Whittington Health NHS

T R U S T B O A R D

MEETING IN PUBLIC

1400hrs – 1630hrs

Wednesday 6 April 2016

Whittington Education Centre Room 7
Jenner Building
Whittington Health
Magdala
London N19 5NF

Whittington Health NHS

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Meeting	**Trust Board – Public**
Date & time	**6 April 2016 1400hrs – 16.30hrs**
Venue	**WEC 7**

AGENDA

Members – Non-Executive Directors	**Members – Executive Directors**
Steve Hitchins, Chair Paul Lowenberg, Non-Executive Director Tony Rice, Non-Executive Director Anu Singh, Non-Executive Director Prof Graham Hart, Non-Executive Director David Holt, Non-Executive Director Yuahaw Yoe, Non-Executive Director	Simon Pleydell, Chief Executive Siobhan Harrington, Director of Strategy & Deputy Chief Executive (extended leave) Stephen Bloomer, Chief Finance Officer Dr Richard Jennings, Medical Director Philippa Davies, Director of Nursing and Patient Experience Carol Gillen, Chief Operating Officer

Attendees – Associate Directors
Dr Greg Battle, Medical Director (Integrated Care)
Norma French, Director of Workforce
Lynne Spencer, Director of Communications & Corporate Affairs
Secretariat
Kate Green, Minute Taker

Contact for this meeting: Kate Green (kate.green4@nhs.net) or 020 7288 3554

Agenda Item		Paper	Action and Timing
Patient Story			
	Patient Story *Philippa Davies, Director of Nursing & Patient Experience*	*Verbal*	*Note* 1400hrs
16/044	**Declaration of Conflicts of Interests** *Steve Hitchins, Chair*		*Declare* *1420hrs*
16/045	**Apologies & Welcome** *Steve Hitchins, Chair*		*Note* 1425hrs
16/046	**Minutes, Action Log and Matters Arising 2 March** *Steve Hitchins, Chair*	**1**	*Approve* 1430hrs
16/047	**Chairman's Report** *Steve Hitchins, Chair*	*Verbal*	*Note* 1435hrs
16/048	**Chief Executive's Report** *Simon Pleydell, Chief Executive*	**2**	*Note* 1445hrs
Patient Safety & Quality			
16/049	**Serious Incident Report** *Philippa Davies, Director of Nursing & Patient Experience*	**3**	*Approve* 1455hrs
16/050	**Safe Staffing Report** *Philippa Davies, Director of Nursing & Patient Experience*	**4**	*Approve* 1505hrs

	Item withdrawn	*5*	
Performance			
16/051	**Financial Performance Month 11** *Stephen Bloomer, Chief Finance Officer*	**6**	*Approve* 1515hrs
16/052	**Performance Dashboard Month 11** *Carol Gillen, Chief Operating Officer*	**7**	*Approve* 1525hrs
16/053	**Staff Survey 2015/16 Results and Action Plan 2016/17** *Norma French, Director of Workforce*	**8**	*Approve* *1545hrs*
Governance			
16/054	**Budget Setting 2016/17** *Stephen Bloomer, Chief Finance Officer*	**9**	*Note* 1600hrs
16/055	**Quality Committee Draft Minutes 9 March 2016** *Anu Singh, NED Chair*	**10**	*Note* 1615hrs
16/056	**Register of Trust Deed of Executive / Seal** *Lynne Spencer, Director of Communications & Corporate Affairs*	**11**	*Approve* 1620hrs
16/057	**Trust Board forward planner April 2016 to March 2017** *Lynne Spencer, Director of Communications & Corporate Affairs*	**12**	*Approve* 1625hrs
16/058	**Standing Orders, Scheme of Delegation and Trust Board Committees Terms of Reference** *Steve Hitchins, Chair*	**13**	*Approve* 1630hrs
Any other urgent business and questions from the public			
	No items notified to the Chair		
Date of next Trust Board Meeting			
	4 May 2016 Whittington Education Centre, Room 7		

Register of Conflicts of Interests:
The Register of Members' Conflicts of Interests is available for viewing during working hours from Lynne Spencer, Director of Communications & Corporate Affairs, at Trust Headquarters, Ground Floor, Jenner Building, Whittington Health, Magdala Avenue, London N19 5NF - communications.whitthealth@nhs.net.

Whittington Health NHS

ITEM: ONE
Doc: 16/046

The draft minutes of the meeting of the Trust Board of Whittington Health held in public at 1400hrs on Wednesday 2nd March 2016 in the Whittington Education Centre

Present:	Stephen Bloomer	Chief Finance Officer
	Anita Charlesworth	Non-Executive Director
	Philippa Davies	Director of Nursing and Patient Experience
	Norma French	Director of Workforce
	Carol Gillen	Acting Chief Operating Officer
	Steve Hitchins	Chairman
	David Holt	Non-Executive Director
	Richard Jennings	Medical Director
	Paul Lowenberg	Non-Executive Director
	Simon Pleydell	Chief Executive
	Anu Singh	Non-Executive Director
In attendance:	Kate Green	Minute Taker
	Lynne Spencer	Director of Communications & Corporate Affairs

Patient Story

Philippa Davies introduced Lianne Smith who explained her patient experience whilst accessing the urology service. Lianne had been apprehensive about her treatment due to her being transgender (pre-operative). Lianne highlighted that staff had been unaware of how best to manage communication with transgender patients. She highlighted that 2008 guidance on the treatment of transgender patients is available for health services, however Lianne felt this was fairly out of date, and commended the House of Commons Transgender Equality Report published in January 2016. Phillipa Marszall informed the Board that the guidance had been circulated, and that service managers had arranged training for staff. The Chairman and Board members thanked Lianne for attending and sharing her experience.

16/029 Declaration of Conflicts of Interest

29.01 No Board members declared any interest in any of the items scheduled for discussion at that afternoon's meeting.

16/030 Apologies and welcome

30.01 Steve Hitchins welcomed everyone to the meeting. Apologies for absence were received from Greg Battle, Graham Hart, Siobhan Harrington, Tony Rice and Paul Convery.

16/031 Minutes, Action Log and Matters Arising

31.01 The minutes of the Trust Board meeting held on Wednesday 3rd February were agreed as a true record, and there were no matters arising other than those already scheduled for discussion.

Actions

31.02 105.08 IT Review: Stephen Bloomer confirmed this was under way. The fieldwork had been completed, and he hoped to be able to bring the report to the Board in April.

160.09 Dashboard: the review of the contents of the dashboard was under way, and Carol Gillen would continue to keep the Board informed of progress.

160.11 Speak up Champion: Norma French informed the Board that there was currently a national consultation in progress which was likely to result in new national policy, and she expected to be able to report on this further before the start of the new financial year.

16/032 Chairman's Report

32.01 Steve Hitchins began his report by congratulating Philippa Davies on having been awarded an MBE, which she had received from Prince Charles the previous week. Her award had attracted much favourable publicity. He congratulated the diabetes team, who in the recent national audit had scored the highest for eight quality standards of all Trusts in England, with a score of 95% against the national average of 54%.

32.02 Whittington Health highlighted pioneering work with a leading football club around the self-management of people with long-term conditions.

33.03 This was Anita Charlesworth's last Board meeting with the Trust, and Steve paid tribute to all the hard work she had undertaken and commitment she had shown in her five years as a Non-Executive Director, describing her as a voice of common sense who would be greatly missed. Gillian Greenhalgh had stepped down as Chair of Islington CCG and Jo Sauvage had been appointed as new Chair.

16/033 Chief Executive's Report

33.01 Simon Pleydell drew attention to the considerable pressure facing the Trust's Emergency Department at present, and invited Carol Gillen to elaborate on this under the Performance Report. Steve Hitchins added that Board members should be aware how hard staff were working and how impressed he was by their level of commitment and energy.

33.02 Anita Charlesworth commented on the difference between the infection control statistics when she first joined Whittington health five years ago and commended the Infection Control Team for the marked improvements they had achieved for patients.

16/034 Serious Incident Report

34.01 Philippa Davies informed the Board that four serious incidents (SIs) had been declared in January, bringing the total for the year to 48 since 1st April 2015. The four new ones declared were as follows:

- 5 Grade 3 pressure ulcers (reported now in clusters rather than as individual cases)
- An unexpected admission to NICU
- An unexpected maternal death following delivery (related to a pre-existing condition)
- A delayed diagnosis due to a screening issue for haemoglobinopathy

34.02 The report contained a focus on falls, of which 481 had been reported during the calendar year, and the top five areas where these had been reported. She reported that 'falls' could include trips, or loss of control as a result of which a patient had been lowered to the ground, and that in only 6 cases of the 481 declared had a fracture been sustained.

34.03 Richard Jennings confirmed that the Trust culture of reporting is continually improving with an increased focus on sharing learning from incidents. The risk management software 'DATIX' is being developed and this will make the system more user friendly for staff to further improve reporting.

16/35 Safer Staffing Report

35.01 The safer staffing report covered the position for nursing and midwifery on the wards during January, and Philippa reported that the majority of areas had reported greater than 95% actual rather than planned staffing levels. Where those levels had exceeded 100% this had been due to the need for 'specials', although the amount of specialling required on the wards had decreased between December and January.

35.02 A recruitment day for Health Visitors had been held the previous weekend, and Norma French informed the Board that the Trust (through its recruitment and retention group) was actively looking at different options for recruitment since recruitment days were attracting fewer applicants and were very labour intensive.

16/36 Report from Quality Committee

36.01 Anu Singh informed the Board that the draft minutes circulated were those of the most recent meeting of the committee therefore not yet signed off by the whole committee but authorised for circulation by her as the Chair. She highlighted the meeting's focus on the Friends & Family test, saying that this needed to be used in a far more proactive way within community services, adding that she and Philippa Davies were working on this in order to ensure the use of all available national resources.

16/037 Financial Report

37.01 Stephen Bloomer highlighted that the Trust was reporting a £12.5m deficit at the end of Month 10, which was £647k off plan. There had been some improvement in-month, and Stephen remained confident that the Trust would achieve its forecast year-end deficit of £15m. Key to this would be maintaining control of the position on temporary staffing and managing the working capital position.

37.02 The Trust had been given a date where it could draw down the agreed cash facility. As at the previous month, the Trust continued to trigger the income cap for all North Central London CCGs except Islington, and the team was working with commissioners to resolve this.

37.02 Steve Hitchins congratulated Stephen and his team on maintaining a position so close to target; he also thanked members of the Board and Finance & Business Development Committee for their guidance, and Simon for his work with the clinicians in the new ICSU structure. In answer to a question from Anita Charlesworth about staffing, Norma replied that there was currently a 19% vacancy factor within nursing, midwifery and health care assistants, this equated to 274 vacancies, of which 112 were Band 5 nurses.

37.03 The attrition rate was very high, with some leaving within a year of appointment. Work was in hand to fully understand the reasons for this, and consideration was being given to reviewing the study leave policy so that staff in whom considerable investment was being made were asked to commit to staying at the Trust for a set (yet to be agreed) period of time. Philippa Davies added that the Trust's position was by no means unique – there were some 10,000 vacancies in London, and she was due to attend a meeting the following day to discuss how Trusts could better work together to attract nurses.

37.04 Norma French informed the Board that she would be presenting a draft Recruitment & Retention Strategy to the Trust Management Group; this strategy would then be presented to the Workforce Assurance Committee and Trust Board in May.

37.05 In answer to a question from David Holt about the Trust's Cost Improvement Programmes (CIP) performance, Stephen replied that the Trust had delivered 78% of its CIP plan to date. Some schemes were behind (e.g. procurement) and would carry over into next year. Teams had been working on next year's CIP plan since last November, but it was acknowledged the first quarter was likely to be challenging. A number of schemes were being worked on through the budget-setting process.

37.06 Year-end figures will be competed in April and reported to the Trust Board in May.

16/038 Performance Dashboard

38.01 Carol Gillen informed the Board that the Trust was performing well on RTT, and had been successful in securing some additional funding for validation. DNA targets were improving, and theatre utilisation was improving. The Trust was on track to achieve all its cancer targets. Good progress had been made on diagnostics though audiology targets remained challenging. There were plans to integrate the service with medicine, and the March figures were expected to show full compliance.

38.02 Within community services it was noted that the demand for MSK services had now increased by 13%, this increase was felt to be due in part to an increase in self-referrals. The rehabilitation service was on track to meet its targets from April. A recent loss of podiatrists had caused a dip in that service, and there were plans to address this through a combination of recruitment and skill mix.

38.03 Carol reported that ED services faced immense pressures throughout London. There had been a 12-15% increase in urgent care patients, and throughout the service the number of admissions had risen sharply. ED was frequently seeing over 300 patients per day, and on occasion had over 100 admissions during the night. It was acknowledged that it was not just the ED but the whole pathway that was under pressure, and there had consequently been several breaches. There was a need to create capacity earlier in the morning, and to review some of the lengths of stay. Staff were working incredibly hard throughout the organisation, and Steve Hitchins, acknowledging the pressures they faced, asked Carol to pass on the thanks of the Board.

38.04 Anita Charlesworth asked about the apparent dip in 'death in place of choice', which appeared off target. Carol confirmed this was likely due to very small numbers distorting percentages, there were also cases where patients simply changed their minds.

38.05 In answer to a question from Paul Lowenberg about podiatry, Carol replied that there were certain areas within the therapies where recruitment was very difficult, but there were plans to address the problem through a combination of flexibility and skill mix. David Holt enquired about the section of the report addressing harm free care, and Philippa Davies replied that the cause of the position here was attributable to pressure ulcers. It was noted that there was a misprint in the VTE figure, and the Trust had achieved its target in this area.

16/039 Local Supervising Authority Annual Audit Report

39.01 Head of Midwifery Manjit Roseghini presented the report, and Steve Hitchins began by congratulating her on her substantive appointment. Midwife Sinead Farrell was also present. The LSA audit had been held across London the previous October, and the Trust provided evidence to four domains:

- Interface of Statutory Supervision of Midwives with Clinical Governance
- The profile and effectiveness of Statutory Supervision
- Teamwork, Leadership and development
- Interface of Supervision with Service

39.02 Feedback had been extremely positive, particularly in the areas of women-centred care and the Trust's highly positive profile with midwives. In summary the Trust had fully met two of the domains; the other two had been identified as needing some improvement.

39.03 The report contained an action plan complete with recommendations, and Manjit took the Board through these, which were as follows:

- To maintain its continuous commitment to women focused care
- To work on succession planning to meet the NMC standard 1:15 SoM /Midwife ratio
- To work to reduce the C/S rate, noting that the team is fully engaged and working is in progress
- To continue to raise the profile in the Children's centre, including setting a date for a roadshow, and
- To support midwives in adapting to the concept of Revalidation.

Manjit added that the service had recently updated its Friends & Family test data collection sheet, which now included informing people they could contact supervisors with any feedback.

39.04 In answer to a question from Norma French about the vacancy figure, Manjit replied that this had now reduced from 3% to 2%. She added that there were no difficulties in recruiting to the midwifery service, although there were some problems with location, which was a pan-London issue.

39.05 Anita Charlesworth asked about home births, and Manjit replied that Whittington Health's figures were above the London average, however she pointed out that some mothers who might initially have chosen to have a home birth had opted instead to use the birth centre.

39.06 Manjit reported that a new clinical governance manager had recently been appointed to the service.

16/040 <u>Nursing Establishment Review</u>

40.01 Philippa Davies explained that the Trust carried out a bi-annual review of its nursing establishment, and that this for the first time included ED, maternity services, theatres and intensive care. The report contained considerable detail to demonstrate the complexity of the position, and to enable a full discussion to take place at Quality Committee.

40.02 In summary, the report gave the Board assurance that all wards were safely staffed, and once the Allocate roster was fully rolled out it would be possible to match establishment with acuity. Anita Charlesworth expressed the hope that it would also be possible to link this information with the use of 'specials'. Philippa added that the daily assessment of acuity should in time contribute towards the reduction in the use of agency staff. In consideration of the financial implications of this, Stephen Bloomer invited Philippa to let him know whether there were areas where the Programme Management Office (PMO) might usefully lend its support.

40.03 It was noted there would be a further, more detailed discussion of the report at Quality Committee the following week, and the Board agreed to delegate any decisions to be made to that body.

16/041 Finance & Business Development Committee

41.01 Paul Lowenberg reported that there had been two main topics of discussion, one being cash flow and the need to gain agreement on the DH loan and its terms, and the second being the financial plan for 2016/17. He commended the work staff had done on CIP plans, saying that the committee had been shown some very detailed schemes in which he felt the Board could have confidence.

16/042 Audit & Risk Committee

42.01 There had been considerable work within the Audit & Risk Committee on preparations for the year end, including discussion on VFM. The auditors had carried out detailed work, and although the Trust would not meet its control total due to its deficit position, there had been considerable debate about the good progress of the financial plan.

16/043 Business Conduct

Lynne Spencer informed the Board that this policy strengthened the Trust governance arrangements, aligned with the NHS Code of Governance and included the 2016/17 Trust Board Register of Interests. The revised policy had been shared with internal/external auditors and the counter-fraud team to ensure compliance with good governance principles. It was agreed that the ICSU directors should be added to the register and staff who were in a position of influence and seniority for decision making.

16/044 Any other business

44.01 No matters were raised.

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Action Notes Summary

Ref	**Action**	**Progress**	**Deadline**
105.08	IT Review: Stephen Bloomer confirmed this was under way. The fieldwork had been completed, and he hoped to be able to bring the report to the Board in April.	Included in April Board Seminar	
160.09	Dashboard: the review of the contents of the dashboard was under way, and Carol Gillen would continue to keep the Board informed of progress.	Ongoing	tbc
160.11	Speak up Champion: Norma French informed the Board that there was currently a national consultation in progress which was likely to result in new national policy, and she expected to be able to report on this further before the start of the new financial year.	Ongoing	tbc
37.04	Recruitment & Retention Strategy to the Trust Management Group; this strategy would then be presented to the Workforce Assurance Committee and Trust Board in May.	Presented to TMG- Board Agenda May	May
37.06	CIP Year-end figures will be competed in April and reported to the Trust Board in May.	April	April
16/043	ICSU directors should be added to the register and staff who were in a position of influence and seniority for decision making.	Completed	April

Whittington Health NHS

Nursing and Patient Experience
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The Whittington Hospital NHS Trust
Magdala Avenue
London N19 5NF

Whittington Health Trust Board

6 April 2016

Title:	Serious Incidents - Monthly Update Report		
Agenda item:	**03**	**Paper**	**16/049**
Action requested:	For Information		
Executive Summary:	This report provides an overview of serious incidents submitted externally via StEIS (Strategic Executive Information System) as of February 2016. This includes SI reports completed during this timescale in addition to recommendations made, lessons learnt and learning shared following root cause analysis. This report also details Whittington Health position following publication of the 'Learning from Mistakes league' launched by Monitor and the NHS TDA		
Summary of recommendations:	None		
Fit with WH strategy:	1. Integrated care 2. Efficient and Effective care 3. Culture of Innovation and Improvement		
Reference to related / other documents:	• Supporting evidence towards CQC fundamental standards (12) (13) (17) (20). • Ensuring that health service bodies are open and transparent with the relevant person/s. • National Framework for Reporting and Learning from Serious Incidents Requiring Investigation, • Whittington Health Serious Incident policy. • Health and Safety Executive RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013).		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	**Corporate Risk 636.** Create a robust SI learning process across the Trust. Trust Intranet page has been updated with key learning points following recent SIs and RCA investigations.		
Date paper completed:	18/03/2016		

Author name and title:		**Jayne Osborne, Quality Assurance Officer and SI Co-ordinator**		**Director name and title:**		**Philippa Davies, Director of Nursing and Patient Experience**	
Date paper seen by EC	**04 /16**	**Equality Impact Assessment complete?**	**n/a**	**Risk assessment undertaken?**	**n/a**	**Legal advice received?**	**n/a**

Serious Incidents Monthly Report

1. Introduction

This report provides an overview of serious incidents submitted externally via StEIS (Strategic Executive Information System) as of the end of February 2016.

The management of Serious Incident's (SIs) includes not only identification, reporting and investigation of each incident but also implementation of any recommendations following investigation and dissemination of learning to prevent recurrences.

2. Background

The Serious Incident Executive Approval Group (SIEAG) comprising the Executive Medical Director, Director of Nursing and Patient Experience, Chief Operating Officer, the Head of Integrated Risk Management and SI Coordinator meet weekly to review Serious Incident investigation reports in addition to investigations into high severity incidents to ascertain whether these meet the reporting threshold of a serious incident (as described within the NHSE Serious Incident Framework (March 2015).

3. Serious Incidents

3.1 The Trust has declared 8 serious incidents during February 2016 bringing the total to 56 since 1st April 2015. This includes 2 incidents that were later downgraded (de-escalated).

The Trust has no overdue SI investigations. 4 investigations have extended deadlines agreed;

a). Medication Incident (Nitrofurantoin) –an extension has been requested and approved for further 60 days due to the complexities surrounding this incident.

b). Delayed Diagnosis and treatment of Colorectal cancer –an extension has been requested and approved for further 60 days due to the requirement for an independent investigator and external expert being appointed.

c). Catastrophic subdural haematoma after a patient fell on an escalator (Deceased) –an extension has been requested and approved for further 20 days due to the requirement for an independent external Trauma Centre Neurosurgical Consultant being appointed.

d). Unexpected death following issues around Nutritional and Safeguarding in the Community– an extension has been requested and approved for further 3 weeks due to further review required to address safeguarding queries.

All serious incidents are reported to North East London Commissioning Support Unit (NEL CSU) via StEIS and a lead investigator is assigned to each by the Clinical Director of the relevant Integrated Clinical Support Unit.

All serious incidents are uploaded to the NRLS (National Reporting and Learning Service) in line with national guidance and CQC statutory notification requirements.

3.2 **The table below details the Serious Incidents currently under investigation**

Category	Month Declared	Summary
Delayed Diagnosis (Ref Oct DD) (2015.33113)	Oct 15	Delayed diagnosis and treatment of colo-rectal cancer
Medication Incident (Ref; Oct MI) (2015.33733)	Oct 15	Patient sustained long term harm from prolonged treatment with oral antimicrobials
Sub optimal care of deteriorating patient Ref 650	Dec 15	Unexpected death in the community following issues around nutrition and safeguarding.
Slip/Trips Falls Ref 604	Dec 15	Patient suffered a subdural haematoma following a fall on an escalator.
Pressure Ulcer meeting SI Criteria- (2016.2612)	Jan 16	Pressure Ulcer Cluster. 5 separate patients acquired Grade 3 pressure on the same ward between 20/01/2016-26/01/2016.
Maternity/Obstetric incident (2016.1302)	Jan 16	Unexpected admission to NICU, baby sustained shoulder dystocia
Maternity/Obstetric incident (2016.835)	Jan 16	Unexpected maternal death following delivery of probably cardio myopathy related to sickle cell disease.
Delayed Diagnosis (2016.732)	Jan 16	Delayed diagnosis - failure to screen appropriately for haemoglobinopathy.
Slip/Trips Falls (2016.3456)	Feb16	Patient sustained a fractured neck of femur following an unwitnessed fall.
Sub-optimal care of the deteriorating patient (2016.4117)	Feb16	Sub optimal care relating to sepsis
Slip/Trips Falls (2015.4100)	Feb16	Patient sustained a fractured neck of femur following an unwitnessed fall.
Diagnostic incident (including failure to act on test results) (2016.4127)	Feb16	Musculoskeletal Imaging appointment referral breach.
Maternity Birth Centre Closure (2016.5557)	Feb16	Maternity Birth Centre closure due to capacity and demand issues.
Unexpected Admission to NICU- Baby (2016.5552)	Feb16	Baby born in poor condition, requiring resuscitation.
Slips/trips/falls meeting SI criteria (2016.5535)	Feb16	Patient sustained a fractured neck of femur following an unwitnessed fall.
Unexpected Admission to NICU- Baby (2016.7570)	Feb16	Baby born in poor condition transferred to NICU and then UCLH for total body cooling

3.3. The table below details serious incidents by category reported to the NEL CSU. The Trust reported 8 serious incidents in February 2016

STEIS 2015-16Category	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan 2016	Feb	total
Child protection	0	0	0	1	0	0	0	0	0	0	0	1
Communication issue	1	0	0	0	0	0	0	0	0	0	0	1
Confidential information leak/loss/Information governance breach	1	2	0	0	1	2	1	0	0	0	0	7
Diagnostic Incident including delay	0	2	0	1	0	0	1	0	1	1	1	7
Drug incident	0	0	0	0	1	0	1	1	1	0	0	4
Failure to obtain appropriate bed for child who needed it	0	0	0	0	0	0	0	1	0	0	0	1
Maternity/Obstetric incident mother and baby (includes foetus/neonate/infant)	0	1	0	1	0	1	0	1	1	2	3	10
Pressure ulcer grade 3 (including cluster)	5	1	0	0	0	0	0	0	0	1	0	7
Screening Issues	0	0	0	1	0	0	0	0	0	0	0	1
Slips/Trips/Falls	1	0	0	0	0	0	0	3	1	0	3	8
Suboptimal care of deteriorating patient	0	1	0	2	0	0	1	0	2	0	1	7
Medical equipment/ devices/disposables incident	0	0	0	0	0	1	0	0	0	0	0	1
Unexpected death	0	0	0	0	0	0	0	0	1	0	0	1
Total	8	7	0	6	2	4	4	6	7	4	8	**56**

4. Submission of SI reports

All final investigation reports are reviewed at weekly SIEAG meeting chaired by an Executive Director (Trust Medical Director or Director of Nursing and Patient Experience) comprising membership from the Chief Operating Officer, Executive Operational Team and Integrated Risk Management. The Integrated Clinical Support Unit's (ICSU) Operational Directors or their deputies are required to attend each meeting when an investigation from their services is being presented.

The remit of this meeting is to scrutinise the investigation and its findings to ensure that contributory factors have been fully explored, root causes identified and that actions are aligned with the recommendations, so that lessons are learnt and appropriate action taken to prevent future harm.

On completion of the report the patient and/or relevant family member receive a final outcome letter highlighting the key findings of the investigation, actions taken to improve services and learn from mistakes. A 'being open' meeting is offered in line with duty of candour recommendations.

The Trust has executed its duties under the Duty of Candour for the investigation completed and submitted in February 2016.

Lessons learned following the investigation are shared with all staff and departments involved in the patient's care through various means including the 'Big 4' in theatres, 'message of the week' in Maternity and Obstetrics and other departments. Learning from identified incidents is also published on the Trust Intranet making them available to all staff.

4.1 The Trust submitted 9 reports to NELCSU in February 2016.

4.2. The table below provides a brief summary of a selection of actions taken as a result of the lessons learnt.

Summary	Actions taken as result of lessons learnt
• **Ref 590**	**Unexpected death of a patient re-admitted to hospital with sepsis and bleeding following ERCP (Endoscopic Retrograde Cholangio Pancreatogram).** • Updated 'Anticoagulant Therapy: peri-operative bridging: Guidelines for patients on anticoagulant therapy undergoing surgical or other invasive procedures', now include a proforma and a bridging anticoagulation plan requesting a Consultant level decision making. • Improved peri-procedural ERCP documentation to identify bleed risk pre-procedure such as bridging anticoagulation and triggers directing escalation of unexpected findings or increased bleed or infection risk. • Consent Policy currently under review to reflect national best practice and include locally agreed core information about risks and benefits.
• **Ref:818**	**Unexpected stillbirth at 29 weeks gestation.** • The Did Not Attend pathway in the Maternity Day Unit is being fully reviewed and systems put in place so that DNAs are easy to identify and followed up appropriately • An annual education programme for midwives and obstetricians is now in place and has a focus on current guidelines for the recognition of pre-eclampsia, including the changing importance of proteinuria. • The referral pathway to the High Risk midwife is being reviewed to identify and implement a more robust referral process. • Undertake a review of the current process when patients call to rearrange a consultant appointment. •

Summary	Actions taken as result of lessons learnt
• **Ref: 657**	**Sub optimal care of debridement of pressure ulcer procedure carried out**. • In-house training on management of the vascular foot and pressure ulcers has been arranged for all Podiatrists, TVN and District Nurse services across Islington and Haringey. • A Standard Operating Procedure (SOP) is being developed for ulcer debridement in diabetic and vascular ulcers with referral to NICE guidelines. • A new structured clinical supervision procedure in Podiatry is being implemented to ensure that all staff receive appropriate guidance and support. • The Trust has implemented mandatory training for all Podiatrists to complete the in-house foot ulcer rotation thus ensuring assessment and management of pressure ulcers be carried out in accordance to evidence-based clinical policies and guidelines.
• **Ref: 236**	**Misplaced central venous line into the carotid artery.** • Modification of the Care bundle sticker to include checks which will be used for all ED, Theatre and ITU Central line insertions. • Verification of correct line placement must now be obtained before use for infusing medication

5.0 Sharing Learning

In order to ensure learning is shared widely across the organisation, a dedicated site has been created on the Trust intranet detailing a range of patient safety case studies.

6.0 Learning from Mistakes

A league table identifying levels of openness and transparency within NHS trusts and foundation trusts was produced by Monitor and the Trust Development Authority (TDA) and published 9th March 2016

The league table has been drawn together by scoring providers based on the fairness and effectiveness of procedures for reporting errors; near misses and incidents; staff confidence and security in reporting unsafe clinical practice; and the percentage of staff who feel able to contribute towards improvements at their trust.

The data for 2015/16 – which is drawn from the 2015 NHS staff survey and from the National Reporting and Learning System – shows that:

- 18 providers were outstanding
- 102 were good
- 78 gave cause for significant concern
- 32 had a poor reporting culture

Whittington Health has been awarded a ranking of **'Good'** indicating good levels of openess and transparency.

In terms of ranking, Whittington Health features 78th out of 230 Trusts.

See Appendix 1 – Learning from Mistakes League , all Trusts

Appendix 2 - Learning from Mistakes League, London Region

7.0 Summary

The Trust Board is asked to note the content of this report which aims to provide assurance
that the serious incident process is managed effectively, that there are good levels of openness and transparency within the organisation and that lessons learnt as a result of serious
incident investigations are shared widely.

APPENDIX ONE

LEARNING FROM MISTAKES LEAGUE

The rankings are as follows:

1 – **outstanding levels** of openness and transparency

2 – **good** levels of openness and transparency

3 – **significant concerns** about openness and transparency

4 – **poor reporting culture**

Outstanding levels

Good

Significant concerns

Poor reporting culture

Trust	Category	Rank
Northumbria Healthcare NHS Foundation Trust	★	1
Oxleas NHS Foundation Trust	★	2
The Royal Marsden NHS Foundation Trust	★	3
Tees, Esk and Wear Valleys NHS Foundation Trust"	★	4
Salisbury NHS Foundation Trust	★	5
Wrightington, Wigan and Leigh NHS Foundation Trust	★	6
Birmingham Children's Hospital NHS Foundation Trust	★	7
Tameside Hospital NHS Foundation Trust	★	8
Guy's and St Thomas' NHS Foundation Trust	★	9
Sussex Community NHS Trust	★	10
Liverpool Heart and Chest Hospital NHS Foundation Trust	★	11
Nottinghamshire Healthcare NHS Foundation Trust	★	12
Great Western Hospitals NHS Foundation Trust	★	13
Cambridgeshire Community Services NHS Trust	★	14
Bradford District Care NHS Foundation Trust	★	15
The Walton Centre NHS Foundation Trust	★	16
Surrey and Borders Partnership NHS Foundation Trust	★	17
Central London Community Healthcare NHS Trust	★	18
2Gether NHS Foundation Trust	✓	19
South Essex Partnership University NHS Foundation Trust	✓	20
The Christie NHS Foundation Trust	✓	21
Great Ormond Street Hospital for Children NHS Foundation Trust	✓	22

★ **Outstanding levels** ✓ **Good** ? **Significant concerns** ! **Poor reporting culture**

Trust	Category	Rank
Lancashire Care NHS Foundation Trust	✓	23
Moorfields Eye Hospital NHS Foundation Trust	✓	24
Wirral Community NHS Trust	✓	25
Homerton University Hospital NHS Foundation Trust	✓	26
Calderstones Partnership NHS Foundation Trust	✓	27
Berkshire Healthcare NHS Foundation Trust	✓	28
Papworth Hospital NHS Foundation Trust	✓	29
Poole Hospital NHS Foundation Trust	✓	30
University Hospital Southampton NHS Foundation Trust	✓	31
Royal Surrey County Hospital NHS Foundation Trust	✓	32
Bridgewater Community Healthcare NHS Foundation Trust	✓	33
Bolton NHS Foundation Trust	✓	34
Hounslow And Richmond Community Healthcare NHS Trust	✓	35
Nottingham University Hospitals NHS Trust	✓	36
Worcestershire Health and Care NHS Trust	✓	37
Dudley And Walsall Mental Health Partnership NHS Trust	✓	38
Derbyshire Community Health Services NHS Foundation Trust	✓	39
The Clatterbridge Cancer Centre NHS Foundation Trust	✓	40
Frimley Health NHS Foundation Trust	✓	41
Central Manchester University Hospitals NHS Foundation Trust	✓	42
City Hospitals Sunderland NHS Foundation Trust	✓	43
Northumberland, Tyne and Wear NHS Foundation Trust	✓	44

★ **Outstanding levels** ✓ **Good** ? **Significant concerns** ! **Poor reporting culture**

Trust	Category	Rank
Pennine Care NHS Foundation Trust	✓	45
Burton Hospitals NHS Foundation Trust	✓	46
Harrogate and District NHS Foundation Trust	✓	47
Hertfordshire Community NHS Trust	✓	48
Queen Victoria Hospital NHS Foundation Trust	✓	49
South Staffordshire and Shropshire Healthcare NHS Foundation Trust	✓	50
Dartford And Gravesham NHS Trust	✓	51
Oxford Health NHS Foundation Trust	✓	52
Wye Valley NHS Trust	✓	53
Dorset Healthcare University NHS Foundation Trust	✓	54
Sheffield Children's NHS Foundation Trust	✓	55
Northamptonshire Healthcare NHS Foundation Trust	✓	56
South London and Maudsley NHS Foundation Trust	✓	57
Cumbria Partnership NHS Foundation Trust	✓	58
Rotherham Doncaster and South Humber NHS Foundation Trust	✓	59
Shropshire Community Health NHS Trust	✓	60
Lincolnshire Community Health Services NHS Trust	✓	61
Greater Manchester West Mental Health NHS Foundation Trust	✓	62
Cornwall Partnership NHS Foundation Trust	✓	63
Portsmouth Hospitals NHS Trust	✓	64
5 Boroughs Partnership NHS Foundation Trust	✓	65
Surrey And Sussex Healthcare NHS Trust	✓	66

★ **Outstanding levels** ✓ **Good** ? **Significant concerns** ! **Poor reporting culture**

Trust	Category	Rank
Cheshire and Wirral Partnership NHS Foundation Trust	✓	67
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust	✓	68
University Hospitals Coventry And Warwickshire NHS Trust	✓	69
Mid Cheshire Hospitals NHS Foundation Trust	✓	70
Camden and Islington NHS Foundation Trust	✓	71
East Lancashire Hospitals NHS Trust	✓	72
Cambridgeshire and Peterborough NHS Foundation Trust	✓	73
Royal Devon and Exeter NHS Foundation Trust	✓	74
West Middlesex University Hospital NHS Trust	✓	75
Blackpool Teaching Hospitals NHS Foundation Trust	✓	76
The Royal Wolverhampton NHS Trust	✓	77
The Whittington Hospital NHS Trust	✓	78
James Paget University Hospitals NHS Foundation Trust	✓	79
Hampshire Hospitals NHS Foundation Trust	✓	80
Hertfordshire Partnership University NHS Foundation Trust	✓	81
Milton Keynes Hospital NHS Foundation Trust	✓	82
Warrington and Halton Hospitals NHS Foundation Trust	✓	83
County Durham and Darlington NHS Foundation Trust	✓	84
Liverpool Women's NHS Foundation Trust	✓	85
Salford Royal NHS Foundation Trust	✓	86
Royal National Orthopaedic Hospital NHS Trust	✓	87
Devon Partnership NHS Trust	✓	88

★ **Outstanding levels** ✓ **Good** ? **Significant concerns** ! **Poor reporting culture**

Trust	Category	Rank
University Hospitals Birmingham NHS Foundation Trust	✓	89
Derby Teaching Hospitals NHS Foundation Trust	✓	90
Ipswich Hospital NHS Trust	✓	91
Yeovil District Hospital NHS Foundation Trust	✓	92
Oxford University Hospitals NHS Foundation Trust	✓	93
Bedford Hospital NHS Trust	✓	94
Epsom And St Helier University Hospitals NHS Trust	✓	95
Staffordshire And Stoke On Trent Partnership NHS Trust	✓	96
Leicestershire Partnership NHS Trust	✓	97
Sandwell And West Birmingham Hospitals NHS Trust	✓	98
Royal Liverpool And Broadgreen University Hospitals NHS Trust	✓	99
Birmingham Women's NHS Foundation Trust	✓	100
The Hillingdon Hospitals NHS Foundation Trust	✓	101
Gateshead Health NHS Foundation Trust	✓	102
Solent NHS Trust	✓	103
Mersey Care NHS Trust	✓	104
York Teaching Hospital NHS Foundation Trust	✓	105
Somerset Partnership NHS Foundation Trust	✓	106
The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	✓	107
West Suffolk NHS Foundation Trust	✓	108
Bradford Teaching Hospitals NHS Foundation Trust	✓	109
Torbay and South Devon Healthcare NHS Foundation Trust	✓	110

★ **Outstanding levels** ✓ **Good** ? **Significant concerns** ! **Poor reporting culture**

Trust	Category	Rank
Barnsley Hospital NHS Foundation Trust	✓	111
North Tees and Hartlepool NHS Foundation Trust	✓	112
Airedale NHS Foundation Trust	✓	113
Maidstone And Tunbridge Wells NHS Trust	✓	114
Southend University Hospital NHS Foundation Trust	✓	115
Countess of Chester Hospital NHS Foundation Trust	✓	116
South West Yorkshire Partnership NHS Foundation Trust	✓	117
Dorset County Hospital NHS Foundation Trust	✓	118
Lancashire Teaching Hospitals NHS Foundation Trust	✓	119
South Tees Hospitals NHS Foundation Trust	✓	120
Tavistock and Portman NHS Foundation Trust	?	121
East London NHS Foundation Trust	?	122
Royal Brompton & Harefield NHS Foundation Trust	?	123
Northern Devon Healthcare NHS Trust	?	124
Central and North West London NHS Foundation Trust	?	125
South Warwickshire NHS Foundation Trust	?	126
Barnet, Enfield And Haringey Mental Health NHS Trust	?	127
Luton and Dunstable University Hospital NHS Foundation Trust	?	128
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	?	129
Southern Health NHS Foundation Trust	?	130
St Helens And Knowsley Hospitals NHS Trust	?	131
King's College Hospital NHS Foundation Trust	?	132

★ **Outstanding levels** ✓ **Good** ? **Significant concerns** ! **Poor reporting culture**

Trust	Category	Rank
Taunton and Somerset NHS Foundation Trust	?	133
Chelsea and Westminster Hospital NHS Foundation Trust	?	134
University College London Hospitals NHS Foundation Trust	?	135
Kingston Hospital NHS Foundation Trust	?	136
East And North Hertfordshire NHS Trust	?	137
The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust	?	138
Stockport NHS Foundation Trust	?	139
Kent And Medway NHS And Social Care Partnership Trust	?	140
Birmingham and Solihull Mental Health NHS Foundation Trust	?	141
Lewisham and Greenwich NHS Trust	?	142
Peterborough and Stamford Hospitals NHS Foundation Trust	?	143
Kent Community Health NHS Foundation Trust	?	144
The Dudley Group NHS Foundation Trust	?	145
East Cheshire NHS Trust	?	146
The Princess Alexandra Hospital NHS Trust	?	147
The Royal Orthopaedic Hospital NHS Foundation Trust	?	148
Basildon and Thurrock University Hospitals NHS Foundation Trust	?	149
Leeds Community Healthcare NHS Trust	?	150
Sheffield Health & Social Care NHS Foundation Trust	?	151
South West London And St George's Mental Health NHS Trust	?	152
University Hospitals Of North Midlands NHS Trust	?	153
North Middlesex University Hospital NHS Trust	?	154

★ **Outstanding levels** ✓ **Good** ? **Significant concerns** ! **Poor reporting culture**

Trust	Category	Rank
Derbyshire Healthcare NHS Foundation Trust	?	155
Weston Area Health NHS Trust	?	156
Hull And East Yorkshire Hospitals NHS Trust	?	157
Pennine Acute Hospitals NHS Trust	?	158
Cambridge University Hospitals NHS Foundation Trust	?	159
Coventry And Warwickshire Partnership NHS Trust	?	160
Calderdale and Huddersfield NHS Foundation Trust	?	161
Norfolk Community Health And Care NHS Trust	?	162
Imperial College Healthcare NHS Trust	?	163
Avon And Wiltshire Mental Health Partnership NHS Trust	?	164
University Hospitals Bristol NHS Foundation Trust	?	165
Doncaster and Bassetlaw Hospitals NHS Foundation Trust	?	166
Hinchingbrooke Health Care NHS Trust	?	167
Liverpool Community Health NHS Trust	?	168
Leeds and York Partnership NHS Foundation Trust	?	169
North Staffordshire Combined Healthcare NHS Trust	?	170
Leeds Teaching Hospitals NHS Trust	?	171
London North West Healthcare NHS Trust	?	172
Gloucestershire Care Services NHS Trust	?	173
Aintree University Hospital NHS Foundation Trust	?	174
Royal United Hospitals Bath NHS Foundation Trust	?	175
Wirral University Teaching Hospital NHS Foundation Trust	?	176

★ **Outstanding levels** ✓ **Good** ? **Significant concerns** ! **Poor reporting culture**

Trust	Category	Rank
Humber NHS Foundation Trust	?	177
North East London NHS Foundation Trust	?	178
Buckinghamshire Healthcare NHS Trust	?	179
North Bristol NHS Trust	?	180
Sussex Partnership NHS Foundation Trust	?	181
Barking, Havering And Redbridge University Hospitals NHS Trust	?	182
Northern Lincolnshire and Goole NHS Foundation Trust	?	183
Colchester Hospital University NHS Foundation Trust	?	184
University Hospitals of Morecambe Bay NHS Foundation Trust	?	185
George Eliot Hospital NHS Trust	?	186
Royal Berkshire NHS Foundation Trust	?	187
Birmingham Community Healthcare NHS Trust	?	188
Mid Essex Hospital Services NHS Trust	?	189
Royal Free London NHS Foundation Trust	?	190
Southport And Ormskirk Hospital NHS Trust	?	191
Gloucestershire Hospitals NHS Foundation Trust	?	192
Plymouth Hospitals NHS Trust	?	193
Black Country Partnership NHS Foundation Trust	?	194
South Tyneside NHS Foundation Trust	?	195
Chesterfield Royal Hospital NHS Foundation Trust	?	196
Sheffield Teaching Hospitals NHS Foundation Trust	?	197
The Rotherham NHS Foundation Trust	?	198

★ **Outstanding levels** ✓ **Good** ? **Significant concerns** ! **Poor reporting culture**

Trust	Category	Rank
Croydon Health Services NHS Trust	!	199
West London Mental Health NHS Trust	!	200
Brighton And Sussex University Hospitals NHS Trust	!	201
University Hospital of South Manchester NHS Foundation Trust	!	202
University Hospitals Of Leicester NHS Trust	!	203
St George's University Hospitals NHS Foundation Trust	!	204
West Hertfordshire Hospitals NHS Trust	!	205
Western Sussex Hospitals NHS Foundation Trust	!	206
Northampton General Hospital NHS Trust	!	207
Barts Health NHS Trust	!	208
Ashford and St Peter's Hospitals NHS Foundation Trust	!	209
Sherwood Forest Hospitals NHS Foundation Trust	!	210
Norfolk and Norwich University Hospitals NHS Foundation Trust	!	211
Isle of Wight NHS Trust (acute sector)	!	212
Kettering General Hospital NHS Foundation Trust	!	213
Shrewsbury And Telford Hospital NHS Trust	!	214
Walsall Healthcare NHS Trust	!	215
Lincolnshire Partnership NHS Foundation Trust	!	216
East Kent Hospitals University NHS Foundation Trust	!	217
North Essex Partnership University NHS Foundation Trust	!	218
Worcestershire Acute Hospitals NHS Trust	!	219
United Lincolnshire Hospitals NHS Trust	!	220

★ **Outstanding levels** ✓ **Good** ? **Significant concerns** ! **Poor reporting culture**

Trust	Category	Rank
Heart of England NHS Foundation Trust	!	221
Isle of Wight NHS Trust (mental health sector)	!	222
Norfolk and Suffolk NHS Foundation Trust	!	223
North Cumbria University Hospitals NHS Trust	!	224
Alder Hey Children's NHS Foundation Trust	!	225
Medway NHS Foundation Trust	!	226
Manchester Mental Health and Social Care Trust	!	227
Mid Yorkshire Hospitals NHS Trust	!	228
Royal Cornwall Hospitals NHS Trust	!	229
East Sussex Healthcare NHS Trust	!	230

★ Outstanding levels ✓ Good ? Significant concerns ! Poor reporting culture

APPENDIX TWO
LEARNING FROM MISTAKES LEAGUE
(London Region)

The following summary report follows publication on 9th March 2016 of – Transparency Data; Learning from mistakes league.

NHS trusts and foundation trusts will be publically ranked on their openness and transparency under a new 'Learning from mistakes league' launched by Monitor and the NHS TDA.

The rankings each trust has been categorised into are as follows:

1 - Outstanding levels of openness and transparency
2 - Good levels of openness and transparency
3 - Significant concerns about openness and transparency
4 - Poor reporting culture

The published league tables have been drawn together by scoring providers trusts based on criteria that include; the fairness and effectiveness of procedures for reporting errors, near misses and incidents; staff confidence and security in reporting unsafe clinical practice; and the percentage of staff who feel able to contribute towards improvements at their trust.

Please see below for the data sources published at 'Learning from mistakes league':

Staff Survey Data 2015

Key Finding 7. Percentage of staff able to contribute towards improvements at work	Key Finding 30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	Key Finding 31. Staff confidence and security in reporting unsafe clinical practice	Key Finding 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

NRLS

Potential underreporting	Potential underreporting of severe harm or death	Harmful incidents	Reporting consistency past 6 months

Data for 2015/16 – which is drawn from the National Reporting and Learning System (NRLS) and the 2015 NHS staff survey - http://www.nhsstaffsurveys.com/Page/1010/Home/NHS-Staff-Survey-2015/ shows that in London:

- 4 providers were outstanding
- 11 were good
- 17 gave cause for significant concern
- 4 had a poor reporting culture

Bromley Community Healthcare, Your Healthcare and London Ambulance Service have not been included on the Learning from mistakes league.

APPENDIX TWO
LEARNING FROM MISTAKES LEAGUE
(London Region)

Appendix 1 - details London Region trusts, area and respective category
Appendix 2 - details the London Region trusts in category ranking order

Appendix 1

Trust	National Ranking	Category	Area
Central London Community Healthcare NHS Trust	18	1	North East and Central
Great Ormond Street Hospital for Children NHS Trust	22	2	
Moorfields Eye Hospital NHS Foundation Trust	24	2	
Homerton University Hospital NHS Foundation	26	2	
Camden & Islington NHS Foundation Trust	71	2	
Whittington Health NHS Trust	78	2	
Royal National Orthopaedic Hospital NHS Trust	87	2	
Tavistock and Portman NHS Foundation Trust	121	3	
East London Foundation NHS Trust	122	3	
Barnet, Enfield and Haringey Mental Health NHS Trust	127	3	
University College London Hospital NHS Foundation Trust	135	3	
North Middlesex University Hospital NHS Trust	154	3	
North East London Foundation NHS Trust	178	3	
Barking, Havering and Redbridge Hospitals NHS Trust	182	3	
Royal Free London NHS Foundation Trust	190	3	
Barts Health NHS Trust	208	4	
Hounslow and Richmond Community Healthcare NHS Trust	35	2	North West
West Middlesex University Hospital NHS Trust	75	2	
The Hillingdon Hospitals NHS Foundation Trust	101	2	
Royal Brompton and Harefield NHS Foundation Trust	123	3	
Central North West London NHS Foundation Trust	125	3	
Chelsea and Westminster Hospital NHS Foundation Trust	134	3	
Imperial College Healthcare NHS Trust	163	3	
London North West Healthcare NHS Trust	172	3	
West London Mental Health NHS Trust	200	4	
Oxleas NHS Foundation Trust	2	1	South
The Royal Marsden NHS Foundation Trust	3	1	
Guy's and St Thomas' NHS Foundation Trust	9	1	
South London and Maudsley NHS Foundation Trust	57	2	
Epsom and St Helier University Hospitals NHS Trust	95	2	
King's College Hospital NHS Foundation Trust	132	3	
Kingston Hospital NHS Foundation Trust	136	3	
Lewisham & Greenwich Healthcare NHS Trust	142	3	
South West London and St George's Mental Health NHS Trust	152	3	

APPENDIX TWO
LEARNING FROM MISTAKES LEAGUE
(London Region)

Croydon Health Services NHS Trust	199	4	
St George's Healthcare NHS Trust	204	4	

Appendix 2

Trust	Category
Oxleas NHS Foundation Trust	1 Outstanding (4)
The Royal Marsden NHS Foundation Trust	
Guy's and St Thomas' NHS Foundation Trust	
Central London Community Healthcare NHS Trust	
Great Ormond Street Hospital for Children NHS Trust	2 Good (11)
Moorfields Eye Hospital NHS Foundation Trust	
Homerton University Hospital NHS Foundation Trust	
Hounslow and Richmond Community Healthcare NHS Trust	
South London and Maudsley NHS Foundation Trust	
Camden & Islington NHS Foundation Trust	
West Middlesex University Hospital NHS Trust	
Whittington Health NHS Trust	
Royal National Orthopaedic Hospital NHS Trust	
Epsom and St Helier University Hospitals NHS Trust	
The Hillingdon Hospitals NHS Foundation Trust	
Tavistock and Portman NHS Foundation Trust	3 Significant Concerns (17)
East London Foundation NHS Trust	
Royal Brompton and Harefield NHS Foundation Trust	
Central North West London NHS Foundation Trust	
King's College Hospital NHS Foundation Trust	
Chelsea and Westminster Hospital NHS Foundation	
University College London Hospital NHS Foundation Trust	
Kingston Hospital NHS Foundation Trust	
Lewisham & Greenwich Healthcare NHS Trust	
South West London and St George's Mental Health NHS Trust	
North Middlesex University Hospital NHS	
Imperial College Healthcare NHS Trust	
London North West Healthcare NHS Trust	
North East London Foundation NHS Trust	
Barking, Havering and Redbridge Hospitals NHS Trust	
Royal Free London NHS Foundation Trust	
Barnet, Enfield and Haringey Mental Health NHS Trust	
Croydon Health Services NHS Trust	4 Poor Reporting Culture
West London Mental Health NHS Trust	
St George's Healthcare NHS Trust	

APPENDIX TWO
LEARNING FROM MISTAKES LEAGUE
(London Region)

Barts Health NHS Trust	

Andy Lyons, Patient Safety Team, NHE England, London

Whittington Health Trust Board

6 April 2016

Title:	Safe Staffing (Nursing and Midwifery)		
Agenda item:	**16/050**	**Paper**	**04**
Action requested:	For information		
Executive Summary:	This paper summarises the safe staffing position for nursing and midwifery on our hospital wards in February 2016. Key issues to note include: • The majority of areas reported greater than 95 per cent 'actual' versus 'planned' staffing levels except Maternity which reported a 89% fill rate for Midwives on night duty • A number of areas reported 'actual hours worked' over and above those 'planned' which was attributed in the main to the provision of extra support required due to the increase in beds to accommodate patients as well as an increase in those requiring special care on a 1:1 basis. • The number of shifts required for 'specialing' purposes decreased in February compared to January • 29 shifts triggered 'Red' in February		
Summary of recommendations:	Trust Board members are asked to note the February UNIFY return position and processes in place to ensure safe staffing levels in the organisation. Unify is the online collection system used for collating, sharing and reporting NHS and social care data.		
Fit with WH strategy:	Efficient and effective care, Francis Report recommendations, Cummings recommendations and NICE recommendations.		
Reference to related / other documents:	Complies with quality governance		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	3.4 Staffing ratios versus good practice standards		
Date paper completed:	March 2016		

Author name and title:		**Dr Doug Charlton Deputy Director of Nursing & Patient Experience**		**Director name and title:**		**Philippa Davies – Director of Nursing and Patient Experience**	
Date paper seen by EC	**April 2016**	**Equality Impact Assessment complete?**	**n/a**	**Risk assessment undertaken?**	**n/a**	**Legal advice received?**	**n/a**

Safe Nurse Staffing Levels

1.0 Purpose

To provide the Board with an overview of nursing and midwifery staffing levels in terms of 'actual' versus 'planned' hours on our wards in February 2016 and an assurance that these levels are monitored and managed daily.

2.0 Background

Whittington Health is committed to ensuring that levels of nursing staff, which include Registered Nurses (RNs), Registered Midwives (RMs) and Health Care Assistants (HCAs), match the acuity and dependency needs of patients within clinical ward areas in the hospital. This includes an appropriate level of skill mix of nursing staff to provide safe and effective care. These staffing levels are viewed along with reported outcome measures, 'registered nurse to patient ratios', percentage skill mix ratio of registered nurses to HCAs and the number of staff per shift required to provide safe and effective patient care.

Staff fill rate information appears on the NHS Choices website www.nhschoices.net. Fill rate data from 1st – 29th February 2016 for The Whittington Hospital has been uploaded and submitted on UNIFY, the online collection system used for collating, sharing and reporting NHS and social care data. Patients and the public are now able to see how hospitals are performing on this indicator on the NHS Choices website. This data sits alongside a range of other safety indicators.

3.0 Fill rate indicator return

As described above, the 'Fill rate indicator return' was completed and submitted. A copy of the UNIFY submission is available on request and is available to view on the Trust website. The 'actual' number of staffing hours planned is taken directly from our nurse roster system, following which a look back exercise is undertaken. There were occasions when planned hours were revised either up or down taking into account an increase or reduction in patient bed numbers. On occasions when there was a deficit in 'planned' hours versus 'actual' hours, staff are moved from other clinical areas to ensure safe staffing levels across our hospital. Staff are also moved to ensure wards/areas were staffed to a safe ratio of permanent versus temporary staff.

Appendix 1 details a summary of fill rates 'actual' versus 'planned' in February 2016. The average fill rate was 99.1 % for registered staff and 93.2% or care staff during the day and 97.5% for registered staff and 98.6% for care staff during the night.

Five wards reported below 95% fill rates for qualified nurses but were managed safely by moving staff from other green RAG rated areas and with support from matrons and practice development nurses. Above 100% fill rates occurred in ten areas where nurses were required to care for patients who needed 1:1 care due to high dependency or acuity needs of those patients with mental health needs.

3.1 Additional Staff (Specials 1:1)

When comparing February's requirement for 1:1 'specials' with previous month, the figures demonstrate a decrease level of need. February saw 55 requests for 1:1 specials compared to 95 requests in January. The requests made for this level of care are to ensure the safe management of particularly vulnerable groups of patients including elderly patients at risk of falls due to severe confusion, agitation and those patients detoxifying from drugs or alcohol. The number of RMN 'specials' required to care for patients with a mental health condition decreased in February (19) compared to January (41).

4.0 'Real Time' management of staffing levels to mitigate risk

Safe staffing levels are reviewed and managed on a daily basis. At the daily 08.30am bed meeting, the Director of Nursing/Deputy Director of Nursing in conjunction with matrons, site managers and other senior staff review all registered and unregistered workforce numbers by ward. Consideration is given to bed capacity and operational activity within the hospital which may impact on safe staffing. Actions are agreed to ensure that all areas are made safe.
Ward shifts are rated 'red' 'amber' or 'green' according to numbers of staff on duty, taking into account patient numbers, acuity and dependency.

- Green shifts are determined to be safe levels and would not require escalation as these constitute the levels expected through the agreed ward establishment.

- Amber shifts are determined to be at a minimum safe level. The matron will be alerted, but no further escalation will be required. Staff will prioritise their work and adjust their workload through the shift accordingly, with a continual review of any changes to the acuity and dependency of patients.

- Red shifts are determined to be at an unsafe level. Mitigating actions will be taken, and documented, which may include the movement of staff from another ward and utilisation of supernumerary staff within the numbers or reducing the number of patients on the ward to match the staff availability. In exceptional circumstances, activity would be reduced through reduction in the number of beds. This addresses the risk and reduces the shift to an amber rating.

In summary, in February a total of 29/1392 (2.1%) shifts initially triggered 'red' which was higher than previous months. Of these, 0/348 (0%) occurred in the Surgical Integrated Care Service Unit, 20/87 (23%) in the Women's ICSU and 9/609 (1.5%) shifts were reported to have triggered 'red' in the Medicine, Frailty & Networked Service ICSU. 0/279 (0.0%) triggered red in the Emergency and Urgent Care ISCU and 0/93 (0.0%) in Children's ICSU.

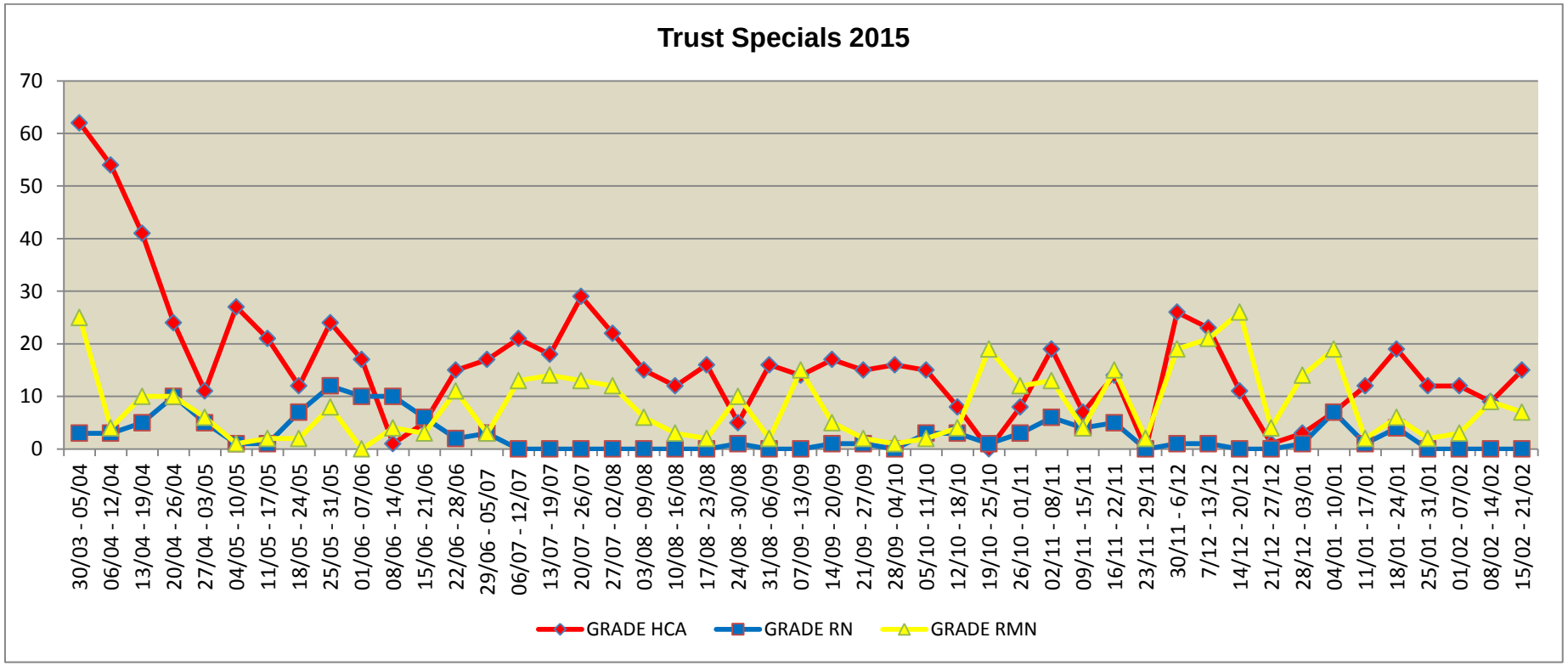
5.0 Conclusion

Trust Board members are asked to note the February UNIFY return position and processes in place to ensure safe staffing levels in the organisation.

Fill rate data - summary
February 2016

Day				**Night**				**Average fill rate data- Day**		**Average fill rate data- Night**	
Registered nurses/ midwives		Care staff		Registered nurses/ midwives		Care staff		Registered nurses/ midwives	Care staff	Registered nurses/ midwives	Care staff
Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual				
Hours 30743	Hours 30467	Hours 10905	Hours 10167	Hours 25686	Hours 25033	Hours 7981	Hours 7866	99.1 %	93.2%	97.5%	98.6%

February 2016



Whittington Health NHS

The Whittington Hospital NHS Trust
Magdala Avenue
London N19 5NF

Trust Board – Finance Report

05 April 2016

Title:	Month 11 2015/16 - Financial Performance		
Agenda item:	16/051	**Paper**	06
Action requested:	Consider the report and endorse the management actions taken to date and proposed to deliver the forecast year-end position		
Executive Summary:	The paper analyses the financial performance of the Trust covering income and expenditure, cash, CIPs and capital		
Summary of recommendations:	To note the financial results relating to February 2016		
Fit with WH strategy:	Delivering efficient, affordable and effective services. Meet statutory financial duties.		
Reference to related / other documents:	Previous monthly finance reports to the Trust Board. Operational Plan papers. Board Assurance Framework (Section 3).		
Date paper completed:	30 March 2016		

Author name and title:		**Stephen Bloomer, Chief Financial Officer**		**Director name and title:**		**Stephen Bloomer, Chief Financial Officer**	
Date paper seen by EC	**n/a**	**Equality Impact Assessment complete?**	**n/a**	**Quality Impact Assessment complete?**	**n/a**	**Financial Impact Assessment complete?**	**n/a**

Finance overview | Financial performance summary

As at month 11 the organisation reported a £13.8m year to date (YTD) deficit (c.5.2% as a proportion of turnover), this is £460k better than the planned position. The organisation continues to forecast the achievement of the full year planned deficit of £15m. Achievement of the forecast is dependent on constraining expenditure for the remainder of the financial year, and an appropriate full year income settlement for care services provided.

The table below provides a summary of the key finance metrics (£k) and actual performance against plan both for the February monthly position (in-month) and cumulative YTD

Indicator	Measure	In-Month Plan	In-Month Actual	YTD Plan	YTD Actual
Monitor COSR	score	-	-	1	1
EBITDA margin	%	-4.33%	-1.37%	0.09%	0.17%
EBITDA achieved	£000s	-1,028	-347	246	452
Adjusted net deficit margin	%	-9.92%	-4.93%	-5.39%	-5.18%
Adjusted net deficit achieved	£000s	-2,356	-1,253	-14,253	-13,796
Liquidity ratio	days	-	-	-20	-22
Capital Servicing Capacity	times	-	-	-0.34	0.10
Income	£000s	23,744	25,397	264,421	266,556
Pay	£000s	17,605	17,956	194,516	195,732
Non-Pay	£000s	7,167	7,788	69,660	70,373
CIPs	£000s	1,178	1,124	14,952	11,336

Finance overview | Statement of comprehensive income

At the end of February, the Trust posted a cumulative deficit of £13.8m, which is £460k better than the planned position.

At an aggregate level the Trust reported income position is £2.1m better than plan; however this is predominantly due to the additional income collected for non-patient care services (e.g. education funding which offsets pay expenditure) and masks a cumulative income shortfall for patient care services. Reported NHS patient care income is c.£209k worse than the planned position, this however represents an improvement from previously reported patient service income performance.

As reported at month 9, the Trust continues to forecast triggering the contractual income cap for all north central London CCGs except Islington. The Trust is seeking to agree an appropriate contract settlement for 2015/16 that reflects the care provided.

Within expenditure, pay costs exceeded the budgeted level by £352k during February and £1.2m on a cumulative basis; the premium costs of temporary staffing reliance is a material contributor towards this cost pressure. There continues to be close scrutiny applied to temporary staffing expenditure across the Trust, detailed reviews of usage and cost are ongoing with ICSU and corporate areas. The non-pay position was materially overspent in month due to a range of issues which require greater management control, for example unplanned backlog record storage costs of £112k in-month. These issues have been subjected to an increased management focus following month 11 reporting, in each area a more sustainable management plan is required as a priority and linked to 2016/17 financial planning.

In order to deliver the forecast full-year income and expenditure deficit (£15m), the Trust needs to contain the agency expenditure reported since the start of 2016, deliver financial control in-line with the agreed ICSU forecast positions and achieve a satisfactory income settlement from north central London commissioners.

The Trust continues to restrict capital expenditure and closely manage the working capital position, to ensure sufficient cash balances are available to support payroll and high priority creditor commitments. The Trust has also accessed a £18.3m cash support facility from the Department of Health during March; this is subsequently referred to later in this report.

The table below is a statement of comprehensive income for the period up to month 11 for the Trust.

in £000	In Month Budget (£000s)	In Month Actual (£000s)	Variance (£000s)	YTD Budget (£000s)	Ytd Actuals (£000s)	Variance (£000s)	Full Year (£000s)
Nhs Clinical Income	19,702	20,879	1,178	223,046	222,837	-209	243,894
Non-Nhs Clinical Income	1,982	2,112	131	18,302	19,112	810	20,284
Other Non-Patient Income	2,061	2,405	345	23,072	24,607	1,535	25,997
Total Income	**23,744**	**25,397**	**1,653**	**264,421**	**266,556**	**2,135**	**-290,176**
Non-Pay	7,167	7,788	-620	69,660	70,373	-713	77,258
Pay	17,605	17,956	-352	194,516	195,732	-1,216	211,890
Total Operating Expenditure	**24,772**	**25,744**	**-972**	**264,175**	**266,105**	**-1,929**	**289,148**
EBITDA	**-1,028**	**-347**	**681**	**246**	**452**	**206**	**1,028**
Depreciation	699	592	107	7,464	7,310	154	9,663
Dividends Payable	375	17	358	4,375	4,119	257	4,750
Interest Payable	260	304	-44	2,732	2,871	-139	3,231
Interest Receivable	1	3	2	9	27	18	10
Other Finance Costs	0	0	0	0	28	-28	0
Total	**1,333**	**910**	**422**	**14,562**	**14,300**	**262**	**17,634**
Net Surplus / (Deficit) - before IFRIC 12 adjustment	**-2,361**	**-1,257**	**1,103**	**-14,317**	**-13,848**	**468**	**-16,606**
Add back impairments and adjust for IFRS & Donate	5	5	0	64	53	-10	1,569
Adjusted Net Surplus / (Deficit) - including IFRIC 12 adjustments	**-2,356**	**-1,253**	**1,103**	**-14,253**	**-13,796**	**457**	**-15,037**

Finance overview | Statement of Financial Position

The statement of financial position shows the assets, liabilities and equity held by the Trust and is used to assess the financial soundness of an entity in terms of liquidity risk, financial risk, credit risk and business risk.

Property, Plant & Equipment: The variance of £16.2m for property, plant and equipment is predominantly explained by the underspend against the capital plan (c.£12.7m). The largest scheme in the Trust capital programme (Maternity and Neonatal proposal) accounts for c.£8.3m of this underspend; the Trust does not to date have approval to proceed with this externally funded investment and is working closely with the NHS TDA to agree a forward resolution. Aside from the Maternity and Neonatal development, the Trust continues to slow down other areas of the capital programme to ensure sufficient cash balances are available to meet payroll obligations and operational creditor liabilities.

Trade Receivables: Continue to be higher than planned. This is mainly be due to the recent agreement of balances as NHS organisations tend to reduce payment of invoices while they run through the exercise; additionally the Trust is experiencing slow payment by Local Authorities for services received and an old contractual dispute with Islington CCG.

Cash: The annual cash plan assumed the Trust would have received £23.9m cash support from the Department of Health. Due to the constrained national finance position the final application for cash support agreed with the Department of Health was for £18.3m, the Trust has accessed this funding during March and repaid the temporary loan facility (£15m) using the formalised loan product.

The cash variance to date is explained by the shortfall in central cash support accessed versus the original (higher) planned cash support requested from the Department of Health. The cash management plan includes robust collection of outstanding debt, targeted management and prioritisation of creditor settlements (to minimise disruption to care delivery) and controlled slippage of the capital programme. The Trust has an agreed minimum cash balance with the NHS TDA and Department of Health, and must ensure we manage our cash flow in accordance with this position.

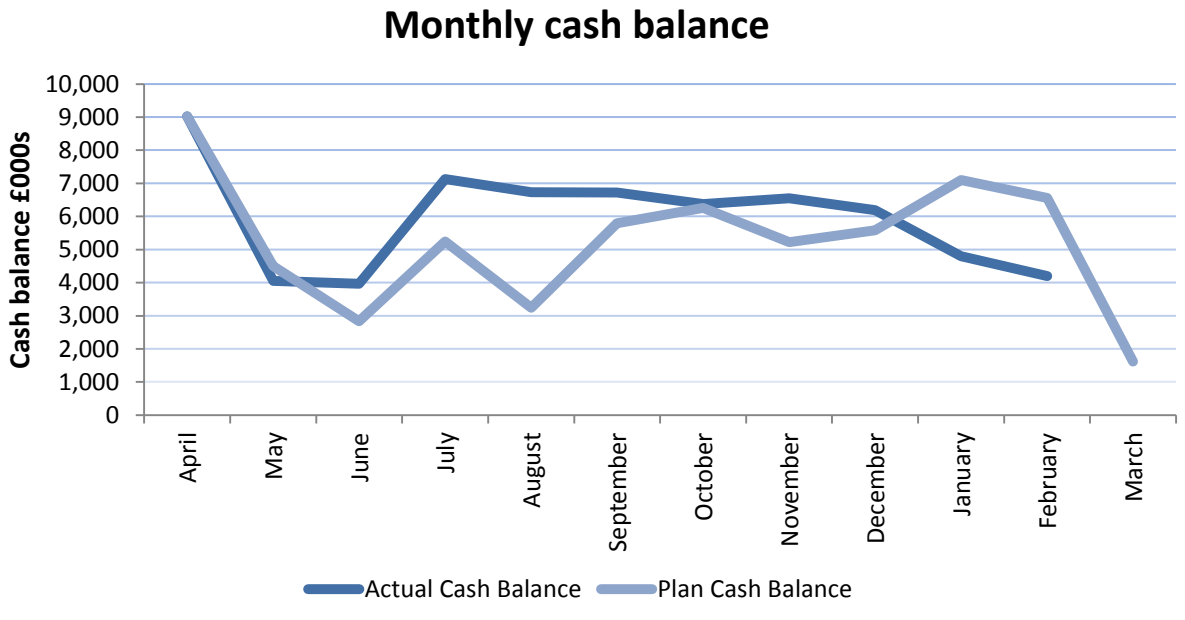
Payables: Delays in receiving cash support and increase in debtors (see above) have impacted adversely on creditors. The Trust is closely managing creditor payments to ensure we appropriately meet our supplier obligations in the context of the overall working capital position.

Borrowings: Borrowings (non-current) are £5.3m greater than planned due to a combination of factors; principally £15.0m working capital loan funding received up to month 11 offset by £9.3m of capital investment loan funding included in the plan but not accessed (Maternity and Neonatal is the largest component). The 2015/16 Trust plan assumed deficit support funding would be provided via PDC funding (in-line with historical precedent), during 2015/16 Department of Health funding policy was revised with deficit funding issued as loan financing generating a variance for loan funding and a consequential shortfall against plan for PDC.

The table below is the statement of financial position for the period up to month 11.

			Year to Date	Year to Date	
	As at 1 April 2015 £000	Plan 31 March 2015 £000	Plan YTD 29 Feb 2016 £000	As at 29 Feb 2016 £000	Variance YTD 29 Feb 2016 £000
Property, plant and equipment	194,918	211,762	207,825	191,576	16,249
Intangible assets	4,481	2,891	3,030	4,096	(1,066)
Trade and other receivables	757	533	755	698	57
Total Non Current Assets	**200,156**	**215,186**	**211,610**	**196,370**	**15,240**
Inventories	1,427	1,356	1,456	1,875	(419)
Trade and other receivables	19,223	22,224	18,925	22,100	(3,175)
Cash and cash equivalents	1,347	1,619	6,558	4,196	2,362
Total Current Assets	**21,997**	**25,199**	**26,939**	**28,171**	**(1,232)**
Total Assets	222,153	240,385	238,549	224,541	14,008
Trade and other payables	38,847	39,551	38,817	42,682	(3,865)
Borrowings	1,809	255	218	269	(51)
Provisions	1,380	723	522	817	(295)
Total Current Liabilities	**42,036**	**40,529**	**39,557**	**43,768**	**(4,211)**
Net Current Assets (Liabilities)	**(20,039)**	**(15,330)**	**40,079**	**44,585**	**(4,506)**
Total Assets less Current Liabilities	**180,117**	**199,856**	**198,992**	**180,773**	**18,219**
Borrowings	34,950	43,993	44,247	49,498	(5,251)
Provisions	1,952	1,697	1,952	1,908	44
Total Non Current Liabilities	**36,902**	**45,690**	**46,199**	**51,406**	**(5,207)**
Total Assets Employed	143,215	154,166	152,793	129,367	23,426
Public dividend capital	62,377	86,277	86,277	62,377	23,900
Retained earnings	6,187	(10,120)	(7,861)	(7,387)	(474)
Revaluation reserve	74,651	78,009	74,377	74,377	0
Total Taxpayers' Equity	143,215	154,166	152,793	129,367	23,426
Capital cost absorption rate	**3.5%**	**3.5%**	**3.5%**	**3.5%**	

The graph below illustrates the cash trajectory for 2015/16 and accounts for the receipt of deficit loan support



Finance overview | Cost improvement programmes

In month 11 savings amounting to £1.12m (63%) were delivered against the plan of £1.8m. Year to date £11.3m (76%) has been achieved.

February's CIP performance was 63%, £1.12m delivered against a plan of £1.78m. YTD, the Trust has delivered 76% of its planned savings (£11.3m).

Against savings schemes allocated to ICSUs and divisions (PMO schemes), February's performance was 91% and YTD it is 107%. However the overall YTD CIP delivery includes £3.5m of non-recurrent (one-off benefit) schemes. Non-recurrent schemes effectively subsidise in-year CIP slippage and only provide a short-term benefit that does not improve the underlying run-rate performance of the organisation. Improving the proportion of recurrent cost base savings during 2016/17 is a priority for the Trust. This would in-turn allow non-recurrent saving benefits to serve as mitigation for unplanned income and expenditure risk

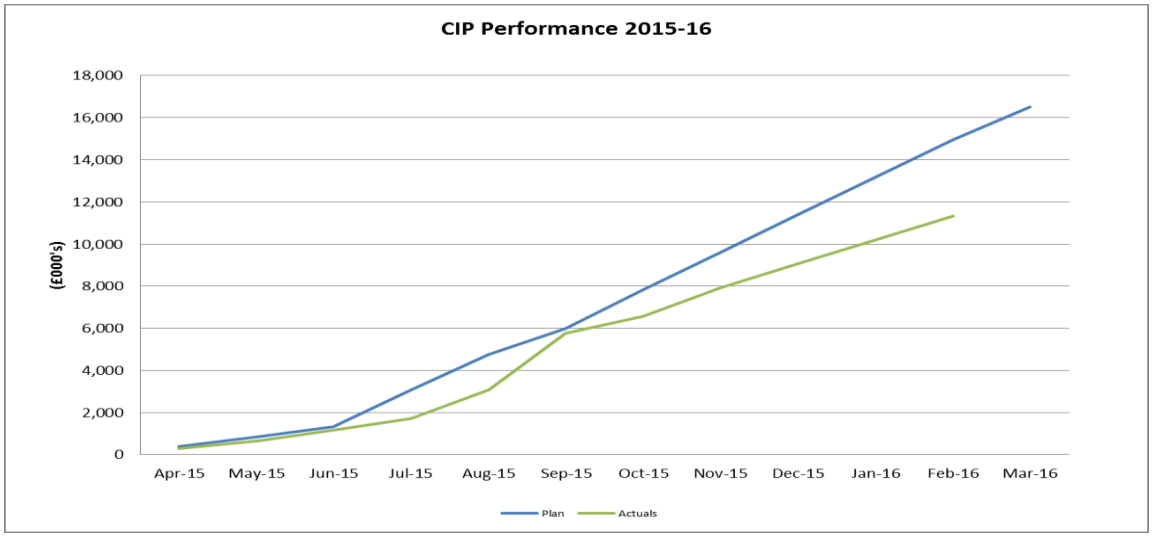
A summary CIP performance table by ICSU and Trust-wide schemes is shown below.

	Annual	February				YTD			
	Plan	Plan	Act	%	Var	Plan	Act	%	Var
Integrated Clinical Service Units	£'000	£'000	£'000	achieved	£'000	£'000	£'000	achieved	£'000
Medicine Frailty and Network Services	1,413	132	168	127%	36	1,280	1,224	96%	(56)
Surgical Services	1,557	144	120	84%	(23)	1,413	1,293	92%	(120)
Emergency and Urgent Care	490	43	51	118%	8	446	356	80%	(90)
Women's Services	995	107	57	53%	(51)	888	678	76%	(210)
Children's Services	1,362	128	123	96%	(5)	1,233	1,215	98%	(19)
Clinical Support Services	635	52	29	55%	(24)	583	327	56%	(256)
OP and Long Term Conditions Services	673	88	74	84%	(14)	584	602	103%	18
Corporate Services	2,891	277	265	96%	(12)	2,514	3,852	153%	1,338
Peformance against PMO schemes	**10,016**	**972**	**886**	**91%**	**(86)**	**8,941**	**9,547**	**107%**	**605**
Trust-wide Schemes									
Procurement	935	134	98	73%	(36)	801	416	52%	(385)
Trust-wide Schemes	5,550	673	140	21%	(533)	3,432	1,373	40%	(2,059)
Performance against Operating Plan	**16,500**	**1,778**	**1,124**	**63%**	**(654)**	**14,952**	**11,336**	**76%**	**(3,616)**

In order to deliver the planned Income and Expenditure deficit, the Trust must:

- continue delivering existing saving schemes - at least matching the current CIP run rate;
- minimise additional budgetary overspends;
- control 'influenceable' spend for areas such as temporary staff usage

The graphic below illustrates the CIP performance up to February 2016.



Operations Directorate
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The Whittington Hospital NHS Trust
Magdala Avenue, London N19 5NF

Whittington Health Trust Board
6th April 2016

Title:	Trust Board Report April 2016 (February 16 data) January data for cancer targets in line with the validation process and sign off for cancer reporting)		
Agenda item:	**15/052**	**Paper**	**07**
Action requested:	To receive assurance that the Trust is meeting its national and local operational targets and that it has plans in place to continuously improve off plan areas.		
Executive Summary:	The Operational Performance report for February data **Access** Whittington Health has **achieved their target for Incomplete Referral to Treatment.** **Within the hospital**, clinic cancellations for first appointments and follow up appointments achieved target. **Overall Did Not Attend** figures, for first appointment now achieved and follow up appointments continue to show an improving trend. **Theatre Utilisation** maintaining 81%, an extensive plan is in place to improve under-utilised lists. **Cancer** targets all achieved for January 2016 and on track to achieve February 2016. **In the community**, overall service **cancellations and DNAs** continue to achieve their target. The **MSK service** has improved but remains under achieving against target due to increased demand. Discussions are continuing to take place on how to continue service delivery within the existing service specifications. Islington **Intermediate Care Services** are on track to achieve targets in April 2016. Figures show an increasing trend of the number of patients being seen for first appointment within 6 weeks of referral. **GUM targets** achieved for last 3 months. **The Podiatry** Plans are on track for recruiting new staff.		

	Hospital Emergency and Urgent Care Continued challenges in the Emergency Department with plans in place to improve which are being led by the COO.						
Summary of recommendations:	Approve the Trust Board performance report						
Fit with WH strategy:	Clinical Strategy						
Reference to related / other documents:	Complies with Operational Plan						
Reference to areas of risk and corporate risks on the Board Assurance Framework:	Captured on relevant risk register and/or BAF						
Date paper completed:	23rd March 2016						
Author name and title:		**Hester de Graag, Performance Lead**		**Director name and title:**		**Carol Gillen, Chief Operating Officer**	
Date paper seen by EC	**April 2016**	**Equality Impact Assessment complete?**	**n/a**	**Quality Impact Assessment complete?**	**n/a**	**Financial Impact Assessment complete?**	**n/a**

Mar 2016 Trust Board Report (Feb data)

Whittington Health NHS

Quality	Threshold	Dec-15	Jan-16	Feb-16
Number of Inpatient Deaths	-	35	39	31
NHS number completion in SUS (OP & IP)	99%	98.9%	98.6%	arrears
NHS number completion in A&E data set	95%	95.3%	92.8%	arrears

Quality (Mortality index)	Threshold	Apr 14 - Mar 15	Jul 14 - Jun 15	Oct 14 - Sep 15
SHMI	-	0.67	0.66	0.65

Quality (Mortality index)	Threshold	Sep-15	Oct-15	Nov-15
Hospital Standardised Mortality Ratio (HSMR)	<100	91	77	94
Hospital Standardised Mortality Ratio (HSMR) - weekend	-	15.3	55.9	119.3
Hospital Standardised Mortality Ratio (HSMR) - weekday	-	111.7	84.0	80.1

Patient Safety	Threshold	Dec-15	Jan-16	Feb-16
Harm Free Care	95%	93.2%	93.7%	93.7%
VTE Risk assessment	95%	95.4%	95.3%	arrears
Medication Errors actually causing Serious/Severe Harm	0	0	0	0
Never Events	0	0	0	0
CAS Alerts (Central Alerting System)	-	0	0	0
Proportion of reported patient safety incidents that are harmful	-	38.1%	46.7%	42.6%
Serious Incident reports	-	7	4	8

Access Standards

Referral to Treatment (in arrears)	Threshold	Nov-15	Dec-15	Jan-16
Diagnostic Waits	99%	99.6%	98.4%	99.1%
Referral to Treatment 18 weeks - 52 Week Waits	0	0	0	0

Efficiency and productivity - Community	Threshold	Dec-15	Jan-16	Feb-16
Service Cancellations - Community	8%	6.6%	7.0%	6.5%
DNA Rates - Community	10%	6.4%	6.3%	5.9%
Community Face to Face Contacts	-	54,482	58,882	58,307
Community Appts with no outcome	0.5%	0.7%	1.9%	0.9%

Community Access Standards	Threshold	Dec-15	Jan-16	Feb-16
MSK Waiting Times - Non-Consultant led patients seen in month (% < 6 weeks)	95%	61.4%	51.0%	67.2%
MSK Waits - Consultant led patients seen in month (% < 18 weeks)	95%	100.0%	100.0%	arrears
IAPT - patients moving to recovery	50%	49.6%	50.0%	arrears
IAPT Waiting Times - patients waiting for treatment (% < 6 weeks)	75%	92.6%	94.9%	arrears
GUM - Appointment within 2 days	98%	98.1%	98.1%	99.4%

Efficiency and Productivity

Efficiency and productivity - acute	Threshold	Dec-15	Jan-16	Feb-16
First:Follow-up ratio - acute	2.31	1.44	1.56	1.44
Theatre Utilisation	92%	79.5%	81.9%	81.1%
Hospital Cancellations - acute - First Appointments	8%	5.9%	5.8%	5.7%
Hospital Cancellations - acute - Follow-up Appointments	8%	8.3%	7.9%	7.0%
DNA rates - acute - First appointments	10%	11.5%	11.9%	9.8%
DNA rates - acute - Follow-up appts	10%	13.3%	12.0%	11.1%
Hospital Cancelled Operations	0	1	16	3
Cancelled ops not rebooked < 28 days	0	0	0	0
Urgent procedures cancelled	0	1	0	0

Mar 2016 Trust Board Report (Feb data)

Whittington Health NHS

Patient Experience	Threshold	Dec-15	Jan-16	Feb-16
Patient Satisfaction - Inpatient FFT (% recommendation)	-	96%	96%	94%
Patient Satisfaction - ED FFT (% recommendation)	-	93%	94%	92%
Patient Satisfaction - Maternity FFT (% recommendation)	-	94%	95%	88%
Mixed Sex Accommodation breaches	0	0	0	0
Complaints	-	22	23	32
Complaints responded to within 25 working day	80%	78%	100%	arrears
Patient admission to adult facilities for under 16 years of age	-	0	0	0

Emergency and Urgent Care	Threshold	Dec-15	Jan-16	Feb-16
Emergency Department waits (4 hrs wait)	95%	91.5%	84.6%	84.0%
ED Indicator - median wait for treatment (minutes)	<60	81	85	94
30 day Emergency readmissions	-	172	165	arrears
12 hour trolley waits in A&E	0	0	0	1
Ambulatory Care (% diverted)	>5%	2.7%	2.8%	3.5%
Ambulance Handover (within 30 minutes)	0	5	5	arrears
Ambulance Handover (within 60 minutes)	0	0	0	arrears

Infection Prevention	Threshold	Dec-15	Jan-16	Feb-16
Hospital acquired MRSA infection	0	0	1	0
Hospital acquired *C difficile* Infections	17 (15/16)	1	0	0
Hospital acquired *E. coli* Infections	-	0	0	0
Hospital acquired MSSA Infections	-	3	0	0
Ward Cleanliness	-	98%	99%	-

Cancer Access Standards (in arrears)	Threshold	Nov-15	Dec-15	Jan-16
Cancer - 14 days to first seen	93%	89.9%	88.0%	93.2%
Cancer - 14 days to first seen - breast symptomatic	93%	87.4%	90.8%	93.4%
Cancer - 31 days to first treatment	96%	96.8%	100.0%	100.0%
Cancer - 31 days to subsequent treatment - surgery	94%	100.0%	100.0%	100.0%
Cancer - 31 days to subsequent treatment - drugs	98%	100.0%	100.0%	-
Cancer - 62 days from referral to treatment	85%	88.4%	91.7%	93.2%

Access Standards (RTT)

Referral to Treatment (in arrears)	Threshold	Dec-15	Jan-16	Feb-16
Referral to Treatment 18 weeks - Admitted	90%	84.2%	73.5%	arrears
Referral to Treatment 18 weeks - Non-admitted	95%	92.4%	90.1%	arrears
Referral to Treatment 18 weeks - Incomplete	92%	92.1%	92.3%	arrears

Maternity	Threshold	Dec-15	Jan-16	Feb-16
Women seen by HCP or midwife within 12 weeks and 6 days	90%	81.9%	77.2%	81.9%
New Birth Visits - Haringey	95%	80.8%	87.7%	arrears
New Birth Visits - Islington	95%	91.5%	94.5%	81.9%
Elective Caesarean Section rate	14.8%	11.9%	9.8%	12.0%
Breastfeeding initiated	90%	86.8%	92.9%	91.5%
Smoking at Delivery	<6%	5.9%	3.0%	7.4%

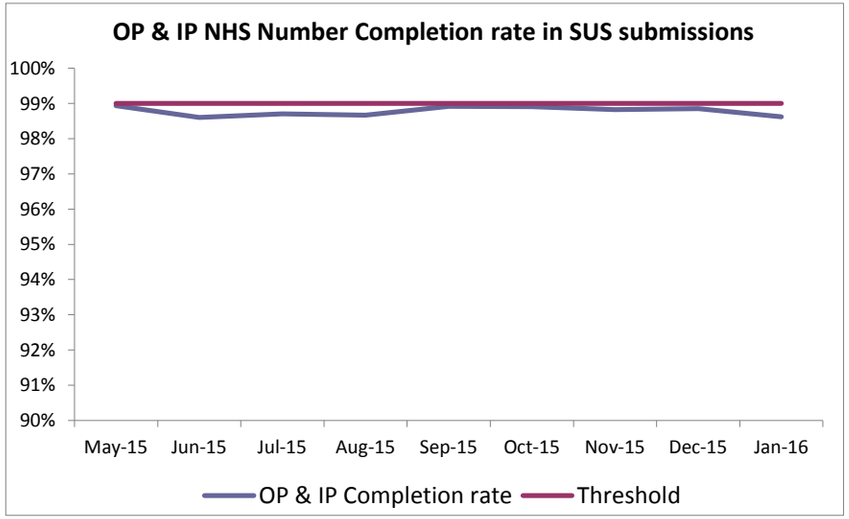
Meeting threshold

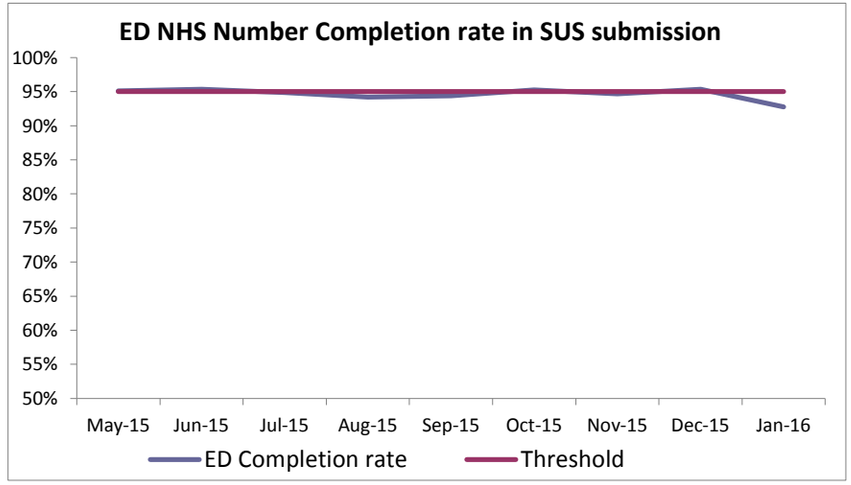
Failed threshold

	Threshold	Trust Actual		
		Dec-15	Jan-16	Feb-16
Number of Inpatient Deaths	-	35	39	31
Completion of a valid NHS number in SUS (OP & IP)	99%	98.9%	98.6%	arrears
Completion of a valid NHS number in A&E data sets	95%	95.3%	92.8%	arrears

	Standardised National Average	Trust		
		Sep-15	Oct-15	Nov-15
Hospital Standardised Mortality Ratio	<100	91.1	77.4	94.1
Hospital Standardised Mortality Ratio (HSMR) - weekend	-	15.3	55.9	119.3
Hospital Standardised Mortality Ratio (HSMR) - weekday	-	111.7	84.0	80.1

		Lower Limit	Upper Limit	RKE SHMI Indicator
SHMI	Oct 2014 - Sep 2015	0.89	1.12	0.65
	Jul 2014 - Jun 2015	0.89	1.12	0.66
	Apr 2015 - Mar 2015	0.89	1.12	0.67
	Jan 2014 - Dec 2014	0.89	1.12	0.66
	Oct 2013 - Sep 2014	0.88	1.13	0.60
	Jul 2013 - Jun 2014	0.88	1.14	0.54
	Apr 2013 - Mar 2014	0.87	1.15	0.54





Commentary

Completion of NHS number in SUS and A&E data set

Issue: Below target of Jan 16, but achieved target for Dec 15 retrospectively.

Action: Netcall now also targeted to ensure NHS number is collated. Flex and freeze date reporting used in the data above which means that target is achieved by the freeze date.

Timeframe: Current validation on track and should be achieving target for January data by freeze date next month.

SHMI and HMSR

The above metrics are a ration of observed to expected death

Whittington Health mortality is consistently below the level that is expected for the hospital.

The two different metric employ slightly different methodologies, so result in different values.

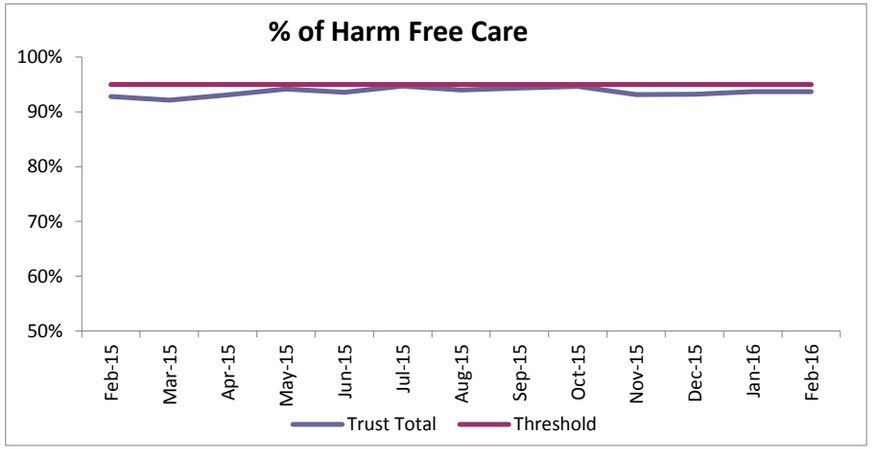
Weekend vs weekend mortality rate show extreme variability, because on a monthly basis the numbers are low. No inference can be made from this data.

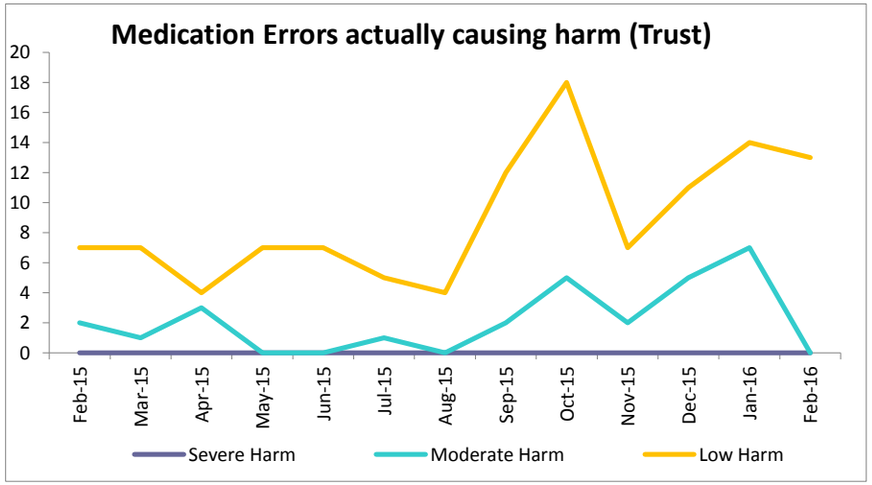
Patient Safety

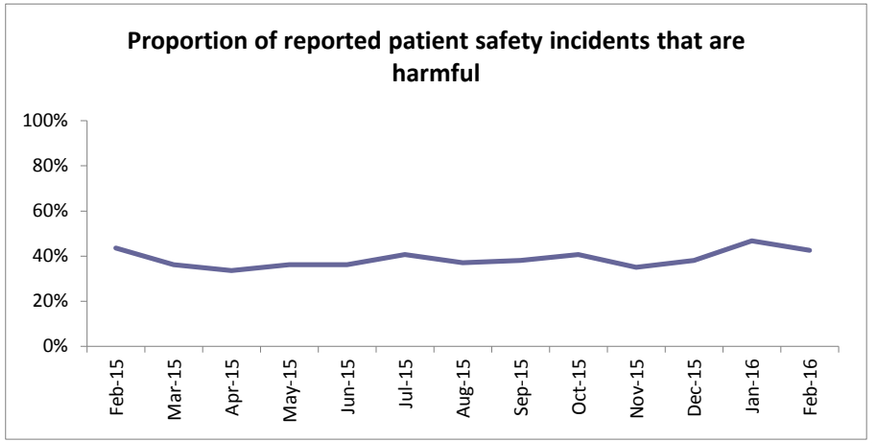
Whittington Health NHS

Data extracted on 09/02/2016

	Threshold	Trust Actual Nov-15	Dec-15	Jan-16	Feb-16	Trend
Harm Free Care	95%	93.2%	93.2%	93.7%	93.7%	
Pressure Ulcers (prevalence)	-	5.78%	5.65%	5.64%	5.33%	
Falls (audit)	-	0.56%	0.88%	0.18%	0.49%	
VTE Risk assessment	95%	95.5%	95.4%	95.3%	arrears	
Medication Errors actually causing **Serious** or **Severe** Harm	0	0	0	0	0	
Medication Errors actually causing **Moderate** Harm	-	2	5	7	0	
Medication Errors actually causing **Low** Harm	-	7	11	14	13	
Never Events	0	0	0	0	0	
Open CAS Alerts (Central Alerting System)	-	0	0	0	0	
Proportion of reported patient safety incidents that are harmful	-	35.0%	38.1%	46.7%	42.6%	
Serious Incidents (Trust Total)	-	6	7	4	8	







Commentary

Harm Free Care and Pressure Ulcer prevalence

Harm Free Care and the figure for prevalence of pressure ulcers include non-avoidable pressure ulcers. It remains just below target at 93%.

Falls (audit)

Issue: Falls are increasing within the hospital. A number of falls with harm on the wards, in the last 6 months , have been identified and are investigated using the Serious Incidence framework.

Action: Falls awareness and prevention training session now included on new ward training programme (2pm daily).

Sign up to Safety- Pledge to reduce falls resulting in SI by 50% on-going work on Falls bundle, including development of new multifactorial risk assessment in line with NICE (to be in place by September 16).Business case for care of older persons nurse specialist and increased awareness and recognition of Delirium through screening project

Timescale: Feedback in April 16

VTE

Target achieved

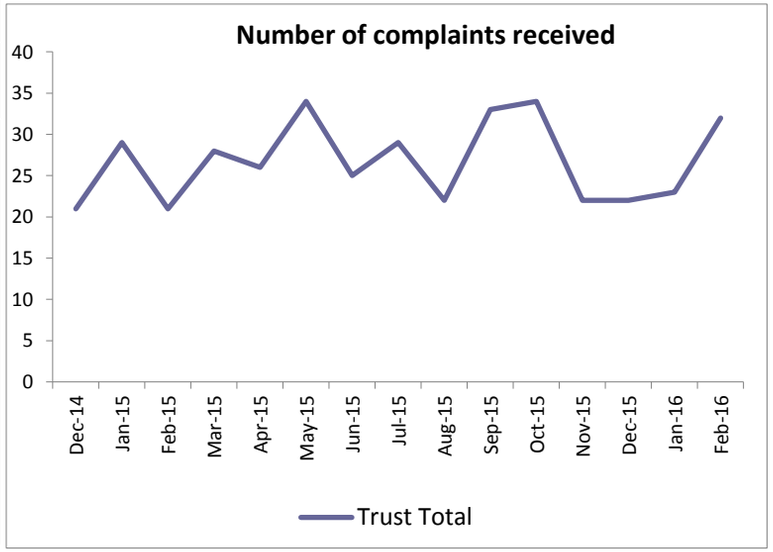
Medication errors causing harm in February 16

There were 37 medication incidents reported on Datix in February 2016 – a significant decrease compared with the last 4 months. January 2016 = 57 incidents, 4th quarter 2015 mean = 57. There were no incidents causing high harm or moderate harm and 13 causing low harm. The ICSU which reported the highest number of incidents was Emergency and Urgent Care with 18 (49%). Twelve incidents (32%) were reported by community staff. One incident was reported by medical staff.

Serious Incidents

Whittington Health declared 8 SIs in February 2016. Two falls in MFNS, one fall in Surgery, one in EUC suboptimal care, two unexpected admissions to NICU and one birth centre closure and one CSS imaging referrals breach. All identified learning form these incidents has been shared with the Services.

	Threshold	Trust Actual Nov-15	Dec-15	Jan-16	Feb-16	Trend
Patient Satisfaction - Inpatient FFT (% recommendation) **	-	96%	96%	96%	94%	
Patient Satisfaction - Emergency Department FFT (% recommendation) **	-	95%	93%	94%	92%	
Patient Satisfaction - Maternity FFT (% recommendation) **	-	95%	94%	95%	88%	
Mixed Sex Accommodation (not Clinically justified)	0	0	0	0	0	
Complaints (**incl Corporate**)	-	22	22	23	32	
Complaints responded to within 25 working day	80%	63%	78%	100%	Arrears	
Patient admission to adult facilities for under 16 years of age	-	0	0	0	0	



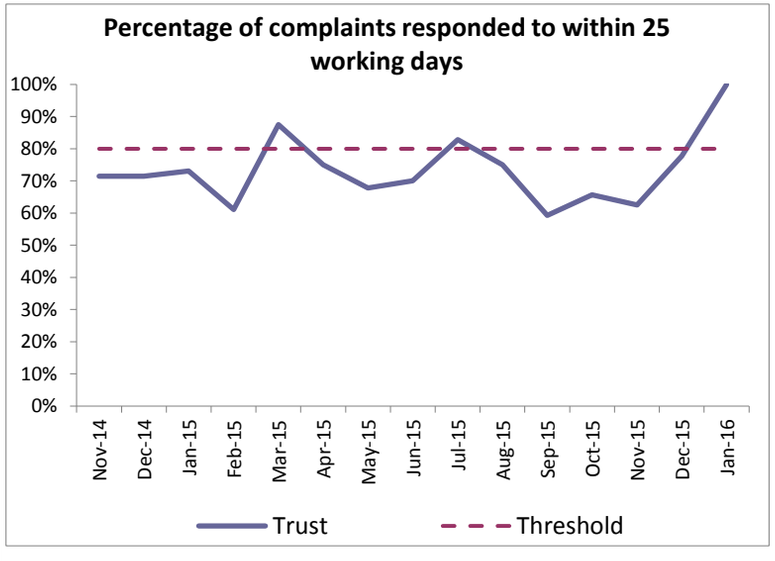
* Complaints responded to within 25 working days are previous months figures (reported in arrears)
** FFT calculation has now changed nationally from Nov 2014

Commentary

Patient Satisfaction
Maternity scoring under the local standard of 90%. The response rate of 19.4% is the highest return rate this year and almost at the 20% target. The satisfaction score is down to the ward FFT question and partly due to 'don't know' answers. If they were discounted the score would reach 90% .
Action: continue to raise awareness and role out into community and OPD . Under achieving areas now identified through the Meridian system.
Timescale: On-going

Mixed Sex Accommodation
Achieved

Complaints
All ICSUs achieved 100% compliance this month.



Infection Prevention

Whittington Health NHS

		Trust Actual				
	Threshold	Nov-15	Dec-15	Jan-16	Feb-16	Trend
MRSA	0	0	0	1	0	
E. coli Infections*	-	2	0	0	0	
MSSA Infections	-	0	3	0	0	

	Threshold	Nov 15	Dec 15	Jan 16	Feb 16	2015/16 Trust YTD
C difficile Infections	17 (Year)	0	1	0	0	7

* E. coli infections are not specified by ward or division

Ward Cleanliness

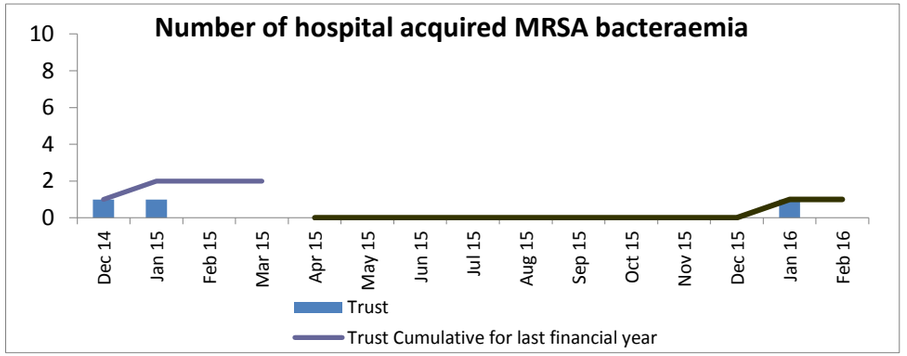
Audit period	Trust					
	14/04/15 to 01/05/15	15/06/15 to 10/07/15	01/09/15 to 30/09/15	05/10/15 to 03/11/15	22/12/15 to 31/01/15	Trend
Trust %	98.4%	97.9%	97.7%	97.8%	98.6%	

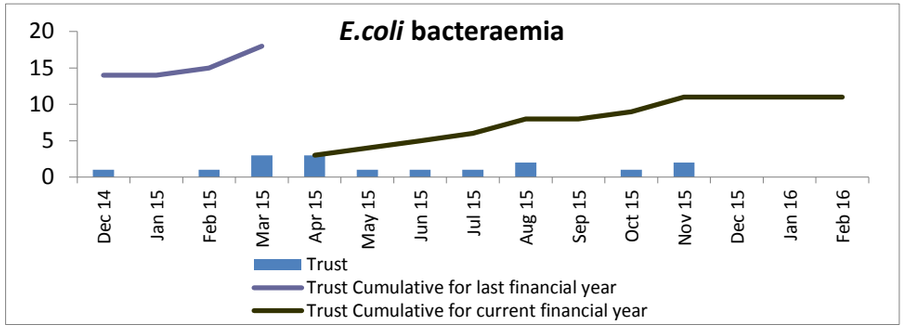
Commentary

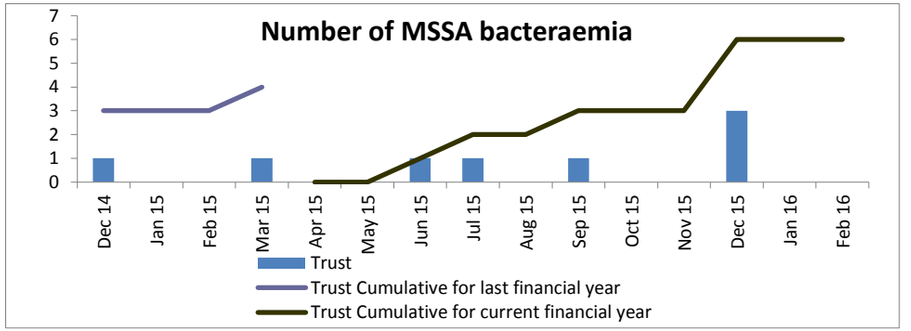
No new bacteraemia

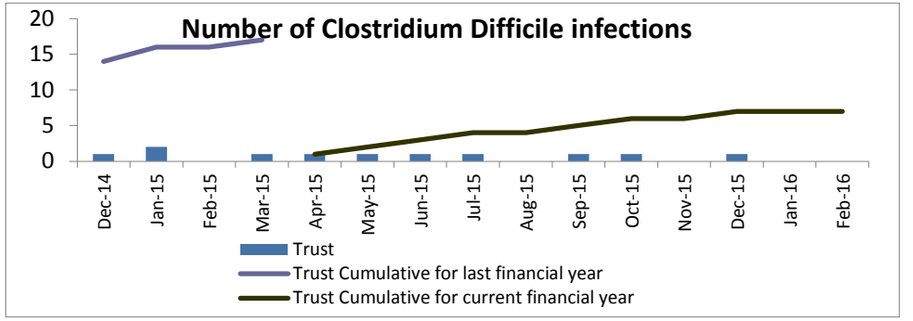
MRSA

One MRSA attributed to the hospital in January 16. All correct procedures were followed. Post review report completed.





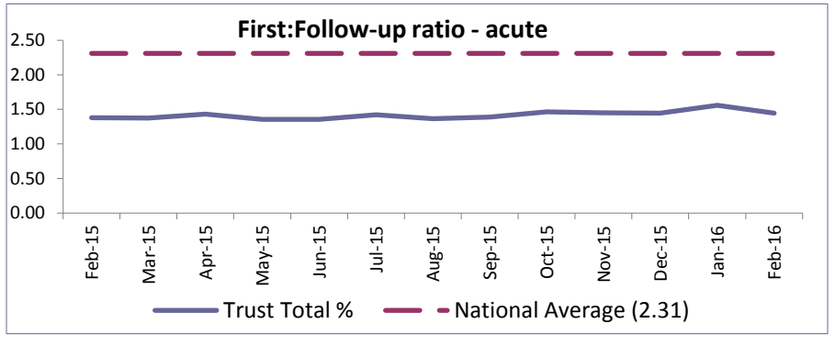


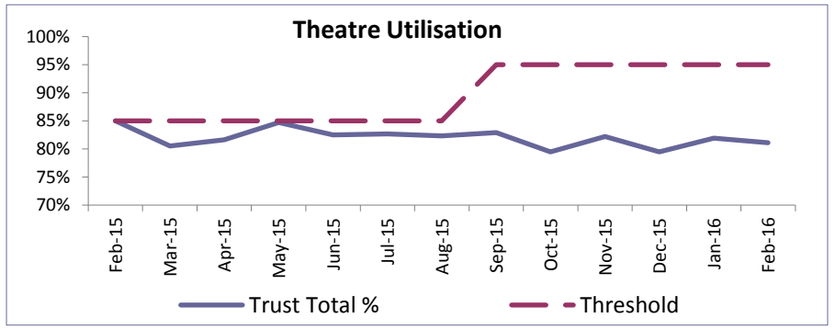


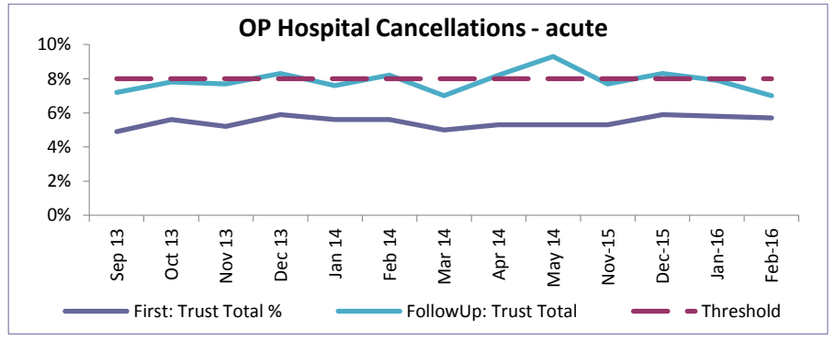
Efficiency and productivity - acute

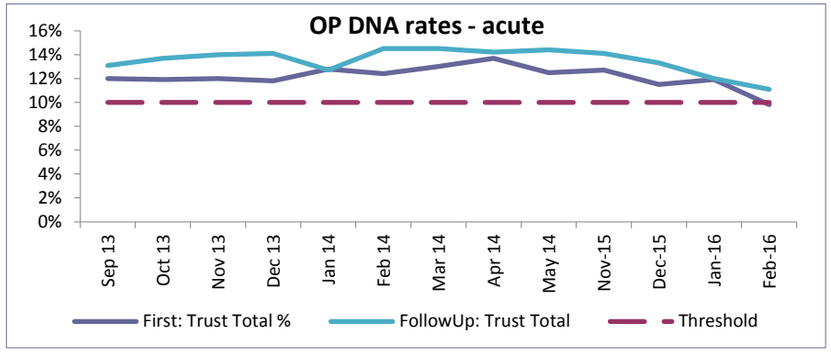
Whittington Health NHS

	Trust						
	Threshold	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Trend
First:Follow-up ratio - acute	2.31	1.46	1.45	1.44	1.56	1.44	
Theatre Utilisation	92%	79.5%	82.2%	79.5%	81.9%	81.1%	
Hospital Cancellations - acute - First Appointments	<8%	5.3%	5.3%	5.9%	5.8%	5.7%	
Hospital Cancellations - acute - Follow-up Appointments	<8%	9.3%	7.7%	8.3%	7.9%	7.0%	
DNA rates - acute - First appointments	10%	12.5%	12.7%	11.5%	11.9%	9.8%	
DNA rates - acute - Follow-up appointments	10%	14.4%	14.1%	13.3%	12.0%	11.1%	
Hospital Cancelled Operations	0	6	1	1	16	3	
Cancelled ops not rebooked < 28 days	0	0	0	0	0	0	
Urgent Procedures cancelled	0	3	0	1	0	0	
Urgent Procedures cancelled (of these how many cancelled 2nd time)	0	0	0	0	0	0	









Commentary

First: Follow-up ratio - acute
The new to follow up rate is continuing to be is under the national benchmark of 2.31.

Theatre Utilisation
Issue : stretch threshold of 95% has not been achieved.
Action: ENT list stopped in Jan 2016, T&O will use in meantime, review underway of urology sessions to stop increased use for Spinal lists in place and additional Gynae will be in place from beginning of April 2016.
Timescale : Paper to be taken to ICSU Board in April 2016 with proposal for future use of theatres, linked with CIP/income opportunities

Hospital Cancellations - acute
Overall achieved.

Did not attend
Issue: Overall for First Appointment achieved. Follow up appointments show improvement.
Action: Stepped improvement seen as expected.
Timescale: To be within target within the new financial year.

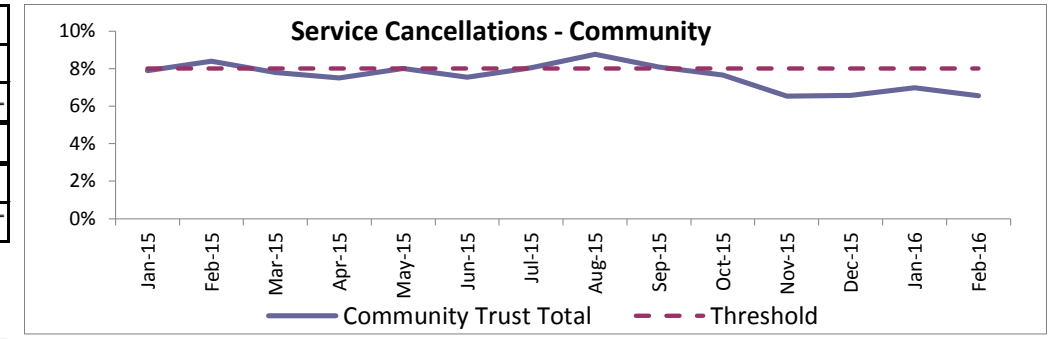
Hospital Cancelled Operations
Issue: There were 3 reportable cancelled operation. All 3 were routine operations. Two were due to the list over running in Gynaecology and one in Orthopaedics due to equipment failure. All operation were rescheduled within 28 days.
Action: The Surgical board monitor cancellations.

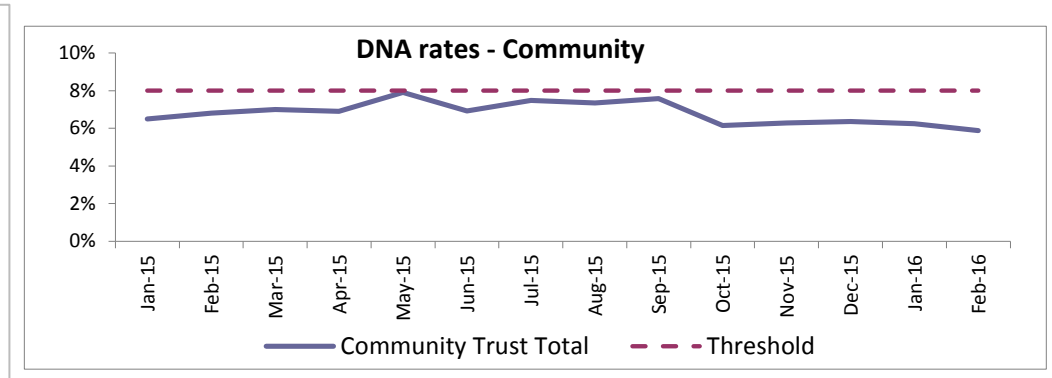
Efficiency and productivity - Community

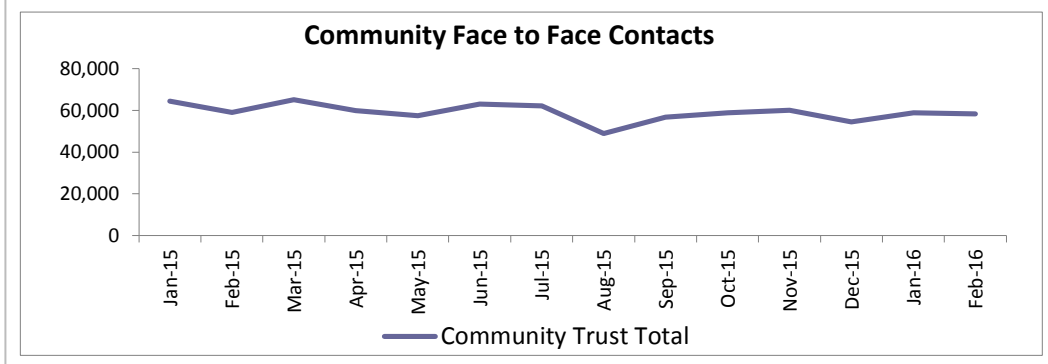
Whittington Health NHS

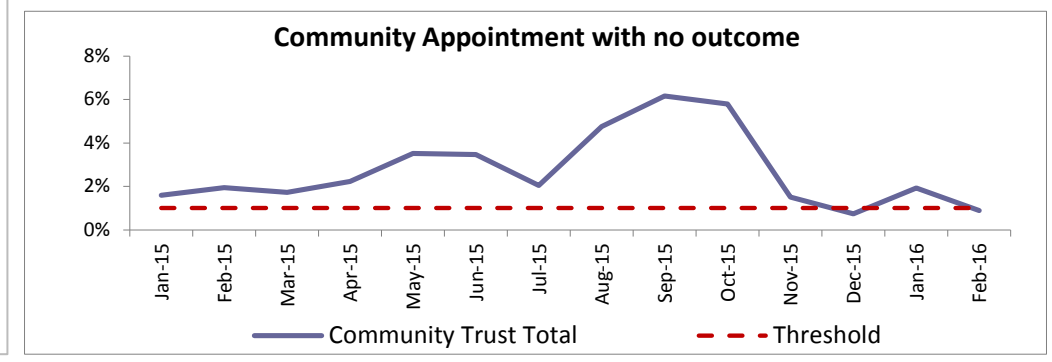
	Trust					
	Threshold	Nov-15	Dec-15	Jan-16	Feb-16	Trend
Service Cancellations - Community	8%	6.5%	6.6%	7.0%	6.5%	
DNA Rates - Community	10%	6.3%	6.4%	6.3%	5.9%	
Community Face to Face Contacts	-	60,139	54,482	58,882	58,307	
Community Appointment with no outcome	0.5%	1.5%	0.7%	1.9%	0.9%	

N.B. From October 2014, figures include Community Dental activity (SCD)









Commentary

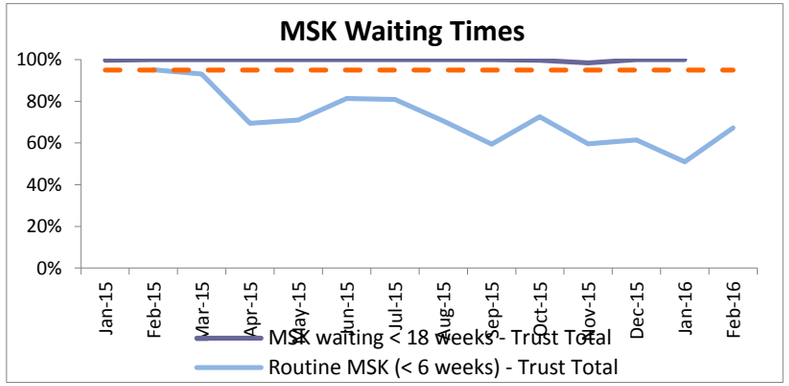
Service Cancellations - Community
Achieved

DNA Rates - Community
Achieved.

Community Face to Face Contacts
All services are monitored against activity targets.

Community Appointment with no outcome
Improved flex data snapshot. Large volume services responsible for no outcomed appointments, i.e SLT and DN. All appointments are outcomed by the freeze date.
Action: Monitored monthly.
Timescale: Immediately.

	Threshold	Trust Actual Dec-15	Trust Actual Jan-16	Trust Actual Feb-16	Trust YTD
District Nursing Wait Time - 2hrs assess (Islington)	-	75.0%	80.0%	100.0%	63.3%
District Nursing Wait Time - 2hrs assess (Haringey)	-	83.3%	93.3%	88.2%	86.8%
District Nursing Wait Time - 48hrs for visit (Islington)	-	96.3%	96.4%	88.4%	94.5%
District Nursing Wait Time - 48hrs for visit (Haringey)	-	95.4%	97.7%	97.8%	96.4%
MSK Waiting Times - Routine MSK (<6 weeks)	95%	61.4%	51.0%	67.2%	67.8%
MSK Waiting Times - Consultant led (<18 weeks)	95%	100.0%	100.0%	arrears	99.8%
IAPT - patients moving to recovery	50%	49.6%	50.0%	arrears	49%
GUM - Appointment within 2 days	98%	99.0%	98.1%	99.4%	97.4%
Haringey Adults Community Rehabilitation (<6weeks)	85%	89.1%	84.2%	89.3%	81.9%
Haringey Adults Podiatry (Foot Health) (<6 weeks)	-	70.2%	51.6%	60.4%	67.9%
Islington Community Rehabilitation (<12 weeks)	-	78.6%	78.2%	80.4%	81.8%
Islington Intermediate Care (<6 weeks)	85%	50.3%	50.2%	66.5%	57.5%
Islington Podiatry (Foot Health) (<6 weeks)	-	83.2%	66.6%	62.4%	71.4%
IAPT Waiting Times - patients waiting for treatment (% < 6 weeks)	75%	96.0%	96.8%	arrears	94.3%
Death in place of choice	90%	59%	61%	76%	
Number of DN teams completing a monthly review of Patients of Concern (POC) (eight teams)	8	8	8	8	
Number of DN teams completing a monthly caseload review of timely discharge (eight teams)	8	8	8	8	



Commentary

District Nursing
Improvement seen in both 2 and 48 hours targets. The data above shown is un-triaged referrals.
Issue: Continued manual triaging of urgency for 2hr referrals and true urgent referrals are still phoned through to the Service and seen within 2 hours. 48 hour waits in Islington for February (88.4%) has dropped slightly during February due to the increased number of DN referrals to the South East Islington and Central Islington teams and increased demand in overall activity. During the last two weeks in February there was a peak in unplanned staff sickness causing the number of unallocated units to increase and the visits required on subsequent days to increase.
Action: The RiO report capturing this data is monitored and will be reviewed.
Timescale: Improvements seen and expected to continue.

Death in place of choice
Issue: The service has worked hard to ensure that nurses are proactively engaging in conversation about death in place of choice and documenting it. Unpredictable admissions to another place of care mean that the target has not been met.
Action: Working with the palliative care rotation nurses particularly to continuously review and re document preferred place of death.

Cont. commentary

GUM
Achieved target.
IAPT
Achieved target

MSK
Issue: Capacity and demand. The percentage , although expected to decrease, fixes put in place this month have had a positive short term effect, resulting in an increased number of new patient being seen in February.
Action: Increased funding to meet the demand or a review and possible reduction in service provision and the acceptance criteria, including self-referrals. This is part of a service specification review. The service remains on the risk register
Timescale: Continues review to maximise efficiency and piloting new initiatives.

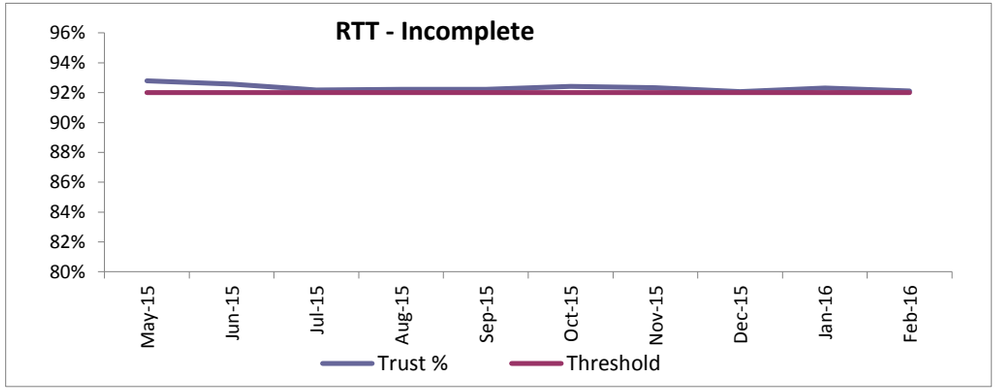
Podiatry
Issue: Recruitment drive on track.
Action: Interview scheduled for April 16
Timescale: New staff to be in place in May 2016 and targets expected to improve from then.

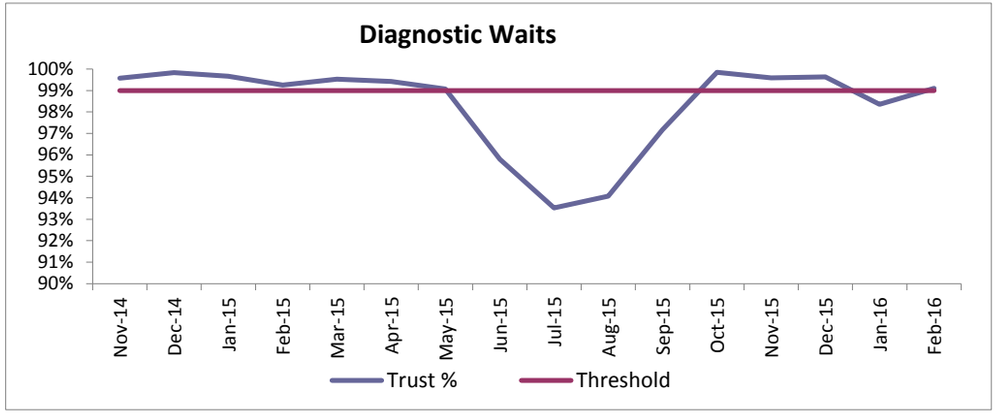
Reach service Islington
Issue: There has been an improvement in the overall performance in the Reach service but slower than expected. Still concerns around Physiotherapy resource including high rate of sickness and absence.
Action: Plan developed to manage backlog and to be addressed with commissioners for additional support.
Timescale: Meeting setup in April 2016 with Islington.

Referral to Treatment (RTT) and Diagnostic waits

Whittington Health NHS

	Trust				
	Threshold	Nov-15	Dec-15	Jan-16	Trend
Referral to Treatment 18 weeks - Admitted	90%	77.6%	84.2%	73.5%	
Referral to Treatment 18 weeks - Non-admitted	95%	91.6%	92.4%	90.1%	
Referral to Treatment 18 weeks - Incomplete	92%	92.3%	92.1%	92.3%	
Referral to Treatment 18 weeks - 52 Week Waits	0	0	0	0	
Diagnostic Waits	99%	99.6%	98.4%	99.1%	





Commentary

RTT
National KPI for 18 weeks incomplete achieved.
Issues: 18 weeks admitted and non-admitted data reported above is un-validated.
Action: Focus on Incomplete RTT data will improve the Admitted and non-Admitted targets.
Timescale: Stepped improvement to be seen in the next months.

Diagnostic Waits
Achieved target

Waiting times - OPD appointment
Cardiology 10 Weeks, Dermatology 10 Weeks , Endocrine 8 Weeks, ENT 12 Weeks, Gastroenterology 9 Weeks, General Surgery 12 Weeks , Gynaecology 8 Weeks, Neurology 14 Weeks, Pain 25 Weeks, Rheumatology 7 Weeks, Thoracic Medicine 11 Weeks, T&O 8 weeks, Vascular 17 Weeks, Ophthalmology 8 weeks.

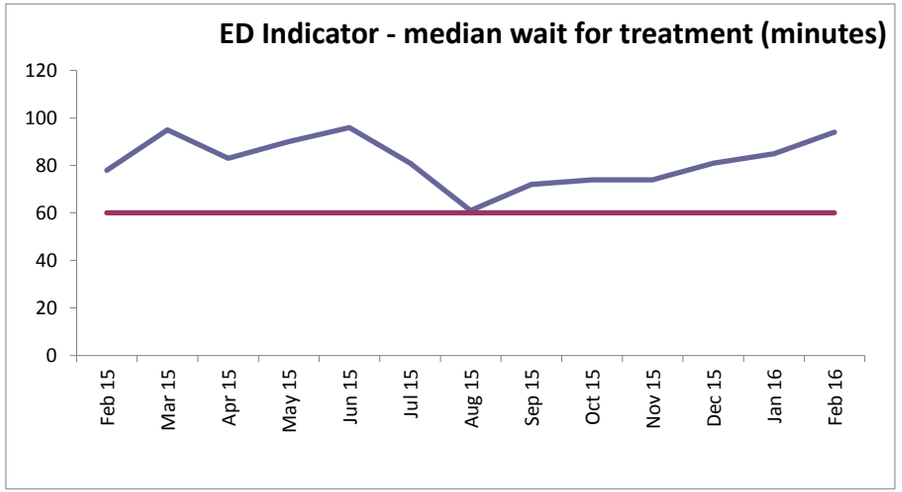
Diagnostic waiting times (radiology) all under 6 weeks (42 days) waiting time standard
See table to the right.

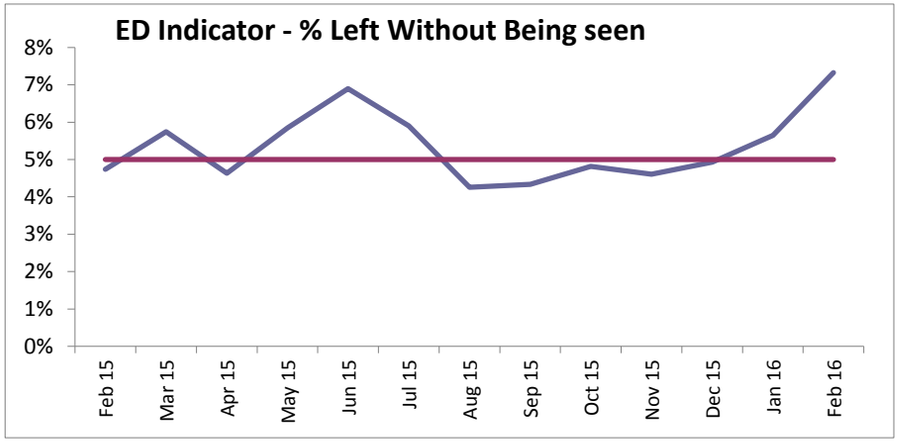
Modality	Waiting Time in Days
CT	17
DEXA	12
Fluoroscopy	34
Mammography	14
MRI	33
Nuclear Medicine	7
Ultrasound - Abdomen & Gynae at Hornsey General	15
Ultrasound - Dating - ANC	31
Ultrasound - General (Radiologist Lead)	29
Ultrasound - Gynae	22
Ultrasound - Hernias	28
Ultrasound - MSKs	35
Ultrasound - Obstetrics - Anomaly	55
Ultrasound - Obstetrics - Growth	16
Ultrasound - Paediatrics	39

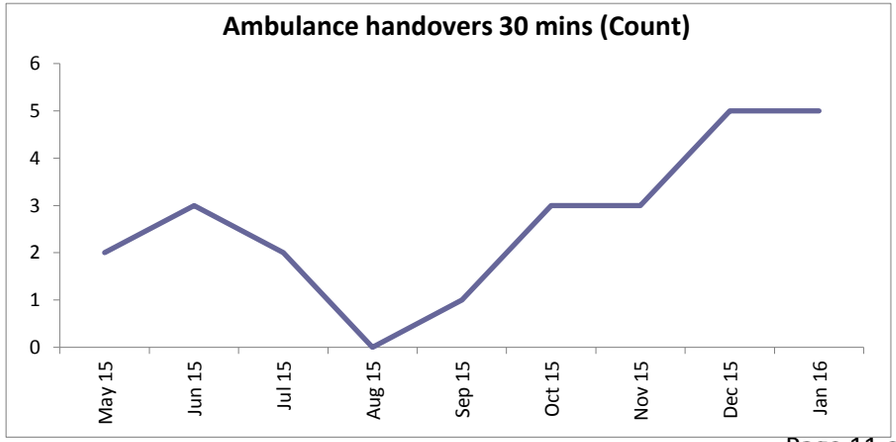
Emergency Care

Whittington Health NHS

	Threshold	Trust Actual Jan-16	Trust Actual Feb-16	2015/16 Trust YTD
Emergency Department waits (4 hrs wait)	95%	84.6%	84.0%	92.1%
Emergency Department waits (4 hrs wait) Paeds only	95%	95.3%	94.0%	96.5%
Wait for assessment (minutes - 95th percentile)	<=15	16	17	15
ED Indicator - median wait for treatment (minutes)	60	85	94	81
Total Time in ED (minutes - 95th percentile)	<=240	554	542	369
ED Indicator - % Left Without Being seen	<=5%	5.7%	7.3%	5.4%
12 hour trolley waits in A&E	0	0	1	1
Ambulance handovers 30 minutes	0	5	arrears	30
Ambulance handovers exceeding 60 minutes	0	0	arrears	0
Ambulatory Care (% diverted)	>5%	2.8%	3.5%	







Commentary

ED four hour wait remains a significant challenge across the sector. Main issues relate to bed pressures and sustained increase in activity.

Actions:

COO chairing weekly meetings overseeing recovery plan:

- Increasing pre 11am discharges
- Criteria led discharge
- Review of all patients with LoS >9 days
- Benchmarking LoS

Time to assessment and treatment have deteriorated due to pressures associated with increased activity and exit block from ED.

Actions:

- Interim staffing model in place to provide additional nursing support for patients awaiting allocation of a bed
- Additional GP sessions in the evening and senior ED doctor in place

The number of patients who leave without being seen has increased and is linked to longer waits.

Regrettably the department reported one 12 hour trolley wait in Feb. A full investigation was undertaken and although far from good patient experience, the patients' safety was not compromised and therefore did not meet the criteria to declare an SI. However, the SI panel are overseeing the report and feedback will be reported in April.

A step change in ambulatory diverts had been made.

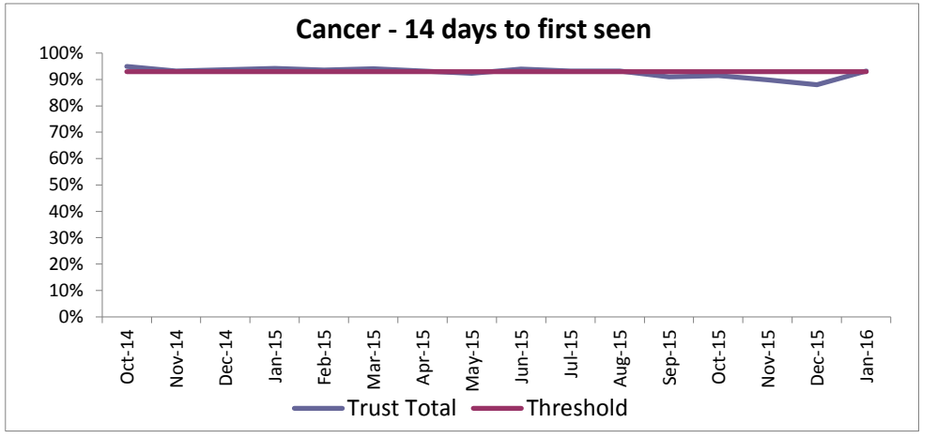
Cancer

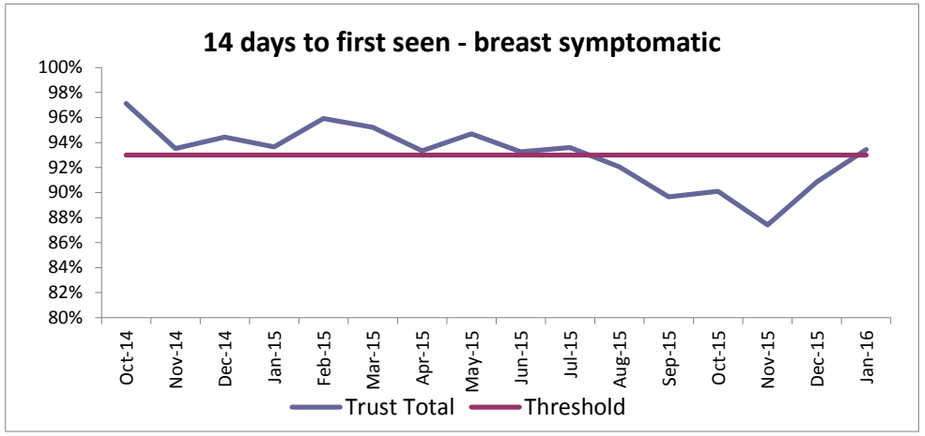
Whittington Health NHS

	Threshold	Trust Nov-15	Trust Dec-15	Trust Jan-16	Trend	2015/16 Trust Q1	2015/16 Trust Q2	2015/16 Trust Q3	2015/16 Trust Q4	2015/16 Trust YTD
Cancer - 14 days to first seen	93%	89.9%	88.0%	93.2%		93.2%	92.5%	89.7%	93.2%	91.8%
Cancer - 14 days to first seen - breast symptomatic	93%	87.4%	90.8%	93.4%		93.6%	91.7%	89.4%	93.4%	91.8%
Cancer - 31 days to first treatment	96%	96.8%	100.0%	100.0%		100.0%	100.0%	99.0%	100.0%	99.7%
Cancer - 31 days to subsequent treatment - surgery	94%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%
Cancer - 31 days to subsequent treatment - drugs	98%	100.0%	100.0%	-		100.0%	100.0%	100.0%	-	100.0%
Cancer - 62 days from referral to treatment	85%	88.4%	91.7%	93.2%		93.2%	85.5%	87.8%	93.2%	89.7%
Cancer - 62 days from consultant upgrade	-	-	100%	50%		92.9%	83.3%	60.0%	50.0%	85.4%

Commentary

All targets achieved as expected for January 2016
All targets also on track for February 2016





Maternity

Whittington Health NHS

	Threshold	Trust Actual Dec-15	Trust Actual Jan-16	Trust Actual Feb-16	2015/16 Trust YTD
Women seen by HCP or midwife within 12 weeks and 6 days	90%	81.9%	77.2%	81.9%	82.3%
New Birth Visits - Haringey	95%	80.8%	87.7%	Arrears	86.6%
New Birth Visits - Islington	95%	91.5%	94.5%	Arrears	92.4%
Elective Caesarean Section rate	14.8%	11.9%	9.8%	12.0%	12.5%
Emergency Caesarean Section rate	-	20.0%	18.4%	20.0%	18.9%
Breastfeeding initiated	90%	86.8%	92.9%	91.5%	89.5%
Smoking at Delivery	<6%	5.9%	3.0%	7.4%	4.7%

Commentary

12+6

Issue: Improved but remains just below target and continue to experience significant DNA at first appointment. Over 400 appointments in February offered and 367 women booked. Capacity available but admin support needed to be able to contact women 72 to 48 hours prior to appointments.

Action: Aim to establish a clinical coordinator role to support the process of reminder calls.

Timescale: 3 to 4 months to implementation, expected to see improvement in June 2016

New birth visits

Issue: Improved but both below target

Action: Workforce plan in place to mitigate. New staff in the process of starting.

Timescale: Ongoing

Elective Caesarean Section rate

Target achieved

Breast feeding initiated

Target achieved

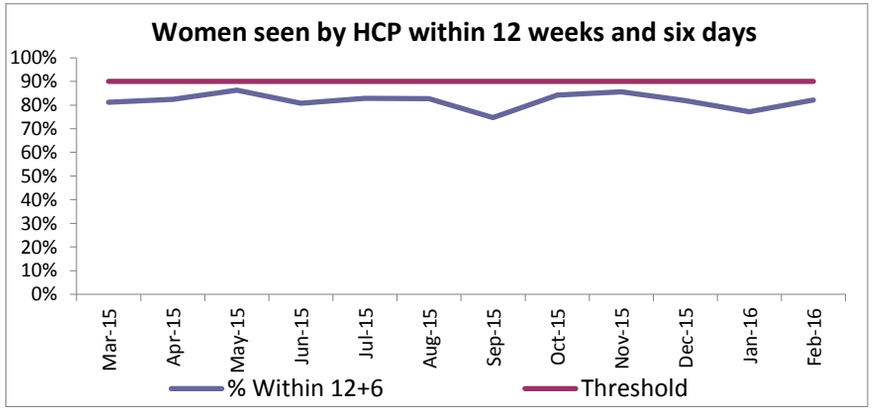
Smoking at Delivery

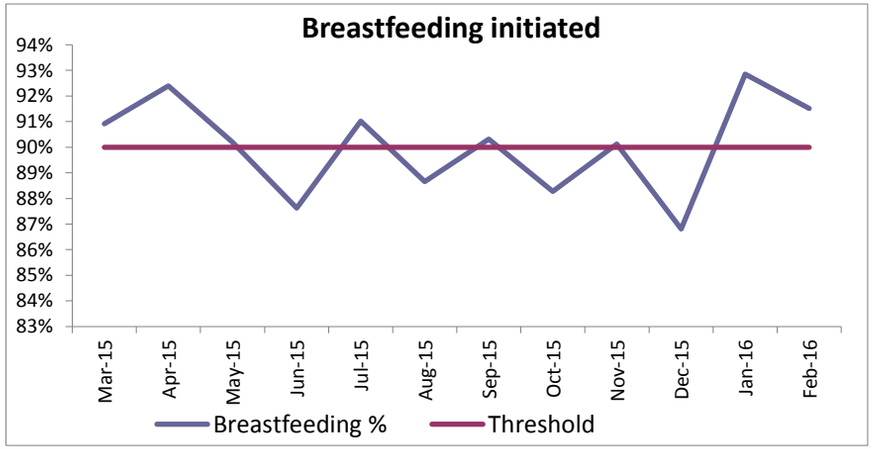
Target not achieved this month.

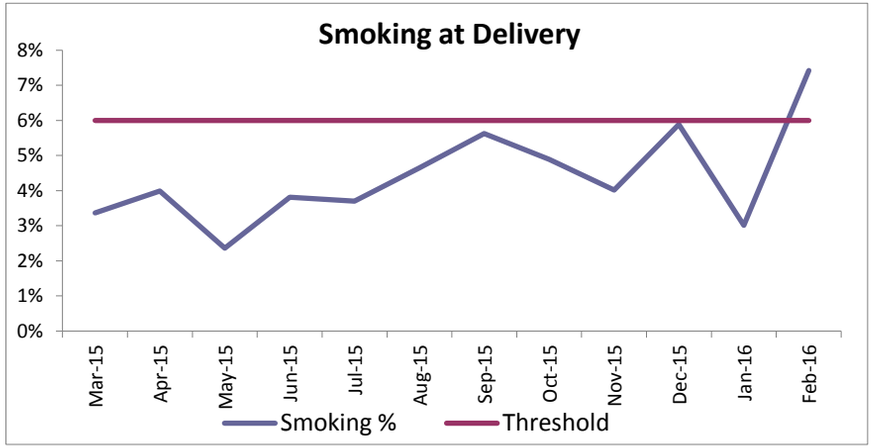
Issue: This data is entered by midwives at birth. All women are asked about smoking at booking and referred to smoking cessation team at Whittington Health.

Action: A pilot just completed included, the Smoking cessation team sharing information on the numbers of women who take up their service and are successful at quitting at birth and in the immediate postnatal period. The CO monitoring was only in 3 of the 5 teams during the pilot, but will be rolled out to all team in the next 3-4 weeks. A report is in the process of being written about the pilot with learning and recommendations.

Timescale: Implementation of CO monitoring during April 2016







Whittington Health NHS

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Trust Board
6 April 2016

The Whittington Hospital NHS Trust
Jenner Building
Magdala Avenue
London
N19 5NF

Title:	**Whittington Health NHS Staff Survey Results 2015**
Agenda item:	**16/054** **Paper 08**
Action requested:	Approve the Staff Survey results and agree for a detailed action plan and progress update to be presented to the Board July 2016
Executive Summary:	**Whittington Health NHS Staff Survey Results 2015** Whittington Health's (WH) overall response rate was 30% against the Acute Trust average of 38%, equating to 1,215 responses. This was a decrease of 10% on 2014, where 1,564 staff completed and returned the questionnaire. One of our key performance indicators staff engagement, improved slightly in 2015 scoring 3.79 (3.74 in 2014) which is in line with the national average. Of the 32 key findings from the results, the Trust scored significantly better than average in five areas and significantly worse than average in eight areas. Further details can be found in paragraph 3.4 of the report. Since 2014 the Trust has significantly improved in the following areas: 1 Staff Satisfaction with level of responsibility and involvement 2 Staff motivation at work 3 Percentage of staff appraised in last 12 months The Trust has deteriorated in one area: • Staff confidence and security in reporting unsafe clinical practice saw our scores decrease from 3.72 in 2014 to 3.63 in 2015. Our suggested areas for improvement corporately are as follows: **NHS Pledge 1** • Staff satisfaction with level of involvement and responsibility • Staff satisfaction with resourcing and support **NHS Pledge 2** • Staff appraised in last 12 months **NHS Pledge 3** • Working extra hours • Suffering work related stress • Organisation and management interest in and action on health and wellbeing

	• Experiencing physical violence from staff • Reporting most recent experience of violence • Experiencing harassment, bullying or abuse from patients or relatives • Experiencing harassment or bullying from staff • Reporting most recent experience of harassment, bullying or abuse **NHS Pledge themes Equality & Diversity / Errors and Incidences** • Experiencing discrimination at work • Believing the organisation provides equal opportunity for career progression / promotion • Reporting errors, near misses or incidents witnessed in last month • Action Staff feeling confident and secure in reporting unsafe practice
Summary of recommendations:	Approve the Staff Survey results and agree for a detailed action plan and progress update to be presented to the Board July 2016
Fit with WH strategy:	In line with our draft Workforce, OD and Staff engagement strategies
Reference to related / other documents:	2014 National NHS Survey and previous Staff FFT TMG reports
Date paper completed:	25/02/16

Author name and title:		**Rai Gallo Leadership Coach**		**Director name and title:**		**Norma French Director of Workforce**	
Date paper seen by TMG	**01/03/16**	**Equality Impact Assessment complete?**	**N/A**	**Risk assessment undertaken?**	**N/A**	**Legal advice received?**	**N/A**

Whittington Health

Paper to: **Trust Board**

Paper from: **Leadership Coach**

Director of Workforce

Subsect: **NHS National Staff Survey Results 2015**

Date:

1.0 Introduction

1.1 This is the fifth year in which Whittington Health as an Integrated Care organisation (ICO) has conducted the national staff survey and the second year that the Trust has elected to conduct a full staff survey. This paper summarises the results of the survey, draws out key comparative data and provides details of a proposed action and communications plan.

1.2 The findings from this NHS survey will be considered in conjunction with the progress made on last year's staff survey action plan, and the analysis of these results will be discussed with the Trust Management Group (TMG) for agreement of priorities and approach to the development of a robust staff survey action plan, to be presented to the Trust Board in April 2016.

1.3 The Trust commissions the Picker Institute to run its survey as do a further 63 other Trusts. This means that in addition to the national comparisons, we have access to reports at Directorate and individual service levels, for a more detailed and local analysis. The ICSUs and Directorates will receive detailed local reports through their management structure following presentation at TMG.

1.4 The 2015 NHS staff survey has seen some significant changes to the questions asked and the number of key findings reported on. This year there are 32 key findings reported under the four staff pledges of the NHS Constitution and three additional themes which are detailed below:

Staff Pledge 1:
To provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities.

Staff Pledge 2: To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.

Staff Pledge 3: To provide support and opportunities for staff to maintain their health, well-being and safety.

Staff Pledge 4: To engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families.

Additional Themes:

- Equality and diversity;
- Errors and incidents;
- Patient experience measures.

A summary of Whittington Health's 2015 Survey Results can be found in appendix 1 of this report.

2.0 Response and Respondent Details

Whittington Health's (WH) overall response rate was 30% against the Acute Trust average of 38%, equating to 1,215 responses. This was a decrease of 10% on 2014, where 1,564 staff completed and returned the questionnaire. Demographic characteristics of respondents was:

- **Age**, between 16 and 30, 15%. Between 31 and 40, 27%. Between 41 and 50, 28%. 51 and over 29%. There were 151 respondents that did not specify their age.

- **Gender,** Male respondents 23%, female respondents 77%. There were 359 Responses were gender was not specified.

- **Ethnicity**, White responses 67%, BME responses 33%. There were 130 responses where ethnicity was not specified

- **Disabled**, Responses from staff with a disability 14%, those responses from staff without a disability 86%. There were 137 responses who did not specify.

- **Length of service**, less than a year 12%, between 1 to 2 years 16%, between 3-5years 15%, 6 to 10 years 24%,, between 11 to 15 years 13% and over 15 years 19%. There were 131 respondents who did not specify their length of service.

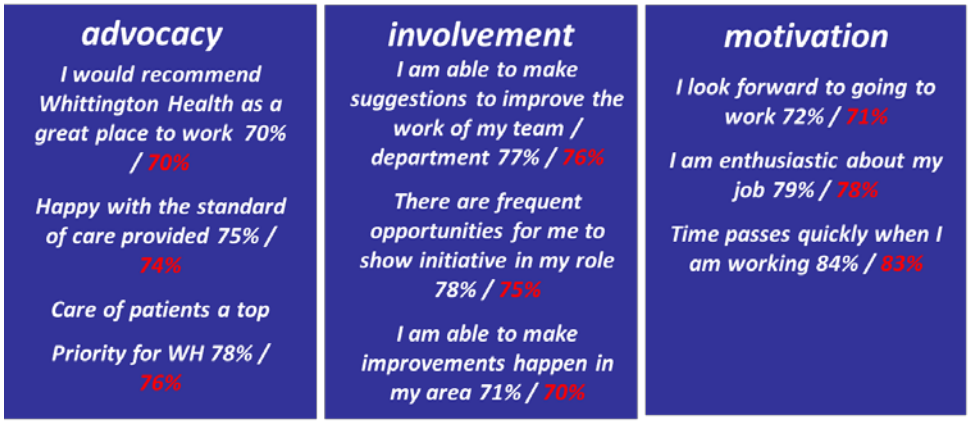
- **Full time / Part time**, full time staff 83%, part time staff 17%. There were 72 respondents who did not specify.

3.0 The CQC Staff Survey Results Overview

3.1 Staff Engagement Indicator

The CQC report provides an overall indicator of staff engagement for Whittington Health and how it compares with other acute Trusts. The possible scores range from 1 to 5 (with 1 indicating poor engagement and 5 high engagement). The Trust's score of 3.79 is in line with the national average and a local improvement from 3.74 in 2014. The diagram below illustrates how this score is made up and how were rated under each of the nine staff engagement questions.

The NHS survey includes an index of questions designed to measure employee engagement at Whittington



National staff engagement index 2014 3.74, 2015 3.79

The scores in red represent the Acute Trust average across the country

3.2 **Top Ranking Scores**

Whittington Health compares most favourably with other acute Trusts in England in the following areas:

	Indicator	**Trust**	**National**
1	Staff experiencing violence from patients	9%	14%
2	Staff satisfied with opportunities for flexible working patters	53%	51%
3	Quality of appraisals	3.13	3.04
4	Effective team working	3.80	3.77
5	Staff reporting good communication between senior management and staff	31%	30%

It is encouraging to note improvements in areas such as, good communication between senior managers and staff and the quality of appraisals as these were targeted improvement actions from last year's survey.

3.3 **Bottom Ranking Scores**

Where the Trust compares least favourably with other acute Trusts is set out below.

	Indicator	Trust	National
1	Staff working extra hours	79%	72%
2	Staff Suffering work related stress in last 12 months	42%	36%
3	Staff experiencing harassment, bullying or abuse from staff	29%	24%
4	Staff reporting errors, near misses or incidents witnessed in last month	87%	90%
5	Staff reporting most recent experience of violence	48%	52%

.

Whilst these are WH's bottom five ranking scores, the Trust has made improvements locally in the percentage of staff suffering from work related stress and reporting errors and near misses. The percentage of staff experiencing bullying or harassment remains the same as 2014. WH has seen a slight deterioration in scores around staff reporting experiences of violence and percentage of staff working extra hours.

3.4 **Comparisons with other Trusts**

Of the 32 key findings the Trust scored significantly ***better than average*** in five areas comparison to acute Trusts. These can be grouped as follows:-

Staff Pledge 1: *To provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities.*	
KF9	Effective team working
Staff Pledge 2: *To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.*	
KF12	Quality of Appraisals
Staff Pledge 3: *To provide support and opportunities for staff to maintain their health, well-being and safety.*	
KF15	Staff satisfied with the opportunities for flexible working
KF22	Staff experiencing physical violence from patients, relatives or the public
Staff Pledge 4: *To engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families*.	
KF6	Staff reporting good communication between senior management and staff

There are also eight problem scores where the Trust scored ***significantly worse than average.*** These are as follows:

Staff Pledge 1: *To provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities.*	
KF8	Staff satisfaction with level of involvement and responsibility
KF14	Staff satisfaction with resourcing and support
Staff Pledge 2: *To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.*	
KF11	Staff appraised in last 12 months
Staff Pledge 3: *To provide support and opportunities for staff to maintain their health, well-being and safety.*	

KF16	Working extra hours
KF17	Suffering work related stress
KF19	Organisation and management interest in and action on health and wellbeing
KF23	Experiencing physical violence from staff
KF24	Reporting most recent experience of violence
KF25	Experiencing harassment, bullying or abuse from patients or relatives
KF26	Experiencing harassment or bullying from staff
KF27	Reporting most recent experience of harassment, bullying or abuse
Additional Theme: *Equality and Diversity*	
KF20	Experiencing discrimination at work
KF21	Believing the organisation provides equal opportunity for career progression / promotion
Additional Theme: *Errors and Incidents*	
KF29	Reporting errors, near misses or incidents witnessed in last month

3.5 Local Changes since 2014

The report highlights key findings where staff experiences have significantly improved or deteriorated locally since the 2014 survey. These are set out below:-

3.5.1 Improved Staff Experiences

	Indicator	2014	2015
1	Staff Satisfaction with level of responsibility and involvement	3.8	3.89
2	Staff motivation at work	3.85	3.92
3	Percentage of staff appraised in last 12 months	78%	81%

Whilst it is encouraging to note that the Trust is improving in these areas, there is still a way to go as the Trust is below average in regards to number of staff being appraised and staff satisfaction levels for responsibility and involvement.

3.5.2 Deteriorating Staff Experiences

This year the Trust has only deteriorated locally in one area and that is staff confidence and security in reporting unsafe clinical practice saw our scores decrease from 3.72 in 2014 to 3.63 in 2015.

It should be noted, however that in 2014 WH was rated the best in the UK and our score in 2015 still places us amongst the average scores.

4.0 <u>Equalities Indicators</u>

4.1 The table below sets out the equality and diversity indicators in line with the Workforce race Equality Scheme (WRES). It shows the comparison of WH against other Trusts as well as changes since 2014

4.2 KF21 - Percentage of staff believing that the organisation provides equal opportunities for career progression and promotion. You will see from the table below, that there is a clear difference in perception between our White and BME staff although a slight improvement locally from 2014.

			Your Trust in 2015	Average (median) for combined acute and community trusts	Your Trust in 2014
KF25	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	White	29%	28%	27%
		BME	29%	26%	30%
KF26	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	White	27%	24%	25%
		BME	27%	26%	33%
KF21	Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	White	87%	89%	87%
		BME	67%	74%	62%
Q17b	In the 12 last months have you personally experienced discrimination at work from manager/team leader or other colleagues?	White	7%	5%	9%
		BME	14%	13%	16%

4.3 WH is slightly above average on the number of staff experiencing harassment, bullying or abuse from staff, however there is no differential between BME staff.

4.4 Those with a disability were more likely to report having suffered workplace stress – 59% (60% in 2014) against 42% Trust average.

4.5 There has been a significant improvement of those staff with a disability saying that they have received an appraisal. However there is still a negative variance when asked whether the appraisal was well structured, 2.91 against a Trust average of 3.13.

5.0 Progress on 2014 Staff Survey Action Plan

5.1 During 2015 the Trust Board agreed that as a result of our staff survey feedback we would focus on seven corporate priorities as detailed below:

1. Improve senior management visibility and staff engagement;
2. Whittington Health to address uncertainty by implementing a clear vision for the future;
3. Address management behaviours to inspire and motivate staff and act as leaders, encouraging staff to reach their potential;
4. Training, development and career path opportunities across the Trust;
5. Understand the underlying cause and act where staff have reported excessive workload;
6. Bullying and harassment from managers and colleagues, with an increase in staff not reporting these incidences;
7. Percentage of staff being appraised and having a well-structured appraisal.

5.2 A corporate action plan was developed and an Accountable Executive identified for leading on each of these corporate priorities. Trust Board approved this action plan in June 2015 with a progress update given in September 2015. Since then significant progress has been made in each of these areas. Some of the actions taken included:

- A new appraisal process developed with an going roll out programme for line managers;

- Improved appraisal compliance reporting and monthly performance updates provided to TMG;
- New monthly Chief Executive Briefing , compulsory for senior managers;
- Details of postholders in management positions communicated and circulated across the Trust;
- New internal staff awards scheme linked to our organisational values;
- The introduction of organisational values across the Trust;
- New Corporate Induction programme for new staff;
- Restructuring from clinical divisions to seven Integrated Clinical Service Units (ICSUs);
- The development of a new leadership and management offer across the Trust being rolled out in 2016;
- The initial production of our equality data, this has highlighted a number of gaps, in our equality data and an action plan is being developed to ensure that we can continue with our WRES reporting in 2016.

6.0 Suggested Response and Action Plan

The focus of the Action Plan for the 2015 survey will be areas where there has either been deterioration in local performance or where the Trust compares less favourably with other Trusts. The action plan will be grouped under pledges and key themes of the NHS Constitution as follows:

6.1 Staff Pledge 1: To provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities.		
Areas for improvement:	• Staff satisfaction with level of involvement and responsibility • Staff satisfaction with resourcing and support	Suggested Corporate lead
Suggested actions:	• The development of a staff communication and engagement plan, which keeps staff up to date and encourages involvement • CEO Briefings – Ensure the right managers are attending and that team briefings are happening locally within their business areas • Operational staff are involved in our Organisational Transformation plans, CIP / QIP • Cascade of Level 2 / 3 staff survey results to ICSU's and service areas. HRBP / OD support offered where necessary in facilitating staff survey action planning workshops • Organisational goals and objectives cascaded within service areas and individual objectives aligned so there is a clear line of sight between individual role and organisational objectives	Director of Communications COO Clinical Directors Clinical Directors

6.2	**Staff Pledge 2**: To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.	
Areas for improvement:	• Staff appraised in last 12 months	Corporate lead
Suggested actions:	• Continue with managers' appraisal training twice monthly • Continue with staff appraisee training once a quarter • Monthly appraisal performance reporting to TMG • ICSU monthly performance reporting to Executive team • Quarterly reporting to Workforce Assurance Committee and Trust Board	Leadership Coach / Head of L&D Director of Workforce

6.3	**Staff Pledge 3:** To provide support and opportunities for staff to maintain their health, well- being and safety.	
Areas for improvement:	• Working extra hours • Suffering work related stress • Organisation and management interest in and action on health and wellbeing • Experiencing physical violence from staff • Reporting most recent experience of violence • Experiencing harassment, bullying or abuse from patients or relatives • Experiencing harassment or bullying from staff • Reporting most recent experience of harassment, bullying or abuse	Corporate lead
Suggested actions:	• Occupational Health (OH) to promote the use of the stress self-assessment questionnaire • L&D to organise training for managers around work related stress • Promote the Employee Assistance Programme (EAP) through OH and other support available through OH • Promote bi-annual health and well-being month, promoting well-being for staff and what is on offer • Trained bullying and harassment advisors, available to both alleged victims and alleged perpetrators • Develop our unconscious bias masterclass for all managers • Equality and Diversity training introduced as management induction training • Re-enforce our organisational values and zero tolerance of bullying and harassment • Incorporate unconscious bias training as part of our recruitment and retention workshops • Introduce a half yearly health and safety bulletin communicated to all staff • Review and promote our flexible working policy	Head of OH Head of L&D Head of OH Head of L&D Leadership Coach Head of L&D Director of Workforce

6.4 Staff Pledge themes – Equality and Diversity		
Areas for improvement:	• Experiencing discrimination at work • Believing the organisation provides equal opportunity for career progression / promotion	Corporate lead
Suggested actions:	• Develop our unconscious bias masterclass for all managers • Refresh our E&D training as a formal programme • Re-enforce our organisational values and zero tolerance of bullying and harassment • Trained bullying and harassment advisors, available to both alleged victims and alleged perpetrators • Incorporate unconscious bias training as part of our recruitment and retention workshops • To introduce and monitor outcomes relating to workforce race equality standards.	Head of L&D

6.5 Staff Pledge themes – Errors and incidences		
Areas for improvement:	• Reporting errors, near misses or incidents witnessed in last month • Action Staff feeling confident and secure in reporting unsafe practice	Corporate lead
Suggested actions:	• Review mechanism for staff feedback who report an incident • Commitment to staff to acknowledge they reported an incident, and when they can expect feedback • Quarterly analysis / report feeding back learning and outcomes from reported incidences to all staff on a half-yearly basis • Raising awareness on how, what and where you can report a serious incident	Head of Risk

7.0 Communication Plan

The results and action plan from the national Staff Survey 2015 will be communicated as follows:

• Trust Management Group	1st March 2016
• Trust Board	6th April 2016
• Partnership Group	end March 2016
• ICSUs and Directorates	through March 2016
• Chief Executive Briefing	7th March 2016
• Trust wide communications	6th April onwards

8.0 Recommendation

The Trust Board to approve this report and agree the action plan 2016/17.

2015 National NHS staff survey

Brief summary of results from The Whittington Hospital NHS Trust

Table of Contents

1. Introduction to this report

This report presents the findings of the 2015 national NHS staff survey conducted in The Whittington Hospital NHS Trust.

In section 2 of this report, we present an overall indicator of staff engagement. Full details of how this indicator was created can be found in the document ***Making sense of your staff survey data***, which can be downloaded from www.nhsstaffsurveys.com.

In sections 3 and 4 of this report, the findings of the questionnaire have been summarised and presented in the form of 32 Key Findings.

These sections of the report have been structured around four of the seven pledges to staff in the NHS Constitution which was published in March 2013 (http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution) plus three additional themes:

- Staff Pledge 1: To provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities.
- Staff Pledge 2: To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.
- Staff Pledge 3: To provide support and opportunities for staff to maintain their health, well-being and safety.
- Staff Pledge 4: To engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families.
- Additional theme: Equality and diversity
- Additional theme: Errors and incidents
- Additional theme: Patient experience measures

Please note, the questionnaire, key findings and benchmarking groups have all undergone substantial revision since the previous staff survey. For more detail on these changes, please see the ***Making sense of your staff survey data*** document.

As in previous years, there are two types of Key Finding:

- percentage scores, i.e. percentage of staff giving a particular response to one, or a series of, survey questions

- scale summary scores, calculated by converting staff responses to particular questions into scores. For each of these scale summary scores, the minimum score is always 1 and the maximum score is 5

A longer and more detailed report of the 2015 survey results for The Whittington Hospital NHS Trust can be downloaded from: www.nhsstaffsurveys.com. This report provides detailed breakdowns of the Key Finding scores by directorate, occupational groups and demographic groups, and details of each question included in the core questionnaire.

Your Organisation

The scores presented below are un-weighted question level scores for questions Q21a, Q21b, Q21c and Q21d and the un-weighted score for Key Finding 1. The percentages for Q21a – Q21d are created by combining the responses for those who “Agree” and “Strongly Agree” compared to the total number of staff that responded to the question.

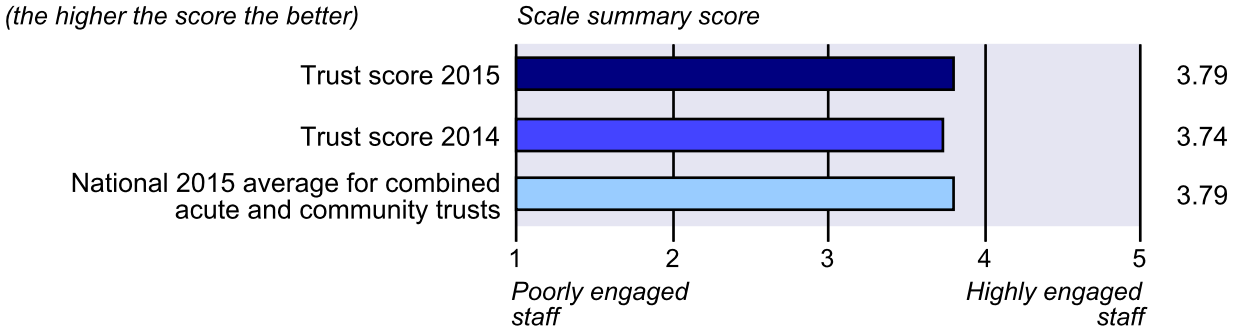
Q21a, Q21c and Q21d feed into Key Finding 1 “Staff recommendation of the organisation as a place to work or receive treatment”.

		Your Trust in 2015	Average (median) for combined acute and community trusts	Your Trust in 2014
Q21a	"Care of patients / service users is my organisation's top priority"	75%	73%	70%
Q21b	"My organisation acts on concerns raised by patients / service users"	72%	72%	72%
Q21c	"I would recommend my organisation as a place to work"	58%	58%	58%
Q21d	"If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"	69%	68%	66%
KF1.	Staff recommendation of the organisation as a place to work or receive treatment (Q21a, 21c-d)	3.71	3.71	3.68

2. Overall indicator of staff engagement for The Whittington Hospital NHS Trust

The figure below shows how The Whittington Hospital NHS Trust compares with other combined acute and community trusts on an overall indicator of staff engagement. Possible scores range from 1 to 5, with 1 indicating that staff are poorly engaged (with their work, their team and their trust) and 5 indicating that staff are highly engaged. The trust's score of 3.79 was average when compared with trusts of a similar type.

OVERALL STAFF ENGAGEMENT



This overall indicator of staff engagement has been calculated using the questions that make up Key Findings 1, 4 and 7. These Key Findings relate to the following aspects of staff engagement: staff members' perceived ability to contribute to improvements at work (Key Finding 7); their willingness to recommend the trust as a place to work or receive treatment (Key Finding 1); and the extent to which they feel motivated and engaged with their work (Key Finding 4).

The table below shows how The Whittington Hospital NHS Trust compares with other combined acute and community trusts on each of the sub-dimensions of staff engagement, and whether there has been a change since the 2014 survey.

	Change since 2014 survey	Ranking, compared with all combined acute and community trusts
OVERALL STAFF ENGAGEMENT	✓ Increase (better than 14)	• Average
KF1. Staff recommendation of the trust as a place to work or receive treatment *(the extent to which staff think care of patients/service users is the trust's top priority, would recommend their trust to others as a place to work, and would be happy with the standard of care provided by the trust if a friend or relative needed treatment.)*	• No change	• Average
KF4. Staff motivation at work *(the extent to which they look forward to going to work, and are enthusiastic about and absorbed in their jobs.)*	• No change	• Average
KF7. Staff ability to contribute towards improvements at work *(the extent to which staff are able to make suggestions to improve the work of their team, have frequent opportunities to show initiative in their role, and are able to make improvements at work.)*	✓ Increase (better than 14)	• Average

Full details of how the overall indicator of staff engagement was created can be found in the document ***Making sense of your staff survey data***.

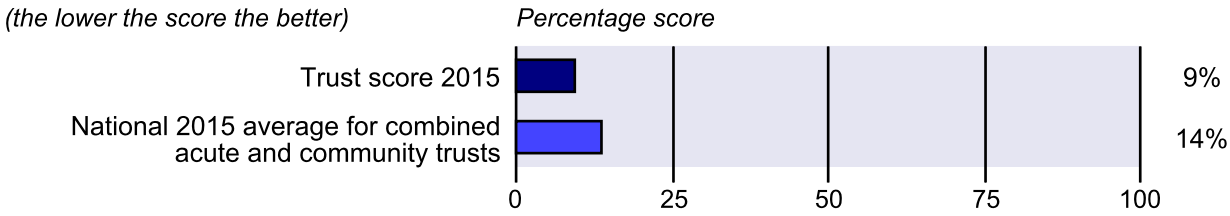
3. Summary of 2015 Key Findings for The Whittington Hospital NHS Trust

3.1 Top and Bottom Ranking Scores

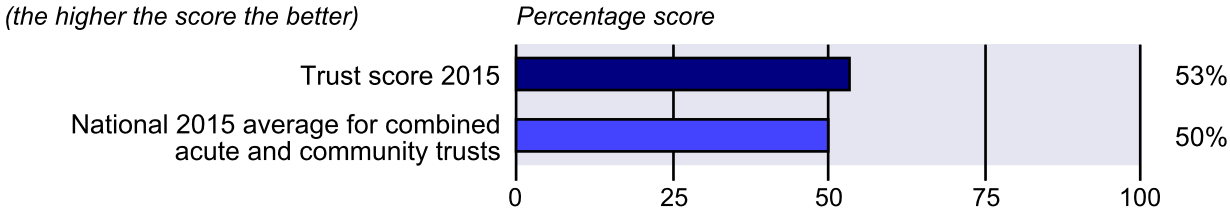
This page highlights the five Key Findings for which The Whittington Hospital NHS Trust compares most favourably with other combined acute and community trusts in England.

TOP FIVE RANKING SCORES

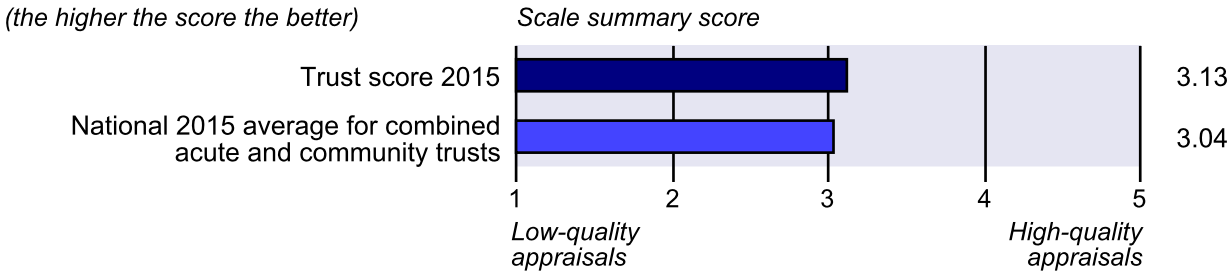
✓KF22. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months



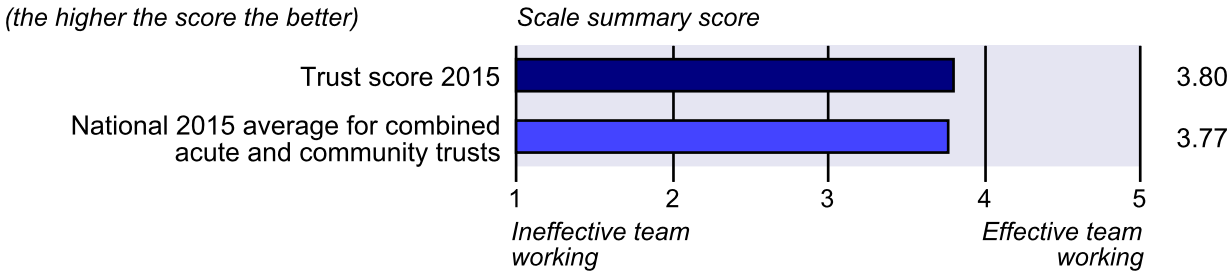
✓KF15. Percentage of staff satisfied with the opportunities for flexible working patterns



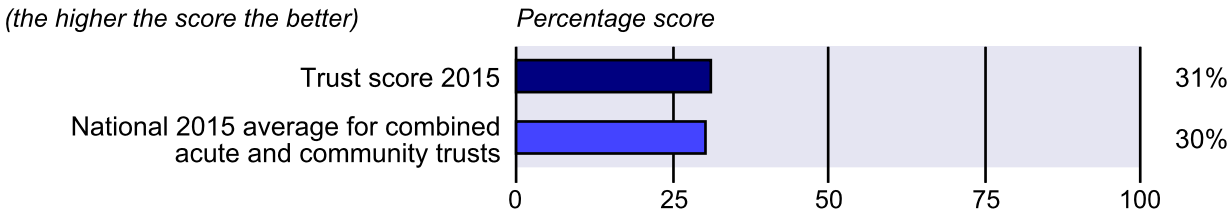
✓KF12. Quality of appraisals



✓KF9. Effective team working



✓KF6. Percentage of staff reporting good communication between senior management and staff



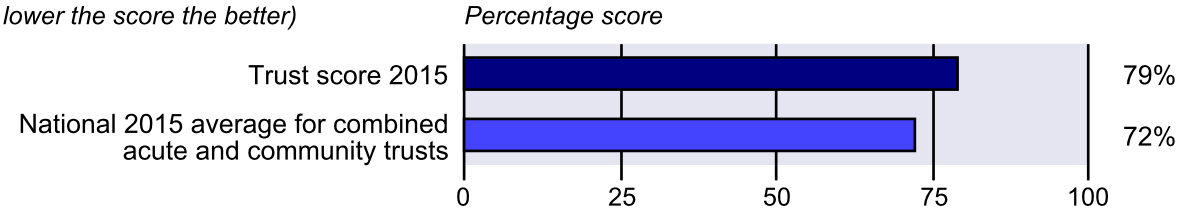
For each of the 32 Key Findings, the combined acute and community trusts in England were placed in order from 1 (the top ranking score) to 38 (the bottom ranking score). The Whittington Hospital NHS Trust's five highest ranking scores are presented here, i.e. those for which the trust's Key Finding score is ranked closest to 1. Further details about this can be found in the document ***Making sense of your staff survey data***.

This page highlights the five Key Findings for which The Whittington Hospital NHS Trust compares least favourably with other combined acute and community trusts in England. It is suggested that these areas might be seen as a starting point for local action to improve as an employer.

BOTTOM FIVE RANKING SCORES

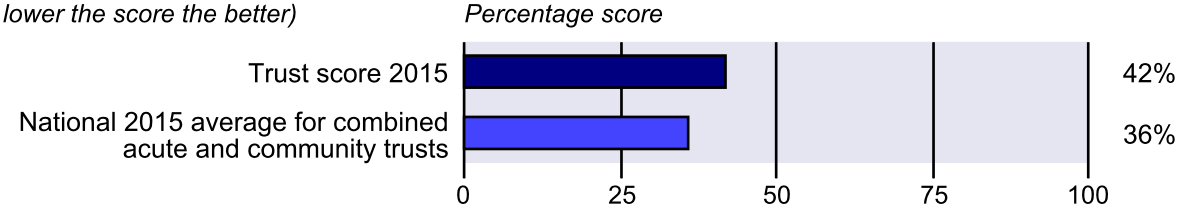
! KF16. Percentage of staff working extra hours

(the lower the score the better)



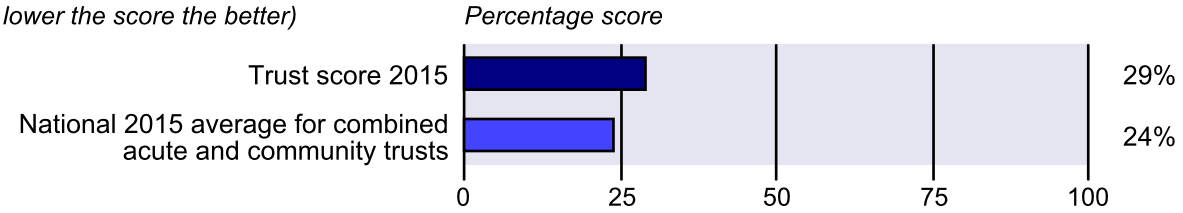
! KF17. Percentage of staff suffering work related stress in last 12 months

(the lower the score the better)



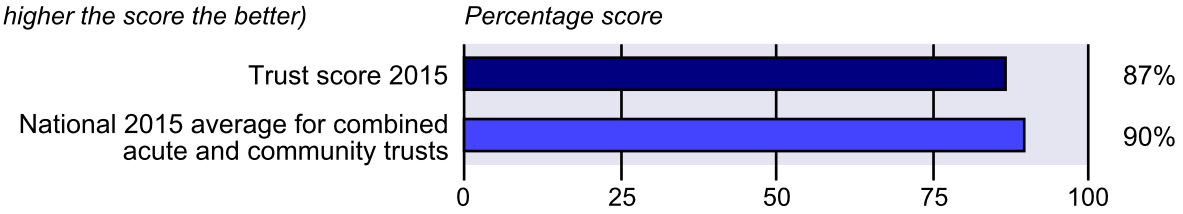
! KF26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

(the lower the score the better)



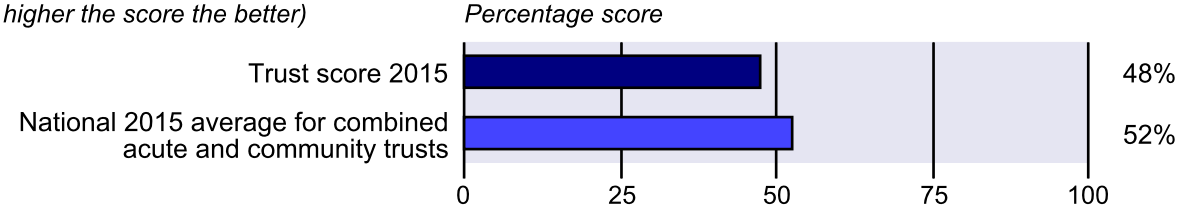
! KF29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month

(the higher the score the better)



! KF24. Percentage of staff / colleagues reporting most recent experience of violence

(the higher the score the better)



For each of the 32 Key Findings, the combined acute and community trusts in England were placed in order from 1 (the top ranking score) to 38 (the bottom ranking score). The Whittington Hospital NHS Trust's five lowest ranking scores are presented here, i.e. those for which the trust's Key Finding score is ranked closest to 38. Further details about this can be found in the document ***Making sense of your staff survey data***.

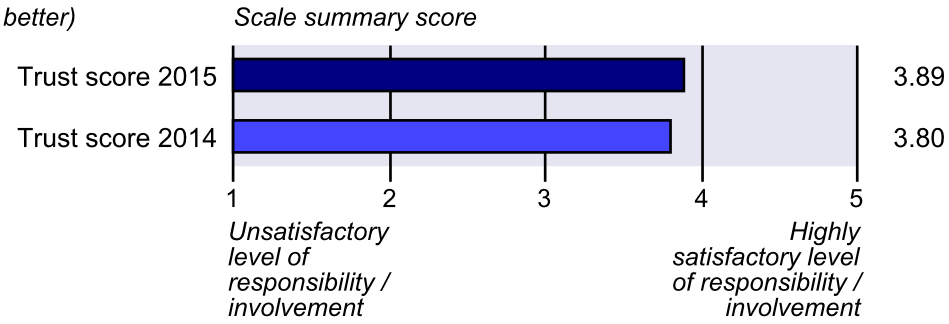
3.2 Largest Local Changes since the 2014 Survey

This page highlights the three Key Findings where staff experiences have improved at The Whittington Hospital NHS Trust since the 2014 survey. (This is a positive local result. However, please note that, as shown in section 3.3, when compared with other combined acute and community trusts in England, the scores for Key findings KF8, and KF11 are worse than average).

WHERE STAFF EXPERIENCE HAS IMPROVED

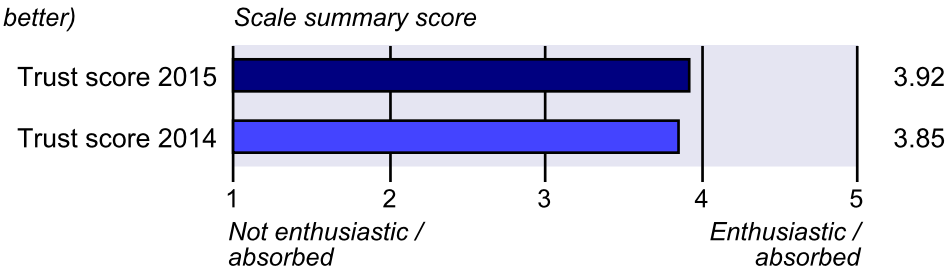
✓KF8. Staff satisfaction with level of responsibility and involvement

(the higher the score the better)



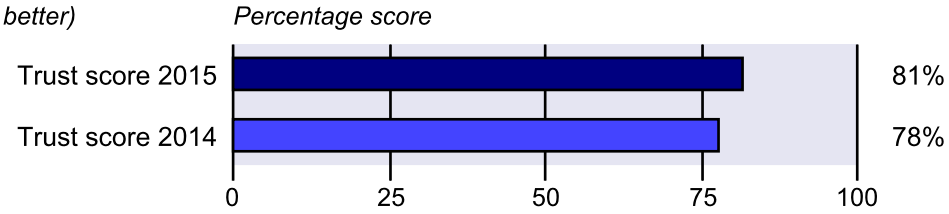
✓KF4. Staff motivation at work

(the higher the score the better)



✓KF11. Percentage of staff appraised in last 12 months

(the higher the score the better)

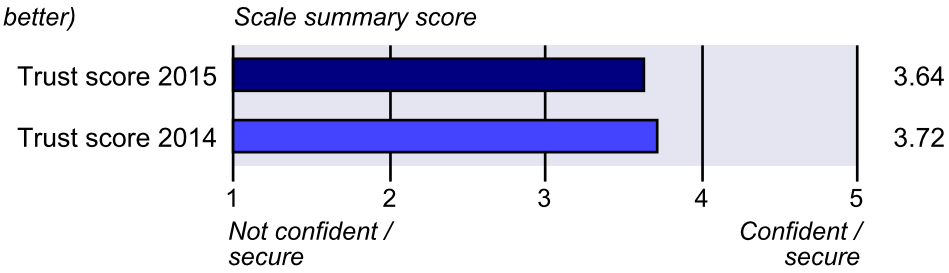


This page highlights the Key Finding that has deteriorated at The Whittington Hospital NHS Trust since the 2014 survey. It is suggested that this might be seen as a starting point for local action to improve as an employer.

WHERE STAFF EXPERIENCE HAS DETERIORATED

! KF31. Staff confidence and security in reporting unsafe clinical practice

(the higher the score the better)



3.3. Summary of all Key Findings for The Whittington Hospital NHS Trust

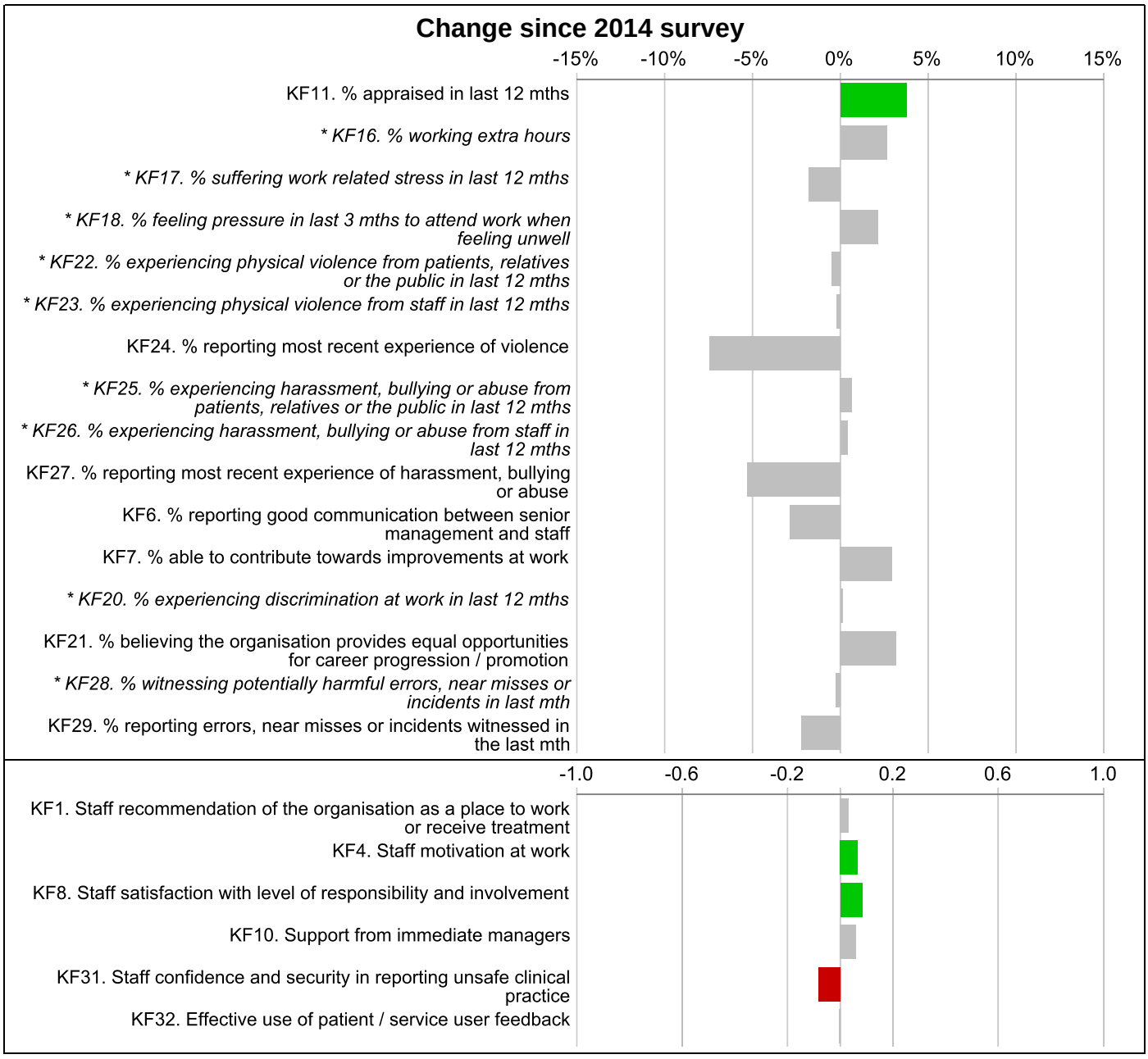
KEY

Green = Positive finding, e.g. there has been a statistically significant positive change in the Key Finding since the 2014 survey.

Red = Negative finding, e.g. there has been a statistically significant negative change in the Key Finding since the 2014 survey.

Grey = No change, e.g. there has been no statistically significant change in this Key Finding since the 2014 survey.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.



3.3. Summary of all Key Findings for The Whittington Hospital NHS Trust

KEY

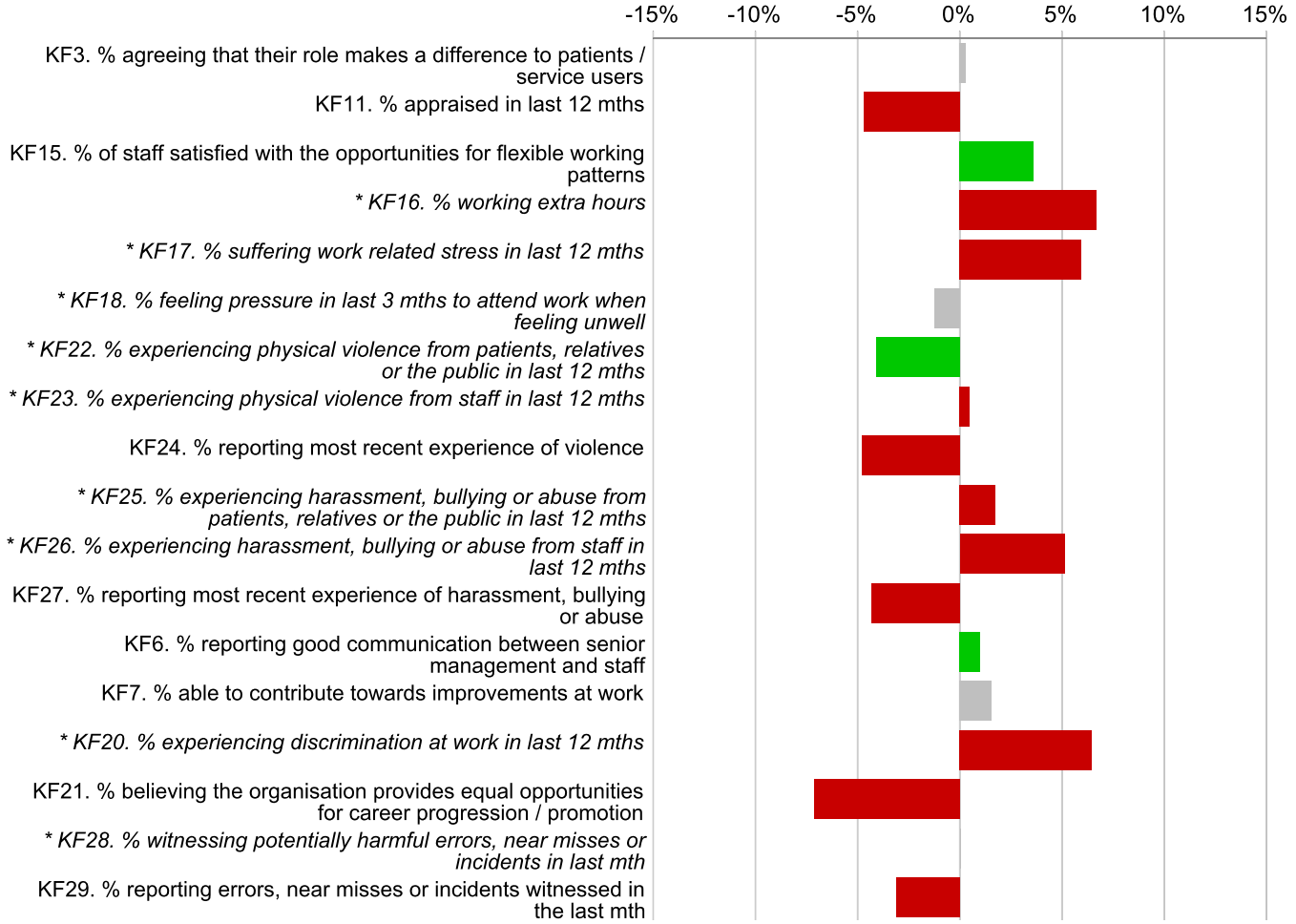
Green = Positive finding, e.g. better than average.

Red = Negative finding, e.g. worse than average.

Grey = Average.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.

Comparison with all combined acute and community trusts in 2015



3.3. Summary of all Key Findings for The Whittington Hospital NHS Trust

KEY

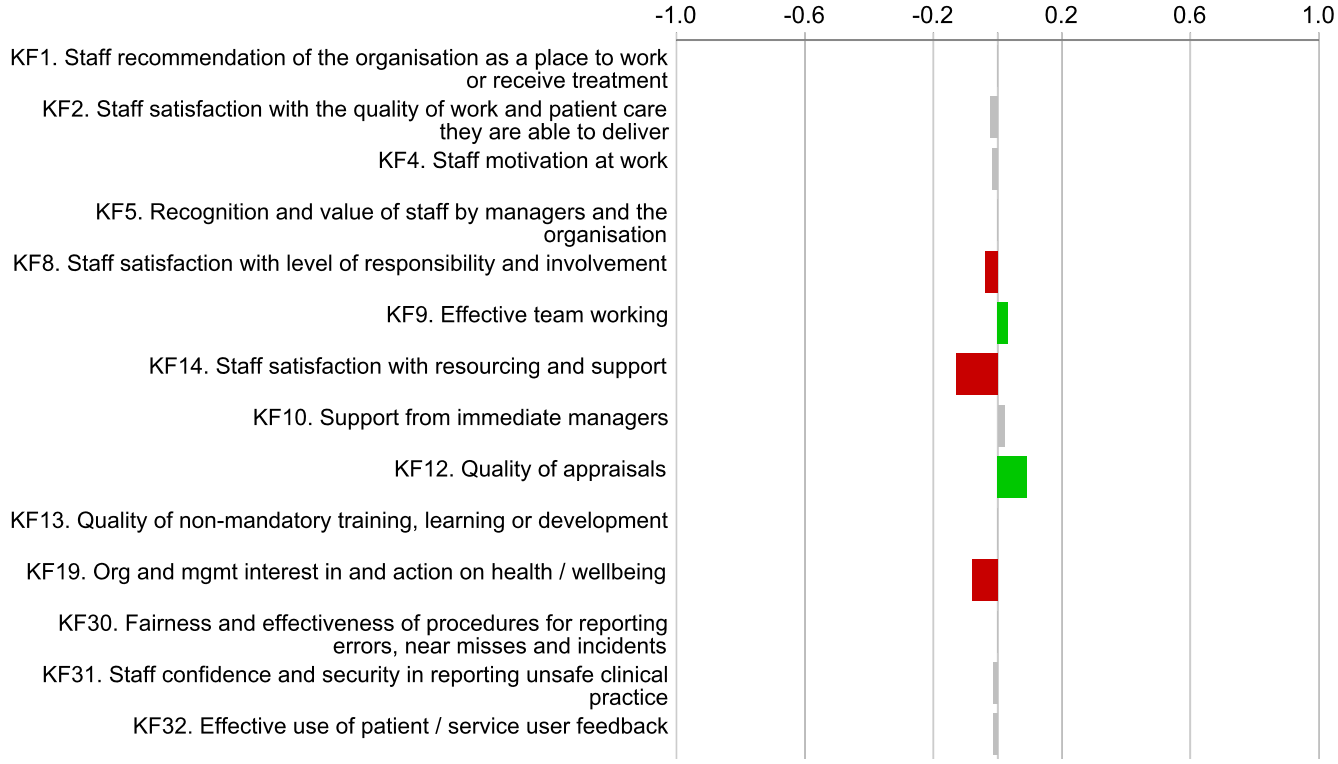
Green = Positive finding, e.g. better than average.

Red = Negative finding, e.g. worse than average.

Grey = Average.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.

Comparison with all combined acute and community trusts in 2015 (cont)



3.4. Summary of all Key Findings for The Whittington Hospital NHS Trust

KEY

✓ Green = Positive finding, e.g. better than average, better than 2014.

! Red = Negative finding, e.g. worse than average, worse than 2014.

'Change since 2014 survey' indicates whether there has been a statistically significant change in the Key Finding since the 2014 survey.

-- Because of changes to the format of the survey questions this year, comparisons with the 2014 score are not possible.

* For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.

	Change since 2014 survey	Ranking, compared with all combined acute and community trusts in 2015
STAFF PLEDGE 1: To provide all staff with clear roles, responsibilities and rewarding jobs.		
KF1. Staff recommendation of the organisation as a place to work or receive treatment	• No change	• Average
KF2. Staff satisfaction with the quality of work and patient care they are able to deliver	--	• Average
KF3. % agreeing that their role makes a difference to patients / service users	--	• Average
KF4. Staff motivation at work	✓ Increase (better than 14)	• Average
KF5. Recognition and value of staff by managers and the organisation	--	• Average
KF8. Staff satisfaction with level of responsibility and involvement	✓ Increase (better than 14)	! Below (worse than) average
KF9. Effective team working	--	✓ Above (better than) average
KF14. Staff satisfaction with resourcing and support	--	! Below (worse than) average
STAFF PLEDGE 2: To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.		
KF10. Support from immediate managers	• No change	• Average
KF11. % appraised in last 12 mths	✓ Increase (better than 14)	! Below (worse than) average
KF12. Quality of appraisals	--	✓ Above (better than) average
KF13. Quality of non-mandatory training, learning or development	--	• Average
STAFF PLEDGE 3: To provide support and opportunities for staff to maintain their health, well-being and safety.		
Health and well-being		
KF15. % of staff satisfied with the opportunities for flexible working patterns	--	✓ Above (better than) average
* *KF16. % working extra hours*	• No change	! Above (worse than) average
* *KF17. % suffering work related stress in last 12 mths*	• No change	! Above (worse than) average
* *KF18. % feeling pressure in last 3 mths to attend work when feeling unwell*	• No change	• Average
KF19. Org and mgmt interest in and action on health / wellbeing	--	! Below (worse than) average

3.4. Summary of all Key Findings for The Whittington Hospital NHS Trust (cont)

	Change since 2014 survey	Ranking, compared with all combined acute and community trusts in 2015
Violence and harassment		
* *KF22. % experiencing physical violence from patients, relatives or the public in last 12 mths*	• No change	✓ Below (better than) average
* *KF23. % experiencing physical violence from staff in last 12 mths*	• No change	! Above (worse than) average
KF24. % reporting most recent experience of violence	• No change	! Below (worse than) average
* *KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths*	• No change	! Above (worse than) average
* *KF26. % experiencing harassment, bullying or abuse from staff in last 12 mths*	• No change	! Above (worse than) average
KF27. % reporting most recent experience of harassment, bullying or abuse	• No change	! Below (worse than) average
STAFF PLEDGE 4: To engage staff in decisions that affect them, the services they provide and empower them to put forward ways to deliver better and safer services.		
KF6. % reporting good communication between senior management and staff	• No change	✓ Above (better than) average
KF7. % able to contribute towards improvements at work	• No change	• Average
ADDITIONAL THEME: Equality and diversity		
* *KF20. % experiencing discrimination at work in last 12 mths*	• No change	! Above (worse than) average
KF21. % believing the organisation provides equal opportunities for career progression / promotion	• No change	! Below (worse than) average
ADDITIONAL THEME: Errors and incidents		
* *KF28. % witnessing potentially harmful errors, near misses or incidents in last mth*	• No change	• Average
KF29. % reporting errors, near misses or incidents witnessed in the last mth	• No change	! Below (worse than) average
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	--	• Average
KF31. Staff confidence and security in reporting unsafe clinical practice	! Decrease (worse than 14)	• Average
ADDITIONAL THEME: Patient experience measures		
KF32. Effective use of patient / service user feedback	• No change	• Average

4. Key Findings for The Whittington Hospital NHS Trust

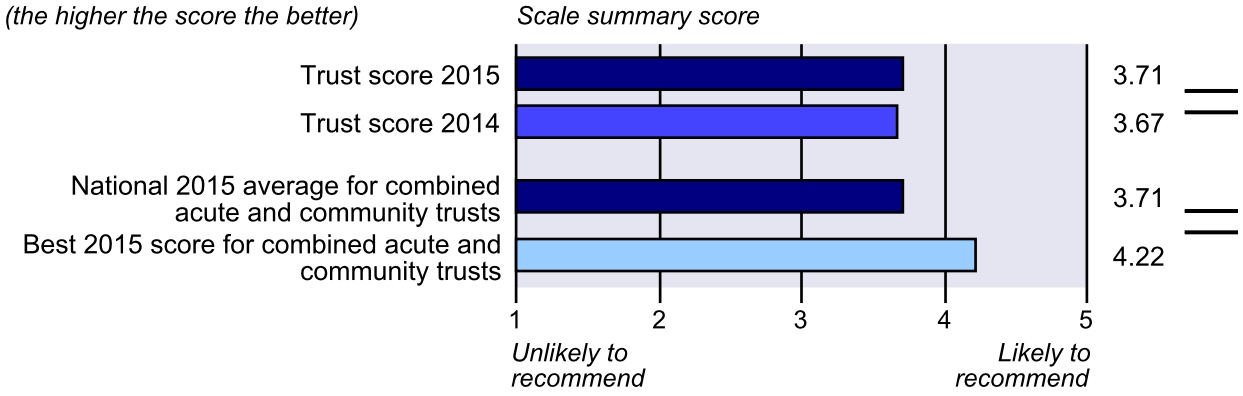
1215 staff at The Whittington Hospital NHS Trust took part in this survey. This is a response rate of 30%[1] which is below average for combined acute and community trusts in England, and compares with a response rate of 39% in this trust in the 2014 survey.

This section presents each of the 32 Key Findings, using data from the trust's 2015 survey, and compares these to other combined acute and community trusts in England and to the trust's performance in the 2014 survey. The findings are arranged under seven headings – the four staff pledges from the NHS Constitution, and the three additional themes of equality and diversity, errors and incidents, and patient experience measures.

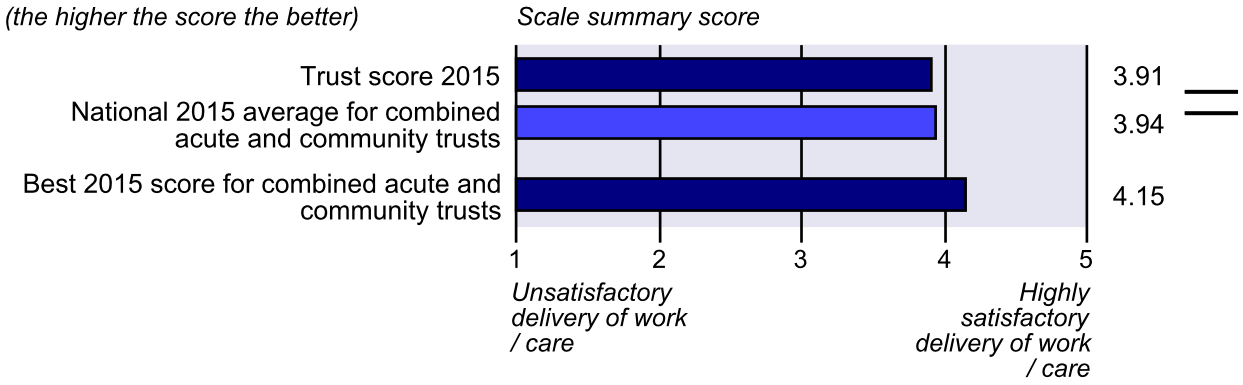
Positive findings are indicated with a green arrow (e.g. where the trust is better than average, or where the score has improved since 2014). Negative findings are highlighted with a red arrow (e.g. where the trust's score is worse than average, or where the score is not as good as 2014). An equals sign indicates that there has been no change.

STAFF PLEDGE 1: To provide all staff with clear roles, responsibilities and rewarding jobs.

KEY FINDING 1. Staff recommendation of the organisation as a place to work or receive treatment

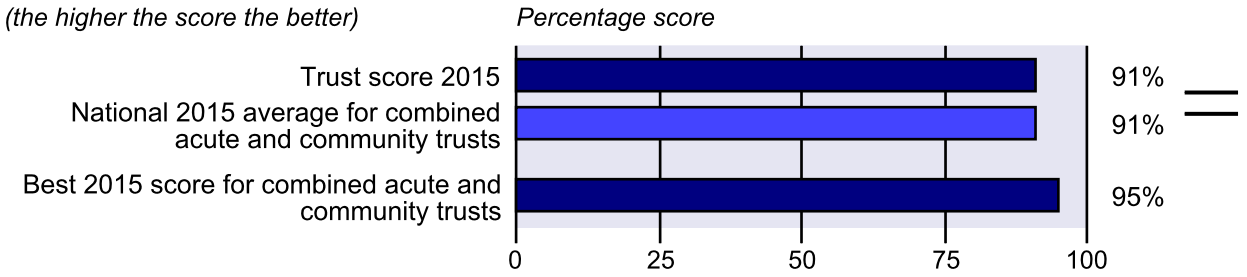


KEY FINDING 2. Staff satisfaction with the quality of work and patient care they are able to deliver

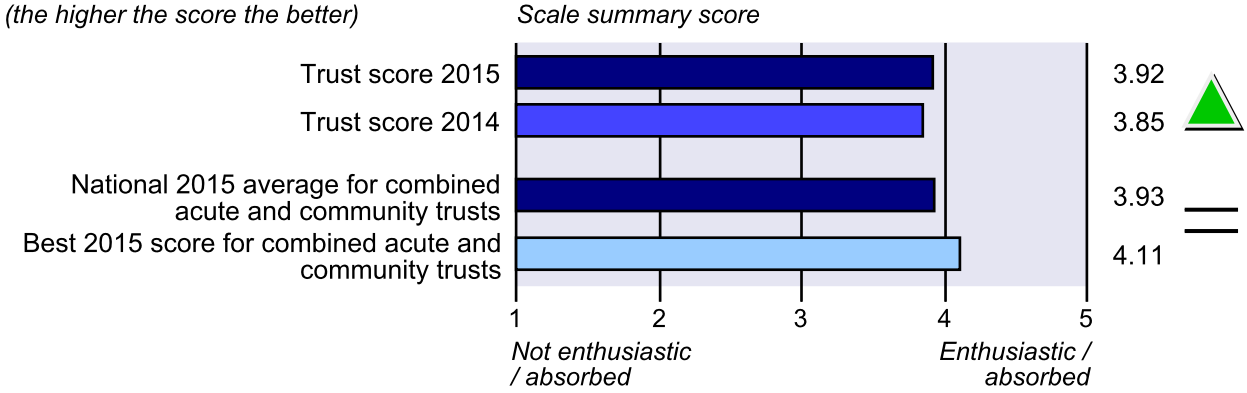


[1]Questionnaires were sent to all 4071 staff eligible to receive the survey. This includes only staff employed directly by the trust (i.e. excluding staff working for external contractors). It excludes bank staff unless they are also employed directly elsewhere in the trust. When calculating the response rate, questionnaires could only be counted if they were received with their ID number intact, by the closing date.

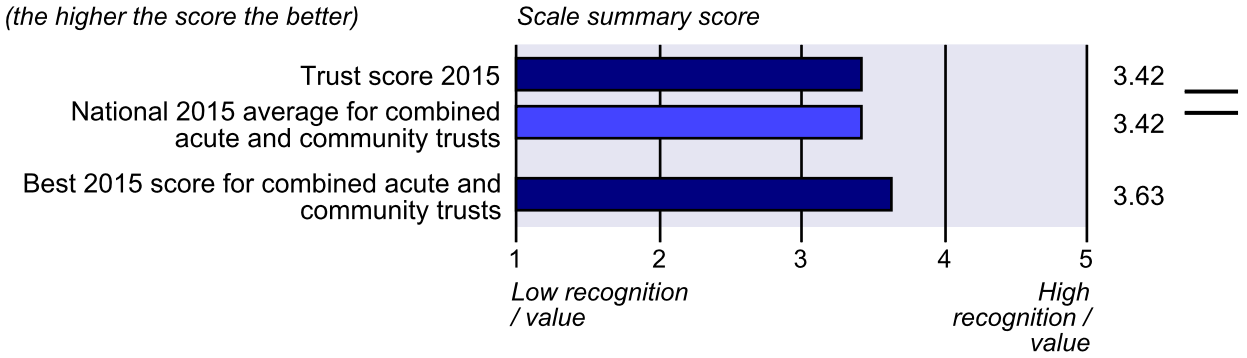
KEY FINDING 3. Percentage of staff agreeing that their role makes a difference to patients / service users



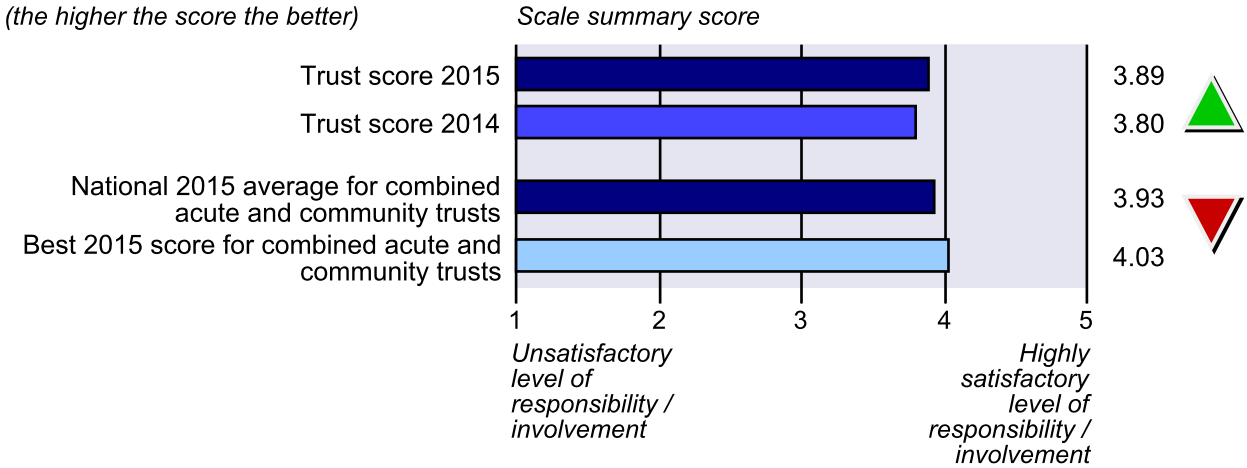
KEY FINDING 4. Staff motivation at work



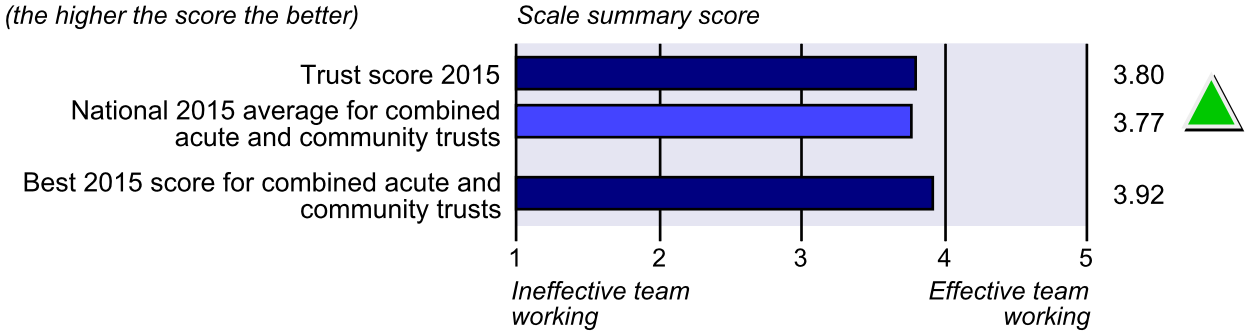
KEY FINDING 5. Recognition and value of staff by managers and the organisation



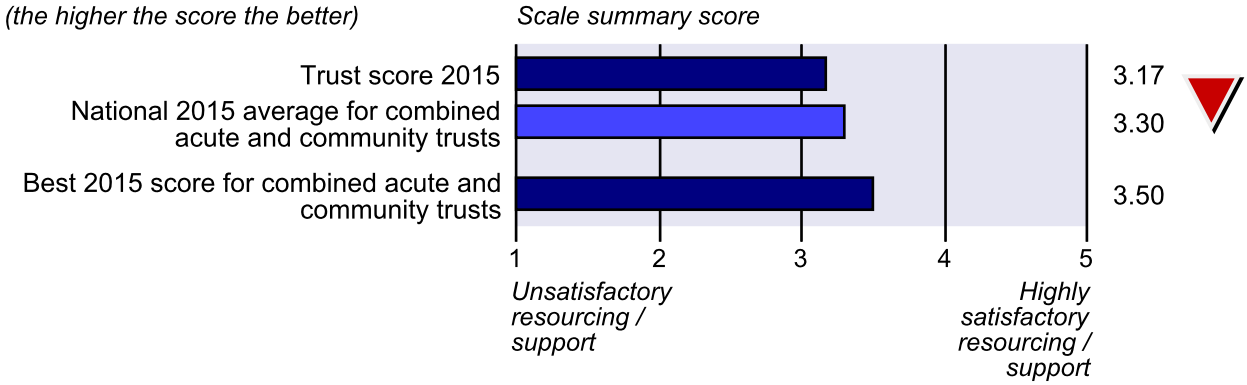
KEY FINDING 8. Staff satisfaction with level of responsibility and involvement



KEY FINDING 9. Effective team working

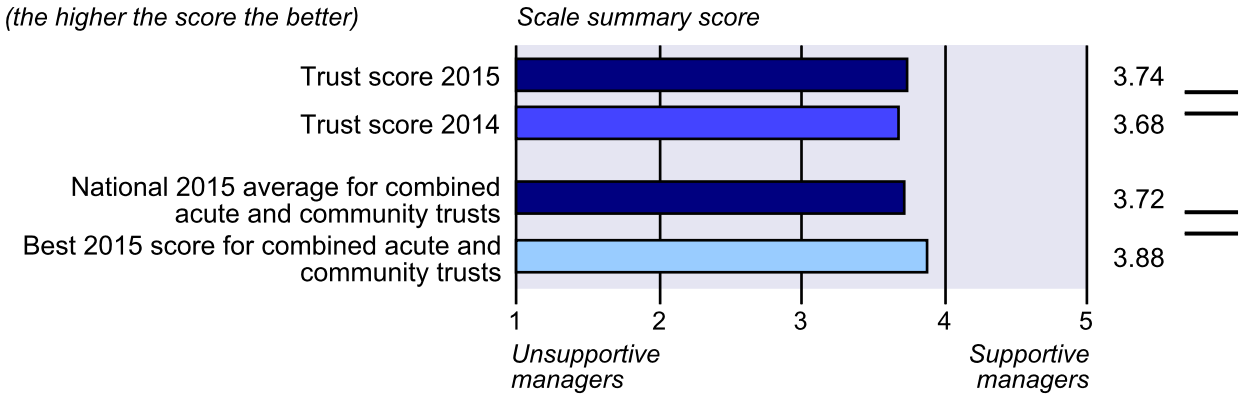


KEY FINDING 14. Staff satisfaction with resourcing and support

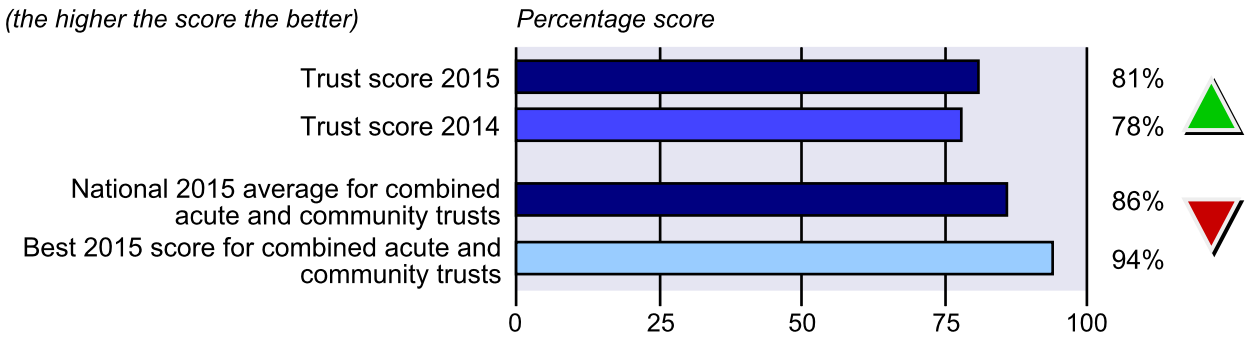


STAFF PLEDGE 2: To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.

KEY FINDING 10. Support from immediate managers

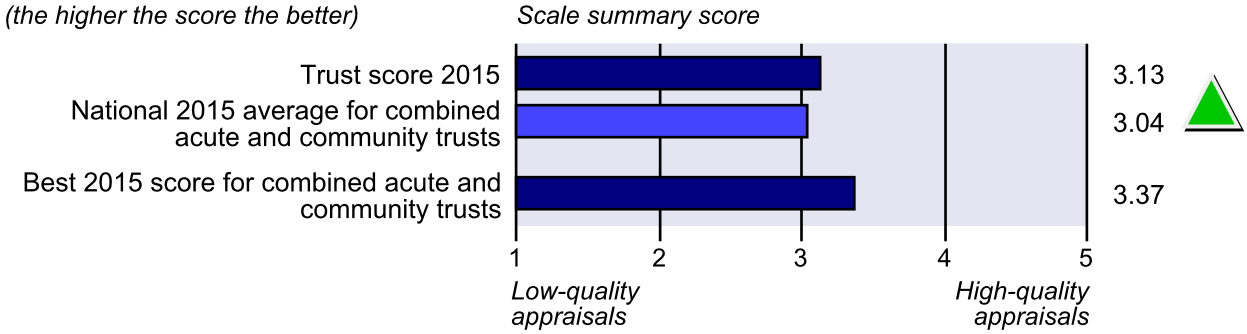


KEY FINDING 11. Percentage of staff appraised in last 12 months



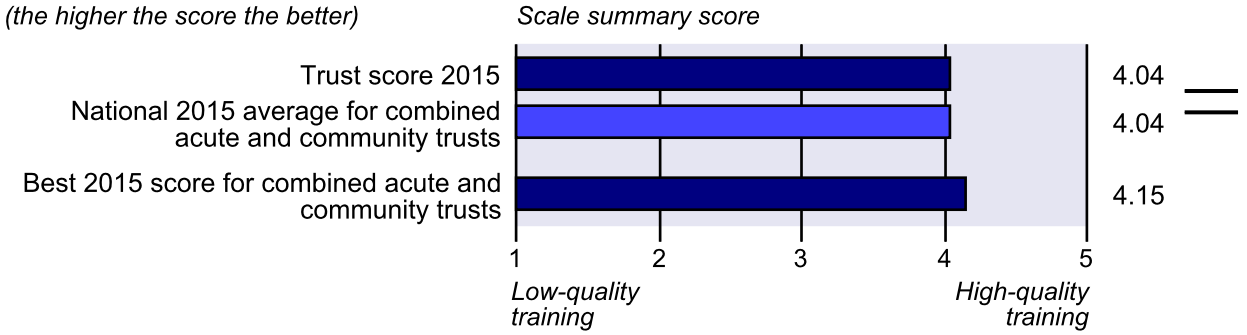
KEY FINDING 12. Quality of appraisals

(the higher the score the better)



KEY FINDING 13. Quality of non-mandatory training, learning or development

(the higher the score the better)

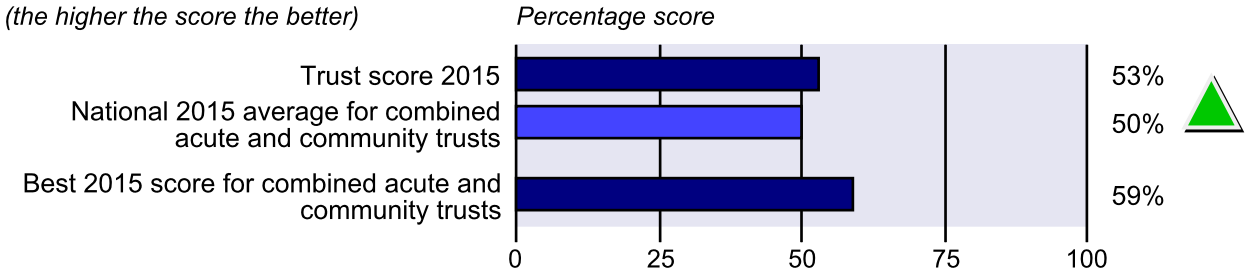


STAFF PLEDGE 3: To provide support and opportunities for staff to maintain their health, well-being and safety.

Health and well-being

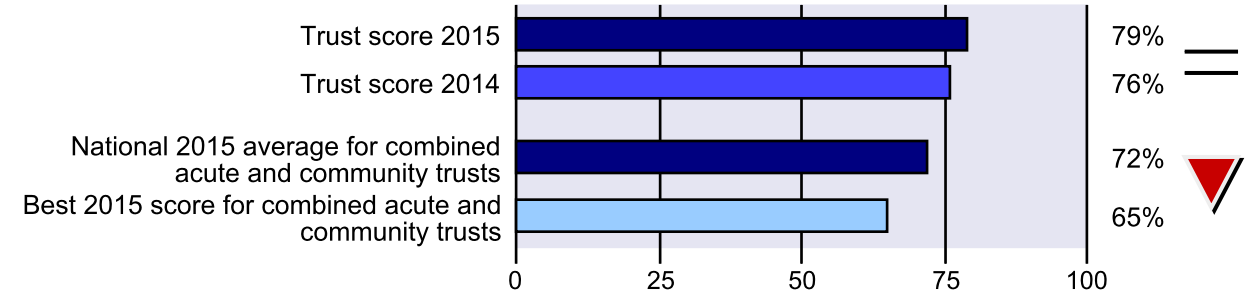
KEY FINDING 15. Percentage of staff satisfied with the opportunities for flexible working patterns

(the higher the score the better)



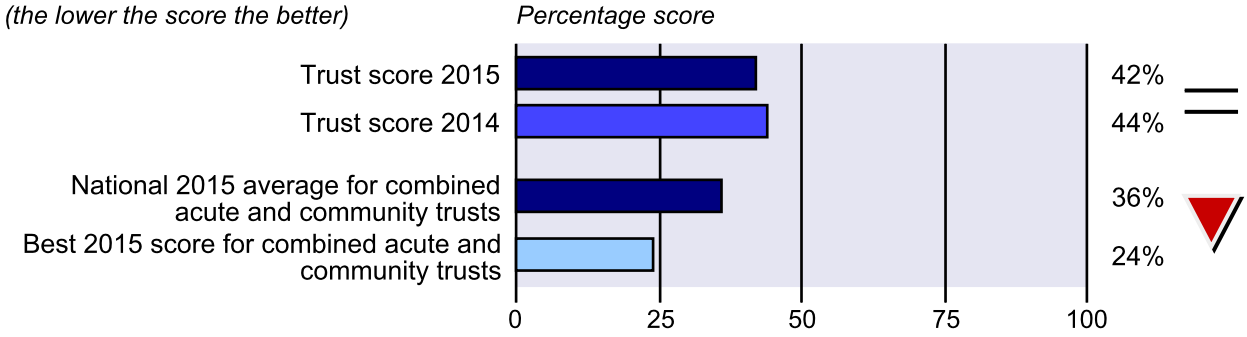
KEY FINDING 16. Percentage of staff working extra hours

(the lower the score the better)



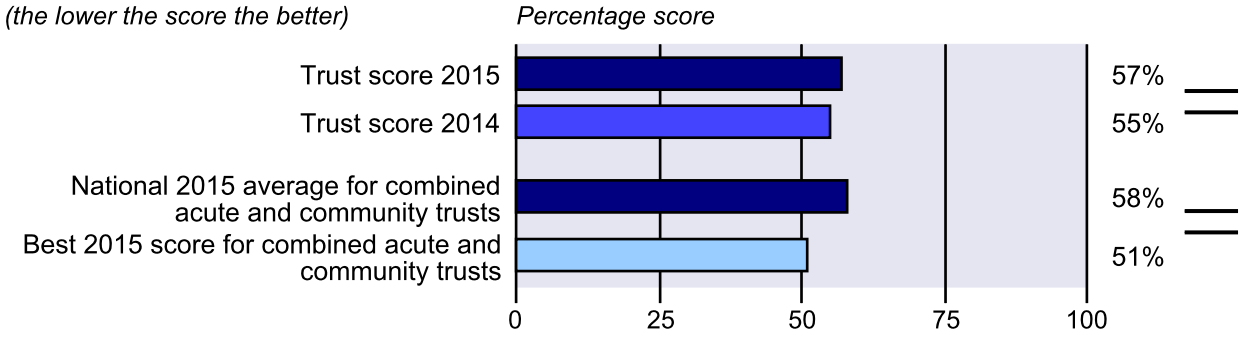
KEY FINDING 17. Percentage of staff suffering work related stress in last 12 months

(the lower the score the better)



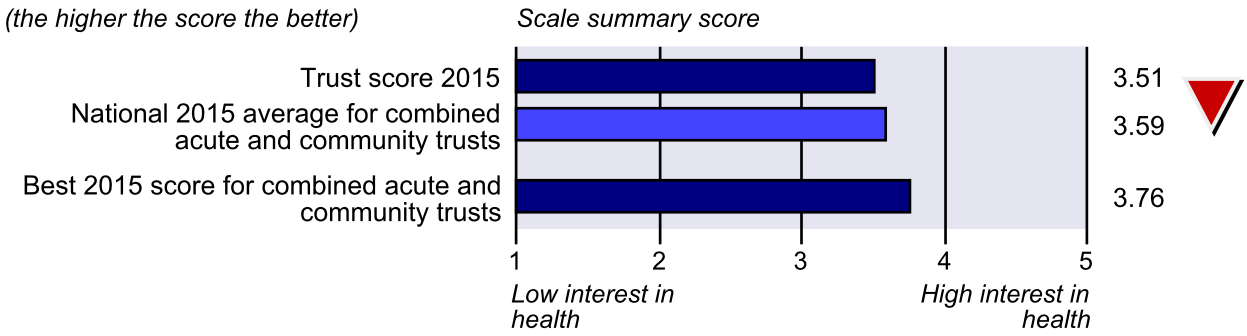
KEY FINDING 18. Percentage of staff feeling pressure in the last 3 months to attend work when feeling unwell

(the lower the score the better)



KEY FINDING 19. Organisation and management interest in and action on health and wellbeing

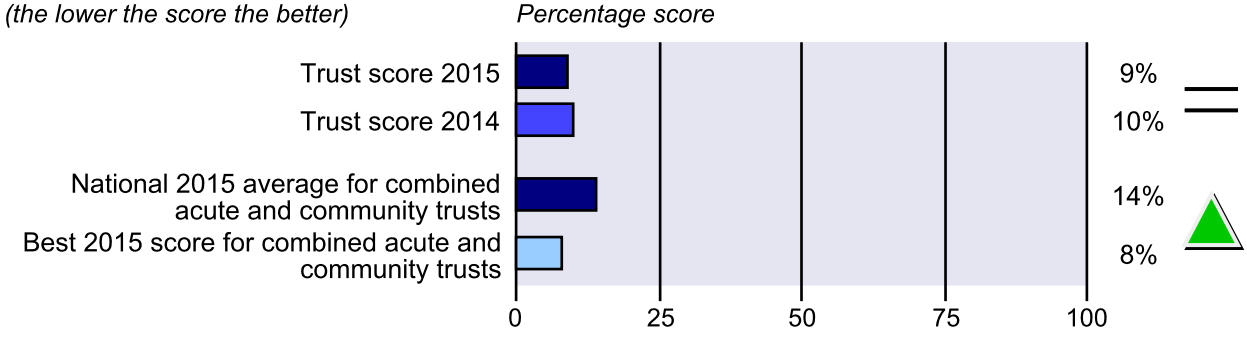
(the higher the score the better)



Violence and harassment

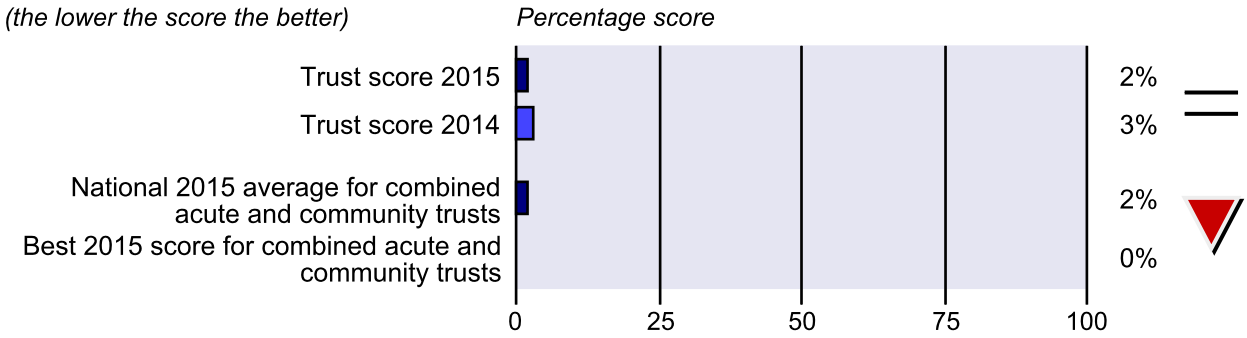
KEY FINDING 22. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months

(the lower the score the better)



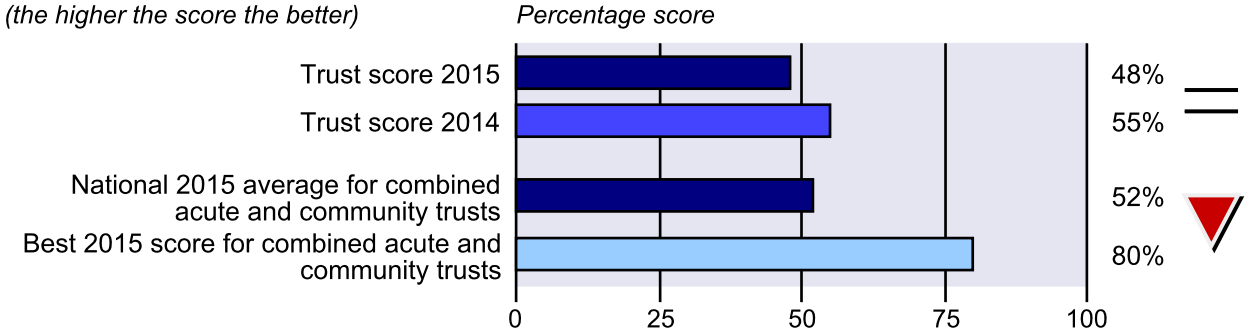
KEY FINDING 23. Percentage of staff experiencing physical violence from staff in last 12 months

(the lower the score the better)



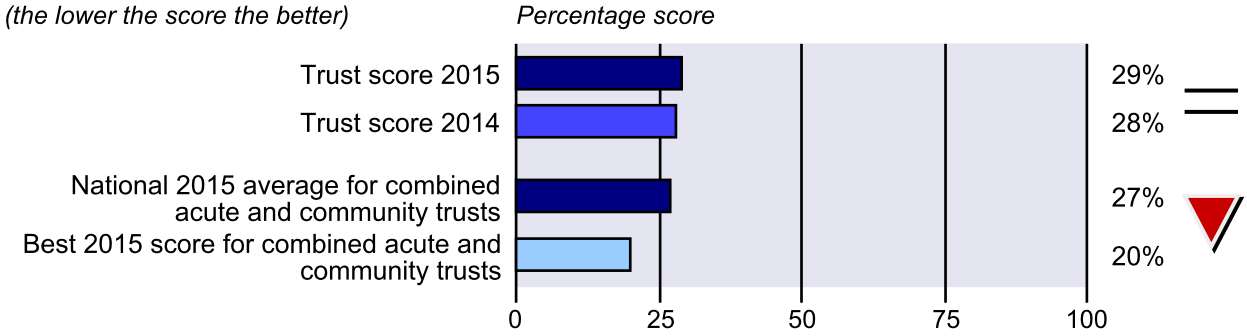
KEY FINDING 24. Percentage of staff / colleagues reporting most recent experience of violence

(the higher the score the better)



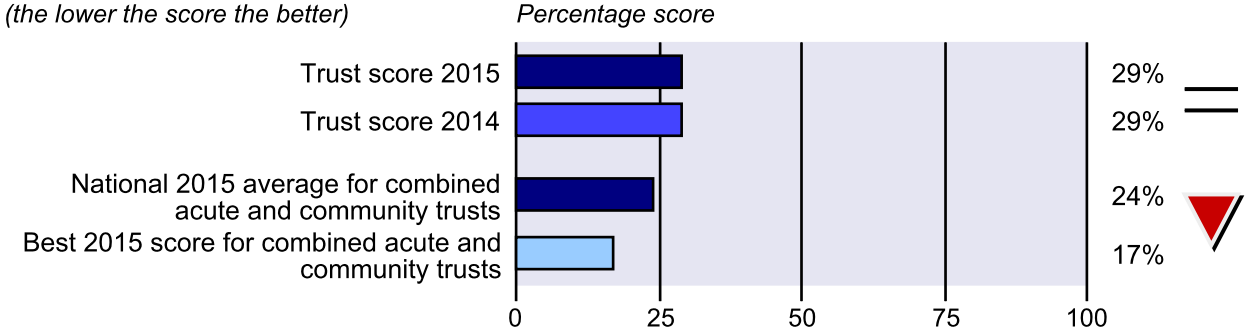
KEY FINDING 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

(the lower the score the better)



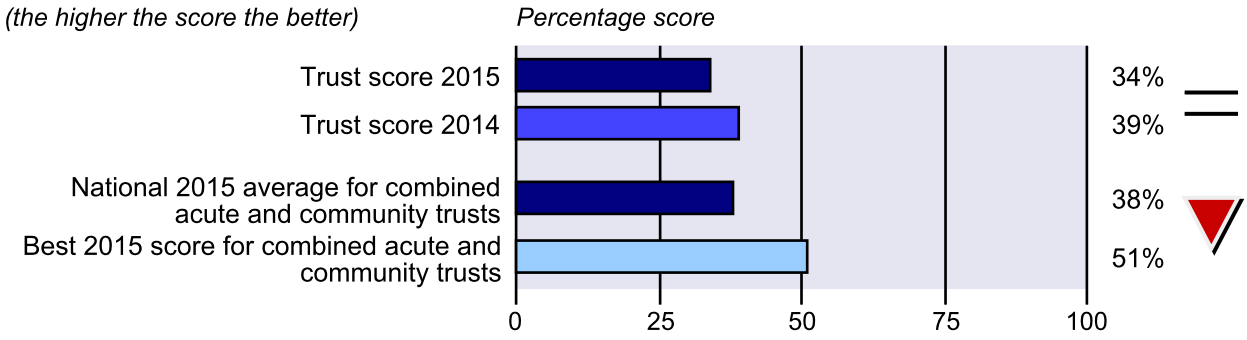
KEY FINDING 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

(the lower the score the better)



KEY FINDING 27. Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse

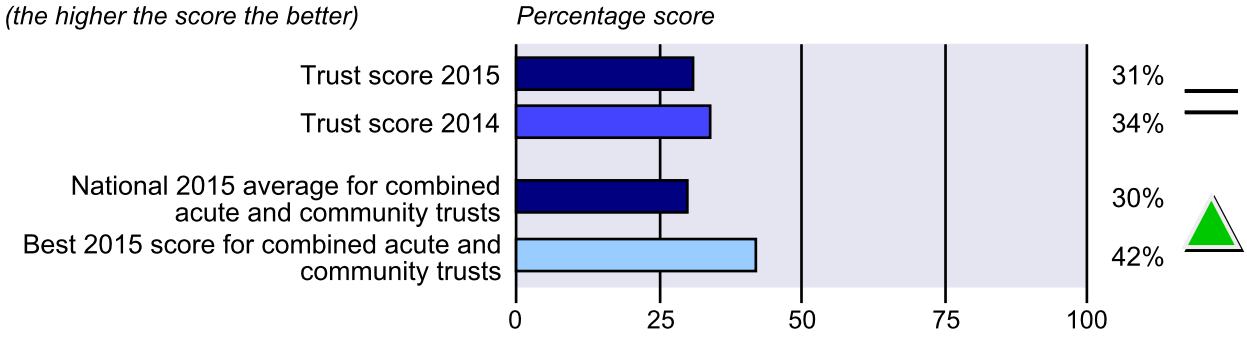
(the higher the score the better)



STAFF PLEDGE 4: To engage staff in decisions that affect them, the services they provide and empower them to put forward ways to deliver better and safer services.

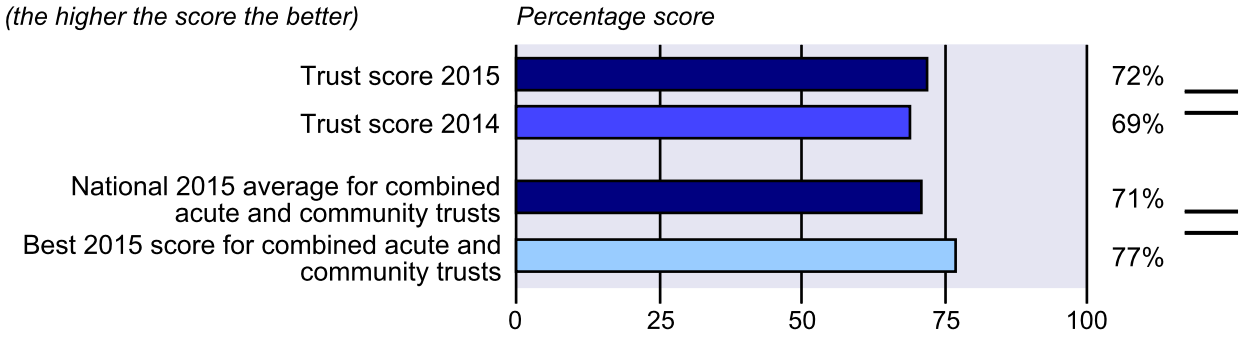
KEY FINDING 6. Percentage of staff reporting good communication between senior management and staff

(the higher the score the better)



KEY FINDING 7. Percentage of staff able to contribute towards improvements at work

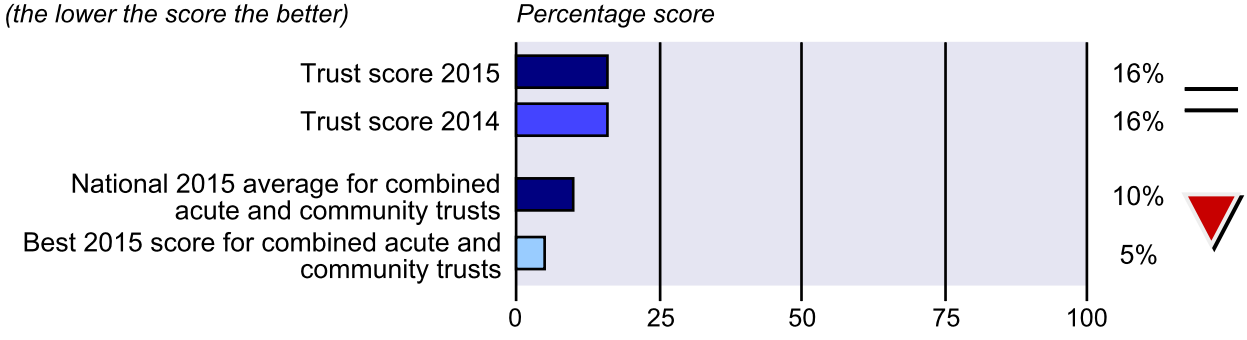
(the higher the score the better)



ADDITIONAL THEME: Equality and diversity

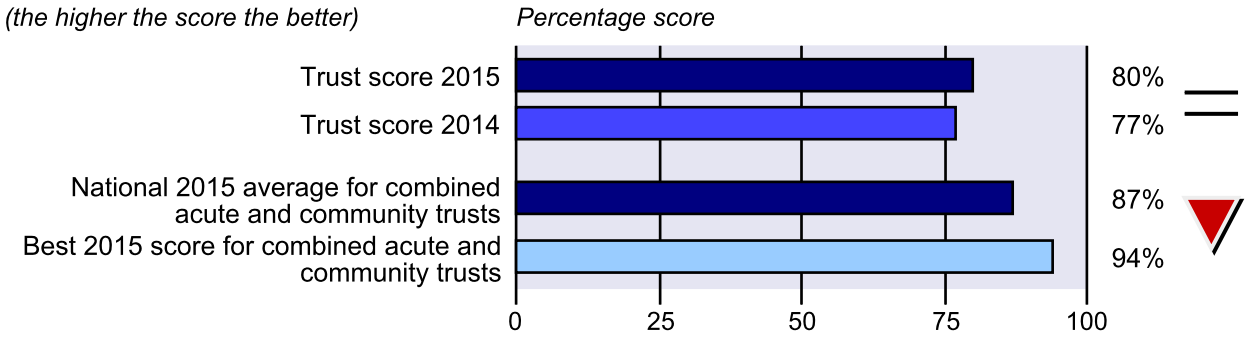
KEY FINDING 20. Percentage of staff experiencing discrimination at work in last 12 months

(the lower the score the better)



KEY FINDING 21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion

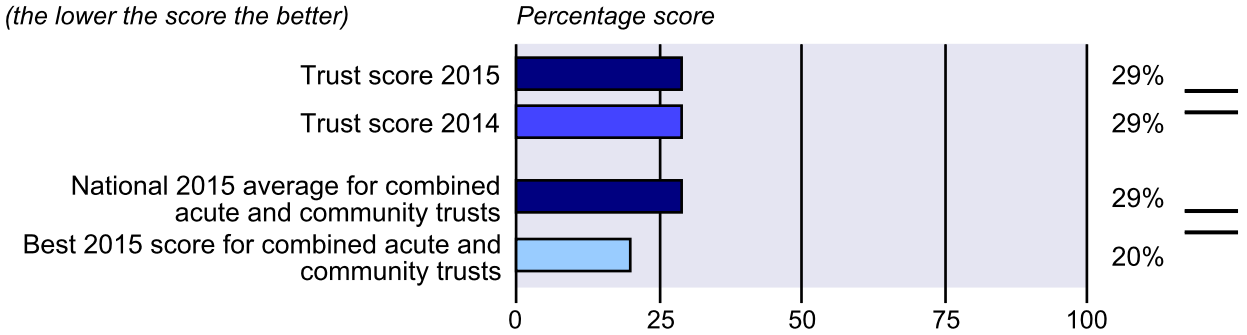
(the higher the score the better)



ADDITIONAL THEME: Errors and incidents

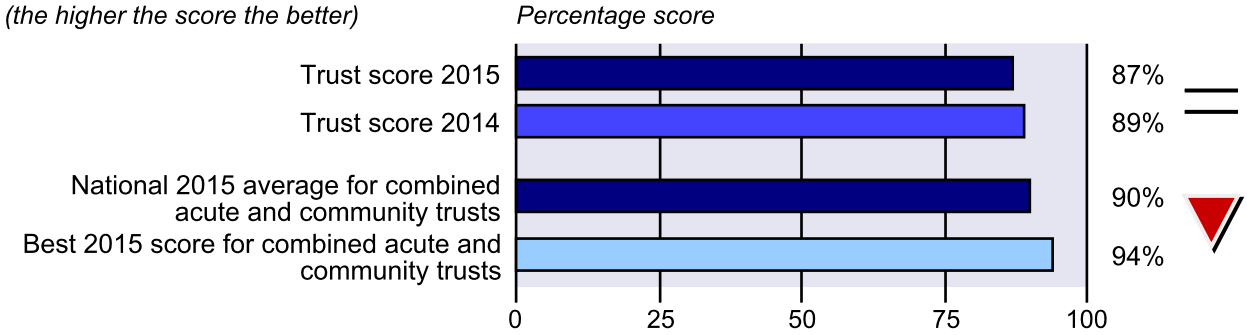
KEY FINDING 28. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month

(the lower the score the better)



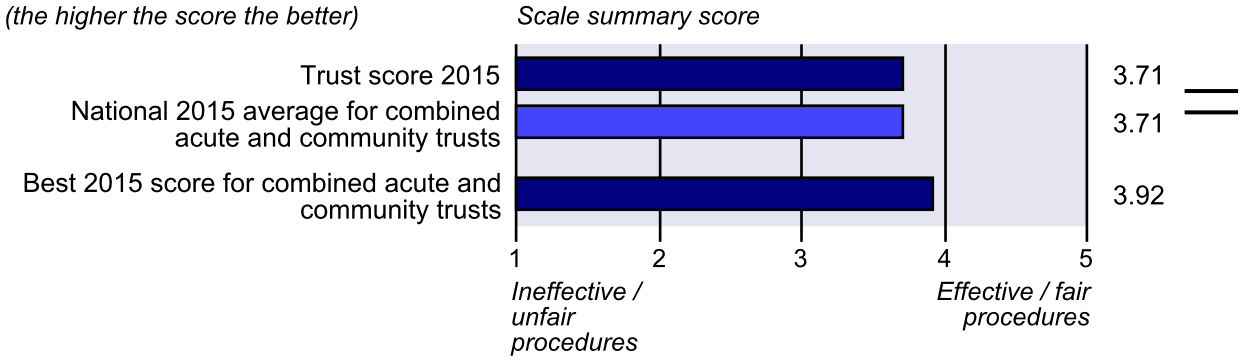
KEY FINDING 29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month

(the higher the score the better)

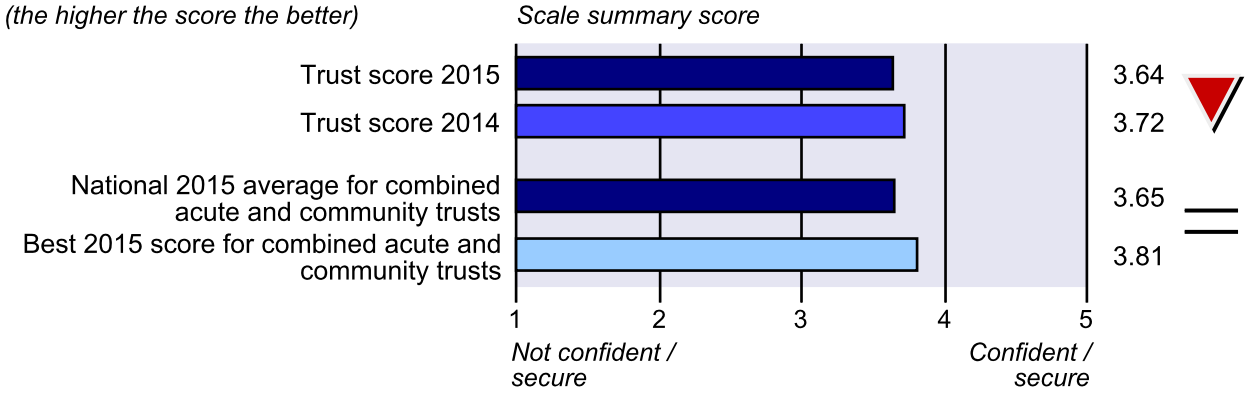


KEY FINDING 30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents

(the higher the score the better)

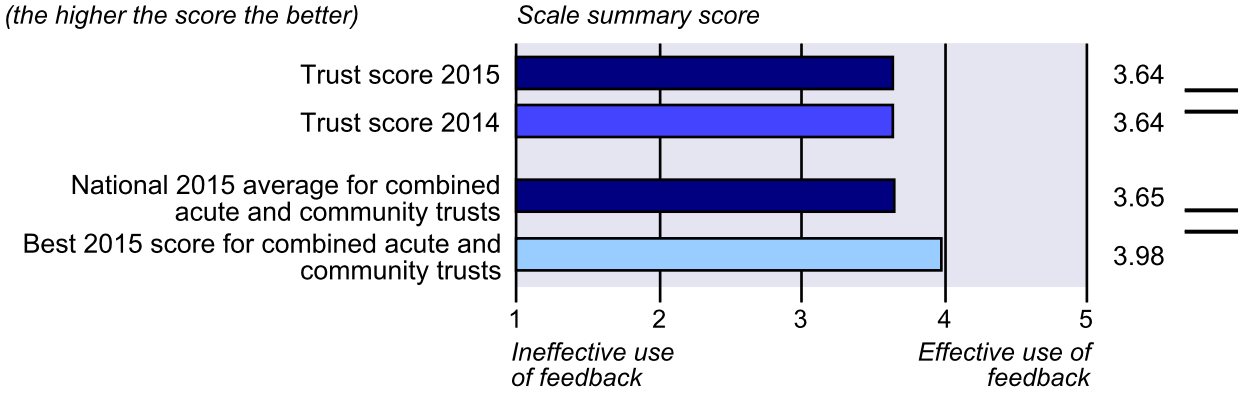


KEY FINDING 31. Staff confidence and security in reporting unsafe clinical practice



ADDITIONAL THEME: Patient experience measures

KEY FINDING 32. Effective use of patient / service user feedback



Whittington Health NHS

Whittington Health Trust Board
6 April 2016

Title:	Quality Committee Meeting 19 March 2016 Draft Minutes cleared by Chair and Executive Lead						
Agenda item:	**16/055**		**Paper**		**10**		
Action requested:	For the Board to note the business of the 9 March Quality Committee Meeting and its effective decision making						
Executive Summary:	This paper presents the draft 9 March 2016 Quality Committee Minutes						
Summary of recommendations:	The Trust Board is asked to take assurance that the Quality Committee is compliant with its terms of reference and delegated authority						
Fit with WH strategy:	The Quality Committee, a sub-committee of the Trust Board, considers business relating to quality and safety of services						
Reference to related / other documents:	SO's. SFI's and Scheme of Delegation						
Date paper completed:	24 March 2016						
Author name and title:	**Lynne Spencer, Director of Communications & Corporate Affairs**		**Director name and title:**		**Anu Singh, Non-Executive Chair**		
Date paper seen by EC	**April 2016**	**Equality Impact Assessment complete?**	**N/A**	**Risk assessment undertaken?**		**Legal advice received?**	**N/A**

Whittington Health NHS

DRAFT Minutes cleared by Chair
Quality Committee, Whittington Health

Date & time:	Wednesday 9th March 2016 3:00pm – 5:00pm
Venue:	Room 6 Whittington Education Centre, Whittington Hospital
Chair:	Anu Singh (AS) Non-Executive Director (Chair)
Members Present:	Graham Hart (GH), Non-Executive Director Lynne Spencer (LS), Director of Communications & Corporate Affairs Doug Charlton (DC), Deputy Director of nursing & Patient Experience
In attendance	Steve Hitchins (SH), NED Chairman Mark Madams, Head of Nursing, Children's Services Daniela Petre (DP), Head of Risk Lisa Smith (LSm), Assistant Director of Nurse Education and Workforce Phillipa Marszall (PM), Head of Patient Experience Beverleigh Senior (BS), Director of Operations, OPLTC Caroline Edwards, (CE), Chief Pharmacist, CSS (deputising for Helen Taylor, CD and Danielle Morrell, DO) Logan Van Lessen (LV), Consultant Midwife (deputising for Manjit Roseghini, Head of Midwifery) Deborah Clatworthy, Head of Nursing, Surgery and Cancer Maria Lygoura, Matron, MFNS Gillian Lewis (GL), Compliance and Quality Improvement Manager (minutes) Helena Kania (HK), lay representative
Apologies:	Richard Jennings (RJ), Clinical Director Clarissa Murdoch (SM), Clinical Director MFNS Philippa Davies (PD), Director of Nursing and Patient Experience Carol Gillen (CG), Acting Chief Executive Officer Anita Charlesworth (AC), Non-Executive Director Amanda Hallums (AH), Director of Operations, WFS Manjit Roseghini (MR), Head of Midwifery

DRAFT

Agenda items

1.	**Welcome & Apologies**	AS
	AS noted the findings from the new annual 'Learning from Mistakes League' produced by Monitor and the NHS TDA, published 9 March 2016 and presented at the Global Patient Safety Summit. Whittington Health received a rating of 'good' and was ranked 78 out of 230 NHS Trusts. AS highlighted the Serious Incident Board paper as a good example of Whittington Health's openness and transparency in learning from mistakes. AS highlighted that poor attendance at the Quality Committee had been discussed at the Trust Board, however the junior doctor's strike today was recognised as an exception with respect to attendance at this meeting. AS welcomed Steve Hitchins, Chairman. While not a member of the Quality Committee, SH attends all Board Committee meetings at least once annually. SH reported that all NEDs can substitute for any NED to maintain quoracy at Board Committee meetings.	

Actions	**Deadline**	**Owner**
The findings of the 'Learning from Mistakes League' to be sent to the CCG and key stakeholders, in addition to internal communications via CEO team briefing and all staff noticeboard.	April 2016	LS
The findings of the 'Learning from Mistakes League' to be included in the SI report to the next Board.	April 2016	PD

2.	**Minutes of the previous meeting (13th January 2016)**	MM
	The minutes of the last meeting were approved subject to minor amendments, as outlined below; • DCl was added to the apologies list • The owner of the patient experience actions was amended to PM from DC	

Actions	**Deadline**	**Owner**
Draft Minutes to be included in the next Trust Board public meeting for assurance to the Board and to ensure timely reporting.	April 2016	LS

3.	**Action Log**	AS
	The Action Log was approved and updates recorded.	

Actions	**Deadline**	**Owner**
See Action Log	On Log	On Log

4.	**Nursing Midwifery Establishment Review**	LSm

AS reported that the Trust Board had delegated authority to the Quality Committee to approve this report.

LSm summarised the report, key issues were highlighted as follows;

- The National Quality Board publication requires hospitals to review nurse staffing levels every six months using validated methods. For this review, two national acuity based tools, Shelford Safer Nursing Care Tool (Shelford Group 2012) and Nursing Hours per Patient Day (Twigg 2011) were used to measure patient acuity, nursing staffing levels and activity, in addition to the professional judgement model.
- The overall conclusion was that staffing levels were safe in October, which included a 20% uplift to cover annual leave, sickness and study/training. DC highlighted that the nurse to patient ratios were positive, which shows the Trust has the appropriate staffing and skill mix.
- The introduction of e-rostering tool (Allocate) was discussed, which will help to standardise shifts and provide a more accurate and consistent measurement tool going forward. It will also enable direct benchmarking with other Trusts using the system, e.g. Homerton. GH asked if e-rostering would enable live reporting. DC explained that the package included a 'safer care' tool which compares the acuity of patients to the number of staff throughout the day. It provides live feedback to highlight where further support is needed.
- LSm noted that while some of the wards were identified as having higher staffing establishments based on national tools, when the layout and size of the wards were considered, the staffing was deemed appropriate. The Quality Committee approved the recommendation for staffing levels on Mercers, Mary Seacole North and Emergency Department to remain unchanged, on the basis that the establishment was reviewed in six months on implementation of the new Allocate software.
- Victoria ward was highlighted as an exception. NICE guidance suggested that there could be a decrease in staffing however this measure does not consider the acuity of patients. Based on acuity levels, a temporary uplift in staffing was proposed. The Quality Committee approved this recommendation, on the basis that the establishment was reviewed in six months on implementation of the new Allocate software.
- DCl highlighted that this report does not include when additional beds are needed during winter pressures.
- AS asked if more work was needed to ensure efficiency of staffing. DC noted that the findings of this report provided assurance that staffing levels were as efficient as possible in order to maintain safety and quality.
- DCl and MM praised LSm for her collaborative work with front line nursing staff in carrying out the review. AS acknowledged the high quality of the report.

The Quality Committee approved the report and recommendations, with the caveat that nursing levels are reviewed again following the implementation of Allocate, e-rostering system.

Actions	**Deadline**	**Owner**
Nursing Midwifery Establishment Review to be reported to Quality Committee following the introduction on Allocate, e-rostering software	November 2016	LSm

5.	**Patient and Public Involvement – Action Plan and Toolkit**	PM
	The Patient and Public Involvement Action Plan and Toolkit were approved by the Quality Committee. PM noted that the report had been discussed at the Trust Board and the Patient Experience Committee. These documents had been uploaded to the Trust website to consult with the public and encourage feedback. The report was well received and suggestions were made regarding the success criteria section, PM will include these comments in the next version of the report. PM further added that an implementation plan was in progress. AS asked PM to ensure that a section on hard to reach groups was included in the next version of the report. AS noted that separate work was in progress with the national team, which would provide an independent review of the report.	

Actions	**Deadline**	**Owner**
PM to update the PPI toolkit with comments from the Patient Experience Committee, the Quality Committee and feedback from the consultation.	May 2016	PM

6	**CQC Strategy 2016-21 Consultation – Trust Response**	PD
	The Quality Committee approved the CQC Strategy 2016-21 Consultation Trust response. GL highlighted to the Committee key changes in the CQC strategy, including a proposal for providers to share their internal quality assurance reports with the CQC. The Committee discussed the issue of sharing internal quality reports, which are intended as early warning, pro-active tools for learning and improvement.	

Actions	**Deadline**	**Owner**
Quality Committee to feedback on the consultation to GL for collation and sign-off by PD, Nominated CQC Lead.	10/3/16	GL

7	**Quality Performance Reports** **Clinical Support Services** **Outpatients, Prevention and Long Term Conditions**	**ICSU Leads**
7.1	The CSS Quality Report was approved by the Quality Committee. Key points were highlighted as follows: • Work is in progress to review practice following a number of complaints relating to sonographers.	

	• The increase in medication incidents reported reflects an increase in reporting of no harm/ near miss incidents. This is a positive improvement for the ICSU in promoting incident reporting and supporting a blame free culture. HK asked how Whittington benchmarked with other trusts with regard to medication incident reporting. CE replied that NRLS data showed Whittington mid-range. Whittington Health has a Medication Safety Officer in post who reviews all medication incidents to identify actions and learning themes. • AS asked about the ICSU's approach to quality governance. CE described the process which was newly established; senior managers from each area meet monthly to discuss quality and safety issues, and a quality dashboard is in development, in consultation with other ICSUs as well as Clinical Support Services staff.
7.2	**The OPLTC Quality Report** was approved by the Quality Committee. Key points were highlighted as follows: • BS noted the ICSU was a new group of services, and work to develop the dashboard was ongoing to ensure it was reflective of OPLTC. • A new Quality Lead was appointed in OPLTC and quality meetings established within the ICSU. • No SIs reported in February but learning from previous serious incident investigations is ongoing. Learning points had included that more MDT work and sharing of information between teams is required. • There is ongoing work with respect to compliance of appraisal rates and mandatory training. BS noted that there had been a surge in uptake prior to the CQC inspection and it was important to continue this work. • With respect to patient experience, iPads were recently installed in outpatients but the response rate was low (62 responses). PM added that there appeared to be some issues with the kiosks, and the low response rate may be due to a technical fault. Work is ongoing to address this and SP had asked the Director of I&MT to investigate the practical use of the iPads and Kiosks to ensure they are working effectively for patients to feedback.

Actions	**Deadline**	**Owner**
PM to liaise with the Director of I&MT to review operational capacity of kiosks with IM&T and feedback to May Quality Committee.	May 2016	PM

8.	**Director of Nursing Patient Safety Report**	DC
	The Patient Safety Report (January and February data) was approved by the Quality Committee. Key issues were highlighted as follows; • On the National Safety Thermometer, the pressure ulcer rate was stabilising. This is in contrast to the 'cluster' of pressure ulcers reported on Victoria ward, which is currently being investigated as an SI. • AS asked why pressure ulcers had not been highlighted as a reputational risk on the Medical Director's report to the Board and asked for assurance that quality and safety issues on Victoria ward were being addressed appropriately. LS noted that Victoria Ward had been proposed as a new >16 risk for the corporate risk register, for discussion at the next TMG. DC reported that a new interim	

	lead had been appointed on Victoria ward which was having a positive effect on quality and the efficiency of ward. • The number of falls reported was increasing; the Trust Falls Group is reviewing the numbers in order to identify causes and areas for improvement. However, DC highlighted that in the recent national falls audit Whittington benchmarked favourably. • Controlled Drug issues were highlighted as an area of focus and work is underway to continuously improve the management and governance. • AS noted that the process for safeguarding referrals is improving; DC and MM commented that local leads are good at reporting to their respective Heads of Nursing and that the supervision sessions led by safeguarding leads were well received by staff.

Actions	**Deadline**	**Owner**
Victoria ward risks to be discussed at TMG for potential inclusion on the corporate risk register if mitigating actions were not in place	April 2016	LS
A narrative on the quality and safety position on Victoria Ward to be provided as part of the Quality Committee report to the next Board	April 2016	AS

9.	**Director of Nursing Patient Experience Report**	PM
	The Patient Experience report was approved by the Quality Committee. Key issues were highlighted as follows; • With regards to the Friends and Family test, community services and maternity showed improvements in response rates. The slight improvement in the ED department was acknowledged given the extreme pressure the service was under with demand and capacity. The recommended response rate was lower in February, and the analysis showed this reflected the pressure the Trust was under which was being experienced across the health economy. • PM noted that the full results of the inpatient survey result were included in the papers. The Trust position had declined on a number of questions relating to communication and information, which correlates with the maternity patient feedback report. • HK noted the national inpatient survey results on food were negative for Whittington Health and asked if there was an action plan to address this. LV noted that the comments on availability of gluten free meals were also reflected in the maternity report and that work was underway to improve this area. • AS commented that the challenge following this inpatient survey report is to analyse the comments sections and develop responsive action plans to address concerns. PM noted that picker would be providing a facilitated workshop next month from which the action plan would be developed. Picker also offer a comments analysis service, however the cost is £900 and a decision will be taken on whether to opt for this service.	

	• MM noted that children's services were working with the Patient Experience team to make meridian more accessible for children's services feedback.

Actions	Deadline	Owner
Inpatient Survey Action Plan to be presented at the May Quality Committee meeting	May 2016	PM

10	**Serious Incident Report**	PD
	The Serious Incident report was approved by the Quality Committee. LS noted that the inclusion of the Serious Incident report in the public Trust Board had contributed to the positive ranking on openness and transparency within the annual Learning from Mistakes League table. This approach had been a significant statement of the Trust's commitment to promoting an open and non-punitive culture where staff flourished and implemented continuous learning. SI highlighted that the report now included a trend analysis section, which this month focused on falls. DC noted that the statistics on Coyle ward and Victoria ward required amendment. AS acknowledged the high number of hits on the Trust new intranet patient safety learning page which provided evidence that staff were accessing information on lessons from across the organisation. DP reported that the recent Executive SI Panel had recognised the need to update the Trust learning page with more stories to ensure cross department and function sharing of lessons and embedding of good practice.	

Actions	Deadline	Owner
DP to update ward details on the next SI report	May 2016	DP
DP to create a robust process to regularly update the patient safety learning page on the Trust intranet with lessons learned	May 2016	DP

11	**Quality and Safety Risk Register**	**DP**
	The Risk Register was approved by the Quality Committee. The Committee discussed the formulation of the risk register and the importance of ensuring the Quality Committee maintains oversight of all quality related risks from >12, regardless of the owner (e.g. procurement risk managed by Finance but has impact on quality and safety). AS suggested that the primary Quality and Safety Risk Register as presented today is owned by the Quality Committee, and then a secondary risk register for oversight of quality related risks owned/transferred elsewhere was created to enable clear tracking and progress of mitigating risks. DC asked for clarification that there is just one Committee risk register, feeding from ICSUs to corporate level. While this is the process outlined in the Risk Strategy, DC and MM raised concerns this was not reflected in practice on the current risk register	

	as some ICSU risks were not included. LS would review the new process with DP and GL and feedback to the Committee to ensure new process continued to be embedded across the Trust. Changes to the Risk Register and strengthening the risk management process: • LS proposed that all new >16 quality and safety risks should first be discussed at TMG where all CDs and Executive Directors were present, and then if agreed as >16 should be presented to the Quality Committee • It was noted that the Quality Committee review all risks>12 for safety and quality to ensure robust oversight. • The Committee agreed the process to ensure transparency of risks to the Trust Executive and CDs who formed the most senior decision making body. • New >16 risks proposed in this meeting include Victoria ward and ED ultrasound equipment which will be highlighted to the next TMG. • LS proposed de-escalating learning from mistakes risk from 12 to 9 given current improvements and mitigations. • LS proposed reducing mandatory training from 16 to 12. • AS proposed reassigning mandatory training and appraisal risks to the new Workforce Committee for oversight and LS will retain the Quality Committee to the new secondary risk register of transferred risks to ensure progress reporting was fed back to the Quality Committee. • All actions agreed by Quality Committee

Actions	**Deadline**	**Owner**
LS and GL to review the risk register review process to ensure that Quality Committee maintain oversight of quality related risks owned by other sub-committees.	May 2016	LS/GL
LS and DP to review the risk escalation process from ICSUs, to ensure that all risks over 12 are signed off by ICSU clinical directors and accurately reflected in the corporate risk register.	May 2016	LS/DP
DP to make changes to the Risk Register in line with Quality Committee recommendations.	May 2016	DP

12.	**Nursing Quality Indicators**	**DC**
	The Nursing Quality Indicators report was approved by the Quality Committee. Key issues were highlighted as follows; • DC noted work was ongoing to develop a RAG rating system for the indicators. • DC highlighted that falls per thousand bed days remain low, despite the rising numbers at the Trust. • The sickness rate in January, while slightly in the red, was noted as a positive achievement given winter season. SH questioned the accuracy of sickness data and DC acknowledged that the data currently only reflects those who	

	report sickness; the new e-rostering tool will improve accuracy going forward. SH noted that Internal Audit will be asked to audit some of the Trust KPIs for accuracy. MM noted children's services will be bringing their quality indicators to the next Quality Committee for sign-off.

Actions	**Deadline**	**Owner**
MM to bring Children's Quality Indicators to May Quality Committee for approval	May 2016	MM

13	**Local Supervising Authority (LSA) Annual Audit Report – monitoring the standards of supervision and midwifery**	**LV**
	The LSA Annual Audit Report was approved by the Quality Committee. Key issues were highlighted as follows; • Two domains were fully met, and two required improvement. An action plan was developed to address areas of improvement. • Recruitment for a new supervisory post is behind schedule but has now gone out to advert. • The clinical governance structure was strengthened and the new clinical governance midwife is now in post • Maternity services submitted the LSA Impact Analysis tool and are awaiting feedback	

Actions	**Deadline**	**Owner**
Update on LSA audit recommendations to be provided at next Women's Services report to Quality Committee (July 2016)	July 2016	MR

14.	**Nursing Midwifery and AHP Education Quarterly**	**PD**
	The Nursing Midwifery and AHP Education Quarterly report was approved by the Quality Committee. Key issues were highlighted as follows; • The education audit results were positive. • LSm highlighted that a 20% reduction in funding for education was expected next year, however this had not been confirmed. The Trust will need to review capacity if the funding reduction takes place.	

Actions	**Deadline**	**Owner**
LSm to report back to Committee on changes in the future	Ongoing	LSm

15.	Trust Policies Update	DP
	List of Trust policies approved since the last meeting received and noted.	

Actions	Deadline	Owner
None		

16	Terms of Reference and annual work plan	AS

The Terms of Reference and annual work plan were approved by the Quality Committee.

Membership:

- Membership was expanded to include ICSU representation at each meeting, as advised by Simon Pleydell.
- SH reported that lay membership on Trust Board Committees and other groups would be 'paused' while the Board is considering how best to evolve its engagement and involvement for lay members to meet the needs of the changing external environment. With regards to NED membership, SH advised
  - All NEDs can act as substitutes on all Board Committees.
  - Secretariat of Trust Board and Committee meetings will continue to liaise with NEDs to ensure relevant attendance.

Duties:

- The impact, relationship and information flows regarding the establishment of the new workforce committee were considered, AS and LS to discuss with Norma French.
- The Quality Committee agreed that CQUIN monitoring was not required in the Terms of Reference and should remain a performance target via TMG.
- GL confirmed that the quality impact of Cost Improvement Programmes (CIPs) was on the Quality Committee annual work plan.
- The minutes from ICSU Quality and Safety meetings to be included for information at Quality Committee.
- DC asked where external reports, e.g. Francis Inquiry, Berwick, national audits, were reviewed. GL confirmed that national audits would be reported to Quality Committee via the re-instated Clinical Audit and Effectiveness Committee. The Quality Committee terms of reference include oversight of all external reports impacting on quality on an ad hoc basis. DC suggested ICSUs provide dates of relevant external reports for inclusion on the work plan.

Actions	Deadline	Owner
AS/LS to discuss relationship and information flows with the new Workforce Committee with Norma French, Director of Workforce	May 2016	AS/LS
GL to add ICSU quality and safety meeting minutes to the Terms of Reference	May 2016	GL
GL to liaise with ICSU Heads of Nursing and Clinical Directors on dates for external reports to add to work plan.	May 2016	GL

17.	Self-assessment of Committee	DC
	LS reported that the majority of members had completed the annual self-assessment of the Quality Committee. The feedback from members had informed the revised Terms of Reference and will shape the ongoing improvements to the management and effectiveness of the Committee.	
Actions	**Deadline**	**Owner**
None		

18.	AOB	Lead
	LS highlighted that maternity services had successfully secured DH funding for a new digital app which will form part of the improvements to encourage more patient engagement for the service. AS congratulated the team and especially Manjit Roseghini, Head of Midwifery, who had coordinated the application for the Trust.	
Actions	**Deadline**	**Owner**
None		

Next meeting: Wednesday 11th May, 2:00pm, Room 6, Whittington Education Centre

Executive Offices
Direct Line: 020 7288 3939/5959
www.whittington.nhs.uk

The Whittington Hospital NHS Trust
Magdala Avenue
London N19 5NF

Whittington Health Trust Board

6 April 2015

Title:	Register of Deed of Execution and Seal		
Agenda item:	**16/056**	**Paper**	**11**
Action requested:	Approval		
Executive Summary:	A report to the Board of the use of the Trust Deed of Execution / Seal which is recorded on the Whittington Health Trust formal Register for the period 1 April 2014 to 31 March 2015		
Summary of recommendations:	To take assurance that the use of the Trust's Deed of Execution / Seal has been administered in accordance with Trust Standing Orders.		
Fit with WH strategy:	Compliance with good governance		
Reference to related / other documents:	SO's. SFI's and Scheme of Delegation		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	Captured on risk registers and/or Board Assurance Framework.		
Date paper completed:	March 2015		

Author name and title:		**Lynne Spencer, Director of Communications and Corporate Affairs**		**Director name and title:**		**Lynne Spencer, Director of Communications and Corporate Affairs**	
Date paper seen by EC	-	**Equality Impact Assessment complete?**	-	**Quality Impact Assessment complete?**	-	**Financial Impact Assessment complete?**	-

Register of Deed of Execution 1 April 2014 to 31 March 2015

Reference	Details	Date
15/01	Asteral Agreements. Purchase of Asteral by Permira from Brook Henderson Group • Funders Direct agreement. • Deed of Release.	29/08/14
15/02	Whittington Hospital NHS Trust and Nationwide Building Society Authorised Guarantee Agreement.	14/11/14
15/03	Whittington Hospital NHS Trust and Nationwide Building Society and Notemachine UK Limited: Licence to assign and Deed of Variation relating to ATM.	14/11/14
15/04	Lease for cell site no 4342 and Whittington Hospital Cornerstone Telecoms Infrastructure Ltd.	23/12/14
15/05	London Borough of Haringey. Contract for the provision of Sexual Health Services 2014/15.	09/01/15
15/06	London Borough of Haringey – Contract for the provision of Public Health Services 2014/16.	09/01/15
15/07	Contract Documents for Rapid Assessment Refurbishment.	05/02/15

Whittington Health NHS

Whittington Health Trust Board
6 April 2016

Title:	Trust Board Forward Plan of Business 2016/17		
Agenda item:	**16/057**	**Paper**	**12**
Action requested:	For the Board to approve the forward plan of business to be reported to the Trust Public and Private Board meetings and to note that additional reports may be presented in year as appropriate and agreed by the Chair and Chief Executive Officer		
Executive Summary:	This paper presents the draft Trust Board forward plan of business for the financial year 1 April 2016 to 31 March 2017. This document provides transparency of reporting on progress of Whittington Health's vision, values, strategy, culture, corporate objectives, partnerships, performance, safety and quality		
Summary of recommendations:	The Trust Board is asked to approve the forward plan for the financial year 2016/17 to ensure it is compliant with public body statutory duties for reporting to patients, staff, members of the public and stakeholders		
Fit with WH strategy:	Complies with Nolan Principles, Code of Conduct for Boards and statutory duties of a public body		
Reference to related / other documents:	SO's. SFI's and Scheme of Delegation		
Date paper completed:	31 March 2016		

Author name and title:		**Lynne Spencer, Director of Communications & Corporate Affairs**		**Director name and title:**		**Lynne Spencer, Director of Communications & Corporate Affairs**	
Date paper seen by EC	**Mar 2016**	**Equality Impact Assessment complete?**	**N/A**	**Risk assessment undertaken?**		**Legal advice received?**	**N/A**

Whittington Health NHS

Board Draft Forward Plan of Business 2016/17 *Version 6 April 2016* Trust Board - Lynne Spencer, Director of Communications/Corporate Affairs

6th APRIL 2016	4th MAY 2016	1st JUNE 2016	6th JULY 2016	7th SEPT 2016 & AGM	5th OCTOBER 2016	2nd NOVEMBER 2016	7th DECEMBER 2016	4th JANUARY 2017	1st FEBRUARY 2017	1st MARCH 2017
Open Board	**Open Board**	**Open Board**	**Open Board**	**Open Board**	**Open Board**	**Open Board**	**Open Board**	**Open Board**	**Open Board**	**Open Board**
Strategic	**Strategic**	**Strategic**	**Strategic**	**Strategic**	**Strategic**	**Strategic**	**Strategic**	**Strategic**	**Strategic**	**Strategic**
Business Cases in line with Scheme Delegation sign off	Business Cases in line with Scheme Delegation sign off	Business Cases in line with Scheme Delegation sign off	Business Cases in line with Scheme Delegation sign off	Business Cases in line with Scheme Delegation sign off	Business Cases in line with Scheme Delegation sign off	Business Cases in line with Scheme Delegation sign off	Business Cases in line with Scheme Delegation sign off	Business Cases in line with Scheme Delegation sign off	Business Cases in line with Scheme Delegation sign off	Business Cases in line with Scheme Delegation sign off
	5 Yr Capital Programme & Investment Plan update	Heatwave Plan 16/17	5 Yr Capital Programme & Investment Plan update	HENCEL (LETBs) update	5 Yr Capital Programme & Investment Plan update	draft Winter Plan 16/17	5 Yr Capital Programme & Investment Plan update	Emergency Preparedness (Major Incident Plan) Refresh 17/18	draft Forward Plan 17/18 (Annual COs) informed by tariff	Annual Operating Plan 17/18 (Annual COs to review/approve)
	Workforce Strategy 16/20	I&MT Strategy	Maria Barnhard Post Grad info / annual plan R&D / Ed & Trng - ***NEW tbc***	Sustainability and Transformation Plan (STP), NHS England 5YFP	Research Strategy 15/20 Review	Cancer Strategy - tbc	draft Operating Plan 17/18 (allocations published Dec)	Revised National Tariff Announced by Monitor	5 Yr Capital Programme & Investment Plan update	Risk Management Strategy
	Annual Operating Plan 16/17 (TDA compliant)	HENCEL (LETB) update		Equality & Human Rights Strategy	End of Life update		HENCEL (LETB)	IG Strategy		HENCEL (LETB) update
	Strategic Estates Partnership	Maria Barnhard Post Grad info / annual plan R&D / Ed & Trng								
Performance	**Performance**	**Performance**	**Performance**	**Performance**	**Performance**	**Performance**	**Performance**	**Performance**	**Performance**	**Performance**
Finance	Finance	Finance	Finance	Finance	Finance	Finance	Finance	Finance	Finance	Finance
Performance Dashboard	Performance Dashboard	Performance Dashboard	Performance Dashboard	Performance Dashboard	Performance Dashboard	Performance Dashboard	Performance Dashboard	Performance Dashboard	Performance Dashboard	Performance Dashboard
NHS Annual Staff Survey 15/16 and Action Plan 16/17	Quarterly Workforce Report		CQUIN Annual Report 15/16	Quarterly Workforce Report	NHS Staff Survey 16/17 Action Plan update	Quarterly Workforce Report			Quarterly Workforce Report	
Patient Safety and Quality	**Patient Safety and Quality**	**Patient Safety and Quality**	**Patient Safety and Quality**	**Patient Safety and Quality**	**Patient Safety and Quality**	**Patient Safety and Quality**	**Patient Safety and Quality**	**Patient Safety and Quality**	**Patient Safety and Quality**	**Patient Safety and Quality**
Nursing Safer Staffing	Nursing Safer Staffing	Nursing Safer Staffing	Nursing Safer Staffing	Nursing Safer Staffing	Nursing Safer Staffing	Nursing Safer Staffing	Nursing Safer Staffing	Nursing Safer Staffing	Nursing Safer Staffing	Nursing Safer Staffing
Serious Incidents	Serious Incidents	Serious Incidents	Serious Incidents	Serious Incidents	Serious Incidents	Serious Incidents	Serious Incidents	Serious Incidents	Serious Incidents	Serious Incidents
Learning from Mistakes Annual League Table	Quarterly Safety and Quality Board Report, including annual review 15/16of Sign up to Safety	Patient Experience (complaints, Sis) Annual Report 15/16	Safeguarding Children & Young People Annual Report 15/16	Quarterly Safety and Quality Board Report, including Sign up to Safety	Safeguarding Adults Annual Report 15/16	Medical Director Safer Staffing Report	Medical Director Safer Staffing	Medical Director Safer Staffing	Quarterly Safety and Quality Board Report, including Sign up to Safety	Quality Account Update
	CQC Published Report -tbc	Hygiene Code Compliance & Infection Control AR CQC O8	H&S (inc fire) Annual Report 15/16	Clinical Audit and Effectiveness Annual Report	Medical Director Safer Staffing Report	Mid Year Review of Internal Audit	Quarterly Safety and Quality Board Report -Sign up to Safety		Medical Director Safer Staffing	Medical Director Safer Staffing
	Quality Account review 15/16 and draft 16/17		Spinal, Orthopaedic & General Surgery update paper - Need more info, is this needed for 2016/17	Medical Director Safer Staffing Report ***NEW - include medical education and Junior Doctor engagement***		Mid Year Review of External Audit				
Governance	**Governance**	**Governance**	**Governance**	**Governance**	**Governance**	**Governance**	**Governance**	**Governance**	**Governance**	**Governance**
16/17 Seal / Deed Execution - authorised users	BAF	Annual Governance Statement 15/16	Report on Director's Fit and Proper Person's req'rmts	BAF	Environmental & Sustainability Annual Report 15/16	BAF	Budget Setting 16/17 (allocations published by December)	Charitable Funds Annual Report 15/16	NHS Constitution Plan	BAF 16/17 end of year
Draft Trust Board Forward Plan of Business16/17	Corporate Risk Register	draft Board Development Skills Analysis & Plan - tbc	IG Toolkit Compliance Review	Corporate Risk Register		Corporate Risk Register			17/18 budgets to approve	BAF 17/18
Annual Refresh SO's, SFI's, Scheme of Delegation & Terms of Reference	Final Budget 16/17	Annual Accounts/AGS/AR/ Quality Account 15/16		Bribery Policy & Statement 15/16					Draft Board Forward Plan 2017/18	Corporate Risk Register
Budget setting 2016-17		Head of Internal Audit Opinion 15/16		Section 75 Agreements Update						Business Conduct and Code of Conduct for Boards & Senior Staff
		External Audit Letter 15/16		AGM, Annual Report, Annual Accounts/AGS/Quality Account						IG Toolkit subnission & Caldicott
										draft Trust Regulatory Framework 17/18
Standing Items	**Standing Items**	**Standing Items**	**Standing Items**	**Standing Items**	**Standing Items**	**Standing Items**	**Standing Items**	**Standing Items**	**Standing Items**	**Standing Items**
Committee Assurance reports	Committee Assurance reports	Committee Assurance reports	Committee Assurance reports	Committee Assurance reports	Committee Assurance reports	Committee Assurance reports	Committee Assurance reports	Committee Assurance reports	Committee Assurance reports	Committee Assurance reports
Policies for Approval by Board	Policies for Approval by Board	Policies for Approval by Board	Policies for Approval by Board	Policies for Approval by Board	Policies for Approval by Board	Policies for Approval by Board	Policies for Approval by Board	Policies for Approval by Board	Policies for Approval by Board	Policies for Approval by Board
New Risks & Litigation	New Risks & Litigation	New Risks & Litigation	New Risks & Litigation	New Risks & Litigation	New Risks & Litigation	New Risks & Litigation	New Risks & Litigation	New Risks & Litigation	New Risks & Litigation	New Risks & Litigation
Chair Report & CEO Report	Chair Report & CEO Report	Chair Report & CEO Report	Chair Report & CEO Report	Chair Report & CEO Report	Chair Report & CEO Report	Chair Report & CEO Report	Chair Report & CEO Report	Chair Repot & CEO Report	Chair Report & CEO Report	Chair Report & CEO Report
Patient Story	Patient Story	Patient Story	Patient Story	Patient Story	Patient Story	Patient Story	Patient Story	Patient Story	Patient Story	Patient Story
Confidential Board	**Confidential Board**	**Confidential Board**	**Confidential Board**	**Confidential Board**	**Confidential Board**	**Confidential Board**	**Confidential Board**	**Confidential Board**	**Confidential Board**	**Confidential Board**
Strategic	**Strategic**	**Strategic**	**Strategic**	**Strategic**	**Strategic**	**Strategic**	**Strategic**	**Strategic**	**Strategic**	**Strategic**
Strategic Estate Partnership										
Reputation Issues	**Reputation Issues**	**Reputation Issues**	**Reputation Issues**	**Reputation Issues**	**Reputation Issues**	**Reputation Issues**	**Reputation Issues**	**Reputation Issues**	**Reputation Issues**	**Reputation Issues**
Oral update by Medical Director	Verbal update by Medical Director	Verbal update by Medical Director	Verbal update by Medical Director	Verbal update by Medical Director	Verbal update by Medical Director	Verbal update by Medical Director	Verbal update by Medical Director	Verbal update by Medical Director	Verbal update by Medical Director	Verbal update by Medical Director
Governance	**Governance**	**Governance**	**Governance**	**Governance**	**Governance**	**Governance**	**Governance**	**Governance**	**Governance**	**Governance**
Serious Case Reviews	Serious Case Reviews	Serious Case Reviews	Serious Case Reviews	Serious Case Reviews	Serious Case Reviews	Serious Case Reviews	Serious Case Reviews	Serious Case Reviews	Serious Case Reviews	Serious Case Reviews
Budget Setting										
Standing Items	**Standing Items**	**Standing Items**	**Standing Items**	**Standing Items**	**Standing Items**	**Standing Items**	**Standing Items**	**Standing Items**	**Standing Items**	**Standing Items**
New Risks & Litigation	New Risks & Litigation	New Risks & Litigation	New Risks & Litigation	New Risks & Litigation	New Risks & Litigation	New Risks & Litigation	New Risks & Litigation	New Risks & Litigation	New Risks & Litigation	New Risks & Litigation
Business Pipeline	Business Pipeline	Business Pipeline	Business Pipeline	Business Pipeline	Business Pipeline	Business Pipeline	Business Pipeline	Business Pipeline	Business Pipeline	Business Pipeline
Contracting	Contracting	Contracting	Contracting	Contracting	Contracting	Contracting	Contracting	Contracting	Contracting	Contracting
Mins last Meeting /Action Log	Mins last Meeting/ Action Log	Mins last Meeting /Action Log	Mins last Meeting /Action Log	Mins last Meeting /Action Log	Mins last Meeting /Action Log	Mins last Meeting /Action Log	Mins last Meeting /Action Log	Mins last Meeting /Action Log	Mins last Meeting /Action Log	Mins last Meeting / Action Log
Medical & Dental Staff Exclusions	Medical & Dental Staff Exclusions	Medical & Dental Staff Exclusions	Medical & Dental Staff Exclusions	Medical & Dental Staff Exclusions	Medical & Dental Staff Exclusions	Medical & Dental Staff Exclusions	Medical & Dental Staff Exclusions	Medical & Dental Staff Exclusions	Medical & Dental Staff Exclusions	Medical & Dental Staff Exclusions

Whittington Health NHS

Whittington Health Trust Board
6 April 2016

Title:	Trust Board Standing Orders, Standing Financial Instructions, Scheme of Delegation and Trust Board Committees' Terms of Reference						
Agenda item:	**16/058**		**Paper**		**13**		
Action requested:	For the Board to approve and adopt the Trust key governance documents						
Executive Summary:	This paper presents the revised: • Trust Board Standing Orders – agreed at Audit & Risk March 16 • Standing Financial Instructions – agreed at Audit & Risk March16 • Scheme of Delegation – agreed at Audit & Risk March16 • Audit & Risk – approved & adopted by Trust Board November 15 • Workforce and Assurance – approved & adopted by Trust Board March 16 • Quality TORs – agreed at Committee March 16 • Finance & Business Development TORs – agreed 2014 • Charitable Fund TORs – agreed by Committee April 16 • Nomination & Remuneration – agreed at Committee July 15						
Summary of recommendations:	The Trust Board is asked to approve and adopt the revised Trust key governance documents						
Fit with WH strategy:	Complies with statutory duties						
Reference to related / other documents:	NHS public body duties, good governance and Nolan Principles						
Date paper completed:	31 March 2016						
Author name and title:	**Steve Bloomer, Chief Finance Officer / Lynne Spencer, Director of Communications & Corporate Affairs**		**Director name and title:**		**Steve Hitchins, Chair**		
Date paper seen by EC	**2016**	**Equality Impact Assessment complete?**	**N/A**	**Risk assessment undertaken?**		**Legal advice received?**	**N/A**

Whittington Health NHS

The Whittington Hospital NHS Trust

Standing Orders, Reservation & Delegation of Powers & Standing Financial Instructions

Agreed at 30 March 2016 Audit & Risk Committee

- **Updated 2006**
- **Review/Updated November 2008**
- **Review / Updated February 2009**
- **Review/ updated July 2010**
- **Review/Updated May 2012**
- **Review/Updated October 2013**
- **Review/Updated April 2014**
- **Review/Updated February 2016**

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Note: Throughout this document, references to male gender should be interpreted as referring to both genders.

SECTION A

1. INTERPRETATION AND DEFINITIONS FOR STANDING ORDERS AND STANDING FINANCIAL INSTRUCTIONS

1.1 Save as otherwise permitted by law, at any meeting the Chairman of the Trust shall be the final authority on the interpretation of Standing Orders (on which they should be advised by the Chief Executive or Secretary to the Board).

1.2 Any expression to which a meaning is given in the National Health Service Act 1977, National Health Service and Community Care Act 1990, the NHS Act 2006 and other Acts relating to the National Health Service or in the Financial Regulations made under the Acts shall have the same meaning in these Standing Orders and Standing Financial Instructions and in addition:

1.2.1 **"Accountable Officer"** means the NHS Officer responsible and accountable for funds entrusted to the Trust. The officer shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust it shall be the Chief Executive.

1.2.2 **"Trust"** means the Whittington Hospital NHS Trust.

1.2.3 **"Board"** means the Chairman, executive and non-executive members of the Trust collectively as a body.

1.2.4 **"Budget"** means a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.

1.2.5 **"Budget holder"** means the director or employee with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisation.

1.2.6 **"Chairman of the Board (or Trust)"** is the person appointed by the Secretary of State for Health to lead the Board and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expression "the Chairman of the Trust" shall be deemed to include the Vice Chairman of the Trust if the Chairman is absent from the meeting or is otherwise unavailable.

1.2.7 **"Chief Executive"** means the chief officer of the Trust.

1.2.8 **"Commissioning"** means the process for determining the need for and for obtaining the supply of healthcare and related services by the Trust within available resources.

1.2.9 **"Committee"** means a committee or sub-committee created and appointed by the Trust.

1.2.10 **"Committee members"** means persons formally appointed by the Board to sit on or to chair specific committees.

1.2.11 **"Contracting and procuring"** means the systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets.

1.2.12 **"Chief Finance OfficerChief Finance Officer"** means the Chief Financial Officer of the Trust.

1.2.13 **“Funds held on trust”** shall mean those funds which the Trust holds on date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under powers derived under S.90 of the NHS Act 1977, as amended. Such funds may or may not be charitable.

1.2.14 **"Member"** means officer or non-officer member of the Board as the context permits. Member in relation to the Board does not include its Chairman.

1.2.15 **“Associate Member”** means a person appointed to perform specific statutory and non-statutory duties which have been delegated by the Trust Board for them to perform and these duties have been recorded in an appropriate Trust Board minute or other suitable record.

1.2.16 **"Membership, Procedure and Administration Arrangements Regulations"** means NHS Membership and Procedure Regulations (SI 1990/2024) and subsequent amendments.

1.2.17 **"Nominated executive"** means an executive charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions.

1.2.18 **"Non-executive member"** means a member of the Trust who is not an executive of the Trust and is not to be treated as an executive by virtue of regulation 1(3) of the Membership, Procedure and Administration Arrangements Regulations.

1.2.19 **"Officer"** means employee of the Trust or any other person holding a paid appointment or office with the Trust.

1.2.20 **"Officer member**" means a member of the Trust who is either an officer of the Trust or is to be treated as an officer by virtue of regulation 1(3) (i.e. the Chairman of the Trust or any person nominated by such a Committee for appointment as a Trust member).

1.2.21 **"Secretary"** means a person appointed to act independently of the Board to provide advice on corporate governance issues to the Board and the Chairman and monitor the Trust’s compliance with the law, Standing Orders, and Department of Health guidance.

1.2.22 **"SFIs"** means Standing Financial Instructions.

1.2.23 **"SOs"** means Standing Orders.

1.2.24 **"Deputy Chairman"** means the non-executive member appointed by the Board to take on the Chairman’s duties if the Chairman is absent for any reason.

SECTION B – STANDING ORDERS

1. INTRODUCTION

1.1 Statutory Framework

The Whittington Hospital NHS Trust (the Trust) is a statutory body which came into existence on 4th November 1992 under The Whittington Hospital NHS Trust (Establishment) Order 1992 No 2510 (the Establishment Order).

(1) The principal place of business of the Trust is Magdala Avenue, London N19 5NF.

(2) NHS Trusts are governed by Act of Parliament, mainly the National Health Service Act 1977 (NHS Act 1977), the National Health Service and Community Care Act 1990 (NHS & CC Act 1990) as amended by the Health Authorities Act 1995 the, Health Act 1999 and consolidated in the National Health Service Act 2006 and the NHS (Consequential Provision) Act 2006.

(3) The functions of the Trust are conferred by this legislation.

(4) As a statutory body, the Trust has specified powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable. as well as to the Secretary of State for Health for any other funds held on trust.

(5) The Trust also has statutory powers under Section 28A of the NHS Act 1977, as amended by the Health Act 1999, to fund projects jointly planned with local authorities, voluntary organisations and other bodies.

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

(7) The Trust will also be bound by such other statutes and legal provisions which govern the conduct of its affairs.

1.2 NHS Framework

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

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

(3) The Code of Practice on Openness in the NHS sets out the requirements for public access to information on the NHS. From 1 January 2005, this was superseded by the Freedom of Information Act 2000.

1.3 Delegation of Powers

The Trust has powers to delegate and make arrangements for delegation. The Standing Orders (SO) set out the detail of these arrangements. Under the Standing

Order relating to the Arrangements for the Exercise of Functions (SO 5) the Trust is given powers to "make arrangements for the exercise, on behalf of the Trust of any of their functions by a committee, sub-committee or joint committee appointed by virtue of SO 4 or by an officer of the Trust, in each case subject to such restrictions and conditions as the Trust thinks fit or as the Secretary of State may direct".

Reservation of Powers are covered in Section C. These documents have the effect as if incorporated into the Standing Orders.

1.4 Integrated Governance

Trust Boards are now encouraged to move away from silo governance and develop integrated governance that will lead to good governance and to ensure that decision-making is informed by intelligent information covering the full range of corporate, financial, clinical, information and research governance. Guidance from the Department of Health on the move toward and implementation of integrated governance has been issued and will be incorporated in the Trust's Governance Strategy. Integrated governance will better enable the Board to take a holistic view of the organisation and its capacity to meet its legal and statutory requirements and clinical, quality and financial objectives.

2. THE TRUST BOARD: COMPOSITION OF MEMBERSHIP, TENURE AND ROLE OF MEMBERS

2.1 Composition of the Membership of the Trust Board

In accordance with the Membership, Procedure and Administration Arrangements regulations the composition of the Board shall be:

(1) The Chairman of the Trust (Appointed by the NHS Appointments Commission);

(2) Up to 6 non-executive members (appointed by the NHS Appointments Commission);

(3) Up to 5 executive members (but not exceeding the number of non-executive members) including:

- the Chief Executive;
- the Chief Finance Officer;
- a Medical Practitioner;
- a Registered Nurse or Midwife;

The Trust shall have not more than 12 and not less than 8 voting members (unless otherwise determined by the Secretary of State for Health and set out in the Trust's Establishment Order or such other communication from the Secretary of State).

2.2 Appointment of Chairman and Members of the Trust

(1) Appointment of the Chairman and Members of the Trust - Paragraph 4 of Schedule 5A to the 1977 Act, as inserted by the Health Act 1999, provides that the Chairman is appointed by the Secretary of State, but otherwise the appointment and tenure of office of the Chairman and members are set out in the Membership, Procedure and Administration Arrangements Regulations.

2.3 Terms of Office of the Chairman and Members

(1) The regulations setting out the period of tenure of office of the Chairman and members and for the termination or suspension of office of the Chairman and members are contained in Sections 2 to 4 of the Membership, Procedure and Administration Arrangements and Administration Regulations.

2.4 Appointment and Powers of Vice Chairman

(1) Subject to SO 2.4 (2) below, the Chairman and members of the Trust may appoint one of their number, who is not also an executive member, to be Vice Chairman, for such period, not exceeding the remainder of his term as a member of the Trust, as they may specify on appointing him.

(2) Any member so appointed may at any time resign from the office of Vice Chairman by giving notice in writing to the Chairman. The Chairman and members may thereupon appoint another member as Vice Chairman in accordance with the provisions of SO 2.4 (1).

(3) Where the Chairman of the Trust has died or has ceased to hold office, or where they have been unable to perform their duties as Chairman owing to illness or any other cause, the Vice Chairman shall act as Chairman until a new Chairman is appointed or the existing Chairman resumes their duties, as the case may be; and references to the Chairman in these Standing Orders shall, so long as there is no Chairman able to perform those duties, be taken to include references to the Vice Chairman.

2.5 Joint Members

(1) Where more than one person is appointed jointly to a post mentioned in regulation 2(4)(a) of the Membership, Procedure and Administration Arrangements and Regulations those persons shall count for the purpose of SO 2.1 as one person.

(2) Where the office of a member of the Board is shared jointly by more than one person:

(a) either or both of those persons may attend or take part in meetings of the Board;

(b) if both are present at a meeting they should cast one vote if they agree;

(c) in the case of disagreements no vote should be cast;

(d) the presence of either or both of those persons should count as the presence of one person for the purposes of SO 3.11 Quorum.

2.6 Role of Members

The Board will function as a corporate decision-making body, Executive and Non-executive Members will be full and equal members. Their role as members of the Board of Directors will be to consider the key strategic and managerial issues facing the Trust in carrying out its statutory and other functions.

(1) **Executive Director**

Executive Directors are normally employees of the Trust. However, a person holding a post in a university or a person seconded to work for the Trust may be appointed as an Executive director. Executive directors (apart from the Chief

Executive and the Chief Financial Officer) may be removed from the Trust Board if, in the view of the appointing committee, it is not in the interest of the Trust for them to continue as a Director. If any Executive director is suspended from his post with the Trust, he will also be suspended from being a director for the period of his suspension. Executive Directors shall exercise their authority within the terms of these Standing Orders and Standing Financial Instructions and the Scheme of Delegation.

(2) **Chief Executive**

The Chief Executive shall be responsible for the overall performance of the executive functions of the Trust. He is the **Accountable Officer** for the Trust and shall be responsible for ensuring the discharge of obligations under Financial Directions and in line with the requirements of the Accountable Officer Memorandum for Trust Chief Executives.

(3) **Chief Finance Officer**

The Chief Finance Officer shall be responsible for the provision of financial advice to the Trust and to its members and for the supervision of financial control and accounting systems. He shall be responsible along with the Chief Executive for ensuring the discharge of obligations under relevant Financial Directions.

(4) **Non-Executive Members**

The Non-Executive Members shall not be granted nor shall they seek to exercise any individual executive powers on behalf of the Trust. They may however, exercise collective authority when acting as members of or when chairing a committee of the Trust which has delegated powers.

(5) **Chairman**

The Chairman shall be responsible for the operation of the Board and chair all Board meetings when present. The Chairman has certain delegated executive powers. The Chairman must comply with the terms of appointment and with these Standing Orders.

The Chairman shall liaise with the NHS Appointments Commission over the appointment of Non-Executive Directors and once appointed shall take responsibility either directly or indirectly for their induction, their portfolios of interests and assignments, and their performance.

The Chairman shall work in close harmony with the Chief Executive and shall ensure that key and appropriate issues are discussed by the Board in a timely manner with all the necessary information and advice being made available to the Board to inform the debate and ultimate resolutions.

2.7 Corporate role of the Board

(1) All business shall be conducted in the name of the Trust.

(2) All funds received in trust shall be held in the name of the Trust as corporate trustee.

(3) The powers of the Trust established under statute shall be exercised by the Board meeting in public session except as otherwise provided for in SO No. 3.

(4) The Board shall define and regularly review the functions it exercises on behalf of the Secretary of State.

2.8 Schedule of Matters reserved to the Board and Scheme of Delegation

(1) The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These powers and decisions are set out in the 'Schedule of Matters Reserved to the Board' and shall have effect as if incorporated into the Standing Orders. Those powers which it has delegated to executives and other bodies are contained in the Scheme of Delegation. Both are set out in section C.

2.9 Lead Roles for Board Members

The Chairman will ensure that the designation of Lead roles or appointments of Board members as required by the Department of Health or as set out in any statutory or other guidance will be made in accordance with that guidance or statutory requirement (e.g. appointing a Lead Board Member with responsibilities for Infection Control or Child Protection Services).

3. MEETINGS OF THE TRUST

3.1 Calling meetings

(1) Ordinary meetings of the Board shall be held at regular intervals at such times and places as the Board may determine.

(2) The Chairman of the Trust may call a meeting of the Board at any time.

(3) One third or more members of the Board may requisition a meeting in writing. If the Chairman refuses, or fails, to call a meeting within seven days of a requisition being presented, the members signing the requisition may forthwith call a meeting.

3.2 Notice of Meetings and the Business to be transacted

(1) Before each meeting of the Board a written notice specifying the business proposed to be transacted shall be delivered to every member, or sent by post to the usual place of residence of each member, so as to be available to members at least three clear days before the meeting. The notice shall be signed by the Chairman or by an executive authorised by the Chairman to sign on their behalf. Want of service of such a notice on any member shall not affect the validity of a meeting.

(2) In the case of a meeting called by members in default of the Chairman calling the meeting, the notice shall be signed by those members.

(3) No business shall be transacted at the meeting other than that specified on the agenda, or emergency motions allowed under SO 3.6.

(4) A member desiring a matter to be included on an agenda shall make his request in writing to the Chairman at least [15] clear days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than [15] days before a meeting may be included on the agenda at the discretion of the Chairman.

(5) Trust Board papers must be written in the required Trust Board format and be submitted to the Trust Office at least 7 days before the date of the Trust Board meeting to facilitate timely distribution of the papers

(6) Before each meeting of the Board a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed at the Trust's principal offices and on the Trust's website at least three clear days before the

meeting, (required by the Public Bodies (Admission to Meetings) Act 1960 Section 1 (4) (a)).

3.3 Agenda and Supporting Papers

The Agenda will be sent to members on the Friday of the week before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be despatched no later than two clear days before the meeting, save in emergency.

3.4 Petitions

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

3.5 Notice of Motion

(1) Subject to the provision of SOs 3.7 'Motions: Procedure at and during a meeting' and 3.8 'Motions to rescind a resolution', a member of the Board wishing to move a motion shall send a written notice to the Chief Executive who will ensure that it is brought to the immediate attention of the Chairman.

(2) The notice shall be delivered at least [l5] clear days before the meeting. The Chief Executive shall include in the agenda for the meeting all notices so received that are in order and permissible under governing regulations. This Standing Order shall not prevent any motion being withdrawn or moved without notice on any business mentioned on the agenda for the meeting.

3.6 Emergency Motions

Subject to the agreement of the Chairman, and subject also to the provision of SO 3.7 'Motions: Procedure at and during a meeting', a member of the Board may give written notice of an emergency motion after the issue of the notice of meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. If in order, it shall be declared to the Trust Board at the commencement of the business of the meeting as an additional item included in the agenda. The Chairman's decision to include the item shall be final.

3.7 Motions: Procedure at and during a meeting

i) **Who may propose**

A motion may be proposed by the Chairman of the meeting or any member present. It must also be seconded by another member.

ii) **Contents of motions**

The Chairman may exclude from the debate at their discretion any such motion of which notice was not given on the notice summoning the meeting other than a motion relating to:

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

iii) **Amendments to motions**

A motion for amendment shall not be discussed unless it has been proposed and seconded.

Amendments to motions shall be moved relevant to the motion, and shall not have the effect of negating the motion before the Board.

If there are a number of amendments, they shall be considered one at a time. When a motion has been amended, the amended motion shall become the substantive motion before the meeting, upon which any further amendment may be moved.

iv) **Rights of reply to motions**

a) Amendments

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

b) Substantive/original motion

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

v) **Withdrawing a motion**

A motion, or an amendment to a motion, may be withdrawn.

vi) **Motions once under debate**

When a motion is under debate, no motion may be moved other than:

- an amendment to the motion;
- the adjournment of the discussion, or the meeting;
- that the meeting proceed to the next business;
- that the question should be now put;
- the appointment of an 'ad hoc' committee to deal with a specific item of business;
- that a member/director be not further heard;
- a motion under Section l (2) or Section l (8) of the Public Bodies (Admissions to Meetings) Act l960 resolving to exclude the public, including the press (see SO 3.17).

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

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

3.8 Motion to Rescind a Resolution

(1) Notice of motion to rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the member who gives it and also the signature of three other members, and before considering any such motion of which notice shall have been

given, the Trust Board may refer the matter to any appropriate Committee or the Chief Executive for recommendation.

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

3.9 Chairman of meeting

(1) At any meeting of the Trust Board the Chairman, if present, shall preside. If the Chairman is absent from the meeting, the Vice Chairman (if the Board has appointed one), if present, shall preside.

(2) If the Chairman and Vice Chairman are both absent, the remaining Board members shall choose a Non-Executive director from among their number to act as Chair. An Executive director cannot take the chair.

3.10 Chairman's ruling

The decision of the Chairman of the meeting on questions of order, relevancy and regularity (including procedure on handling motions) and their interpretation of the Standing Orders and Standing Financial Instructions, at the meeting, shall be final.

3.11 Quorum

(i) No business shall be transacted at a meeting unless at least one-third of the whole number of the Chairman and members (including at least two Executive directors and two Non-Executive directors) is present.

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

(iii) If the Chairman or member has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest (see SO No.7) that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

3.12 Voting

(i) Save as provided in SOs 3.l3 - Suspension of Standing Orders and 3.l4 - Variation and Amendment of Standing Orders, every question put to a vote at a meeting shall be determined by a majority of the votes of members present and voting on the question. In the case of an equal vote, the person presiding (ie: the Chairman of the meeting shall have a second, and casting vote.

(ii) At the discretion of the Chairman all questions put to the vote shall be determined by oral expression or by a show of hands, unless the Chairman directs otherwise, or it is proposed, seconded and carried that a vote be taken by paper ballot.

(iii) If at least one third of the members present so request, the voting on any question may be recorded so as to show how each member present voted or did not vote (except when conducted by paper ballot).

(iv) If a member so requests, their vote shall be recorded by name.

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

(vi) A manager who has been formally appointed to act up for an Officer Member during a period of incapacity or temporarily to fill an Executive Director vacancy shall be entitled to exercise the voting rights of the Officer Member.

(vii) A manager attending the Trust Board meeting to represent an Officer Member during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Officer Member. An Officer's status when attending a meeting shall be recorded in the minutes.

(viii) For the voting rules relating to joint members see SO 2.5.

3.13 Suspension of Standing Orders

(i) Except where this would contravene any statutory provision or any direction made by the Secretary of State or the rules relating to the Quorum (SO 3.11), any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the whole number of the Members of the Board are present (including at least one Member who is an Executive Member of the Trust and one member who is not) and that at least two-thirds of those members present signify their agreement to such suspension. The reason for the suspension shall be recorded in the Trust Board's minutes.

(ii) A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Chairman and members of the Trust.

(iii) No formal business may be transacted while Standing Orders are suspended.

(iv) The Audit Committee shall review every decision to suspend Standing Orders.

3.14 Variation and amendment of Standing Orders

These Standing Orders shall not be varied except in the following circumstances:

- upon a notice of motion under SO 3.5;
- upon a recommendation of the Chairman or Chief Executive included on the agenda for the meeting;
- that two thirds of the Board members are present at the meeting where the variation or amendment is being discussed, and that at least half of the Trust's Non-Executive members vote in favour of the amendment;
- providing that any variation or amendment does not contravene a statutory provision or direction made by the Secretary of State.

3.15 Reporting of Waivers of Standing Orders and Standing Financial Instructions

(1) All waivers of Standing Orders should be reported to the Audit Committee after approval has been granted. The Audit Committee should ensure that waivers have only been granted in compliance with the regulations and where necessary. However, these provisions do not apply where the competitive tendering process is to be omitted or modified. Approval should then be sought as detailed in the relevant section of the Standing Financial Instructions. All such waivers will be reported retrospectively to the Trust's Audit Committee.

3.16 Record of Attendance

The names of the Chairman and Directors/Members present at the meeting shall be recorded in the minutes.

3.17 Minutes

The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they shall be signed by the person presiding at it.

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

3.18 Admission of public and the press

(i) **Admission and exclusion on grounds of confidentiality of business to be transacted**

The public and representatives of the press may attend all meetings of the Trust, but shall be required to withdraw upon the Trust Board resolving as follows:

- 'that representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest', Section 1 (2), Public Bodies (Admission to Meetings) Act l960

- Guidance should be sought from the NHS Trust's Freedom of Information Lead to ensure correct procedure is followed on matters to be included in the exclusion.

(ii) **General disturbances**

The Chairman (or Vice-Chairman if one has been appointed) or the person presiding over the meeting shall give such directions as he thinks fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Trust's business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Trust Board resolving as follows:

- `That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Trust Board to complete its business without the presence of the public'. Section 1(8) Public Bodies (Admissions to Meetings) Act l960.

(iii) **Business proposed to be transacted when the press and public have been excluded from a meeting**

Matters to be dealt with by the Trust Board following the exclusion of representatives of the press, and other members of the public, as provided in (i) and (ii) above, shall be confidential to the Members of the Board.

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

(iv) **Use of Mechanical or Electrical Equipment for Recording or Transmission of Meetings**

Nothing in these Standing Orders shall be construed as permitting the introduction by the public, or press representatives, of recording, transmitting, video or similar apparatus into meetings of the Trust or Committee thereof. Such permission shall be granted only upon resolution of the Trust.

3.19 Observers at Trust meetings

The Trust will decide what arrangements and terms and conditions it feels are appropriate to offer in extending an invitation to observers to attend and address any of the Trust Board's meetings and may change, alter or vary these terms and conditions as it deems fit.

4. APPOINTMENT OF COMMITTEES AND SUB-COMMITTEES

4.1 Appointment of Committees

Subject to such directions as may be given by the Secretary of State for Health, the Trust Board may appoint committees of the Trust.

The Trust shall determine the membership and terms of reference of committees and sub-committees and shall if it requires to, receive and consider reports of such committees.

4.2 Joint Committees

(i) Joint committees may be appointed by the Trust by joining together with one or more other Trusts or health bodies consisting of, wholly or partly of the Chairman and members of the Trust or other health service bodies, or wholly of persons who are not members of the Trust or other health bodies in question.

(ii) Any committee or joint committee appointed under this Standing Order may, subject to such directions as may be given by the Secretary of State or the Trust or other health bodies in question, appoint sub-committees consisting wholly or partly of members of the committees or joint committee (whether or not they are members of the Trust or health bodies in question) or wholly of persons who are not members of the Trust or health bodies in question or the committee of the Trust or health bodies in question.

4.3 Applicability of Standing Orders and Standing Financial Instructions to Committees

The Standing Orders and Standing Financial Instructions of the Trust, as far as they are applicable, shall as appropriate apply to meetings and any committees established by the Trust. In which case the term “Chairman” is to be read as a reference to the Chairman of other committee as the context permits, and the term “member” is to be read as a reference to a member of other committee also as the context permits. (There is no requirement to hold meetings of committees established by the Trust in public.)

4.4 Terms of Reference

Each such committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board), as the Board shall decide and shall be in accordance with any legislation and regulation or direction issued by the Secretary of State. Such terms of reference shall have effect as if incorporated into the Standing Orders.

4.5 Delegation of powers by Committees to Sub-Committees

Where committees are authorised to establish sub-committees they may not delegate executive powers to the sub-committee unless expressly authorised by the Trust Board.

4.6 Approval of Appointments to Committees

The Board shall approve the appointments to each of the committees which it has formally constituted. Where the Board determines, and regulations permit, that persons, who are neither members nor officers, shall be appointed to a committee the terms of such appointment shall be within the powers of the Board as defined by the Secretary of State. The Board shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with national guidance. The appointment of directors to committees and sub-committees of the Trust comes to an end on the termination of their terms of office as directors.

4.7 Appointments for Statutory functions

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

4.8 Committees established by the Trust Board

The committees, sub-committees, and joint-committees established by the Board are:

4.8.1 **Audit Committee**

In line with the requirement of the NHS Audit Committee Handbook, NHS Codes of Conduct and Accountability and more recently the Higgs report, an Audit Committee will be established and constituted to provide the Trust Board with an independent and objective review on *inter alia* its financial systems, financial information, risk management systems, clinical governance, health and safety, and compliance with laws, guidance, and regulations governing the NHS. The Terms of Reference will be approved by the Trust Board and reviewed on a periodic basis.

The Higgs report recommends a minimum of three non-executive members be appointed, unless the Board decides otherwise, of which one must have significant, recent and relevant financial experience. No executive directors will be members of the Audit Committee.

4.8.2 **Remuneration and Terms of Service Committee**

In line with the requirements of the NHS Codes of Conduct and Accountability, and more recently the Higgs report, a Terms of Service and Remuneration Committee will be established and constituted.

The Higgs report recommends the committee be comprised exclusively of Non-Executive Directors, a minimum of three, who are independent of management.

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

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

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

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

4.8.3 **Trust and Charitable Funds Committee**

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

The provisions of this Standing Order must be read in conjunction with SO 2.7 and Standing Financial Instructions 29.

4.8.4 **Other Committees**

The Board may also establish such other committees as required to discharge the Trust's responsibilities.

4.9 **Confidential Proceedings**

A director or officer of the Trust shall not disclose a matter considered by the Trust Board or a Committee in confidence without its permission until the Board or Committee has considered the matter in public or has resolved to make the matter public.

5. ARRANGEMENTS FOR THE EXERCISE OF TRUST FUNCTIONS BY DELEGATION

5.1 Delegation of Functions to Committees, Officers or other bodies

5.1.1 Subject to such directions as may be given by the Secretary of State, the Board may make arrangements for the exercise, on behalf of the Board, of any of its functions by a committee, sub-committee appointed by virtue of SO 4, or by an executive of the Trust, or by another body as defined in SO 5.1.2 below, in each case subject to such restrictions and conditions as the Trust thinks fit.

5.1.2 Section 16B of the NHS Act 1977 allows for regulations to provide for the functions of Trust's to be carried out by third parties. In accordance with The Trusts (Membership, Procedure and Administration Arrangements) Regulations 2000 the functions of the Trust may also be carried out in the following ways:

(i) by another Trust;

(ii) jointly with any one or more of the following: NHS trusts, Strategic Health Authorities or PCTs;

(iii) by arrangement with the appropriate Trust or PCT, by a joint committee or joint sub-committee of the Trust and one or more other health service bodies;

(iv) in relation to arrangements made under S63(1) of the Health Services and Public Health Act 1968, jointly with one or more Strategic Health Authorities, SHAs, NHS Trusts or PCT.

5.1.3 Where a function is delegated by these Regulations to another Trust, then that Trust or health service body exercises the function in its own right; the receiving Trust has responsibility to ensure that the proper delegation of the function is in place. In other situations, i.e. delegation to committees, sub-committees or officers, the Trust delegating the function retains full responsibility.

5.2 Emergency Powers and urgent decisions

The powers which the Board has reserved to itself within these Standing Orders (see SO 2.8) may in emergency or for an urgent decision be exercised by the Chief Executive and the Chairman after having consulted at least two non-executive members. The exercise of such powers by the Chief Executive and Chairman shall be reported to the next formal meeting of the Trust Board in public session for formal ratification.

5.3 Delegation to Committees

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

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

5.4 Delegation to Officers

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

5.4.2 The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals which shall be considered and approved by the Board. The Chief Executive may periodically propose amendment to the Scheme of Delegation which shall be considered and approved by the Board.

5.4.3 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of the Chief Finance Officer to provide information and advise the Board in accordance with statutory or Department of Health requirements. Outside these statutory requirements the roles of the Chief Finance Officer shall be accountable to the Chief Executive for operational matters.

5.5 Schedule of Matters Reserved to the Trust and Scheme of Delegation of powers

5.5.1 The arrangements made by the Board as set out in the "Schedule of Matters Reserved to the Board" and "Scheme of Delegation" of powers shall have effect as if incorporated in these Standing Orders.

5.6 Duty to report non-compliance with Standing Orders and Standing Financial Instructions

If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Board for action or ratification. All members of the Trust Board and staff have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

6. OVERLAP WITH OTHER TRUST POLICY STATEMENTS/PROCEDURES, REGULATIONS AND THE STANDING FINANCIAL INSTRUCTIONS

6.1 Policy statements: general principles

The Trust Board will from time to time agree and approve Policy statements/ procedures which will apply to all or specific groups of staff employed by Whittington Health Trust. The decisions to approve such policies and procedures will be recorded in an appropriate Trust Board minute and will be deemed where appropriate to be an integral part of the Trust's Standing Orders and Standing Financial Instructions.

6.2 Specific Policy statements

Notwithstanding the application of SO 6.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following Policy statements:

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

6.3 Standing Financial Instructions

Standing Financial Instructions adopted by the Trust Board in accordance with the Financial Regulations shall have effect as if incorporated in these Standing Orders.

6.4 Specific guidance

Notwithstanding the application of SO 6.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following guidance and any other issued by the Secretary of State for Health:

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

7. DUTIES AND OBLIGATIONS OF BOARD MEMBERS/DIRECTORS AND SENIOR MANAGERS UNDER THESE STANDING ORDERS

7.1 Declaration of Interests

7.1.1 Requirements for Declaring Interests and applicability to Board Members

i) The NHS Code of Accountability requires Trust Board Members to declare interests which are relevant and material to the NHS Board of which they are a member. All existing Board Members should declare such interests. Any Board members appointed subsequently should do so on appointment.

7.1.2 Interests which are relevant and material

(i) Interests which should be regarded as "relevant and material" are:

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

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

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

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

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

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

g) Interests in pooled funds that are under separate management

h) Any other interest in relation to an issue to be considered by the Trust Board.

(ii) Any member of the Trust Board who comes to know that the Trust has entered into or proposes to enter into a contract in which he/she or any person connected with him/her (as defined in SO 7.3 below and elsewhere) has any pecuniary interest, direct or indirect, the Board member shall declare his/her interest by giving notice in writing of such fact to the Trust as soon as practicable.

7.1.3 Advice on Interests

If Board members have any doubt about the relevance of an interest, this should be discussed with the Chairman of the Trust or with the Trust's Corporate Secretary.

Financial Reporting Standard No 8 (issued by the Accounting Standards Board) specifies that influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

7.1.4 Recording of Interests in Trust Board minutes

At the time Board members' interests are declared, they should be recorded in the Trust Board minutes.

Any changes in interests should be declared at the next Trust Board meeting following the change occurring and recorded in the minutes of that meeting.

7.1.5 **Publication of declared interests in Annual Report**

Board members' directorships of companies likely or possibly seeking to do business with the NHS should be published in the Trust's annual report. The information should be kept up to date for inclusion in succeeding annual reports.

7.1.6 **Conflicts of interest which arise during the course of a meeting**

During the course of a Trust Board meeting, if a conflict of interest is established, the Board member concerned should withdraw from the meeting and play no part in the relevant discussion or decision. (See overlap with SO 7.3)

7.2 Register of Interests

7.2.1 The Chief Executive will ensure that a Register of Interests is established to record formally declarations of interests of Board or Committee members. In particular the Register will include details of all directorships and other relevant and material interests (as defined in SO 7.1.2) which have been declared by both executive and non-executive Trust Board members.

7.2.2. These details will be kept up to date by means of an annual review of the Register in which any changes to interests declared during the preceding twelve months will be incorporated.

7.2.3 The Register will be available to the public and the Chief Executive will take reasonable steps to bring the existence of the Register to the attention of local residents and to publicise arrangements for viewing it.

7.3 Exclusion of Chairman and Members in proceedings on account of pecuniary interest

7.3.1 **Definition of terms used in interpreting 'Pecuniary' interest**

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

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

(ii) "contract" shall include any proposed contract or other course of dealing.

(iii) "Pecuniary interest"

Subject to the exceptions set out in this Standing Order, a person shall be treated as having an indirect pecuniary interest in a contract if:-

a) he, or a nominee of his, is a Member of a company or other body (not being a public body), with which the contract is made, or to be made or which has a direct pecuniary interest in the same, or

b) he/she is a partner, associate or employee of any person with whom the contract is made or to be made or who has a direct pecuniary interest in the same.

iv) Exception to Pecuniary interests

A person shall not be regarded as having a pecuniary interest in any contract if:-

a) neither he or any person connected with him has any beneficial interest in the securities of a company of which he or such person appears as a member, or

b) any interest that he or any person connected with him/her may have in the contract is so remote or insignificant that it cannot reasonably be regarded as likely to influence him/her in relation to considering or voting on that contract, or

c) those securities of any company in which he/she (or any person connected with him/her) has a beneficial interest do not exceed £5,000 in nominal value or one per cent of the total issued share capital of the company or of the relevant class of such capital, whichever is the less.

Provided however, that where paragraph (c) above applies the person shall nevertheless be obliged to disclose/declare their interest in accordance with SO 7.1.2 (ii).

7.3.2 **Exclusion in proceedings of the Trust Board**

(i) Subject to the following provisions of this Standing Order, if the Chairman or a member of the Trust Board has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Trust Board at which the contract or other matter is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

(ii) The Secretary of State may, subject to such conditions as he/she may think fit to impose, remove any disability imposed by this Standing Order in any case in which it appears to him/her in the interests of the National Health Service that the disability should be removed. (See SO 7.3.3 on the 'Waiver' which has been approved by the Secretary of State for Health).

(iii) The Trust Board may exclude the Chairman or a Member of the Board from a meeting of the Board while any contract, proposed contract or other matter in which he/she has a pecuniary interest is under consideration.

(iv) Any remuneration, compensation or allowance payable to the Chairman or a Member by virtue of paragraph 11 of Schedule 5A to the National Health Service Act 1977 (pay and allowances) shall not be treated as a pecuniary interest for the purpose of this Standing Order.

(v) This Standing Order applies to a committee or sub-committee and to a joint committee or sub-committee as it applies to the Trust and applies to a member of any such committee or sub-committee (whether or not he/she is also a member of the Trust) as it applies to a Member of the Trust.

7.3.3 **Waiver of Standing Orders made by the Secretary of State for Health**

(1) Power of the Secretary of State to make waivers

Under regulation 11(2) of the NHS (Membership and Procedure Regulations SI 1999/2024 ("the Regulations"), there is a power for the Secretary of State to issue waivers if it appears to the Secretary of State in the interests of the health service that the disability in regulation 11 (which prevents a chairman or a member from taking part in the consideration or discussion of, or voting on any question with respect to, a matter in which he has a pecuniary interest) is removed. A waiver has been agreed in line with sub-sections (2) to (4) below.

(2) Definition of 'Chairman' for the purpose of interpreting this waiver

For the purposes of paragraph 7.3.3.(3) (below), the "relevant chairman" is –

(a) at a meeting of the Trust, the Chairman of that Trust;

(b) at a meeting of a Committee –

(i) in a case where the member in question is the Chairman of that Committee, the Chairman of the Trust;

(ii) in the case of any other member, the Chairman of that Committee.

(3) Application of waiver

A waiver will apply in relation to the disability to participate in the proceedings of the Trust on account of a pecuniary interest.

It will apply to:

(i) A member of the Whittington Hospitals NHS Trust ("the Trust"), who is a healthcare professional, within the meaning of regulation 5(5) of the Regulations, and who is providing or performing, or assisting in the provision or performance, of –

(a) services under the National Health Service Act 1977; or

(b) services in connection with a pilot scheme under the National Health Service Act 1997;

for the benefit of persons for whom the Trust is responsible.

(ii) Where the 'pecuniary interest' of the member in the matter which is the subject of consideration at a meeting at which he is present:-

(a) arises by reason only of the member's role as such a professional providing or performing, or assisting in the provision or performance of, those services to those persons;

(b) has been declared by the relevant chairman as an interest which cannot reasonably be regarded as an interest more substantial than that of the majority of other persons who:–

(i) are members of the same profession as the member in question,

(ii) are providing or performing, or assisting in the provision or performance of, such of those services as he provides or performs, or assists in the provision or performance of, for the benefit of persons for whom the Trust is responsible.

(4) Conditions which apply to the waiver and the removal of having a pecuniary interest

The removal is subject to the following conditions:

(a) the member must disclose his/her interest as soon as practicable after the commencement of the meeting and this must be recorded in the minutes;

(b) the relevant chairman must consult the Chief Executive before making a declaration in relation to the member in question pursuant to paragraph 7.3.3 (2) (b) above, except where that member is the Chief Executive;

(c) **in the case of a meeting of the Trust**:

(i) the member may take part in the consideration or discussion of the matter which must be subjected to a vote and the outcome recorded;

(ii) may not vote on any question with respect to it.

(d) **in the case of a meeting of the Committee:**

(i) the member may take part in the consideration or discussion of the matter which must be subjected to a vote and the outcome recorded;

(ii) may vote on any question with respect to it; but

(iii) the resolution which is subject to the vote must comprise a recommendation to, and be referred for approval by, the Trust Board.

7.4 Standards of Business Conduct

7.4.1 Trust Policy and National Guidance

All Trust staff and Members of must comply with :

7.4.1.1 The Trust's Standards of Business Conduct and Conflicts of Interest Policy and the national guidance contained in HSG(93)5 on 'Standards of Business Conduct for NHS staff' (see SO 6.2).

7.4.1.2 The Seven Principles of Public Life as set out by the Nolan Committee and which apply to everyone who works in public services

7.4.2 Interest of Executives in Contracts

i) Any officers or employee of the Trust who comes to know that the Trust has entered into or proposes to enter into a contract in which he/she or any person connected with him/her (as defined in SO 7.3) has any pecuniary interest, direct or indirect, the executive shall declare their interest by giving notice in writing of such fact to the Chief Executive or Trust's Company Secretary as soon as practicable.

ii) An executive should also declare to the Chief Executive any other employment or business or other relationship of his/her, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

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

7.4.3 **Canvassing of and Recommendations by Members in Relation to Appointments**

i) Canvassing of members of the Trust or of any Committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates. This provision does not prevent candidates from arranging to meet non-executive and executive members as part of their preparation for competition and interview.

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

7.4.4 **Relatives of Members or Officers**

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

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

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

iv) Where the relationship to a member of the Trust is disclosed, the Standing Order headed 'Disability of Chairman and members in proceedings on account of pecuniary interest' (SO 7) shall apply.

7.5 Acceptance of Gifts and Donations

(1) Staff should not accept gifts in any form, whether from patients, patients" relatives or carers, or from potential or actual suppliers, other than as provided below. The Trust's Standards of Business Conduct Policy sets out the rules in relation to gifts and donations and should be read as if incorporated into Standing Orders.

(2) It is in order in certain circumstances for staff to accept small gifts to a maximum value of £25 but their senior officer must be informed and a record made.

(3) Any donated sums of money, cheques or gift vouchers given to a member of staff must be passed to the relevant charitable fund. A receipt should be issued and letter of thanks sent.

(4) Where the donor specifies how the money is to be spent, his/her wishes must be followed.

8. CUSTODY OF SEAL, SEALING OF DOCUMENTS AND SIGNATURE OF DOCUMENTS

8.1 **Custody of Seal**

The common seal of the Trust shall be kept by the Chief Executive or a nominated Manager by him/her in a secure place.

8.2 **Sealing of Documents**

Where it is necessary that a document shall be sealed, as required by law or requested by any other party, the seal shall be affixed in the presence of two senior managers duly authorised by the Chief Executive, and not also from the originating department, and shall be attested by them.

8.3 **Register of Sealing**

The Chief Executive shall keep a register in which he, or another manager of the Authority authorised by him/her, shall enter a record of the sealing of every document.

8.4 **Signature of documents**

Where any document will be a necessary step in legal proceedings on behalf of the Trust, it shall, unless any enactment otherwise requires or authorises, be signed by the Chief Executive or any Executive Director.

In land transactions, the signing of certain supporting documents will be delegated to Managers and set out clearly in the Scheme of Delegation but will not include the main or principal documents effecting the transfer (e.g. sale/purchase agreement, lease, contracts for construction works and main warranty agreements or any document which is required to be executed as a deed).

9. MISCELLANEOUS (see overlap with SFI No. 21.3)

9.1 **Joint Finance Arrangements**

The Board may confirm contracts to purchase from a voluntary organisation or a local authority using its powers under Section 28A of the NHS Act 1977. The Board may confirm contracts to transfer money from the NHS to the voluntary sector or the health related functions of local authorities where such a transfer is to fund services to improve the health of the local population more effectively than equivalent expenditure on NHS services, using its powers under Section 28A of the NHS Act 1977, as amended by section 29 of the Health Act 1999.

See overlap with Standing Financial Instruction No. 21.3.

SECTION C - SCHEME OF RESERVATION AND DELEGATION

REF	THE BOARD	DECISIONS RESERVED TO THE BOARD
NA	THE BOARD	**General Enabling Provision** The Board may determine any matter, for which it has delegated or statutory authority, it wishes in full session within its statutory powers.
NA	THE BOARD	***Regulations and Control*** 1. Approve Standing Orders (SOs), a schedule of matters reserved to the Board and Standing Financial Instructions for the regulation of its proceedings and business. 2. Suspend Standing Orders. 3. Vary or amend the SOs. 4. Ratify any urgent decisions taken by the Chairman and Chief Executive in public session in accordance with SO 5.2 5. Approve a scheme of delegation of powers from the Board to committees**.** 6. Require and receive the declaration of Board members' interests that may conflict with those of the Trust and determining the extent to which that member may remain involved with the matter under consideration. 7. Require and receive the declaration of officers' interests that may conflict with those of the Trust. 8. Approve arrangements for dealing with complaints. 9. Adopt the organisation structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications thereto. 10. Receive reports from committees including those that the Trust is required by the Secretary of State or other regulation to establish and to take appropriate action on. 11. Confirm the recommendations of the Trust's committees where the committees do not have executive powers. 12. Approve arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust. 13. Establish terms of reference and reporting arrangements of all committees and sub-committees that are established by the Board. 14. Approve arrangements relating to the discharge of the Trust's responsibilities as a bailer for patients' property 15.

REF	THE BOARD	DECISIONS RESERVED TO THE BOARD
		Ratify or otherwise instances of failure to comply with SOs brought to the Chief Executive's attention in accordance with SO 5.6. 16. Discipline members of the Board or employees who are in breach of statutory requirements or SOs.
NA	THE BOARD	**Appointments/ Dismissal** 1. Appoint the Vice Chairman of the Board. 2. Appoint and dismiss committees (and individual members) that are directly accountable to the Board. 3. Appoint, appraise, discipline and dismiss Executive Directors (subject to SO 2.2). 4. Confirm appointment of members of any committee of the Trust as representatives on outside bodies. 5. Appoint, appraise, discipline and dismiss the Secretary (if the appointment of a Secretary is required under SOs). 6. Approve proposals of the Remuneration Committee regarding directors and senior employees and those of the Chief Executive for staff not covered by the Remuneration Committee.
NA	THE BOARD	***Strategy, Plans and Budgets*** 1. Define the strategic aims and objectives of the Trust. 2. Approve proposals for ensuring quality and developing clinical governance in services provided by the Trust, having regard to any guidance issued by the Secretary of State. 3. Approve the Trust's policies and procedures for the management of risk. 4. Approve Outline and Final Business Cases for Capital Investment in excess of £1.5m 5. Approve budgets. 6. Approve annually Trust's proposed organisational development proposals. 7. Ratify proposals for acquisition, disposal or change of use of land and/or buildings. 8. Approve PFI proposals. 9. Approve the opening of bank accounts. 10. Approve proposals on individual contracts (other than NHS contracts) of a capital or revenue nature amounting to, or likely to amount to over £1.5m over a 3 year period or the period of the contract if longer. 11. Approve proposals in individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive and Chief Finance Officer (for losses and special payments) previously approved by the Board.

REF	THE BOARD	DECISIONS RESERVED TO THE BOARD
		12. Approve individual compensation payments. 13. Approve proposals for action on litigation against or on behalf of the Trust. 14. Review use of NHSLA risk pooling schemes
	THE BOARD	**Policy Determination** 1. Approve management policies including personnel policies incorporating the arrangements for the appointment, removal and remuneration of staff. Policies so adopted shall be listed and appended to this document [by the Secretary]
	THE BOARD	**Audit** 1. Receipt of the annual management letter received from the external auditor and agreement of proposed action, taking account of the advice, where appropriate, of the Audit Committee. 2. Receipt of an annual report from the Internal Auditor and agree action on recommendations where appropriate of the Audit Committee.
NA	THE BOARD	**Annual Reports and Accounts** 1. Receipt and approval of the Trust's Annual Report and Annual Accounts. 2. Receipt and approval of the Annual Report and Accounts for funds held on trust.
NA	THE BOARD	**Monitoring** 1. Receive of such reports as the Board sees fit from committees in respect of their exercise of powers delegated. 2. Continuous appraisal of the affairs of the Trust by means of the provision to the Board as the Board may require from directors, committees, and officers of the Trust as set out in management policy statements. All monitoring returns required by the Department of Health and the Charity Commission shall be reported, at least in summary, to the Board. Receive reports from DoF on financial performance against budget and financial p

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
SFI 11.1.1	AUDIT COMMITTEE	The Committee will: 1. Review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives; 2. Act as guardian of the Assurance Framework and Health Commission Annual Core Standards Healthcheck, responsible for updating and monitoring action plans 3. Ensure policies and procedures in respect of governance are in line with NHS guidelines 4. Report to the Board on risk management, controls, and assurance issues 5. Agree reporting formats and frequency of reports 6. Agree and monitor the Clinical Governance Development Plan and the Annual Clinical Governance Report 7. Consider action in response to Health Commission and NICE recommendations 8. Support a culture of learning 9. Advise the Board on internal and external audit services; 10. Monitor compliance with SOs and Standing Financial Instructions; 11. Review schedules of losses and compensations and making recommendations to the Board. 12. Review schedules of debtor/creditor balances >£5k, >6 months 13. Review the annual financial statements prior to submission to the Board. 14. Review tender waivers and write off of debts
SFI 20.1.2	REMUNERATION AND TERMS OF SERVICE COMMITTEE	The Committee will advise and report to the Board on 1. Appropriate remuneration and terms of service for the Chief Executive, other Executive Directors and other senior employees including: 2. All aspects of salary (including any performance-related elements/bonuses); 3. Provisions for other benefits, including pensions and cars; 4. Arrangements for termination of employment and other contractual terms; 5. Recommendations to the Board on the remuneration and terms of service of executive directors and

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
		senior employees to ensure they are fairly rewarded for their individual contribution to the Trust - having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such staff; 6. Proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate advise on and oversee appropriate contractual arrangements for such staff; 7. The Committee shall report in writing to the Board the basis for its recommendations.
	OTHER COMMITTEES	PFI Decision-making Sub-Committee has delegated authority to take urgent decisions relating to the PFI contract subject to advice from the DoH PFU

SCHEME OF DELEGATION DERIVED FROM THE ACCOUNTABLE OFFICER MEMORANDUM

REF	DELEGATED TO	DUTIES DELEGATED
7	CHIEF EXECUTIVE (CE)	Accountable through NHS Accounting Officer to Parliament for stewardship of Trust resources
9	CE AND CHIEF FINANCE OFFICER (DOF)	Ensure the accounts of the Trust are prepared under principles and in a format directed by the SofS. Accounts must disclose a true and fair view of the Trust's income and expenditure and its state of affairs. Sign the accounts on behalf of the Board.
10	CHIEF EXECUTIVE	Sign a statement in the accounts outlining responsibilities as the Accountable Officer. Sign a statement in the accounts outlining responsibilities in respect of Internal Control.
12 & 13	CHIEF EXECUTIVE	*Ensure effective management systems that safeguard public funds and assist the Trust Chairman to implement requirements of corporate governance including ensuring managers:* • "have a clear view of their objectives and the means to assess achievements in relation to those objectives • be assigned well defined responsibilities for making best use of resources • have the information, training and access to the expert advice they need to exercise their responsibilities effectively."
12	CHAIRMAN	Implement requirements of corporate governance.
13	CHIEF EXECUTIVE	Achieve value for money from the resources available to the Trust and avoid waste and extravagance in the organisation's activities. Follow through the implementation of any recommendations affecting good practice as set out on reports from such bodies as the Audit Commission and the National Audit Office (NAO).
15	DOF	Operational responsibility for effective and sound financial management and information.
	CHIEF EXECUTIVE	Primary duty to see that DoF discharges this function.

REF	DELEGATED TO	DUTIES DELEGATED
15		
16	CHIEF EXECUTIVE	Ensuring that expenditure by the Trust complies with Parliamentary requirements.
18	CE and DoF	Chief Executive, supported by Chief Finance Officer, to ensure appropriate advice is given to the Board on all matters of probity, regularity, prudent and economical administration, efficiency and effectiveness.
19	CHIEF EXECUTIVE	If CE considers the Board or Chairman is doing something that might infringe probity or regularity, he should set this out in writing to the Chairman and the Board. If the matter is unresolved, he/she should ask the Audit Committee to inquire and if necessary the SHA and Department of Health.
21	CHIEF EXECUTIVE	If the Board is contemplating a course of action that raises an issue not of formal propriety or regularity but affects the CE's responsibility for value for money, the CE should draw the relevant factors to the attention of the Board. If the outcome is that the CE is overruled it is normally sufficient to ensure that the CE's advice and the overruling of it are clearly apparent from the papers. Exceptionally, the CE should inform the Strategic Health Authority and the DH. In such cases, and in those described in paragraph 24, the CE should as a member of the Board vote against the course of action rather than merely abstain from voting.

SCHEME OF DELEGATION DERIVED FROM THE CODES OF CONDUCT AND ACCOUNTABILITY

REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
1.3.1.7	BOARD	Approve procedure for declaration of hospitality and sponsorship.
1.3.1.8	BOARD	Ensure proper and widely publicised procedures for voicing complaints, concerns about misadministration, breaches of Code of Conduct, and other ethical concerns.
1.31.9 & 1.3.2.2	ALL BOARD MEMBERS	Subscribe to Code of Conduct.
1.3.2.4	BOARD	Board members share corporate responsibility for all decisions of the Board.
1.3.2.4	CHAIR AND NON EXECUTIVE/OFFICER MEMBERS	Chair and non-officer members are responsible for monitoring the executive management of the organisation and are responsible to the SofS for the discharge of those responsibilities.
1.3.2.4	BOARD	The Board has six key functions for which it is held accountable by the Department of Health on behalf of the Secretary of State: 1. to ensure effective financial stewardship through value for money, financial control and financial planning and strategy; 2. to ensure that high standards of corporate governance and personal behaviour are maintained in the conduct of the business of the whole organisation; 3. to appoint, appraise and remunerate senior executives; 4. to ratify the strategic direction of the organisation within the overall policies and priorities of the Government and the NHS, define its annual and longer term objectives and agree plans to achieve them; 5. to oversee the delivery of planned results by monitoring performance against objectives and ensuring corrective action is taken when necessary; 6. to ensure effective dialogue between the organisation and the local community on its plans and performance and that these are responsive to the community's needs.
1.3.24	BOARD	It is the Board's duty to:

REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
		1. act within statutory financial and other constraints; 2. be clear what decisions and information are appropriate to the Board and draw up SOs, a schedule of decisions reserved to the Board and Standing Financial Instructions to reflect these, 3. ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives for the main programmes of action and for performance against programmes to be monitored and senior executives held to account; 4. establish performance and quality measures that maintain the effective use of resources and provide value for money; 5. specify its requirements in organising and presenting financial and other information succinctly and efficiently to ensure the Board can fully undertake its responsibilities; 6. establish Audit and Remuneration Committees on the basis of formally agreed terms of reference that set out the membership of the sub-committee, the limit to their powers, and the arrangements for reporting back to the main Board.
1.3.2.5	CHAIRMAN	It is the Chairman's role to: 1. provide leadership to the Board; 2. enable all Board members to make a full contribution to the Board's affairs and ensure that the Board acts as a team; 3. ensure that key and appropriate issues are discussed by the Board in a timely manner, 4. ensure the Board has adequate support and is provided efficiently with all the necessary data on which to base informed decisions; 5. lead Non-Executive Board members through a formally-appointed Remuneration Committee of the main Board on the appointment, appraisal and remuneration of the Chief Executive and (with the latter) other Executive Board members; 6. advise the Secretary of State on the performance of Non-Executive Board members.
1.3.2.5	CHIEF EXECUTIVE	The Chief Executive is accountable to the Chairman and Non-Executive members of the Board for ensuring that its decisions are implemented, that the organisation works effectively, in accordance with Government policy and public service values and for the maintenance of proper financial stewardship. The Chief Executive should be allowed full scope, within clearly defined delegated powers, for action in fulfilling the decisions of the Board. The other duties of the Chief Executive as Accountable Officer are laid out in the Accountable Officer Memorandum.

REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
1.3.2.6	NON EXECUTIVE DIRECTORS	Non-Executive Directors are appointed by Appointments Commission to bring independent judgement to bear on issues of strategy, performance, key appointments and accountability through the Department of Health to Ministers and to the local community.
1.3.2.8	CHAIR AND DIRECTORS	Declaration of conflict of interests.
1.3.2.9	BOARD	NHS Boards must comply with legislation and guidance issued by the Department of Health on behalf of the Secretary of State, respect agreements entered into by themselves or in on their behalf and establish terms and conditions of service that are fair to the staff and represent good value for taxpayers' money.

SCHEME OF DELEGATION FROM MODEL STANDING ORDERS

SO REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
1.1	CHAIRMAN	Final authority in interpretation of Standing Orders (SOs).
2.4	BOARD	Appointment of Vice Chairman
3.1	CHAIRMAN	Call meetings.
3.9	CHAIRMAN	Chair all Board meetings and associated responsibilities.
3.10	CHAIRMAN	Give final ruling in questions of order, relevancy and regularity of meetings.
3.12	CHAIRMAN	Having a second or casting vote
3.13	BOARD	Suspension of SOs
3.13	AUDIT COMMITTEE	Audit Committee to review every decision to suspend SOs (power to suspend SOs is reserved to the Board)
3.14	BOARD	*Variation or amendment of SOs*
4.1	BOARD	Formal delegation of powers to sub committees or joint committees and approval of their constitution and terms of reference. (Constitution and terms of reference of sub committees may be approved by the Chief Executive.)
5.2	CHAIRMAN & CHIEF EXECUTIVE	The powers which the Board has retained to itself within these SOs may in emergency be exercised by the Chair and Chief Executive after having consulted at least two Non-Executive members.
5.4	CHIEF EXECUTIVE	The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals that shall be considered and approved by the Board, subject to any amendment agreed during the discussion.
5.6	ALL	Disclosure of non-compliance with SOs to the Chief Executive as soon as possible.
7.1	THE BOARD	Declare relevant and material interests.
7.2	CHIEF EXECUTIVE	Maintain Register(s) of Interests.

SO REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
7.4.	ALL STAFF	Comply with national guidance contained in HSG 1993/5 “Standards of Business Conduct for NHS Staff” and the Seven Principles of Public Life as set out by the Nolan Committee
7.4	ALL	Disclose relationship between self and candidate for staff appointment. (CE to report the disclosure to the Board.)
8.1/8.3	CHIEF EXECUTIVE	Keep seal in safe place and maintain a register of sealing.
8.4	CHIEF EXECUTIVE/EXECUTIVE DIRECTOR	Approve and sign all documents which will be necessary in legal proceedings.

* Nominated officers and the areas for which they are responsible should be incorporated into the Trust’s Scheme of Delegation document.

SCHEME OF DELEGATION FROM MODEL STANDING FINANCIAL INSTRUCTIONS

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
10.1.3	CHIEF FINANCE OFFICER	Approval of all financial procedures.
10.1.4	CHIEF FINANCE OFFICER	Advice on interpretation or application of SFIs.
10.1.6	ALL MEMBERS OF THE BOARD AND EMPLOYEES	Have a duty to disclose any non-compliance with these Standing Financial Instructions to the Director of Performance and Finance as soon as possible.
10.2.4	CHIEF EXECUTIVE	Responsible as the Accountable Officer to ensure financial targets and obligations are met and have overall responsibility for the System of Internal Control.
10.2.4	CHIEF EXECUTIVE & CHIEF FINANCE OFFICER	Accountable for financial control but will, as far as possible, delegate their detailed responsibilities.
10.2.5	CHIEF EXECUTIVE	To ensure all Board members, officers and employees, present and future, are notified of and understand Standing Financial Instructions.
10.2.6	CHIEF FINANCE OFFICER	Responsible for: 1. Implementing the Trust's financial policies and co-ordinating corrective action; 2. Maintaining an effective system of financial control including ensuring detailed financial procedures and systems are prepared and documented; 3. Ensuring that sufficient records are maintained to explain Trust's transactions and financial position; 4. Providing financial advice to members of Board and staff; 5. Maintaining such accounts, certificates etc as are required for the Trust to carry out its statutory duties.
10.2.7	ALL MEMBERS OF THE BOARD AND EMPLOYEES	Responsible for security of the Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming to SOs, Financial Instructions and financial procedures.
10.2.8	CHIEF EXECUTIVE	Ensure that any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income are made aware of these instructions and their requirement to comply.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
11.1.1	AUDIT COMMITTEE	Provide independent and objective view on internal control and probity.
11.1.2	CHAIR	Raise the matter at the Board meeting where Audit Committee considers there is evidence of ultra vires transactions or improper acts.
11.1.3 & 11.2.1	CHIEF FINANCE OFFICER	Ensure an adequate internal audit service, for which he/she is accountable, is provided (and involve the Audit Committee in the selection process when/if an internal audit service provider is changed.)
11.2.1	CHIEF FINANCE OFFICER	Decide at what stage to involve police in cases of misappropriation and other irregularities not involving fraud or corruption.
11.3	HEAD OF INTERNAL AUDIT	Review, appraise and report in accordance with NHS Internal Audit Manual and best practice.
11.4	AUDIT COMMITTEE	Ensure cost-effective External Audit.
11.5	CHIEF EXECUTIVE & CHIEF FINANCE OFFICER	Monitor and ensure compliance with SofS Directions on fraud and corruption including the appointment of the Local Counter Fraud Specialist.
11.6	CHIEF EXECUTIVE	Monitor and ensure compliance with Directions issued by the Secretary of State for Health on NHS security management including appointment of the Local Security Management Specialist.
13.1.1	CHIEF EXECUTIVE	Compile and submit to the Board an Integrated Business Plan (IBP) which takes into account financial targets and forecast limits of available resources. The IBP will contain: • a statement of the significant assumptions on which the plan is based; • details of major changes in workload, delivery of services or resources required to achieve the plan.
13.1.2 & 13.1.3	CHIEF FINANCE OFFICER	Submit budgets to the Board for approval. Monitor performance against budget; submit to the Board financial estimates and forecasts.
13.1.6	CHIEF FINANCE OFFICER	Ensure adequate training is delivered on an on going basis to budget holders.
13.3.1	CHIEF EXECUTIVE	Delegate budget to budget holders.
13.3.2	CHIEF EXECUTIVE & BUDGET HOLDERS	Must not exceed the budgetary total or virement limits set by the Board.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
13.4.1	CHIEF FINANCE OFFICER	Devise and maintain systems of budgetary control.
13.4.2	BUDGET HOLDERS	Ensure that *a) no overspend or reduction of income that cannot be met from virement is incurred without prior consent of Board;* b) approved budget is not used for any other than specified purpose subject to rules of virement; c) no permanent employees are appointed without the approval of the CE other than those provided for within available resources and manpower establishment.
13.4.3	CHIEF EXECUTIVE	Identify and implement cost improvements and income generation activities in line with the LDP.
13.6.1	CHIEF EXECUTIVE	Submit monitoring returns
14.1	CHIEF FINANCE OFFICER	Preparation of annual accounts and reports.
15.1	CHIEF FINANCE OFFICER	Managing banking arrangements, including provision of banking services, operation of accounts, preparation of instructions and list of cheque signatories. (Board approves arrangements.)
16.	CHIEF FINANCE OFFICER	Income systems, including system design, prompt banking, review and approval of fees and charges, debt recovery arrangements, design and control of receipts, provision of adequate facilities and systems for employees whose duties include collecting or holding cash.
16.2.3	ALL EMPLOYEES	Duty to inform DoF of money due from transactions which they initiate/deal with.
17.	CHIEF EXECUTIVE	Tendering and contract procedure.
17.5.3	CHIEF EXECUTIVE/CHIEF FINANCE OFFICER	Waive formal tendering procedures.
17.5.3	CHIEF FINANCE OFFICER	Report waivers of tendering procedures to the Audit Committee
17.5.5	CHIEF FINANCE OFFICER	Where a supplier is chosen that is not on the approved list the reason shall be recorded in writing to the CE.
17.6.2	CHIEF EXECUTIVE	Responsible for the receipt, endorsement and safe custody of tenders received.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
17.6.3	CHIEF EXECUTIVE	Shall maintain a register to show each set of competitive tender invitations despatched.
17.6.4	CHIEF EXECUTIVE AND CHIEF FINANCE OFFICER	Where one tender is received will assess for value for money and fair price.
17.6.6	CHIEF EXECUTIVE	No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.
17.6.8	CHIEF EXECUTIVE	Will appoint a manager to maintain a list of approved firms.
17.6.9	CHIEF EXECUTIVE	Shall ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote.
17.7.2	CHIEF EXECUTIVE	The Chief Executive or his nominated officer should evaluate the quotation and select the quote which gives the best value for money.
17.7.4	CHIEF EXECUTIVE or CHIEF FINANCE OFFICER	No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.
17.10	CHIEF EXECUTIVE	The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.
17.10	BOARD	All PFI proposals must be agreed by the Board.
17.11	CHIEF EXECUTIVE	The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.
17.12	CHIEF EXECUTIVE	The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.
17.15	CHIEF EXECUTIVE	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.
17.15.5	CHIEF EXECUTIVE	The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
18.1.1	CHIEF EXECUTIVE	Must ensure the Trust enters into suitable Service Level Agreements (SLAs) with service commissioners for the provision of NHS services
18.3	CHIEF EXECUTIVE	As the Accountable Officer, ensure that regular reports are provided to the Board detailing actual and forecast income from the SLA
20.1.1	BOARD	Establish a Remuneration & Terms of Service Committee
20.1.2	REMUNERATION COMMITTEE	*Advise the Board on and make recommendations on the remuneration and terms of service of the CE, other officer members and senior employees to ensure they are fairly rewarded having proper regard to the Trust's circumstances and any national agreements;* *Monitor and evaluate the performance of individual senior employees;* Advise on and oversee appropriate contractual arrangements for such staff, including proper calculation and scrutiny of termination payments.
20.1.3	REMUNERATION COMMITTEE	Report in writing to the Board its advice and its bases about remuneration and terms of service of directors and senior employees.
20.1.4	BOARD	Approve proposals presented by the Chief Executive for setting of remuneration and conditions of service for those employees and officers not covered by the Remuneration Committee.
20.2.2	CHIEF EXECUTIVE	Approval of variation to funded establishment of any department.
20.3	CHIEF EXECUTIVE	Staff, including agency staff, appointments and re-grading.
20.4.1 and 20.4.2	CHIEF FINANCE OFFICER	Payroll: a) specifying timetables for submission of properly authorised time records and other notifications; b) final determination of pay and allowances; c) making payments on agreed dates; d) agreeing method of payment; e) issuing instructions (as listed in SFI 10.4.2).
20.4.3	NOMINATED MANAGERS*	Submit time records in line with timetable. **Complete time records and other notifications in required form.** Submitting termination forms in prescribed form and on time.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
20.4.4	CHIEF FINANCE OFFICER	*Ensure that the chosen method for payroll processing 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.*
20.5	NOMINATED MANAGER*	Ensure that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and Deal with variations to, or termination of, contracts of employment.
21.1	CHIEF EXECUTIVE	Determine, and set out, level of delegation of non-pay expenditure to budget managers, including a list of managers authorised to place requisitions, the maximum level of each requisition and the system for authorisation above that level. [It is good practice to append such lists to the Scheme of Delegation document.]
21.1.3	CHIEF EXECUTIVE	Set out procedures on the seeking of professional advice regarding the supply of goods and services.
21.2.1	REQUISITIONER*	In choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's adviser on supply shall be sought.
21.2.2	CHIEF FINANCE OFFICER	Shall be responsible for the prompt payment of accounts and claims.
21.2.3	CHIEF FINANCE OFFICER	a) Advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in SOs and regularly reviewed; b) Prepare procedural instructions [where not already provided in the Scheme of Delegation or procedure notes for budget holders] on the obtaining of goods, works and services incorporating the thresholds; c) Be responsible for the prompt payment of all properly authorised accounts and claims; d) Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable; e) A timetable and system for submission to the Chief Finance Officer of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment; f) Instructions to employees regarding the handling and payment of accounts within the Finance Department;

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
		g) Be responsible for ensuring that payment for goods and services is only made once the goods and services are received
21.2.4	APPROPRIATE EXECUTIVE DIRECTOR	Make a written case to support the need for a prepayment.
21.2.4	CHIEF FINANCE OFFICER	Approve proposed prepayment arrangements.
21.2.4	BUDGET HOLDER	Ensure that all items due under a prepayment contract are received (and immediately inform DoF if problems are encountered).
21.2.5	CHIEF EXECUTIVE	Authorise who may use and be issued with official orders.
21.2.6	MANAGERS AND OFFICERS	Ensure that they comply fully with the guidance and limits specified by the Chief Finance Officer.
21.2.7	CHIEF EXECUTIVE CHIEF FINANCE OFFICER	Ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within CONCODE and ESTATECODE. The technical audit of these contracts shall be the responsibility of the relevant Director.
21.3	CHIEF FINANCE OFFICER	Lay down procedures for payments to local authorities and voluntary organisations made under the powers of section 28A of the NHS Act.
22.1.1	CHIEF FINANCE OFFICER	The DoF will advise the Board on the Trust's ability to pay dividend on PBC and report, periodically, concerning the PDC debt and all loans and overdrafts.
22.1.2	BOARD	Approve a list of employees authorised to make short term borrowings on behalf of the Trust. (This must include the CE and DoF.)
22.1.3	CHIEF FINANCE OFFICER	Prepare detailed procedural instructions concerning applications for loans and overdrafts.
22.1.4	CHIEF EXECUTIVE OR CHIEF FINANCE OFFICER	Be on an authorising panel comprising one other member for short term borrowing approval.
22.2.2	CHIEF FINANCE OFFICER	Will advise the Board on investments and report, periodically, on performance of same.
22.2.3	CHIEF FINANCE OFFICER	Prepare detailed procedural instructions on the operation of investments held.
23	CHIEF FINANCE OFFICER	Ensure that Board members are aware of the Financial Framework and ensure compliance
24.1.1 & 2	CHIEF EXECUTIVE	Capital investment programme:

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
		a) ensure that there is adequate appraisal and approval process for determining capital expenditure priorities and the effect that each has on plans b) responsible for the management of capital schemes and for ensuring that they are delivered on time and within cost; c) ensure that capital investment is not undertaken without availability of resources to finance all revenue consequences; d) ensure that a business case is produced for each proposal.
24.1.2	CHIEF FINANCE OFFICER	Certify professionally the costs and revenue consequences detailed in the business case for capital investment.
24.1.3	CHIEF EXECUTIVE	Issue procedures for management of contracts involving stage payments.
24.1.4	CHIEF FINANCE OFFICER	Assess the requirement for the operation of the construction industry taxation deduction scheme.
24.1.5	CHIEF FINANCE OFFICER	Issue procedures for the regular reporting of expenditure and commitment against authorised capital expenditure.
24.1.6	CHIEF EXECUTIVE	Issue manager responsible for any capital scheme with authority to commit expenditure, authority to proceed to tender and approval to accept a successful tender. Issue a scheme of delegation for capital investment management.
24.1.7	CHIEF FINANCE OFFICER	Issue procedures governing financial management, including variation to contract, of capital investment projects and valuation for accounting purposes.
24.2.1	CHIEF FINANCE OFFICER	Demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.
24.2.1	BOARD	Proposal to use PFI must be specifically agreed by the Board.
24.3.1	CHIEF EXECUTIVE	Maintenance of asset registers (on advice from DoF).
24.3.5	CHIEF FINANCE OFFICER	Approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.
24.3.8	CHIEF FINANCE OFFICER	Calculate and pay capital charges in accordance with Department of Health requirements.
24.4.1	CHIEF EXECUTIVE	Overall responsibility for fixed assets.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
24.4.2	CHIEF FINANCE OFFICER	Approval of fixed asset control procedures.
24.4.4	BOARD, EXECUTIVE MEMBERS AND ALL SENIOR STAFF	Responsibility for security of Trust assets including notifying discrepancies to DoF, and reporting losses in accordance with Trust procedure.
25.2	CHIEF EXECUTIVE	Delegate overall responsibility for control of stores (subject to DoF responsibility for systems of control). Further delegation for day-to-day responsibility subject to such delegation being recorded. (Good practice to append to the scheme of delegation document.)
25.2	CHIEF FINANCE OFFICER	Responsible for systems of control over stores and receipt of goods.
25.2	DESIGNATED PHARMACEUTICAL OFFICER	Responsible for controls of pharmaceutical stocks
25.2	DESIGNATED ESTATES OFFICER	Responsible for control of stocks of fuel oil and coal.
25.2	NOMINATED OFFICERS*	*Security arrangements and custody of keys*
25.2	CHIEF FINANCE OFFICER	Set out procedures and systems to regulate the stores.
25.2	CHIEF FINANCE OFFICER	Agree stocktaking arrangements.
25.2	CHIEF FINANCE OFFICER	Approve alternative arrangements where a complete system of stores control is not justified.
25.2	CHIEF FINANCE OFFICER	Approve system for review of slow moving and obsolete items and for condemnation, disposal and replacement of all unserviceable items.
25.2	NOMINATED OFFICERS*	Operate system for slow moving and obsolete stock, and report to DoF evidence of significant overstocking.
25.3.1	CHIEF EXECUTIVE	Identify persons authorised to requisition and accept goods from NHS Supplies stores.
26.1.1	CHIEF FINANCE OFFICER	Prepare detailed procedures for disposal of assets including condemnations and ensure that these are notified to managers.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
26.2.1	CHIEF FINANCE OFFICER	Prepare procedures for recording and accounting for losses, special payments and informing police in cases of suspected arson or theft.
26.2.2	ALL STAFF	Discovery or suspicion of loss of any kind must be reported immediately to either head of department or nominated officer. The head of department / nominated officer should then inform the CE and DoF.
26.2.2	CHIEF FINANCE OFFICER	Where a criminal offence is suspected, DoF must inform the police if theft or arson is involved. In cases of fraud and corruption DoF must inform the relevant LCFS and CFSMS Regional Team in line with SoS directions.
26.2.2	CHIEF FINANCE OFFICER	Notify CFSMS and External Audit of all frauds.
26.2.3	CHIEF FINANCE OFFICER	Notify Board and External Auditor of losses caused theft, arson, neglect of duty or gross carelessness (unless trivial).
26.2.4	AUDIT COMMITTEE	Approve write off of losses (within limits delegated by DH).
26.2.6	CHIEF FINANCE OFFICER	Consider whether any insurance claim can be made.
26.2.7	CHIEF FINANCE OFFICER	Maintain losses and special payments register.
27.1	CHIEF FINANCE OFFICER	Responsible for accuracy and security of computerised financial data.
27.1	CHIEF FINANCE OFFICER	Satisfy himself that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation assurances of adequacy must be obtained from them prior to implementation.
27.1.3	DIRECTOR OF INFORMATION	Shall publish and maintain a Freedom of Information Scheme.
27.2.1	RELEVANT OFFICERS	Send proposals for general computer systems to DoF
27.3	CHIEF FINANCE OFFICER	*Ensure that contracts with other bodies for the provision of computer services for financial applications clearly define responsibility of all parties for security, privacy, accuracy, completeness and timeliness of data during processing, transmission and storage, and allow for audit review.* Seek periodic assurances from the provider that adequate controls are in operation.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
27.4	CHIEF FINANCE OFFICER	*Ensure that risks to the Trust from use of IT are identified and considered and that disaster recovery plans are in place.*
27.5	CHIEF FINANCE OFFICER	Where computer systems have an impact on corporate financial systems satisfy himself that: a) systems acquisition, development and maintenance are in line with corporate policies; b) data assembled for processing by financial systems is adequate, accurate, complete and timely, and that a management rail exists; c) DoF and staff have access to such data; Such computer audit reviews are being carried out as are considered necessary.
28.2	CHIEF EXECUTIVE	Responsible for ensuring patients and guardians are informed about patients' money and property procedures on admission.
28.3	CHIEF FINANCE OFFICER	Provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of.
28.6	DEPARTMENTAL MANAGERS	Inform staff of their responsibilities and duties for the administration of the property of patients.
29.1	CHIEF FINANCE OFFICER	Shall ensure that each trust fund which the Trust is responsible for managing is managed appropriately.
30	CHIEF FINANCE OFFICER	Ensure all staff are made aware of the Trust policy on the acceptance of gifts and other benefits in kind by staff
32	CHIEF EXECUTIVE	Retention of document procedures in accordance with HSC 1999/053.
33.1	CHIEF EXECUTIVE	Risk management programme.
33.1	BOARD	Approve and monitor risk management programme.
33.2	BOARD	Decide whether the Trust will use the risk pooling schemes administered by the NHS Litigation Authority or self-insure for some or all of the risks (where discretion is allowed). Decisions to self-insure should be reviewed annually.
33.4	CHIEF FINANCE OFFICER	Where the Board decides to use the risk pooling schemes administered by the NHS Litigation Authority the Chief Finance Officer shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Chief Finance Officer shall ensure that

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
		documented procedures cover these arrangements. Where the Board decides not to use the risk pooling schemes administered by the NHS Litigation Authority for any one or other of the risks covered by the schemes, the Chief Finance Officer shall ensure that the Board is informed of the nature and extent of the risks that are self insured as a result of this decision. The Chief Finance Officer will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses that will not be reimbursed.
33.4	CHIEF FINANCE OFFICER	Ensure documented procedures cover management of claims and payments below the deductible.

- Nominated officers and the areas for which they are responsible should be incorporated into the Trust's Scheme of Delegation document.

DELEGATED MATTER	AUTHORITY RELATED TO
Requisitioning, Ordering and Paying for Revenue Goods and Services	
Non Pay Expenditure which has been budgeted	
All invoices /requisitions up to £5,000	Service Manager/Budget Holder
All invoices /requisitions up to £10,000	Head of Services
All invoices /requisitions up to £20,000	Director of Operations
All invoices /requisitions up to£50,000	Director

SECTION D - STANDING FINANCIAL INSTRUCTIONS

10. INTRODUCTION

10.1 General

10.1.1 These Standing Financial Instructions (SFIs) are issued in accordance with the Trust (Functions) Directions 2000 issued by the Secretary of State which require that each Trust shall agree Standing Financial Instructions for the regulation of the conduct of its members and officers in relation to all financial matters with which they are concerned. They shall have effect as if incorporated in the Standing Orders (SOs).

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

10.1.3 These Standing Financial Instructions identify the financial responsibilities which apply to everyone working for the Trust and its constituent organisations including Trading Units. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial procedure notes. All financial procedures must be approved by the Chief Finance Officer.

10.1.4 Should any difficulties arise regarding the interpretation or application of any of the Standing Financial Instructions then the advice of the Chief Finance Officer must be sought before acting. The user of these Standing Financial Instructions should also be familiar with and comply with the provisions of the Trust's Standing Orders.

10.1.5 **The failure to comply with Standing Financial Instructions and Standing Orders can in certain circumstances be regarded as a disciplinary matter that could result in dismissal.**

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

10.2 Responsibilities and delegation

10.2.1 **The Trust Board**

The Board exercises financial supervision and control by:

(a) formulating the financial strategy;

(b) requiring the submission and approval of budgets within approved allocations/overall income;

(c) and defining and approving essential features in respect of important procedures financial systems (including the need to obtain value for money);

(d) defining specific responsibilities placed on members of the Board and employees as indicated in the Scheme of Delegation document.

10.2.2 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the 'Reservation of Matters Reserved to the Board' document. All other powers have been delegated to such other committees as the Trust has established.

10.2.4 **The Chief Executive and Chief Finance Officer**

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

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

10.2.5 It is a duty of the Chief Executive to ensure that Members of the Board and, employees and all new appointees are notified of, and put in a position to understand their responsibilities within these Instructions.

10.2.6 **The Chief Finance Officer**

The Chief Finance Officer is responsible for:

(a) implementing the Trust's financial policies and for coordinating any corrective action necessary to further these policies;

(b) maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

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

and, without prejudice to any other functions of the Trust, and employees of the Trust, the duties of the Chief Finance Officer include:

(d) the provision of financial advice to other members of the Board and employees;

(e) the design, implementation and supervision of systems of internal financial control;

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

10.2.7 **Board Members and Employees**

All members of the Board and employees, severally and collectively, are responsible for:

(a) the security of the property of the Trust;

(b) avoiding loss;

(c) exercising economy and efficiency in the use of resources;

(d) conforming with the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation.

10.2.8 **Contractors and their employees**

Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

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

11. AUDIT

11.1 Audit Committee

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

(a) overseeing Internal and External Audit services;

(b) reviewing financial and information systems and monitoring the integrity of the financial statements and reviewing significant financial reporting judgments;

(c) ensure the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives;

(d) monitoring compliance with Standing Orders and Standing Financial Instructions;

(e) reviewing schedules of losses and compensations and making recommendations to the Board;

(f) reviewing schedules of debtors/creditors balances over 6 months and £5,000 old and explanations/action plans;

(g) Reviewing the arrangements in place to support the Assurance Framework process prepared on behalf of the Board and advising the Board accordingly.

11.1.2 Where the Audit Committee considers there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Committee wishes to raise, the Chairman of the Audit Committee should raise the matter at a full meeting of the Board. Exceptionally, the matter may need to be

referred to the Department of Health. (To the Chief Finance Officer in the first instance.)

11.1.3 It is the responsibility of the Chief Finance Officer to ensure an adequate Internal Audit service is provided and the Audit Committee shall be involved in the selection process when/if an Internal Audit service provider is changed.

11.2 Chief Finance Officer

11.2.1 The Chief Finance Officer is responsible for:

(a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective Internal Audit function;

(b) ensuring that the Internal Audit is adequate and meets the NHS mandatory audit standards;

(c) deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption;

(e) ensuring that an annual internal audit report is prepared for the consideration of the Audit Committee [and the Board]. The report should cover:

(i) a clear opinion on the effectiveness of internal control in accordance with current assurance framework guidance issued by the Department of Health including for example compliance with control criteria and standards;
(ii) major internal financial control weaknesses discovered;
(iii) progress on the implementation of internal audit recommendations;
(iv) progress against plan over the previous year;
(v) strategic audit plan covering the coming three years;
(vi) a detailed plan for the coming year.

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

(a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

(b) access at all reasonable times to any land, premises or members of the Board or employee of the Trust;

(c) the production of any cash, stores or other property of the Trust under a member of the Board and an employee's control; and

(d) explanations concerning any matter under investigation.

11.3 Role of Internal Audit

11.3.1 Internal Audit will review, appraise and report upon:

(a) the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;

(b) the adequacy and application of financial and other related management controls;

(c) the suitability of financial and other related management data;

(d) the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

(i) fraud and other offences;
(ii) waste, extravagance, inefficient administration;
(iii) poor value for money or other causes.

(e) Internal Audit shall also independently verify the Assurance Statements in accordance with guidance from the Department of Health.

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

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

11.3.4 The Chief Internal Auditor shall be accountable to the Chief Finance Officer. The reporting system for internal audit shall be agreed between the Chief Finance Officer, the Audit Committee and the Chief Internal Auditor. The agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Internal Audit Standards. The reporting system shall be reviewed at least every three years.

11.4 External Audit

11.4.1 From December 2016, the Trust Board, on recommendation of the Auditor Panel, will appoint the external auditor, external audit fees shall be paid for by the Trust. The Audit Committee must ensure a cost efficient service. If there are any problems relating to the service provided by the External Auditor, then this should be raised with the External Auditor and referred on to the National Audit Office if the issue cannot be resolved.

11.5 Fraud and Corruption

11.5.1 In line with their responsibilities, the Trust Chief Executive and Director of Finance shall monitor and ensure compliance with Directions issued by the Secretary of State for Health on fraud and corruption.

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

11.5.3 The Local Counter Fraud Specialist shall report to the Trust Director of Finance and shall work with staff in the Regional Counter Fraud and Security Management Services (CFSMS) in accordance with the Department of Health Fraud and Corruption Manual.

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

11.6 Security Management

11.6.1 In line with their responsibilities, the Trust Chief Executive will monitor and ensure compliance with Directions issued by the Secretary of State for Health on NHS security management.

11.6.2 The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS) as specified by the Secretary of State for Health guidance on NHS security management.

11.6.3 The Trust shall nominate a Non-Executive Director to be responsible to the Board for NHS security management.

11.6.4 The Chief Executive has overall responsibility for controlling and coordinating security. However, key tasks are delegated to the Security Management Director (SMD) and the appointed Local Security Management Specialist (LSMS).

12. RESOURCE LIMIT CONTROL

Not applicable to NHS Trusts.

13. ALLOCATIONS, PLANNING, BUDGETS, BUDGETARY CONTROL, AND MONITORING

13.1 Preparation and Approval of Plans and Budgets

13.1.1 The Chief Executive will compile and submit to the Board a Business Plan which takes into account financial targets and forecast limits of available resources. The Business Plan will contain:

(a) a statement of the significant assumptions on which the plan is based;

(b) details of major changes in workload, delivery of services or resources required to achieve the plan.

13.1.2 As soon as possible at the start of the financial year the Chief Finance Officer will, on behalf of the Chief Executive, prepare and submit a corporate budget for approval by the Board. As soon as practicable at the beginning of the financial year detailed budgets will be agreed with directors and submitted for to the Board for approval. Such budgets will:

(a) be in accordance with the aims and objectives set out in the Local Delivery Plan;

(b) accord with workload and manpower plans;

(c) be produced following discussion with appropriate budget holders;

(d) be prepared within the limits of available funds;

(e) identify potential risks.

13.1.3 The Chief Finance Officer shall monitor financial performance against budget and plan, periodically review them, and report to the Board.

13.1.4 All budget holders must provide information as required by the Chief Finance Officer to enable budgets to be compiled.

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

13.1.6 The Chief Finance Officer has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage successfully.

13.2 Budgetary Delegation

13.3.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

(a) the amount of the budget;
(b) the purpose(s) of each budget heading;
(c) individual and group responsibilities;
(d) authority to exercise virement;
(e) achievement of planned levels of service;
(f) the provision of regular reports.

13.2.2 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board. In circumstances where revenue expenditure proposals cannot be contained within existing budgetary provision and insufficient virements are available, the investment template requires completion and submitted to the Executive Committee for scrutiny. Any decision to incur unfunded pressures may only be taken by the Chief Executive with reporting to the Trust Board for information, as part of the Finance Report.

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

13.2.4 Non-recurring budgets should not be used to finance recurring expenditure without the agreement of the agreement of the Chief Executive as advised by the Chief Finance Officer.

13.2.5 Investment/cost pressure requests, other than for replacement capital expenditure schemes e.g. backlog maintenance require completion of the investment template prior to submission to the Divisional Management Teams or Corporate Department and subsequently to the Operations Senior Management Team in the case of Operational Divisions Templates require validation by the relevant Finance Manager before submission. Schemes that are anticipated to be self-financing through either income or savings are still required to submit cases. The Divisional Team and Senior Management Team may support the submission and can agree self-financing proposals. Proposals which generate a cost pressure will require the additional approval of the Executive Committee and Chief Executive before there is authority to proceed.

13.2.6 Capital schemes which are developments will also require the approval of the Capital Monitoring group, prior to obtaining authorisation from the Executive Committee. The revenue consequences of these schemes must also follow the process outlined in 13.2.5.

13.3 Budgetary Control and Reporting

13.3.1 The Chief Finance Officer will devise and maintain systems of budgetary control. These will include:

(a) monthly financial reports to the Board in a form approved by the Board containing:

(i) income and expenditure to date showing trends and forecast year-end position;

(ii) movements in working capital;

(iii) Movements in cash and capital;

(iv) capital project spend and projected outturn against plan;

(v) explanations of any material variances from plan;

(vi) details of any corrective action where necessary and the Chief Executive's and/or Chief Finance Officer's view of whether such actions are sufficient to correct the situation;

(b) the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

(c) investigation and reporting of variances from financial, workload and manpower budgets;

(d) monitoring of management action to correct variances; and

(e) arrangements for the authorisation of budget transfers.

13.3.2 Each Budget Holder is responsible for ensuring that:

(a) any likely overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of theChief Executive and that the template process for submission to Executive Committee is followed;

(b) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement;

(c) no permanent employees are appointed without the approval of the Chief Executive other than those provided for within the available resources and manpower establishment as approved by the Board.

13.3.3 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Operating Framework and a balanced budget.

13.4 Capital Expenditure

13.4.1 The general rules applying to delegation and reporting shall also apply to capital expenditure. (The particular applications relating to capital are contained in SFI 24).

13.5 Monitoring Returns

13.5.1 The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to the requisite monitoring organisation.

14. ANNUAL ACCOUNTS AND REPORTS

14.1 The Chief Finance Officer, on behalf of the Trust, will:

(a) prepare financial returns in accordance with the accounting policies and guidance given by the Department of Health and the Treasury, the Trust's accounting policies, and generally accepted accounting practice;

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

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

14.2 The Trust's annual accounts must be audited by an auditor appointed by the Audit Commission. The Trust's audited annual accounts must be presented to a public meeting and made available to the public.

14.3 The Trust will publish an annual report, in accordance with guidelines on local accountability, and present it at a public meeting. The document will comply with the Department of Health's Manual for Accounts.

15. COMMERCIAL AND GBS BANK ACCOUNTS

15.1 General

15.1.1 The Chief Finance Officer is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account guidance/directions issued from time to time by the Department of Health. In line with 'Cash Management in the NHS' Trusts should minimize the use of commercial bank accounts and consider using Government Banking Service (GBS) accounts for all banking services.

15.1.2 The Board shall approve the banking arrangements.

15.2 Commercial and GBS Accounts

15.2.1 The Chief Finance Officer is responsible for:

(a) Lloyds accounts and Government Banking Services (GBS) accounts, the latter comprising Citibank and NatWest/Royal Bank of Scotland (RBS) accounts;

(b) establishing separate bank accounts for the Trust's non-exchequer funds;

(c) ensuring that payments made from Lloyds, Citibank or NatWest/RBS accounts do not exceed the amount credited to the accounts except where arrangements have been made;

(d) reporting to the Board all arrangements made with the Trust's bankers for accounts to be overdrawn.

(e) monitoring compliance with DH guidance on the level of cleared funds.

15.3 Banking Procedures

15.3.1 The Chief Finance Officer will prepare detailed instructions on the operation of Lloyds and GBS accounts which must include:

(a) the conditions under which each bank account is to be operated;

(b) those authorised to sign cheques or other orders drawn on the Trust's accounts.

15.3.2 The Chief Finance Officer must advise the Trust's bankers in writing of the conditions under which each account will be operated.

15.4 Tendering and Review

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

15.4.2 Competitive tenders should be sought at least every five years. The results of the tendering exercise should be reported to the Board. This review is not necessary for GBS accounts.

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

16.1 Income Systems

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

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

16.2 Fees and Charges

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

16.2.2 The Chief Finance Officer is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health 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's Commercial Sponsorship – Ethical standards in the NHS shall be followed.

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

16.3 Debt Recovery

16.3.1 The Chief Finance Officer is responsible for the appropriate recovery action on all outstanding debts.

16.3.2 Income not received should be dealt with in accordance with losses procedures.

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

16.4 Security of Cash, Cheques and other Negotiable Instruments

16.4.1 The Chief Finance Officer is responsible for:

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

(d) prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

16.4.2 Official money shall not under any circumstances be used for the encashment of private cheques or IOUs.

16.4.3 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Chief Finance Officer.

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

17. TENDERING AND CONTRACTING PROCEDURE

17.1 Duty to comply with Standing Orders and Standing Financial Instructions

The procedure for making all contracts by or on behalf of the Trust shall comply with these Standing Orders and Standing Financial Instructions (except where Standing Order No. 3.13 Suspension of Standing Orders is applied).

17.2 EU Directives Governing Public Procurement

Directives by the Council of the European Union promulgated by the Department of Health (DH) prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in these Standing Orders and Standing Financial Instructions.

17.3 Reverse eAuctions

Prior to running Reverse eAuctions the Trust should have policies and procedures in place for the control of all tendering activity carried out through Reverse eAuctions. A decision to run reverse eAuctions will lie with the procurement department and is covered within the trust Contracts and Purchasing Procedures Document.

17.4 Capital Investment Manual and other Department of Health Guidance

The Trust shall comply as far as is practicable with the requirements of the Department of Health "Capital Investment Manual" in respect of capital investment and estate and property transactions.

17.5 Formal Competitive Tendering

17.5.1 General Applicability

The Trust shall ensure that competitive tenders are invited for:

- the supply of goods, materials and manufactured articles;
- the rendering of services including all forms service contracts and management consultancy services temporary staffing whether through a temporary staff agency or directly contracted and management consultancy services (other than specialised services sought from or provided by the DH);
- For the design, construction and maintenance of building and engineering
- works (including construction and maintenance of grounds and gardens); for disposals.

THRESHOLDS	
Supplies & Services	
1 quote	1 quote minimum up to £5,000
3 quotes	3 quotes minimum £5,001 to £50,000
Tender process £ or More Written Tenders	From £50,001 to OJEU Limit
Works	
1 quote	**1 quote minimum up to £10,000**
3 quotes	**3 quotes minimum £10,001 to £50,000**
Tender Process 4 Tenders	**Minimum 4 tenders** received for works/estates £50,001 to £500,409
Tender Process 5 Tenders	**Minimum 5 tenders** received for works/estates £500,410 to OJEU Limit
Tender process >OJEU Limit	Tender Process European procurement requirements adhered to. ie advert in OJEU and formal tender.

17.5.2 **Health Care Services**

Where the Trust elects to invite tenders for the supply of healthcare services these Standing Orders and Standing Financial Instructions shall apply as far as they are applicable to the tendering procedure and need to be read in conjunction with Standing Financial Instruction No. 18 and No. 19.

17.5.3 **Exceptions and instances where formal tendering need not be applied**

Formal tendering procedures **need not be applied** where:

(a) the estimated expenditure or income does not, or is not reasonably expected to, exceed **£50,000**;

(b) where the supply of goods and services/works is proposed under framework agreements to which the Trust has access, the requirement to tender is not applied provided that either a mini competition of prices is permissable or that a direct award would, following proof, deliver value for money. In the event that neither of these options is available then a framework agreement should not be used. The framework agreements include but not limited to, those negotiated by the Government Procurement Service, NHS Logistics, London Procurement Partnership (LPP), Health Trust Europe, Shared Business Services and Eastern Shires Purchasing Organisation.

These frameworks include the following options:

I. award direct;
II. undertake a mini competition.

The Trust policy is to maximise the use of framework agreements where they directly correspond with the Trust's requirements. It is also Trust policy to undertake a further mini competition, where this option is available from a framework agreement, to ensure that value for money is obtained. If however, there is compelling financial and technical evidence that awarding direct to a contractor chosen would provide value for money without undertaking further competition, then a direct award is permissible by Trust persons with the appropriate financial delegation covering the total value of the contract for the full contract term.

(c) regarding disposals as set out in Standing Financial Instructions No. 25;

17.5.4 **Formal tendering procedures <u>may be waived</u> in the following circumstances:**

(a) where the Chief Executive or Chief Finance Officer decides that formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures, and the circumstances are detailed in an appropriate Trust record;

(b) where framework agreements are in place (see (b) above;

(c) 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;

(d) where the timescale genuinely precludes competitive tendering but failure to plan the work properly would not be regarded as a justification for a single tender;

(e) where specialist expertise is required and is available from only one source;

(f) 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;

(g) 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;

(h) where specialist expertise is required and is available from only one source;

(i) where allowed and provided for in the Capital Investment Manual.

The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.

Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded in an appropriate Trust record and reported to the Audit Committee at each meeting.

. An Application to waive Standing Financial Instructions must be completed in all instances.

17.5.5 **Fair and Adequate Competition**

Where the exceptions set out in SFI Nos. 17.1 and 17.5.3 apply, the Trust shall ensure that invitations to tender are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate, and in no case less than two firms/individuals, having regard to their capacity to supply the goods or materials or to undertake the services or works required.

17.5.6 **List of Approved Firms**

The Trust shall ensure that the firms/individuals invited to tender (and where appropriate, quote) are among those on approved lists. The list of suppliers established on the Electronic Requisitioning and Ordering System (EROS) shall constitute the approved list. Where in the opinion of the Chief Finance Officer it is desirable to seek tenders from firms not on the approved lists, the reason shall be recorded in writing to the Chief Executive (see SFI 17.6.8 List of Approved Firms).

17.5.7 **Building and Engineering Construction Works**

Competitive Tendering cannot be waived for building and engineering construction works and maintenance (other than in accordance with Concode) without Departmental of Health approval.

17.5.8 **Items which subsequently breach thresholds after original approval**

Items estimated to be below the limits set in this Standing Financial Instruction for which formal tendering procedures are not used which subsequently prove to have a value above such limits shall be reported to the Chief Executive, and be recorded in an appropriate Trust record.

17.6 Contracting/Tendering Procedure

17.6.1 **Invitation to tender**

(i) All tenders shall be run through the Trust's electronic tendering system operated by the Procurement Department in accordance with the guidance set out in section 2.9 and section 4 of the Trust Purchasing and Contracts Procedures. The Trust's system provides an electronic governance framework that ensures a record is kept of tender issue and return date, opening procedures and executives involved in opening, all documents, forms and terms and conditions used in the tender, a record of all written queries and trust responses, and notification to successful and unsuccessful tenderers.

(ii) Every tender for goods, materials, services, contracts or disposals shall embody such of the NHS Standard Contract Conditions as are applicable.

(iii) Every tender for building or engineering works except those let under P21 or PFI governance shall embody or be in the terms of the current edition of one of the Joint Contracts Tribunal Standard Forms of Building Contract or Department of the Environment (GC/Wks) Standard forms of contract amended to comply with concode; or, when the content of the work is primarily engineering, the General Conditions of Contract recommended by the Institution of Mechanical and Electrical Engineers and the Association of Consulting Engineers (Form A), or (in the case of civil engineering work) the General Conditions of Contract recommended by the Institute of Civil Engineers, the Association of Consulting Engineers and the Federation of

Civil Engineering Contractors. These documents shall be modified and/or amplified to accord with Department of Health guidance and, in minor respects, to cover special features of individual projects.

17.6.2 **Opening tenders and Register of tenders**

(i) As soon as practicable after the date and time stated as being the latest time for the receipt of tenders, they shall be opened by two executive directors designated by the Chief Executive.

(ii) Two members of the trust executive committee will be required to open all tenders. The rules relating to the opening of tenders will need to be read in conjunction with any delegated authority set out in the Trust's Scheme of Delegation.

The Trust's Company Secretary will count as a Director for the purposes of opening tenders.

(iii) 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 his 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. (Standing Order No. 17.6.5 below).

17.6.3 **Admissibility**

i) 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.

(ii) Where only one tender is sought and/or received, the Chief Executive and Chief Finance Officer shall, as far practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Trust.

17.6.4 **Late tenders**

(i) The eTendering system prevents the submission of late tenders and there are no circumstances in which the controls can be over ridden.

(ii) 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 his nominated officer.

17.6.5 **Acceptance of formal tenders (See overlap with SFI No. 17.7)**

(i) Any discussions with a tenderer which are deemed necessary to clarify technical aspects of his tender before the award of a contract will not disqualify the tender.

(ii) The lowest tender, if payment is to be made by the Trust, or the highest, if payment is to be received by the Trust, shall be accepted unless there are good and sufficient reasons to the contrary. Such reasons shall be set out in either the contract file, or other appropriate record.

It is accepted that for professional services such as management consultancy, the lowest price does not always represent the best value for money. Other factors affecting the success of a project include:

(a) experience and qualifications of team members;

(b) understanding of client's needs;

(c) feasibility and credibility of proposed approach;

(d) ability to complete the project on time.

Where other factors are taken into account in selecting a tenderer, these must be clearly recorded and documented in the contract file, and the reason(s) for not accepting the lowest tender clearly stated.

(iii) No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.

(iv) The use of these procedures must demonstrate that the award of the contract was:

(a) not in excess of the going market rate / price current at the time the contract was awarded;

(b) that best value for money was achieved.

(v) All tenders should be treated as confidential and should be retained for inspection.

17.6.6 **Tender reports to the Trust Board**

Reports to the Trust Board will be made on an exceptional circumstance basis only.

17.6.7 **List of approved firms (see SFI No. 17.5.5)**

(a) **Responsibility for maintaining list**

Only companies set up on eProcurement can be used by the trust. Companies not on eProc may be added after due diligence has established their technical and financial competence. Technical competence shall be assessed by the Procurement Department in association with nominated trust officers. A finance officer nominated by the Director of Finance shall assess financial competence. The status of all suppliers will be reviewed regularly and those who fail the re-assessment or who have not been used in the relevant period for the type of procurement will be removed from the database.

All suppliers must be made aware of the Trust's terms and conditions of contract.

(b) **Building and Engineering Construction Works**

(i) Invitations to tender shall be made only to firms included on the approved list of tenderers..

ii) Firms included on the approved list of tenderers shall ensure that when engaging, training, promoting or dismissing employees or in any conditions of employment, shall not discriminate against any person because of colour, race, ethnic or national origins, religion or sex, and will comply with the provisions of the Equal Pay Act 1970, the Sex Discrimination Act 1975, the Race Relations Act 1976, and the Disabled Persons (Employment) Act 1944 and any amending and/or related legislation.

iii) Firms shall conform at least with the requirements of the Health and Safety at Work Act and any amending and/or other related legislation concerned with the health, safety and welfare of workers and other persons, and to any relevant British Standard Code of Practice issued by the British Standard Institution. Firms must provide to the appropriate manager a copy of its safety policy and evidence of the safety of plant and equipment, when requested.

(c) **Financial Standing and Technical Competence of Contractors**

The Chief Finance Officer may make or institute any enquiries he deems appropriate concerning the financial standing and financial suitability of approved contractors. The Director with lead responsibility for clinical governance will similarly make such enquiries as is felt appropriate to be satisfied as to their technical / medical competence.

17.6.8 **Exceptions to using approved contractors**

If in the opinion of the Chief Executive and the Chief Finance Officer or the Director with lead responsibility for clinical governance it is impractical to use a potential contractor from the list of approved firms/individuals (for example where specialist services or skills are required and there are insufficient suitable potential contractors on the list), or where a list for whatever reason has not been prepared, the Chief Executive should ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote.

An appropriate record in the contract file should be made of the reasons for inviting a tender or quote other than from an approved list.

17.7 Quotations: Competitive and non-competitive

17.7.1 **General Position on quotations**

One quotation is required for the initial purchase of items expected to cost up to £5,000. Competitive quotations are required where formal tendering procedures are not adopted and where the intended expenditure or income exceeds, or is reasonably expected to exceed £5,000 but not exceed £50,000.

17.7.2 **Competitive Quotations**

(i) Quotations shall be sought in accordance with the Request for Quotation Procedure set out in the Purchasing and Contracts Procedures and should be obtained from at least 3 firms/individuals based on specifications or terms of reference prepared by, or on behalf of, the Trust.

(ii) Quotations should be in writing unless the Chief Executive or his nominated officer determines that it is impractical to do so in which case quotations may be obtained by telephone. Confirmation of telephone quotations should be obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in a permanent record.

(iii) All quotations should be treated as confidential and should be retained for inspection.

(iv) The Chief Executive or his nominated officer should evaluate the quotation and select the quote which gives the best value for money. If this is not the lowest quotation if payment is to be made by the Trust, or the highest if payment is to be received by the Trust, then the choice made and the reasons why should be recorded in a permanent record.

v) In the event that the Trust introduces a formal quotation tool then this method will be the authorised channel for obtaining quotations.

17.7.3 **Non-Competitive Quotations**

Non-competitive quotations in writing may be obtained in the following circumstances:

(i) the supply of proprietary or other goods of a special character and the rendering of services of a special character, for which it is not, in the opinion of the responsible officer, possible or desirable to obtain competitive quotations. This assessment should be supported by an opinion obtained from the Procurement Department

(ii) the supply of goods or manufactured articles of any kind which are required quickly and are not obtainable under existing contracts;

(iii) miscellaneous services, supplies and disposals;

(iv) where the goods or services are for building and engineering maintenance the responsible works manager must certify that the first two conditions of this SFI (i.e.: (i) and (ii) of this SFI) apply.

(v) Business Planning Group to recommend to Chief Executive/Chief Finance Officer whether or not to accept a non-competitive quote.

17.7.4 **Quotations to be within Financial Limits**

No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with Standing Financial Instructions except with the authorisation of either the Chief Executive or Chief Finance Officer.

17.8 Authorisation of Tenders and Competitive Quotations

Providing all the conditions and circumstances set out in these Standing Financial Instructions have been fully complied with, formal authorisation and awarding of a contract will be decided according to the scheme of delegation which may be varied or changed by the Trust Board. Current levels of authorisation are set out in the Contracts and Purchasing Procedures document which is an appendix to this document.

Formal authorisation must be put in writing. In the case of authorisation by the Trust Board this shall be recorded in the minutes.

17.9 Private Finance for capital procurement (see overlap with SFI No. 24)

The Trust should normally market-test for PFI (Private Finance Initiative funding) when considering a capital procurement. When the Board proposes, or is required, to use finance provided by the private sector the following should apply:

(a) The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.

(b) Where the sum exceeds delegated limits, a business case must be referred to the appropriate Department of Health for approval or treated as per current guidelines.

(c) The proposal must be specifically agreed by the Board of the Trust.

(d) The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

17.10 Compliance requirements for all contracts

The Board may only enter into contracts on behalf of the Trust within the statutory powers delegated to it by the Secretary of State and shall comply with:

(a) The Trust's Standing Orders and Standing Financial Instructions;

(b) EU Directives and other statutory provisions;

(c) any relevant directions including the capital investment guidelines

(d) such of the NHS Standard Contract Conditions as are applicable.

(e) contracts with Foundation Trusts must be in a form compliant with appropriate NHS guidance.

(f) Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited.

(g) In all contracts made by the Trust, the Board shall endeavour to obtain best value for money by use of all systems in place. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.

17.11 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.

The Director of Human Resources is responsible for ensuring the trust has robust procedures covering engagement of agency staff and for entering into appropriate and robust agreements with agencies through national framework agreements or exception circumstances directly. In all cases the rules of competition as set out by this instruction (SFI 17) must be adhered to.

17.12 Healthcare Services Agreements (see overlap with SFI No. 18)

Service agreements with NHS providers for the supply of healthcare services shall be drawn up in accordance with the NHS and Community Care Act 1990 and administered by the Trust. Service agreements are not contracts in law and therefore not enforceable by the courts. However, a contract with a Foundation Trust, being a PBC, 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.

17.13 Disposals (See overlap with SFI No. 26)

Competitive Tendering or Quotation procedures shall not apply to the disposal of:

(a) any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or his nominated officer;

(b) obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Trust;

(c) items to be disposed of with an estimated sale value of less than £30k, this figure to be reviewed on a periodic basis;

(d) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;

(e) land or buildings concerning which DH guidance has been issued but subject to compliance with such guidance.

17.14 In-house Services

17.14.1 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Trust may also determine from time to time that in-house services should be market tested by competitive tendering.

17.14.2 In all cases where the Board determines that in-house services should be subject to competitive tendering the following groups shall be set up:

(a) Specification group, comprising the Chief Executive or nominated officer/s and specialist.

(b) In-house tender group, comprising a nominee of the Chief Executive and technical support.

(c) Evaluation team, comprising normally a specialist officer, a supplies officer and a Chief Finance Officer representative. For services having a likely annual expenditure exceeding a sum to be determined in each case, a non-officer member should be a member of the evaluation team.

17.14.3 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.

17.14.4 The evaluation team shall make recommendations to the Board.

17.14.5 The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.

17.15 Applicability of SFIs on Tendering and Contracting to funds held in trust (see overlap with SFI No. 29)

These Instructions shall not only apply to expenditure from Exchequer funds but also to works, services and goods purchased from the Trust's trust funds and private resources.

18. NHS SERVICE AGREEMENTS FOR PROVISION OF SERVICES (see overlap with SFI No. 17.13)

18.1 Service Level Agreements (SLAs)

18.1.1 The Chief Executive, as the Accountable Officer, is responsible for ensuring the Trust enters into suitable Service Level Agreements (SLA) with service commissioners for the provision of NHS services.

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

- the standards of service quality expected
- the relevant national service framework (if any)
- the provision of reliable information on cost and volume of services
- the NHS National Performance Assessment Framework
- that SLAs build where appropriate on existing Joint Investment Plans
- that SLAs are based on integrated care pathways
- Acceptable levels of risk and performance metrics/non-mandatory penalties
- The need to maintain adequate cash flow arrangements for the Trust
- that SLAs reflect the advent of the patient–led NHS and practice-based commissioning

18.2 Reports to Board on SLAs

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

19. COMMISSIONING

In circumstances when the Trust may become involved in the commissioning of services, it will refer to the model SFIs on commissioning provided for PCTs and/or the relevant paragraph in the host commissioner's SFIs.

20. TERMS OF SERVICE, ALLOWANCES AND PAYMENT OF MEMBERS OF THE TRUST BOARD AND EXECUTIVE COMMITTEE AND EMPLOYEES

20.1 Remuneration and Terms of Service (see overlap with SO No. 4)

20.1.1 In accordance with Standing Orders the Board shall establish a Remuneration and Terms of Service Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting. (See NHS guidance contained in the Higgs report.)

20.1.2 The Committee will:

(a) advise the Board about appropriate remuneration and terms of service for the Chief Executive, other officer members employed by the Trust and other senior employees including:

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

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

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

(b) make such recommendations to the Board on the remuneration and terms of service of officer members of the Board (and other senior employees) to ensure they are fairly rewarded for their individual contribution to the Trust - having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such members and staff where appropriate;

(c) monitor and evaluate the performance of individual officer members (and other senior employees);

(d) 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.

20.1.3 The Committee shall report in writing to the Board the basis for its recommendations. The Board shall use the report as the basis for their decisions, but remain accountable for taking decisions on the remuneration and terms of service of officer members. Minutes of the Board's meetings should record such decisions.

20.1.4 The Board will consider and need to approve proposals presented by the Chief Executive for the setting of remuneration and conditions of service for those employees and officers not covered by the Committee.

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

20.2 **Funded Establishment**

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

20.2.2 The funded establishment of any department may not be varied without the approval of the Chief Executive.

20.3 Staff Appointments

20.3.1 No executive or Member of the Trust Board 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:

(a) unless authorised to do so by the Chief Executive; and

(b) within the limit of their approved budget and funded establishment.

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

20.4 Processing Payroll

20.4.1 The Chief Finance Officer is responsible for:

(a) specifying timetables for submission of properly authorised time records and other notifications;

(b) the final determination of pay and allowances;

(c) making payment on agreed dates;

(d) agreeing method of payment.

20.4.2 The Chief Finance Officer will issue instructions regarding:

(a) verification and documentation of data;

(b) 79the timetable for receipt and preparation of payroll data and the payment of employees and allowances;

(c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

(d) security and confidentiality of payroll information;

(e) checks to be applied to completed payroll before and after payment;

(f) authority to release payroll data under the provisions of the Data Protection Act;

(g) methods of payment available to various categories of employee and officers;

(h) procedures for payment by cheque, bank credit, or cash to employees and officers;

(I) procedures for the recall of cheques and bank credits;

(j) pay advances and their recovery;

(k) maintenance of regular and independent reconciliation of pay control accounts;

(l) separation of duties of preparing records and handling cash;

(m) a system to ensure the recovery from those leaving the employment of the Trust of sums of money and property due by them to the Trust.

20.4.3 Appropriately nominated managers have delegated responsibility for:

(a) submitting time records, and other notifications in accordance with agreed timetables;

(b) completing time records and other notifications in accordance with the Chief Finance Officer's instructions and in the form prescribed by the Chief Finance Officer;

(c) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's or officer's resignation, termination or retirement. Where an employee fails to report for duty or to

fulfill obligations in circumstances that suggest they have left without notice, the Chief Finance Officer must be informed immediately.

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

20.5 Contracts of Employment

20.5.1 The Board shall delegate responsibility to an officer for:

(a) ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation;

(b) dealing with variations to, or termination of, contracts of employment.

21. NON-PAY EXPENDITURE

21.1 Delegation of Authority

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

21.1.2 The Chief Executive will set out:

(a) the list of managers who are authorised to place requisitions for the supply of goods and services;

(b) the maximum level of each requisition and the system for authorisation above that level.

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

21.2 Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services (see overlap with Standing Financial Instruction No. 17)

21.2.1 **Requisitioning**

The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's Procurement Department shall be sought. Where this advice is not followed, the Chief Finance Officer (and/or the Chief Executive) shall be consulted.

21.2.2 **System of Payment and Payment Verification**

The Chief Finance Officer shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

21.2.3 The Chief Finance Officer will:

(a) advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once

approved, the thresholds should be incorporated in Standing Orders and Standing Financial Instructions and regularly reviewed;

(b) prepare procedural instructions or guidance within the Scheme of Delegation on the obtaining of goods, works and services incorporating the thresholds;

(c) be responsible for the prompt payment of all properly authorised accounts and claims;

(d) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

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

(ii) Certification that:

- goods have been duly received, examined and are in accordance with specification and the prices are correct;

- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;

- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;

- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;

- the account is arithmetically correct;

- the account is in order for payment.

(iii) A timetable and system for submission to the Chief Finance Officer of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

(iv) Instructions to employees regarding the handling and payment of accounts within the Finance Department.

(e) be responsible for ensuring that payment for goods and services is only made once the goods and services are received. The only exceptions are set out in SFI No. 21.2.4 below.

21.2.4 **Prepayments**

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

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

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

(c) The Chief Finance Officer will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the EU public procurement rules where the contract is above a stipulated financial threshold);

(d) 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.

21.2.5 **Requisitions and Official orders**

Official Orders must placed on EROS in the form of a requisition which, will remain as a requisition until properly authorised and released to the supplier in the form of an order. Orders will

(a) be consecutively numbered;

(b) be issued in the standard EROS format;

(c) state the Trust's terms and conditions of trade;

(d) only be issued to, and used by, those duly authorised by the Chief Executive.

21.2.6 **Duties of Managers and Officers**

Managers and officers must ensure that they comply fully with the guidance contained in the Purchasing and Contracts Procedures and limits specified by the Chief Finance Officer and that:

(a) all contracts (except as otherwise provided for in the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Chief Finance Officer in advance of any commitment being made;

(b) contracts above specified thresholds are advertised and awarded in accordance with EU rules on public procurement;

(c) where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Department of Health;

(d) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:

(i) isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;

(ii) conventional hospitality, such as lunches in the course of working visits;

(This provision needs to be read in conjunction with Standing Order No. 6 and the principles outlined in the national guidance contained in HSG 1993/5 "Standards of Business Conduct for NHS Staff");

(e) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Chief Finance Officer on behalf of the Chief Executive;

(f) all goods, services, or works are ordered through EROS including works and services executed in accordance with a contract or tender but excluding purchases from petty cash;

(g) 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". Staff who request goods or services verbally without appropriate authority will be held personally responsible for any expenditure incurred.

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

(i) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

(j) changes to the list of employees and officers authorised to certify invoices are notified to the Chief Finance Officer;

(k) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Chief Finance Officer;

(l) petty cash records are maintained in a form as determined by the Chief Finance Officer.

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

21.3 Joint Finance Arrangements with Local Authorities and Voluntary Bodies (see overlap with SO 9.1)

21.3.1 Payments to local authorities and voluntary organisations made under the powers of section 28A of the NHS Act shall comply with procedures laid down by the Chief Finance Officer which shall be in accordance with these Acts. (See overlap with SO 9.1)

22. EXTERNAL BORROWING

22.1.1 The Chief Finance Officer will advise the Board concerning the Trust's ability to pay dividend on, and repay Public Dividend Capital and any proposed new borrowing, within the limits set by the Department of Health. The Chief Finance Officer is also responsible for reporting periodically to the Board concerning the PDC debt and all loans and overdrafts.

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

22.1.3 The Chief Finance Officer must prepare detailed procedural instructions concerning applications for loans and overdrafts.

22.1.4 All short-term borrowings should be kept to the minimum period of time possible, consistent with the overall cashflow position, represent good value for money, and comply with the latest guidance from the Department of Health.

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

22.1.6 All long-term borrowing must be consistent with the plans outlined in the current LDP and be approved by the Trust Board.

22.2 INVESTMENTS

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

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

22.2.3 The Chief Finance Officer will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

23. FINANCIAL FRAMEWORK

23.3.1 The Chief Finance Officer should ensure that members of the Board are aware of the Financial Framework. This document contains directions which the Trust must follow. It also contains directions to Strategic Health Authorities regarding resource and capital allocation and funding to Trusts. The Chief Finance Officer should also ensure that the direction and guidance in the framework is followed by the Trust.

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

24.1 Capital Investment

24.1.1 The Chief Executive:

(a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;

(b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost;

(c) shall ensure that the capital investment is not undertaken without confirmation of purchaser(s) support and the availability of resources to finance all revenue consequences, including capital charges.

24.1.2 For every capital expenditure that is an investment proposal the Chief Executive shall ensure:

(a) that a business case (in line with the guidance contained within the *Capital Investment Manual*) is produced setting out:

(i) an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs;

(ii) the involvement of appropriate Trust personnel and external agencies;

(ii) appropriate project management and control arrangements;

(b) that the Chief Finance Officer has certified professionally to the costs and revenue consequences detailed in the business case.

24.1.3 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management.

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

24.1.5 The Chief Finance Officer shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

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

The Chief Executive shall delegate to the director responsible for the overall programme:

(a) specific authority to commit expenditure;

(b) authority to proceed to tender (see overlap with SFI No. 17.6);

(c) approval to accept a successful tender (see overlap with SFI No. 17.6).

The Chief Executive will issue a scheme of delegation for capital investment management in accordance with the Trust's Standing Orders.

24.1.7 The Chief Finance Officer shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes. These procedures shall fully take into account the delegated limits for capital schemes included in Annex C of HSC (1999) 246.

24.2 Private Finance (see overlap with SFI No. 17.10)

24.2.1 The Trust should normally test for PFI when considering capital procurement. When the Trust proposes to use finance which is to be provided other than through its Allocations, the following procedures shall apply:

(a) The Chief Finance Officer shall demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.

(b) Where the sum involved exceeds delegated limits, the business case must be referred to the Department of Health or in line with any current guidelines.

(c) The proposal must be specifically agreed by the Board.

24.3 Asset Registers

24.3.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Chief Finance Officer concerning the form of any

register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.

24.3.2 Each Trust shall maintain an asset register recording fixed assets

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

(a) properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

(b) stores, requisitions and wages records for own materials and labour including appropriate overheads;

(c) lease agreements in respect of assets held under a finance lease and capitalised.

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

24.3.5 The Chief Finance Officer shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

24.3.6 The value of each asset shall be indexed to current values in accordance with methods specified in the *Capital Accounting Manual* issued by the Department of Health, or an alternative approach that has been approved by the Audit Committee in accordance with the latest valuation policies that can be followed

24.3.7 The value of each asset shall be depreciated using methods and rates as specified in the *Capital Accounting Manual* issued by the Department of Health, or in accordance with the latest policies specifed by the Department of health.

24.3.8 The Chief Finance Officer of the Trust shall calculate and pay capital charges as specified in the *Capital Accounting Manual* issued by the Department of Health.

24.4 Security of Assets

24.4.1 The overall control of fixed assets is the responsibility of the Chief Executive.

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

(a) recording managerial responsibility for each asset;

(b) identification of additions and disposals;

(c) identification of all repairs and maintenance expenses;

(d) physical security of assets;

(e) periodic verification of the existence of, condition of, and title to, assets recorded;

(f) identification and reporting of all costs associated with the retention of an asset;

(g) reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

24.4.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Chief Finance Officer.

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

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

24.4.6 Where practical, assets should be marked as Trust property.

25. STORES AND RECEIPT OF GOODS

25.1 General position

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

(a) kept to a minimum;

(b) subjected to annual stock take;

(c) valued at the lower of cost and net realisable value.

25.2 Control of Stores, Stocktaking, condemnations and disposal

25.2.1 Subject to the responsibility of the Chief Finance Officer for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Chief Executive. The day-to-day responsibility may be delegated by him to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Chief Finance Officer. The control of any Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of any fuel oil of a designated estates manager.

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

25.2.3 The Chief Finance Officer shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

25.2.4 Stocktaking arrangements shall be agreed with the Chief Finance Officer and there shall be a physical check covering all items in store at least once a year.

25.2.5 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Chief Finance Officer.

25.2.6 The designated Manager/Pharmaceutical Officer shall be responsible for a system approved by the Chief Finance Officer for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles.

The designated Officer shall report to the Chief Finance Officer any evidence of significant overstocking and of any negligence or malpractice (see also overlap with SFI No. 25 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.

25.3 Goods supplied by NHS Logistics

25.3.1 For goods supplied via the NHS Logistics , the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note before forwarding this to the Chief Finance Officer who shall satisfy himself that the goods have been received before accepting the recharge.

26. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

26.1 Disposals and Condemnations

26.1.1 **Procedures**

The Chief Finance Officer must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers.

26.1.2 When it is decided to dispose of a Trust asset, the Procurement Department working in collaboration with the relevant Head of Department or authorised deputy will determine and advise the Chief Finance Officer of the estimated market value of the item, taking account of professional advice where appropriate.

26.1.3 All unserviceable articles shall be:

(a) condemned or otherwise disposed of by an employee authorised for that purpose by the Chief Finance Officer;

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

26.1.4 The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Chief Finance Officer who will take the appropriate action.

26.2 Losses and Special Payments

26.2.1 **Procedures**

The Chief Finance Officer must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments.

26.2.2 Any employee or officer discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Chief Executive and the Chief Finance Officer or inform an officer charged with responsibility for responding to concerns involving loss. This officer will then appropriately inform the Chief Finance Officer and/or Chief Executive. Where a criminal offence is suspected, the Chief Finance Officer must immediately inform the Local Security Management Specialist (LSMS) if theft or arson is involved. In cases of fraud and corruption or of anomalies which may indicate fraud or corruption, the

Chief Finance Officer must inform the relevant LCFS and CFSMS regional team in accordance with Secretary of State for Health's Directions.

The Chief Finance Officer must notify the Counter Fraud and Security Management Services (CFSMS) and the External Auditor of all frauds.

26.2.3 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Chief Finance Officer must immediately notify:

(a) the Board,

(b) the External Auditor.

26.2.4 Within limits delegated to it by the Department of Health, the Board shall approve the writing-off of losses.

26.2.5 The Chief Finance Officer shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

26.2.6 For any loss, the Chief Finance Officer should consider whether any insurance claim can be made.

25.2.7 The Chief Finance Officer shall maintain a Losses and Special Payments Register in which write-off action is recorded.

26.2.8 No special payments exceeding delegated limits shall be made without the prior approval of the Department of Health.

26.2.9 All losses and special payments must be reported to the Audit Committee at every meeting.

27. INFORMATION TECHNOLOGY

27.1 Responsibilities and duties of the Chief Finance Officer

27.1.1 The Chief Finance Officer, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:

(a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which the Director is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998;

(b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

(c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

(d) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as the Director may consider necessary are being carried out.

27.1.2 The Chief Finance Officer shall need to ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another

organisation, assurances of adequacy must be obtained from them prior to implementation.

27.2 Responsibilities and duties of other Directors and Officers in relation to computer systems of a general application

27.2.1 In the case of computer systems which are proposed General Applications (i.e. normally those applications which the majority of Trusts in a particular locality wish to sponsor jointly) all responsible directors and employees will send to the Head of Information Technology

(a) details of the outline design of the system;

(c) in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

27.2.2 The officer within the Corporate Secretariat responsible for implementing the requirements of the Freedom of Information Act (FOI) shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority.

27.3 Contracts for Computer Services with other health bodies or outside agencies

The Chief Finance Officer shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

Where another health organisation or any other agency provides a computer service for financial applications, the Chief Finance Officer shall periodically seek assurances that adequate controls are in operation.

27.4 Risk Assessment

The Chief Executive shall ensure that risks to the Trust arising from the use of IT are effectively identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans.

27.5 Requirements for Computer Systems which have an impact on corporate financial systems

Where computer systems have an impact on corporate financial systems the Chief Finance Officer shall need to be satisfied that:

(a) systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy;

(b) data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

(c) Chief Finance Officer staff have access to such data;

(d) such computer audit reviews as are considered necessary are being carried out.

28. PATIENTS' PROPERTY

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

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

- notices and information booklets; ***(notices are subject to sensitivity guidance)***
- hospital admission documentation and property records;
- the oral advice of administrative and nursing staff responsible for admissions,

that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

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

28.4 Where Department of Health instructions require the opening of separate accounts for patients' moneys, these shall be opened and operated under arrangements agreed by the Chief Finance Officer.

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

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

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

29. FUNDS HELD ON TRUST

29.1 Corporate Trustee

(1) Standing Order No. 2.8 outlines the Trust's responsibilities as a corporate trustee for the management of funds it holds on trust, along with SFI 4.9.3 that defines the need for compliance with Charities Commission latest guidance and best practice.

(2) The discharge of the Trust's corporate trustee responsibilities are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general

principles of financial regularity, prudence and propriety. Trustee responsibilities cover both charitable and non-charitable purposes.

The Chief Finance Officer shall ensure that each trust fund which the Trust is responsible for managing is managed appropriately with regard to its purpose and to its requirements.

29.2 Accountability to Charity Commission and Secretary of State for Health

(1) The trustee responsibilities must be discharged separately and full recognition given to the Trust's dual accountabilities to the Charity Commission for charitable funds held on trust and to the Secretary of State for any other funds held on trust.

(2) The Schedule of Matters Reserved to the Board and the Scheme of Delegation make clear where decisions regarding the exercise of discretion regarding the disposal and use of the funds are to be taken and by whom. All Trust Board members and Trust officers must take account of that guidance before taking action.

29.3 Applicability of Standing Financial Instructions to funds held on Trust

(1) In so far as it is possible to do so, most of the sections of these Standing Financial Instructions will apply to the management of funds held on trust. (See overlap with SFI No 17.16).

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

30. ACCEPTANCE OF GIFTS BY STAFF AND LINK TO STANDARDS OF BUSINESS CONDUCT (see overlap with SO No. 6 and SFI No. 21.2.6 (d))

The Chief Finance Officer shall ensure that all staff are made aware of the Trust policy on acceptance of gifts and other benefits in kind by staff. This policy follows the guidance contained in the Department of Health circular HSG (93) 5 'Standards of Business Conduct for NHS Staff' and is also deemed to be an integral part of these Standing Orders and Standing Financial Instructions (see overlap with SO No. 6).

31. AUTHORISATION AND CONTRACTING FOR MANAGEMENT CONSULTANTS AND INTERIM MANAGERS

31.1 The Trust on occasions may require to contract for the services of management consultants and interim management to fulfil specific project work; that is a piece of work that has a defined timescale and deliverables in return for payment.

31.2 Prior to considering the contracting of management consultants and/or interim managers, financial authorisation to proceed should be sought from Chief Finance Officer with an indication from the Trust sponsor of purpose, term and cost. The Trust sponsor is required to be at executive director level. Once authorisation is secured to proceed, then the Trust sponsor is authorised to source the requirement via tendering or single-sourcing routes in accordance with current procurement procedures. Once the sourcing of managing consultants or interim managers has been completed the sign-off of contract for such services rests solely with either CEO or Chief Finance Officer. Under no circumstances should verbal contracts be established.

31.3 The engagement of all management consultants and interim staff is required to be covered by a formal contract of services. In the majority of cases, NHS Terms and Conditions for management consultancy services should be applied and form part of any contract. In all cases, a schedule of project work should be drawn-up, that includes the project deliverables, the term, payment, performance management and review and termination clauses. The contract should also make clear that the person and or persons do not constitute a contract of employment. The formal contract reference is required to be quoted on all invoices, and if absent, then payment should be withheld. In the event that consultants and interim staff are already employed by the Trust then retrospective contracts need to be established by the lead directorate executive director at the earliest opportunity.

31.4 Any contract term extension is required to be authorised by the CE or Chief Finance Officer. Changes to the contract schedule may be amended by an executive director provided the financial liability to the Trust is not increased over and above the original contract value. Any changes to the value of the contract, incurring additional financial liability within the term of contract is required to be authorised by the Chief Finance Officer.

31.5 As part of the decision to employ management consultants and interim managers through a limited company or partnership, Trust sponsors are to check to establish whether IR35 rules will apply to the contract as this will change the tax and NI that the contractor will have to pay as part of the contract. If the consultant and/or interim can answer 'yes' to the following questions, then this individual would probably be classed as an employee of the Trust and IR35 rules apply:

- Do you work set hours, or a given number of hours a week or a month?
- Do you have to do the work yourself rather than hire someone else to do the work?
- Can someone tell you at any time what to do, when to do it and how to do it?
- Are you paid by the hour, week or month?
- Do you work at the premises of the person you work for, or at a place or places that they decide?
- Do you generally work for one client at a time, rather than having a number of contracts?

31.6 If the management consultant or interim manager can answer 'yes' to many of the following questions, they would probably **not** be classified as an employee of the Trust and are therefore outside of the IR 35 rules.

- Are they hired to undertake a specific project for a finite duration?
- Do they decide how, when and where to carry out your services?
- Can they make a loss on the contract?
- Do they provide the main items of equipment they need to do the job for the Trust?
- Are they free to hire other people on there own terms to do the project work that they have taken on? Do they pay them out of their own pocket?
- Do they have to correct unsatisfactory work in their own time and their own expense?
- Do you have a number of customers at the same time?

31.7 As part of the formal sign-off by the CE and or Chief Finance Officer, the Trust sponsor is required to declare the IR 35 status of the management consultant and/or interim manager to be contracted for based on the above tests.

32. RETENTION OF RECORDS

32.1 The Chief Executive shall be responsible for maintaining archives for all records required to be retained in accordance with Department of Health guidelines.

32.2 The records held in archives shall be capable of retrieval by authorised persons.

32.3 Records held in accordance with latest Department of Health guidance shall only be destroyed at the express instigation of the Chief Executive. Detail shall be maintained of records so destroyed.

33. RISK MANAGEMENT AND INSURANCE

33.1 Programme of Risk Management

The Chief Executive shall ensure that the Trust has a programme of risk management, in accordance with current Department of Health assurance framework requirements, which must be approved and monitored by the Board.

The programme of risk management shall include:

a) a process for identifying and quantifying risks and potential liabilities;

b) engendering among all levels of staff a positive attitude towards the control of risk;

c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

d) contingency plans to offset the impact of adverse events;
e) audit arrangements including; Internal Audit, clinical audit, health and safety review;

f) a clear indication of which risks shall be insured;

g) arrangements to review the Risk Management programme.

The existence, integration and evaluation of the above elements will assist in providing a basis to make a Statement on the effectiveness of Internal Control (SIC) within the Annual Report and Accounts as required by current Department of Health guidance.

33.2 Insurance: Risk Pooling Schemes administered by NHSLA

The Board shall decide if the Trust will insure through the risk pooling schemes administered by the NHS Litigation Authority or self insure for some or all of the risks covered by the risk pooling schemes. If the Board decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

33.3 Insurance arrangements with commercial insurers

33.3.1 There is a general prohibition on entering into insurance arrangements with commercial insurers. There are, however, **three exceptions** when Trust's may enter into insurance arrangements with commercial insurers. The exceptions are:

(1) Trust's may enter commercial arrangements for **insuring motor vehicles** owned by the Trust including insuring third party liability arising from their use;

(2) where the Trust is involved with a consortium in a **Private Finance Initiative contract** and the other consortium members require that commercial insurance arrangements are entered into; and

(3) where **income generation activities** take place. Income generation activities should normally be insured against all risks using commercial insurance. If the income generation activity is also an activity normally carried out by the Trust for a NHS purpose the activity may be covered in the risk pool. Confirmation of coverage in the risk pool must be obtained from the Litigation Authority. In any case of doubt concerning a Trust's powers to enter into commercial insurance arrangements the Finance Director should consult the Department of Health.

33.4 Arrangements to be followed by the Board in agreeing Insurance cover

(1) Where the Board decides to use the risk pooling schemes administered by the NHS Litigation Authority the Chief Finance Officer shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Chief Finance Officer shall ensure that documented procedures cover these arrangements.

(2) Where the Board decides not to use the risk pooling schemes administered by the NHS Litigation Authority for one or other of the risks covered by the schemes, the Chief Finance Officer shall ensure that the Board is informed of the nature and extent of the risks that are self insured as a result of this decision. The Chief Finance Officer will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed.

(3) All the risk pooling schemes require Scheme members to make some contribution to the settlement of claims (the 'deductible'). The Chief Finance Officer should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

Whittington Health NHS

Quality Committee of Trust Board
Terms of Reference, AGREED 9 March 2016

1. Constitution and Authority

The Quality Committee is constituted as a standing Committee of the Trust Board. Its constitution and terms of reference shall be as set out below, subject to amendment by the Trust Board.

The Committee is authorised by the Trust Board to act within its terms of reference and provide scrutiny in terms of quality for all services provided by the Integrated Care Organisation. The committee is authorised to obtain such internal information as is necessary to exercise its functions and discharge its duties. It is authorised to conduct deeper reviews of services with supporting evidence from all parts of the ICO and escalate findings as necessary to the Trust Board.

Subject to the conditions set out in the Trust's Standing Orders, the Committee is authorised by the Trust Board to instruct professional advisors and request the attendance of individuals and authorities from outside the organisation with relevant experience and expertise if the committee feels this is necessary to exercise its functions and discharge its duties, in the course of appointing external representation the committee will notify the Trust Board.

2. Purpose

The purpose of the Committee is to focus on service quality and improvement through the following three NHS defined components:

- Patient Safety and Clinical Risk
- Audit and Effectiveness, and
- Patient Experience.

3. Role

The role of the Committee is to ensure the establishment and maintenance of effective risk management and quality governance systems within the Trust.

This can be defined as being:

i. To provide assurance to the Trust Board that the Trust has adequate systems and processes in place to ensure and continuously improve patient safety, quality, clinical effectiveness, management of risk

ii. To provide assurance to the Trust Board that the Trust has effective structures in place to measure and continuously strive to improve the effectiveness of care

iii. To provide assurance to the Trust Board that the Trust is responding to patients' feedback about their experiences and taking action appropriately.

iv. To promote a culture of openness and transparency across the Trust, which values innovation and improvement.

4. Duties

4.1 To monitor, review and implement quality assurance and risk management strategies and action plans, including quality assessments for all Cost Improvement Plans.

4.2 The Committee has risk management duties;

- to review the Quality and Safety Risk Register monthly (defined as risks of >12, specific to quality and safety).
- to seek assurance that risks to patients are minimised through the application of a comprehensive risk management system.
- to contribute to the review of the Trust Risk Management Strategy.

4.3 The Committee will receive reports from each ICSU twice per year, with a focus on areas within the ICSU quality report which are below target, as well as areas of excellence.

4.4 The Committee will review, approve and monitor implementation of the Trust's Quality Strategy and Quality Account.

4.5 The Committee has responsibility for monitoring organisational compliance against the CQC Essential Standards of Quality and Safety, and providing assurance to the Trust Board that effective systems are in place to monitor compliance (ie quality inspection programme)

4.6 The Committee will receive reports on the Patient Safety Huddles programme, providing assurance to the Trust Board of executive visibility and Board-to-ward contact. (CQC well-led domain)

4.7 The Committee will seek assurance on patient safety issues through regular reporting, including the National Safety Thermometer, Sign up to Safety, learning from serious incidents, infection control, and clinical incidents.

4.8 To seek assurance that there are robust arrangements in place for the management of safeguarding adults and children and a system in place for managing patients who are Deprived of their Liberties (DoLs) at Whittington Health.

4.9 To seek assurance on clinical audit and effectiveness through regular reporting, including national audits, NICE guidelines, and recommendations from relevant external reports.

4.10 To seek assurance on patient experience through regular reporting, including the friends and family test, complaints, PALS, and equality and diversity.

4.11 To seek assurance that appropriate action is taken in response to adverse clinical incidents, complaints and litigation.

4.12 To seek assurance that the research programme and associated governance frameworks is implemented and appropriately monitored.

4.13 The Committee will receive workforce information concerning, Mandatory Training, Turnover, Sickness Absence, Vacancy Rates and Bank/Agency Usage and any other aspects of workforce monitoring where this impacts on quality for the organisation via ICSU reporting and by exception at chair's request.

4.14 To review the NHS Constitution and assurance action plan annually.

4.15 The Committee will receive regular reports and/or minutes from reporting groups.

4.16 The Committee will maintain oversight of all relevant national and external reports (e.g. Francis Inquiry, Berwick, Winterbourne)

5. Membership

- Non-Executive Director (Chair)
- Non-Executive Director (Deputy Chair)
- Non-Executive Director
- Medical Director
- Director of Nursing and Patient Experience
- Deputy Director of Nursing and Patient Experience
- Chief Operating Officer
- Director of Communications and Corporate Affairs
- ICSU X 7 Directors of Operations (or ICSU Clinical Directors, to be agreed by each ICSU)

6. Attendees

The committee is empowered to request any other office employed by the Trust to attend meetings for the purpose of providing advice, clarification, recommendation or explanation in respect of any matter that falls within the responsibilities of the Committee.
Regular attendees are expected to be managers preparing functional papers.

7. Terms of Membership

Membership to be reviewed as part of the Terms of Reference review annually.

8. Administration

Director of Communications and Corporate Affairs and Compliance and Quality Improvement Manager will ensure the effective and efficient management of the Committee under the leadership of the Committee Chair.

9. Planning and Recording

The Quality Committee will agree an annual workplan.

10. Reporting and Accountability

The Quality Committee is accountable to the Trust Board and will provide formal minutes and/or assurance reports with an action tracker after each meeting.

The following groups report to the Quality Committee:

- Patient Safety Committee
- Patient Experience Committee
- Clinical Audit and Effectiveness Committee
- Research Management and Governance Committee
- Clinical Ethics Committee
- Safeguarding Adults and Safeguarding Children's Committees
- Drugs and Therapeutics Committee

11. Frequency of Meetings

Quality Committee meetings will be held every two months, with a minimum of six per year. Members are required to attend a minimum of four meetings per year. In the event of any executive member being unavailable, a nominated deputy should attend in their place, and such deputies should be recorded in the minutes as having been in attendance. A record of attendance will be included in the Trust annual governance statement.

12. Quorum

The Committee shall be deemed to be quorate if attended by any two non-executive directors of the Trust (to include the Chair or designated alternate) and two executive or associate directors. All NEDs can act as substitutes on all Board Committees.

13. Monitoring and Self-Assessment

An annual self-assessment monitoring the effectiveness of the Quality Committee will be prepared by the Director of Communications and Corporate Affairs and an outcome report agreed by the Quality Committee.

Whittington Health NHS

CHARITABLE FUNDS COMMITTEE

Terms of Reference

1. Core Accountabilities

Date of Adoption	6 April 2016
Review Frequency	Annual
Drafting	Director Communications/Corporate Affairs
Approval	Charitable Funds Committee
Adoption and Ratification	Trust Board

2. Purpose of the Committee

The Committee is established to represent the interests of the Trust, as the Corporate Trustee of Whittington Hospital Charitable Funds. It will

i. Oversee the operation of the Charity and its transactions; and the management of the investments owned by the Charity

ii. Seek assurance that the Charity is operating in accordance with relevant legislation and with the regulations associated with its registration with the Charities Commission

3. Authority

The Trust Board hereby resolves to establish a Committee of the Board to be known as the Charitable Funds Committee ("the Committee")

i. The Trust Board is the Corporate Trustee of the group of charitable funds registered together with the Charity Commission under the charity registration number 1056452 in the name of 'The Whittington Hospital Charitable Funds' (the Charity). The Committee is appointed as the Trust's agent in accordance with Section 16 of the NHS Trusts (Membership and Procedures) Regulations 1990

ii. The Committee is constituted as a standing committee of the Trust's Board of Directors. Its constitution and terms of reference shall be as set out below; and will be subject to amendments approved by the Trust Board

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

iv. The Committee is authorised by the Board to instruct professional advisers and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to the exercise of its functions

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

vi. Committee members have delegated powers to ensure that the Charity acts within the terms of its Declaration of Trust, appropriate legislation and Charity Commission guidance; and to provide assurance to the Trust Board that the Charity is properly governed and well managed across its full range of activities.

4. Membership and attendance at meetings

4.1 The membership of the Committee shall consist of

i. Two Non-Executive Directors of the Trust; one who will chair the Committee –tenure review every three years

ii. The Chief Finance Officer of the Trust or nominated deputy

4.2 Quorum

i. Quorum will be achieved through the presence of three Committee members including the Committee Chair and Chief Finance Officer or nominated deputy.

4.3 Attendance

Meetings of the Committee shall be attended by:

i. The Financial Controller and/or Head of Financial Accounts

ii. The Head of Fundraising/Director of Communications/Corporate Affairs

iii. Any other person who has been invited to attend a meeting by the Committee so as to assist in deliberations

5. Roles and responsibilities

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

i. Oversee the operation of the Charitable Funds to ensure they are managed and operated in accordance with their governing documents and comply with relevant legislation and guidance from the Charity Commission

ii. Approve the Trust Fundraising Strategy 2016/21

iii. Decide whether donations given with restrictions applied should be accepted by the Charity

iv. Receive reports detailing the establishment of new funds and all new staff appointments made from Charitable Funds

v. Receive reports detailing balances of the Charity's General Funds

vi. Receive reports on all individual charitable non-pay transactions in excess of £10,000

vii. Approve expenditure of all individual charitable non-pay transactions value £25,000 or more (where there is an urgent requirement for an order to be placed, the equivalent of a quorum may give approval by email, and minuted at the next Committee meeting)

viii. Review the spending plans and balances held within individual Charitable Funds

ix. Recommend the appointment of investment managers/advice to provide investment advice and manage the Trusts investment portfolio

x. In conjunction with the investment managers/advice, agree an investment policy which lays down guidelines in respect of

   a. The balance required between income and capital growth

   b. The balance of risk within the portfolio

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

xi. Determine a policy for the distribution, or otherwise, of realised and unrealised gains on losses on investments

xii. Review the impact on the Charity of changes in legislation both of a charitable and non-charitable nature and make appropriate recommendations to the Trust Board, as Corporate Trustee, as to how any new requirements will be met

xiii. Ensure compliance with the Trust's Standing Financial Instructions, Financial Control Procedures and Scheme of Delegation

xiv. Receive audit reports on the charity controls

xv. Review all fundraising developments

xvi. Consider the Charity's annual report and accounts

5.2 Delegated powers and duties of the Chief Finance Officer

The Chief Finance Officer has prime responsibility for the Trust's charitable funds as defined in the Trust's standing financial instructions. The specific powers, duties and responsibilities delegated are:

i. To administer and account for all existing charitable funds

ii. To identify any new charity that may be created (of which the Trust is trustee) and to deal with any legal steps that may be required to formalise the trusts of

any such charity

iii. To provide guidelines with respect to donations, legacies and bequests, fundraising and trading income

iv. Responsibility for the management of investment of funds held on trust

v. To ensure appropriate banking services are available to the Trust. The banking arrangements for the charitable funds should be kept entirely distinct from the Trust's NHS funds

vi. To prepare reports to the Trust Board including the annual accounts

5.3 The Committee will receive the following reports on a quarterly or annual basis:

Quarterly Reports

- Investment performance reports
- Quarterly investment valuation and review
- Details of the Charity's six month operational cash requirements
- Summary of General Fund balances
- Details of individual non-pay transactions over £25,000 in value
- Details of funds with balances in excess of £100,000
- Fundraising update

Annual Reports

- Annual Accounts and Letter of Representation signed on behalf of the Charity (for approval)
- Report of the audit of the accounts and audit opinion from the external auditor
- Charitable Funds Annual Report (for approval)

6. Conduct of business

6.1 Administration

- The Personal Assistant or nominated member of staff reporting to the Chief Finance Officer shall be the secretary to the Committee and shall attend to take minutes of the meeting and provide appropriate support to the chair and Committee members.

- The Committee Secretary will

  - provide timely notice of meetings

  - liaise with the Chairman, Chief Finance Officer and Director of Communications and Corporate Affairs to agree meeting agendas

and attendees

- collect and forward agendas and supporting documents to members and attendees in advance of the meetings

- attend to take minutes of the meeting

- maintain an action log and matters arising to be carried forward

6.2 Frequency

- Meetings will be held bi-quarterly. Additional meetings may be held on an exceptional basis at the request of the Chairman.

6.2 Notice of meetings

- An agenda of items to be discussed will be forwarded to each member of the Committee and any other person required to attend, no later than five working days before the date of the meeting. Supporting papers will be sent to Committee members and to other attendees as appropriate, at the same time.

6.3 Reporting

- The Committee will provide a report to the Trust Board after each meeting

- The minutes of the Committee shall be formally recorded and circulated to all members of the Committee

7. Review

- The Committee will review the terms of reference annually. This review will include a self-assessment of its effectiveness in discharging its responsibilities

- As part of this assessment, the Committee will consider whether or not it receives adequate and appropriate support and information in fulfilment of its role

Whittington Health NHS

Audit & Risk Committee

Terms of Reference

Audit and Risk Committee
Terms of Reference

1. Constitution

1.1 The Board of Directors hereby resolves to establish a Committee to be known as the Audit & Risk Committee (the Committee). This Committee has no executive powers other than those delegated in these terms of reference.

2. Membership

2.1 The Audit & Risk Committee will be appointed by the Board of Directors.

2.2 All members of the Committee should be independent Non-Executive Directors of the Trust. For the avoidance of doubt, the Trust Chair shall not be a member of the Committee.

2.3 The Committee shall consist of at least three members.

2.4 The Board should appoint the Chair of the Audit & Risk Committee from amongst its independent Non-Executive Directors.

2.5 At least one member of the Audit & Risk Committee should have recent and relevant financial experience.

3. Attendance

3.1 The Chief Finance Officer and appropriate External and Internal Audit and LCFS representatives shall normally attend meetings.

3.2 At least once a year the External and Internal Auditors shall be offered an opportunity to report to the Committee any concerns they may have in the absence of all Executive Directors and officers. This need not be at the same meeting.

3.3 The Chief Executive and other Executive Directors shall attend Committee meetings by invitation only. This shall be required particularly when the Committee is discussing areas of risk or operation that are the responsibility of that Director. When an internal audit report or other report shows significant shortcomings in an area of the Trust's operations, the Director responsible will normally be required to attend in order to respond to the report.

3.4 The Chief Executive should be invited to attend, at least annually, to discuss with the Audit & Risk Committee the process for assurance that supports the Annual Governance Statement.

3.5 The Local Counter Fraud Specialist shall attend to agree a work programme and report on their work as required.

4. Quorum

4.1 This shall be at least two members.

5. Frequency of meetings

5.1 The Committee shall meet at least four times per year.

5.2 The external or internal auditor may request a meeting when they consider it necessary.

6. Secretary

6.1 A Secretary shall be appointed for the Audit & Risk Committee.

7. Agenda & Papers

7.1 Meetings of the Committee will be called by the Committee Chair. The agenda will be drafted by the Committee Secretary and approved by the Committee Chair prior to circulation.

7.2 Notification of the meeting, location, time and agenda will be forwarded to Committee members, and others called to attend, at least five days before the meeting. Supporting papers will also be sent out at this time. If draft minutes from the previous meeting have not been circulated in advance then they will be forwarded to Committee members at the same time as the agenda.

8. Minutes of the Meeting

8.1 The Committee Secretary will minute proceedings, action points, and resolutions of all meetings of the Committee, including recording names of those present and in attendance.

8.2 Approved minutes will be forwarded to the Board of Directors for noting.

8.3 In advance of the next meeting, the minutes and the log of action points will be circulated to all involved, so that the action log can be updated and included in the papers for the meeting.

9. Authority

9.1 The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek information it

requires from any employee, and all employees are directed to co-operate with any request made by the Committee.

9.2 The Committee is authorised to obtain outside legal advice or other professional advice and to secure the attendance of outsiders with relevant experience if it considers this necessary.

10. Duties

10.1 Governance, Risk Management and Internal Control

10.1.1 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 supports the achievement of the Trust's objectives

10.1.2 In particular, the Committee will review the adequacy of:

10.1.2.1 all risk and control related disclosure statements (in particular the Annual Governance Statement and declarations of compliance with the Care Quality Commission's *Judgement Framework*), together with any accompanying Head of Internal Audit statement, External Audit opinion or other appropriate independent assurances, prior to endorsement by the Board of Directors

10.1.2.2 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

10.1.2.3 the policies for ensuring compliance with relevant regulatory, legal, and code of conduct requirements in conjunction with the Clinical Quality, Safety, and Governance Committee

10.1.2.4 the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by NHS Protect.

10.1.2.5 the financial systems

10.1.2.6 the Internal and External Audit services, and counter fraud services

10.1.2.7 compliance with *Board of Directors' Standing Orders* (BDSOs) and *Standing Financial Instructions* (SFIs)

10.1.3 The Committee should review the Assurance Framework process on a periodic basis, at least twice in each year, in respect of the following:

- the process for the completion and up-dating of the Assurance Framework;
- the relevance and quality of the assurances received;
- whether assurances received have been appropriately mapped to individual committee's or officers to ensure that they receive the due consideration that is required; and
- Whether the Assurance Framework remains relevant and effective for the organisation.

10.1.4 The Committee shall review the arrangements by which Trust staff can raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety, or other matters. The Committee should ensure that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action.

10.1.5 In carrying out this work, the Committee will primarily utilise the work of Internal Audit, External Audit, the Local Counter-Fraud Service, and other assurance functions. It will also seek reports and assurances from Directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

10.1.6 The Committee shall review at each meeting a schedule of debtors balances, with material debtors more than six months requiring explanations/action plans.

10.1.7 The Committee shall review at each meeting a report of tenders and tender waivers since the previous meeting.

10.2 Internal Audit

10.2.1 The Committee shall ensure that there is an effective internal audit function established by management that meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Committee, Chief Executive and Board of Directors. This will be achieved by:

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

10.2.1.2 review and approval of the Internal Audit strategy, operational plan and more detailed programme of work,

ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework

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

10.2.1.4 ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation

10.2.1.5 monitoring and assessing the role of and effectiveness of the internal audit function on an annual basis in the overall context of the Trust's risk management framework

10.2.1.6 ensuring that previous internal audit recommendations are followed up on a regular basis to ensure their timely implementation

10.3 External Audit

10.3.1 The Committee shall review the work and findings of the External Auditor appointed by the Trust Board, and consider the implications and management's responses to their work. This will be achieved by:

10.3.1.1 approval of the remuneration to be paid to the External Auditor in respect of the audit services provided

10.3.1.2 consideration of recommendations to the Trust Board relating to the appointment and performance of the External Auditor

10.3.1.3 discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensuring co-ordination, as appropriate, with other External Auditors in the local health economy

10.3.1.4 discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee

10.3.1.5 review all External Audit reports and any work carried out outside the annual audit plan, together with the appropriateness of management responses

10.4 Other Assurance Functions

10.4.1 The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the Trust

10.4.2 These will include, but will not be limited to, any reviews by Monitor, Department of Health Arm's Length Bodies or Regulators / Inspectors (e.g. Care Quality Commission, NHS Litigation Authority, etc.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.)

10.4.3 In addition, the Committee will review the work of other Committees within the organisation, whose work can provide relevant assurance to the Committee's own scope of work. Particularly with the Quality, Committee, it will meet at least annually with the Chair and/or members of that Committee to assure itself of the processes being followed.

10.4.4 In reviewing the work of the Quality Committee, and issues around clinical risk management, the Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function.

10.4.5 The Audit & Risk Committee should incorporate within its schedule a review of the underlying processes for the Information Governance Toolkit and the Quality Accounts production to be able to provide assurance to the Board that these processes are operating effectively prior to disclosure statements being produced.

10.4.6 The Audit & Risk Committee will oversee the work of the Health and Safety Committee and receive regular performance and assurance reports.

10.4.7 The Audit & Risk Committee will oversee the work of the Information Governance Committee and receive regular performance and assurance reports

10.5 Management

10.5.1 The Committee shall request and review reports and assurances from Directors and managers on the overall arrangements for governance, risk management and internal control

10.5.2 They may also request specific reports from individual functions within the Trust (e.g. clinical audit) as they may be appropriate to the overall arrangements

10.6 Financial Reporting

10.6.1 The Committee shall review the Annual Report and Financial Statements before submission to the Board of Directors, focusing particularly on:

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

10.6.1.2 changes in, and compliance with, accounting policies and practices

10.6.1.3 unadjusted mis-statements in the financial statements

10.6.1.4 major judgemental areas

10.6.1.5 significant adjustments resulting from the audit

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

10.7 Appointment, reappointment, and removal of external auditors

10.7.1 The Committee shall make recommendations to the Board of Directors, in relation to the setting of criteria for appointing, re-appointing, and removing External Auditors

10.7.2 The Committee shall make recommendations to the Board of Directors, in relation to the appointment, reappointment, and removal of the External Auditors, providing the Board of Directors with information on the performance of the External Auditor

10.7.3 The Committee shall approve the remuneration and terms of engagement of the External Auditors

11. Other Matters

11.1 At least once a year the Committee will review its own performance, constitution and Terms of Reference to ensure that it is operating at maximum effectiveness and recommend any changes it considers necessary to the Board of Directors for approval.

11.2 The Committee should consider holding a discussion at the end of some meetings with regards to the effectiveness of the committee, considering those areas highlighted within this paper.

12. Sources of Information

12.1 The Committee will receive and consider minutes from the other Committees when requested. The Committee will receive and consider other sources of information from the Chief Finance Officer

13. Reporting

13.1 The minutes of the Committee, once approved by the Committee, will be submitted to the Board of Directors for noting. The Committee Chair shall draw the attention of the Audit & Risk Committee or the Board of Directors to any issues in the minutes that require disclosure or executive action.

13.2 The Committee will report annually to the Board of Directors on its work in support of the Annual Governance Statement , specifically commenting on the completeness and integration of risk management in the Trust, the integration of governance arrangements, and the appropriateness of the self-assessment against the Care Quality Commission's *Judgement Framework*.

13.3 The Committee Chair shall attend the Annual General Meeting (AGM) prepared to respond to any Member's questions on the Committee's activities.

Board of Directors Nominations and Remuneration Committee
Terms of Reference

1. Constitution

The Board of Directors (the "Board") hereby resolves to establish a Committee of the Board to be known as the Board of Directors' Nominations and Remuneration Committee (the "Committee"). The Committee has no executive powers other than those specifically delegated in these Terms of Reference.

2. Terms of Reference

Nominations Role

2.1.The Committee shall, in respect of nominations:

2.1.2 Regularly review the structure, size and composition (including the skills, knowledge and experience) required of the Executive Directors and make recommendations to the Board with regard to any changes. Make recommendations to the Board to improve its own governance and effectiveness.

2.1.3 Give full consideration to and make plans for succession planning for Executive Directors, taking into account the challenges and opportunities facing the Trust and the skills and expertise needed on the Board in the future, including the route to Foundation Trust status.

2.1.4 Be responsible for identifying and nominating for appointment, candidates to fill posts within its remit as and when they arise.

2.1.5 Ensure that Executive Directors meet the requirements of the 'Fit and Proper' Persons Test.

2.1.6 Before an appointment is made, evaluate the balance of skills, knowledge and experience on the Board and, in the light of this evaluation, agree a description of the role and capabilities required for a particular appointment.

2.1. 7 Consider any matter relating to the continuation in office of any Executive Director at any time, including the suspension or termination of service of an individual as an employee of the NHS Trust.

2.1.8 To consider the engagement or involvement of any suitably qualified third party or advisers to assist with any aspects of its responsibilities.

Remuneration Role

2.2 The Committee shall in respect of remuneration:

2.2.1 Establish and keep under review a remuneration policy for Executive Directors.

2.2.2 Consult the Chief Executive about proposals relating to the remuneration of Executive Directors.

2.2.3 In accordance with all relevant laws, regulations and Trust policies, determine the terms and conditions of office of the Executive Directors, including all aspects of salary and the provision of other benefits (for example allowances or payable expenses).

2.2.4 Shall determine the levels of remuneration and terms of employment for Executive Directors to ensure they are fairly rewarded for their individual contribution to the Trust – having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such staff.

2.2.5 Use national guidance and market benchmarking analysis in the annual determination of remuneration of the Executive Directors.

2.2.6 Approve the arrangements for the termination of employment of any Executive Director and other contractual terms, having regard to any national guidance.

2.2.7 Approve contractual payments over £50,000 to all staff.

2.2.8 Approve any non-contractual severance payments to all staff.

2.2.9 Ensure that any proposed compromise agreement is justified and that it is drafted in such a way as not to prevent proper public scrutiny by NHSTDA, the Department of Health or external auditors.

2.2.10 Oversee the performance review arrangements for the Executive Directors ensuring that each receives an annual appraisal

3 Membership and attendance

3.1The membership of the Committee comprises:

• Chairman of the Board (Chair)
• All Non-Executive Directors
• The Chief Executive shall be a member but will withdraw from the meeting during any discussions regarding his terms of condition and remuneration.

3.2. The Director of Human Resources shall normally be invited to attend meetings in an advisory capacity. Other members of staff and external advisers may attend all or part of a meeting by invitation of the committee chair where required.

4 Quorum

4.1No business shall be transacted at a meeting unless the Chairman or Vice Chairman or Senior Independent Director and three Non-Executive Directors are present for the whole meeting.

5 Frequency of meetings

5.1The committee shall meet at least once a year.

6 Authority

6.1The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

6.2The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience if it considers this necessary.

7 Monitoring Effectiveness

7.1The Committee will undertake an annual review of its performance against its work plan in order to evaluate the achievement of its duties.

8 Other Matters
8.1The Committee shall be supported administratively by the Director of Corporate Affairs, whose duties in this respect will include:

• Agreement of the agenda with the Chairman;

Collation and distribution of the papers;

8.2 The Director of Workforce will minute the meeting.

9 Review
9.1These terms of reference will be reviewed at least annually as part of the monitoring effectiveness process.

Workforce Assurance Committee
Terms of Reference

1.0 Purpose

The purpose of the Committee is to provice assurance to the Trust Board:

- that there is an effective structure, process and system of control for workforce governance and risk management;
- that human resources services are provided in line with national and local standards and policy and in line with the Trust's corporate objectives;
- with regard to the development and delivery of the Trust's Workforce Strategy;
- that the Trust complies with relevant equality, diversity and human rights legislation.

2.0 Responsibilities

The Committee will lead on assurance in relation to the workforce; including the following:

2.1 To keep under review the development and delivery of the Trust's Workforce Strategy to ensure performance management is aligned to strategy implementation. The Committee will ensure that the workforce is agile and adaptable so that the Trust can respond swiftly to changes in the external environment;
2.2 To receive details of workforce planning priorities that arise from annual business planning processes and to receive exception reports on any significant risks or issues;
2.3 To ensure that effective workforce enablers are put in place to drive high performance and quality improvement;
2.4 To review performance indicators relevant to the Committee;
2.5 To monitor and evaluate Trust compliance in relation to the Public Sector Equality Duty;
2.6 To advise the Board on key strategic risks relating to workforce and employment practice and consider plans for mitigation as appropriate;
2.7 To receive and review regular reports on human capital management including leadership capability, workforce planning, cost management, regulation of the workforce and their health and wellbeing;
2.8 To receive and review reports on the staff survey and ensure that action plans support improvement in staff experience and services to patients;

2.9 Remit For Non-Executive Directors

- Ensure there are robust systems and processes in place across the organisation to make informed and accurate decisions concerning workforce planning and provision.
- Review data on workforce on a regular basis and hold Executive Directors to account for ensuring that the right staff are in place to provide high quality care to patients.
- Ensure that decisions taken at a Board level, such as implementing cost improvement plans, have sufficiently considered and taken account of impacts on staffing capacity and capability and key quality and outcome measures.
- Understand the principles which should be followed in workforce planning, and seek assurance that these are being followed in the organisation.

3.0 Membership

The membership of the Committee shall comprise:

- At least two Non-Executive Directors (one of whom shall Chair this Committee);
- Director of Strategy/ Deputy CEO
- Director of Workforce;
- Director of Nursing;
- Chief Operating Officer;
- Director of Finance
- Deputy Director of Workforce
- Director of Integrated Care Education Representative

All members of the Committee are expected to attend.
Other staff will be invited to attend as required.
On occasions deputies may attend with the agrement of the Chair in advance.
Attendance will be reported to the Trust Board and in the annual accounts / report.

4.0 Agenda Setting

- The agenda setting process will be initiated two weeks prior to the meeting by the Director of Workforce;
- A formal agenda and papers will be forwarded to all members one week prior to the meeting;
- If agenda items are required to be heard in confidence, the Director of Workforce will make arrangements for a separate confidential agenda and minutes, and ensure the meeting is conducted in such a way as ensures confidentiality.

Routine agenda items will include:

- The Workforce performance dashboard

5.0 Accountability and Authority

The Committee is accountable to the Trust Board and is a standing committee of the Board.
The Committee is authorised by the Board to investigate any activity within its remit. It is authorised to seek any information it requires from any employee of the Trust, and all employees are directed to co-operate with any request made by the committee.

The Committee is authorised by the Board to obtain outside legal or other independent professional advice. It may secure the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary.

6.0 Reporting

The Committee reports to the Board.

The Chair of the Committee will provide a verbal report to the Trust Board after each meeting and the committee minutes will be circulated to all Board members.

7.0 Review Date

The Committee's programme and functioning will be reviewed after one year.

Whittington Health NHS

FINANCE AND BUSINESS DEVELOPMENT COMMITTEE

TERMS OF REFERENCE

1. Authority

1.1 The Finance and Business Development Committee is constituted as a standing committee of the Trust Board. Its constitution and terms of reference are set out below and can only be amended with the approval of the Trust Board.

1.2 The Committee is authorised by the Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee of the Trust and all employees are directed to cooperate with any request made by the Committee.

1.3 The Committee is authorised by the Trust Board to secure the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary.

2. Purpose

2.1 The Finance and Business Development Committee shall review financial performance, business development and investment decisions of the Trust. The Committee will focus on assurance around risks (financial, delivery and regulatory) in both plans and delivery of plans. The Committee will seek assurances, mitigations and recovery action plans where appropriate.

2.2 The Committee will work with the CEO and Executive Management to ensure the organisation has the structure, resources and capacity to develop and grow third party business without any impact on its core operation of fully servicing the primary and social needs of the local community.

2.3 The Board may request that the Committee reviews specific aspects of finance and/or business development matters where the Board requires additional scrutiny and assurance.

3. Membership

3.1 The Committee shall be appointed by the Trust Board and be composed of:

- Three Non Executive Directors appointed by the Board
- Chief Executive Officer
- Chief Finance Officer
- Chief Operating Officer
- Director of Strategy

3.2 One Non Executive member of the Board will be appointed as the Chair of the Committee by the Trust Board.

3.3 A quorum shall be three members, at least two of whom should be Non Executive members of the Trust Board.

3.4 Members should make every effort to attend all meetings of the Committee and will be required to provide an explanation to the Chair of the Committee if they fail to attend more than two scheduled meetings in a calendar year. In this event, the Chair of the Committee will consider the appropriate action to be taken, including the option of recommending to the Trust Board the removal of the member from the Committee. The Committee Secretary will monitor attendance by members and report this to the Chair of the Committee on a regular basis.

4. Attendance

4.1 All other Non Executive Directors shall be welcome to attend. Executive Directors shall be invited to attend for specific agenda items as appropriate.

4.2 The following members of staff will also attend the Finance and Business Development Committee: Director of Contracts and Business Development, Deputy Director of Finance.

4.3 The Committee may invite other Trust staff to attend its meetings for specific agenda items as appropriate.

4.4 The Chief Finance Officer will ensure the provision of a Secretary to the Committee and appropriate support to the Chair and committee members. This shall include agreement of the agenda with the Chair and the Chief Finance Officer, collation of papers, taking the minutes and keeping a record of matters arising and issues to be carried forward and advising the Committee on pertinent areas.

5. Frequency of meetings

5.1 Meetings will normally be held every 8 weeks. Additional meetings may be arranged to discuss specific issues but any such meetings should be infrequent and exceptional.

6. Reporting

6.1 The Chair of the Finance and Business Development Committee will provide a written summary to the Trust Board after each meeting, highlighting key issues arising from the monthly finance report for discussion and any other items requiring decision. The approved minutes of the Committee's meetings will be available to all Trust Board members on request. The Chair of the Committee will draw to the attention of the Board any issues that require disclosure to the full Board, including those that are considered to affect the financial standing of the Trust or require executive action.

7. Review

7.1 The terms of reference shall be reviewed by the Finance and Business Development Committee and approved by the Trust Board at least annually.

8. Duties

Finance

8.1 Oversee and evaluate the development of the Trust's financial strategy to deliver its integrated business plan (IBP), incorporating a review of the risks and opportunities.

8.2 Gain assurance that an appropriate performance management process is in place to allow the executive to identify the need for corrective action and identify emerging risks.

8.3 Review the Trust's annual financial plans: revenue (OpEx), capital (CapEx), working capital, investments, borrowing and key performance targets; ensuring these are consistent with operational plans and risk assessed. Financial Plans should also be assessed against regulatory requirements and demonstrate appropriate consultation with key stakeholders, as appropriate.

8.4 Review and maintain an overview of the Trust's contract and service delivery agreements (>£5m pa) and material supplier agreements (>£1m pa) and ensure an adequate assessment of delivery risk. The Committee may wish to conduct a review of any new and innovative contract structures below the figures above. To conduct post implementation reviews of major contracts.

8.5 Review the Trust's Estates Strategy to ensure consistency with overall Trust Strategy assess for acceptable risk (delivery risk and residual risks). Any disposal plans should be assessed for political and reputational risks.

8.6 Review major investment plans (business cases) as defined by:

- Capital schemes (including leased assets and property) with an investment value in excess of £1 million.
- All revenue investment proposals with a cost implication in excess of £3 million over three years
- All proposed asset disposals where the value of the asset exceeds £1 million.

8.7 Review Trust performance against in-year delivery of the financial plan (income, expenditure, capital, cash, working capital and regulatory requirements), including delivery of the Trusts improvement programme supporting the financial plan; while recognising that the primary ownership and accountability for the Trust's financial performance rests with the full Trust Board.

8.8 Request, review and monitor any corrective action against financial plans.

8.9 Oversee the development of information systems to support the business interests of the Trust, including the review and development of performance and financial reporting.

8.10 To Oversee the development and application of Service Line Reporting and Reference Costs to support operational improvement and strategic decision making.

8.11 Consider key financial policies, issues and developments to ensure that they are shaped, developed and implemented in the Trust appropriately.

8.12 Request and receive training and development to assist the Committee in its responsibilities. This will include sessions from the Trust finance team and where appropriate from external sources.

8.13 ddress any specific requests by the Trust Board in relation to finance matters.

Business Development

8.14 Oversee and evaluate the development of the Trust's Business Development Strategy to deliver its integrated business plan (IBP), incorporating a review of consistency with Trust Strategy, risks (business, delivery and reputational) and market conditions.

8.15 Approve the resource structure, operating policies and procedures for the preparation of business development bids.

8.16 Receive, review and recommend to the Board proposals for new business development and existing major contracts due for renewal: market development, acquisitions, potential investments and disinvestments in order to recommend options to the Board.

8.17 Review the case for, and make recommendation to the Trust Board for, the establishment of any subsidiary bodies, joint ventures, strategic partnerships or other commercial partnerships (within the Trust's delegated authority under the Health and Social Care Act 2012) having regard to the risk profile and adequacy of investment requirements.

8.18 Review and support the development of the Whittington Charitable Trust to maximise the income from such activities available for investment in supplementing the core infrastructure and services capability of the Trust.

8.19 Make recommendations to the Trust Board in relation to any due diligence, warranties, assignments, investment agreements, intellectual property rights etc. related to joint ventures, commercial partnerships or incorporation of startup companies.

8.20 Monitor the outcomes of business development initiatives. Receive regular reports and updates from management regarding progress in the achievement of the business development elements of the Strategic Plan.

8.21 Examine any matter referred to the Committee by the Trust Board.