of the risk occurring i.e. likelihood?*
• Negative impact on staff and patients • - Damage to building fabric/ - Loss of heating • - Significant negative financial consequence both on actual costs to rectify the pipes as well as potential negative impact on activity & income • Significant capital investment c £1.0m in rectifying Steel. • Reputational risk	Loss of activity due to unknown risk of further leaks Phase 2 works commenced April 2019 and are due to complete in Autumn 2019. Phase 3 currently in development.

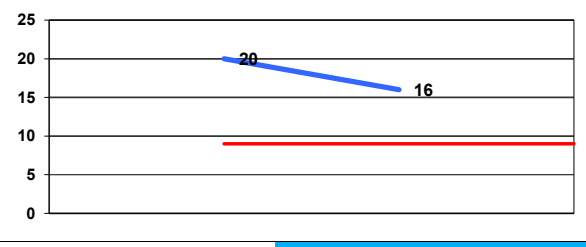
Key Controls or Mitigation: What are we currently doing to control the risks? Provide the date e.g. when the policy/procedure was last updated	Key Gaps in Control: Where we are failing to put controls/systems in place?
1. Established working group to: 2. Determine and co-ordinate actions 3. Facilitate communication 4. Oversee planning for replacement scheme 5. Continuation of works with Phase 1 contractor 6. Continued monitoring and dosing of system 7. Development of Stage 3 design 8. Development of capital scheme for replacement: 9. Strategic/feasibility study by Arup 10. Appointed technical team to develop design and manage scheme 11. Continued Trust Communications	1. Replacement scheme likely to cause disruption to hospital operations (extent not yet known) 2. Spontaneous and unpredictability of further leaks

Assurances: What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?	Gaps in Assurance: Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?
Level 1 Monthly Operational Group Reported into Health, Safety & Security Group Reported into Medical Devices & Facilities Group **Level 2** Monthly Heating Committee **Level 3**	

Corrective Actions: To address gaps in control and gaps in assurance		Action Owner	Forecast Completion Date	Action Status
1	Undertake new phase 2 pipework installation in preparation for "multiple" phase 3 approach	DoSO	Oct-19	On track
2	Develop proposals for various phase 3 schemes	DoSO		On track
3	Continual liaison with individual staff to discuss logistics for planned works	DoSO	Dec-19	On track
4	Continual review of risks for Phase 2 and Phase 3.	DoSO	Oct-19	On track
5	Work with Trust Comms team to ensure effective communications to all parties	DoSO	Oct-19	On track
6	"Investigate ward decant and redevelopment of the fallow space options for	DoSO	Oct-19	On track

Risk ID: 0041	Date risk identified: July 2019	Date of last review:	Sept 2019
Risk Title: If methods of Cyber Crime continue to evolve then the Trust may receive a cyber-attack leading to service disruption, loss of data and financial penalties.		Date of next review:	Nov 2019
		CQC Regulation:	Regulation 17 Good Governance
		Ambition:	3 – Financially Strong
		Assurance Committee:	
		Lead Executive:	Director of Finance and IT

Risk Journey (Likelihood x Consequence)



Risk Appetite	Cautious

	Consequence	Likelihood	Rating
Initial	Major 4	Almost Certain 5	20
Current	Major 4	Likely 4	16
Target	Moderate 2	Possible 2	9

Key Impact or Consequence	Performance: *What evidence do we have of the risk occurring i.e. likelihood?*
Loss of operational and clinical disruption or a ransom; -Potential financial loss to loss of activity could lead to financial, business and operational impacts as well as reputational damage; - potential data breaches leading to a fine from the ICO with increased penalties under GDPR (up to 4% of turnover Non compliance with Data Protection Laws/NIS Directive Loss of Trust from patients, service users and other organisations we may supply services to.	No of Care Certs received in first 6 mths of 2019 = 425 Rolling 4 week no of Care Certs received = 62

Key Controls or Mitigation: What are we currently doing to control the risks? Provide the date e.g. when the policy/procedure was last updated	Key Gaps in Control: Where we are failing to put controls/systems in place or where are we failing to make them effective?
1. Firewall in place and kept up to date Ongoing 2. Security Information and Event Management(SIEM) monitors all live systems 3. Antivirus Installed on All Computers 4. Vulnerability Protection 5. Hard drive encryption (Laptops) 6. Endpoint Encryption on all computers to prevent local distribution of malware 7. 2 factor Authentication on Server Rooms - Ongoing 8. Swipe Access for staff areas 9. Smart water protection on all devices 10. Asset register and inventory 11. ISO27001 Accreditation process Annual 12. Member of the Cheshire and Mersey Cyber Security Group Ongoing 13. Pilot for NHS Digital Programmes relating to Cyber security Ongoing 14. CareCERT Processing on a regular basis Ad Hoc 15. Cyber Security Dashboard Jul 2019 16. Network groups - IG - Radiology etc Ongoing	1. Limited funding and investment nationally regarding Cyber Security

Assurances: What evidence do we have to demonstrate that the controls are having an impact? How is the effectiveness of the control being assessed?	**Gaps in Assurance**: Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective?
Level 1 TIAG review of CareCERTs Weekly Cyber Security Awareness Presentation to Executive Board - July 19 **Level 2** Monthly report from Information Governance Forum to Business Performance Committee Annual Report of Senior Information Responsible Officer - Trust Board July 2019 " **Level 3** ISO27001 – accreditation August 2019 for 3 years MIAA audits of Data Security and Protection Toolkit Dec 2018, Jan 2019 - Substantial Assurance	1. Cheshire & Merseyside system wide recovery response not tested 2. Third party assurances required regarding satellite sites 3. Ongoing work with NHS Digital to inform funding requirements

Corrective Actions: To address gaps in control and gaps in assurance		Action Owner	Forecast Completion Date	Action Status
1	Close working with MIAA to inform C&M system wide disaster recovery exercise	MB	March 2020	On track
2	Transformation Team review of satellite sites to include obtaining 3rd party assurances of cyber security	JR	March 2020	On track
3	On-going work with NHS Digital to inform funding requirements	MB	March 2020	On track
5	Collaboration with C&M and NHS Digital to expand virtual protection team	MB	March 2020	On track

Chair's Report

Prepared by Lindsey Vlasman, Deputy Director of Nursing and Governance on behalf of Seth Crofts, Non-Executive Director and Quality Committee Chair

The following report summarises the discussions held on 21st November 2019 by the Quality Committee. Agenda items are listed in order of the meeting and areas of discussion that the Board may wish to consider will have additional commentary alongside.

Agenda item	Discussions at the meeting
Medical Directors Update	**Presented by Dr Nicolson** The GIRFT visit was discussed and a summary of the report was that it was found difficult to benchmark with other units, the Walton centre case mix is very different. It was highlighted how good patient experience information was and they were very impressed with the work of the AHPs, and the MDT approach at the trust. 1 issue highlighted was that we were high on a number of infections the work the trust is doing around this was shared and discussed. They also mentioned that we could do more research, at the trust. 1 Never Event with a central line being inserted and a guide wire left insitu which was later identified on an x-ray. Full RCA has been commenced.
What Quality Looks Like to me	**What is Speech and Language Therapy,** The service has 3 Quality statements, which mirrors the trust strategy. Mouth Care Matters: NHSE initiatives, staff at the trust were trained to deliver mouth care appropriately and then deliver training to other staff. Data was shared about mouth care and the quality of mouth care at the Walton centre, significant improvements have been made with this. The team want to be at the forefront of clinical excellence The chatterbox project was shared this is a project for patients with young children, funding was received from charity committee for an iPad and Lego to support family's with children so they can understand acquired communication difficulties. The team support in house training and professional development. Fibreoptic Endoscopic Evaluation of Swallow (FEES) – new equipment for speech and language therapy, business case completed and the trust have supported the kit to undertake this.
Making Every Contact Count	**Presented by Suzanne Simpson:** The issues with recording on EP2 were discussed and the plans to record for the CQUIN for alcohol and tobacco, which will go live on25th November 2019. Training on track for MECC Ahead of other trusts with training MECC has also been added onto Health and Safety programme Still further work to be completed for the SLA for alcohol and tobacco.

Integrated Performance Report – August 2019	**Presented by Lindsey Vlasman** A discussion was had regarding the IPR and how this should be reported by the divisions and not corporately, and the vision would be to go for a dashboard, rather than a report, Mark Foy will be taking this to the board away day in December then will attend quality committee in December 2019. • Caring - Green • Effective - Green / Amber • Responsive - Amber • Well Led - Amber • Safe - Green KPIs not met for October is nursing turnover which is at 17.22% which is down from September 17.34% FFT remains positive 0 SUIs 0 Never Events 0 Mixed Sex breeches 0 VTE 0 Cdif 0 MRSA 0 Ecoli 0 MSSA Overall vacancy levels for the trust 6.37% nursing 7.52% Trust sickness 5.75%
Quarterly Trust Risk Register	**Presented by Tom Fitzpatrick** A discussion about the salary sacrifice risk was had and what are the plans to manage this which will need to be discussed with HR, The top risks were discussed and a focus on the violence and aggression risk as this is high on the BAF and much lower on the trust risk register. The exec team are currently reviewing this risk. A discussion regarding legionella was had this has now been put on the corporate risk register as a 10 and there is a management plan in place.
NICE Exception Report Q1 and Q2	**Presented by Dr Nicolson** An update was given from Dr Nicolson regarding the NICE Exceptions
Pharmacy Quarterly update report KPIs	**Presented by Jenny Sparrow** An update was given regarding the pharmacy quarterly KPIs, a discussion was held about TTOs, and how Aintree pharmacy work closely with The Walton Centre.
CARES Update	**Presented by Julie Kane** An update was given on the assessments and how the process has changed, to Gold Silver and Bronze and how we asses the clinical areas.
FFT Update	**Presented by Lindsey Vlasman** An update was given regarding the changes from April 2020 to FFT.

Inpatient Survey Results and Action Plan	**Presented by Lindsey Vlasman** An update was given re the inpatient survey and the trust is still awaiting the results for the current survey for 2019.
Clinical Audit Progress Report	**Presented by Dr Nicolson** Dr Nicolson provided an update on the clinical audits, the majority of audits have been completed or within an agreed timescale. Positive report on schedule.
Digital Strategy Update	**Presented by Martin Wilson** Justin Griffiths was unable to attend to present the strategy Martin Wilson gave an update to the committee (the highlights of the strategy) and Justin will attend in January 2020l to give an in-depth update.
Risk Management Strategy Update	**Presented by Tom Fitzpatrick** An update was given about the risk management strategy and how this will be combined into the risk management policy.
Quality Accounts	**Presented by Julie Kane** An update given on the quality accounts and this year we only need to pick 3 quality accounts rather than the number selected in previous years ideas to be sent to Julie by the 2nd of December
Quality Committee Terms of Reference	**Presented by Jane Hindle** Janes role is to review terms of reference of all committees she has already completed BPC and Audit Committee. Membership and quoracy was discussed.
Terms of reference clinical effectiveness group	**Presented by Dr Nicolson** Terms of reference was discussed no changes
Chairs reports and sub committee minutes	**Updates were given for all of the sub committees**

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The Walton Centre Charity Committee Meeting

18 October 2019 - Chair's Report

Prepared by Helen Wells, Deputy Director of Finance on behalf of

Ms Su Rai, Non-Executive Director, Chair of Meeting

Agenda Item	Discussions at the meeting
Declarations of Interest	None.
Matters Arising – Home from Home Update report	MF clarified that approx. £20k per annum income was generated compared to costs incurred in this area, however the value that would be required for a full upgrade was not known. It was agreed to ask Estates and the patient experience team to undertake a strategic evaluation of the home from home space and calculate the potential costs required for a full upgrade to enable a 'sinking fund' to be created. IB suggested that some charitable funds could be transferred into an investment company for the 'sinking fund', given that the funds can be accessed quickly and given the value of funds currently within the charitable bank account. Agreed that a new action be created to monitor and review this moving forward. An update will be given at the January meeting
Matters Arising – Ethical donations Policy	MF to update the ethical donations policy to remove Chair, Chief Executive and Medical Director from the Fundraising Review Group, as previously discussed.
Matters Arising – Fundraising Activity Report	The issue around payment of deposits for keys was discussed as there has been a significant drop in donations from this following security staff no longer handling cash. Relatives are given keys for the home from home environment and asked to take the deposit to the cash office if given the key out of hours which does not appear to be happening. Previously relatives would often choose to donate their deposit to the charity rather than claim it back but this isn't happening as deposits are not being received. The Committee queried whether a card machine could be used but there may still be an issue with the initial transaction. MF to investigate further to see what options could be put in place.
Annual Report and Accounts (incl. Independent Review Statement)	Annual report and accounts for 2018/19 were presented to the Committee. There were no material changes from the draft accounts presented to the Committee in July (minor wording changes including a more detailed description of debtors and creditors). An independent examination of the accounts has been undertaken with a report issued by Grant Thornton, which raised no matters or concerns. The auditors did comment that the accounts were of a high standard and passed their thanks to the finance team for their support the high quality information presented. The final report from Grant Thornton will be issued once the Board has formally approved the accounts. The committee approved the accounts and will recommend that the Trust

	Board approves them in November. The committee also approved sign off of the letter of representation which is now a requirement of the accounts.
Annual Investment Performance Analysis by Jagger and Associates	No representative from Jagger & Associates was able to attend but a written report had been submitted. Ian Benjamin presented a summary of the report which was commissioned to provide an independent summary of the last 12 months investment activity by CCLA and Ruffer CAT. Due to the national market downturn in Q4 2018 investments with both companies suffered although both are starting to recover, with CCLA has recovered at a quicker pace due to its more aggressive investment positions. The committee discussed whether Jagger & Associates would continue to be commissioned to provide independent reports given the high quality of reports submitted by CCLA and Ruffer. It was agreed to keep the option of using Jagger & Associates open dependent on the continued reports sent by CCLA and Ruffer.
Update on Investment Position Valuations: • **Ruffer Investment report to June 2019** • **CCLA Investment report to June 2019**	Detailed update reports had been provided by both Ruffer and CCLA although September reports were not yet available. December 2018 showed low investment balances as a result of the national market downturn but balances were now starting to recover. £0.5m was invested with each company in July 2018 with no further money being invested with them since this point. Overall there has been approx. £22k growth against this investment. The Chair requested that the table showing the book value of the investments was changes to show the value invested per company (as it currently looks as if only £0.5m has been invested in total rather than £1m that has actually been invested). The Chair requested that in future an Executive summary of both companies reports, showing key highlights from the reports are provided in addition to the detailed reports from the companies.
Finance Report as at 30 September 2019	The Committee noted the financial position to 30 September 2019 and available funds to date. The fund balance at 30 September 2019 was confirmed to be £1,681,658, with year to date income totalling £404,239 and year to date expenditure totalling £146,815. Year to date, £43,679 of funds have been disbursed to beneficiaries. The Committee queried whether there were any funds that were not being spent/ committed and it was agreed that the Charitable Funds Accountant would contact all fund managers to understand commitments/ plans for their funds. It was also noted that the Charity will be investigating how to be involved with will making and associated legacies that this would result in.
Fundraising Activity Report	The Committee received the report and noted the contents. The Head of Fundraising highlighted the following sections from the report; The Jan Fairclough Ball is in 3 weeks with plans well underway. Unfortunately 1 of the sponsors has had to withdraw, leaving only 2 sponsors. The Head of Fundraising has been trying to find a replacement sponsor but this is particularly difficult especially given the time frame. It was noted that companies are uncertain about the economy as a result of Brexit and are thus less willing to commit expenditure at the current time. It

	was queried as to whether the Ball could be made bigger in the future. The Head of Fundraising explained that this may not be possible as a lot of people like the intimate nature of the event but that she will be re-assessing this position for the 2020 Ball. The web platform for the Everton lottery is now fully developed with some final checks now being undertaken. It is planned to launch this in the New Year. Promotional materials/ branding – plans are underway to increase brand visibility across the hospital which will include new vinyls on the fundraising office glass front as well as a branded charity area on the main corridor. There was also some discussion about investigating putting the brand logo at the bottom of patient letters (without making patients feel obliged to donate). It was agreed that a sub-group of the committee would be formed (led by Director of HR) to look at how the Charity can increase its profile and visibility in the Trust and how to balance this with other charities associated with care provided in the Trust (e.g. brain charity, MS society) The Head of Fundraising also noted that she had recently met with the Chair of the Brain and Spine Charity in London (who Sid Watkins had also been involved with). It was a very positive meeting and we will be looking at ways of working together more in the future (the brain and spine charity have close links to the motor racing fraternity). Further updates will be provided to the committee as work is undertaken.
Applications for funding from Training and Development	All 11 applications for funding that came from individual members of staff for training and development were approved by the Committee. The Chair requested that a table was prepared for future committees to provide a summary of applications and values with the detailed application forms being provided as appendices. It was also requested that an annual report is provided showing the impact of the approved funding (again in a table format)
• **Respiratory Equipment (metaneb) - physiotherapy**	The application for equipment to support patients with feeding and swallowing was presented. It is not an essential piece of kit but can help across the patient population for both ventilated and non-ventilated patients especially those with anxiety around this area. It was agreed that at some point in the future this may become part of business as usual but at the present time it is in addition to current equipment. The committee agreed to fund the full value requested including VAT (even though VAT would not be payable) with the VAT element being used to cover additional consumables (over and above those included in the case).
• **MultiTomRax**	A general X-Ray room needs replacement which MultiTomRax could be put in its place instead. This is state of the art equipment that allows a lot wider range of scans to be undertaken (e.g. patients in wheelchairs to check impact on spine, obese patients, no need to move trauma patients between trollies). Originally this was within the 19/20 Trust capital plan but given national changes and restrictions to capital funding rules this may not be affordable within the capital funding allocation (although the Trust have requested from NHSE/I that the capital allocation is increased). As

• **Healthcare Apprenticeships**	such funding may be required from the charity but this will not be known until feedback has been received from NHSE/I. There was no request to the Committee at the present time but members were asked to note this in case future discussion is required. S Niven raised that generally training funding supported by the Committee was for band 5 staff and above which meant that junior staff (particularly HCA's) were often excluded. A new route for career progression is available for HCA's for which funding is available but would incur a cost to cover backfill and it was requested whether the Committee would be prepared to support from Charitable funds. The Head of Fundraising was particularly nervous about this as it would be a rolling commitment and whether this was really the roll of the Charity. The Chair requested further information around this before a decision could be made
• **Long Service Awards**	Director of HR presented a request for £6,150 for recognition gifts to be awarded to staff with long service at The Walton Centre. It was noted that staff were given the option whether the accept the gifts or donate back to the Charity and that staff were only eligible if they had long service with the Trust rather than the NHS. The Committee supported this application.
• **Theatre Application**	A patient had made a donation and although it wasn't restricted it to be used in theatres, had wanted to improve the environment for patients and staff (it was a wish rather than specific request). A number of items had been requested which would improve the environment for both patients and staff and would not be appropriate to be funded through revenue. The committee supported the request (up to £6,748) with the Head of Fundraising to contact the donor to let them know what the donation had been spent on.
Terms of Reference	The Committee noted the Terms of Reference. The Chair requested that the Quoracy of the committee be shown separately in the ToR. The Committee approved the Terms of Reference
Report on Long Term Commitments to the Charity	This is a report presented twice a year to the committee, who noted and approved the report.
Any Other Business	The Head of HR raised the Faculty of Medical Leadership and Management Pilot that had been discussed and funding not approved at the last committee. He has been discussing this further and reviewing how the business model can be changed and that no future request for funding will be made to the Committee. Thanks was extended to Ian Benjamin (Financial Accountant) as this was his last committee before he leaves for a new role in another NHS organisation.

Date of next meeting: Friday 17 January 2020

The Walton Centre NHS Foundation Trust

REPORT TO THE TRUST BOARD
Date 28th November 2019

Report Title	**Chairs Assurance Report**
Sponsoring Director	Su Rai – Non-Executive Chair
Author (s)	Jane Hindle, Corporate Secretary
Purpose of Paper:	
The Audit Committee continues to receive reports and provide assurance to the Board of Directors against its work programme via a summary report submitted to the Board after each meeting. Full minutes and enclosures are made available on request. The paper provides an update the Board of the meeting of the Audit Committee held on 15th October 2019	
Recommendations	The Board is requested to: • Note the summary report

1.0 Matters for the Board's attention

There were no matters requiring the Board's attention.

2.0 Items for the Board's information and assurance

The Committee received the following updates:

a) Internal Audit Update Report and Follow Up Report

The Committee noted that the Trust's Year End Forecasting process received substantial assurance. It was recommended that the Trust establishes clear guidance or a procedure outlining the roles and responsibilities of staff involved in the process as the Trusts reliance on a small number of staff exposes it to risk in terms of resilience.

The Committee noted that the Risk Management process had received substantial assurance and that there were no matters of significant concern raised.

There were a number of outstanding follow up actions from previous audits however progress had been seen since the last report.

b) *External Audit Update*

The audit of the 2018/19 financial statements was complete and the final position had been reported to the Trust's Annual Member's Meeting in September 2019. The recommendations made to management will be followed up as part of the 2019/20 audit planning. The auditors continue to work closely with the finance team regarding emerging developments to ensure the audit process for 2019-20 is smooth and effective.

c) **Scheme of Reservation and Delegation and Standing Financial Instructions**

The Committee noted some minor amends to the documents relating mainly to job titles and responsibilities. A number of policies reserved to the Board had also been included within the revised version. The Committee agreed to recommend the revised documents for approval by the Board.

d) Losses and Special Payments

The Committee reviewed the register of losses and special payments noting that the year to date figure for 2019/20 was £13,600 which was as a result of 5 separate payments. In 2018/19 the final total was £6243. One claim in 2019 had resulted in a payment of £10,000 as a result of an incident relating to the physical assault of a member of staff.

e) Bad Debt Write-Offs

The Committee noted that the current figure for bad debt write offs was 9 items amounting to £245. October 2019 included 3 items which met the requirements for write off against the bad debt provision with no impact on the Trust's financial performance. All 3 items represented balances too small to pursue.

f) Tender Waivers

The committee received a report of tender waivers made in quarter 2 of 2019. There had been 2 occasions where a waiver had been provided. One related to Liverpool Health Partnership The Trust is now looking to put this on a purchase order. The second waiver related to the Occupational Health contract with Aintree University Hospital. The Committee had requested a comparison of waiver limits against similar size trusts.

g) Overseas Patients

The Committee received the revised Overseas Patients Policy for comment. The key changes reflect amendments to the Charging Regulations in 2017 and previous Internal Audit recommendations and are reflected in the financial procedures within section 7 of the policy.

h) Board Assurance Framework

The Committee reviewed the Board Assurance Framework and the position of the strategic risks The Committee noted the inclusion of a new risk relating to Cyber Security.

i) Review of Committee Terms of Reference

The Committee considered revised terms of reference which contained a number of minor changes most notably the inclusion of the Director of Nursing and Governance as a key attendee of the Committee and revised wording around the committee's role in relation to Whistleblowing and raising concerns.

j) Committee Cycle of Business 2020-21

The Committee approved a revised cycle of business for 2020-21. Key changes included removal of the review of the Register of the Trust Seal – this is a matter reserved to the Board.

3.0 Progress against the Committee's annual work plan

The Committee continues to follow its annual work plan and there have been no deferred matters during the year. . Areas of focus for the coming meeting will be

- Timetable for the preparation of the Financial Statements 2019/20
- External Audit Plan & Fees for 2020-21
- Tender Waivers
- Counter Fraud Progress Report

The Walton Centre NHS Foundation Trust

REPORT TO THE TRUST BOARD
Date _____

Title	**Staff Seasonal `Flu Campaign 2019 - 2020**
Sponsoring Director	Name: Lindsey Vlasman Title: Deputy Director Nursing and Governance
Author (s)	Name: Helen Oulton Title: Lead Nurse Infection Prevention & Control/Tissue Viability
Previously considered by:	N A

Executive Summary

This information paper outlines the actions undertaken to deliver the 2019 - 2020 seasonal staff `flu vaccination campaign at the Walton Centre NHS Foundation Trust (WCFT).

- Flu contributes to unnecessary morbidity and mortality in vulnerable patients
- Up to 50% of confirmed influenza infections are subclinical (i.e. asymptomatic)
- Unvaccinated, asymptomatic staff may pass on the virus to vulnerable patients and colleagues
- Flu-related staff sickness affects service delivery, impacting on patients and on other staff
- Vaccination is a core component of staff health and well being

In addition NHS Improvement/NHS England (NHSE/I) has mandated that Trusts are required to submit a self-assessment for Trust Board that details the performance of their organisation against the best practice management checklist. WCFT compliance is outlined in appendix 1.

Related Trust Ambitions	• Best practice care • Be financially strong • Be recognised as excellent in all we do
Risks associated with this paper	• Risk to business continuity due to potential `flu outbreaks, bed closures, reduced staffing • Loss of income if CQUIN not achieved
Related Assurance Framework entries	
Equality Impact Assessment completed	• No
Any associated legal implications / regulatory requirements?	• Yes – Compliance with the Care Quality Commission Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12
Action required by the Board	• To consider and note

Staff Seasonal `Flu Campaign 2019 - 2020

Executive Summary

This information paper outlines the actions undertaken to deliver the 2019 - 2020 seasonal staff `flu vaccination campaign at the Walton Centre NHS Foundation Trust (WCFT).

As required by NHS Improvement/NHS England (NHSE/I) in a letter dated 17 September 2019 to all Chief Executives, the Trust is required to publish a self-assessment for Trust Board that details our performance against the recommended best practice management checklist (appendix 1)

Background

Healthcare workers with direct patient contact need to be vaccinated because:

- Flu contributes to unnecessary morbidity and mortality in vulnerable patients
- Up to 50% of confirmed influenza infections are subclinical (i.e. asymptomatic)
- Unvaccinated, asymptomatic (but nevertheless infected) staff may pass on the virus to vulnerable patients and colleagues
- Flu-related staff sickness affects service delivery, impacting on patients and on other staff

In 2018 - 2019, WCFT immunised 80.2% of frontline staff which exceeded the `flu CQUIN requirement of 75%. However, some organisations achieve over 90% of staff vaccinated with a national ambition that 100% of healthcare workers with direct patient contact will be vaccinated.

Key Issues

Consideration of factors that will impact upon the attainment of 100% uptake:

- WCFT has historically had a good uptake of vaccine from its health care workers and there are some staff who perceive that this is a coercive approach
- Staff may become resentful if constantly asked if they have had their flu jab in a prolonged campaign
- Some staff that have a genuine reaction to the vaccine
- Some staff expressed fears of the safety of the vaccine
- There is a perception amongst some staff that the evidence does not prove the vaccines efficacy
- Some staff have significant fear of needles
- The vaccination sessions must be commensurate to the needs of the individual

Myths detected in Walton Centre staff include:

- The flu vaccine does not offer protection
- They are healthy so don’t need it
- The campaign is target driven

What motivates staff:

- Peer support and pressure
- Flu vaccination will protect their family and their patients

- Receipt of incentives
- Not wanting to be ill

To deliver an effective staff flu campaign the Trust has provided:

- Committed leadership and promotion at all levels of the Organisation.
- An effective communications plan
- Flexible accessibility for vaccination recipients
- Incentives for uptake

Key areas to enable delivery of the plan;

- To ensure that staff are aware of what is expected of them in terms of the benefits of being vaccinated
- To ensure that staff are given the correct facts about the flu vaccination in order to eliminate rumours/myths this will be facilitated with the support of the Communication Team
- Infection Prevention and Control Team engagement with the clinical areas/divisions in the lead up to the campaign, to rally support for departmental peer vaccinators and to ensure 'buy in' from the organisation as to the multifaceted benefits of vaccination
- Give engaged staff the opportunity to be vaccinated at their convenience in the form of clinics, flu walkabouts, dial a jab, drop in sessions, availability of vaccinators during the evening and at night within the ward and departments, early morning, nights and weekend vaccination sessions throughout the Trust

Timescales for delivery

Flu vaccinations have been available from 2nd October 2019 and will be available until 29th February 2020 (campaign may conclude at an earlier date). The submission of uptake to IMMFORM closes on 29th February 2019.

WCFT purchases `flu vaccine via Aintree University Hospital. Due to a manufacturing supply issue the Trust received a reduced amount of vaccine at the start of the campaign and ran out of vaccine on two occasions during October 2019. Traditionally the majority of vaccinations take place in October/early November and therefore this may impact on vaccine uptake.

12. Resources

The campaign is delivered by the Infection Prevention and Control Team, with support from trained peer vaccinators with some sessions provided by The Centre of Health and Wellbeing.

Implications / Impact of non-delivery of the seasonal flu campaign

- Quality – the impact on patient care delivery if we have a depleted workforce
- Finance – the cost of using bank and agency staff to cover potential sickness
- Workforce – the impact on both patient facing and support staff roles if high levels of transmission of flu occur within the workplace

- Compliance – the Trust has been mandated by NHSE/I to provide this assurance paper and strive towards 100% uptake in patient facing roles

Conclusion

The self-assessment (appendix 1) demonstrates the delivery of best practice in the effective delivery of the flu campaign to our workforce. Despite the desire to achieve 100% uptake amongst our frontline staff it is likely that the Trust will have a cohort of employees who chose to make an informed decision, and decline the offer of the vaccine. We will continue to capture the reasons as to refusal where possible.

Action required

The Trust Board is asked to:

- note the contents of this report and to have assurance in the effective implementation of the seasonal staff flu campaign.

Helen Oulton
Lead Nurse/Infection Prevention and Control/Tissue Viability

Appendix 1

A	Committed leadership	Evidence	Trust self-assessment
A1	Board record commitment to achieving the ambition of 100% of front line healthcare workers being vaccinated, and for any healthcare worker who decides on the balance of evidence and personal circumstance against getting the vaccine should anonymously mark their reason for doing so	Board support at commencement of campaign. Staff declining offer of vaccine asked to complete anonymised proforma to capture reasons for refusal	
A2	Trust has ordered and provided the quadrivalent (QIV) flu vaccine for healthcare workers	QIV ordered for HCW's and TIV available for HCW's over the age of 65 via Occupational Health	
A3	Board receive an evaluation of the flu programme including data, successes, challenges and lessons learnt	Infection Prevention and Control Committee minutes, quarterly IPC reports	
A4	Agree on a board champion for flu campaign (3,6)	Director of Nursing & Governance identified as board champion	
A5	All board members receive flu vaccination and publicise this	Offered to all Board members information circulated by social media, email, Walton weekly	
A6	Flu team formed with representatives from all directorates, staff groups and trade union representatives	All departments invited to Flu Planning Group. Peer vaccinators trained September 2019 and written instruction approved, staff side representative involved in the opt out process	
A8	Flu team to meet regularly from September 2019	August –September 2019, review December 2019. Weekly communications to Trust Flu Fighters A 'wrap up and review' meeting to be held at the closure of the campaign	
B	Communications plan		
B1	Rationale for the flu vaccination programme and myth busting to be published – sponsored by senior clinical leaders and trade unions	Communication programme implemented under direction of Director of Nursing & Governance/Infection Prevention & Control	
B2	Drop in clinics and mobile vaccination schedule to be published electronically, on social media and on paper	Accessibility across a 24/7 programme with open access to all employees	
B3	Board and senior managers having their vaccinations to be publicised	Photographs and promotion through Trust media	
B4	Flu vaccination programme and access to vaccination on induction programmes	Offered at induction and details of mobile vaccination and flu clinics provided	
B5	Programme to be publicised on screensavers, posters and social media	Established communications programme e.g. poster, social media, notice boards Trust wide	

B6	Weekly feedback on percentage uptake for directorates, teams and professional groups	Weekly figures submitted to executive team and headline figures promoted widely e.g. safety huddle, Walton Weekly, Trust wide email	
C	Flexible accessibility		
C1	Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered	Support from senior leadership for identified peer vaccinators Director of Nursing and Governance IPC is a vaccinator Increased number of vaccinators compared to 2018-2019 campaign	
C2	Schedule for easy access drop in clinics agreed	Clinics offer 'no appointment needed' drop in format	
C3	Schedule for 24 hour mobile vaccinations to be agreed	Peer immunisers to cover 24 hour 7 day operation	
D	Incentives		
D1	Board to agree on incentives and how to publicise this	Donation to charity for each vaccination given	
D2	Success to be celebrated weekly	Feature in Walton Weekly and key messages on social media, email	

Ms Hayley Citrine

Chief Executive,
The Walton Centre NHS Foundation Trust

NHS England and NHS Improvement

Pauline.Philip@nhs.net

17 September 2019

CC: Ms Janet Rosser

Chair,
The Walton Centre NHS Foundation Trust

Dear Hayley,

Healthcare worker flu vaccination

The vaccination of healthcare workers against seasonal flu is a key action to help protect patients, staff and their families. Provider flu plans for 2018/19 saw a national uptake rate amongst front line staff of 70.3%, with some organisations vaccinating over 90% of staff. Our ambition is to improve on this through the actions outlined in this letter.

In March 2019, the Department of Health and Social Care (DHSC), NHS England and Improvement and Public Health England (PHE) wrote to all trusts setting out the appropriate vaccines for adults up to 64, the egg and cell-base Quadrivalent influenza vaccines (QIVe and QIVc) and for over 65s, the adjuvanted trivalent influence vaccine (aTIV) as well as QIVc.

Today, we are writing to ask you to tell us how you plan to ensure that all of your frontline staff are offered the vaccine and how your organisation will achieve the highest possible level of vaccine coverage this winter.

Background

Healthcare workers with direct patient contact need to be vaccinated because:

a) Flu contributes to unnecessary morbidity and mortality in vulnerable patients

b) Up to 50% of confirmed influenza infections are subclinical (i.e. asymptomatic). Unvaccinated, asymptomatic (but nevertheless infected) staff may pass on the virus to vulnerable patients and colleagues

c) Flu-related staff sickness affects service delivery, impacting on patients and on other staff – recently published evidence suggests a 10% increase in vaccination may be associated with as much as a 10% fall in sickness absence

d) Patients feel safer and are more likely to get vaccinated when they know NHS staff are vaccinated

Whilst overall uptake levels have increased every year since 2015/16, there is significant variation in the uptake rates achieved as some trusts have developed excellent flu programmes that deliver very high level of vaccination coverage, however others have not made the same progress.

An evaluation of last year's flu season showed that trusts that have developed a multicomponent approach have achieved higher uptake levels. Innovative methods to reach staff, going ward-to-ward, holding static and remote drop-in clinics and encouraging staff to contact vaccinators directly have been established. Trusts also used incentives to encourage staff, and even small incentives, such as badge stickers, worked to reinforce positive messages. Above all, board and ward leadership are critically important to promote vaccination to staff, providing visibility and transparency.

In order to ensure your organisation is doing everything possible as an employer to protect staff and patients from flu, we would strongly recommend working with your recognised professional organisations and trade unions to maximise uptake of the vaccine within your workforce. You can also access resources including National Institute for Health and Care Excellence (NICE) guidelines: https://www.nice.org.uk/guidance/ng103 and Public Health England's Campaign Resource Centre: https://campaignresources.phe.gov.uk/resources/campaigns/92-healthcare-workers-flu-immunisation-

We are now asking that you complete the best practice management checklist for healthcare worker vaccination [appendix 1] and publish a self-assessment against these measures in your trust board papers before the end of December 2019. Your regional lead will also work with you to share best practice approaches to help support an improvement in your uptake rates.

It is important that we can track trusts' overall progress towards the 100% ambition and all trusts will be expected to report uptake monthly during the vaccination season via 'ImmForm'.

As discussed, there is variation of uptake rates between trusts. Many trusts have made successful progress and have achieved near full participation, whilst other trusts are not increasing uptake rates quickly enough to protect staff and patients. It is important that improvements are made in those trusts. To support this, the healthcare worker flu vaccination CQUIN is in place again this year. New thresholds for payment have been set at 60% (minimum) and 80% (maximum).

We are also increasing requirements for trusts who have had low uptake rates. Each trust that was in the bottom quartile for vaccination uptake (at 61.7% or below) in the published data (Immform in 2018/19) will be required to buddy with a higher uptake trust. Working with them will provide an opportunity to learn how to prepare, implement and deliver a successful vaccination programme.

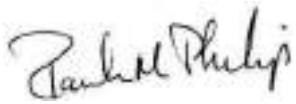
For trusts in this quartile progress will be reviewed weekly during the flu season by regional teams in addition to the monthly reporting that is provided to PHE via Immform.

In 2018/19, your trust achieved a frontline healthcare worker flu vaccination uptake rate of 80.2%. This does not put your trust in the lower quartile of trusts.

Organisations should use the Written Instruction for the administration of seasonal 'flu vaccination developed by The Specialist Pharmacy Service. NHS trusts vaccinating their own staff may consider that a PGD is more appropriate if it offers a benefit to service delivery e.g. provision by healthcare practitioners other than nurses, who may legally operate under a PGD. Health and social care workers should be offered either the egg or cell-based quadrivalent influenza vaccine. For the small number of healthcare workers aged 65 and over, if you are unable to offer the cell-based flu vaccine, these staff should ask their GP or pharmacy for an adjuvanted trivalent influenza vaccine (aTIV) which is preferable to the non-adjuvanted egg-based flu vaccine particularly if they are in an at risk group.

Finally, we are pleased to confirm that NHS England and Improvement this year is offering the vaccine to social care and hospice workers free of charge this year. Independent providers such as GPs, dental and optometry practices, and community pharmacists, should also offer vaccination to staff. There are two parallel letters to primary care and social care outlining these proposals in more detail.

Yours sincerely,



Pauline Philip
National Director of Emergency and Elective Care
NHS England and NHS Improvement

Ruth May
Chief Nursing Officer
NHS England and NHS Improvement

Professor Stephen Powis
National Medical Director
NHS England and NHS Improvement

Appendix 1 – Healthcare worker flu vaccination best practice management checklist – for public assurance via trust boards by December 2019

A	**Committed leadership** (number in brackets relates to references listed below the table)	**Trust self-assessment**
A1	Board record commitment to achieving the ambition of 100% of front line healthcare workers being vaccinated, and for any healthcare worker who decides on the balance of evidence and personal circumstance against getting the vaccine should anonymously mark their reason for doing so.	
A2	Trust has ordered and provided the quadrivalent (QIV) flu vaccine for healthcare workers	
A3	Board receive an evaluation of the flu programme 2018/19, including data, successes, challenges and lessons learnt	
A4	Agree on a board champion for flu campaign	
A5	All board members receive flu vaccination and publicise this	
A6	Flu team formed with representatives from all directorates, staff groups and trade union representatives	
A7	Flu team to meet regularly from September 2019	
B	**Communications plan**	
B1	Rationale for the flu vaccination programme and facts to be published – sponsored by senior clinical leaders and trades unions	
B2	Drop in clinics and mobile vaccination schedule to be published electronically, on social media and on paper	
B3	Board and senior managers having their vaccinations to be publicised	
B4	Flu vaccination programme and access to vaccination on induction programmes	
B5	Programme to be publicised on screensavers, posters and social media	
B6	Weekly feedback on percentage uptake for directorates, teams and professional groups	
C	**Flexible accessibility**	
C1	Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered	
C2	Schedule for easy access drop in clinics agreed	
C3	Schedule for 24 hour mobile vaccinations to be agreed	
D	**Incentives**	
D1	Board to agree on incentives and how to publicise this	
D2	Success to be celebrated weekly	

The Walton Centre NHS Foundation Trust

Doc Ref XX/XX

REPORT TO TRUST BOARD
Date 28th November 2019

Title	**Modern Slavery Statement 2019**
Sponsoring Director	Name: Lisa Salter Title: Director of Nursing & Governance
Author (s)	Name: Andrew Lynch Title: Equality and Inclusion Lead
Previously considered by:	• Committee (please specify) __N/A • Group (please specify) __N/A • Other (please specify) __ N/A
Executive Summary The statement constitutes the Walton Centre's annual response to the requirements of the Modern Slavery Act 2015 to be published online in accordance with the public sector duties under that Act.	
Related Trust Ambitions	• Be recognised as excellent in all we do
Risks associated with this paper	There are no risks identified that are associated with this paper, as the actions undertaken by the Trust which are mentioned in the paper have already been undertaken and those actions, taken alongside the Board considering the paper and the Trust publishing the paper online, constitute full compliance with the Trusts duties in respect of the Modern Slavery Act 2015.
Related Assurance Framework entries	• N/A
Equality Impact Assessment completed	• N/A
Any associated legal implications / regulatory requirements?	• No
Action required by the Board	• To consider and note

https://www.thewaltoncentre.nhs.uk/474/modern-slavery.html

Modern Slavery Statement 2019

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: All contracts established by The Walton Centre use the NHS Terms and Conditions for Supply of Goods, 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 has 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:

1. Verification of identity checks

2. Right to work checks

3. Professional registration and qualification checks

4. Employment history and reference checks 5. Criminal record checks

6. 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.

A factsheet and other materials are available on following link - https://www.gov.uk/government/publications/modern-slavery-duty-to-notify

More information on Modern Day Slavery can be found by visiting: https://modernslavery.co.uk/

The Walton Centre NHS Foundation Trust

Doc Ref XX/XX

REPORT TO THE TRUST BOARD
Date 28th November 2019

Title	**Emergency Planning Resilience & Response (EPRR) self-assessment against NHS England Core Standard**
Sponsoring Director	**Name:** Jan Ross **Title:** Director of Operations & Strategy
Author (s)	**Name:** Tom Fitzpatrick **Title:** Head of Risk
Previously considered by:	• Business & Performance Committee • Resilience Planning Group
Executive Summary This report highlights the Emergency Preparedness, Resilience & Response (EPRR) annual assurance self-assessment outcome and onward reporting process.	
Related Trust Ambitions	Delete as appropriate: • Be recognised as excellent in all we do
Risks associated with this paper	None
Related Assurance Framework entries	NA
Equality Impact Assessment completed	• No – (please specify) Not applicable
Any associated legal implications / regulatory requirements?	• Yes – Civil Contingencies Act 2004 • No – (please specify) _____
Action required by the Board	Delete as Appropriate • To consider and note

1. Emergency Preparedness, Resilience & Response (EPRR) Annual assurance self-assessment process

Provider organisations are asked to undertake a self-assessment against the relevant individual core standards and rate their compliance. These individual ratings will then inform the overall organisational rating of compliance and preparedness.

Core standards

The 2019-20 Core standards are in essence the same standards as 2018-19. There are 55 Core standards applicable to Specialist providers of which 51 are applicable to the Trust. The 4 standards which are not applicable relate to the management of Hazardous Materials (HAZMAT) and Chemical Biological Radiological Nuclear (CBRN) decontamination.

The Trust is compliant with the applicable standards.

Deep dive

There is also an additional deep dive element for "Severe Weather Response," which is not scored in the overall submission.

The Trust is also compliant with these standards.

Statement of compliance

Organisations are required to complete a Statement of Compliance and report this via the relevant group/committee to a public Board meeting.

The statement of compliance (see appendix) have been approved at the Resilience Planning Group on the 21st October 2019 and will be submitted to the November Board.

This report, along with the Core Standards assurance ratings are submitted to the CCG and Local Health Resilience Partnership (LHRP) which in turn reports to NHS England.

2. Conclusion

There have been significant improvements within our internal and external EPRR arrangements within the past 6 months. We continue to utilise the learning from local, regional and national incidents to strengthen response arrangements.

For the remainder of this year there will be ongoing testing and updating of business continuity management arrangements in line with the Resilience Planning Groups work plan.

3. Recommendation

The Board are asked to note this report.

Appendix

Cheshire & Merseyside Local Health Resilience Partnership (LHRP)
Emergency Preparedness, Resilience and Response (EPRR) assurance 2019-2020

STATEMENT OF COMPLIANCE

The Walton Centre NHS Foundation NHS Trust (RET) has undertaken a self-assessment against required areas of the NHS England Core Standards for EPRR. Following assessment, the organisation has been self-assessed as demonstrating the Full compliance level (from the four options in the table below) against the core standards.

Compliance Level	Evaluation and Testing Conclusion
Full	Arrangements are in place and the organisation is fully compliant with all core standards that the organisation is expected to achieve. The Board has agreed with this position statement.
Substantial	Arrangements are in place however the organisation is not fully compliant with one to five of the core standards that the organisation is expected to achieve. A work plan is in place that the Board or Governing Body has agreed.
Partial	Arrangements are in place however the organisation is not fully compliant with six to ten of the core standards that the organisation is expected to achieve. A work plan is in place that the Board or Governing Body has agreed.
Non-compliant	Arrangements in place do not appropriately address 11 or more core standards that the organisation is expected to achieve. A work plan has been agreed by the Board or Governing Body and will be monitored on a quarterly basis in order to demonstrate future compliance.

The results of the self-assessment were as follows:

Number of applicable standards	Standards rated as **Red**	Standards rated as **Amber**	Standards rated as **Green**
51**	xx	xx	51
Specialist providers: **55**			

** *Includes 7 HAZMAT/CBRN standards.*

NB: 4 of these standards are not applicable as the Trust is a Specialist Tertiary Unit with no A&E or walk in facility.
Where areas require further action, this is detailed in the attached core standards improvement plan and will be reviewed in line with the organisation's EPRR governance arrangements.
I confirm that the above level of compliance with the core standards has been agreed by the organisation's board / governing body along with the enclosed action plan and governance deep dive responses.

Ross — Sign Name

Jan — Print Name

The organisation's Accountable Emergency Officer

28/11/2019 — Date of board

01/10/2019 — Date signed

Revised in July 2018
Filepath: S:drive/BoardSecretary/FrontSheets
S:drive/ExecOfficeCentreMins/FrontSheets

Please select type of organisation: **Specialist Providers**

Core Standards	Total standards applicable	Fully compliant	Partially compliant
Governance	6	6	0
Duty to risk assess	2	2	0
Duty to maintain plans	14	14	0
Command and control	2	2	0
Training and exercising	3	4	0
Response	5	7	0
Warning and informing	3	3	0
Cooperation	4	7	0
Business Continuity	9	9	0
CBRN	7	7	0
Total	55	61	0

Deep Dive	Total standards applicable	Fully compliant	Partially compliant
Severe Weather response	15	15	0
Long Term adaptation planning	5	5	0
Total	20	20	0

Non compliant
0
0
0
0
0
0
0
0
0
0
0

Non compliant
0
0
0

Overall assessment:

Instructions:
Step 1: Select the type of orgar
Step 2: Complete the Self-Asse
Step 3: Complete the Self-Asse
Step 4: Ambulance providers o
Step 5: Click the 'Produce Actic

Publishing Approval Reference: 000719

Substantially compliant

nisation from the drop-down at the top of this page
essment RAG in the 'EPRR Core Standards' tab
essment RAG in the 'Deep dive' tab
nly: Complete the Self-Assessment in the 'Interoperable capabilities' tab
on Plan' button below

Please select type of organisation: **Specialist Providers**

Publishing Approval Reference: 300719

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	6	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	14	14	0	0
Command and control	2	2	0	0
Training and exercising	3	4	0	0
Response	5	7	0	0
Warning and informing	3	3	0	0
Cooperation	4	7	0	0
Business Continuity	9	9	0	0
CBRN	7	7	0	0
Total	55	61	0	0

Deep Dive	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Severe Weather response	15	15	0	0
Long Term adaptation planning	5	5	0	0
Total	20	20	0	0

Overall assessment:	Substantially compliant

Instructions:
Step 1: Select the type of organisation from the drop-down at the top of this page
Step 2: Complete the Self-Assessment RAG in the 'EPRR Core Standards' tab
Step 3: Complete the Self-Assessment RAG in the 'Deep dive' tab
Step 4: Ambulance providers only: Complete the Self-Assessment in the 'Interoperable capabilities' tab
Step 5: Click the 'Produce Action Plan' button below

Ref	Domain	Standard	Detail	Specialist Providers	Evidence - examples listed below
1	Governance	Senior Leadership	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director, and have the appropriate authority, resources and budget to direct the EPRR portfolio. A non-executive board member, or suitable alternative, should be identified to support them in this role.	Y	• Name and role of appointed individual
2	Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy statement. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested • Include references to other sources of information and supporting documentation.	Y	Evidence of an up to date EPRR policy statement that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.
3	Governance	EPRR board reports	The Chief Executive Officer / Clinical Commissioning Group Accountable Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board / Governing Body, no less frequently than annually. These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process	Y	• Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board
4	Governance	EPRR work programme	The organisation has an annual EPRR work programme, informed by: • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes.	Y	• Process explicitly described within the EPRR policy statement • Annual work plan

5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties.	Y	• EPRR Policy identifies resources required to fulfil EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff • Organisation structure chart • Internal Governance process chart including EPRR group
6	Governance	Continuous improvement process	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the development of future EPRR arrangements.	Y	• Process explicitly described within the EPRR policy statement
7	Duty to risk assess	Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider community and national risk registers.	Y	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register
8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring and escalating EPRR risks.	Y	• EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document
9	Duty to maintain plans	Collaborative planning	Plans have been developed in collaboration with partners and service providers to ensure the whole patient pathway is considered.	Y	Partners consulted with as part of the planning process are demonstrable in planning arrangements
11	Duty to maintain plans	Critical incident	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a critical incident (as defined within the EPRR Framework).	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
12	Duty to maintain plans	Major incident	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a major incident (as defined within the EPRR Framework).	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
13	Duty to maintain plans	Heatwave	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of heatwave on the population the organisation serves and its staff.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required

14	Duty to maintain plans	Cold weather	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of snow and cold weather (not internal business continuity) on the population the organisation serves.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
15	Duty to maintain plans	Pandemic influenza	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to pandemic influenza	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
16	Duty to maintain plans	Infectious disease	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases such as Viral Haemorrhagic Fever. These arrangements should be made in conjunction with Infection Control teams; including supply of adequate FFP3 and PPE trained individuals commensurate with the organisational risk.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
17	Duty to maintain plans	Mass countermeasures	In line with current guidance and legislation, the organisation has effective arrangements in place to distribute Mass Countermeasures - including arrangement for administration, reception and distribution of mass prophylaxis and mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop or support Mass Countermeasure distribution arrangements. Organisations should have plans to support patients in their care during activation of mass countermeasure arrangements. CCGs may be required to commission new services to support mass countermeasure distribution locally, this will be dependant on the incident.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
18	Duty to maintain plans	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to mass casualties. For an acute receiving hospital this should incorporate arrangements to free up 10% of their bed base in 6 hours and 20% in 12 hours, along with the requirement to double Level 3 ITU capacity for 96 hours (for those with level 3 ITU bed).	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required

19	Duty to maintain plans	Mass Casualty - patient identification	The organisation has arrangements to ensure a safe identification system for unidentified patients in an emergency/mass casualty incident. This system should be suitable and appropriate for blood transfusion, using a non-sequential unique patient identification number and capture patient sex.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
20	Duty to maintain plans	Shelter and evacuation	In line with current guidance and legislation, the organisation has effective arrangements in place to shelter and/or evacuate patients, staff and visitors. This should include arrangements to shelter and/or evacuate, whole buildings or sites, working in conjunction with other site users where necessary.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
21	Duty to maintain plans	Lockdown	In line with current guidance and legislation, the organisation has effective arrangements in place to safely manage site access and egress for patients, staff and visitors to and from the organisation's facilities. This should include the restriction of access / egress in an emergency which may focus on the progressive protection of critical areas.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
22	Duty to maintain plans	Protected individuals	In line with current guidance and legislation, the organisation has effective arrangements in place to respond and manage 'protected individuals'; Very Important Persons (VIPs), high profile patients and visitors to the site.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
23	Duty to maintain plans	Excess death planning	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
24	Command and control	On-call mechanism	A resilient and dedicated EPRR on-call mechanism is in place 24 / 7 to receive notifications relating to business continuity incidents, critical incidents and major incidents. This should provide the facility to respond to or escalate notifications to an executive level.	Y	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Include 24 hour arrangements for alerting managers and other key staff.

25	Command and control	Trained on-call staff	On-call staff are trained and competent to perform their role, and are in a position of delegated authority on behalf of the Chief Executive Officer / Clinical Commissioning Group Accountable Officer. The identified individual: • Should be trained according to the NHS England EPRR competencies (National Occupational Standards) • Can determine whether a critical, major or business continuity incident has occurred • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout.	Y	• Process explicitly described within the EPRR policy statement
26	Training and exercising	EPRR Training	The organisation carries out training in line with a training needs analysis to ensure staff are competent in their role; training records are kept to demonstrate this.	Y	• Process explicitly described within the EPRR policy statement • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff
27	Training and exercising	EPRR exercising and testing programme	The organisation has an exercising and testing programme to safely test major incident, critical incident and business continuity response arrangements. Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure learning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement	Y	• Exercising Schedule • Evidence of post exercise reports and embedding learning
28	Training and exercising	Strategic and tactical responder training	Strategic and tactical responders must maintain a continuous personal development portfolio demonstrating training in accordance with the National Occupational Standards, and / or incident / exercise participation	Y	• Training records • Evidence of personal training and exercising portfolios for key staff
30	Response	Incident Co-ordination Centre (ICC)	The organisation has a preidentified Incident Co-ordination Centre (ICC) and alternative fall-back location(s). Both locations should be annually tested and exercised to ensure they are fit for purpose, and supported with documentation for its activation and operation.	Y	• Documented processes for establishing an ICC • Maps and diagrams • A testing schedule • A training schedule • Pre identified roles and responsibilities, with action cards • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards
31	Response	Access to planning arrangements	Version controlled, hard copies of all response arrangements are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	Y	Planning arrangements are easily accessible - both electronically and hard copies

32	Response	Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	Y	• Business Continuity Response plans
33	Response	Loggist	The organisation has 24 hour access to a trained loggist(s) to ensure decisions are recorded during business continuity incidents, critical incidents and major incidents. Key response staff are aware of the need for keeping their own personal records and logs to the required standards.	Y	• Documented processes for accessing and utilising loggists • Training records
34	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to business continuity incidents, critical incidents and major incidents.	Y	• Documented processes for completing, signing off and submitting SitReps • Evidence of testing and exercising
37	Warning and informing	Communication with partners and stakeholders	The organisation has arrangements to communicate with partners and stakeholder organisations during and after a major incident, critical incident or business continuity incident.	Y	• Have emergency communications response arrangements in place • Social Media Policy specifying advice to staff on appropriate use of personal social media accounts whilst the organisation is in incident response • Using lessons identified from previous major incidents to inform the development of future incident response communications • Having a systematic process for tracking information flows and logging information requests and being able to deal with multiple requests for information as part of normal business processes • Being able to demonstrate that publication of plans and assessments is part of a joined-up communications strategy and part of your organisation's warning and informing work
38	Warning and informing	Warning and informing	The organisation has processes for warning and informing the public (patients, visitors and wider population) and staff during major incidents, critical incidents or business continuity incidents.	Y	• Have emergency communications response arrangements in place • Be able to demonstrate consideration of target audience when publishing materials (including staff, public and other agencies) • Communicating with the public to encourage and empower the community to help themselves in an emergency in a way which complements the response of responders • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing
39	Warning and informing	Media strategy	The organisation has a media strategy to enable rapid and structured communication with the public (patients, visitors and wider population) and staff. This includes identification of and access to a trained media spokespeople able to represent the organisation to the media at all times.	Y	• Have emergency communications response arrangements in place • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing • Having an agreed media strategy which identifies and trains key staff in dealing with the media including nominating spokespeople and 'talking heads'
40	Cooperation	LRHP attendance	The Accountable Emergency Officer, or an appropriate director, attends (no less than 75% annually) Local Health Resilience Partnership (LHRP) meetings.	Y	• Minutes of meetings
41	Cooperation	LRF / BRF attendance	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	Y	• Minutes of meetings • Governance agreement if the organisation is represented

42	Cooperation	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. These arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	Y	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Signed mutual aid agreements where appropriate
46	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders, during major incidents, critical incidents or business continuity incidents.	Y	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation and the Civil Contingencies Act 2004 'duty to communicate with the public'.
47	Business Continuity	BC policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) in alignment to the ISO standard 22301.	Y	Demonstrable a statement of intent outlining that they will undertake BC - Policy Statement
48	Business Continuity	BCMS scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented.	Y	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • Stakeholders
49	Business Continuity	Business Impact Assessment	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(s).	Y	Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support
50	Business Continuity	Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Y	Statement of compliance
51	Business Continuity	Business Continuity Plans	The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure These plans will be reviewed regularly (at a minimum annually), or following organisational change, or incidents and exercises.	Y	• Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation

52	Business Continuity	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers
53	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Audit reports
54	Business Continuity	BCMS continuous improvement process	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Action plans
55	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements work with their own.	Y	• EPRR policy document or stand alone Business continuity policy • Provider/supplier assurance framework • Provider/supplier business continuity arrangements

Ref	Standard	Standard	Detail	Specialist Procedure	Evidence / Assessment Detail Action	Organisational Evidence	Self-assessment RAG Red: Non-compliant, or fail to comply with the core standard. The organisation's EPRR work programme shows compliance will not be met within these timescales. Amber: Partially compliant: the organisation's EPRR work programme shows that progress against all the requirements within the standard will be met by the next reporting period. Green: Fully compliant with the standard	Action to be taken	Lead	Timescale	Completion
Resp Div - Severe Weather Scenario: Severe Weather Response											
1	Severe Weather response	Overheating	The organisation's heatwave plan allows for the identification and monitoring of inpatient and staff areas that overheat (inc community and non inpatient areas may include patients own home, or nursing/care home facility)	Y	The monitoring processes is explicitly identified in the organisational heatwave plan. This includes staff areas as well as inpatient areas. This process clearly identifies relevant temperature triggers and subsequent actions	1. Evidence contained within Heatwave Plan 2. Evidence of implementation of heatwave plan in the main 2018	Fully compliant				
2	Severe Weather response	Overheating	The organisation has contingency arrangements in place to ensure temperatures (for example AC's or BUAs for cooling units) and provide welfare support to patients and staff in high risk areas (i.e community and NHS inpatient areas may include patients own homes, or nursing/care home facility)	Y	Arrangements are in place to ensure that areas that have been identified as overheating comes closest to within reasonable temperature ranges, this may include use of cooling units or other methods identified in national heatwave plan.	1. Evidence contained within Heatwave Plan 2. Evidence of business cases to maintain air conditioning in Patient Therapy areas in Summer 2018 3. Additional cooling fans purchased for CPH/Chessalees Wards in Summer 2018.	Fully compliant				
3	Severe Weather response	Staffing	The organisation has plans to ensure staff can attend work during a period of severe weather (snow, flooding or heatwave), and has access an alternative secure transportation any staff need to remain on sites (includes provision of bed where needed)	Y	The organisations arrangements outline: - What staff should do if they cannot attend work - Arrangements to maintain services, including how staff may be brought in site during disruption - Arrangements for placing staff into accommodation where they live onsite/on local basis	1. Evidence contained within Heatwave and Cold Weather Plan 2. Arrangements for cook from home to work Team Notice 3. A number of staff have 4x4 vehicles, arrangements for car sharing etc in place	Fully compliant				
4	Severe Weather response	Service provision	Organisations providing services in the community have arrangements to allow for vulnerable to be clinically prioritised and alternative support delivered during periods of severe weather disruption. (This includes midwifery led time community, mental health services, district nursing etc)	Y	The organisations arrangements identify how staff will prioritise patients during periods of severe weather, and alternative delivery methods to ensure continued patient care.	1. Arrangements in place to prioritise caseloads. 2. Arrangements in place to undertake consultations and video links	Fully compliant				
5	Severe Weather response	Discharge	The organisation has policies or processes in place to ensure that any vulnerable patients (including community, mental health, and maternity services) are discharged to a warm home or are referred to a local single point of contact health and housing referral system. (Appropriate, in line with the NICE Guidelines on Hospital Winter Deaths)	Y	The organisations arrangements include how to deal with discharges or transfers of care into non health settings. Organisation can demonstrate information sharing regarding vulnerability to cold or heat with other supporting agencies at risk/large	1. Evidence within discharge and safeguarding policies	Fully compliant				
6	Severe Weather response	Access	The organisation has arrangements in place to ensure site access is maintained during periods of snow or wet weather, including gritting and business plans activated by predefined triggers	Y	The organisation arrangements have action/ trigger for the prioritisation/ placement of grit on key roadways and pavements within the organisations boundaries. Whilst simply it has account these are clear triggers and actions to clear priority roadways and pavements. Arrangements may include the use of a third party gritting or snow clearance service.	1. Gritting Contract in place - evidence of thresholds to grit, KPIs monitored by Head of Facilities	Fully compliant				
7	Severe Weather response	Assessment	The organisation has arrangements to assess the impact of National Severe Weather Warnings (including Met Office Cold and Heatwave Alerts, Daily Air Quality Index and Flood Forecasting Centre alerts) and takes predefined action to mitigate the impact of these where necessary	Y	The organisations arrangements are clear in how it will assesses all weather warnings. These arrangements should identify the roles/responsibilities for undertaking these assessments and the predefined triggers and action to be taken.	1. Head of Risk and Dep Head of Site responsible for cascade alerts including Environmental Weather Alerts	Fully compliant				
8	Severe Weather response	Flood prevention	The organisation has planned preventative maintenance programme, are in place to ensure that on site drainage is clear to reduce flooding risk from surface water. the program has taken into account seasonal variations	Y	The organisation has clearly demonstrated Planned Preventative Maintenance programmes for its assets. Where third party owns the drainage system there is a clear mechanism to alert the responsible owner to ensure drainages cleared and managed in a timely manner	1. Held within Estates PPM	Fully compliant				
9	Severe Weather response	Flood response	The organisation is aware of, and takes applicable contributes to, the Local Resilience Forum Multi Agency Flood Plan. The organisation understands its role in this plan. The organisation's communications arrangements include working with the LRF and multi-agency partners to warn and inform, outline alert during periods of Severe Weather, including the use of any national messaging for Heat and Cold.	Y	The organisation has reference to its role and responsibilities in the Multi Agency Flood Plan in its arrangements. Key on call response staff are clear how to obtain a copy of the Multi Agency Flood Plan	1. Evidence within MP and SOP including updated hyperlinks 2. Reinstatement in LRF and Linkin	Fully compliant				
10	Severe Weather response	Warning and response		Y	The organisation has within a arrangements document mas for issue/communications teams in the event of Severe Weather warns and a response. This includes the ability for the organisation to issue appropriate messaging (incl. Communications plans are clear in what the organisations will support in terms of severe weather alert event.	1. Evidence within MP and SOP including updated hyperlinks 2. Generic text within Service Manager/Director on call pack	Fully compliant				

11	Severe Weather response	Flood response	The organisation has plans in place for any identified areas of their sites at risk of flooding. These plans include measures to locate and evacuate all reported	3	The organisation has evidence that it regularly risk assesses its sites against flood risk (pluvial, fluvial and coastal flooding). It has clear and specific arrangements for flood response, the known day high risk areas. On site flood plans are in place for all risk areas of the organisation's estate.	1. Risk assessment and site plans maintained	Fully compliant
12	Severe Weather response	Risk assess	The organisation has identified which severe weather events are likely to impact on its patients, services and staff, and takes account of these in emergency plans and business continuity arrangements.	3	The organisation has documented the severe weather risks on its risk register, and has appropriate plans to address these	1. Evidence within ORCM Business Impact Analysis	Fully compliant
13	Severe Weather response	Supply chain	The organisation is assured that its suppliers can maintain essential services during periods of severe weather, and periods of disruption caused by these.	2	The organisation has a documented process of seeking and receiving assurance from suppliers that services can be maintained during extreme weather events. Where these services can't be maintained the organisation has alternative documented mitigating arrangements in place.	1. Evidence within Procurement BCP 2. Evidence within BCDoIT planning	Fully compliant
14	Severe Weather response	Forecasting	The organisation has exercised its emergency response & associated action case scenarios, or used them in an actual severe weather incident response, and they were effective in managing the risks they were designed to. From these exercises/ cases identified and have been incorporated into revised arrangements	1	The organisation can demonstrate that its arrangements have been tested in the past 12 months and learning has resulted in changes to its response arrangements.	1. Evidence within Business Continuity Exercises	Fully compliant
15	Severe Weather response	ICT BC	The organisations ICT Services have been thoroughly assessed and equipment tested which allows for remote access and remote services are able to provide resilience in extreme weather (e.g. and meeting systems even operationally in operation conditions, e.g. the data centre protected areas from areas of flood risk	1	The organisations arrangements includes the robust deployed access services and remote services to ensure the total number of concurrent users meets the number that may exist remotely to maintain identified critical services	1. The trust provides a resilient VPN remote access for key staff who have been approved for remote working and the solution is utilised and tested daily. All aspects of the solution can be scaled as required.	Fully compliant
Domain: long term adaptation planning							
16	Long term adaptative planning	Risk assess	Are all relevant organisations risks highlighted in the Climate Change Risk Assessment are incorporated into the organisations risk register	1	Evidence that the there is an entry in the organisations risk register detailing climate change risk and any mitigating actions	1. Evidence held within Environmental Management Plan,waste & and efficacy reports	Fully compliant
17	Long term adaptative planning	Overheating risk	The organisation has identified and recorded those parts of their buildings that regularly overheat (access 27 degrees Celsius) and their risk register. The register identifies the long term mitigation required to address this taking into account the sustainable development commitments in the long term plan, such as avoiding mechanical cooling and use of cooling highreachs.	1	The organisation has access that identifies areas exceeding 27 degrees and the register entries for these areas with action to assess risk	1. As part of Heatwave Planning arrangements, temperature assessments undertaken throughout site. 2. Capital planning approved upgrades for air conditioning as in mechanical ventilation.	Fully compliant
18	Long term adaptative planning	Building amendments	The organisation has in place an adaptation plan which includes necessary modifications to buildings and infrastructure to maintain normal business during extreme temperature or other extreme weather events.	1	The organisation has an adaptation plan that includes suggested building modifications or infrastructure changes, in future	1. Evidence within 2018/19 capital plan to install air conditioning. 2. Evidence within capital plan to upgrade heating system.	Fully compliant
19	Long term adaptative planning	Flooding	The organisations adaptation plans include modifications to secure their buildings and estates impact on the surrounding environment for example Sustainable Urban Drainage Systems to reduce flood risks	1	Areas are identified in the organisations adaptation plans that might benefit from legal confusion, or evidence that new hard standing areas considered for SUDS	1. No evidence of flooding. 2. Within initial capital scheme, flood planning included SuDS.	Fully compliant
20	Long term adaptative planning	New build	The organisation considers for all its new facilities relevant adaptation requirements for long term climate change	1	The organisation has relevant documentation that it is including adaptation plans for all new builds	1. Evidence within briefing for building of the Old Academ Building	Fully compliant