Whittington Health NHS

T R U S T B O A R D PUBLIC

14.00 – 16.30
Wednesday 5 April 2017

Whittington Education Centre
Room 7

NHS
Whittington Health
NHS Trust

Meeting	**Trust Board – Public**
Date & time	**05 April 2017 at 1400hrs – 1630hrs**
Venue	**Whittington Education Centre, Room 7**

AGENDA

Members – Non-Executive Directors	**Members – Executive Directors**
Steve Hitchins, Chair Deborah Harris-Ugbomah, Non-Executive Director Tony Rice, Non-Executive Director Anu Singh, Non-Executive Director Prof Graham Hart, Non-Executive Director David Holt, Non-Executive Director Yua Haw Yoe, Non-Executive Director	Simon Pleydell, Chief Executive Siobhan Harrington, Director of Strategy & Deputy Chief Executive 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:lynne.spencer1@nhs.net or 07733 393178

Agenda Item		Paper	Action and Timing
Patient Story			
	Patient Story *Philippa Davies, Director of Nursing & Patient Experience*	*Verbal*	*Note* 1400hrs
17/041	**Declaration of Conflicts of Interests** *Steve Hitchins, Chair*	*Verbal*	*Declare* 1420hrs
17/042	**Apologies & Welcome** *Steve Hitchins, Chair*	*Verbal*	*Note* 1425hrs
17/043	**Draft Minutes, Action Log & Matters Arising 1 March 2017** *Steve Hitchins, Chair*	1	*Approve* 1430hrs
17/044	**Chairman's Report** *Steve Hitchins, Chair*	*Verbal*	*Note* 1435hrs
17/045	**Chief Executive's Report** *Simon Pleydell, Chief Executive*	2	*Approve* 1445hrs
Patient Safety & Quality			

17/046	**Serious Incident Report Month 11** *Philippa Davies, Director of Nursing & Patient Experience*	3	*Approve* 1455hrs
17/047	**Safer Staffing Report Month 11** *Philippa Davies, Director of Nursing & Patient Experience*	4	*Approve* 1505hrs
17/048	**National Guidance on Learning from Deaths** *Richard Jennings, Medical Director*	5	*Approve* 1515hrs
Performance			
17/049	**Financial Performance Month 11** *Stephen Bloomer, Chief Finance Officer*	6	*Approve* 1525hrs
17/050	**Item withdrawn**	7	
17/051	**Performance Dashboard Month 11** *Carol Gillen, Chief Operating Officer*	8	*Approve* 1535hrs
Governance			
17/052	**Pharmacy Transformation Plan** *Siobhan Harrington, Deputy Chief Executive*	9	*Approve* 1545hrs
17/053	**Staff Survey 2016/17 Results and Action Plan 2017/18** *Norma French, Director of Workforce*	10	*Approve* *1555hrs*
17/054	**Standing Financial Instructions** *Stephen Bloomer, Chief Finance Officer*	11	*Approve* 1605hrs
17/055	**Register of Trust Deed of Executive / Seal** *Lynne Spencer, Director of Communications & Corporate Affairs*	12	*Approve* *1615hrs*
17/056	**Trust Board forward plan April 2017 to March 2018** *Lynne Spencer, Director of Communications & Corporate Affairs*	13	*Approve* *1625hrs*
17/057	**Draft Finance and Business Development Committee** *Tony Rice, Non-Executive Director*	14	*Note* *1635hrs*
Any other urgent business and questions from the public			
	No items		
Date of next Trust Board Meeting			
	03 May 2017 at 1400hrs to 1630hrs at the Whittington Education Centre Room 7, Magdala Avenue, N19 5NF		

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.

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Whittington Health NHS

ITEM: 01
Doc: 17/ 043

The minutes of the meeting of the Trust Board of Whittington Health held in public at 1400hrs on Wednesday 1st March 2017 in the Whittington Education Centre

Present:	Stephen Bloomer	Chief Finance Officer
	Philippa Davies	Director of Nursing and Patient Experience
	Carol Gillen	Chief Operating Officer
	Deborah Harris-Ugbomah	Non-Executive Director
	Siobhan Harrington	Director of Strategy/Deputy Chief Executive
	Steve Hitchins	Chairman
	David Holt	Non-Executive Director
	Richard Jennings	Medical Director
	Simon Pleydell	Chief Executive
	Tony Rice	Non-Executive Director
	Anu Singh	Non-Executive Director
	Yua Haw Yoe	Non-Executive Director
In attendance:	Janet Burgess	London Borough of Islington
	Norma French	Director of Workforce
	Kate Green	Minute Taker
	Lynne Spencer	Director of Communications & Corporate Affairs

Patient Story

Steve Hitchins introduced Chris Warburton, a patient of the Trust's respiratory services, and Philippa Davies thanked him for attending the meeting and introduced respiratory consultant Louise Restrick and clinical psychologist Sarah Lunn.

Chris informed the Board that he had been a Hackney resident for twenty-five years and had worked as a social worker and latterly as a web designer. Louise provided some statistics on the incidence of COPD (chronic obstructive pulmonary disease), explaining that 4000 residents in Islington suffered from it and that of these, at least one person per day was admitted to hospital. Their job was to enable patients suffering from COPD to live better lives. She went on to express her gratitude to Chris for the work he did with both the London Respiratory Network and the British Lung Foundation.

Chris introduced and showed the video made for the British Lung Foundation (watched by some 97,000 people) which gave an account of his living with COPD. Following the showing, Board members asked questions around the links between respiratory services and smoking cessation, the advantages Londoners have in terms of accessibility of services, and the invaluable support patients receive from the clinical psychology service.

17/27 Declaration of Conflicts of Interest

27.01 No member of the Board declared any conflicts of interest in the business scheduled for discussion at that afternoon's Board meeting.

17/28 Apologies and welcome

28.01 Steve Hitchins welcomed everyone to the meeting, and in particular Deputy Director of Workforce Helen Gordon, deputising for Norma French. Apologies for absence were received from Norma, Greg Battle, and Graham Hart.

17/29 Minutes, Matters Arising & Action Log

29.01 The minutes of the Trust Board meeting held on 1st February were approved. There were no matters arising other than those already scheduled for discussion.

29.02 Moving to the action log, it was noted that all actions had either been completed or were already scheduled on the agenda for either a future Board meeting or seminar. The only exception to this was the SI external review, and Richard Jennings undertook to keep Board members informed of progress on this.

17/30 Chairman's Report

30.01 On 23rd February Steve Hitchins had attended a meeting of the newly-established young people's forum, accompanied by Neeta Patel and Colette Datt. On 3rd February he had attended the Trust's cancer conference, a very successful and well attended event sponsored by Macmillan.

30.02 A retirement party had been arranged for a long-serving member of staff Jennifer Patterson, who had worked at Whittington Health for forty-one years. This event had prompted Steve to convene a meeting with Norma French to discuss long service awards, and he would welcome any suggestions from Board colleagues on how this might be instigated. A staff award ceremony was to be held on 29th June at the Royal College of Surgeons; there would be approximately sixteen categories of award and nominations would open on 24th March.

30.03 Together with Siobhan Harrington and Greg Battle, Steve had attended a meeting at the Goodinge Group Practice (where Greg is a partner) to hold discussions with representatives of the local authority and a local church about a possible joint initiative involving an adjacent building. If an agreement to proceed was reached this would link in with the Strategic Estates Partnership work. In answer to a question from Janet Burgess about who was representing the local authority in discussions, Siobhan replied that she had been liaising with Jess McGregor.

17/31 Chief Executive's Report

31.01 Simon Pleydell began his report by informing the Board that the Care Quality Commission (CQC) had recently imposed a new requirement on NHS organisations; this was to submit a quarterly return on avoidable deaths. A great deal of importance was attached to this return, which would in due course be published.

31.02 New guidelines on conflicts of interest had been published by NHS England and would come into force in June.

31.03 Moving on to targets, Simon confirmed that the Trust had still declared only one case of MRSA this year, and there had been no additional cases of C. Difficile. He was pleased to report that all cancer targets had been met in December, commenting that this demonstrated the level of attention to detail shown by staff. IAPT targets also continued to improve.

31.04 The Trust was to formally change its name from 'The Whittington Hospital NHS Trust' to 'Whittington Health'; this far better reflected the nature and ethos of an integrated care organisation and was of particular importance to community staff.

31.05 The Trust was involved in the work of the local cancer vanguard, a collaboration which would enable work to continue on designing improved care pathways with other local providers and thus improve outcomes for local people.

31.06 Siobhan Harrington informed the Board that work continued to secure the future provision of the LUTS clinic, including the establishment of a tertiary clinic at UCLH, however this remained complicated, and three meetings had been held recently with both UCLH and the commissioners. She had also met with Professor Malone-Lee that morning, and a meeting with the service users was scheduled for the following week. A paper would come to the Board which would focus on safety, governance and the succession plan, and this would be completed once some outstanding issues concerning the MDT were resolved. Regrettably the Trust would not be in a position to open the clinic to new patients next month, but remains committed to keeping the clinic open for existing patients.

31.07 Numbers recorded for January and February indicate that the Emergency Department remains under significant pressure, and the challenge now was how to achieve and maintain a level of performance that consistently fell within the 90% or above range.

31.08 The Trust had now appointed a Freedom to Speak Up Guardian, an important new role. Simon commented that he liked to feel that Whittington Health was an organisation where staff could speak openly about concerns, but he also understood that for some individuals this was not always possible.

31.09 Stephen Bloomer would be speaking about the Trust's financial position, in the meantime Simon stressed the importance of limiting expenditure wherever possible in order to meet the control totals to which we are committed.

31.10 The following Sunday would see the annual London mayors' charity walk from the Whittington Hospital to Mansion House – all were most welcome to attend and participate in this historical occasion, which would end with lunch at Mansion House.

31.11 Referring back to the requirement to report on 'avoidable deaths', Richard Jennings said that this was something which should be welcomed, since it had long been proven that the more transparent organisations were, the safer they became. There were definitions, but it was acknowledged that the term 'avoidable' was not a black and white concept. What was important was the identification of care issues which may have contributed to a death. He spoke about the improvements the Trust had made to sepsis care, saying that a learning event was planned in the near future; the basic underlying message being that improvements could not be made unless mistakes were acknowledged and efforts were made to put things right.

17/32 <u>Freedom to speak up Guardian</u>

32.01 Dorian Cole had recently been appointed to the role of Freedom to speak up Guardian, and he informed the Board that his first few weeks in post had been spent in looking at best practice followed by other organisations and creating publicity materials which would be presented at the Patient Experience Committee the following day.

Philippa Davies was the executive lead for this initiative; Yua Haw Yoe the non-executive director lead. Dorian had linked in with the national programme, and had also established a 'buddying' relationship with his equivalent at the North Middlesex. He had also updated the Trust's policy, and this too would be presented at the Patient Experience Committee the following day before going to the Policy Approval Group for ratification.

32.02 Dorian had commenced work on branding, saying that he would welcome Board members' views on this. A dedicated e-mail address had been created, plus a web-based referral form. A whistleblowing tab was also to be added to the Datix incident reporting system. The mobile telephone number listed in publicity was Dorian's own work one, and would be answered out of hours, although Richard Jennings pointed out that if really urgent issues were raised out of hours and needed immediate attention it would be more appropriate for them to be reported to Gold on call.

32.03 Dorian planned to hold roadshows, and to carry out some outreach work to junior doctors and student nurses; he would also be seeking views from the ICSUs about which groups should best be prioritised. For patients and carers wishing to raise issues of concern the PALS and complaints routes remained open. Dorian had received one call from a patient but had re-routed him appropriately to the correct clinical service and to PALS. It was agreed that there also needed to be a clear border between the Guardian role and HR processes such as the bullying and harassment policy. Dorian would maintain a close relationship with HR colleagues, and stressed that every contact would need to be looked at on a case by case basis. Helen Gordon reminded the Board that the Trust had also recently appointed anti-bullying and harassment advisors. Dorian invited David Holt to give this work and his role consideration; he said that he was looking forward to speaking to the Trust's Partnership Group on the role.

32.04 In answer to a question from Stephen Bloomer about how success would be measured, Dorian said that results would be incremental, with a sustained number of people raising concerns, although conversely he hoped that in the long time there would be a reduction in numbers as people gained confidence in the ability of local services to resolve issues. David Holt had asked the senior team at the Tavistock to consider how practices had changed, and Deborah Harris asked Dorian for further clarification on branding and whistleblowing. Dorian replied that there was a huge variety of practices amongst organisations, but some common themes included visibility, transparency and openness; he would also look to the NED champion and the audit Committee to help measure success. Philippa Davies added that she had now been the executive lead for whistleblowing for two years, and no concerns had been raised with her directly, although she had received two notifications from the CQC.

32.05 Turning back to branding, Janet Burgess pointed out that it was very difficult to read white lettering on a yellow background, and Dorian thanked her for this observation. Richard Jennings informed the Board that he had received one communication via the Guardian of Safe Working which had proved invaluable in terms of learning. He also said that experience had taught him that it appeared easier for staff to raise issues with him when he was visible in a clinical role rather than when he was in a suit as Medical Director – the moral of this was that the more visible leaders were on the floor, the more likely it was that issued would be raised. Dorian would provide regular feedback reports to the Board.

17/33 <u>Serious Incident Report</u>

33.01 Philippa Davies informed the Board that four serious incidents had been declared during January, taking the total to 49 incidents declared since 1st April. Three of these concerned falls, and Philippa reminded the Board that two of these had been reported the previous month due to their having resulted in severe harm. These incidents had

been discussed at the Trust Management Group (TMG) the previous day, and it had been agreed that there was no common theme, but a considerable amount of learning could be gleaned from all of them. It had been agreed at that meeting that TMG would receive a regular update on actions arising from learning in addition to reports being submitted to both the Patient Safety Committee and Quality Committee.

33.02 The organisation remained under huge pressure, with patients moving very rapidly through the system, so although there were no clear common themes arising from the serious incidents declared, it was acknowledged that at times when the hospital was extremely busy (particularly in winter) it became more of a challenge to prevent people from falling.

33.03 Whittington Health had joined the national falls collaborative, and had established a small team to work on that. Janet Burgess informed the Board that the local authority was also carrying out work on falls. Simon Pleydell spoke in support of the Trust's participation in the national collaborative and the learning that would come from this. Steve Hitchins enquired what measures could be put in place to prevent patients falling at home, and Carol replied that falls assessments were carried out on those deemed to be at risk. Richard Jennings added that a great many ED admissions came about as a result of people having fallen in the community.

17/34 Safe Staffing Report

34.01 Philippa Davies introduced the safe staffing report for January, saying that there had been an increased fill rate for care staff but a reduced use of specials that month. A table on Page 8 showed that agency usage had peaked on 16 January; this related to the need to open additional beds during a period of high demand.

34.02 Generally, safety on the wards had been managed through moving permanent staff to cover the additional beds opened and backfilling other areas. There had been an increase in shift booking through the Employee on Line service, and it was noted that if an agency nurse had been booked to cover a shift a member of the bank staff could 'bump' agency staff if they wished to cover that same shift.

34.03 There had been 27 reports submitted on Datix where staff had felt staffing levels to be unsafe; most related to the labour ward or maternity services. Philippa noted however that no harm had been reported to any patient during these times, although she assured the Board that she continued to maintain a close eye on all areas.

34.04 In answer to a question from David Holt about annual leave, Philippa replied that this was closely monitored by the heads of nursing. Some took annual leave in order to cover shifts on the staff bank, and the Board discussed this in detail, with some expressing considerable concern about work/life balance and the risk of staff making themselves unwell through working additional hours. Philippa assured the Board however that appropriate mitigations (including the working time directive, rests, breaks and long nights) were programmed into the health roster. It was not possible to say exactly what proportion of leave was taken up by working additional shifts since the Trust was only able to 'police' hours worked in its own organisation and staff were free to work additional hours elsewhere if they so chose.

17/35 End of Life Care Strategy Update

35.01 The End of Life Care Strategy Group was chaired by Greg Battle, with Carol Gillen and Steve Hitchins also attending. In Greg's absence, Carol took the Board through the report, highlighting some of the key achievements and main areas of focus mentioned.

There had been an increase in referrals to the Specialist Palliative Care Team (SPCT), and all Key Performance Indicators (KPIs) had been achieved for 2015/16. There had been an emphasis on training, with 50% of nursing staff in adult wards having completed their 'Sage & Thyme' training.

35.02 It was noted that the CQC inspection carried out in December 2015 had raised the fact that the palliative care service had not always been aware of the patient's preferred place of death (PPD), and considerable work was in hand to remedy this. In addition, the 'Co-ordinate my Care' facility was to be relaunched during the summer. Progress was also being made towards providing a 7 day palliative care service and options were currently being explored with the Central & North West London Foundation Trust as to how this might best be achieved.

35.04 Carol and Richard paid tribute to the immense contribution made by lead consultant Anna Kurowska who had recently retired from the Trust but had left a considerable legacy of good practice in this area.

17/36 Board Assurance Framework

36.01 Siobhan Harrington introduced the latest version of the Board Assurance Framework (BAF), which derived from ICSUs, Directorates and a range of other risk registers maintained across the Trust; it also included the first iteration of a risk profile for the Trust. She added that some new risks had been added, and it was also planned to add one which focused on cyber-security; financial risks would also need updating in readiness for the next financial year. The possible impact on Trusts of the new GP federations was also a matter for consideration.

36.02 The BAF was to be discussed at the Audit & Risk Committee the following day, and that committee would make recommendations around governance including the frequency with which it should be brought to the Board. It was agreed that the BAF would be placed on the agenda for discussion at a Board seminar in around three months' time. Before then, however, Siobhan would be establishing a task and finish group on risk. David Holt suggested that it would be useful for the Board to see some examples of what an amber rating might mean for each risk.

17/37 UCLH and Whittington Health Clinical Collaboration Memorandum of Understanding

37.01 Introducing this item, Simon Pleydell informed the Board that the memorandum of understanding (MoU) had been drawn up to reflect clinical collaboration between the two organisations, primarily focusing on hospital services but also including some community services. He stressed that this was categorically not about a merger, but was an attempt to make services more sustainable and of an even higher quality over time, there might also be an opportunity to work together on some back office functions. The MoU also did not preclude collaboration with other organisations. This was an important step for the Trust, and Simon said how important it was that staff and other stakeholders understood the rationale behind the decision.

37.02 Turning to the memorandum itself, Simon acknowledged that some parts of it had been captured extremely well; there were other sections which may not have been scoped as thoroughly. All in all though this was a good approach and one to which the Board could confidently lend its support.

37.03 Siobhan Harrington said that most of the detail was captured in the templates for the individual workstreams, including milestones and lessons learnt, although there was a need for additional thinking about evaluation. At this stage the only resource to support the collaborative came from a percentage of individuals' time, going forward, it was possible there might be a joint post which would be funded by UCLH.

37.04 It had been agreed by Simon and by Marcel Levi (UCLH's Chief Executive) that no attempt would be made to force anything through the collaborative unless both parties were fully supportive of it. Also essential to the success of this initiative was the caucus of goodwill between the two sets of clinicians. There might be occasions on which either or both sides might be unable to collaborate and this must in no way be viewed as a sign of failure. Richard Jennings reminded the Board that in a sense this was adding governance arrangements to current practice since there was already collaboration between the organisations, and he cited the TB service as an example.

17/38 Digital Strategy 2017-2020

Director of IM&T Glenn Winteringham was welcomed to this, his last meeting of Whittington Health's Board, since he was leaving the Trust that week. He gave apologies from Chief Clinical Information Officer Sam Barclay, who was currently working nights. Glenn went on to explain that the strategy had been developed with a great deal of input from the ICSUs, there had been a helpful Board seminar, and useful discussion at TMG – all suggestions and comments arising from these fora had now been incorporated, but the strategy was not vastly changed from the version circulated for the seminar. Both Tony Rice and David Holt expressed their support for the strategy and agreed it was a good piece of work. Richard Jennings added his support and thanked Glenn and Sam for the work that had gone into its creation.

38.01 Glenn also informed the Board that Whittington Health had been selected as Digital Fast Follower partner to University Hospital Bristol, the Global Digital Exemplar for the System CEPR. This would bring £5m central funding to advance the Trust's Digital Strategy. On behalf of the Board, Steve Hitchins thanked Glenn for all that he had achieved in his eighteen years at the Trust.

17/39 Financial Report

39.01 Stephen Bloomer introduced the financial report, saying that in January the Trust had reported a £0.8m deficit, bringing the year to date position to a deficit of £5.9m, a £0.2m adverse position against planned performance. The key driver remained pay expenditure, and Stephen confirmed that the Trust continued to struggle with agency costs. This in turn meant that the Trust would be unable to deliver on the associated CIP; this would therefore have to be downgraded.

39.02 The position on non-pay for January was better, but with the exception of Patient Access, Prevention & Planned Care, most of the ICSUs were not achieving their projected control totals. Further financial controls have been put in place for Months 11 and 12, and Stephen expected the position at Month 11 to be no better but improved at Month 12.

ICSUs and all Directorates had been asked to adhere to the controls imposed; they had been asked to plan for the first quarter of 2017/18. The Trust had agreed a lower capital spend. Steve Hutchins spoke of the importance of staff supporting finance colleagues as they worked towards achievement of the planned position at year end.

17/40 Performance Dashboard

40.01 Carol Gillen began her report by saying that ED had been particularly challenged in January, with a very high level of acuity. The Trust had been forced to cancel all elective activity bar urgent cases and cancer. Because of the level of acuity Carol had commissioned a distinct report, and would be happy to share this with Board colleagues. There had been an increase in length of stay, particularly amongst the elderly. ECIP had visited the Trust the Trust the previous day to look at back of house functions, and had been very impressed by the commitment and energy of the team. The aim now, Carol said, was to focus on a full capacity protocol, creating a 'perfect week' momentum every day.

40.02 All cancer targets had been achieved, as had the emergency readmission target. Turning to theatre utilisation, Carol informed the Board that 57 procedures had been cancelled during January due to bed pressures. Appraisal compliance had risen slightly, however performance relating to complaints response times had fallen in-month. There had been two mental health twelve-hour breaches in January, in both cases caused by a lack of available mental health beds; this was therefore quite outside Whittington Health's control. Data on such incidents is being captured and shared with the Trust's commissioners and the Commissioning Support Unit (CSU). Carol explained that mental health patients would be admitted to Whittington Health beds only where it was deemed to be in their best interests.

40.03 Simon Pleydell acknowledged the outstanding hard work people had been putting in within the emergency and urgent care pathway, but stressed that the Trust really needed to raise its ED performance to 95% again. Carol replied that the team did try very hard to aim for a performance in the nineties. She added that there was a renewed focus on enhanced recovery techniques, but occasionally despite the best efforts of staff sometimes patients could not be discharged for external reasons e.g. a recent case where a patient could not be discharged as his family had failed to bring in his keys. Richard Jennings added that there was a growing awareness amongst patients that a hospital was a place where one might catch a disease (flu, for example).

17/41 <u>Trust Board and Senior Team Declaration of Interests Register</u>

41.01 Lynne Spencer invited everyone to check the register for accuracy and continue to follow the national guidance on declaring interests. She was thanked for all the work that had gone into preparing this.

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Action Notes Summary

Minute	**Action**	**Date**	**Lead**
29.02	SI external review - Richard Jennings to keep Board members informed of progress	**tbc**	**RJ**
31.06	A paper would come to the Board on safety, governance and the succession plan; once MDT outstanding issues resolved	**tbc**	**SMH**
32.05	Freedom to Speak Up – regular reports to Board	**Forward plan**	**PD**
36.02	It was agreed that the BAF would be placed on the agenda for discussion at a Board seminar in around three months' time	**July 2017**	**SMH**

Whittington Health Trust Board

5 April 2017

Title:	Chief Executive Officer's Report for February 2017 to the Board		
Agenda item:	**17/045**	**Paper**	**02**
Action requested:	For discussion and information.		
Executive Summary:	The purpose of this report is to highlight specific issues to the Trust Board and to update the Board on local, regional and national key issues facing the Trust.		
Summary of recommendations:	To note the report.		
Fit with WH strategy:	This report provides an update on key issues for Whittington Health's strategic intent.		
Reference to related / other documents:	Whittington Health's regulatory framework, strategies and policies.		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	Risks captured in risk registers and/or Board Assurance Framework.		
Date paper completed:	27 March 2017		

Author name and title:		**Lynne Spencer, Director of Communications & Corporate Affairs**		**Director name and title:**		**Simon Pleydell, Chief Executive**	
Date paper seen by EC n/a	**n/a**	**Equality Impact Assessment complete?**	**n/a**	**Quality Impact Assessment complete?**	**n/a**	**Financial Impact Assessment complete?**	**n/a**

CHIEF EXECUTIVE OFFICER REPORT

The purpose of this report is to highlight issues and key priorities to the Trust Board.

STAFF AWARDS

We will be hosting an Annual Award Ceremony on 29 June 2017 at the Royal College of Surgeons. Staff will be encouraged to nominate different categories throughout April and May and our judging panel will make the final decision on winners who will be invited to the event to celebrate their achievement.

1. QUALITY AND PATIENT SAFETY

National Guidance on Learning from Deaths

The first edition of the *'National Guidance on Learning from Deaths*' has been published by the National Quality Board. This is in response to a number of high level reviews that have concluded that learning from deaths was not being given sufficient priority in some NHS organisations. This has resulted in missed opportunities to improve NHS services through the review of deaths. The guidance will be used nationally to standardise the approach to governance and reporting arrangements. Today's Board meeting will receive a full report from the Medical Director.

MRSA Bacteraemia

We have reported 1 case of hospital acquired MRSA bacteraemia in February and this brings the total to 2 cases for the reporting year 1 April 2016 to 31 March 2017. We will continue to manage our high profile infectious control campaign across the community and hospital in 2017/18.

Clostridium Difficile

We have reported 6 cases of Clostridium Difficile up to the end of February. The target is for no more than 17 cases this year.

Cancer Waiting Time Targets

We were pleased to have exceeded our cancer targets for January with the exception of the 62 days from referral to treatment**.** *Reported in arrears in line with the national cancer data validation process*.

- 31 days to first treatment 97.8% against target of 96%
- 31 days to subsequent treatment (surgery)100% against target of 98%
- 31 days to subsequent treatment (drugs)100% against a target of 93%
- 62 days from referral to treatment 82.7% against a target of 85%
- 14 days cancer to be first seen 94.7% against a target of 93%
- 14 days to be first seen for breast symptomatic 93.4% against a target of 93%

Cause of breaches for 62 days from referral to treatment target: Breast – 0.5 breach – Colorectal – 0.5 breach – Cancer – 1.0 – Gynaecology – 1.5 breaches – Lung – 1 breach (2 half breaches), Urology – 2 breaches. We will continue to monitor our care pathways and treatment with a threshold of day 38 to trigger onward referral for patients.

Community Access Targets

Our Improving Access to Psychological Therapies (IAPT) targets continue to improve:

- IAPT - patients moving to recovery 50.4% - target of 50%
- IAPT – patients waiting for treatment <6 weeks – 97.2% - target 75%

2. STRATEGIC

Strategic Estates Partnership (SEP)

We have continued to meet different providers during this month and have received detailed final presentations. We have now closed the process and will be reporting to the Board in June on our decision for a preferred partner to help us delivery our Estate Strategy over the forthcoming years.

Lower Urinary Tract Services (LUTs) Clinic

We continue work to deliver the action plan against the Royal College of Physicians invited service review recommendations. We attended the North Central London Joint Overview and Scrutiny Committee last month with commissioners and reported on the complexities of ensuring the service is relocated to a tertiary centre and that a succession plan is concluded to secure clinical leadership of the LUTs service.

3. OPERATIONAL

Emergency Department

Extreme pressures within the emergency care pathway continue to be an issue. Our 4hr performance for February was 86.6% against a target of 95%. Year to date our performance is 87.3%. The admitted pathway continued to be a pressure with total attendances slightly down on last year. Delayed transfers of care improved from January and daily reviews of patients medically fit for discharge will continue to be a focus.

The Emergency Care Improvement Programme (ECIP) supported a review of the 'back of hospital 'having undertaken a review of 'front of house' in November and December. We are taking forward the key recommendations which include:

- Implementation of the SAFER patient bundle supported by the red 2 green approach
- Measurement and monitoring of inter professional standards developed from our 'Perfect Week / Breaking the Cycle' held in January
- Development of a full capacity protocol to support ambulance handovers to mitigate the risk at times of peak escalation

We will be taking part in a whole system external event at the end of April to complete the emergency pathway diagnostic and improvement plan.

Perfect Week / Breaking the Cycle

The Perfect Week initiative aims to change the way patients are seen, treated and discharged from hospital, to improve safety, patient experience, and our performance.

There is good evidence to show that improving patient flow saves patient lives and we have made good progress implementing the lessons from previous Perfect Week initiatives. To help us make sure our hospital is running as well as possible we will be running the Perfect Week III from 24 – 28 April 2017.

4. WORKFORCE

London Marathon

We have 7 marathon runners for this year's event which will take place on Sunday 23 April. The communications team will be at the event to follow our runners and post messages of support on social media. They will be at our cheering point at the junction of Birdcage Walk and Horse Guard's Road from 10.30am and everyone is welcome.

The runners are members of staff Christine Lane, Clinical Governance, Lisa Basi, District Nursing Manager, Paul Abdey, Lead Resus Officer, Sabrina Mijjoo, Resus Officer, and ex member of staff Tara Boyle, (former Midwife Screening Co-ordinator) and 2 members of public and supporters of our charity Jan Mikulin and Jonathan Abrams.

Annual Staff Survey 2015/16

Overall there is an improvement in our position from the previous year. Our top scores compared with other Trusts are set out below:

	Indicator	Our Trust	National
1	Percentage of staff reporting errors, near misses or incidents witnessed in last month	97%	91%
2	Quality of appraisals	3.35	3.11
3	Percentage of staff/colleagues reporting most recent experience of violence	78%	67%
4	Percentage of staff agreeing that their roles make a difference to patients / service users	93%	91%
5	Percentage of staff reporting good communication between senior management and staff	36%	32%

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. There has been a focus on incident reporting and feedback and this appears to have been reflected in the results.

Our lower scores compared with other Trusts are set out below:

	Indicator	Our Trust	National
1	Staff working extra hours	78%	71%
2	Staff suffering work related stress in last 12 months	42%	36%
3	Staff experiencing harassment, bullying or abuse from staff	30%	23%
4	% of staff experiencing discrimination at work in the last 12 months	19%	10%
5	% of staff experiencing harassment, bullying or abuse form patients, relatives or the public in last 12 months	31%	26%

It is the first time that the % of staff experiencing harassment, bullying or abuse from patients has been highlighted as a concern.

Full details of our results are set out in our staff survey report to the Board which includes our action plan to address the areas which are of the highest concern to staff and which rank lower than other Trusts as above.

5. FINANCE – APRIL TO FEBRUARY - MONTH 11

We reported a £0.5m deficit in February in line with our expected run rate. During this month we introduced stronger financial controls for pay and non-pay to manage expenditure. We are £0.2m off plan year to date and will continue our enhanced controls to meet our £6.4m control total for 2016/17.

Summary issues:

- Pay expenditure was £0.3m adverse against plan in February and £2.9m adverse year to date. In total the pay bill for February was £18.3m the lowest month since September.
    - Total agency costs for February were £1.1m, an increase of c£0.1m compared to January. Overall pay costs were lower due to a reduction in permanent whole time equivalent staffing; notably in medical and nursing.
    - Increase in agency costs for medical, scientific and other staff offset by a reduction in administration and nursing staff and nursing agency reported was 7.3% slightly over the cap of 6%.

- Non Pay expenditure was favourable against plan at £0.2m in month and £4.3m year to date.

- Total income for the month was £25.5m in line with our plan.

The cash balance of £3.1m is on target and this includes our Sustainability and Transformation Funding (STF) for Q1 and Q2.

Capital spending commitments total £3.2m with £2.8m incurred to date. We reforecast our capital spend for the year to 6m in line with NHS Improvement requirements.

6. AWARDS

Congratulations to Louise Restrick, Integrated Consultant Respiratory Physician, who has won the March staff excellence award. Louise is this month's winner because of her innovation, passion and ability to inspire and motivate colleagues. She works tirelessly and enthusiastically to improve the safety and quality of care for patients.

Congratulations to Drs Celia Bielawski, Pauline Leonard and Rhodri Edwards who won the UCLP Postgraduate Medical Education Awards 2017 Innovative Integrated Education working across primary and secondary care settings.

Congratulations to UCLP Postgraduate trainer of the year, Dr Caroline Fertleman.

Simon Pleydell
Chief Executive

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April 2017

Title:	Serious Incidents - Monthly Update Report		
Agenda item:	17/046	**Paper**	03
Action requested:	For Information		
Executive Summary:	This report provides an overview of serious incidents (SI) submitted externally via StEIS (Strategic Executive Information System) as of the end of February 2017. This includes SI reports completed during this timescale in addition to recommendations made, lessons learnt and learning shared following root cause analysis.		
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. • NHS England 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:	30/03/2017		

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		**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 2017.

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

2. Background

The Serious Incident Executive Approval Group (SIEAG) comprising the Executive Medical Director/Associate 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, high risk incidents are reviewed by the panel 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 declared 7 serious incidents during February 2017 bringing the total of reportable serious incidents to 56 since 1st April 2016.

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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
Safeguarding Incident Ref:13782	May 16	Safeguarding incident in relation to a patient on a current caseload.
Sub Optimal Care of Patient Ref:28091 (submitted 10/03/2017)	Oct 16	Patient developed pressure ulcers due to pressure relieving equipment not being provided.
Suboptimal Care of Deteriorating patient. Ref: 29018 (submitted 10/03/2017)	Nov 16	Patient admitted to ITU with a type 2 respiratory failure and acute kidney injury.
Unexpected Death Ref:29379 (submitted 30/03/2017)	Nov 16	Patient assessed and discharged and was subsequently found unresponsive.

Category	Month Declared	Summary
Unexpected Death Ref:31941	Dec16	Patient assessed and discharged by the Mental Health Liaison Team with referral to the crisis team. Patient was subsequently found unresponsive.
Patient Fall (ward 1) Ref: 33339 (submitted 31/03/2017)	Dec 16	Patient fell from standing position resulting in a fractured skull and intra-cerebral bleed.
Patient Fall (ward 2) Ref:390 (submitted 10/03/2017)	Jan 17	Patient fell forward from the bottom of the bed resulting in a subdural haematoma
Patient Fall (ward 2) Ref:2718	Jan 17	Patient had an unwitnessed fall resulting in a fractured neck of femur.
Delayed Diagnosis Ref:2722	Jan 17	A delay in diagnosing a perforation of the gastrointestinal tract.
Patient Fall (ward 3) Ref:2706	Jan 17	Patient had an unwitnessed fall resulting in subdural haematoma.
Sub optimal care of deteriorating patient Ref: 4094	Feb 17	Patient was admitted with exacerbation of Chronic Obstructive Pulmonary Disease (COPD)
Treatment Delay Ref: 4095	Feb 17	Patient underwent planned surgery was discharged home, and later presented to a neighbouring hospital with a CVA.
Unexpected Death- Influenza Ref: 4856	Feb 17	Patient was admitted and treated for community acquired pneumonia.
Safe guarding Incident - patient absconding from ward Ref: 4788	Feb 17	Teenager detained under section 5.2 of the Mental Health Act absconded prior to completion of essential treatment.
Delayed Diagnosis Ref: 5501	Feb 17	Delay in follow up CT scan and subsequent diagnosis.
Patient Fall Ref:6087	Feb 17	Patient stood to use commode and fell sideward resulting in a fractured neck of femur.
Unexpected Admission to NICU Ref: 6159	Feb 17	Following an emergency caesarean section infant was born in poor condition requiring resuscitation. The baby was transferred to the Neonatal Intensive Care unit.

The table below details serious incidents by category reported to the NEL CSU. The Trust reported 7 serious incidents during February 2017.

STEIS 2016-17 Category	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Total
Safeguarding	0	1	1	0	1	0	1	0	0	0	1	5
Attempted self-harm	0	0	0	0	0	0	0	1	0	0	0	1
Confidential information leak/loss/Information governance breach	1	2	1	0	1	1	0	0	0	0	0	6
Diagnostic Incident including delay	2	1	0	0	0	1	1	1	0	1	1	8
Failure to source a tier 4 bed for a child	0	0	0	1	0	0	0	0	0	0	0	1
Failure to meet expected target (12 hr trolley breach)	0	0	0	0	0	0	1	0	0	0	0	1
Maternity/Obstetric incident mother and baby (includes foetus neonate/infant)	1	1	1	0	0	2	1	0	0	0	1	7
Maternity/Obstetric incident mother only	0	0	0	0	1	0	1	0	0	0	0	2
Medical disposables incident meeting SI criteria	0	0	0	0	0	0	1	0	0	0	0	1
Nasogastric tube	0	0	0	0	0	0	1	0	0	0	0	1
Slip/Trips/Falls	0	0	0	1	0	0	0	0	2	3	1	7
Sub optimal Care	0	0	0	0	0	0	1	1	0	0	1	3
Treatment Delay	0	0	0	0	0	0	1	0	0	0	1	2
Unexpected death	0	1	0	1	0	1	0	5	1	0	1	10
Retained foreign object	0	0	0	0	0	1	0	0	0	0	0	1
Total	4	6	3	3	3	6	9	**8**	**3**	**4**	**7**	**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. The panel discuss lessons learnt and appropriate action, both immediate if applicable, and planned to prevent future harm occurrences.

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, what has been learnt and what steps are being put in place. 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 investigations completed and submitted during February 2017.

Lessons learnt 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, 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 6 reports to NELCSU during February 2017.**

The table below provides a brief summary of lessons learnt and actions put in place relating to a selection of the serious incident investigation report submitted in February 2017.

Summary	Actions taken as result of lessons learnt
• **Ref:25397**	**2016.25397 Unexpected death of patient with bilateral pulmonary embolism**. • A review has taken place of all team email addresses and contact numbers and all 'old' groups have been deleted. • Patient Information Leaflets are being provided to all patients referred to the District Nursing (DN) Service including 'virtual ward' referrals prior to discharge. • The Trust is continuing its work in improving the safety-netting of the discharge of complex or vulnerable patients and considering extra measures on discharge (e.g. engaging family, contacting GP, telephone call to DN coordinator). • Capacity assessments are now formally documented on ICE (Electronic patient record system) in addition to being referenced in the medical notes.
• **Ref:30701**	**2016.30701 Inappropriate surgical referral and delayed diagnosis.** • Introduction of a new surgical booklet with integrated monitoring plans and treatment escalation plan to improve compliance across the surgical ICSU. • An Audit to be undertaken to determine theatre utilisation of specific lists in hours and out of hours to determine whether opportunities are missed to operate on specific patients sooner.
• **Ref:30095**	**2016.30095 A delay in reviewing biopsy results, led to delay in diagnosis.** • A clear and robust standard operating policy in line with the guidelines is being produced which will be reviewed annually • Recruitment and retention plans in place to ensure that the service has a full complement of staff**.** • A review of the service to be undertaken.

5. 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. National Reporting and Learning System (NRLS)

The latest Organisation Patient Safety Incident report from the National Reporting and Learning System (NRLS) recently released for incidents occurring between 01 April 2016 to 30 September 2016, shows the Trust to be in the highest 25% of reporters (across 136 Acute organisations) . We reported 48.6 incidents per 1000 bed days. The lowest reporting rate was 21, with the median being 40.02 per 1000 bed days.

The report states the following: "*Organisations that report more incidents usually have a better and more effective safety culture. You can't learn and improve if you don't know what the problems are.*" It goes on to say "*An NHS trust where staff feel encouraged and supported to report should show a higher rate of incident reports, a higher proportion of no harm reports, and staff survey responses about incident reporting behaviour that are above average*".

This is a great achievement for the Trust and we hope to maintain (and improve on) this positive reporting culture.

7. Summary

The Trust Board is asked to note the content of the above report which aims to provide assurance that the serious incident process is managed effectively and lessons learnt as a result of serious incident investigations are shared widely.

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Whittington Health Trust Board

March 2017

Title:	Safe Staffing - Nursing and Midwifery – February data		
Agenda item:	**17/047**	**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 2017. Key issues to note include: 1. A decreased fill rate for Registered Nurses displayed in the UNIFY report 2. An increase use of shifts to provide enhanced care to support vulnerable patients February (142) vs January (114) 3. No red shifts were reported in February 4. The number of RMNs used to provide enhanced care for patients with a mental health conditions was higher in February (43) compared to January (26). 5. CHPPD measure during the month was decreased from (8.46) in February compared to (8.54) on January 6. The continued use of agency and bank staff to support safe staffing. 7. 14 Datix reports in February highlighting staffing as an issue none of which were defined as “Patient Harm”		
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:			
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 2017		

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		**Equality Impact Assessment complete?**		**Risk assessment undertaken?**		**Legal advice received?**	

Ward Staffing Levels – Nursing and Midwifery

1.0 Purpose

1.1 To provide the Trust Board with assurance with regard to the management of safe nursing and midwifery staffing levels for the month of February 2017.

1.2 To provide context for the Trust Board on the UNIFY safe staffing submission for the month of February 2017.

1.3 To provide assurance of the constant review of nursing/midwifery resource using Healthroster.

2.0 Background

2.1 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.

2.2 Staffing levels are viewed alongside reported outcome measures, patient acuity, '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.

2.3 The electronic HealthRoster (Allocate) with its 'SafeCare' module is utilised across all inpatient wards. The data extracted, provides information relating to the dependency and acuity of patients. This, in addition to professional judgement is used to manage ward staffing levels on a number of occasions on a daily basis.

2.4 Care Hours per Patient Day (CHPPD) is an additional parameter to manage the safe level of care provided to all inpatients. This measure uses patient count on each ward at midnight (23.59hrs). CHPPD is calculated using the actual hours worked (split by registered nurses/midwives and healthcare support workers) divided by the number of patients at midnight (See 7.6 for February data by ward).

2.3 Staff fill rate information appears on the NHS Choices website www.nhschoices.net. Fill rate data from 1st – 28th February 2017 for Whittington Hospital was 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 able to see how hospitals are performing on this indicator on the NHS Choices website.

2.4 Summary of Staffing Parameters

Standard	Measure	Summary
Patient safety is delivered though consistent, appropriate staffing levels for the service.	Unify RN fill rate	Day – 87.6% Night – 90.7%
	Care hours per Patient Day - CHPPD	Overall the CHPPD for February was 8.46 which is lower than last month, the RN delivered care continues to be consistent
Staff are supported in their decision making by effective reporting.	No Red triggered shifts	0 shifts triggered red in February 2017 this was less than January
	1.26% of shifts that remained partially mitigated (Amber shifts)	16 shifts i.e. 1.26% of all shifts in month. This was a decrease on January's figure. These consisted of shifts mainly during the day distributed between early and late.

3.0 Fill rate indicator return

3.1 The 'actual' number of staffing hours planned is taken directly from our nurse roster system (Allocate). On occasions when there was a deficit in 'planned' hours versus 'actual' hours, and additional staff were required, staff were reallocated to ensure safe staffing levels across our organisation. Staff are also reallocated to ensure wards/areas are staffed to a safe ratio of permanent to temporary staff.

3.2 Appendix 1 details a summary of fill rates 'actual' versus 'planned'. The average fill rate was 87.6%for registered staff and 115.4% for care staff during the day and 90.7% for registered staff and 121.5% for care staff during the night.

3.3 On the day shift, 12 wards reported below 90% fill rates for qualified nurses. Thirteen wards had above 100% fill rate for unqualified nurse and seven wards had above 100% fill rate for qualified nurses.

3.4 The UNIFY report show some wards with unusually high percentage fill rates; for example, Mary Seacole North and South at above 200% for HCAs. In these areas Band 4 Assistant Practitioners have been appointed as HCAs thereby increasing the HCA workforce on the wards. Where the percentages are low for Registered Nurses they are correspondingly high for Healthcare Assistants and vice versa. This is a professional decision which is taken by the Matron depending on the needs of the specific patient group.

It must be remembered if the establishment of the ward for HCAs is 1 wte and two staff work then this represents a 100% increase.

Day		Night	
Average fill rate registered Nurses /Midwives	Average fill rate Care Staff	Average fill rate registered Nurses/Midwives	Average fill rate Care Staff
87.6%	**115.4%**	**90.7%**	**121.5%**

4.0 Additional Staff to provide 1:1`enhanced care

4.1 When comparing February's total requirement for 1:1 staff to provide enhanced care with previous month, the figures demonstrate an increase in the number of shifts required (Appendix 2). February saw 142 requests for 1:1 enhanced care provision, compared to 114 requests in January. The requests made for this level of care were to ensure the safe management of particularly vulnerable groups of patients.

4.2 The number of RMN staff booked for shifts to provide enhanced for patients with a mental health condition was higher in February (43) compared to January (26). All requests for registered mental health nurses are validated by the Heads of Nursing and a clinical assessment made as to the therapeutic need. These requests may then be downgraded to provide an HCA rather than an RMN.

4.2 There continues to be a high level of need for provision of enhanced acre for patients with mental health conditions and for managing patients who require constant supervision to prevent falls.

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

5.1 Safe staffing levels are reviewed and managed three times daily. 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 all areas are made safe. Matrons and Heads of Nursing review staffing levels again at 13.00 and 17.00 to ensure levels remain safe.

5.2 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 and are managed in conjunction with patient dependency and acuity. The matron will be alerted, and take appropriate action. 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.

5.3 Red Shifts

During February no shifts triggered red.

Month	% shifts triggering red in month	Actual number of red shifts
February	0	0
January	0.2	3
December	0.3	4

5.4 Wards triggering red shift

	Initial Red Shifts				
Wards	Early	Late	Night	Number of shifts where staffing initially fell below agreed levels	% of shifts where staffing fell below agreed levels and triggered a red rating
0	0	0	0	0	**0**

5.5 Summary of factors affecting red triggering shifts

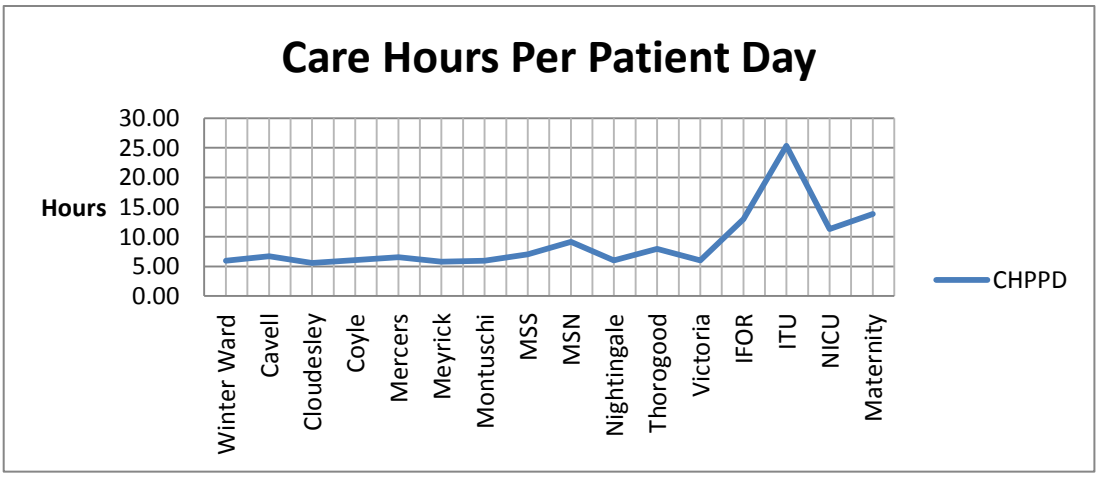
a. Temporary staffing fill
b. Vacancy rate – Nurse Vacancy rate at ward level remains high and continues to impact on temporary staffing requirement.
c. 'Specialing' requirement
d. Additional beds opened to increase bed base capacity

6.0 Reported Incidents of Reduced Staffing (Datix Reports)

6.1 Staff continue to be encouraged to report actual or potential safety incidents. During February 2017, Datix reports submitted relating to staffing numbered 17. These reports outlined a range of issues from increased patient demand to reporting the level of staffing available. Ten of the cases raised were in one clinical area (Labour ward). Staff were redeployed from across the Maternity service to maintain safe staffing levels. All other incidents were risk assessed and managed appropriately by the senior nursing team or site managers.

7.0 Care Hours per Patient Day (CHPPD)

7.1 Care hours per patient day is calculated using the patient count on each ward at midnight (23.59hrs). CHPPD is calculated taking the actual hours worked (split by registered nurses/midwives and healthcare support workers) divided by the number of patients at midnight. The graph below shows the average individual care hours per patient for each clinical area. ITU have the most care hours (25.36) and Cloudesley ward have the least (5.59).



7.2 The average number of hours of Registered Nurse time spent with patients was calculated at 6.05 hours and 2.41 hours for care staff. This provides an overall average of 8.46 hours of care per patient day.

	CHPPD
Registered Nurse	**6.05**
Care Staff	**2.41**
Overall hours	**8.46**

7.3 The total care hours per patient day is one of the metrics used on a daily basis by the Senior Nursing Team to monitor the level of nursing man hours required to delivery care on our inpatient wards.

7.4 The new SaferCare module of the Healthroster system provides an estimate of the total time required to provide the necessary care using the acuity and dependency of patients and calculates the available nursing time.

7.5 The data from CHPPD indicates the total amount of care hours delivered to patients over the last four months has remained similar. Each ward maintained a high level of care delivery when comparing the total registered nurses hours available.

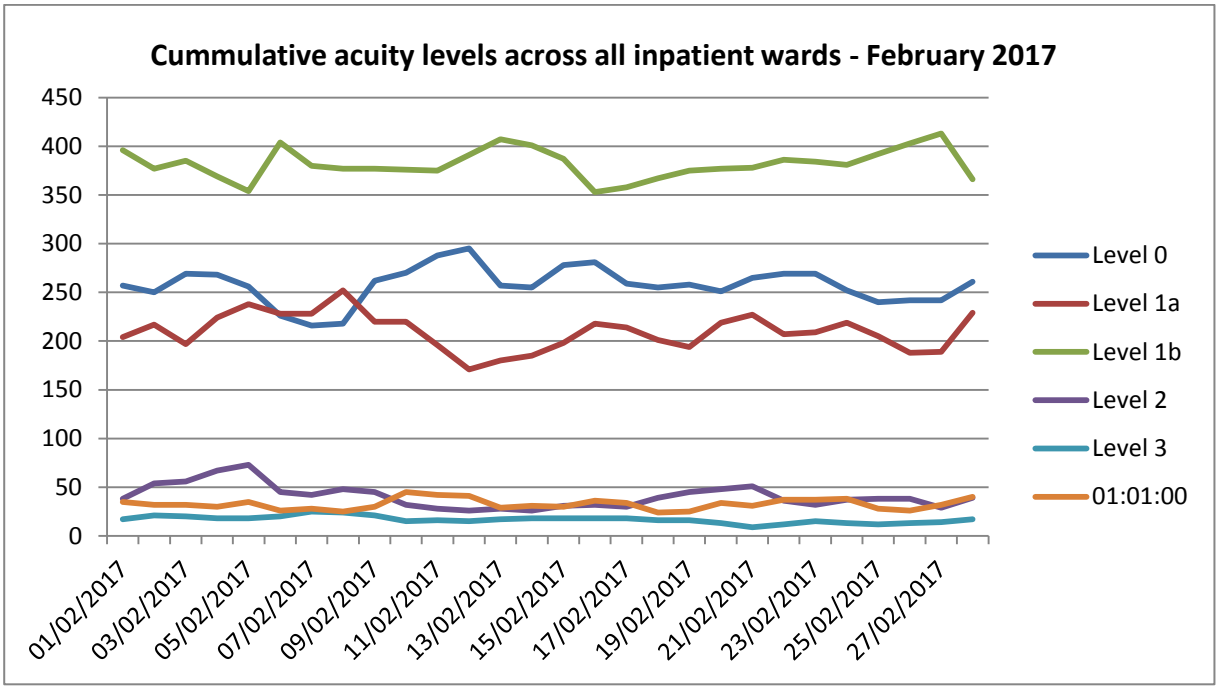
7.6 The table below shows the CHPPD hours for each in patient ward over the last four months and indicates the level of need remained stable overall. There is a slight decrease in hours of care delivered in February compared to January.

Ward Name	Feb-17	Jan-17	Dec-16	Nov-16
Bridges	0	0	0	0
Winter Ward	5.97	5.66	5.51	6.93
Cavell	6.70	5.95	7.00	6.89
Cloudesley	5.59	5.39	5.57	5.32
Coyle	6.04	5.96	5.90	5.57
Mercers	6.54	6.81	7.13	6.65
Meyrick	5.82	5.51	6.20	6.39
Montuschi	5.94	6.13	6.31	6.02
MSS	7.02	6.81	7.10	7.04
MSN	9.17	8.39	8.98	8.42
Nightingale	6.02	6.25	5.93	5.91
Thorogood	7.93	6.67	7.09	6.85
Victoria	6.03	5.80	6.45	7.84
IFOR	12.97	12.85	11.09	8.71
ITU	25.36	26.82	26.71	25.43
NICU	11.33	11.30	11.41	12.30
Maternity	13.84	15.87	15.53	13.71
Total CHPPD	**8.46**	**8.54**	**8.76**	**8.58**

8.0 Patient Acuity

8.1 The acuity of patients is dependent on their care requirements. Those patients requiring a low level of care are assigned level 0 and those requiring intensive care are assigned level 3. The trust is experiencing a high number of patients with levels of acuity at level 1b. This level indicates a patient is requiring a high level of nursing support. Many patients required total support with their activities of daily living which would include washing, toileting and feeding. These patients require two staff to care for their daily needs.

8.2 The graph below demonstrates the level of acuity across inpatient wards in February. As expected, there are a low number of level 3 patients and a high number of level 0 patients. The number of level 1b patients remains high. This increased number of dependant patients requires a greater nursing support.



9.0 Temporary Staff Utilisation

9.1 Temporary staff utilisation (nursing and midwifery) is monitored daily by the Deputy Director of Nursing. All requests for temporary staff (agency) are reviewed by the Head of Nursing/Midwifery. A further review and final authorisation is then made by the Deputy Director of Nursing.

9.2 Monitoring the request for temporary staff in this way serves two purposes:

a) The system in place allows for the most appropriate use of high cost temporary agency staff across the organisation and provides a positive challenge mechanism for all requests.

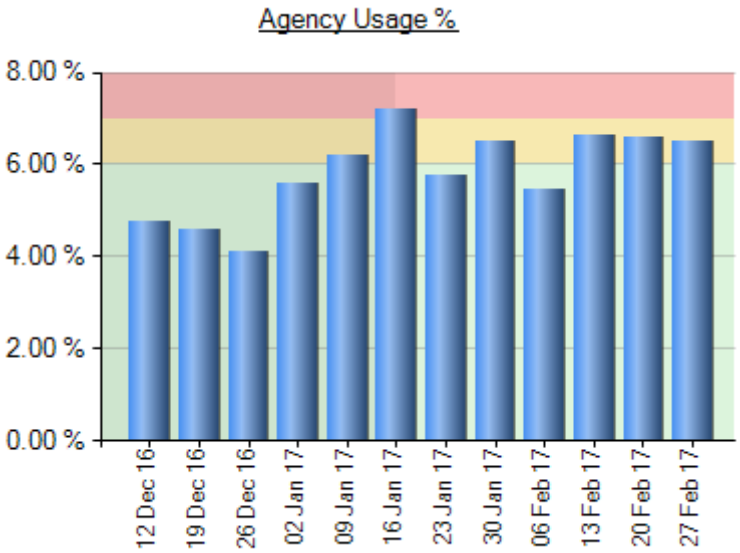
b) The process allows for an overview of the total number of temporary staff (agency) used in different clinical ward areas and provides a monitoring mechanism for the delivery of safe quality care.

10.0 Agency Usage Inpatient Wards (month ending February)

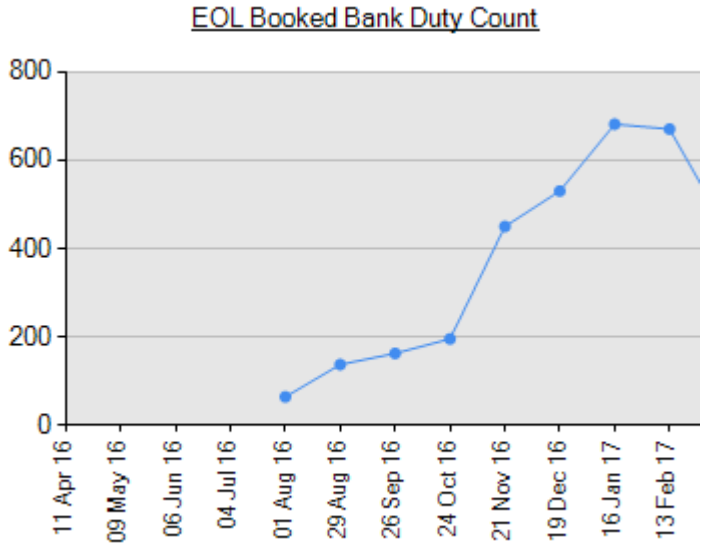
10.1 The utilisation of agency staff across all inpatient wards is monitored using the Healthroster system. The bar chart below graphically represents total usage of agency staff on inpatient wards month ending February (this is cumulative data captured from roster performance reports).

10.2 A key performance indicator (KPI) of less than 6% agency usage (agency shifts compared to total shifts assigned) was set to coincide with the NHS England agency cap. The percentage continues to fluctuate close to the agreed 6% target

The increase in Agency usage during February relates to open additional in-patient beds

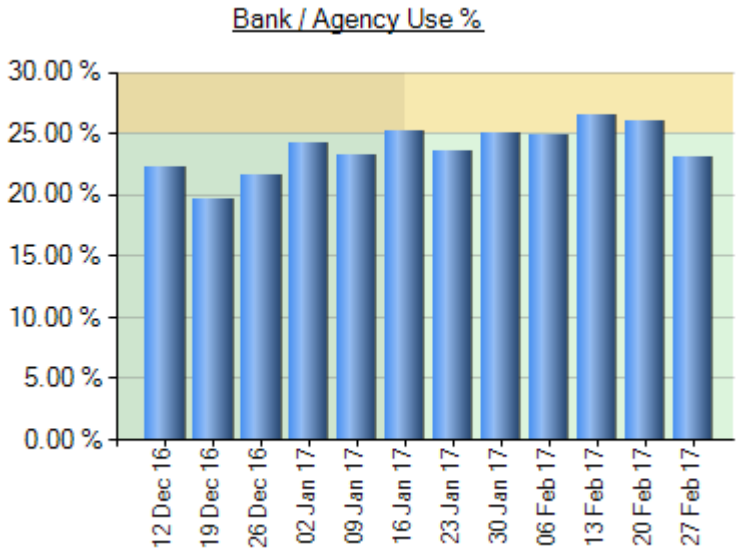


Bank staffs continue to book themselves directly into shifts and this is improving over time. This is however reliant on the wards making these shifts available with sufficient notice.



10.3 Temporary staff usage across the inpatient wards fluctuates depending on nurse vacancies and the need to provide additional support to provide enhanced care or additional beds.

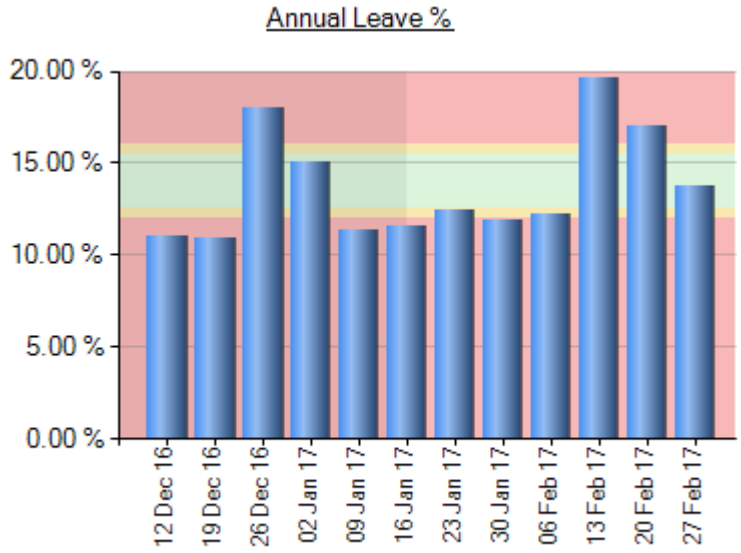
10.4 Temporary staffing usage (Bank and Agency) across inpatients wards remains high and fluctuates between 20 – 24%. Recruitment to reduce the current vacant posts is ongoing.



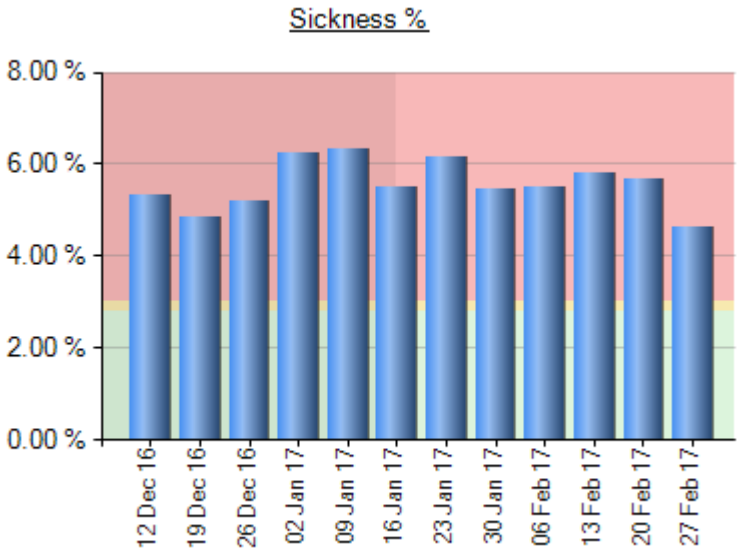
11.0 Managing Staff Resource

11.1 Annual leave taken from February to date varied over the month spanning the set tolerances of 14 -16%. These tolerance levels ensure all staff are allocated leave appropriately and an even distribution of staff are available throughout the year.

11.2 Heads of Nursing are aware of the need to remind staff to request and take holiday. This will be monitored closely over the next couple of months to ensure sufficient staff take annual leave in a more consistent way by year end.



11.3 Sick leave reported in February was above the set parameter of less than 3%. Heads of Nursing ensure all individuals reporting back from sick leave undergo a sickness review. Work is underway with the HR Business Partners to review the sickness more regularly.



12.0 Conclusion

12.1 Trust Board members are asked to note the work currently being undertaken to proactively manage the nursing/midwifery resource across the ICO and the February UNIFY return position

Updated tables

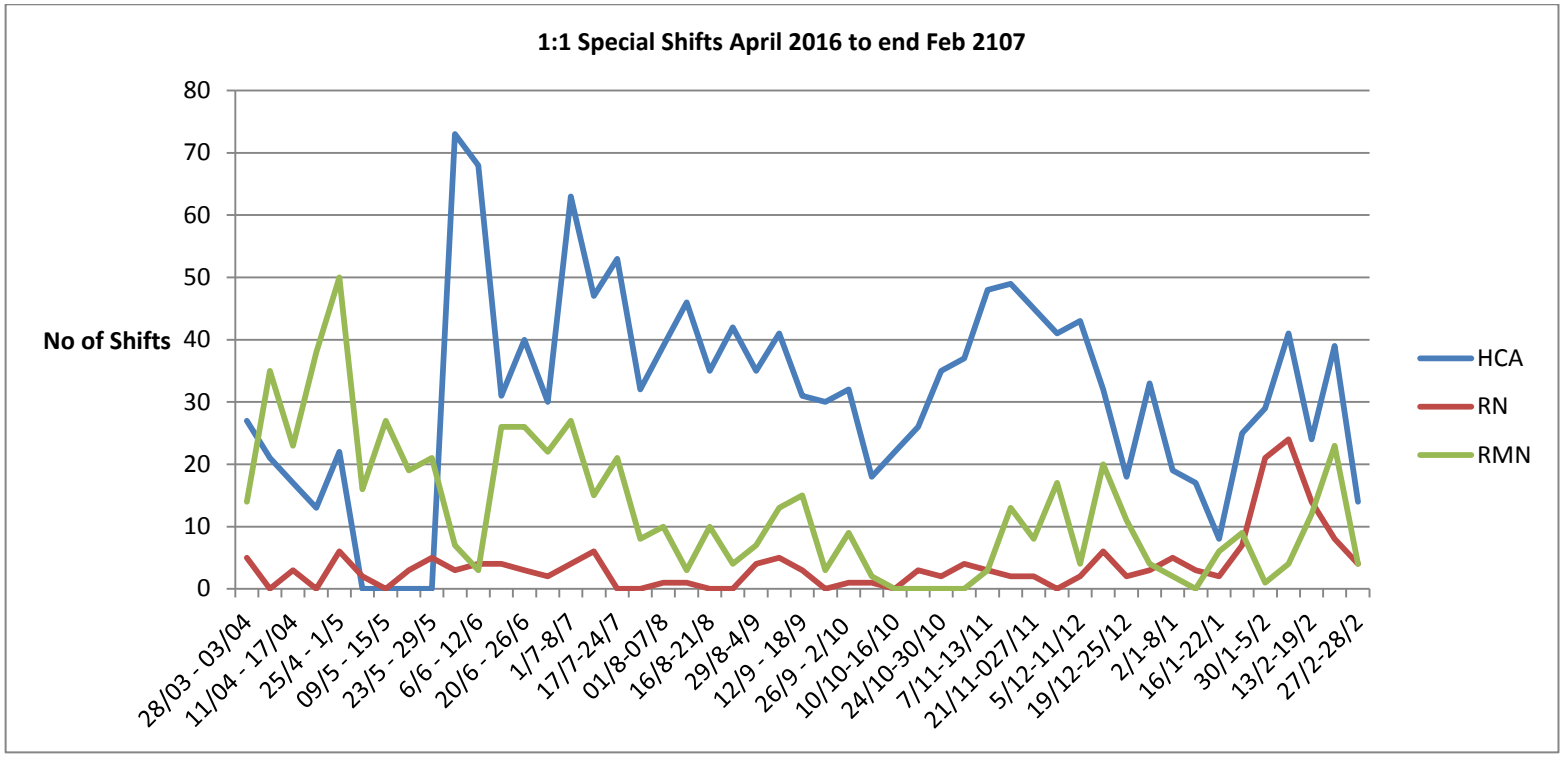
Fill rate data - summary
February 2017

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 (hrs)	Actual (hrs)	Planned (hrs)	Actual (hrs)	Planned (hrs)	Actual (hrs)	Planned (hrs)	Actual (hrs)	**87.6%**	**115.4%**	**90.7%**	**121.5%**
32637	**28588**	**10246**	**11820**	**26962**	**24448**	**7648**	**9291**				

Care Hours per Patient Day
February 2017

Total Patients at Midnight/Month	CHPPD Registered staff	CHPPD Unregistered staff	Average CHPPD (all staff)
8767	**6.05**	**2.41**	**8.46**

February 2016



Average fill rate for Registered and Unregistered staff day and night

	Day		Night	
	Nurses	Care Staff	Nurses	Care Staff
Ward Name	%	%	%	
Winter Ward	91.2%	99.2%	98.8%	106.1%
Cavell	93.0%	100.9%	99.8%	98.4%
Cloudesley	85.3%	108.3%	107.4%	112.0%
Coyle	94.3%	105.5%	93.3%	105.7%
Mercers	81.4%	90.8%	93.3%	126.6%
Meyrick	82.1%	119.4%	106.9%	128.6%
Montuschi	79.7%	189.1%	108.9%	
MSS	63.6%	221.7%	77.3%	201.1%
MSN	68.4%	154.3%	94.7%	266.9%
Nightingale	93.5%	103.4%	74.0%	108.2%
Thorogood	110.6%	84.1%	113.2%	
Victoria	103.6%	95.9%	96.2%	108.8%
IFOR	102.6%	100.0%	92.9%	100.0%
ITU	100.0%	100.0%	100.0%	
NICU	78.0%	100.0%	81.0%	100.0%
Maternity	84.0%	121.8%	79.7%	104.1%
Total	87.6%	115.4%	90.7%	121.5%

Whittington Health NHS

The Whittington Hospital NHS Trust
Magdala Avenue
London N19 5NF

Whittington Health

Trust Board

5th April 2017

Title:	National Guidance on Learning from Deaths		
Agenda item:	**17/048**	Paper	**05**
Action requested:	For information only.		
Executive Summary:	**National guidance for NHS trusts around learning from deaths** The attached paper is the first edition of the *'National Guidance on Learning from Deaths*', which has been published by the National Quality Board. This has been published in response to a number of high level reviews that have concluded that learning from deaths was not being given sufficient priority in some NHS organisations and that this meant that there were missed opportunities to improve NHS services through the review of deaths. This guidance was announced during the Learning from Deaths conference held on 21st March 2017; this conference was attended by both our Director for Nursing and Patient Experience, Philippa Davies, and our Associate Medical Director for Patient Safety, Dr Julie Andrews. The executive lead role for mortality has been delegated to Julie Andrews. This guidance will be used nationally to standardise the approach the governance and reporting arrangements not only to the review, investigation and reporting of deaths, but also to ensuring that learning derived from these processes is always acted upon . **What is expected from trusts?** From April 2017, Trusts will be required to submit a quarterly report to a public Board meeting. For Quarters 1 and 2 of 2017 the expectation will be that these reports will be used to set out the Trust's policy and approach around learning from deaths. Prior to the end of Quarter 2 of 2017 all trusts will need to have a policy in place that: • explains how case note reviews of deaths will be taken; • sets out the criteria for deaths to be reviewed through case note review and how deaths are selected for case review		

From Quarter 3 of 2017 trusts will need to publish data and learning points from case note reviews. This data will include:

- the total number of deaths;
- the numbers subject case note review;
- the numbers investigated as serious incidents;
- the numbers where the review processes concluded that the death was more likely than not to be due to problems in care;
- the themes and issues identified through review and investigation;
- the actions taken in response to the reviews and investigations undertaken and the progress in implementing these actions.

Case note review process

The new national guidance specifies that Trusts should focus case note reviews on inpatient deaths (and all deaths of inpatients within 30 days of discharge) in line with the specified criteria:

- Deaths where families, carers or staff have raised significant concern about the quality of care provision;
- All inpatient, outpatient and community deaths of patients with learning disabilities or severe mental illness;
- All deaths in a service where concerns have been raised either through audit, incident reporting processes or other morality indicators;
- All deaths in areas where deaths would not be expected, for example deaths during elective procedures;
- Deaths where learning will inform the provider's existing or planned improvement work, for example deaths where the patient had sepsis;
- A further sample of all other deaths, for example 25% of all other deaths.

It is proposed that any patient deaths that have been highlighted by the case note review as being potentially related to problems with care should be reviewed by the trust's multi-disciplinary Serious Incident Executive Advisory Group (SIEAG). The SIEAG will then consider whether any highlighted cases meet the criteria to be in[illegible]d as serious incidents, or whether any other process would b[illegible]e, for example feedback of learning to specific services or pro[illegible] groups.

	Involvement of families and carers The new national guidance outlines a clear expectation that trusts should be involving bereaved families and carers in the review process of their loved one's death. Trusts will need to ensure that there is a clear policy for engaging with bereaved families and carers, including giving them the opportunity to raise questions or to share concerns regarding to the care received. NHS England is currently developing the guidance to support this action.
Fit with WH strategy:	To deliver quality, patient safety and patient experience.
Reference to related / other documents:	• '*National Guidance on Learning from Deaths*', National Quality Board (March 2017), available from https://www.england.nhs.uk/wp-content/uploads/2017/03/ngb-national-guidance-learning-from-deaths.pdf • '*Learning, candour and accountability'*, Care Quality Commission (December 2016), available from https://www.cqc.org.uk/sites/default/files/20161213-learning-candour-accountability-full-report.pdf
Reference to areas of risk and corporate risks on the Board Assurance Framework:	• Board Assurance Framework risk reference 1 - Failure to maintain the quality of patient care
Date paper completed:	27th March 2017

Author name and title:		**Philippa Davies, Director of Nursing and Patient Experience** **Ashleigh Soan, Medical Director Portfolio Manager**		**Director name and title:**		**Richard Jennings, Executive Medical Director**	
Date paper seen by EC		**Equality Impact Assessment complete?**	**NA**	**Risk assessment undertaken?**	**NA**	**Legal advice received?**	**NA**

National Guidance on Learning from Deaths

A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care

National Quality Board

First edition March 2017

National Guidance on Learning from Deaths

Contents

Foreword

Following events in Mid Staffordshire, a review of 14 hospitals with the highest mortality noted that the focus on aggregate mortality rates was distracting Trust boards "from the very practical steps that can be taken to reduce genuinely avoidable deaths in our hospitals".

This was reinforced by the recent findings of the Care Quality Commission (CQC) report *Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England*. It found that learning from deaths was not being given sufficient priority in some organisations and consequently valuable opportunities for improvements were being missed. The report also pointed out that there is more we can do to engage families and carers and to recognise their insights as a vital source of learning.

Understanding and tackling this issue will not be easy, but it is the right thing to do. There will be legitimate debates about deciding which deaths to review, how the reviews are conducted, the time and team resource required to do it properly, the degree of avoidability and how executive teams and boards should use the findings.

This first edition of *National Guidance on Learning from Deaths* aims to kickstart a national endeavour on this front. Its purpose is to help initiate a standardised approach, which will evolve as we learn. Following the Learning from Deaths conference on 21st March 2017 we will update this guidance to reflect the collective views of individuals and organisations to whom this guidance will apply to ensure that it is helpful.

Professor Sir Bruce Keogh
National Medical Director
NHS England

Professor Sir Mike Richards
Chief Inspector of Hospitals
Care Quality Commission

Dr Kathy McLean
Executive Medical Director
NHS Improvement

On behalf of the National Quality Board.

Executive Summary

Introduction

1. For many people death under the care of the NHS is an inevitable outcome and they experience excellent care from the NHS in the months or years leading up to their death. However some patients experience poor quality provision resulting from multiple contributory factors, which often include poor leadership and system-wide failures. NHS staff work tirelessly under increasing pressures to deliver safe, high-quality healthcare. When mistakes happen, providers working with their partners need to do more to understand the causes. The purpose of reviews and investigations of deaths which problems in care might have contributed to is to learn in order to prevent recurrence. Reviews and investigations are only useful for learning purposes if their findings are shared and acted upon.

2. The following definitions apply for the purposes of this guidance:

(i) Case record review: The application of a case record/note review to determine whether there were any problems in the care provided to the patient who died in order to learn from what happened, for example Structured Judgement Review delivered by the Royal College of Physicians.

(ii) Investigation: The act or process of investigating; a systematic analysis of what happened, how it happened and why. This draws on evidence, including physical evidence, witness accounts, policies, procedures, guidance, good practice and observation - in order to identify the problems in care or service delivery that preceded an incident to understand how and why it occurred. The process aims to identify what may need to change in service provision in order to reduce the risk of future occurrence of similar events.

(iii) Death due to a problem in care: A death that has been clinically assessed using a recognised methodology of case record/note review and determined more likely than not to have resulted from problems in healthcare and therefore to have been potentially avoidable.

Governance and Capability

3. Learning from a review of the care provided to patients who die should be integral to a provider's clinical governance and quality improvement work. To fulfil the standards and new reporting set out in this guidance for **acute, mental health and community NHS Trusts and Foundation Trusts**, Trusts should ensure their **governance arrangements**

and processes include, facilitate and give due focus to the review, investigation and reporting of deaths, including those deaths that are determined more likely than not to have resulted from problems in care. Trusts should also ensure that they share and act upon any learning derived from these processes. The standards expected of Trust boards are set out at Annex A including having an existing **executive director** take responsibility for the learning from deaths agenda and an existing **non-executive director** take responsibility for oversight of progress. Guidance for non-executive directors is at Annex B.

4. Providers should review and, if necessary, enhance **skills and training** to support this agenda. Providers need to ensure that staff reporting deaths have appropriate skills through specialist training and protected time under their contracted hours to review and investigate deaths to a high standard.

5. Providers should have a **clear policy for engagement with bereaved families and carers**, including giving them the opportunity to raise questions or share concerns in relation to the quality of care received by their loved one. Providers should make it a priority to work more closely with bereaved families and carers and ensure that a consistent level of timely, meaningful and compassionate support and engagement is delivered and assured at every stage, from notification of the death to an investigation report and its lessons learned and actions taken.

Improved Data Collection and Reporting

6. The following minimum requirements are being introduced to complement providers' current approaches in relation to reporting and reviewing deaths:

A. POLICY ON RESPONDING TO DEATHS

- Each Trust should publish an **updated policy** by September 2017 on how it responds to, and learns from, deaths of patients who die under its management and care, including:

  i. How its processes respond to the death of an individual with a **learning disability** (Annex D) or **mental health needs** (Annex E), **an infant or child death** (Annex F) and a **stillbirth or maternal death** (Annex G).
  ii. **The Trust's approach to undertaking case record reviews**. Acute Trusts should use an evidence-based methodology for reviewing the quality of care provided to those patients who die. The Structured Judgement Review (SJR)

case note methodology is one such approach and a programme to provide training in this methodology for acute Trusts will be delivered by the Royal College of Physicians over the coming year (the current version of the SJR approach is available at https://www.rcplondon.ac.uk/projects/outputs/national-mortality-case-record-review-nmcrr-programme-resources Other approaches also exist, such as those based on the PRISM methodology. Methods like SJR were not developed for mental health and community Trusts but can be used as a starting point and adapted by these providers to reflect their individual service user and clinical circumstances. Annex J provides a case study of how SJR is being adapted for mental health Trusts. Case record reviews of deaths of people with learning disabilities by acute, mental health and community Trusts should adopt the methodology developed by the Learning Disabilities Mortality Review (LeDeR) programme in those regions where the programme is available (details of the programme are available from Annex D).

iii. **Categories and selection of deaths in scope for case record review:** As a minimum and from the outset, Trusts should focus reviews on in-patient deaths in line with the criteria specified at paragraph 14(ii). In particular contexts, and as these processes become more established, Trusts should include cases of people who had been an in-patient but had died within 30 days of leaving hospital. Mental Health Trusts and Community Trusts will want to carefully consider which categories of outpatient and/or community patient are within scope for review taking a proportionate approach. The rationale for the scope selected by Trusts will need to be published and open to scrutiny.

B. DATA COLLECTION AND REPORTING

- **From April 2017, Trusts will be required to collect and publish on a quarterly basis specified information on deaths. This should be through a paper and an agenda item to a public Board meeting in each quarter to set out the Trust's policy and approach (by the end of Q2) and publication of the data and learning points (from Q3 onwards).** This data should include the total number of the Trust's in-patient deaths (including Emergency Department deaths for acute Trusts) and those deaths that the Trust has subjected to case record review. Of these deaths subjected to review, Trusts will need to provide estimates of how many deaths were judged more likely than not to have been due to problems in care. The dashboard provided with this guidance shows what data needs to be collected and a suggested format for publishing the information,

accompanied by relevant qualitative information and interpretation.

- **Changes to the Quality Accounts regulations will require that the data providers publish be summarised in Quality Accounts from June 2018** (Annex L), including evidence of learning and action as a result of this information and an assessment of the impact of actions that a provider has taken.

Further Developments

7. In 2017-18, further developments will include:

- **The Care Quality Commission will strengthen its assessment of providers learning from deaths** including the management and processes to review and investigate deaths and engage families and carers in relation to these processes.
- **NHS England, led by the Chief Nursing Officer, will develop guidance for bereaved families and carers.** This will support standards already set for local services within the Duty of Candour[1] and the *Serious Incident Framework*[2] and cover how families should be engaged in investigations. Health Education England will review training of doctors and nurses on engaging with bereaved families and carers.
- **Acute Trusts will receive training to use the Royal College of Physicians' Structured Judgement Review case note methodology.** Health Education England and the Healthcare Safety Investigation Branch (Annex L) will engage with system partners, families and carers and staff to understand broader training needs and to develop approaches so that NHS staff can undertake good quality investigations of deaths.
- **NHS Digital is assessing how to facilitate the development of provider systems and processes** so that providers know when a patient dies and information from reviews and investigations can be collected in standardised way.
- **The Department of Health is exploring proposals to improve the way complaints involving serious incidents are handled** particularly how providers and the wider care system may better capture necessary learning from these incidents[3].

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[1] Further information is available from: http://www.cqc.org.uk/sites/default/files/20141120_doc_fppf_final_nhs_provider_guidance_v1-0.pdf

[2] https://improvement.nhs.uk/resources/serious-incident-framework/

[3] This follows the Parliamentary and Health Service Ombudsman's report *Learning from Mistakes* (July 2016) and the Public Administration and Constitutional Affairs Committee hearings on this report.

Chapter 1 - Mortality Governance

Context

8. In December 2016, the Care Quality Commission (CQC) published its review *Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England.* The CQC found that none of the Trusts they contacted were able to demonstrate best practice across every aspect of identifying, reviewing and investigating deaths and ensuring that learning is implemented.

9. The Secretary of State for Health accepted the report's recommendations and in a Parliamentary statement[4] made a range of commitments to improve how Trusts learn from reviewing the care provided to patients who die. This includes regular publication of specified information on deaths, including those that are assessed as more likely than not to have been due to problems in care, and evidence of learning and action that is happening as a consequence of that information in Quality Accounts from June 2018.

Accountability

10. Mortality governance should be a key priority for Trust boards. Executives and non-executive directors should have the capability and capacity to understand the issues affecting mortality in their Trust and provide necessary challenge.

11. This *National Guidance on Learning from Deaths* should be read alongside the *Serious Incident Framework*. Trust boards are accountable for ensuring compliance with both these frameworks. They should work towards achieving the highest standards in mortality governance. However, different organisations will have different starting points in relation to this agenda and it will take time for all Trusts to meet such standards. Over time this guidance is likely to be updated to include wider providers of NHS care and whole healthcare systems.

Responding to Deaths

12. Each Trust should have a policy in place that sets out how it responds to the deaths of patients who die under its management and care. The standards expected of Trusts are set out at Annex C.

13. Boards should take a systematic approach to the issue of potentially avoidable mortality and have robust mortality governance processes. This will allow them to identify any areas of

[4] https://www.gov.uk/government/speeches/cqc-review-of-deaths-of-nhs-patients]

failure of clinical care and ensure the delivery of safe care. This should include a mortality surveillance group with multi-disciplinary and multi-professional membership, regular mortality reporting to the Board at the public section of the meeting with data suitably anonymised, and outputs of the mortality governance process including investigations of deaths being communicated to frontline clinical staff.

Death Certification, Case Record Review and Investigation

14. There are three levels of scrutiny that a provider can apply to the care provided to someone who dies; (i) death certification; (ii) case record review; and (iii) investigation. They do not need to be initiated sequentially and an investigation may be initiated at any point, whether or not a case record review has been undertaken (though a case record review will inform the information gathering phase of an investigation together with interviews, observations and evidence from other sources). For example, the apparent suicide of an in-patient would lead to a Serious Incident investigation being immediately instigated in advance of death certification or any case record review. The three processes are summarised below:

(i) Death Certification: In the existing system of death certification in England, deaths by natural causes are certified by the attending doctor. Doctors are encouraged to report any death to the coroner that they cannot readily certify as being due to natural causes. Reforms to death certification, when implemented in England (and Wales), will result in all deaths being either scrutinised by a Medical Examiner or investigated by the Coroner in prescribed circumstances. Additionally, Medical examiners will be mandated to give bereaved relatives a chance to express any concerns and to refer to the coroner any deaths appearing to involve serious lapses in clinical governance or patient safety.

(ii) Case Record Review: Some deaths should be subject to further review by the provider, looking at the care provided to the deceased as recorded in their case records in order to identify any learning. At a minimum, providers should require reviews of:

i. all deaths where **bereaved families and carers, or staff, have raised a significant concern about the quality of care provision**;
ii. all in-patient, out-patient and community patient deaths of those with **learning disabilities** (the LeDeR review process outlined at Annex D should be adopted in those regions where the programme is available otherwise Structured Judgement Review or another robust and evidence-based methodology should be used) and

with **severe mental illness**;

iii. all deaths in a **service specialty, particular diagnosis or treatment group where an 'alarm' has been raised** with the provider through whatever means (for example via a Summary Hospital-level Mortality Indicator or other elevated mortality alert, concerns raised by audit work, concerns raised by the CQC or another regulator);

iv. all deaths in areas where people are **not expected to die**, for example in relevant elective procedures;

v. deaths where **learning will inform the provider's existing or planned improvement work**, for example if work is planned on improving sepsis care, relevant deaths should be reviewed, as determined by the provider. To maximise learning, such deaths could be reviewed thematically;

vi. **a further sample of other deaths** that do not fit the identified categories so that providers can take an overview of where learning and improvement is needed most overall. This does not have to be a random sample, and could use practical sampling strategies such as taking a selection of deaths from each weekday.

The above minimum requirements are additional to existing requirements for providers to undertake specific routes of reporting, review or investigations for specific groups of patient deaths, such as deaths of patients detained under the Mental Health Act 1983 (Annex E).

Providers should review a case record review following any linked inquest and issue of a "Regulation 28 Report on Action to Prevent Future Deaths" in order to examine the effectiveness of their own review process.

Providers should apply rigorous judgement to the need for deaths to be subject to a Serious Incident reporting and investigation. For example, there may be instances where deaths clearly meet Serious Incident criteria and should be reported as such (whether or not a case record review has already been undertaken). Equally, problems identified in case record review may lead to the need for investigation whether this is an investigation under the Serious Incident Framework or other framework/procedure (see section iii)

(iii) Investigation: Providers may decide that some deaths warrant an investigation and should be guided by the circumstances for investigation in the Serious Incident Framework.

Some deaths will be investigated by other agents, notably the coroner. Indeed, the coroner has a duty to investigate any death where there are grounds to suspect that the death may have been avoidable. While care should be taken not to compromise such investigations, equally waiting until other investigations are completed may cause unacceptable delay. A good working relationship and close communication are needed to avoid problems.

Providers should review an investigation they undertake following any linked inquest and issue of a "Regulation 28 Report to Prevent Future Deaths" in order to examine the effectiveness of their own investigation process. If an inquest identifies problems in healthcare, providers may need to undertake additional investigation and improvement action, regardless of the coroner's verdict.

Consistency and Judgement in Case Record Review

15. All Trusts currently undertake some form of mortality review. However there is considerable variation in terms of methodology, scope, data capture and analysis, and contribution to learning and improvement. To generate learning for improvement in healthcare, clinicians and staff should engage in robust processes of retrospective case record review to help identify if a death was more likely than not to have been contributed to by problems of care.

16. The Structured Judgement Review (SJR) case note methodology is an approach being rolled out by the Royal College of Physicians. Other methodologies exist and Trusts may already be using them. Trusts need to be assured that the methodology they are using is robust and evidence-based, that it will generate the information they are now being required to publish and that their staff are trained and given sufficient time and resources to undertake case record reviews and act on what they learn.

17. Case record review assessment is finely balanced and subject to significant inter-reviewer variation. It does not support comparison between organisations and should not be used to make external judgements about the quality of care provided.

18. The judgement of whether a problem may have contributed to a death requires careful review of the care that was provided against the care that would have been expected at the time of death. Research has shown that when case record review identifies a death that may have been caused by problems in care, that death tends to be due to a series of problems none of which would be likely to have caused the death in isolation but which in

combination can contribute to the death of a patient[5][6]. Some of these elements of care are likely to have occurred prior to the admission and providers should support other organisations, for example in primary care, to understand and act on areas where care could be improved.

19. Trusts should acknowledge and cooperate with separate arrangements for the review (and where appropriate investigation) of certain categories of deaths, for example suicides, homicides, and child and maternal deaths.

Objectivity in Case Record Review

20. To ensure objectivity, case record reviews should wherever possible be conducted by clinicians other than those directly involved in the care of the deceased. If the specific clinical expertise required only resides with those who were involved in the care of the deceased, the review process should still involve clinicians who were not involved in order to provide peer challenge. Objectivity of reviews should be a component of clinical governance processes. Providers may wish to consider if their review processes should additionally be the responsibility of a designated non-executive director who could do this by chairing the relevant clinical governance committee.

Investigations

21. This *National Guidance on Learning from Deaths* and the *Serious Incident Framework* are complementary. This guidance sets out what deaths should be subject to case record review (paragraph 14(ii)), which is inevitably a wider definition than deaths that constitute Serious Incidents. Equally, when a death meets Serious Incident criteria there is no need to delay the onset of investigation until case record review has been undertaken. A review of records will inevitably be undertaken as part of an investigation process. However, immediate action to secure additional information and evidence to support full investigation should not be lost due an inappropriate requirement for all deaths (regardless of nature) to first undergo a case record review.

[5] Hogan et al. Preventable deaths due to problems in care in English acute hospitals: a retrospective case record review study. *BMJ Qual Saf2012*: 21: 737-45.

[6] Hogan et al. Avoidability of hospital deaths and association with hospital-wide mortality ratios: a retrospective case record *BMJ* 2015; 351:h3239.

22. Inquiries by the coroner[7] and investigations by providers are conducted to understand the cause of death and contributing factors. However provider investigations are not conducted to hold any individual or organisation to account. Other processes exist for that purpose including criminal or civil proceedings, disciplinary procedures, employment law and systems of service and professional regulation, including the General Medical Council and the Care Quality Commission. In circumstances where the actions of other agencies are required then those agencies must be appropriately informed and relevant protocols must be followed.

Medical Examiners

23. The introduction of the Medical Examiner role will provide further clarity about which deaths should be reviewed. Medical Examiners will be able to refer the death of any patient for review by the most appropriate provider organisation(s) and this new mechanism should ensure a systematic approach to selecting deaths for review, regardless of the setting or type of care provided in the period before a patient's death. NHS Improvement and the Department of Health are commissioning research to explore whether Medical Examiners are best placed to select which deaths need further review and ensure they do not inadvertently miss or over-refer certain types of cases. Prior to the implementation of the Medical Examiner system, Trusts are advised to allow for any doctors undertaking the certification of death to refer cases for case record review to the most relevant organisation.

Learning

24. Providers should have systems for deriving learning from reviews and investigations and acting on this learning. The learning should be shared with other services across the wider health economy where they believe this would benefit future patients, including independent healthcare services and social care services. Recommendations within any "Regulation 28 Report on Action to Prevent Future Deaths" from the coroner should also be integral to a provider's systems to support learning within and across their organisation and local system partners.

25. Regardless of whether the care provided to a patient who dies is examined using case record review or an investigation, the findings should be part of, and feed into, robust clinical governance processes and structures. The findings should be considered alongside

[7] Coroner investigations, A short guide (February 2014) is available from: https://www.gov.uk/government/publications/guide-to-coroner-services-and-coroner-investigations-a-short-guide

other information and data including complaints, clinical audit information, mortality data, patient safety incident reports and data and outcomes measures etc. to inform the Trust's wider strategic plans and safety priorities.

26. Where case record review identifies a problem in care that meets the definition of a patient safety incident (any unintended or unexpected incident which could have or did lead to harm to one or more patients receiving NHS care) then this should be reported via local risk management systems to the National Reporting and Learning System (NRLS).

27. All patient safety incidents reported as resulting in death or severe harm to a patient are clinically reviewed by the National Patient Safety Team at NHS Improvement to determine if there are implications for national learning and if a response is appropriate. Any deaths that are identified via case record review as due to problems in healthcare would meet the criteria for NRLS reporting. More information on the national process is available at https://improvement.nhs.uk/resources/patient-safety-alerts. All serious incidents that relate to patients should be reported to the NRLS for the same reason.

Cross-system Reviews and Investigations

28. In many circumstances more than one organisation is involved in the care of any patient who dies. Guidance in relation to cross-system reviews and investigations is at Annex H.

Roles and Responsibilities of National Bodies and Commissioners

29. Guidance is provided at Annex I. The lead roles with overall responsibility for the learning from deaths programme at each of the relevant national organisation are provided at Annex K.

Chapter 2 - Bereaved Families and Carers

Key Principles

30. Providers should engage meaningfully and compassionately with bereaved families and carers in relation to all stages of responding to a death and operate according to the following key principles below.

BEREAVED FAMILIES AND CARERS - KEY PRINCIPLES:

- bereaved families and carers should be treated as **equal partners** following a bereavement;
- bereaved families and carers must always **receive a clear, honest, compassionate and sensitive response** in a sympathetic environment;
- bereaved families and carers should receive a **high standard of bereavement care** which respects confidentiality, values, culture and beliefs, including being offered appropriate support. This includes providing, offering or directing people to specialist suicide bereavement support;
- bereaved families and carers should be informed of their **right to raise concerns about the quality of care** provided to their loved one;
- bereaved families' and carers' views should **help to inform decisions about whether a review or investigation is needed**;
- bereaved families and carers should receive **timely, responsive contact and support in all aspects of an investigation process**, with a single point of contact and liaison;
- bereaved families and carers should be **partners in an investigation** to the extent, and at whichever stages, that they wish to be involved, as they offer a unique and equally valid source of information and evidence that can better inform investigations;
- bereaved families and carers who have experienced the investigation process should be supported to work in partnership with Trusts in **delivering training for staff in supporting family and carer involvement** where they want to.

Context

31. Dealing respectfully, sensitively and compassionately with families and carers of dying or deceased patients within the NHS is crucially important. The principles of openness, honesty, and transparency as set out in the Duty of Candour should also be applied by

providers in all their dealings with bereaved families and carers. Yet the Care Quality Commission's report *Learning, candour and accountability* identified that NHS providers are continuing to fail too many bereaved families and carers of those who die whilst in their care.

32. When a patient dies under the management and care of a Trust, bereaved families and carers should be informed immediately after the death. People who are bereaved need others to recognise and acknowledge their loss. Recognition by professionals, appropriately expressed, may be particularly valued. Communication at the time of a death, and afterwards, should be clear, sensitive and honest. Bereaved families and carers should be given as much information as possible in line with the Duty of Candour for providers. Every effort should be made to hold these discussions in a private, sympathetic environment, without interruptions. Providers should ensure that their staff, including family liaison officers where available, have the necessary skills, expertise and knowledge to engage with bereaved families and carers. This includes recognising and dealing with common issues such as family members feeling guilty about their loss.

33. All too often the terms of the conversation people have with the NHS about a concern or complaint are set by the organisation. Organisations can often be too quick to dismiss or explain away concerns, compounding the grief of bereaved families and carers with obfuscation and a lack of openness. Paying close attention to what bereaved families and carers say can offer an invaluable source of insight to improve clinical practice. Listening to them goes hand in hand with the Duty of Candour. In particular, bereaved families and carers should be asked if they had concerns about the quality of care received by the deceased to inform decisions about the need to undertake a case record review or investigation.

34. When reviewing or investigating possible problems with care, involvement of bereaved families and carers begins with a genuine apology. Saying sorry is not an admission of liability and is the right thing to do. The appropriate staff member should be identified for each case, including to explain what went wrong promptly, fully and compassionately. This may include clinicians involved in the case but this may not always be appropriate and should be considered on a case by case basis.

35. Depending on the nature of the death, it may be necessary for several organisations to make contact with those affected. This should be discussed with the bereaved families and carers and a co-ordinated approach should be agreed with them and the

organisations involved. If other patients and service users are involved or affected by the death they should be offered the appropriate level of support and involvement.

36. The provider should ensure that the deceased person's General Practitioner is informed of the death and provided with details of the death as stated in the medical certificate at the same time as the family or carers. The GP should be informed of the outcome of any investigation.

Bereavement Support

37. Bereavement can influence every aspect of well-being. Providers should offer a bereavement service for families and carers of people who die under their management and care (including offering or directing people to suicide bereavement support) that offers a caring and empathetic service at a time of great distress and sadness. This includes offering support, information and guidance. This should include bereavement advisors to help families and carers through the practical aspects following the death of a loved one such as:

- arranging completion of all documentation, including medical certificates;
- the collection of personal belongings;
- post mortem advice and counselling;
- deaths referred to the coroner;
- emotional support, including counselling;
- collection of the doctor's Medical Certificate of Cause of Death and information about registering a death at the Registrar's Office;
- details of the doctor's Medical Certificate of Case of Death (this is needed to register a death at the Registrar's Office).

38. The following should also be considered:

- timely access to an advocate (independent of the Trust) with necessary skills for working with bereaved and traumatised individuals;
- support with transport, disability, and language needs;
- support during and following an investigation. This may include counselling or signposting to suitable organisations that can provide bereavement or post-traumatic stress counselling, with attention paid to the needs of young family members, especially siblings;

- further meetings with the organisations involved or support in liaising with other agencies such as the police.

Review

39. If the care of a patient who has died is selected for case record review providers should:

- have formed that decision based on the views of the family and carers. Providers should require reviews in cases where family and carers have raised a significant concern about the quality of care provision (paragraph 14 (ii)(i));
- communicate to the family and carers the findings of the review if any problems with care are identified and any lessons the review has contributed for the future.

Investigations

40. If a provider feels that an investigation into a death is needed, early contact should have been made with bereaved families and carers so that their views helped to inform the decision.

41. Bereaved families and carers will expect to know: what happened; how; to the extent possible at the time, why it happened; and what can be done to stop it happening again to someone else. If a provider proceeds with an investigation, skilled and trained investigators need to be able to explain to bereaved families and carers the purpose of the investigation which is to understand what happened. If problems are identified, the investigation should be clear why and how these happened so that action can be taken to prevent the same mistakes from occurring again.

42. Provided the family or carer is willing to be engaged with regarding the investigation, an early meeting should be held to explain the process, how they can be informed of progress, what support processes have been put in place and what they can expect from the investigation. This should set out realistic timescales and outcomes. There should be a named person as a consistent link for the families and carers throughout the investigation, for example a family liaison officer.

43. Bereaved families and carers should:

- be made aware, in person and in writing, as soon as possible of the purpose, rationale and process of the investigation to be held;

- be asked for their preferences as to how and when they contribute to the process of the investigation and be kept fully and regularly informed, in a way that they have agreed, of the process of the investigation;
- have the opportunity to express any further concerns and questions and be offered a response where possible, with information about when further responses will be provided;
- have a single point of contact to provide timely updates, including any delays, the findings of the investigation and factual interim findings. This may disclose confidential personal information for which consent has been obtained, or where patient confidentiality is overridden in the public interest. This should be considered by the organisation's Caldicott Guardian and confirmed by legal advice in relation to each case;
- have an opportunity to be involved in setting any terms of reference for the investigation which describe what will be included in the process and be given expectations about the timescales for the investigation including the likely completion date;
- be provided with any terms of reference to ensure their questions can be reflected and be given a clear explanation if they feel this is not the case;
- have an opportunity to respond on the findings and recommendations outlined in any final report; and,
- be informed not only of the outcome of the investigation but what processes have changed and what other lessons the investigation has contributed for the future.

Guidance

44. NHS England will develop guidance for bereaved families and carers, identifying good practice for local services on the information that families say they would find helpful. It will cover what families can expect by way of local support in relation to investigations and what to expect when services have identified the death as complex or needing an independent investigation so potentially involving longer timeframes and multiple agency involvement.

45. Public Health England has published guidance which provides advice to local authorities and the NHS on developing and providing suicide bereavement support[8].

8 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/590838/support_after_a_suicide.pdf

Annexes

Annex A - Board Leadership

BOARD LEADERSHIP - KEY POINTS

The board should ensure that their organisation:

- has an existing board-level leader acting as **patient safety director** to take responsibility for the learning from deaths agenda and an existing **non-executive director** to take oversight of progress;
- pays particular attention to the care of patients with a **learning disability or mental health needs**;
- has a systematic approach to **identifying those deaths requiring review** and selecting other patients whose care they will review;
- adopts a robust and **effective methodology for case record reviews** of all selected deaths (including engagement with the LeDeR programme) to identify any concerns or lapses in care likely to have contributed to, or caused, a death and possible areas for improvement, with the outcome documented;
- ensures **case record reviews and investigations are carried out to a high quality**, acknowledging the primary role of system factors within or beyond the organisation rather than individual errors in the problems that generally occur;
- ensures that **mortality reporting in relation to deaths, reviews, investigations and learning is regularly provided to the board** in order that the executives remain aware and non-executives can provide appropriate challenge. The reporting should be discussed at the public section of the board level with data suitably anonymised;
- ensures that learning from reviews and investigations is **acted on** to sustainably change clinical and organisational practice and improve care, and **reported in annual Quality Accounts**;
- **shares relevant learning** across the organisation and with other services where the insight gained could be useful;
- ensures sufficient numbers of **nominated staff have appropriate skills** through specialist training and protected time as part of their contracted hours to review and investigate deaths;
- **offers timely, compassionate and meaningful engagement with bereaved families and carers** in relation to all stages of responding to a death;
- acknowledges that an **independent investigation** (commissioned and delivered entirely separately from the organisation(s) involved in caring for the patient) may in

some circumstances be warranted, for example, in cases where it will be difficult for an organisation to conduct an objective investigation due to its size or the capacity and capability of the individuals involved; and,

- **works with commissioners to review and improve their respective local approaches** following the death of people receiving care from their services. Commissioners should use information from providers from across all deaths, including serious incidents, mortality reviews and other monitoring, to inform their commissioning of services. This should include looking at approaches by providers to involving bereaved families and carers and using information from the actions identified following reviews and investigations to inform quality improvement and contracts etc.

Annex B - Non-Executive Directors

Context

1. The board of directors of an NHS Trust or Foundation Trust is collectively responsible for ensuring the quality and safety of healthcare services delivered by the Trust, and in the case of a Foundation Trust taking into consideration the views of the board of governors.

2. Boards must ensure robust systems are in place for recognising, reporting, reviewing or investigating deaths and learning from avoidable deaths that are contributed to by lapses in care. Providers should ensure such activities are adequately resourced. Commissioners are accountable for quality assuring the robustness of providers' systems so that providers develop and implement effective actions to reduce the risk of avoidable deaths, including improvements when problems in the delivery of care within and between providers are identified.

3. All Trust directors, executive and non-executive, have a responsibility to constructively challenge the decisions of the board and help develop proposals on strategy. Non-executive directors, in particular, have a duty to ensure that such challenge is made. They play a crucial role in bringing an independent perspective to the boardroom and should scrutinise the performance of the provider's management in meeting agreed goals and objectives and monitor the reporting of performance. Non-executive directors should satisfy themselves as to the integrity of financial, clinical and other information, and that clinical quality controls and systems of risk management, for example, are robust and defensible.

Learning from Deaths

4. Executive and non-executive directors have a key role in ensuring their provider is learning from problems in healthcare identified through reviewing or investigating deaths by ensuring that:

    - the processes their organisation have in place are robust, focus on learning and can withstand external scrutiny, by providing challenge and support;
    - quality improvement becomes and remains the purpose of the exercise, by championing and supporting learning, leading to meaningful and effective actions that improve patient safety and experience, and supporting cultural change; and

- the information the provider publishes is a fair and accurate reflection of its achievements and challenges.

5. From April 2017, providers will start to collect and publish new data to monitor trends in deaths. Alongside this, they will need to establish an ongoing learning process. Board oversight of this process is as important as board oversight of the data itself. As a critical friend, non-executive directors should hold their organisation to account for its approach and attitude to patient safety and experience, and learning from all deaths, particularly those assessed as having been avoidable. The roles and responsibilities of non-executive directors include:

   i. **Understand the process: ensure the processes in place are robust and can withstand external scrutiny, by providing challenge and support. For example:**
      - be curious about the accuracy of data and understand how it is generated; who is generating it, how are they doing this, is the approach consistent across the Trust, are they sufficiently senior/experienced/trained?
      - seek similar data and trend information from peer providers, to help challenge potential for improvements in your own organisation's processes, but understand limitations of any direct comparisons;
      - ensure timely reviews/investigations (what is the interval between death and review or investigation?), calibre of reviewer/investigator and quality of the review or investigation;
      - is the Care Record Review process objective, conducted by clinicians not directly involved in the care of the deceased?
      - how was the case-record review selection done? For example, does selection reflect the evidence base which suggests older patients who die or those where death may be expected are no less likely to have experienced problems in healthcare that are associated with potentially preventable death? Does it ensure all vulnerable patient groups (not just those with learning disabilities or mental health needs) are not disadvantaged?
      - are deaths of people with learning disabilities reviewed according to the LeDeR methodology?
      - for coordination of responses to reviews/investigations through the provider's clinical governance processes, who is responsible for preparing the report, do problems in care identified as being likely to have contributed to a death feed into the organisation's Serious Incident processes?

ii. **Champion and support learning and quality improvement such as:**

- ensuring the organisation has a long-term vision and strategy for learning and improvement and is actively working towards this;
- understanding the learning being generated, including from where deaths may be expected but the quality of care could have been better;
- understanding how the learning from things going wrong is translated into sustainable effective action that measurably reduces the risks to patients - ensuring that learning and improvements are reported to the board and relevant providers;
- supporting any changes in clinical practice that are needed to improve care resulting from this learning;
- ensuring families and carers are involved reviews and investigations, and that nominated staff have adequate training and protected time to undertake these processes;
- paying attention to the provision of best practice and how the learning from this can be more broadly implemented.

iii. **Assure published information; ensure that information published is a fair and accurate reflection of the provider's achievements and challenges, such as:**

- ensuring that information presented in board papers is fit for publication i.e. it is meaningful, accurate, timely, proportionate and supports improvement;
- checking that relevant team are working towards a timely quarterly publication, in line with the Quality Accounts regulations and guidance;
- checking that arrangements are in place to invite, gather and act on stakeholder feedback on a quarter by quarter basis;
- ensuring the organisation can demonstrate to stakeholders that "this is what we said we would do, and this is what we did" (learning and action), and explain the impact of the quality improvement actions.

Annex C - Responding to Deaths

Trusts should have a policy in place that sets out how they respond to the deaths of patients who die under their management and care.

POLICY FOR RESPONDING TO DEATHS - KEY POINTS

The policy should include how providers:

- **determine which patients are considered to be under their care and included for case record review if they die** (it should also state which patients are specifically excluded);
- **report the death within the organisation and to other organisations who may have an interest** (including the deceased person's GP), including how they determine which other organisations should be informed;
- **respond to the death of an individual with a learning disability** (Annex D) or **mental health needs** (Annex E), **an infant or child death** (Annex F) **and a stillbirth or maternal death** (Annex G) and the provider's processes to support such deaths;
- **review the care provided to patients who they do not consider to have been under their care at the time of death but where another organisation suggests that the Trust should review the care provided to the patient in the past**;
- **review the care provided to patients whose death may have been expected**, for example those receiving end of life care;
- **record the outcome of their decision whether or not to review or investigate the death**, which should have been informed by the views of bereaved families and carers;
- **engage meaningfully and compassionately with bereaved families and carers** - this should include informing the family/carers if the provider intends to review or investigate the care provided to the patient. In the case of an investigation, this should include details of how families/carers will be involved to the extent that they wish to be involved. Initial contact with families/carers are often managed by the clinicians responsible for the care of the patient. Given that providers must offer families/carers the opportunity to express concerns about the care given to patients who have died, then the involvement of clinicians who cared for the patient may be considered a barrier to raising concerns. Providers should therefore offer other routes for doing this;
- **offer guidance, where appropriate, on obtaining legal advice for families,**

carers or staff. This should include clear expectations that the reasons, purpose and involvement of any lawyers by providers will be communicated clearly from the outset, preferably by the clinical team, so families and carers understand the reasons and are also offered an opportunity to have their own advocates.

Annex D - Learning Disabilities

Context

1. Since the 1990s, there have been a number of reports and case studies which have consistently highlighted, that in England, people with learning disabilities die younger than people without learning disabilities. The Confidential Inquiry of 2010-2013 into premature deaths of people with learning disabilities (CIPOLD) reported that for every one person in the general population who died from a cause of death amenable to good quality care, three people with learning disabilities would do so[9]. Overall, people with learning disabilities currently have a life expectancy at least 15 to 20 years shorter than other people[10].

2. A concerning finding from CIPOLD was that assumptions were sometimes made that the death of a person with learning disabilities was 'expected' or even inevitable, because that person had learning disabilities. As with the CQC report of 2016[11], CIPOLD also identified deaths that should have been, but were not, reported to mandatory review processes, including safeguarding reviews and to the coroner.

3. The lives of people with learning disabilities often involve a complex array of service provision with multiple care and support staff. If we are to improve service provision for people with learning disabilities and their families, and reduce premature deaths, we need to look wider than NHS-related circumstances leading to a person's death, in order to identify the wider range of potentially avoidable contributory factors to their death. A cross-sector approach to reviewing deaths of people with learning disabilities is imperative; one that includes families, primary and secondary healthcare, and social and third sector care providers. Such a balanced approach across acute and other settings is needed from the outset of a review process, in order to accurately determine if there are any concerns about the death, or to identify examples of best practice that could lead to service improvement.

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[9] Heslop P, Blair P, Fleming P, Hoghton M, Marriott A, Needleman D, Russ L. (2013) Confidential Inquiry into premature deaths of people with learning disabilities. Bristol: University of Bristol.

[10] Glover G,et al, 2017. Williams R. Heslop P, Oyinlola J, Grey J. (2016) Mortality in people with intellectual disabilities in England. *Journal of Intellectual Disabilities Research, 61, 1, 62-74; Health and Care of People with Learning Disabilities, 2014-15*, NHS Digital, 9 December 2016.

[11] *Learning, candour and accountability: A review of the way NHS Trusts review and investigate the deaths of patients in England*, Care Quality Commission December 2016.

4. There is unequivocal evidence that demands additional scrutiny be placed on the deaths of people with learning disabilities across all settings. This work has already been started by the Learning Disabilities Mortality Review (LeDeR) programme, commissioned by Healthcare Quality Improvement Partnership (HQUIP) for NHS England. Once fully rolled out, the programme will receive notification of all deaths of people with learning disabilities, and support local areas to conduct standardised, independent reviews following the deaths of people with learning disabilities aged 4 to 74 years of age. These will be conducted by trained reviewers.

5. The purpose of the local reviews of death is to identify any potentially avoidable factors that may have contributed to the person's death and to develop plans of action that individually or in combination, will guide necessary changes in health and social care services in order to reduce premature deaths of people with learning disabilities.

Scope

6. A conceptual definition of learning disabilities is used in the Learning Disabilities White Paper 'Valuing People'[12] (2001).

7. At present, NHS England is working with NHS Digital to explore the options and potential of 'flagging' the records of people with learning disabilities on the NHS Spine[13]. Over time, this could provide an access point for identifying that a person who has died had learning disabilities.

8. The LeDeR programme currently supports local reviews of deaths of people with learning disabilities aged 4 years and over. The lower age limit is set at 4 years of age because before that age, it can be difficult to be sure that a child has learning disabilities as defined above.

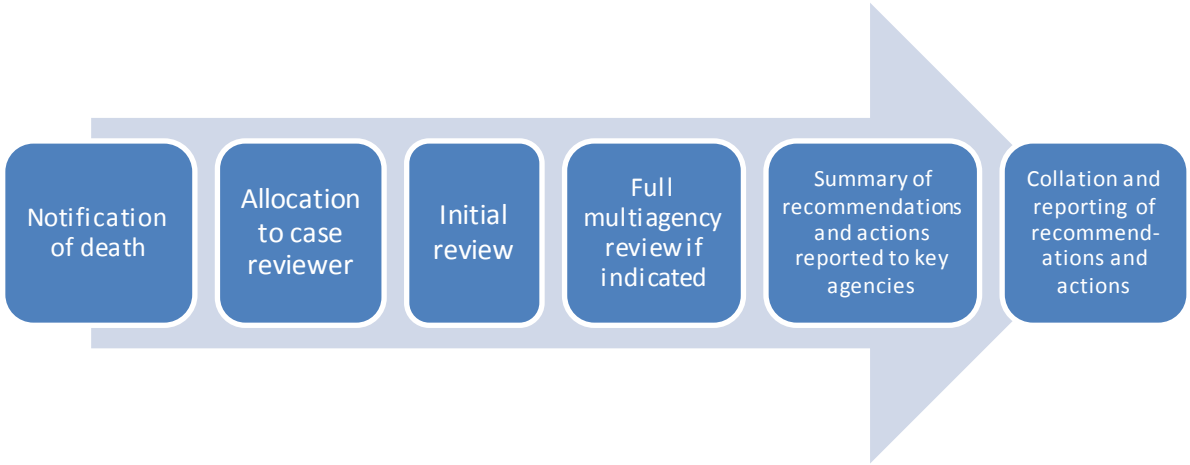
Operationalising Mortality Reviews of People with Learning Disabilities

9. The LeDeR programme has an established and well-tested methodology for reviewing the deaths of people with learning disabilities.

[12] Valuing People: A New Strategy for Learning Disability for the 21st Century, Department of Health, 2001. LeDeR briefing paper.

[13] Spine supports the IT infrastructure for health and social care in England, joining together over 23,000 healthcare IT systems in 20,500 organisations.

Current process



10. All deaths of people with learning disabilities are notified to the programme. Those meeting the inclusion criteria for mortality review receive an initial review of their death by an independent, trained reviewer.

11. The standardised review process involves discussing the circumstances leading up to the person's death with someone who knew them well (including family members wherever possible), and scrutinising at least one set of relevant case notes. Taking a cross-agency approach, the reviewer develops a pen portrait of the individual and a comprehensive timeline of the circumstances leading to their death, identifies any best practice or potential areas of concern, and makes a decision, in conjunction with others if necessary, about whether a multi-agency review is indicated.

12. A full multi-agency review is required if the criteria for the current themed priority review are met (death of a person from a Black and Minority Ethnic background or aged 18-24), or where an assessment of the care received by the person indicates deficiencies in one or more significant areas. A full multi-agency review is recommended if there have been any concerns raised about the death, if any 'red flag alerts'[14] have been identified in the initial review, or if the reviewer thinks that a full multi-agency review would be appropriate. The purpose of the multi-agency review is to gain further learning which will contribute to improving practice and service provision for people with learning disabilities, so the review process concludes with an agreed action plan and recommendations that are fed back to the regional governance structures for the programme.

[14] 'Red flag' alerts are those identified in the initial review that may suggest potential problems with the provision of care e.g. no evidence that an assessment of mental capacity has been considered when this would have been appropriate; delays in the person's care or treatment that adversely affected their health.

13. The LeDeR programme currently operates independently of, but communicates and cooperates with, other review and investigatory processes. This enables an integrated approach to initial reviews of deaths of people with learning disabilities to be taken whenever possible, so as to avoid unnecessary duplication but ensure that the specific focus of the different review or investigation processes is maintained.

14. Alignment of LeDeR with SJR for example will enable a balanced approach to be taken to reviewing deaths of people with learning disabilities that draws on contributions from across acute and other settings. Deaths of people with learning disabilities that occur in hospital settings should be subject to the LeDeR review process in order that insights from families, primary and secondary healthcare, and social and third sector care providers are all included in the mortality review.

15. The LeDeR programme provide annual reports on its findings, collating learning and recommendations at the regional and national level on how best to take forward the learnings across the NHS.

16. Because of the different methodology adopted by the LeDeR programme, it would not be appropriate to use the same definition of 'avoidable death' as used by the SJR, nor to compare rates of avoidable deaths across and between the two review processes. The LeDeR programme will continue to use the Child Death Review Process terminology of 'potentially avoidable contributory causes of death' and the Office for National Statistics definition of avoidable deaths using ICD-10 coding of the underlying cause of death[15].

Integration of the LeDeR Process into National Level Mortality Review Structures

17. When a death of a person with learning disabilities occurs, mandatory review processes need to take precedence, working with the LeDeR programme reviewers to ensure that a coordinated approach is taken to the review of the death in order to minimise duplication and bring in the learning disabilities expertise of the LeDeR reviewers, whilst recognising that some investigatory processes will be more focused than that of LeDeR which is cross-agency in nature and may require the provision of additional information.

[15] Office for National Statistics (2016) Revised Definition of Avoidable Mortality and New Definition for Children and Young People.
https://www.ons.gov.uk/aboutus/whatwedo/statistics/consultationsandsurveys/allconsultationsandsurveys/reviewofavoidablemortalitydefinition

18. Learning and recommendations from LeDeR reviews will identify opportunities for improvement at the local, regional and national level. Governance structures that can support the cross-agency implementation of recommendations from mortality reviews are required at all levels, but in particular for the reviews of deaths of people with learning disabilities. Such structures exist in the form of regional steering groups for the LeDeR programme, and these are usually best placed within the safeguarding framework. Not all deaths of people with learning disabilities are safeguarding issues; however the existing multi-agency framework and statutory responsibility mean that this is a natural 'home' for governance of mortality reviews.

Guidance for Providers

19. Key points to note are:

- All deaths of people with learning disabilities aged four years and older are subject to review using LeDeR methodology;
- The LeDeR programme is currently being rolled out across England. Full coverage is anticipated in all Regions by the end of 2017. If there is a death of a person with learning disabilities in an acute setting in an area that is not yet covered by the LeDeR programme, Trusts are recommended to use the SJR process or a methodology of equivalent quality that meets the requirements for the data that must be collected as an interim measure;
- If a Trust wishes to complete its own internal mortality review, it is recommended that it uses the LeDeR initial review process and documentation available at: http://www.bristol.ac.uk/media-library/sites/sps/leder/Initial%20Review%20Template%20version%201.2.pdf The provider can then submit that as an attachment to the LeDeR notification web-based platform once their internal review is completed;
- Once the LeDeR review has been completed, a copy will be sent to the relevant governance body at the Trust where the death occurred;
- Trusts are encouraged to identify appropriate personnel to undertake LeDeR training and review processes. Reviewers would be expected to conduct reviews independent of the Trust in which they work.

Annex E - Mental Health

1. Physical and mental health are closely linked. People with severe and prolonged mental illness are at risk of dying on average 15 to 20 years earlier than other people[16]. In addition, people with long term physical illnesses suffer more complications if they also develop mental health problems.

2. Reporting and reviewing of any death of a patient with mental health problems should consider these factors i.e. premature death of those with a mental disorder and the increased risk of complications for those with physical and mental health difficulties.

Inpatients detained under Mental Health Act

3. Regulations[17] require mental health providers to ensure that any death of a patient detained under the Mental Health Act (1983) is reported to the Care Quality Commission without delay. In 2015, the Care Quality Commission reported concern that providers were failing to make this notification in 45% of cases. The Commission has since updated its notifications protocols to ensure that providers ensure they report in a timely way.

4. Under the Coroners and Justice Act 2009, coroners must conduct an inquest into a death that has taken place in state detention, and this includes deaths of people subject to the Mental Health Act. Providers are also required to ensure that there is an appropriate investigation into the death of a patient in state detention under the Mental Health Act (1983).

5. In circumstances where there is reason to believe the death may have been due, or in part due to, to problems in care - including suspected self-inflicted death - then the death must be reported to the provider's commissioner(s) as a serious incident and investigated appropriately. Consideration should also be given to commissioning an independent investigation as detailed in the *Serious Incident Framework*.

People with Mental Health Disorders in Prisons

6. Evidence shows that there is a high incidence of mental health problems in prisons: 72% of adult male and 71% of female prisoners may have 2 or more mental disorders (e.g.

[16] *The Five Year Forward View For Mental Health* (NHS England, 2016) is available at: https://www.england.nhs.uk/wp-content/.../Mental-Health-Taskforce-FYFV-final.pdf

[17] Regulation 17, Care Quality Commission (Registration) Regulations 2009

personality disorder, psychosis, anxiety and depression, substance misuse); 20% have 4 or more mental disorders.

7. There have been large increases in the number of natural and non-natural deaths in prisons over the most recent five-year reporting period. The increase in recent years in non-natural deaths in prisons are due to a number of factors. Prisons contain a high proportion of vulnerable individuals, many of whom have experienced negative life events that increase the likelihood of suicide or self-harm. Issues that increase risk include drug/alcohol abuse, family background, social disadvantage or isolation, previous sexual or physical abuse, and mental health problems. The increase in part reflects an ageing prison population. Prisons are also very challenging environments particularly so for those prisoners who have a learning disability. Average estimates of prevalence of learning disabilities amongst adult offenders in the UK is thought to be between 2-10%. This figure is much higher for children who offend[18]. Prisoners with learning disabilities are also more likely than other prisoners to suffer mental ill health. As such, the mental wellbeing of prisoners with learning disabilities should be a key consideration for healthcare staff of NHS providers along with all other prison staff.

8. The *Serious Incident Framework* states that in prison and police custody, any death will be referred (by the relevant organisation) to the Prison and Probation Ombudsman (PPO) or the Independent Police Complaints Commission (IPCC) who are responsible for carrying out the relevant investigations. Healthcare providers must fully support these investigations where required to do so. The PPO has clear expectations in relation to health involvement in PPO investigations into death in custody. Guidance published by the PPO[19] must be followed by those involved in the delivery and commissioning of NHS funded care within settings covered by the PPO.

[18] *Equal Access Equal Care*, Guidance for Prison Healthcare Staff treating Patients with Learning Disabilities (2015) *available at* https://www.england.nhs.uk/.../equal-access-equal-care-guidance-patients-ld.pdf

[19] Guidance is available online: http://www.ppo.gov.uk/updated-guidance-for-clinical-reviews/

Annex F - Children and Young People

Infant and Child Mortality

1. Over the last 20 years, the UK has gone from having one of the lowest mortality rates for 0 to 14 year olds in Europe to one of the highest[1]. In 2014, 4, 419 children and young people aged 0 to 18 years old died in England and Wales. 24% of deaths in children and young people are thought to be preventable[2]. In the year ending March 2016, 68% of all deaths occurred in hospital, 22% in the home, 4% in a public place, and 4% in a hospice. In the year ending March 2016, 32% of all deaths occurred following a perinatal or neonatal event, 26% in children with chromosomal, genetic and congenital anomalies, 8% in children with 'sudden unexpected and unexplained' death, 7% in children with malignancy, 6% in children with acute medical or surgical illnesses, 6% in children with infection, 5% in children suffering trauma, 3% in young people taking their life, and 2% following deliberately inflicted injury, abuse or neglect[2].

2. In child mortality review, professionals have moved away from defining 'avoidability' to instead using the language of 'a preventable death' where the latter is defined as a death in which 'modifiable factors may have contributed to the death and which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths'[3]. In the year ending March 2016, 54% of deaths in hospital and 31% of death in the home were identified as having modifiable factors. Most modifiable factors are found in children dying from perinatal/neonatal events, followed by trauma, followed by those with chromosomal, genetic and congenital anomalies[2].

National Data on Causes of Death and International Comparisons[4]

3. The UK ranks 15 out of 19 Western European countries on infant (under one year of age) mortality and has one of the highest rates for children and young people in Western Europe[5]. There is a strong association between deprivation and mortality; for example infant mortality is more than twice as high in the lowest compared with the highest socio-economic groups[6].

Infants (under 1 year)

4. Around 60% of deaths during childhood occur in infancy. Infant mortality can be split into neonatal mortality (deaths 0–27 days) and post-neonatal mortality (28–365 days). Births without signs of life (stillbirths if after 24 weeks of pregnancy) do not contribute to infant mortality but are also an important indicator of maternal and child health. The Infant

Mortality Rate (IMR) is an indicator of both population health and the quality of healthcare service. It is also a key international indicator in the United Nation's Sustainable Development Goals and in UNICEF international comparisons.

5. Neonatal mortality accounts for between 70% and 80% of infant deaths. The great majority of neonatal deaths are due to perinatal causes, particularly preterm birth, and are strongly related to maternal health, as well as congenital malformations. The remainder of infant deaths are post-neonatal and are due to a broad range of causes including sudden infant death syndrome (SIDS). Stillbirths (defined in the UK as a baby born without signs of life after 24 completed weeks of pregnancy) account for half of all deaths during the perinatal period. In 2014, the IMR across the UK was 3.9 deaths per 1,000 live births. Although there has been an overall decline in the IMR across the UK over the past 45 years, in recent years the reduction in infant mortality in the UK has not equalled the gains observed in comparable countries. An international study of mortality in the UK compared with similar wealthy countries in Europe and elsewhere showed the UK to have IMR in 1970 similar to the average of the group, but that the UK had become among the worst performing 10% by 2008[7].

6. Social inequalities play a role in almost all the leading causes of infant death. The mechanisms underlying this social gradient are related to increased risk of preterm delivery in more deprived groups, as well as to maternal health during pregnancy (for example, smoking, poor nutrition, substance abuse) and uptake of recommended practices such as breastfeeding and safe infant sleeping positions[8]. Maternal age is also associated with infant mortality[6]. Many of the causes of infant mortality are preventable and necessitate actions at both a population and individual level[9]:

    - maximising the health and wellbeing of women before conception and during pregnancy (smoking cessation programmes, promotion of breastfeeding and promoting healthy weight in women of childbearing age)
    - protecting and supporting health promotion and early intervention services (universal midwifery and health visiting services for new mothers)
    - promoting evidence-based research into maternal and infant health, and translating findings into improved practice, standards of care, and ultimately policy
    - identifying best practice and reducing variations in outcomes across health care services

Children (1-9 years)

7. The main factors that contribute to death during childhood are different to those that contribute to death during infancy or adolescence. The common causes of death amongst 1 to 9 year-olds are cancer, injuries and poisonings, congenital conditions and neurological and developmental disorders. Injuries and poisonings from external causes are the leading cause of death in boys aged one to four years, whilst cancer is the leading cause of death in girls of the same age[5]. For both girls and boys five to nine years of age, cancer is the leading cause of death. Very early life also still has an impact on mortality in later childhood; children who were born preterm remain more likely to die before age 10 years compared to children born at term.

8. In the period 2012-2014, the mortality rate in children aged 1-9 years in the U.K. was 12.1 per 100,000 population. Although the mortality rate has declined across the UK since the 1970s, the UK's recent progress has been significantly lower than in other wealthy European countries, and concerningly the incidence of death due to diseases such as asthma and diabetes is higher than equivalent high-income countries. The scale of difference between the UK child mortality rate and the average suggests there are around 130 excess deaths of 1- to 9-year-olds each year in the UK[10].

9. Many childhood deaths are preventable. As with infants there is a strong association between deprivation, social inequality, and mortality. Causes amenable to interventions include environmental and social factors as well as health service factors and key actions include the following[9]:

    - creating safe environments, including access to information and safety equipment schemes to promote safety in the home;
    - reduce road speed limits in built-up areas to 20mph;
    - ensuring that clinical teams looking after children with long-term conditions such as asthma, epilepsy and diabetes deliver care to the highest standards, incorporating good communication, open access for patients and families, use of established tools such as the epilepsy passport and asthma plan, adherence to the components prevalent in the best practice tariff for diabetes, and address early the optimal conditions for safe transition to adult services. Implicit in this is teaching self-management and ownership of the condition;
    - increasing the provision of high-quality end-of-life care and access to appropriate palliative care;

- delivering integrated health systems across primary and secondary care; whilst providing the optimal configuration of specialist services for children with complex conditions needing tertiary care, such as cardiac, renal conditions and children's cancer.

Young People (10-19 years)

10. After the first year of life, adolescence is the life stage when children are most likely to die. The factors leading to death in adolescence are different to those in earlier childhood, and differ between males and females. The most common causes of death in this age group are injuries, violence and suicide, followed by cancer, substance misuse disorders and nervous system and developmental disorders.

11. Although the mortality rate in young people has decreased across the UK since the 1970s, progress recently has been slower than that seen in other wealthy countries[10]. The UK's 'average' adolescent overall mortality today is a mixed picture. Whilst our injury mortality rate is amongst the lowest, we have a higher rate of deaths due to 'non communicable diseases' such as asthma than other equivalent wealthy countries. Social inequalities are important since injury and illness are associated with poor environmental conditions and hazards such as smoking, alcohol, and drug use[8].

12. Many deaths are preventable and key actions include[9]:

- reducing deaths from traffic injuries through the introduction of graduated licensing schemes;
- improving adolescent mental health services;
- improving services for children with long term conditions, and especially those transitioning to adult care;
- increasing the involvement of young people and their families with rare and common long-term conditions in developing guidelines, measuring outcomes, service design and research trials.

13. Underpinning all efforts to reduce child mortality in England lies an urgent need to collect high-quality data to better understand the reasons why children die, to allow accurate international comparisons, and to inform health policy. This requires a national system for the analysis of child mortality data, as well as improved child death review processes.

Historical Background to the Process of Child Mortality Review

14. Since 1st April 2008, Local Safeguarding Children's Boards in England have had a statutory responsibility for Child Death Review (CDR) processes. The relevant legislation underpinning such responsibility is enshrined in the Children's Act 2004 and applies to all children under 18 years of age. The processes to be followed when a child dies are described in Chapter 5 of the statutory guidance document, *Working Together to Safeguard Children*[11]. The overarching purpose of child death review is to understand how and why children die, to put in place interventions to protect other children, and to prevent future deaths. *Working Together* describes two interrelated processes:

    i. a "Rapid Response" multi-professional investigation of an individual unexpected death; and,
    ii. a Child Death Overview Panel (CDOP) review of all deaths in a defined geographical area. The purpose of the CDOP is to establish the exact cause of death, identify patterns of death in community and remedial factors, and to contribute to improved forensic intelligence in suspicious deaths. The family should be kept central to the process.

Drivers for Change including new Legislation

15. The review of child deaths has been, to date, far more comprehensive than that for adults. However the following drivers for change exist:

    i. *Variation in process.* There is significant variation across the system in how child deaths are reviewed, which deaths are reviewed, and the quality of the review. Specifically:

        - 'unexpected' deaths in the community are generally reviewed as per the Sudden Unexpected Deaths in Infancy (SUDI) process. However there is variation in when a death is considered "unexpected" and in the timing of triggering investigations.
        - hospital deaths are usually reviewed at a Mortality and Morbidity (M&M) meeting. However there is wide variation, across the NHS, in how these meetings are convened, no standardisation on terminology, and a confused array of investigations (root cause analysis, serious incident inquiry, mortality review) that follow certain types of deaths.

- there is wide variation in CDOP processes (size, structure and functioning) and many CDOP panels are dislocated from governance processes within their local children's hospital.

ii. *The Wood Review*[12]. In 2016, Alan Wood recommended that national responsibility for child death reviews should move from the Department for Education to the Department of Health, that DH should re-consider how CDOPs should best be supported within the new arrangements of the NHS, and that DH should determine how CDOPs might be better configured on a regional basis with sub-regional structures to promote learning. He also recommended that child deaths be reviewed over a population size that allowed a sufficient number of deaths to be analysed for patterns and themes. He went further to recommend that the NHS consider the role CDOPs should play in the process for achieving a common national standard for high quality serious incident investigations. Finally, he supported the intention to introduce a national child mortality database, and urged DH to expedite its introduction.

iii. *The National Adult Case Review programme*[13]. This programme uses a very different structured judgment review (SJR) methodology to that used in child mortality review. It focuses on problems in heath care processes within an organization rather than trying to understand the cause of death. Cases in which care is judged to be poor are scored according to an 'Avoidability of Death' scale. It is important to recognise that many 16 and 17 year olds die in adult ITU's and therefore it is important to understand what processes should take precedence in the review of such patients.

iv. *Medical Examiner process*. The Medical Examiner will be introduced across England. This appointee will link with bereaved families as well as the Coroner and their involvement will affect all mortality review processes.

v. *CQC report: Learning, Candour, and Accountability*[14]. This report identified inconsistencies in: the involvement of families and carers; the process of identifying and reporting the death; how decisions to review or investigate a death was made; variation in the quality of reviews and investigations; and variation in the governance around processes and questionable demonstration of learning and actions.

vi. *Legislative change (Children and Social Work Bill 2017)*. The Wood Review recommendation that national responsibility for child death reviews should move from the Department for Education to the Department of Health is being enacted through

the Children and Social Work Bill 2017. Under the new legislation, local authorities and clinical commissioning groups are named as 'child death review partners' and must make arrangements for the review of each death of a child normally resident in the local authority area. They may also, if they consider it appropriate, make arrangements for the review of a death in their area of a child not normally resident there. The proposed legislation also states that the 'child death review partners' must make arrangements for the analysis of information about deaths reviewed and identify any matters relating to the death or deaths in that area a) relevant to the welfare of children in the area or to public health and safety and b) to consider whether it would be appropriate for anyone to take action in relation to any matters identified.

National Child Mortality Programme

16. NHS England is undertaking a national review of child mortality review processes both in the hospital and community. A key aim is to make the process easier for families to navigate at a very difficult time in their life. Central to the programme is the creation of a National Child Mortality Database, which is currently being commissioned. The effective functioning of the national database requires high-quality, standardised data arising from simplified and standardised local mortality and CDOP review processes. NHS England have therefore established 3 work streams:

- the simplification and standardisation of mortality review processes in the community and hospital;
- a review of the governance arrangements and standardisation of CDOP processes;
- the creation of the national child mortality database.

17. The goals of the NHS England's child mortality review programme are to:

- establish, as far as possible, the cause or causes of each child's death;
- identify any potential contributory or modifiable factors;
- provide on-going support to the family;
- ensure that all statutory obligations are met;
- learn lessons in order to reduce the risk of future child deaths;
- establish a robust evidence base to inform national policy across government to reduce avoidable child mortality across the UK nations.

18. NHS England, the Department of Health and the Department for Education are working together to produce new statutory guidance for child death review. This guidance will cover the processes which should take place following the death of a child, and in particular how the death should be reviewed at local mortality meeting and child death overview panel. This new guidance will be published in late 2017.

Reporting

19. The definitions used within the adult Case Review programme for record review and to identify problems in care are not recognised within *Working Together*. NHS England's work programme intends to identify best practice and standardise processes across deaths in hospital and the community, to improve the experience of families and professionals. The deaths of children who are treated in acute, mental health and community NHS Trusts should be included by Trusts in quarterly reporting from April 2017. The information should come from child death review processes, and should include reporting problems related to service delivery.

Board Leadership

20. Hospital Trust, Local Authority, Community Trust, Mental Health Trusts, and CCG boards should ensure that learning is derived from the care provided to children who die, by the appropriate application of the child mortality review process, and that learning is shared and acted on.

21. Many of the points around board leadership relating to adult deaths (set out in the main body of this guidance) also apply for child deaths. For example, providers must ensure that they have a board-level leader designated as patient safety director to take responsibility for the learning from deaths agenda (Annex A) and he or she should also have specific responsibility for the learning from child mortality processes. The director should ensure that the reviews are delivered to a high quality, with sufficient numbers of trained staff to lead the child mortality review process.

22. Particular attention should be paid to the deaths of children and young people with learning disabilities or mental health conditions, as these present with frequent co-morbidities and are often a more vulnerable group.

23. Providers should acknowledge that an independent investigation (one commissioned and delivered entirely separately from the organisation(s) involved in caring for the patient) may be required where the integrity of the investigation is likely to be challenged.

Best Practice in responding to Death of a Child who dies under a Trust's Care

24. All Trusts should have a policy in place that sets out how they respond to the deaths of children who die under their care. In doing this they should be mindful of current expectations described within *Working Together to Safeguard Children* (2015) and of NHS England's current review of child mortality review processes. New statutory guidance on child death review will be published in late 2017.

25. That policy should also set out how Trusts:

- communicate with bereaved parents and carers. This should include providing an honest and compassionate account of the reasons for death and knowledge of any potential problems in care that may need further review, ensuring initial contacts are managed by clinicians responsible for the care of the patient, and offering support to express concerns about the care given to patients who have died;
- achieve independence (where relevant) and objectivity in the child mortality review process, as well as lay membership within wider clinical governance systems.

Cross-system Reviews and Investigations

26. When the death of a child involves treatment across the health care pathway (primary: secondary: tertiary care) it is expected that child mortality review processes will not be duplicated and that a single overarching meeting will be convened. Child mortality review processes should interface with existing organisational governance systems. The NHS England child death review programme is mindful of expectations arising from the Serious Incident Framework, which sets out the circumstances in which further investigation is warranted in certain situations. It is therefore anticipated that when a review identifies a problem in care that meets the definition of a patient safety incident (any unintended or unexpected incident which could have or did lead to harm to one or more patients receiving NHS care) then this is reported via local risk management systems to the National Reporting and Learning System (NRLS). Regardless of the type of review, its findings must form an integral part of and feed into the organisation's clinical governance processes and structures. Review findings should be considered alongside other information and data including complaints, clinical audit information, patient safety incident reports and other outcomes measures to inform the Trust's wider strategic plans and safety priorities.

Bereaved Families and Carers

27. *Working Together* places the family at the heart of its processes. However it is recognised that the multitude of investigations that may unfold following a child's death can cause great confusion and distress to parents. The national bereavement group and bereavement charities are closely involved with developing NHS England's child death review programme – both in the co-design of systems and public guidance that explains processes.

28. The national Child Death Review programme recognises the following principles:

- bereaved families and carers should be treated as equal partners both in the delivery of care and following a bereavement;
- bereaved families and carers should receive a high standard of bereavement care, including being offered appropriate support;
- bereaved families and carers must always receive an honest, caring and sensitive response;
- bereaved families and carers should receive timely, responsive contact and support in all aspects of any review process, with a single point of contact and liaison.

Learning Disabilities and Mental Illness

29. NHS England's National Child Mortality Review programme fully recognises the unique challenge in reviewing the deaths of children with learning disabilities and mental health disorders. The Programme is working closely with the Learning and Disabilities Mortality Review (LeDeR) programme, and also aims to align itself with the Children and Young People's (CYP) Mental Health Programme and Specialised Commissioning particularly with regard to deaths in Tier 4 inpatient CAMHS Units. It will also work closely with the National Programme on Suicide in Young People. Going forward, the programme will ensure that there are appropriate mechanisms in place to allow data flows to occur unencumbered between all these systems and the national Child Mortality Database.

Conclusion

30. This section highlights the very different circumstances that pertain to the death of a child in acute, mental health and community organisations. Although infant and child mortality has declined in the UK, these improvements have not been sustained in comparison to other European countries. While poverty and inequality have a major impact on child mortality, we can nonetheless do much in front line service delivery to improve outcomes

for children, and experiences for both bereaved parents and the professionals who deliver care. Sadly, deaths in childhood are often an inevitable consequence of congenital malformations, birth events, and long-term conditions or chronic illness. Many, however, have preventable factors, and there is therefore an absolute imperative to scrutinise all deaths both locally and nationally to ensure that learning always occurs.

31. NHS England is seeking to address this by establishing a National Child Mortality Database to allow analysis and interpretation of child mortality data. The programme will also seek to improve, standardise and simplify the processes that follow the death of a child. This is predominantly to improve the experience of bereaved parents at such an overwhelming time, but also to enable uniformly robust data collection, to ultimately lead to a reduction in infant and child mortality in this country.

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Annex G - Maternity

1. In England, maternity care is generally safe and for the majority of women and their babies there is a good outcome. However, when things go wrong, the impact is devastating and has a profound effect on the parents, partners, siblings and extended family members.

2. Dr Bill Kirkup was tasked by the Secretary of State for Health to investigate and report on maternity services at Morecambe Bay NHS trust. The Report of the Morecambe Bay Investigation in 2015[20] highlighted a number of failures over a number of years at the Trust which resulted in poor care and the tragic deaths of mothers and babies. The report makes recommendations for mandatory reporting and investigation of serious incidents of maternal deaths, late and intrapartum stillbirths and unexpected neonatal deaths. It recommends a requirement that investigation of these incidents be subject to a standardised process, which includes input from and feedback to families, and independent, multidisciplinary peer review. In *Learning not Blaming*[21] the Government accepted this recommendation.

3. In October 2016, *Safer maternity care: next steps towards the national maternity ambition* was published setting out an action plan for the Government's vision for making NHS maternity services some of the safest in the world, by achieving the national ambition to halve the rates of stillbirths, neonatal deaths, brain injuries that occur during or soon after birth and maternal deaths, by 2030 with an interim measure of 20% by 2020. The plan details the actions needed at national and local level that build on the progress already made to improve the safety of maternity services.

4. Currently MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquires across the UK)[22], appointed by Health Quality Improvement Partnership and funded by NHS England, run the national Maternal, Newborn and Infant

[20] The report of the Morecambe Bay Investigation (March 2015): https://www.gov.uk/government/news/morecambe-bay-investigation-report-published

[21] The government response to the Freedom to Speak Up consultation, the Public Administration Select Committee report 'Investigating Clinical Incidents in the NHS', and the Morecambe Bay Investigation (July 2015).

[22] 'MBRRACE-UK' is the collaboration appointed by the Healthcare Quality Improvement Partnership (HQIP) to continue the national programme of work investigating maternal deaths, stillbirths and infant deaths, including the Confidential Enquiry into Maternal Deaths (CEMD). The aim of the MBRRACE-UK programme is to provide robust information to support the delivery of safe, equitable, high quality, patient-centred maternal, newborn and infant health services.

Clinical Outcomes Review to conduct surveillance of all late fetal losses, stillbirths and neonatal deaths, biennial topic-specific confidential enquiries into aspects of stillbirth and neonatal death or serious neonatal morbidity and surveillance and confidential enquiries of all maternal deaths.

5. Surveillance reports on stillbirths and neonatal deaths are published annually. Reports on maternal deaths are published on a triennial basis, because the number of maternal deaths from individual causes is small, and thus three years' worth of data is required to identify consistent lessons learned for future care and to maintain anonymity and confidentiality.

6. A maternal death is defined internationally as a death of a woman during or up to six weeks (42 days) after the end of pregnancy (whether the pregnancy ended by termination, miscarriage or a birth, or was an ectopic pregnancy) through causes associated with, or exacerbated by, pregnancy. Deaths are subdivided on the basis of cause into: direct deaths, from pregnancy-specific causes such as preeclampsia; indirect deaths, from other medical conditions made worse by pregnancy such as cardiac disease; or coincidental deaths, where the cause is considered to be unrelated to pregnancy, such as road traffic accidents. Maternal deaths are very rare. The MBRRACE-UK report 'Saving Lives, Improving Mothers Care highlights that for 2012-14, the maternal death rate was 8.5 per 100,000 women. Overall, 241[23] women among 2,341,745 maternities in 2012–14 died during or within 42 days of the end of pregnancy in the UK.

7. Better Births (2016)[24], the report of the NHS England commissioned National Maternity Review, set out a five year forward view for improving outcomes of maternity services in England. The report highlighted the lack of a standard approach to investigating when things wrong during before, during or after labour: Reviews and investigation are currently undertaken using different protocols and processes by different organisations. The Report recommended there should be a national standardised investigation process for when things go wrong, to get to the bottom of what went wrong and why and how future services can be improved as a consequence. Work has now begun on the development of a Standardised Perinatal Mortality Review Tool that will enable maternity

[23] Of these 41 deaths were classified as coincidental

[24] https://www.england.nhs.uk/wp-content/.../02/national-maternity-review-report.pdf

and neonatal services to systematically review and learn from every stillbirth and neonatal death in a standardised way.

8. Maternal deaths, neonatal deaths and stillbirths occurring in acute, mental health and community Trusts should be included by Trusts in quarterly reporting from April 2017.

9. It should be borne in mind that in addition to hospital obstetric units, maternal deaths can occur in a local midwifery facility (for example, a local midwifery unit or birth centre) or during home births. The definition also covers up to 42 days after the end of pregnancy.

Annex H - Cross-system Reviews & Investigations

1. In many circumstances more than one organisation is involved in the care of any patient who dies, with the most common combinations being primary care and acute care, ambulances services and acute care, or mental health services combined with any of these. Case record reviews typically have to rely on the records held by a single organisation, but even these records can provide indications of possible problems in earlier stages of the patient pathway.

2. Where possible problems are identified relating to other organisations, it is important the relevant organisation is informed, so they can undertake any necessary investigation or improvement. Most trusts already have effective systems to notify other organisations when concerns are raised via incident reports, and are likely to be able to adapt these to address potential problems identified in case record review.

3. Trusts should consider whether they can routinely arrange joint case record reviews or investigations for groups of patients where more than one organisation is routinely providing care at the time of death - for example, for older people with dementia and frailty receiving frequent input from their GP and from community mental health nurses. Commissioners have a role in encouraging appropriate routine collaboration on case record review.

4. Where the provision of care by multiple providers, and particularly the coordination of that care, is thought to have potentially contributed to the death of a patient, investing the significant resources required to coordinate major and complex investigations must be considered. For example, the Serious Incident Framework outlines the principles which underpin a serious incident investigation process and the relevant content is set out in paragraphs 5 to 10 below.

5. The organisation that declares the serious incident is responsible for recognising the need to alert other providers, commissioners and partner organisations as required in order to initiate discussions about subsequent action.

6. All organisations and agencies involved should work together to undertake one single investigation wherever this is possible and appropriate. Commissioners should help to facilitate discussions relating to who is the most appropriate organisation to take responsibility for co-ordinating the investigation process. Commissioners themselves should provide support in complex circumstances. For example, where no one provider organisation is best placed to assume responsibility for co-ordinating an investigation, the commissioner may lead this process. If commissioners do not have the capability or capacity to manage this type of activity this should be escalated to ensure appropriate resources are identified. This may be something to consider escalating through the relevant Quality Surveillance Group or through specific review panels and clinical networks. This should ensure the cumulative impact of problems with care can be resolved.

7. In some circumstances the local authority or another external body may be responsible for managing and co-ordinating an investigation process. Where this is the case, providers and commissioners must contribute appropriately and assure themselves that problems identified will be addressed.

8. Often in complex circumstances, separate investigations are completed by the different provider organisations. Where this is the case, organisations (providers and commissioners and external partners as required) must agree to consider cross boundary issues, such as gaps in the services that may lead to problems in care. The contributing factors and root causes of any problems identified must be fully explored in order to develop effective solutions to prevent recurrence. Those responsible for coordinating the investigation must ensure this takes place. This activity should culminate in the development of a single investigation report.

9. To determine oversight of an investigation, the RASCI (Responsible, Accountable, Supporting, Consulted, Informed) model supports the identification of a single 'lead commissioner' with responsibility for managing oversight of serious incidents within a particular provider. This means that a provider reports and engages with one single commissioning organisation who can then liaise with other commissioners as required. This approach is particularly useful where the 'accountable commissioner' is geographically remote from the provider (and therefore removed from other local systems and intelligence networks) and/or where multiple commissioners' commission services from the same provider. It facilitates continuity in the management of serious incidents, removes ambiguity and therefore the risk of serious incidents being

overlooked and reduces the likelihood of duplication where there is confusion regarding accountability and/or responsibility and general management of the serious incident process.

Healthcare Safety Investigation Branch

10. The Healthcare Safety Investigation Branch (HSIB) will provide capability at national level to offer support and guidance to NHS organisations on investigations, and to carry out up to 30 investigations itself per year where there is a deeper learning opportunity for the NHS. Through a combination of setting exemplary practice and structured support to others, the HSIB is expected to make a decisive difference to the NHS, promoting a culture of learning and a more supportive relationship with patients, families and staff.

11. Providers will benefit from the HSIB, and their expert advice on safety improvement. It should mean timely investigations, with a genuine commitment to openness, transparency and engagement with staff and patients and their families and carers that adopt an ethic of learning and continuous improvement. The HSIB will contribute strongly to the culture change that is needed in the NHS.

Annex I - Roles and Responsibilities of National Bodies and Commissioners

1. Each national organisation will have a single lead at executive level who has accountability, internally and externally for that organisation's support of delivering against the national programme on learning from deaths. This will include ensuring progress is reported to the National Quality Board and ensuring that learning from deaths remains a priority area in future developments. A list of the lead roles for each national organisation is at Annex K and will be made available on each organisation's website.

2. As the independent regulator of health and social care, the **Care Quality Commission** will use this national guidance on learning from deaths to guide its monitoring, inspections and regulation of services. Inspectors will use new key lines of enquiry in relation to safety and governance, set out in the Care Quality Commission's assessment framework, to assess learning from deaths, collect evidence and identify good practice. Where specific concerns are identified, the Care Quality Commission can use its powers to take action with individual providers and will report its findings of good and poor progress in individual inspection reports or national publications to help encourage improvement.

3. **NHS Improvement** will continue to provide national guidance for managing serious incidents. Local processes setting out what deaths should be subject to case record review will inevitably use a wider definition than deaths that constitute Serious Incidents. Equally, when a death clearly meets Serious Incident criteria there is no need for an initial stage of case record review to be completed before work to initiate and support a full investigation is undertaken. Serious Incident guidance provides the framework upon which the Care Quality Commission and commissioners (including CCGs and NHS England) will assess the quality of investigations undertaken across the NHS. NHS Improvement will, alongside the Healthcare Safety Investigation Branch and others, support implementation of best practice in investigations by Trusts.

4. As the revised inspection regime of the Care Quality Commission will assess providers' ability to learn from deaths as a key component of high quality care, work to address this will be factored into NHS Improvement's work to support providers in achieving good or outstanding Care Quality Commission care ratings. Regional teams will work with

providers, their commissioners and NHS England to identify areas where improvements can be made and the strategies which can help deliver the change required.

5. Nationally, NHS Improvement commissions (via the Healthcare Quality Improvement Partnership) the work of the Royal College of Physicians to develop and roll-out the Structured Judgement Review methodology, which will be providing a national training programme for acute Trusts to support them to carry out the methodology for adult inpatient deaths.

6. **NHS England** has a direct commissioning role as well as a role in leading and enabling the commissioning system. This national guidance on learning from deaths will guide its practice in both of these areas.

7. The **National Institute for Health and Care Excellence (NICE)** has produced best practice guidelines on the care of the dying, covering adults and children. These guidelines are supported by measurable quality standards that help Trusts demonstrate high quality care, and by information for the public describing the care that should be expected in the last days of life.

Annex J - Structured Judgement Review in Mental Health Trusts

Background

1. Some mental health providers have seen a missed opportunity in not learning more widely from deaths by reviewing the safety and quality of care of a wider group of people. This is despite research showing that people with mental health problems have greater health care needs than the general population and may suffer unnecessarily with untreated or poorly managed long-term conditions.

Where Next - Making a Decision on the Review Method

2. Since 2014 hospitals in Yorkshire and the Humber have been working together with the AHSN Improvement Academy to refine a mortality review method called Structured Mortality Review (SJR), a method proposed for all acute hospitals in England. The acute sector methodology reviews phases of care appropriate to their settings, such as initial assessment and first 24 hours, care during a procedure, discharge/end of life care and assessment of care overall. Written explicit judgements of care and phase of care scores form the basis of the reviews. This now forms the basis of the national acute hospitals mortality review programme.

3. This methodology and review format was seen as potentially valuable by three regional Mental Health trusts and they have individually worked to create phase of care headings more appropriate to mental health care, with the support of the Improvement Academy and Professor Allen Hutchinson. These three trusts are at different stages of implementation. In the early adopter trust the tool was also adapted to include a pen picture to enable the reviewer to understand both the life and death of the person, considering this fundamental to understanding areas for learning that may include review of physical health and lifestyle choices. In the same trust this approach was used within Learning Disability services prior to the introduction of the Learning Disability Review of Deaths (LeDeR) programme. In another trust both the mental health care and community care facilities have been using the methods.

Introducing the Review Process

4. Just as with the acute services, future reviewers require initial training in how to make explicit judgements of the quality and safety of care and how to assess care scores for

each phase of care. Assessments are made of both poor and good care and it is common to find that good care is far more frequent than poor care.

5. One of the findings from introducing the methods into mental health care is that many of the reviewers naturally have a focus on the mental health care component of the services. But review teams have found that using this review method they also identify common long-term conditions such as diabetes and heart disease that do not appear to have been well managed. For example, in one hospital it became evident that many people had a number of co-existing comorbid/long term conditions, yet it was unclear from the records whether or not the person was receiving support and or review from primary care and or secondary care services for their physical health. There is value, therefore, in also training up review staff who have an understanding of what good care looks like in long-term conditions within the context of mental health facilities.

6. Scoring of the phases of care is a new approach for many clinical staff in mental health care (just as has been the case in acute care) and scoring was initially felt to be very daunting by some reviewers. Nevertheless, as staff become more confident with its use, scoring can often be seen as a natural outcome of their judgements on the level of care provided. Some of the hospital teams have set up a mortality-reviewers support group to provide peer review and guidance. Feedback of the good care may be shared with both the individual staff and the wider teams - this is often well received. Of course, concerns also have to be discussed with services to identify areas for improvement.

Where Next

7. The use of the structured judgement method often receives very positive feedback from staff trained in this methodology and so in one centre SJR is being rolled out for wider use to review the quality of care being received whilst people are currently receiving services. Looking forward, it has been recognised that whilst services can learn from each case, more can be learnt from the aggregation of cases, where patterns of poor care and good care emerge. In one case study that has sought for such patterns it is of note that where patterns exist of poorer care, these have been in the main linked to the management of physical ill health within mental health and learning disability services.

8. For further details please contact Allyson Kent allyson.kent@nhs.net , or Professor Allen Hutchinson allen.hutchinson@sheffield.ac.uk Yorkshire and The Humber AHSN Improvement Academy.

Annex K - National Leads

The list below provides the lead role with overall responsibility for the learning from deaths programme at relevant national organisations:

- NHS Improvement - Executive Medical Director
- Care Quality Commission - Chief Inspector of Hospitals
- Department of Health - Director of Acute Care and Workforce
- NHS England - National Medical Director

Annex L - Background and Links

Learning Disabilities Mortality Review (LeDeR) programme

Background is available at http://www.bristol.ac.uk/sps/leder

Quality Accounts

Background is available at:
http://www.nhs.uk/aboutNHSChoices/professionals/healthandcareprofessionals/quality-accounts/Pages/about-quality-accounts.aspx

Healthcare Safety Investigation Branch

The new Healthcare Investigation Branch (HSIB) will offer support and guidance to NHS organisations on investigations, and carry out certain investigations itself. It is envisaged that the HSIB will be established to:

i. generate investigation findings and recommendations which drive action on the reduction or prevention of incident recurrence;
ii. conduct investigations and produce reports that patients, families, carers and staff value, trust and respect; and,
iii. champion good quality investigation across the NHS, and lead on approaches to enhance local capability in investigation.

The HSIB will be hosted by NHS Improvement and will undertake a small number of investigations annually. It will focus on incident types that signal systemic or apparently intractable risks in local healthcare systems. The HSIB and the role of Chief Investigator will play a crucial part in developing the culture of safety, learning and improvement in the NHS that will be one of the key elements of national policy and cross-system action in the years ahead.

Whittington Health NHS

The Whittington Hospital NHS Trust
Magdala Avenue
London N19 5NF

Trust Board

5 April 2017

Title:	February (Month 11) 2016/17 – Financial Performance		
Agenda item:	**17/049**	**Paper**	**6**
Action requested:	To agree corrective actions to ensure financial targets are achieved and monitor the on-going improvements and trends.		
Executive Summary:	The Trust reported a £0.5m deficit in February and a year to date position of £6.4m deficit. This is £0.2m adverse against the planned year to date (YTD) performance. The Trust continues to forecast delivery of its control total position, and has put in place enhanced financial controls covering both pay and non pay to support this.		
Summary of recommendations:	To note the financial results relating to performance during February 2017		
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:	28 March 2017		

Author name and title:		**Anis Choudhury Head of Financial Planning and Analysis**		**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**

Use of Resources Metric

The Use of Resources Rating forms part of NHSI's Single Oversight Framework, replacing the previous Financial Sustainability Risk Rating (FSRR). It adds to the FSRR by introducing a metric for agency spend as part of the assessment of financial controls.

Scoring is still based on a scale of 1 to 4, although 4 is now seen as worst performing/highest risk, rather than lowest risk as was previously the case.

Use of Resources Metric	Current Period Plan	Current Period Actual	Current Period Variance
Liquidity Ratio (days)	4	4	0
Capital Servicing Capacity (times)	4	4	0
I&E Margin	4	4	0
I&E Margin Variance from Plan		2	
Agency	2	3	1
Use of Resources Rating after overrides		3	

The table above shows that as at Month 11 the Trust's Use of Resources Rating is a 3, which under the Single Oversight Framework would trigger a 'potential support need' on review by NHSI.

Financial Overview

The Trust reported a £0.5m deficit in February, which is in line with the required run rate to achieve the control total at year end. Enhanced financial controls covering both pay and non pay were introduced at the beginning of February to manage expenditure and ensure adherence with funded establishments.

Through the use of these controls the Trust's in-month reported position (for Month 11) is an improvement on the recent trend. Year to date the Trust is reporting a deficit of £6.4m, which remains £0.2m adverse to plan. In view of the improvement the Trust is therefore continuing to forecast delivery of the control total at year end.

Main issues of note:

- Pay expenditure was £0.3m adverse against plan in month, and is now £2.9m adverse year to date. In total the pay bill for February was £18.3m, a reduction in monthly spend compared to January (£18.8m) and the lowest monthly amount since September. Other key points that should be noted include:
    - Total agency costs for February were £1.1m, an increase of c. £0.1m compared to January. However, despite the increase in agency costs the overall pay costs fell, mainly due to a reduction in permanent whole time equivalent staffing, most notably in medical and nursing.
    - There were increases in a number of areas with respect to agency costs including medical, scientific and other staffing, which were partially offset by a reduction in admin and clerical and nursing staffing. Overall, agency spend was 5.8% of the monthly pay bill up from 5.1% in January. When assessed in relation to total qualified nursing spend, nursing agency equates to 7.3%, a reduction from the 8.0% reported for January, but still in excess of the Trust's regulatory limit of 6%.
- Non Pay expenditure continues to be favourable against plan, £0.2m in month and £4.3m year to date.
- Total income for the month was £25.5m, which in broadly in line with plan. Particular points of note include:
    - Clinical income was £0.1m adverse against plan; £1.3m adverse YTD.
    - SLA clinical income was £0.7m favourable against plan in month.
    - The income position includes partial achievement of income efficiencies (CIP).

The in-month position of a £0.5m deficit represents an improvement in performance compared to January (£0.8m deficit). As the in-month performance is broadly in line with plan, and the required run rate to achieve the control total, the year to date position remains £0.2m off plan.

The month end cash balance of £3.1m is as per plan. The position includes STP funding for the first 2 quarters.

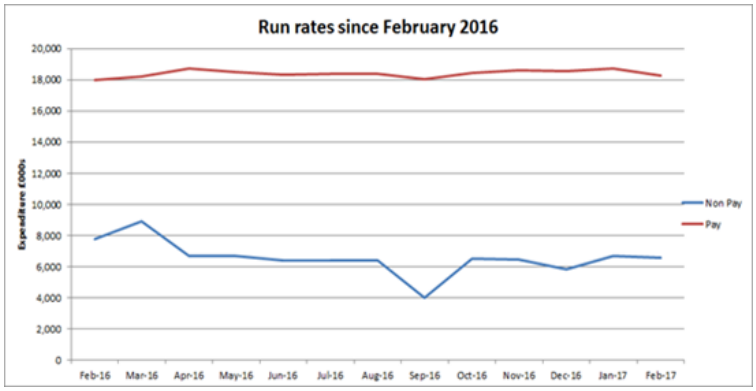
Capital spending commitments now total £3.2m with £2.8m (January £2.5m) actually incurred to date. It should be noted that in response to a national request from NHSI the Trust has re-forecast its capital spend for the year, with the revised total now being £6m.

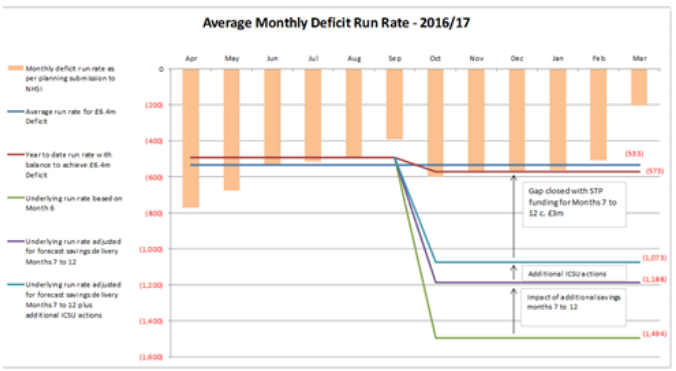
Statement of Comprehensive Income

Statement of comprehensive income

2016/17, Month 11 (February 2017)

Statement of Comprehensive Income	In Month Budget (£000s)	In Month Actual (£000s)	Variance (£000s)	YTD Budget (£000s)	Ytd Actuals (£000s)	Variance (£000s)	Full Year Plan (£000s)
Nhs Clinical Income	21,451	20,768	(683)	236,954	233,205	(3,749)	252,819
Non-Nhs Clinical Income	1,894	2,348	454	20,848	21,878	1,030	24,735
Other Non-Patient Income	2,202	2,397	195	24,294	23,975	(319)	26,115
Total Income	**25,547**	**25,513**	**(34)**	**282,096**	**279,058**	**(3,038)**	**303,669**
Non-Pay	6,746	6,565	181	72,889	68,558	4,331	75,352
Pay	18,001	18,269	(268)	200,077	202,953	(2,876)	219,534
Total Operating Expenditure	**24,747**	**24,834**	**(87)**	**272,966**	**271,511**	**1,455**	**294,886**
EBITDA	**800**	**680**	**(121)**	**9,130**	**7,547**	**(1,583)**	**8,783**
Depreciation	690	644	46	7,590	7,349	241	8,270
Dividends Payable	353	338	15	3,889	3,718	171	4,243
Interest Payable	275	238	37	2,956	2,894	62	3,238
Interest Receivable	(3)	(2)	(1)	(33)	(18)	(15)	(20)
Total	**1,315**	**1,218**	**97**	**14,402**	**13,943**	**459**	**15,731**
Net Surplus / (Deficit) - before IFRIC 12 adjustment	**(515)**	**(539)**	**(23)**	**(5,272)**	**(6,396)**	**(1,124)**	**(6,948)**
Add back impairments and adjust for IFRS & Donate	(7)	(6)	(1)	923	23	900	116
Adjusted Net Surplus / (Deficit) - including IFRIC 12 adjustments	**(508)**	**(533)**	**(24)**	**(6,195)**	**(6,419)**	**(224)**	**(7,064)**





As previously reported, the Trust needs to achieve an average monthly deficit run rate of c. £0.5m in order to achieve its control total for the year and create the necessary exit run rate to position the Trust to achieve its plan for 2017/18.

The deficit run rate of £0.5m in February was a c. £0.3m improvement compared to January, and is in line with the target required to deliver the control total. The enhanced financial controls introduced at the beginning of February have supported the improved position and will remain in place through year end.

The section below provides details of the monthly run rate analysis for expenditure for clinical ICSUs.

Monthly Run Rates – Expenditure

As previously reported the forecasts provided by ICSUs, at Month 7, have become their control totals for the remainder of the financial year, and are being monitored on a monthly basis.

The table below provides the Month 11 actual results against the ICSU control totals, together with the results from the previous month.

Pay

	Previous Month (Month 10)			Current Month (Month 11)			Cumulative
	Forecast Control Total £000s	Actual £000s	Variance £000s	Forecast Control Total £000s	Actual £000s	Variance £000s	Variance to CT £000s
Children's & Young People	3,919	4,018	(99) ↑	3,919	3,975	(56) ↑	(259)
Clinical Support Services	1,279	1,361	(82) ↑	1,279	1,334	(55) ↑	(298)
Emergency & Urgent Care	1,937	2,123	(186) ↑	1,937	2,036	(99) ↑	(283)
Integrated Medicine	2,795	2,905	(110) ↑	2,795	3,239	(444) ↑	(1,011)
Patient Access, Prevention & Planned Care	1,046	1,016	30 ↓	1,046	1,025	21 ↓	14
Surgery & Cancer	2,918	3,130	(212) ↑	2,918	2,796	122 ↓	(583)
Women's Health	1,533	1,655	(122) ↑	1,533	1,619	(86) ↑	(357)
Total Pay - Clinical ICSUs	15,427	16,209	(782) ↑	15,427	16,024	(597) ↑	(2,777)

Non Pay

	Previous Month (Month 10)			Current Month (Month 11)			Cumulative
	Forecast Control Total £000s	Actual £000s	Variance £000s	Forecast Control Total £000s	Actual £000s	Variance £000s	Variance to CT £000s
Children's & Young People	190	173	17 ↓	190	142	48 ↓	30
Clinical Support Services	1,348	1,707	(359) ↑	1,348	1,214	134 ↓	(279)
Emergency & Urgent Care	206	242	(36) ↑	206	203	3 ↓	(155)
Integrated Medicine	257	219	38 ↓	257	199	58 ↓	(14)
Patient Access, Prevention & Planned Care	261	281	(20) ↑	261	172	89 ↓	109
Surgery & Cancer	771	703	68 ↓	771	555	216 ↓	325
Women's Health	184	169	15 ↓	184	131	53 ↓	134
Total Non Pay - Clinical ICSUs	3,217	3,494	(277) ↑	3,217	2,616	601 ↓	150

Combined Pay & Non Pay

	Previous Month (Month 10)			Current Month (Month 11)			Cumulative
	Forecast Control Total £000s	Actual £000s	Variance £000s	Forecast Control Total £000s	Actual £000s	Variance £000s	Variance to CT £000s
Children's & Young People	4,109	4,192	(83) ↑	4,109	4,117	(8) ↑	(230)
Clinical Support Services	2,627	3,067	(440) ↑	2,627	2,548	79 ↓	(576)
Emergency & Urgent Care	2,143	2,365	(222) ↑	2,143	2,239	(96) ↑	(438)
Integrated Medicine	3,052	3,124	(72) ↑	3,052	3,438	(386) ↑	(1,025)
Patient Access, Prevention & Planned Care	1,307	1,297	10 ↓	1,307	1,197	110 ↓	123
Surgery & Cancer	3,689	3,833	(144) ↑	3,689	3,351	338 ↓	(258)
Women's Health	1,717	1,824	(107) ↑	1,717	1,750	(33) ↑	(223)
Total Expenditure - Clinical ICSUs	18,644	19,702	(1,058) ↑	18,644	18,640	4 ↓	(2,627)

Key:

↑ Actual spend higher than Month 7 Forecast - adverse performance

↔ Actual spend in line with Month 7 Forecast - expected performance

↓ Actual spend lower than Month 7 Forecast - favourable performance

In-month, across all ICSUs, a review of expenditure against the agreed control totals highlighted that performance was broadly in line with that expected.

The chart below shows the variance to control total for each ICSU, expenditure only. It should be noted that the expenditure forecasts included an assessment of spend associated with system resilience.

For some of the ICSUs, notably Children's, Clinical Support Services and Integrated Medicine additional income has been received over and above the year-end agreements with commissioners. For example, within Medicine 50% of the variance shown above is linked to Learning Disabilities and is offset with 'new' income.

From the chart the most significant improvement in run rates is within Surgery, which is linked to non pay expenditure as a result of reduced activity.

Cost Improvement Programme

Year to date, £7.7m has been delivered against a target of £8.6m. This equates to a 89% achievement. The CIP profile required a material increase in the rate of cost improvement over the final quarter in order to achieve the CIP target.

Integrated Clincial Service Unit	Annual Plan £'000	YTD Plan £'000	YTD Actual £'000	YTD % achieved	YTD Variance £'000
Children's services	602	520	307	59.1%	-213
Clinical Support Services	1,019	896	229	25.5%	-667
Emergency & Urgent Care	786	675	629	93.2%	-46
Medicine, Frailty & Network Services	1,673	1,452	989	68.1%	-463
Outpatients Prevention & LTC	526	461	693	150.3%	232
Surgery	2,613	2,297	1,190	51.8%	-1,107
Women's services	1,189	1,038	600	57.8%	-438
Corporate	1,592	1,339	1,133	84.6%	-206
Trustwide non-pay	-	-	1,294	-	1,294
Nursing and Admin agency, additional	-	-	669	-	669
Performance against operating plan	**10,000**	**8,678**	**7,733**	**89.1%**	**-945**

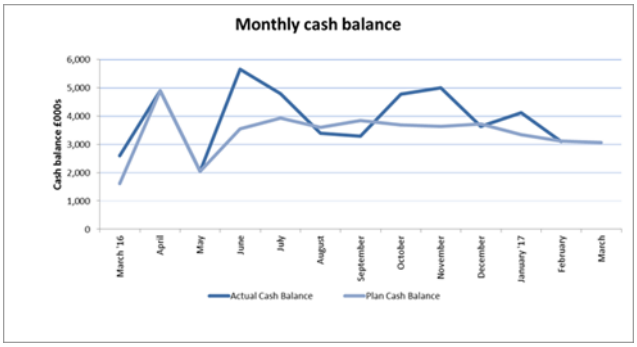
The table above shows actual performance against CIP plans, indicating a shortfall of c. £0.9m year to date. However, it should be noted that this includes a number of non-recurrent benefits c. £1.5m that have been realised outside of the PMO schemes, which support the position together with the Trust being only £0.2m adverse against plan, in overall terms, year to date.

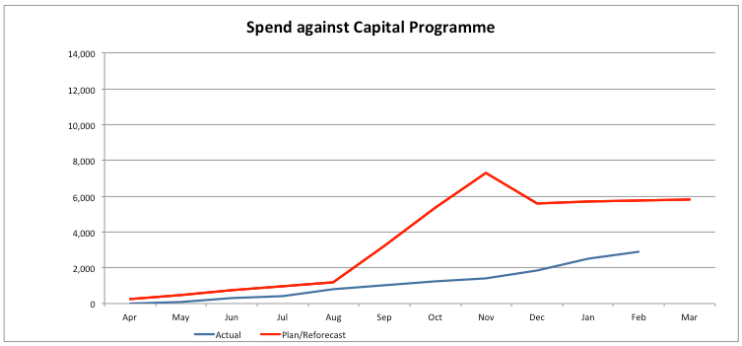
Monitoring of performance against CIP plans continues to be undertaken by the PMO via regular meetings. Shortfalls are principally linked to pay and non-pay schemes and the PMO is working with ICSUs to accelerate future schemes and replace those that will now not achieve during the current financial year.

The Trust's planning submission still requires a cost reduction of £15.5m in 2017/18 for the overall target requirement, across the 2-year period (2016/17 & 2017/18), to be delivered. It should be noted that based on current calculations there will be a net shortfall against the original targets for 2016/17, which will be factored into the plans currently being developed for 2017/18.

Statement of Financial Position

	As at 1 April 2016 £000	Plan 31 March 2017 £000	Year to Date Plan YTD 28 February 2017 £000	Year to Date As at 28 February 2017 £000	Year to Date Variance YTD 28 February 2017 £000
Property, plant and equipment	194,785	203,023	201,695	191,369	10,326
Intangible assets	4,583	2,831	2,973	3,527	(554)
Trade and other receivables	693	851	846	607	239
Total Non Current Assets	**200,061**	**206,705**	**205,514**	**195,503**	**10,011**
Inventories	1,403	1,500	1,500	1,791	(291)
Trade and other receivables	23,535	25,393	20,835	33,931	(13,096)
Cash and cash equivalents	2,598	3,060	3,107	3,102	5
Total Current Assets	**27,536**	**29,953**	**25,442**	**38,824**	**(13,382)**
Total Assets	**227,597**	**236,658**	**230,956**	**234,327**	**(3,371)**
Trade and other payables	39,112	43,391	38,749	45,760	(7,011)
Borrowings	376	2,455	9,385	8,804	581
Provisions	795	756	762	201	561
Total Current Liabilities	**40,283**	**46,602**	**48,896**	**54,765**	**(5,869)**
Net Current Assets (Liabilities)	**(12,747)**	**(16,649)**	**(23,454)**	**(15,941)**	**(7,513)**
Total Assets less Current Liabilities	**187,314**	**190,056**	**182,060**	**179,562**	**2,498**
Borrowings	52,934	61,419	53,183	51,258	1,925
Provisions	1,773	1,513	1,541	1,773	(232)
Total Non Current Liabilities	**54,707**	**62,932**	**54,724**	**53,031**	**1,693**
Total Assets Employed	**132,607**	**127,124**	**127,336**	**126,531**	**805**
Public dividend capital	62,404	62,404	62,404	62,404	0
Retained earnings	(7,873)	(13,356)	(13,144)	(13,623)	479
Revaluation reserve	78,076	78,076	78,076	77,750	326
Total Taxpayers' Equity	**132,607**	**127,124**	**127,336**	**126,531**	**805**
Capital cost absorption rate	**3.5%**	**3.5%**	**3.5%**	**3.5%**	**3.5%**





Property, Plant & Equipment (inc. Intangible Assets): As reported previously the YTD underspend is, in part, as a result of negotiations with a managed equipment services provider, together with revisions to the timing and scope of the Maternity Scheme.

Trade Receivables: The adverse variance of £13.1m is mainly due to delayed settlement of outstanding activity invoices for 2015/16 and 2016/17. Discussions to clear the outstanding amounts remain ongoing, with a number of NHS balances expected to be cleared in Month 12.

Payables: The Trust is in the process of approving and paying significant creditor balances and furthermore the Trust is in discussions with local providers to reduce outstanding balances. As reported previously the Trust will not achieve the Better Payments Target in 2016/17, due to its liquidity position.

Cash: The annual cash plan assumes that the Trust would receive £8.9m cash support. The trust drew down £6.9m as at month 11. The cash position at the close of month 11 was £3.1m.

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

Whittington Health Trust Board
5th April 2017

Title:	Trust Board Report March 2017 (February 2017 data)		
Agenda item:	**17/051**	**Paper**	**08**
Action requested:	For discussion and decision making		
Executive Summary:	**Highlights** **Emergency and Urgent Care** Performance against the 95% target improved during February compared to the previous month On the 28th February ECIP (*emergency care improvement programme)* supported the trust in undertaking a review of the 'back of hospital ' having completed a a review of the 'front of hospital' over two days in Nov and December The key recommendations from this review includes ; Progress implementation of the **SAFER** patient bundle supported by the red 2 green approach. Progress the further implementation , measurement and monitoring of the **inter professional standards** that were developed ahead of the perfect week/breaking the cycle in January Consider further development of a **Full Capacity Protocol** to support ambulance handovers and recue the risk in ED at times of peak escalation. A whole system external event is planned for the end of April to complete the emergency pathway diagnostic and inform the ongoing improvement programme. **Cancer** 62 days to treatment below the threshold by one breach. There were a very high number of treats in month, a total of 38.5 against a monthly average of 21 treats. **Emergency Re-Admission within 30 days** The target was not achieved by a margin of 0.2% **Delayed Transfer of Care** Improved position from last month with a continuous daily focus on DTOCs. **MRSA** One bacteraemia has been reported in February, post-infection reviews have not highlighted any areas of concerns; in particular		

	documentation, use of MRSA suppression therapy, peripheral line care and engagement by staff in the processes has been good or excellent. **Theatre Utilisation** Theatre utilisation improved to 81.1% in February but was still affected by seasonal pressures on bed capacity across the Trust. **HR** Continued improvement in appraisal rate and mandatory training. No change in staff turnover, sickness and vacancy rate. **Complaints** The Trust is compliant this month at 90%
Summary of recommendations:	That the board notes the performance.
Fit with WH strategy:	All five strategic aims
Reference to related / other documents:	N/A
Reference to areas of risk and corporate risks on the Board Assurance Framework:	N/A
Date paper completed:	24rd March 2017

Author name and title:		**Hester de Graag, Performance Lead**		**Director name and title:**		**Carol Gillen, Chief Operating Officer**	
Date paper seen by EC		**Equality Impact Assessment complete?**		**Quality Impact Assessment complete?**		**Financial Impact Assessment complete?**	

Whittington Health NHS

Integrated Performance Report

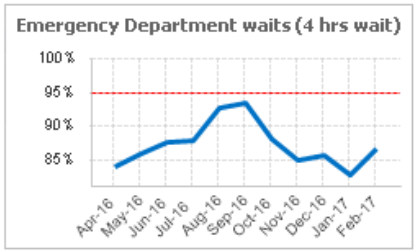
March 2017

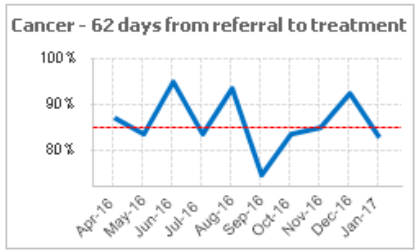
Month 11 (2016 – 2017)

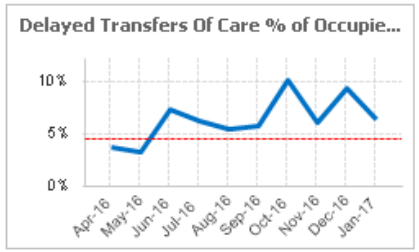
Date & time of production: 29/03/2017 13:02

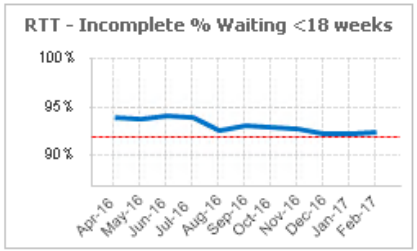
Summary Page - Indicators

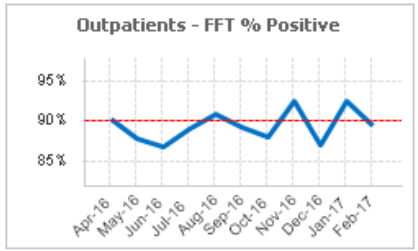
Category	Indicator	16_17 Target	Q1 Apr-16	Q1 May-16	Q1 Jun-16	Q2 Jul-16	Q2 Aug-16	Q2 Sep-16	Q3 Oct-16	Q3 Nov-16	Q3 Dec-16	Q4 Jan-17	Q4 Feb-17	2016-2017
ED	Emergency Department waits (4 hrs wait)	**>95%**	84.1%	85.9%	87.7%	87.9%	92.7%	93.4%	88.1%	85.1%	85.8%	82.9%	86.6%	87.3%
ED	ED Indicator - median wait for treatment (minutes)	**<60 mins**	88	88	85	87	60	62	75	88	76	77	69	77
Cancer	Cancer - 14 days to first seen	**>93%**	97.4%	96.4%	96.4%	97.3%	97.7%	96.6%	97.8%	95.5%	93.4%	94.7%		96.3%
Cancer	Cancer - 62 days from referral to treatment	**>85%**	87.2%	83.6%	94.9%	83.3%	93.5%	74.5%	83.3%	85.0%	92.3%	82.7%		85.7%
Admitted	Non Elective Re-admissions within 30 days	**<5.5%**	4.8%	5.6%	6.8%	6.4%	6.3%	5.7%	5.9%	5.9%	6.0%	4.8%	5.7%	5.8%
Admitted	Delayed Transfers Of Care % of Occupied Bed Days	**<4.5%**	3.8%	3.4%	7.4%	6.3%	5.5%	5.7%	10.1%	6.1%	9.3%	6.3%		5.8%
Access	RTT - Incomplete % Waiting <18 weeks	**>92%**	93.9%	93.8%	94.2%	93.9%	92.7%	93.1%	92.9%	92.8%	92.2%	92.2%	92.4%	93.1%
Outpatients	Outpatients - FFT % Positive	**>90%**	90.2%	87.7%	86.7%	89.1%	90.8%	89.2%	88.0%	92.6%	87.0%	92.5%	89.4%	89.9%
Community	Community - FFT % Positive	**>90%**	97.3%	97.5%	97.5%	97.9%	97.5%	98.4%	98.1%	98.2%	98.7%	98.0%	96.8%	97.7%
Staff	Staff - FFT % Recommend Care	**>70%**			80.1%			76.2%						77.9%

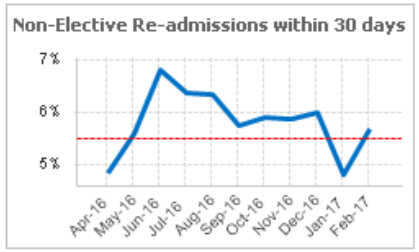












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Safe Services - Indicators and Performance

Category	Indicator	16_17 Target	Q4 Mar-16	Q1 Apr-16	Q1 May-16	Q1 Jun-16	Q2 Jul-16	Q2 Aug-16	Q2 Sep-16	Q3 Oct-16	Q3 Nov-16	Q3 Dec-16	Q4 Jan-17	Q4 Feb-17	2016-2017	Performance
Admitted	Admissions to Adult Facilities of pts under 16 yrs of age	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Admitted	HCAI C Difficile	<17	0	2	1	1	1	0	0	0	0	0	0	1	6	
All Areas	CAS Alerts Outstanding	0	0	0	0	0	0	0	0	0	0	0	0	3	3	
All Areas	Actual Falls	400	26	24	26	36	26	31	38	45	30	45	56	45	402	
All Areas	Avoidable Grade 3 or 4 Pressure Ulcers	0		5	2	1	2	4	5	5	1	3	2	1	31	
Admitted	Harm Free Care %	>95%	93.6%	92.2%	92.6%	93.5%	93.8%	91.9%	90.8%	93.3%	92.6%	93.2%	94.3%	92.9%	92.8%	
Maternity	Non Elective C-Section % Rate	>15%	18.1%	13.6%	18.9%	17.7%	16.4%	17.4%	20.2%	17.7%	21.6%	17.4%	20.5%	18.0%	18.1%	
All Areas	Medication Errors causing serious harm	0	0	1	0	0	0	0	0	0	0	0	0	0	1	
Admitted	MRSA Bacteraemia Incidences	0	0	0	0	0	0	0	0	1	0	0	0	1	2	
Admitted	Never Events	0	0	0	0	0	0	1	0	1	0	0	0	0	2	
All Areas	Proportion of reported Patient Safety Incidents Causing Harm	N/A				20.8%	22.6%	21.6%	21.8%	19.9%	20.1%	21.1%	21.3%	19.5%	21.0%	
All Areas	Serious Incidents	0	2	3	6	3	3	4	6	9	8	3	4	7	56	
Admitted	VTE Risk Assessment %	>95%	95.1%	95.0%	96.0%	96.3%	98.0%	96.2%	96.6%	97.3%	96.4%	95.9%	96.1%		96.4%	

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Safe Services - Commentary

CAS Alerts outstanding
The 3 outstanding CAS alerts were closed after the deadline due to administrative delay. Two of the alerts were not applicable to Whittington Health, the 3rd, regarding high voltage hazard, was acted on in time.

Actual falls
Out of the 45 falls in February 3 resulted in harm. One severe harm fall was declared as SI, Neck of Femur fracture in Surgery ICSU, 2 moderate harm falls in IM ISCU, one downgraded and one investigated as a high risk within the ICSU.

Avoidable pressure ulcer
There was one avoidable pressure ulcer in the hospital. Once identified a plan was put into place to avoid further deterioration.

Non Elective C-section rate
The rate has fallen slightly for this month but is still above the threshold due to the increase in the induction of labours which is influenced by fetal movement advice, where the aim is to reduce still birth rates but with a recognised risk of increasing medical interventions.

MRSA
One MRSA was reported this month. Post-infection reviews have not highlighted any areas of concerns; in particular documentation, use of MRSA suppression therapy, peripheral line care and engagement by staff in the processes has been good or excellent.

Serious incidents
The trust reported 7 SI in February 2017. Two in Integrated Medicine, two in Surgery and one each in Woman and Family Services, Children's Services and Clinical Support Services.

Caring Services - Indicators and Performance

Category	Indicator	16_17 Target	Q4 Mar-16	Q1 Apr-16	Q1 May-16	Q1 Jun-16	Q2 Jul-16	Q2 Aug-16	Q2 Sep-16	Q3 Oct-16	Q3 Nov-16	Q3 Dec-16	Q4 Jan-17	Q4 Feb-17	2016-2017	Performance
ED	ED - FFT % Positive	>90%	85.4%	89.9%	92.0%	87.7%	89.4%	92.4%	95.6%	89.9%	82.1%	83.8%	83.4%	83.9%	85.7%	
ED	ED - FFT Response Rate	>15%	4.0%	4.6%	4.8%	5.1%	4.5%	3.4%	4.1%	4.1%	16.6%	16.6%	14.6%	16.0%	8.6%	
Admitted	Inpatients - FFT % Positive	>90%	94.2%	96.6%	93.6%	95.7%	96.7%	96.0%	95.1%	95.8%	92.7%	95.8%	92.1%	96.1%	95.3%	
Admitted	Inpatients - FFT Response Rate	>25%	14.0%	19.4%	15.5%	15.5%	19.3%	15.4%	20.4%	18.3%	18.0%	12.6%	7.2%	17.1%	16.3%	
Maternity	Maternity - FFT % Positive	>90%	87.9%	94.6%	92.1%	94.6%	91.6%	93.2%	91.1%	91.6%	93.8%	94.8%	88.0%	89.4%	92.0%	
Maternity	Maternity - FFT Response Rate	>15%	19.2%	19.3%	16.1%	18.3%	10.5%	18.9%	24.2%	23.1%	12.8%	24.6%	30.4%	24.0%	20.0%	
Outpatients	Outpatients - FFT % Positive	>90%	84.7%	90.2%	87.7%	86.7%	89.1%	90.8%	89.2%	88.0%	92.6%	87.0%	92.5%	89.4%	89.9%	
Outpatients	Outpatients - FFT Responses	400	144	133	171	166	229	229	305	408	516	193	481	407	3238	
Community	Community - FFT % Positive	>90%	98.5%	97.3%	97.5%	97.5%	97.9%	97.5%	98.4%	98.1%	98.2%	98.7%	98.0%	96.8%	97.7%	
Community	Community - FFT Responses	1500	753	778	752	628	563	609	621	645	880	549	697	1095	7817	
Staff	Staff - FFT % Recommend Care	>70%	82.3%			80.1%			76.2%						77.9%	
All Areas	Complaints responded to within 25 working day	>80%			90.5%	82.1%	95.5%	85.3%	85.7%	100.0%	100.0%	89.3%	66.7%	90.0%	88.4%	
All Areas	Complaints (including complaints against Corporate division)	N/A	48	23	23	31	26	38	32	25	19	32	22	34	305	
Community	End of Life % of patients dying in Pref. Place of care - DN	>70%	75.0%	95.5%	100.0%	96.0%	84.4%	85.7%	72.0%	71.4%	85.7%	83.3%	90.9%	90.7%	87.2%	

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Caring Services - Commentary

Complaints

During February 2017 the Trust had 34 complaints requiring a response, 20 of which were required within 25 working days. The Trust achieved a performance of 90% (18/20) against a target of 80%. 14 complaints were allocated 40 working days for investigation.

The majority of the complaints had been allocated to Surgery & Cancer 32% (11) and EUC 26% (9). Two (6%) complaints were designated 'high risk', 9 (26%) were 'moderate' and 23 (68%) 'low'.

A review of complaints for February shows that 'communication' accounted for 32% (11), with 73% (8) patients indicating that they felt communication about an appointment was "inadequate" or that there was a "lack of information provided to patients"; 23% (8) related to 'medical care' where 37% (3) indicated that "poor treatment" had been provided. In addition, 18% (6) complaints highlighted 'nursing care' as the main concern with 33% (2) indicating that a "poor standard of treatment" had been provided.

Of those complaints that have been closed, 50% (14) were 'upheld', whilst 28% (8) were 'partially upheld', which means that 78% of the 28 closed complaints were upheld in one form or another.

Effective Services - Indicators and Performance

Category	Indicator	16_17 Target	Q4 Mar-16	Q1 Apr-16	Q1 May-16	Q1 Jun-16	Q2 Jul-16	Q2 Aug-16	Q2 Sep-16	Q3 Oct-16	Q3 Nov-16	Q3 Dec-16	Q4 Jan-17	Q4 Feb-17	2016-2017	Performance
Maternity	Breastfeeding Initiated	>90%	93.3%	91.8%	93.4%	90.5%	95.2%	91.5%	90.6%	94.2%	90.2%	90.1%	90.1%	86.1%	91.4%	
Maternity	Smoking at Delivery	<6%	4.1%	4.4%	6.6%	6.2%	3.9%	4.4%	4.8%	3.2%	5.1%	4.8%	3.6%	5.6%	4.8%	
Admitted	Non Elective Re-admissions within 30 days	<5.5%	5.7%	4.8%	5.6%	6.8%	6.4%	6.3%	5.7%	5.9%	5.9%	6.0%	4.8%	5.7%	5.8%	
Trust	Hospital Standardised Mortality Ratio rolling 12 months	100	93.2	75.5	80.4	74.9	116.9	87.8	59.4	78.3	84.4				82.0	
Trust	Hospital Standardised Mortality Ratio rolling 12 months - weekend	100	54.4	42.6	124.1	64.7	83.0	81.1	85.6	76.2	85.6				80.3	
Trust	Summary Hospital Level Mortality Indicator (SHMI) - rolling 12 mont...	1.14	0.68			0.69			0.69						0.69	
Admitted	Mortality rate per 1000 admissions in-months	14.4	7.5	6.5	4.7	6.1	5.8	5.8	4.2	6.5	7.9	7.2	11.7	9.1	6.8	
Community	IAPT Moving to Recovery	>50%		47.4%	51.6%	48.0%	50.0%	51.7%	52.3%	45.7%	47.1%	52.4%	50.4%		49.7%	

Effective Services - Commentary

Breastfeeding Initiated

All clinics are in place and more support in place to ensure that breastfeeding is initiated. In the month of February, however, no major cause was identified that fully explains the drop. The ICSU are still working towards the Baby Friendly Initiative (BFI) Stage 3 follow-up.

Non Elective Re-admission

Although just, 0.2%, above target, a downwards trend overall is observed.

Responsive Services - Indicators and Performance

Category	Indicator	16_17 Target	Q4 Mar-16	Q1 Apr-16	Q1 May-16	Q1 Jun-16	Q2 Jul-16	Q2 Aug-16	Q2 Sep-16	Q3 Oct-16	Q3 Nov-16	Q3 Dec-16	Q4 Jan-17	Q4 Feb-17	2016-2017	Performance
ED	Emergency Department waits (4 hrs wait)	>95%	81.6%	84.1%	85.9%	87.7%	87.9%	92.7%	93.4%	88.1%	85.1%	85.8%	82.9%	86.6%	87.3%	
ED	ED Indicator - median wait for treatment (minutes)	<60 mins	103	88	88	85	87	60	62	75	88	76	77	69	77	
ED	Ambulance handovers waiting more than 30 mins	0	21	23	20	28	31		16	26	45	68	113		370	
ED	Ambulance handovers waiting more than 60 mins	0	0	0	2	9	0		0	1	4	22	37		75	
ED	12 hour trolley waits in A&E	0	0	0	0	1	1	0	1	1	1	0	2	3	10	
Cancer	Cancer - 14 days to first seen	>93%	98.9%	97.4%	96.4%	96.4%	97.3%	97.7%	96.6%	97.8%	95.5%	93.4%	94.7%		96.3%	
Cancer	Cancer - 14 days to first seen - breast symptomatic	>93%	99.4%	98.1%	95.4%	99.2%	100.0%	100.0%	100.0%	97.2%	98.2%	100.0%	93.4%		98.0%	
Cancer	Cancer - 62 days from referral to treatment	>85%	91.4%	87.2%	83.6%	94.9%	83.3%	93.5%	74.5%	83.3%	85.0%	92.3%	82.7%		85.7%	
Cancer	Cancer - 31 days to first treatment	>96%	97.5%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	97.8%		99.7%	
Cancer	Cancer - 31 days to subsequent treatment - surgery	>98%			100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	
Cancer	Cancer - 31 days to subsequent treatment - drugs	>93%	100.0%	100.0%	100.0%			100.0%	100.0%	100.0%	100.0%				100.0%	
Cancer	Cancer - 62 Day Screening	>90%		100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%		100.0%		100.0%	
Cancer	Cancer - 62 Day Upgrade		50.0%		100.0%	50.0%	0.0%		0.0%	100.0%		0.0%	100.0%		50.0%	
Access	DM01 - Diagnostic Waits (<6 weeks)	>99%	99.4%	99.6%	99.4%	99.9%	99.3%	99.5%	99.7%	99.5%	99.8%	99.1%	99.1%	99.6%	99.5%	
Access	RTT - Incomplete % Waiting <18 weeks	>92%	92.7%	93.9%	93.8%	94.2%	93.9%	92.7%	93.1%	92.9%	92.8%	92.2%	92.2%	92.4%	93.1%	
Access	Referral to Treatment 18 weeks - 52 Week Waits	0	0	0	0	0	0	0	0	0	0	0	0	0	0	

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Responsive Services - Commentary

ED four hours' wait and Ambulance handover time

Performance against the 95% target improved during February compared to the previous month, as did **median time to treatment** despite continued demand from both walk in patients and those arriving via ambulance.

The organisation was visited by ECIP during February. The site visit focused on flow from and to the speciality wards, discharge processes and systems in place that respond to pressures within the ED.The final report and recommendations will be available in March.

During February the organisation has continued its focus on the ED improvement plan and meeting the recommendations set out by ECIPs earlier review of the 'front of house 'through the Frailty Pathway PDSA cycle ,embedding a 'RAT' model to increase senior leadership and decision making at the ED front door, developing a new nursing model to support quicker LAS hand over and the recruitment of additional ED Consultant's, which saw an additional Consultant join the team in February.

12 hour trolley waits in A&E

All three 12 hour trolley waits in February were informal mental health patients requiring a mental health bed who were not suitable for a medical admission. The organisation continues to work closely with Camden & Islington Mental Health Trust to ensure that every effort is made to minimise long waits in the department for mental health patients waiting to transfer to a mental health bed. A reviewed multi agency protocol has been developed to ensure that correct escalation processes are adhered to

Cancer – 62 days from referral to treatment

Not compliant for January 2017 performance of 82.7% against a standard of 85%.

There were a very high number of treatments with a total of 38.5 treatments against a monthly average of 21 treatments. For the Trust to be compliant this month we needed 1 less breach i.e. 5.5 instead of 6.5 breaches in total. Cause of breaches were;

Breast – 0.5 breach – delay in getting MR scan done

Colorectal – 0.5 breach – needed multiple diagnostic tests

Cancer of Unknown Primary CUP – 1.0 breach – complex pathway to identify primary

Gynaecology – 1.5 breaches – both cases thought unlikely cancer however histo demonstrated was cancer

Lung – 1 breach (2 half breaches) – both referred to UCLH one day 30, one day 41

Urology – 2 breaches – 1 patient choice delay, one complex diagnostic pathway

Actions: Continue to monitor pathways and send for tertiary treatment by day 38. Service management teams to support clinicians to target treatment in time.

Responsive Services - Indicators and Performance

Category	Indicator	16_17 Target	Q4 Mar-16	Q1 Apr-16	Q1 May-16	Q1 Jun-16	Q2 Jul-16	Q2 Aug-16	Q2 Sep-16	Q3 Oct-16	Q3 Nov-16	Q3 Dec-16	Q4 Jan-17	Q4 Feb-17	2016-2017	Performance
Theatres	Hospital Cancelled Operations	0	3	19	4	7	1	6	1	4	6	2	15		65	
Theatres	Cancelled ops not rebooked < 28 days	0	0	0	0	0	0	0	0	0	0	0	0		0	
Theatres	Urgent Procedures Cancelled > once	0	0	0	0	0	0	0	0	0	0	0	0		0	
Admitted	Delayed Transfers Of Care - Days Lost	N/A	183	148	129	273	240	191	199	364	267	348	236		2395	
Admitted	Delayed Transfers Of Care % of Occupied Bed Days	<4.5%	4.1%	3.8%	3.4%	7.4%	6.3%	5.5%	5.7%	10.1%	6.1%	9.3%	6.3%		5.8%	
Maternity	Women seen by HCP / midwife within 10 weeks	>50%	33.9%	40.4%	43.8%	63.7%	74.5%	69.1%	72.8%	69.4%	67.2%	67.8%	54.1%	57.5%	61.6%	
Community	IAPT Waiting Times for Treatment (% < 6 wks)	>75%		95.7%	95.0%	90.5%	95.1%	93.8%	94.6%	94.4%	94.3%	97.2%	97.2%		94.7%	
Community	GUM - Appointment Offered within 2 days	>98%	98.9%	98.7%	98.5%	99.7%	95.6%	97.8%	99.2%	99.9%	99.6%	99.8%	99.3%	99.5%	98.9%	
Community	Haringey New Birth Visits - % seen within 2 weeks	>95%	85.7%	88.6%	89.8%	87.9%	93.2%	94.6%	94.2%	91.8%	92.2%	91.6%	91.3%		91.5%	
Community	Islington New Birth Visits - % seen within 2 weeks	>95%	94.7%	95.1%	96.1%	94.4%	94.9%	93.7%	88.3%	93.3%	94.1%	94.6%	94.8%		93.9%	

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Responsive Services - Commentary

Hospital Cancelled Operations

This indicator is now going to be a month in arrears because of cancellations rebooked within 28 days wouldn't necessarily be finalised until after the 28th of the month (cancellations on the 31st would have until the 28th of the following month to be actioned).

Delayed Transfer of Care % of Occupied Bed days

This indicator is above the target but improving. Whittington Health has been able to maintain the improvement trend with continuous daily review of delayed transfers of care and medically optimised patients.

New Birth Visits

This indicator remains the same, just below target.

Well Led Services - Indicators and Performance

Category	Indicator	16_17 Target	Q4 Mar-16	Q1 Apr-16	Q1 May-16	Q1 Jun-16	Q2 Jul-16	Q2 Aug-16	Q2 Sep-16	Q3 Oct-16	Q3 Nov-16	Q3 Dec-16	Q4 Jan-17	Q4 Feb-17	2016-2017	Performance
HR	Appraisals % Rate	>90%	72%	71%	69%	68%	67%	66%	63%	66%	66%	67%	72%	75%		
HR	Mandatory Training % Rate	>90%	82%	81%	81%	81%	81%	81%	80%	81%	81%	82%	81%	82%		
HR	Permanent Staffing WTEs Utilised	>90%		87.1%	87.7%	87.8%	86.2%	87.1%	87.0%	88.1%	88.1%	87.7%	87.7%	87.8%	87.5%	
HR	Staff FFT % recommended work	>50%	69.6%			65.1%			59.7%						62.1%	
HR	Staff FFT response rate	>20%	14.7%			19.6%			24.9%						22.3%	
HR	Staff sickness absence %	<3.5%	3.2%	3.0%	3.3%	3.2%	2.9%	2.9%	2.9%	3.3%	2.8%	3.0%	3.0%	3.0%	3.0%	
HR	Staff turnover %	<10%		14.9%	14.9%	15.8%	15.7%	15.5%	15.7%	15.4%	14.9%	15.4%	15.3%	15.1%	15.3%	
HR	Vacancy % Rate against Establishment	<10%		12.9%	12.3%	12.2%	13.8%	12.9%	13.0%	11.9%	11.9%	12.3%	12.3%	12.2%	12.5%	

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Well Led Services - Commentary

Human Resources

Workforce KPIs

Issues of note this month include:

- Small increases in both appraisal and mandatory training, but both are still showing as red and below the 90% target. Further work to bed in the pay progression policy as a means of improving compliance is part of the continuing work to improve overall performance in these areas
- Systematic recruitment activity is being programmed including overseas recruitment in order to tackle the vacancy rate, along with high turnover. This work will be supported by further actions on the outcomes of the staff survey, which is reported elsewhere to the Board.

Activity - Indicators and Performance

Category	Indicator	16_17 Target	Q1 Apr-16	Q1 May-16	Q1 Jun-16	Q2 Jul-16	Q2 Aug-16	Q2 Sep-16	Q3 Oct-16	Q3 Nov-16	Q3 Dec-16	Q4 Jan-17	Q4 Feb-17	Activity
ED	ED Attendances	**8605**	7878	8540	7908	8277	7513	8020	8253	8271	8238	8254	7431	
ED	ED Admission Rate %		17.6%	18.1%	17.8%	18.1%	17.8%	16.7%	16.2%	16.6%	17.5%	17.2%	17.1%	
Community	Community DNA Rate %	**<10%**	5.8%	5.6%	5.7%	5.8%	5.7%	5.4%	5.3%	5.5%	5.7%	5.2%	5.5%	
Community	Community Face to Face Contacts		95611	99704	99797	91598	82066	96398	95072	104843	84683	97830	89833	
Admissions	Elective and Daycase		1861	1860	2083	2004	1769	1935	1947	1876	1712	1876	1687	
Admissions	Emergency Inpatients		2129	2255	2177	2322	2117	2079	2036	2124	2111	2067	1922	
Referrals	GP Referrals to an Acute Service		6710	6177	6433	6135	5903	6342	5978	6314	5167	5825	5387	
Maternity	Maternity Births	**333**	325	324	311	340	299	337	315	324	301	312	274	
Maternity	Maternity Bookings	**377**	331	383	403	354	299	301	353	365	319	323	308	
Outpatients	Outpatient DNA Rate % - New	**<10%**	12.3%	12.1%	11.7%	11.7%	11.9%	12.3%	11.1%	11.3%	12.7%	12.4%	11.9%	
Outpatients	Outpatient DNA Rate % - FUp	**<10%**	11.4%	10.4%	10.2%	10.3%	9.8%	11.2%	10.1%	10.1%	11.7%	12.6%	12.6%	
Outpatients	Outpatient New Attendances		8711	9724	9602	8931	8475	9012	8758	9664	7970	8853	8307	
Outpatients	Outpatient FUp Attendances		16904	17842	18870	18030	18303	18695	18824	19938	17206	18494	16343	
Outpatients	Outpatient Procedures		5604	5870	6285	6167	6261	6018	6269	6185	5630	5942	5228	
Theatres	Theatre Utilisation	**>95%**	78.1%	81.5%	80.7%	78.3%	78.2%	81.8%	81.5%	83.7%	83.5%	72.8%	81.1%	

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Activity - Commentary

Community DNA
Achieved

Hospital DNA
Remains 1 to 2 percent above target.

Theatre utilisation for February 2017
Theatre utilisation was 81.1% in February 2017
Issues in the first two weeks of February included a number of elective patients being cancelled due to number of Medical patients needing beds and all medical beds at full capacity. Not all gaps in theatre, due to this, could be filled at short notice by day cases which was the same for January 2017.
Utilisation by speciality
Breast – 65%

General Surgery	83%
Gynae	81%
T&O	80%
Urology	77%
Breast	65% - very small numbers and patients seen immediately due to nature of disease, thus lists not always full

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Whittington Health NHS

The Whittington Hospital NHS Trust
Magdala Avenue
London N19 5NF

Whittington Health Trust Board
1st April 2017

Title:	**Whittington Health Pharmacy Transformation Plan 2016-2020**		
Agenda item:	**17/052**	**Paper**	**09**
Action requested:	The Board is asked to note and approve the Hospital Pharmacy Transformation Plan prior to onward submission to NHS Improvement.		
Executive Summary:	The Whittington Health Pharmacy Transformation Plan has been developed specifically in response to Recommendation 3 of Lord Carter of Coles' final report "Operational productivity and performance in English NHS acute hospitals". This requires that trusts develop a board approved, HPTP that describes actions that will be taken to ensure that more than 80% of trusts' pharmacist resource is utilised for direct medicines optimisation activities, medicines governance and safety by 2020. The plan describes Whittington Health's current position In relation to the metrics described in the Model Hospital Dashboard against peer and national medians and the actions being taken where required to achieve an agreed target position. This version of the plan incorporates recommendations made by NHSI to a prior draft, predominantly regarding the need to articulate current and proposed collaboration with local organisations and will act as WH's formal submission		
Summary of recommendations:	The Trust Board is asked to take assurance that Whittington Health Pharmacy services have developed a local HPTP plan and are actively progressing the requirements of Lord's Carter's 2016 report.		
Fit with WH strategy:	This plan supports the optimisation of medicines throughout the organisation and across the current boundaries of care. It seeks to deliver the requirements of Lord Carter in terms of reducing unwarranted variation and enhancing operational efficiency whilst continuing to deliver consistent high quality services.		
Reference to related / other documents:	Medicines Optimisation Strategy 2014-2019		
Date paper completed:	22nd March 2017		
Author name and title:	Stuart Richardson, Chief Pharmacist and	**Director name and title:**	Stephen Bloomer, Chief Financial Officer

		DoOps CSS, Helen Taylor, DD Strategy & CD CSS					
Date paper seen by EC	**N/A**	**Equality Impact Assessment complete?**	**N/A**	**Risk assessment undertaken?**		**Legal advice received?**	**N/A**

Whittington Health Pharmacy Transformation Plan 2016-2020

1.0 Executive Summary

1.1 In February 2016, Lord Carter of Coles published his final report, "Operational productivity and performance in English NHS acute hospitals", to the Secretary of State for Health identifying unwarranted variation across all of the main resource areas within the NHS[1]. The report made fifteen recommendations at acute trust, regional and national levels, all of which were accepted with recommendation three applying entirely to Pharmacy services in Acute Trusts (Appendix 1).

1.2 Recommendation 3 requires that trusts develop a Hospital Pharmacy Transformation Plan to ensure that hospital pharmacies achieve their benchmarks such as increasing pharmacist prescribers, electronic prescribing and administration, accurate cost coding of medicines and consolidating stock holdings in agreement with NHS England and NHS Improvement by April 2020, thereby facilitating an increase in time spent by pharmacists and clinical pharmacy technicians on patient facing medicines optimisation activities.

1.3 Whittington Health (WH) is an Integrated Care Organisation providing both acute and community services to the populations of Haringey and Islington. The pharmacy department does not, therefore, fit the standard hospital pharmacy model. Roles within pharmacy are not defined by sector but across pathways and pharmacists work in multidisciplinary teams within acute, community, primary care, social care and care home settings dependent on the needs of patients.

1.4 WH Pharmacy has, however, embraced the principles of the report and developed a local Hospital Pharmacy Transformation Plan (HPTP) as stipulated by the report that is approved by the Trust Board and overseen by an Executive Director – for WH; this is the Chief Financial Officer. The HPTP is aligned with the locally described Carter Metrics.

1.5 The WH pharmacy areas for development are focused on:

- Transforming the outpatient pharmacy services
- The WH Digital Pharmacy Project
- Developing the High Cost Drugs pharmacist role
- Increasing the number of prescribing pharmacists
- Decreasing the number of day stock holding and delivery numbers.
- Developing the pharmacist role as part of the ward establishment in medicines administration and optimising medicines use
- Developing the pharmacist role within the Urgent care pathway in conjunction with Health Education England
- Identifying the Carter Metrics and Model Hospital Benchmarks that are useful for monitoring an Integrated Care Organisation

1.6 Implementation of the HPTP will be led by the Chief Pharmacist and Clinical Director for Clinical Support Services and will be overseen by the Trust's Drug's

& Therapeutics Committee (D&TC), a sub Committee of the Quality Committee which in turn reports to the Trust Board.

1.7 A ‘Carter Dashboard’ will be developed utilising information from the Model Hospital to provide ongoing monitoring of key metrics requiring local improvement. This will be reviewed at CSS Board and CSS quarterly Reviews.

2.0 Carter Metrics and Model Hospital Benchmarks

2.1 The Model Hospital Benchmarks are broadly categorised according to the CQC domains and are published on an NHS Improvement Portal. They are constantly refreshed and updated.

2.2. The data contained within has been reviewed by the Trust against both National and Peer Medians. A planned performance has subsequently been described. Specific comments regarding each of these metrics are described in the table below where relevant. The RAG rating of the metric relates to WH's position benchmarked with the Trust's agreed Peer group and Target Performance. See also Appendix 3 with respect to application of metrics to an integrated care organisation.

2.3 There are standards noted within the table below whereby peer and median data is not yet available. This data will be increasingly populated with the evolution of the model hospital dashboard and data as defined by NHS Improvement.

Standard	WH Feb 2017	Peer Median	National Median	Planned Performance	Transformation Plan and comments
Money & Resources					
Pharmacy Staff &medicines Cost per WAU	**£197**	£340	£350	As per current performance	
Medicines costs per WAU	**£151**	£310	£312	As per current performance	
High Cost Medicines per WAU	**£45**	£94	£112	As per current performance	
Non High cost medicines per WAU	**£106**	£230	£196	As per current performance	
Choice of Paracetamol Formulations [%IV Paracetamol vs Total Spend]	**41.8%**	Data not available	Data not available	Prescribing practice in accordance with local	Intention is to reduce use of IV preparation vs oral preparation. Sufficient controls in place through local protocols to ensure appropriate prescription. Usage can be

				policies	monitored and audited through EPMA system monthly.
Use of Generic Immunosuppresants [% Generic vs Total Spend]	**Model Hospital Data: [0%]** **Local Data: 37.6%**	49%	60%	90%	[STP Peer Median: 90%] Intention is increase generic Immunosuppresants as a percentage of all immunosuppressant use. The majority of branded product is prescribed for outpatients, of which 54% is for renal conditions and 30% for rheumatological conditions. The High Cost Drugs Role will look to work with clinicians in these areas to determine reduction in use of branded preparations where clinically appropriate. [Timescale for completion: April 2018]
Use of Inhalation Anaesthetics % Spend on Sevoflurane	**26%**	Data not available	Data not available	Prescribing practice in accordance with local policies	Intention is to have low % use of Sevoflurane as a proportion of all anaesthetic gas. Sufficient controls in place through local protocols to ensure appropriate prescription. Usage can be monitored and audited through EPMA system. Timeline for action to be determined on receipt of outstanding data.
Safe					
Total Antibiotic consumption in DDD*/1,000 admissions	**10,505**	5,937	4,512	Reduction of consumption by 10% compared with WH figures for 2013/14 monitored through	[STP Peer Median: 6,551) The Trust's planned performance mirrors the requirements of the Antibiotic related CQUIN for 2017-19. WH is a significant outlier subsequent to local service user mix differing from peer groups.

				CQUIN	The following plan is in place to improve the use within the acute trust: 1. Actual quantity dispensing for antibiotics to the closest whole strip and a part-pack interface for the robot to be implement April 2017. 2. Restrict supply of long term antimicrobial therapy to a maximum of one monthly instalment. 3. Provision of MaPPs to patients. 4. 'Antibiotic review 72 hours' prompt for doctors on the EPMA system for doctors to review antimicrobials. 5. Piperacillin-tazobactam & Carbapenem daily reports for Microbiology doctors. 6. Pioneer pharmacists working directly as part of the nursing team on wards to help promote antibiotic reviews 7. Microbiology and Consultant antimicrobial pharmacist undertake daily ward rounds to enhance antimicrobial stewardship [Timescale for completion: April 2020]
% ePrescribing Discharge	**100%**	100%	60%	100%	All discharges are prescribed electronically and discharge summaries are completed electronically. The EPMA system JAC transfers information to Anglia ICE which then is transmitted via DocMan as a PDF to the GP system electronically. JAC is working with Anglia Ice in making this last stage dm+d compliant with Anglia ICE.

					This work is part of the trust IT strategy and links into the wider interoperability strategy of the Trust and the STP digital road map.
% ePrescribing Chemotherapy	**100%**	100%	50%	100%	All adult and paediatric chemotherapy is electronically prescribed.
% ePrescribing IP	**100%**	20%	50%	100%	The trust will look to extend further the provision of ePrescribing to the Virtual ward and District nursing services
% diclofenac vs. ibuprofen & naproxen	**Model Hospital [Data not available]** **Local Data: 8%**	-	-	Maintain at less than 10%	Diclofenac has been removed from most inpatient ward stock lists. All requests are to be made on a case by case basis. Auditable through EPMA.
Effective					
Clinical Pharmacy Activity [Pharmacist Time Spent on Clinical Pharmacy Activities] *NEW*	**73%**	68%	67%	80%	Significant component of pharmacy and pharmacy technician roles already focussed on patient facing medicines optimisation related activities. This will continue to increase following implementation of the transformed outpatient services, implementation of the Urgent Care Pharmacists and enhanced focus on high risk patient identification through the Digital Pharmacist Project. [Timescale for completion: April 2020]
% Pharmacists actively prescribing	**20%**	24%	20%	35%	[STP Peer Median: 11%] We currently have several pharmacists prescribing in pain, oncology, anticoagulation and bone density clinics. We have a qualified prescribing pharmacist in paediatrics and

					new developments in asthma services are being explored to utilise this resource. As part of the transformation plan we have identified areas where prescribing pharmacists will add value. The staff identified are funded and have submitted applications to study. Areas identified are: Rheumatology, Integrated Older Peoples Services, GP Pharmacists, Locality Team Pharmacist, Medical Admissions Unit, Pre-assessment clinics. [Timescale for completion: April 2020]
% Medicines Reconciliation within 24 hours	**78%**	70%	73%	90%	Current performance of 78% level 2 medicines reconciliation is based on a three month audit and includes Saturdays and Sundays. 7 day service for acute wards allows us to conduct medicines reconciliation 7 days a week. Level 1 medicines reconciliation is completed in A+E at point of medical admission. All medicines reconciliations are recorded on EPMA. One of the aims of the Digital Pharmacy Project is to explore ways in which the technology e.g. EPMA system can be used to identify high risk patients and how we can provide targeted clinical care for these patients. This will impact on the way we provide weekend clinical pharmacy services in the future and will be used to improve our performance in medicines reconciliation.

					[Timescale for completion: April 2019]
% Use of Summary Care Record per month	**43.7%**	52.9%	52.1%	May not be relevant due to the digital pharmacy project and the IT programme of the organisation	All staff are trained and use SCR, however due to e-prescribing records and the availability of the interoperability Graphnet and EDMS systems the use of this will remain low as the staff will access EMIS information for medicines reconciliation etc. through these systems rather than SCR. The information available through the other systems in place provides more complete patient and medicines related information. [Timescale for completion: to be determined given relevance]
e.g. % Soluble Prednisolone of Total prednisolone uptake	**Model Hospital: Data not available** **Local Data: 4%**	Data not available	Data not available	Monitor to ensure appropriate use	Soluble prednisolone is restricted for use and is available for patients under 2 years old only.
Dose-Banded Chemotherapy [Doses Delivered as Standardised Bands] *NEW*	**Model Hospital: 23%** **Local Data:97%**	2%	42	70%	Significant improvement from baseline performance in Q1 (23%) 2016/17. Monitored through Dose banding SACT CQUIN. Planned performance is a stretch target in excess of the Q4 CQUIN requirement (70%)
Number of Medication Incidents Reported to NRLS per 100,000 FCEs of Hospital Care *NEW*	**237**	241.6	285.6	To be determined – see comments	[STP Peer Median: 184.1] This metric requires further investigation. The data source is the NHSE Medicines Optimisation Dashboard which utilises National Reporting and Learning System data. However, reports directly provided by the NRLS describe WH as being in the upper

					quartile of reporting of all incidents. Medication incidents as a proportion of these are marginally higher than benchmarked organisations. Nonetheless, increasing medication incident reporting rates remains a key objective of the medicines optimisation strategy and will continue to be pursued and monitored through the Medicines Safety Group. Quality account priority 17/18 to increase reporting of medication incidents by 10% [Timescale for completion: April 18 for Quality account priorities]
% Medication Incidents Reported as Causing Harm or Death/All Medication Errors *NEW*	**10.1%**	13.1%	9.7%	9.1%	[STP Peer Median: 10.3%] This metric requires further investigation. The data source is the NHSE Medicines Optimisation Dashboard which utilises National Reporting and Learning System data. It is recognised from this data that WH has a relatively higher rate of low, moderate and severe harm incidents compared with benchmarked organisations. Further work will take place through the Medicines Safety Group to explore the reasons for this and to ensure that actual rather than potential harm is being accurately described on all incidents. Quality Account priority 17/18 to reduce harm of all medication incidents by 10% - hence target of 9.1% [Timescale for completion: April 18 for Quality Account priorities]

Total Infliximab Usage in 2015/16 that was a Biosimilar Product NOT originator	**Model Hospital: Data not available** **Local data: 379**	Data not available	Data not available	100%	A High Cost Drug Pharmacist role is to be embedded into the clinics to support with consent and switching of patients to new the biosimilar.
% Biosimilar Infliximab Uptake (Monthly) 15/16	**Model Hospital: Data not available** **Local data:20%**	Data not available	Data not available	Work collaboratively with clinicians towards achieving the specialised CQUIN target	A High Cost Drug Pharmacist role is to be embedded into the clinics to support with consent and switching of patients to new the biosimilar. [Timescale for completion: April 2019]
% Total Etanercept Usage YTD 16-17 that was a Biosimilar Product NOT Originator	**Model Hospital: Data not available** **Local data: 0%**	Data not available	Data not available	Work collaboratively with clinicians towards achieving the specialised CQUIN target	High Cost Drug Pharmacist role to be embedded into the clinics to support the consent and switch patients to new the biosimilar. This work has now commenced. [Timescale for completion: April 2019]
Total spend on Etanercept in 15-16	**Model Hospital: Data not available Local data: Etanercept (Homecare): £7 18217 Etanercept (Non-Homecare):£143 285**	Data not available	Data not available	To minimise expenditure on non-biosimilar expenditure of Etanercept.	This metric intends to determine the potential savings available given current expenditure on this particular agent. Plans are in place to reduce the expenditure in this agent by switching to a biosimilar. A High Cost Drug Pharmacist role is to be embedded into the clinics to support the consent and switch patients to new the biosimilar.

	Total: £861502				
Number of days stockholding	**20**	30.0	18.8	15	The transforming of the outpatient pharmacy services will support the reduction in stock holding by value. Automated stock cupboards are in use in ED and we are looking to use them on other wards in the organisation to support safer administration, support the Falsified Medicines Directive (FMD) agenda and reduce stock holding for the organisation. We currently use UCLH to provide us with a direct ward stock top up service so every day we get completed ward stock deliveries for distribution to wards. This means we do not hold the stock or use staff for filling boxes on site. We are exploring the cost effectiveness of direct to ward delivery of fluids as an enabler to support this reduction in stock holding. We currently electronically order but not electronically invoice. Over the next 12 months we will implement electronic invoicing within pharmacy. Our central finance systems, however, do not currently support electronic invoicing. An updated finance system is expected at the end of 2019. When in place we will work with our

					finance colleagues to implement end to end electronic invoicing. [Timescale for completion: April 2020]
Pharmacy Deliveries per Day [Average Number of deliveries]	**15**	15	15	15	The intention is to continue to reduce the number of daily deliveries as far as possible to minimise medicines handling and facilitate more patient facing activity. [Timescale for completion: April 2020).
e-Commerce - Ordering (AAH) *NEW*	**97.0**	67%	82%	>95%	
e-Commerce - Ordering (Alliance) *NEW*	**98.7**	95%	90.4%	>95%	
Data Quality of NHS England Monthly Data Set Submissions From Providers *NEW*	**19**	21	20	100	[STP Peer Median: 21] Upgrade to latest version of EPMA system will enable dm+d and minimum data set reporting compliance. This will support compliance with this metric. The Trust is awaiting formal agreement of NHS England funding to enable upgrade. This requirement is noted with the Trust's Digital Strategy 2017-2020. [Timescale for completion: April 2018]
Caring					

National Inpatients Survey- Medicines Related Questions	**77.6%**	72.3%	73.1%	Year on year improvement	This result has seen an improvement year on year from 74.3% in 2014/15 to 77.6% in 2015/16. This is contrary to the National trend which has seen the positive response to these questions reduce from 75.8% to 73.1% for the same periods. Key findings in the inpatient survey were that patients did not feel they had enough information about their medicines and did not understand the potential side effects of their medicines. To support patients understand their medicines more effectively we are supporting the counselling with the supply of Plain English information Sheets (MaPPs) and where appropriate referring patients to the New medicines service in the community. Further considering the implementation of bilingual labelling in outpatients and on discharge summaries in a selection of languages for patients for whom English is not their primary language.
Responsive					
Sunday ON WARD Clinical Pharmacy hours of Service (Medical Admission Unit/Equivalent)	**8hrs**	3hrs	7hrs	8hrs	The current service provided on Saturdays and Sundays includes a 9-00 am to 5:30pm on ward clinical pharmacy service to the medical admissions unit, acute surgical ward, ITU, neonatal unit and paediatric ward. In May 2017 we will be commencing pilot in

					Urgent Care training pharmacists as Advanced Care Practitioners who will provide a 7 day service in Urgent care. One of the aims of the Digital Pharmacy Project is to explore ways in which the technology e.g. EPMA system can be used to identify high risk patients and how we can provide targeted clinical care for these patients. This will impact on the way we provide weekend clinical pharmacy services in the future.
People, Management & Culture: Well led					
% Sickness Absence	**0.6%**	2.3%	3.1%	Trust target <2.5%	Continue to support staff to maintain the low levels
% Staff with Appraisals completed 2015/16 [NHS Benchmarking]	**97%**	89%	85%	Trust Target >90%	A satisfactory completed appraisal is linked to pay point progression and the completion % is raised in senior meetings.
% Staff with Statutory and Mandatory Training 2015/16	**91%**	95%	91%	Trust Target >90%	Completed mandatory training is linked to pay point progression and the completion % is raised in senior meetings.
% Staff Turnover Rate	**27%**	18%	14%	13% (Trust target)	The turnover of band 6 and band 7 pharmacists high in pharmacy as the roles within the organisation are changing and many get promotions within WH or externally. Working with HR to explore whether staff can be asked to payback some funding for training if leave within 12 months of completion. It is very difficult to recruit technicians at band 4 and as a consequence the plan is increase student technician roles and explore ward automation.

					Currently have 2 pharmacy apprentices to carry out pharmacy assistant work and to succession plan for student technicians.
% Staff Vacancy Rate (New)	**6%**	13%	6%	<6%	Departmental vacancies and all in process recruitment reviewed at senior meetings two weekly.

***RAG: Current position is described in relation to planned performance**
****Blue indicators are noted within the model hospital as indicators for which judgement of performance is not appropriate**

Data obtained from online model hospital tool and checked 29th March 2017

3.0 Local Collaboration

3.1 Hospital Pharmacy Transformation Programmes are expected to consider local, regional and wider collaboration opportunities to facilitate the optimisation of medicines.

3.2 A system wide view of medicines optimisation is currently led locally through the North Central London Medicines Optimisation Network (NCL MON) and the NCL Joint Formulary Committee comprising senior pharmacy and clinical colleagues from primary, secondary and tertiary care organisations.

3.3 There are several examples of collaboration in the provision in pharmacy services in place across the STP footprint, many of which are referred to above and throughout this document. These include, although not exclusively:

a) Ward stock Top up service provided to WH by the UCLH pharmacy department
b) On call service provision between WH and Camden & Islington Mental Health Trust
c) Quality Control (QC) support through the Royal Free Hospital NHS Foundation Trust
d) TPN services and dose banded chemotherapy through local commercial partnerships
e) Joint Medicines Optimisation Committees with Haringey and Islington Clinical Commissioning Groups
f) Attendance and support to the Clinical Governance Committee for Anticoagulation Services across the STP footprint.
g) Collaborative working with London Ambulance Service to support the management of respiratory disease patients
h) Membership and contribution to the Responsible Respiratory Prescribing Group which focuses on the optimisation of medicines for respiratory patients and incorporates consultants, prescribing advisors, GPs, paediatric leads from Camden, Haringey and Islington
i) Review of clinical trials protocols as part of UCLP harmonisation project that helps to reduce NHS approvals time across CRN North Thames region and promotes research
j) Membership and contributors to The North Central London (NCL) Joint Formulary Committee (JFC) which advises Commissioners and Provider Trusts in NCL on appropriate, equitable, evidence-based and cost-effective medicines use.
k) Collaboration with local Child and Adolescent Mental Health Services to support Medicines Optimisation
l) Collaborative working with Royal Free, University college and Royal National Orthopaedic Hospitals in the management of Outpatient Antimicrobial Therapy Services (OPAT)
m) Collaborative working with academia, supporting the training of pharmacy, medical and ERASMUS students

3.4 In further support of ongoing and incremental collaboration the Chief Pharmacists of the NCL acute and mental health trusts (Camden & Islington, Great Ormond Street Hospital, Moorfields, North Middlesex University Hospital, Royal Free London, Royal National Orthopaedic Hospital, University College London Hospitals & Whittington Health) have established a Collaboration Group to consider and develop opportunities for further collaboration across the STP, with particular reference to hospital pharmacy 'infrastructure' services. This group currently meets bimonthly.

The initial principles and workplan agreed for this collaborative work includes:

a) Working up shared models that learn from and build on existing collaboration and models for:
   i. Medicines Procurement
   ii. Pharmacy stores and distribution
   iii. Pharmacy manufacturing and production
   iv. Others appropriate areas of pharmacy practice

b) Establishing and developing networks of specialists across NCL, supported by the Chief Pharmacists within the region, to share expertise and ideas for collaboration
c) Sharing thinking and initiatives to support and develop pharmacy education and research across the sector and further afield working with appropriate academic partners
d) Collectively identify and deploy resource to complete a high level initial scoping exercise to develop a case for further investment based on the invest to save principle.

3.5 The transformed outpatient pharmacy services at Whittington Health will have the potential to support the provision of other services across the STP footprint. The provision of some medicines for Camden & Islington Mental Health Trust will commence in 2017 and further opportunities will be explored in 2017/18 with other local organisations and services.

4.0 Risks & Mitigations

Risk	Mitigation
Dm+d compliance	The EPMA provider is required to interface with Anglia Ice to produce discharge letters. The work with Anglia Ice to ensure dm+d compliance is still in early stages. The requirements are part of the Trust IM&T strategy to ensure there is support for the upgrade when in place
Delivery of the Outpatient Transformation Plan	The plan has an ambitious project implementation date of June 17. A project team is place there is executive and non-executive directorship sponsorship for the plan. Corporate service resource has been identified. Work with partner organisations is in progress.
Moving patients to new biosimilars to ensure savings are made and realising the financial benefits of change	Work with NHSE and CCGs on savings and gain shares or ensuring new process of NHSE high cost dispensing fees is realised.

5.0 Issues and Mitigations

Issues	Mitigation
Prescribing pharmacist training	Due to the recommendations of Carter and concurrent initiatives e.g. GP Practice Pharmacists, there has been an increase in demand for training for independent prescribing. Currently the capacity of Higher Education Institutes does not meet the demands. Applications made to multiple centres to ensure training commences as soon as possible.
Model Hospital Dashboard	The dashboard is acute hospital focused and does not entirely reflect the direction of travel in terms of system wide working. The metrics that support an integrated care organisation will be developed and applied with time.
Reconfiguration of clinical pathways	Working collaboratively across the sector with partners in delivery of the plan

6.0 HPTP Plan Summary

6.1 In order the deliver the plan there are three main areas of development

i. Firstly, implementation of the latest versions of the EPMA system. This will support dm+d compliance and provision of the minimum data set for NHSE. It will also support the Digital Pharmacy Plan which has the principal aim of using technology to support new ways of working in pharmacy identifying high risk patients and supporting clinical pharmacy provision.

ii. Secondly the Outpatient Transformation Project will support the pharmacy in delivering the infrastructure services in a new way. The project also includes working more closely with local organisation's pharmacies including the Royal Free London and Camden and Islington NHS Foundation Trusts.

iii. Finally, system wide working. The new roles that have been developed within WH pharmacy: GP, locality teams, Urgent care, Care Homes, Reablement pharmacists when linked in with the local community pharmacists and the acute admissions pharmacists provide opportunities for system wide learning and improvement of the urgent care pathway.

References:

1. Operational productivity and performance in English NHS acute hospitals: Unwarranted variations- An independent report for the Department of Health by Lord Carter of Coles. February 2016.

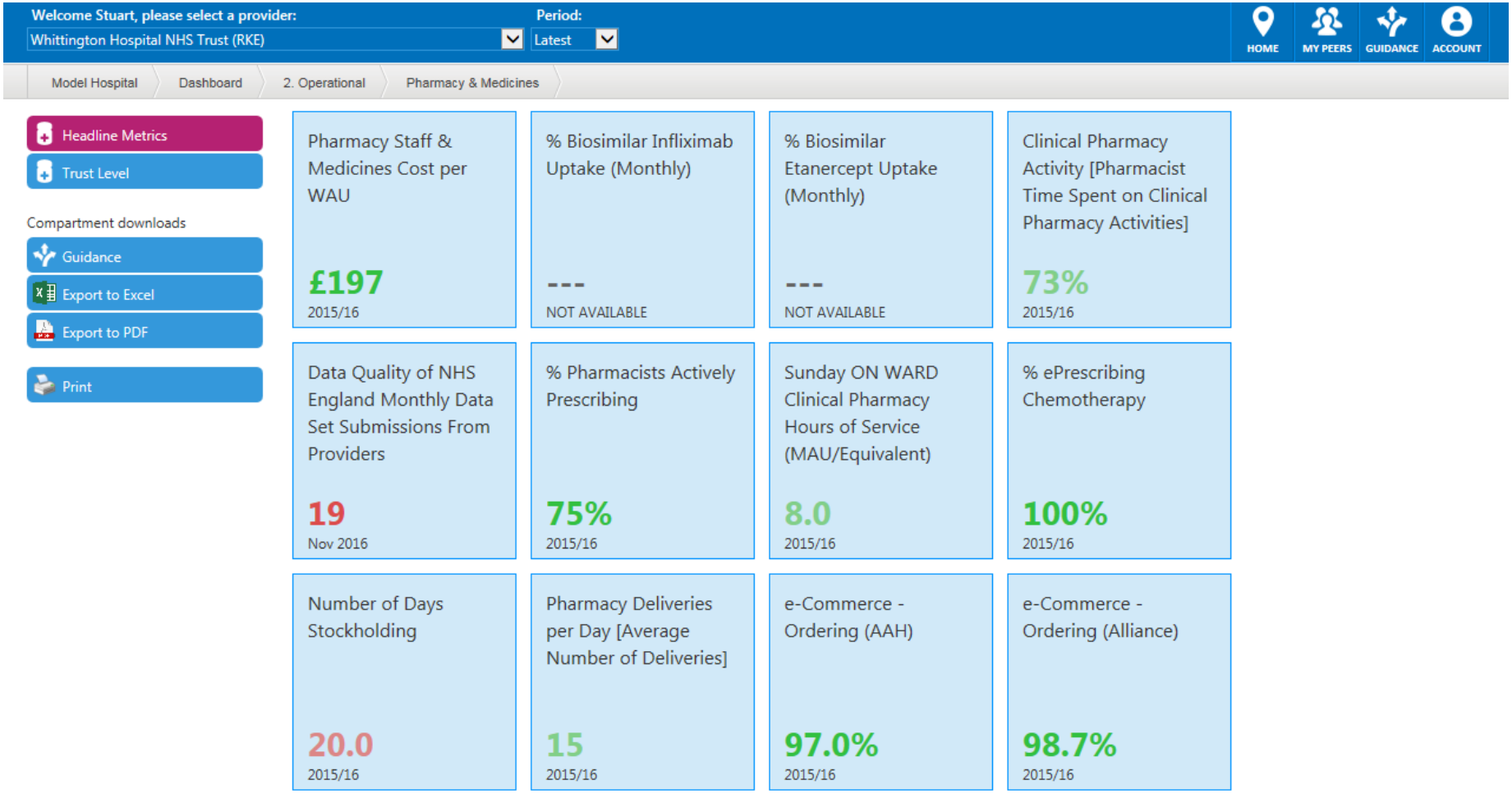
Appendix 1: Operational productivity and performance in English NHS acute hospitals: Unwarranted variations - Recommendation 3

Trusts should, through a Hospital Pharmacy Transformation Programme (HPTP), develop plans by April 2017 to ensure hospital pharmacies achieve their benchmarks such as increasing pharmacist prescribers, e-prescribing and administration, accurate cost coding of medicines and consolidating stock-holding by April 2020, in agreement with NHS Improvement and NHS England so that their pharmacists and clinical pharmacy technicians spend more time on patient-facing medicines optimisation activities.

Recommendation 3 to be delivered by:	
a)	developing HPTP plans at a local level with each trust board nominating a Director to work with their Chief Pharmacist to implement the changes identified, overseen by NHS Improvement and in collaboration with professional colleagues locally, regionally and nationally; with the Chief Pharmaceutical Officer for England signing off each region's HPTP plans (brigaded at a regional level) as submitted by NHS Improvement
b)	ensuring that more than 80% of trusts' pharmacist resource is utilised for direct medicines optimisation activities, medicines governance and safety remits while at the same time reviewing the provision of all local infrastructure services, which could be delivered collaboratively with another trust or through a third party provider
c)	each trust's Chief Clinical Information Officer moving prescribing and administration from traditional paper charts to Electronic Prescribing and Medicines Administration systems (EPMA)
d)	each trust's Finance Director, working with their Chief Pharmacist, ensuring that coding of medicines, particularly high cost drugs, are accurately recorded within NHS Reference Costs
e)	NHS Improvement publishing a list of the top 10 medicines with savings opportunities monthly for trusts to pursue
f)	the Commercial Medicines Unit (CMU) in the Department of Health undertaking regular benchmarking with the rest of the UK and on a wider international scale to ensure NHS prices continue to be competitive, and updating its processes in line with the Department of Health's NHS Procurement Transformation Programme as well as giving consideration as to whether the capacity and capability of the CMU is best located in the Department of Health or in the NHS, working alongside NHS England's Specialist Pharmacy Services and Specialised Commissioning functions
g)	consolidating medicines stock-holding and modernising the supply chain to aggregate and rationalise deliveries to reduce stock-holding days from 20 to 15, deliveries to less than 5 per day and ensuring 90% of orders and invoices are sent and processed electronically
h)	NHS improvement, building on and working with NHS England commissioned Specialist Pharmacy Services, should identify the true value and scale of the opportunity for rationalisation and integration of hospital pharmacy procurement and production, developing an NHS Manufactured Medicines product catalogue and possibly moving towards a four region

	model for these services

Appendix 2: Screenshots from the Model Hospital Dashboard (www.https://model.nhs.uk) Accessed 29.03.17



Appendix 3

How does the Model Hospital treat acute trusts with a large proportion of community work?

The source cost data for the analysis is the published reference costs for 2014/15. Reference cost data do not cover community activity to the same extent that they cover acute activity – on average around 70% of community trusts' expenditure is covered by reference costs, compared to 85% of acute trusts' expenditure on average. This means the estimate of your trust's clinical output, derived from reference Costs, may slightly underestimate the true value of the services you deliver on behalf on the NHS.

We do however take this into account when calculating the productivity measures shown within Lord Carter's final report and within the Test Headline Metrics section of the Model Hospital Portal. An adjustment is made which excludes a proportion of each trust's staff costs from the productivity calculation, based on the proportion of that trust's expenditure covered by Reference Cost data.

Providing a high proportion of community activity as well as acute may impact your relative performance in some areas. This is because of the different 'cost profile' for community activity, which tends to be staffing resource heavy, with less spend on non-pay (medicines etc.) compared to acute activity where we would expect a lower proportion of spend to be on pay with a higher proportion on non-pay. Trusts with a high proportion of community-based activity often appear to have higher than average total staff costs, and lower than average non-pay costs. This can be compounded by being a smaller trust, as smaller trusts also tend to have higher than average staff costs and lower than average non pay costs.

We would recommend that you compare yourselves to other providers of community services to help investigate the extent to which this explanation applies to your trust or whether your trust still appears to be an outlier, in order to best assess and investigate efficiency opportunities.

Whittington Health

Agenda: **17/053 – Paper 10**

Paper to: **Trust Board**

Paper from: **Director of Workforce**

Subsect: **NHS National Staff Survey Results 2016**

Date: **21st March 2017 and 5th April 2017**

1.0 Introduction

1.1 This is the sixth year in which Whittington Health as an Integrated Care Organisation (ICO) has conducted the national staff survey. This year the Trust opted to select a random sample of 1,227 staff to complete the 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) to agree priorities and the overall approach to the development of a staff survey action plan, to be presented to the Trust Board in April 2017.

1.3 The Trust commissions the Picker Institute to run its survey, as do a further 20 other combined acute community Trusts. This means that in addition to the national comparisons, we have access to reports at ICSU 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 2016 NHS staff survey is of a similar format to that of the 2015 survey. 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 2016 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 36% against the national community acute Trust average of 40%, equating to 441 responses. This was a increase of 6% since the 2015 survey. Demographic characteristics of respondents were:

- **Age**: Between 16 and 30, 19%. Between 31 and 40, 26%. Between 41 and 50, 27%. 51 and over 29%.
- **Gender:** Male respondents 26%, female respondents 74%.
- **Ethnicity**: White responses 60%, BME responses 40%.
- **Disabled**: Responses from staff with a disability 13%, those responses from staff without a disability 87%.
- **Length of service**: less than a year 16%; between 1 to 2 years 17%; between 3-5years 14%; 6 to 10 years 19%; between 11 to 15 years 13% and over 15 years 21%.
- **Full time / Part time**: full time staff 84%, part time staff 16%.

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 community Trusts. The possible scores range from 1 to 5 (with 1 indicating poor engagement and 5 high engagement). The Trust's score of 3.83 is above the national average of 3.8 and a local improvement from 3.79 in 2015. The diagram below illustrates how this score is arrived at 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 Health		
ADVOCACY	**INVOLVEMENT**	**MOTIVATION**
I would recommend WH as a great place to work 3.59 / 3.5	I am able to make suggestions to improve the work of my team / dept 3.95 / 3.84	I look forward to going to work 3.6 / 3.61
Happy with the standard of care provided 3.82 / 3.73	There are frequent opportunities for me to show initiative in my role 3.89 / 3.82	I am enthusiastic about my job 3.94 / 4.0
Care of patients a top priority for WH 3.93 / 3.83	I am able to make improvements happen in my area 3.6 / 3.48	Time passes quickly when I am working 4.13 / 4.14
Overall staff engagement index for 2015 3.79, 2016 3.83		
Scores in red represent the Acute Community Trust average across the country		

WH is above average in six of the nine indicators – where we are below average, albeit slightly, is in the "motivation category".

3.2 Top Ranking Scores

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

	Indicator	Trust	National
1	Percentage of staff reporting errors, near misses or incidents witnessed in last month	97%	91%
2	Quality of appraisals	3.35	3.11
3	Percentage of staff/colleagues reporting most recent experience of violence	78%	67%
4	Percentage of staff agreeing that their roles make a difference to patients / service users	93%	91%
5	Percentage of staff reporting good communication between senior management and staff	36%	32%

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. In addition there has been a focus on incident reporting and feedback and this appears to have been reflected in the results.

3.3 Bottom Ranking Scores

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

	Indicator	Trust	National
1	Staff working extra hours	78%	71%
2	Staff suffering work related stress in last 12 months	42%	36%
3	Staff experiencing harassment, bullying or abuse from staff	30%	23%
4	Percentage of staff experiencing discrimination at work in the last 12 months	19%	10%
5	Percentage of staff experiencing harassment, bullying or abuse form patients, relatives or the public in last 12 months	31%	26%

Disappointingly, three of the bottom ranking scores (numbers 1 – 3) appeared in the same category in the Trust's 2015 results and have shown little improvement in year. It is the first time that the percentage of staff experiencing harrassment, bullying or abuse from service users has been highlighted as a concern and this will require specific attention this year.

3.4 Comparisons with other Trusts

Of the 32 key findings the Trust scored significantly ***better than average*** in ten areas comparison to acute community 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.*	
KF7	Able to contribute towards improvments at work
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
KF13	Quality of non-mandatory training, learning and development
Staff Pledge 3: *To provide support and opportunities for staff to maintain their health, well-being and safety.*	
KF24	Reporting most recent experience of violence
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*.	
KF5	Recognition and value of staff by managers and the organisation
KF6	Percentage reporting good communication between senior management and staff
KF10	Support from immediate managers
Additional Theme: *Errors and Incidents*	
KF29	Percentage reporting errors, near misses or incidents within last month
KF13	Fairness and effectiveness of procedures for reporting errors, near misses and incidents
Additional Theme: Patient Experience	
KF3	Percentage agreeing their role makes a difference to patients/service users

There are also ten 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.*	
KF4	Staff motivation at work
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
KF18	Percentage attending work in last 3 months despite feeling unwell because they felt pressure
KF25	Experiencing harassment, bullying or abuse from patients or relatives
KF26	Experiencing harassment or bullying from staff
Additional Theme: *Equality and Diversity*	

KF20	Experiencing discrimination at work
KF21	Believing the organisation provides equal opportunity for career progression / promotion

3.5 Local Changes since 2015

The report highlights key findings where staff experiences have significantly improved or deteriorated locally since the 2015 survey. These are set out below:-

3.5.1 Improved Staff Experiences

	Indicator	2015	2016
1	Percentage of staff reporting errors, near misses or inciddents withessed in the last month	97%	87%
2	Quality of appraisals	3.35	3.12

These local improvements reflect the focus of the action plan following the 2015 survey.

3.5.2 Deteriorating Staff Experiences

This year the Trust has only deteriorated locally in one area and that is percentage of staff experiencing physical violence from patients, relatives or the public in the last 12 months which saw our scores increase from 9% to 13% in 2016.

4.0 Equalities Indicators

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 2015.

4.2

			WH in 2016	Median for acute/community Trusts	WH in 2015
KF25	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	White	30%	27%	29%
		BME	29%	27%	29%
KF26	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	White	25%	22%	27%
		BME	32%	26%	27%
KF21	Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	White	87%	88%	87%
		BME	70%	75%	67%
Q17b	In the last 12 months have you personally experienced discrimination at work from manager / team leader or other colleagues	White	7%	6%	7%
		BME	17%	14%	14%

4.3 There appears to be little discrepancy in KF25 (staff experiencing harassment from service users). However where staff experience bullying, harassment and discrimination or have a belief that the Trust provides equal opportunities for career progression, there is a difference in perception between our white and BME coleagues and no improvement since 2015.

5.0 Progress on 2015 Staff Survey Action Plan

5.1 During 2016 the Trust Board agreed that as a result of our staff survey feedback we would focus on five corporate priorities as detailed below:

1. Staff satisfaction with the level of involvement and responsibility. And staff satisfaction with resourcing and support;
2. Staff appraised in last 12 months;
3. Providing support and opportunities for staff to maintain their health and wellbeing and safety;
4. Reducing discrimination at work and believing the organisation provides equal opportunity for career progression
5. Staff feeling secure and confident in reporting errors and near misses

5.2 A corporate action plan was developed and a Corporate Lead identified on each of these priorities. Trust Board approved this action plan in March 2016, with a progress update given in September 2016. Since then significant progress has been made in each of these areas. Some of the actions taken included:

- The development of a staff communication and engagement plan;
- The involvement of operational staff in our service transformation plans through creation of the Programme Management Office (PMO);
- Cascade of Level 2 / 3 staff survey results to ICSU's and service areas. HRBP support provided in facilitating staff survey action planning workshops;
- The cascade of organisational goals and objectives within service areas and individual objectives aligned, so there is a clear line of sight between individual role and organisational objective;
- Manager and appraisee training takes place twice monthly;
- Quarterly Performance Review Meetings to review all workforce key performance indicators and staff survey action plans by ICSU;
- The promotion of Occupational Health (OH) stress self-assessment questionnaire and a stress survey used as part of the monthly appraisal training for managers;
- Introduction of a half yearly health and safety bulletin communicated to all staff;
- Development of our unconscious bias masterclass for all managers;
- Introduction of Equality and Diversity as management induction training;
- Trained bullying and harassment advisors, available to both alleged victims and alleged perpetrators;
- Launch of new Datix System in June 2016 to ensure a user friendly system which met the organisation's reporting needs.

6.0 Suggested Response and Action Plan

The focus of the Action Plan for the 2016 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 motivation at work • Staff satisfaction with resourcing and support	Suggested Corporate lead
Suggested actions:	• Promotion of stop/start scheme • Local staff recognition arrangements within ICSUs – e.g. employee of the month • Staff awards scheme and annual awards ceremony • Introduction of Long Service Awards	Director of Communications

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**:*	• *Percentage appraised in the last 12 months*	*Suggested Corporate lead*
Suggested actions:	• *Ensure all staff have up to date PDPs* • *Appraisal training for appraisees (3 hours) and appraisers (90 minutes) to become mandatory for those yet to attend - since September 2015.* • *Implement a talent management model/approach for access to appropriate personal and professional development.*	*Head of Learning and Development (HoLD)*

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 • Feeling unwell due to work related stress • Attending work in last 3 months despite feeling unwell because they felt pressure • Experiencing harassment, bullying or abuse from patients or relatives • Experiencing harassment or bullying from staff in last 12 months	Corporate lead
Suggested actions:	• Evaluate findings from anti bullying advisers to date • Tackle specific identified bullying "hotspots" within ICSUs	Deputy Director of

	• Consider Trust-wide participation in anti bullying week in November 2017 • Review EWTD opt outs • Focus health and wellbeing events on mental health, stress management and managing work life balance • Promote "yellow and red card" system for withholding treatment in appropriate circumstances • Conflict resolution training to be reviewed • Robust integration of exit interviews to identify themes and 'learning from' opportunities. • Unconcious bias Masterclass training (3 hours) to become mandatory or 'good practice' for all managers and leaders. • Implement a talent management model/approach for access to appropriate personal and professional development opportunities. • Relaunch Stress Risk Assessment • Develop a cogent Trust-wide communication plan to promote the existence of the Anti-bullying & Harassment Scheme. • Increase intelligence and opportunities for learning and identifying potential solutions by combing data from Datix and Workforce systems	Workforce Assistant Director of OD ICSU Leads Director of Nursing

6.4 Staff Pledge themes – Equality and Diversity		
Areas for improvement:	• Experiencing discrimination at work in last 12 months • Believing the organisation provides equal opportunity for career progression / promotion	Corporate lead
Suggested actions:	• Focus groups to understand the reasons for this reported experience • Focus career management on improving diversity opportunities and spotlighting positive role models. • Robust integration of exit interviews to identify themes and 'learning from' opportunities. • Unconcious bias Masterclass training (3 hours) to become mandatory or 'good practice' for all managers and leaders. • Implement a talent management model/approach for access to appropriate personal and professional development opportunities.	Assistant Director of OD Head of OD HoLD

7.0 **Communication Plan**

The results and action plan from the National Staff Survey 2016 will be communicated as follows:

• Trust Management Group	21st March 2017
• Trust Board	5th April 2017
• Partnership Group	end April 2017
• ICSUs and Directorates	through March and April 2017
• Chief Executive Briefing	April 2016
• Trust wide communications	6th April onwards

8.0 **Recommendation**

8.1 TMG and Trust Board is asked to note the content of this report and agree to the recommended priority areas assigning a member of the executive team / clinical directors for each of the NHS corporate pledges and themes.

8.2 Each of the ICSU Clinical Directors is asked to disseminate their ICSU results to their management teams and agree their local areas for improvement and action plan, which will feed into the corporate staff survey priorities.

2016 National NHS staff survey

Brief summary of results from Whittington Health NHS Trust

Table of Contents

1. Introduction to this report

This report presents the findings of the 2016 national NHS staff survey conducted in Whittington Health 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 thematically so that Key Findings are grouped appropriately. There are nine themes within this report:

- Appraisals & support for development
- Equality & diversity
- Errors & incidents
- Health and wellbeing
- Working patterns
- Job satisfaction
- Managers
- Patient care & experience
- Violence, harassment & bullying

Please note, two Key Findings have had their calculation changed and there have been minor changes to the benchmarking groups for social enterprises since last year. 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 2016 survey results for Whittington Health 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.

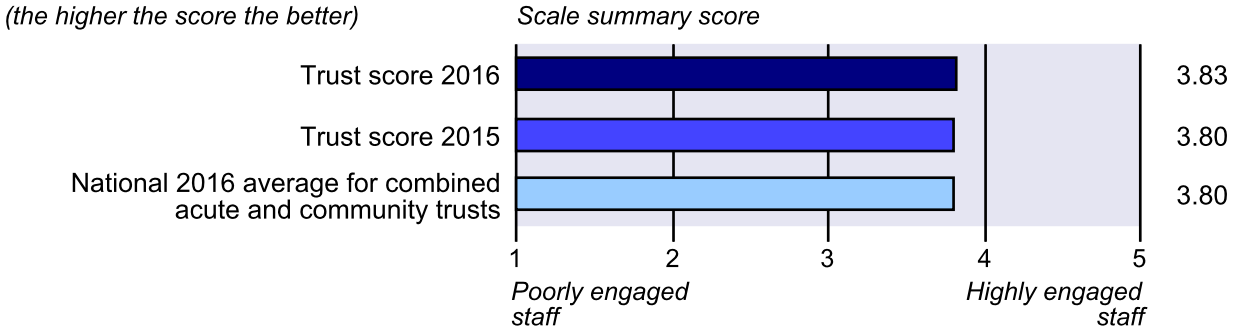
Q21a, Q21c and Q21d feed into Key Finding 1 “Staff recommendation of the organisation as a place to work or receive treatment”.

		Your Trust in 2016	Average (median) for combined acute and community trusts	Your Trust in 2015
Q21a	"Care of patients / service users is my organisation's top priority"	77%	75%	75%
Q21b	"My organisation acts on concerns raised by patients / service users"	78%	73%	72%
Q21c	"I would recommend my organisation as a place to work"	58%	59%	58%
Q21d	"If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"	71%	68%	69%
KF1.	Staff recommendation of the organisation as a place to work or receive treatment (Q21a, 21c-d)	3.78	3.71	3.71

2. Overall indicator of staff engagement for Whittington Health NHS Trust

The figure below shows how Whittington Health 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 3.83 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 Whittington Health 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 significant change since the 2015 survey.

	Change since 2015 survey	Ranking, compared with all combined acute and community trusts
OVERALL STAFF ENGAGEMENT	• No change	• 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	! Below (worse than) 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.)*	• No change	✓ Above (better than) 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 2016 Key Findings for Whittington Health NHS Trust

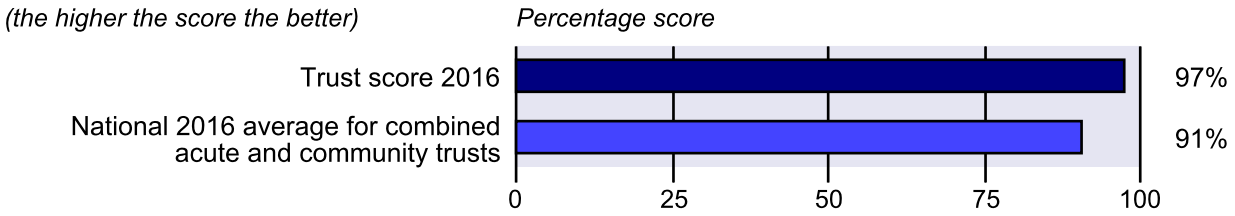
3.1 Top and Bottom Ranking Scores

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

TOP FIVE RANKING SCORES

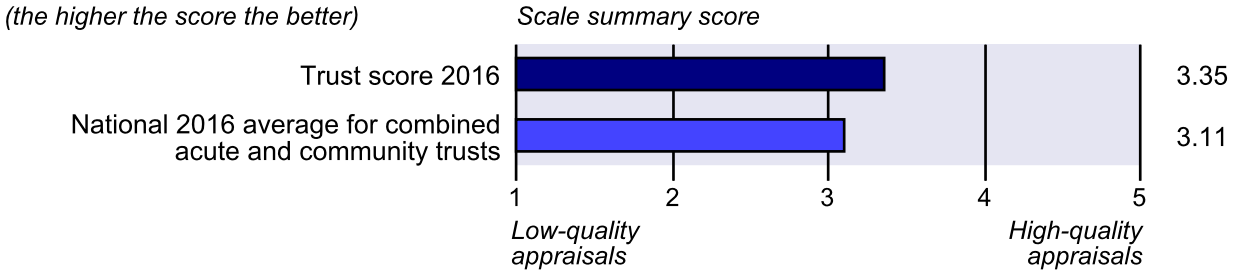
✓ KF29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month

(the higher the score the better)



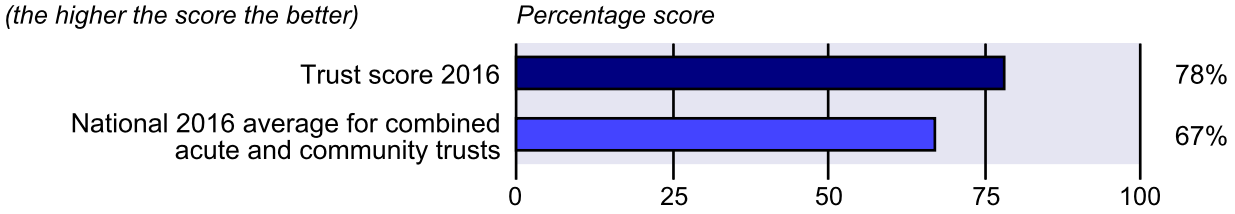
✓ KF12. Quality of appraisals

(the higher the score the better)



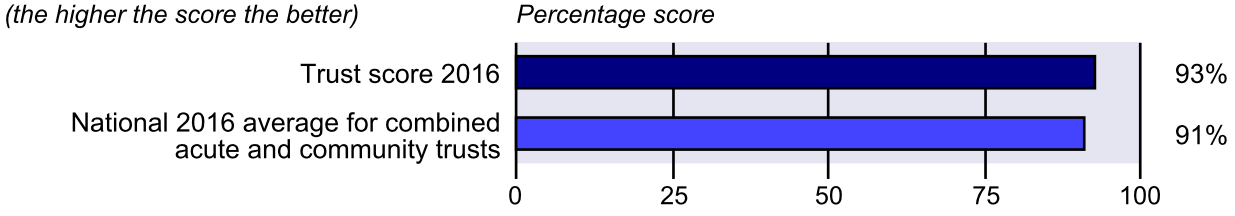
✓ KF24. Percentage of staff / colleagues reporting most recent experience of violence

(the higher the score the better)



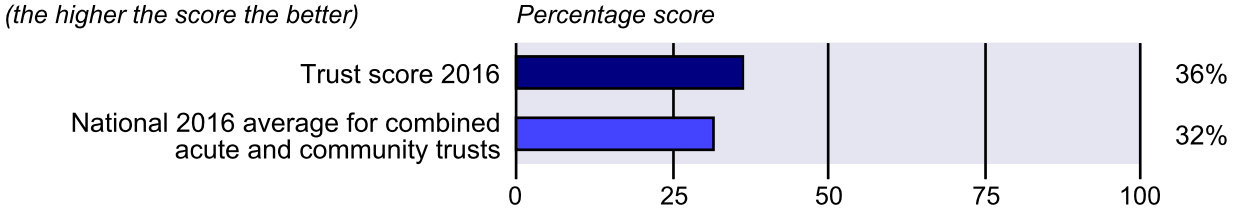
✓ KF3. Percentage of staff agreeing that their role makes a difference to patients / service users

(the higher the score the better)



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

(the higher the score the better)

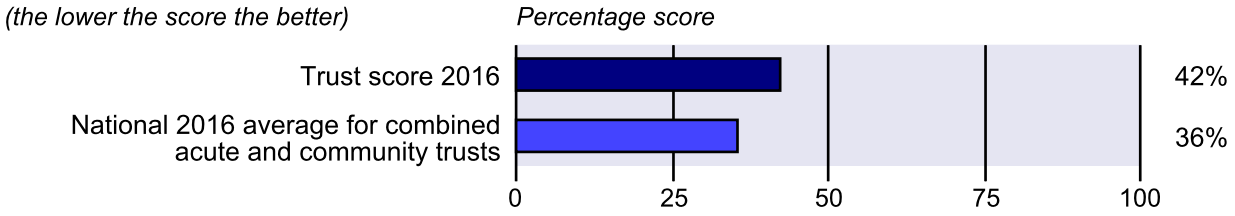


For each of the 32 Key Findings, the combined acute and community trusts in England were placed in order from 1 (the top ranking score) to 39 (the bottom ranking score). Whittington Health NHS Trust's five highest ranking scores are presented here, i.e. those for which the trust's Key Finding score is ranked closest to 1. Further details about this can be found in the document ***Making sense of your staff survey data***.

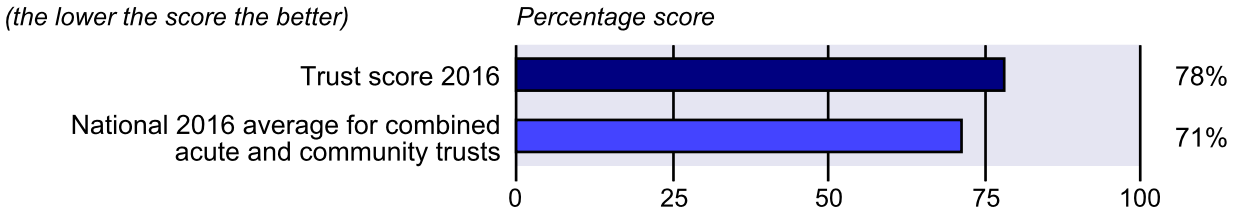
This page highlights the five Key Findings for which Whittington Health NHS Trust compares least favourably with other combined acute and community trusts in England. It is suggested that these areas might be seen as a starting point for local action to improve as an employer.

BOTTOM FIVE RANKING SCORES

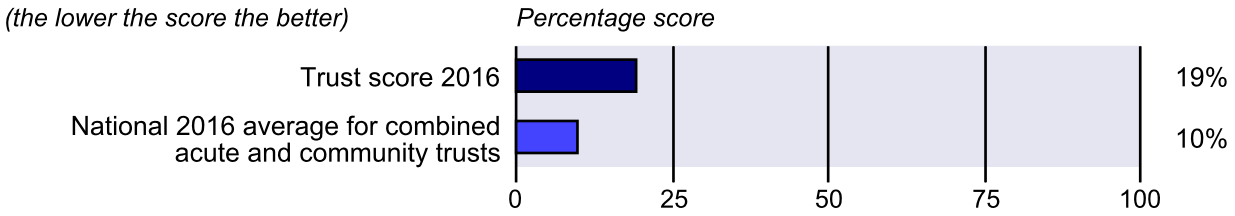
! KF17. Percentage of staff feeling unwell due to work related stress in the last 12 months



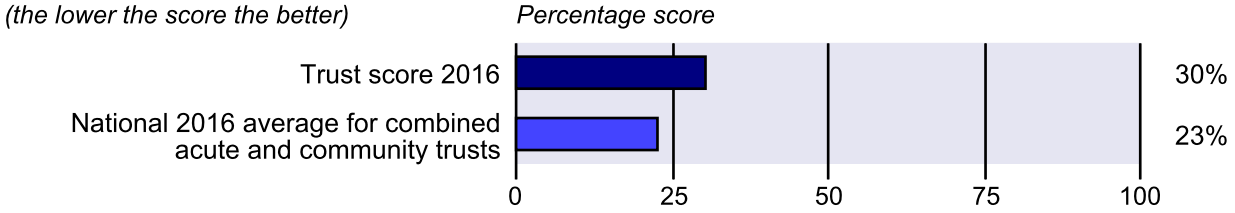
! KF16. Percentage of staff working extra hours



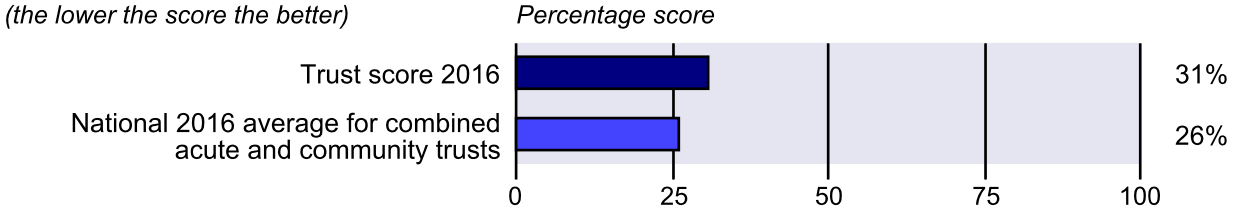
! KF20. Percentage of staff experiencing discrimination at work in the last 12 months



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



! KF25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months



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 39 (the bottom ranking score). Whittington Health 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 39. Further details about this can be found in the document ***Making sense of your staff survey data***.

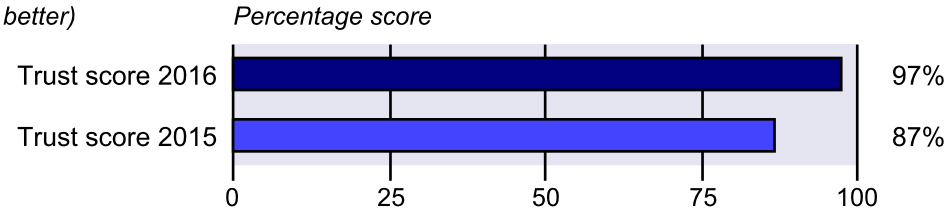
3.2 Largest Local Changes since the 2015 Survey

This page highlights the two Key Findings where staff experiences have improved at Whittington Health NHS Trust since the 2015 survey.

WHERE STAFF EXPERIENCE HAS IMPROVED

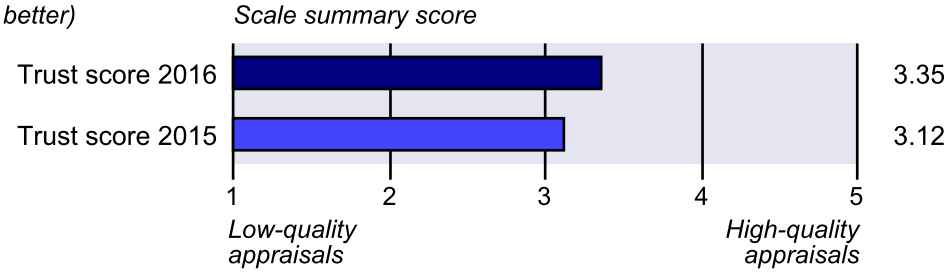
✓KF29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month

(the higher the score the better)



✓KF12. Quality of appraisals

(the higher the score the better)

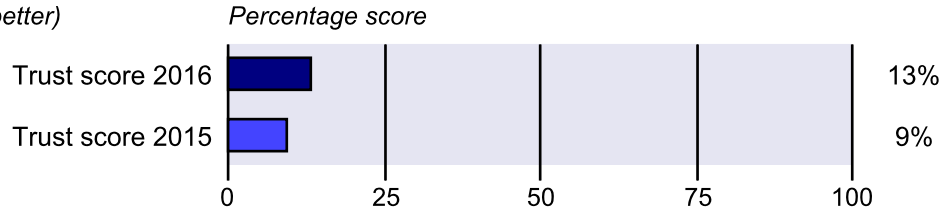


This page highlights the Key Finding that has deteriorated at Whittington Health NHS Trust since the 2015 survey. It is suggested that this might be seen as a starting point for local action to improve as an employer.

WHERE STAFF EXPERIENCE HAS DETERIORATED

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

(the lower the score the better)



3.3. Summary of all Key Findings for Whittington Health NHS Trust

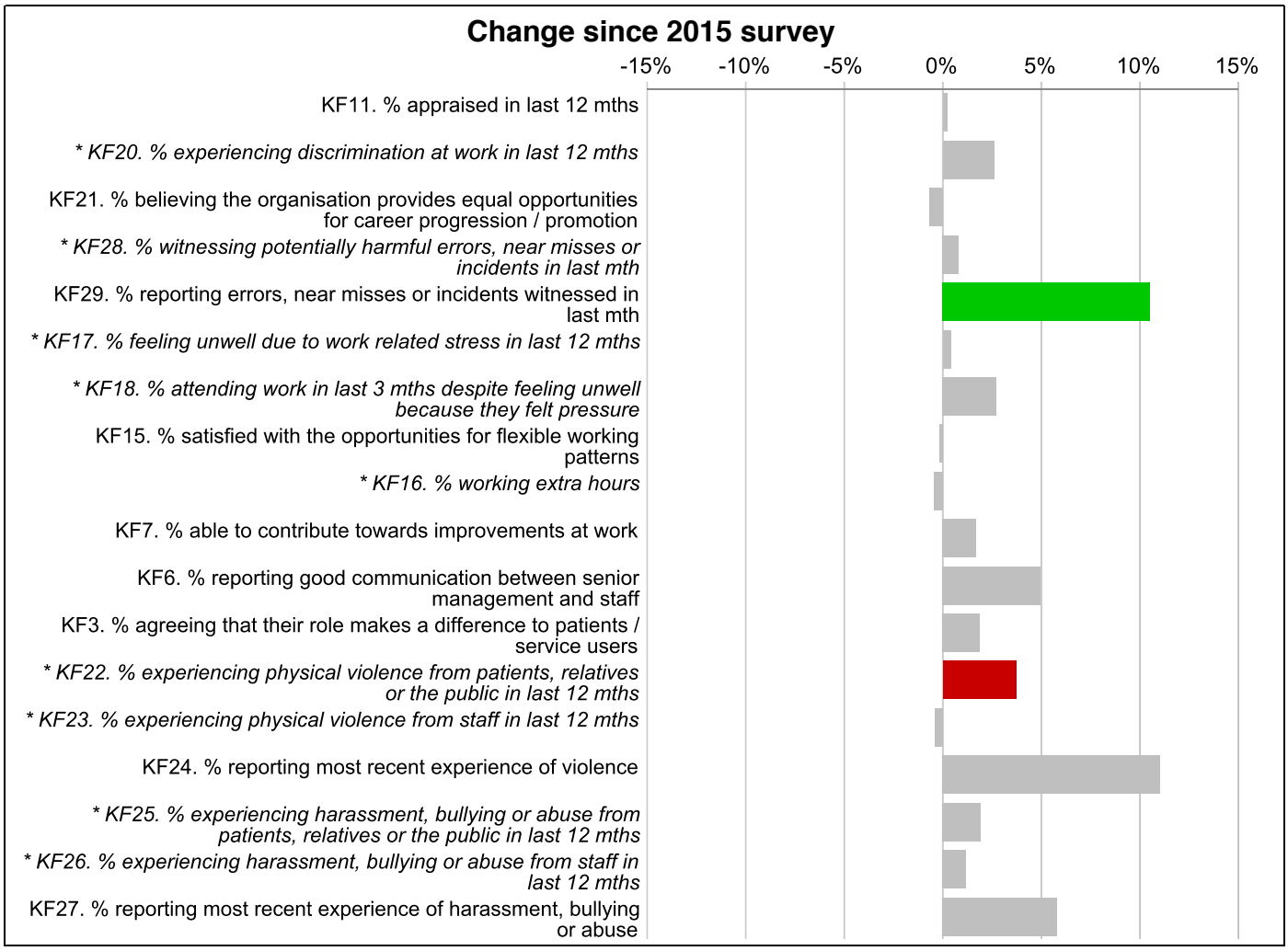
KEY

Green = Positive finding, e.g. there has been a statistically significant positive change in the Key Finding since the 2015 survey.

Red = Negative finding, e.g. there has been a statistically significant negative change in the Key Finding since the 2015 survey.

Grey = No change, e.g. there has been no statistically significant change in this Key Finding since the 2015 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.



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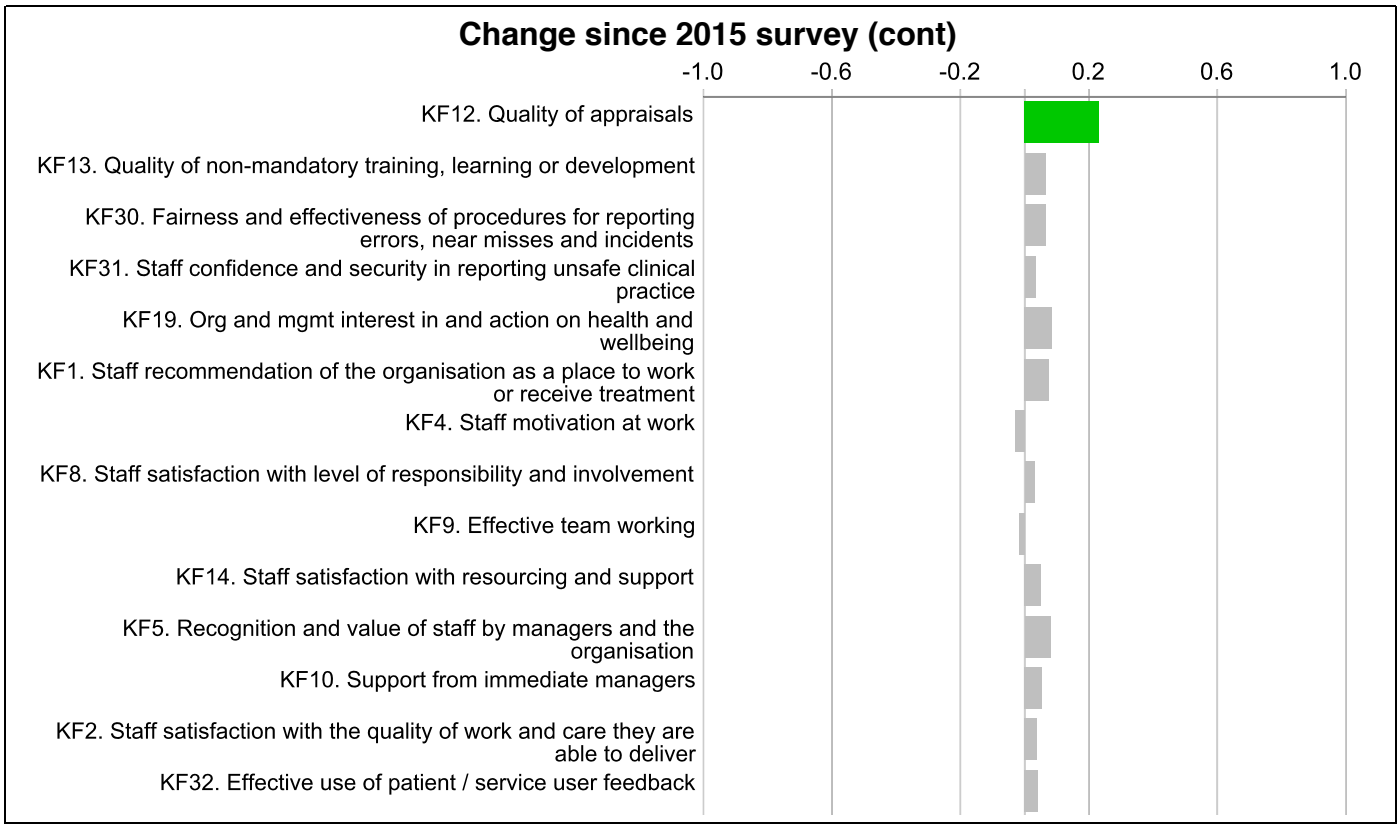


3.3. Summary of all Key Findings for Whittington Health NHS Trust

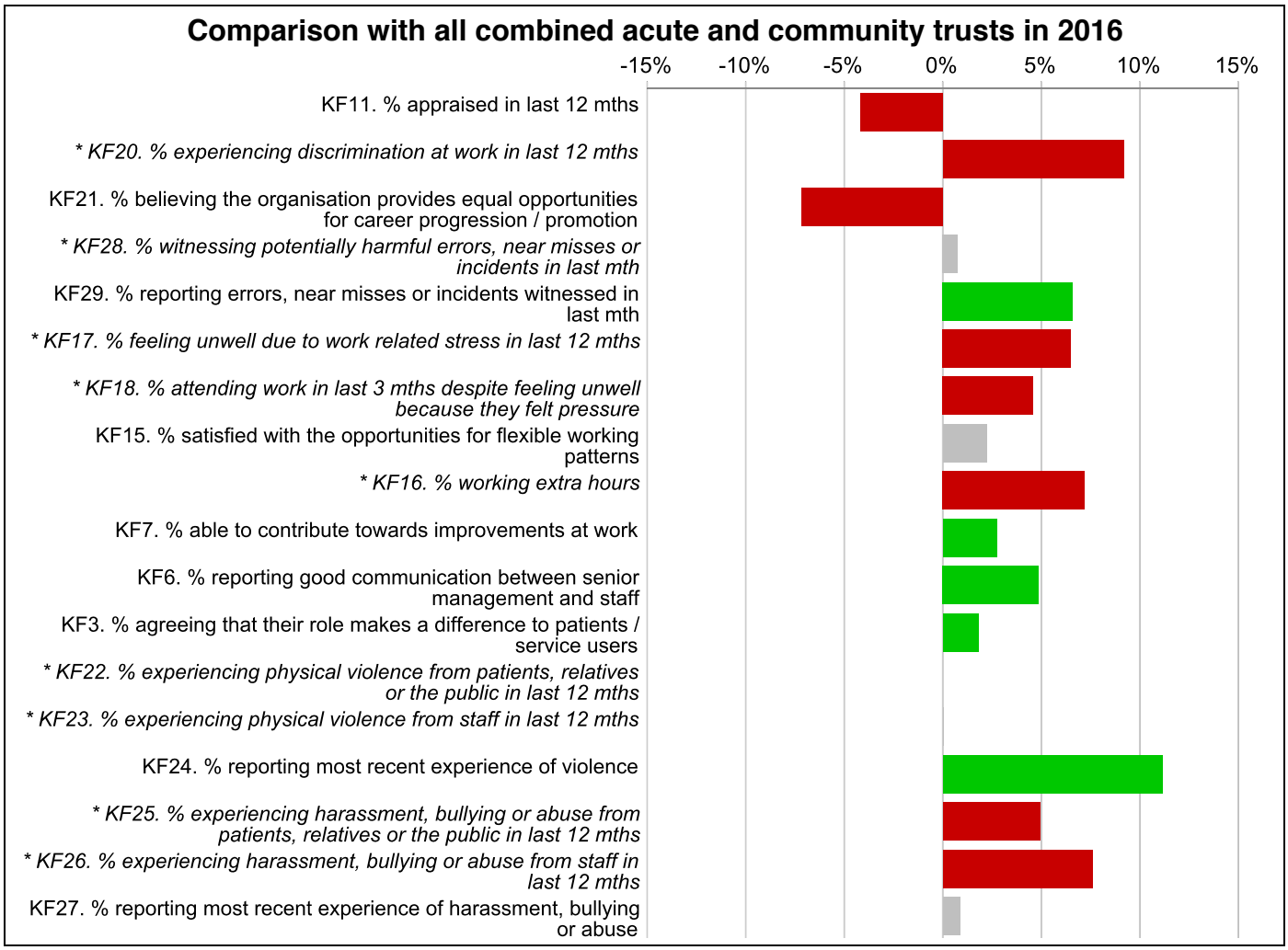
KEY

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

Red = Negative finding, i.e. 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.



3.3. Summary of all Key Findings for Whittington Health NHS Trust

KEY

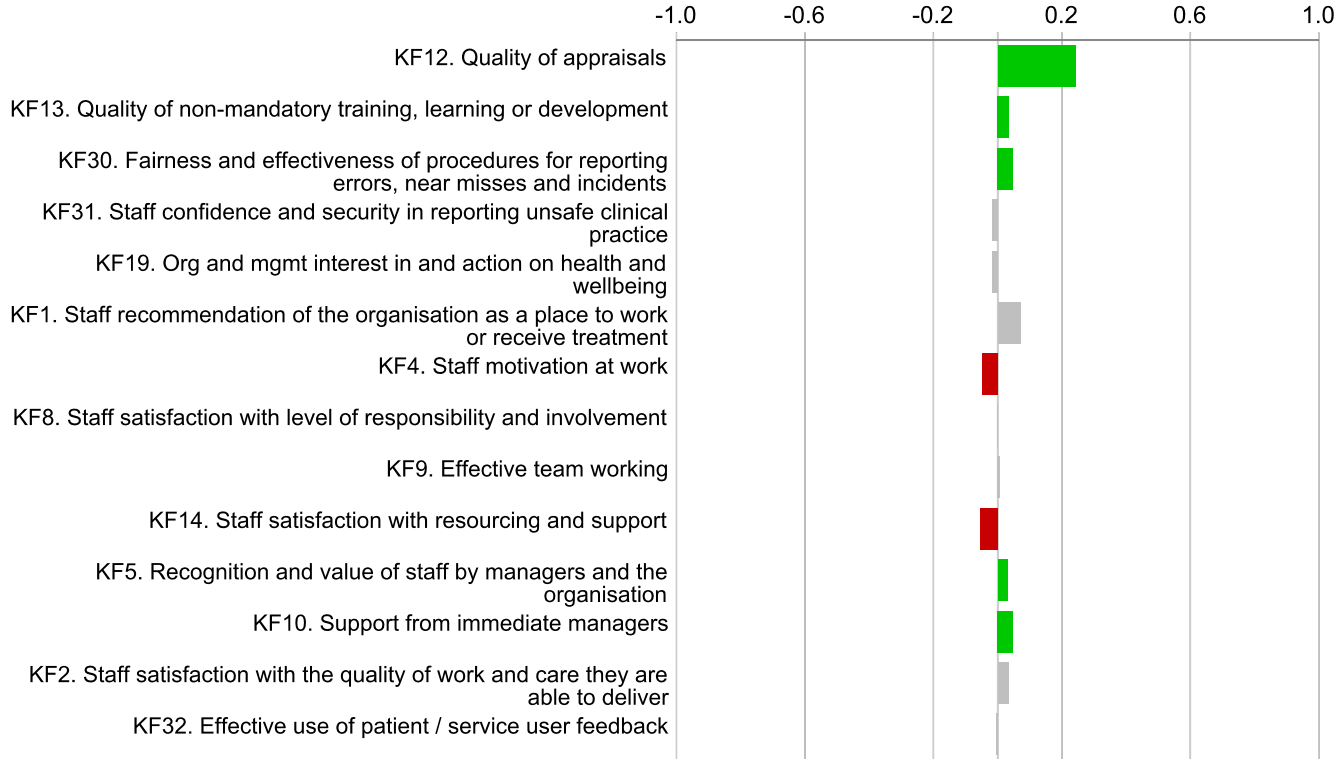
Green = Positive finding, e.g. better than average.

Red = Negative finding, i.e. 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 2016 (cont)



3.4. Summary of all Key Findings for Whittington Health NHS Trust

KEY

✓ Green = Positive finding, e.g. better than average, better than 2015.

! Red = Negative finding, e.g. worse than average, worse than 2015.

'Change since 2015 survey' indicates whether there has been a statistically significant change in the Key Finding since the 2015 survey.

-- Because of changes to the format of the survey questions this year, comparisons with the 2015 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 2015 survey	Ranking, compared with all combined acute and community trusts in 2016
Appraisals & support for development		
KF11. % appraised in last 12 mths	• No change	! Below (worse than) average
KF12. Quality of appraisals	✓ Increase (better than 15)	✓ Above (better than) average
KF13. Quality of non-mandatory training, learning or development	• No change	✓ Above (better than) average
Equality & 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
Errors & 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 last mth	✓ Increase (better than 15)	✓ Above (better than) average
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	• No change	✓ Above (better than) average
KF31. Staff confidence and security in reporting unsafe clinical practice	• No change	• Average
Health and wellbeing		
* *KF17. % feeling unwell due to work related stress in last 12 mths*	• No change	! Above (worse than) average
* *KF18. % attending work in last 3 mths despite feeling unwell because they felt pressure*	• No change	! Above (worse than) average
KF19. Org and mgmt interest in and action on health and wellbeing	• No change	• Average
Working patterns		
KF15. % satisfied with the opportunities for flexible working patterns	• No change	• Average
* *KF16. % working extra hours*	• No change	! Above (worse than) average

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

	Change since 2015 survey	Ranking, compared with all combined acute and community trusts in 2016
Job satisfaction		
KF1. Staff recommendation of the organisation as a place to work or receive treatment	• No change	• Average
KF4. Staff motivation at work	• No change	! Below (worse than) average
KF7. % able to contribute towards improvements at work	• No change	✓ Above (better than) average
KF8. Staff satisfaction with level of responsibility and involvement	• No change	• Average
KF9. Effective team working	• No change	• Average
KF14. Staff satisfaction with resourcing and support	• No change	! Below (worse than) average
Managers		
KF5. Recognition and value of staff by managers and the organisation	• No change	✓ Above (better than) average
KF6. % reporting good communication between senior management and staff	• No change	✓ Above (better than) average
KF10. Support from immediate managers	• No change	✓ Above (better than) average
Patient care & experience		
KF2. Staff satisfaction with the quality of work and care they are able to deliver	• No change	• Average
KF3. % agreeing that their role makes a difference to patients / service users	• No change	✓ Above (better than) average
KF32. Effective use of patient / service user feedback	• No change	• Average
Violence, harassment & bullying		
* *KF22. % experiencing physical violence from patients, relatives or the public in last 12 mths*	! Increase (worse than 15)	• Average
* *KF23. % experiencing physical violence from staff in last 12 mths*	• No change	• Average
KF24. % reporting most recent experience of violence	• No change	✓ Above (better 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	• Average

4. Key Findings for Whittington Health NHS Trust

Whittington Health NHS Trust had 441 staff take part in this survey. This is a response rate of 36%[1] which is below average for combined acute and community trusts in England, and compares with a response rate of 30% in this trust in the 2015 survey.

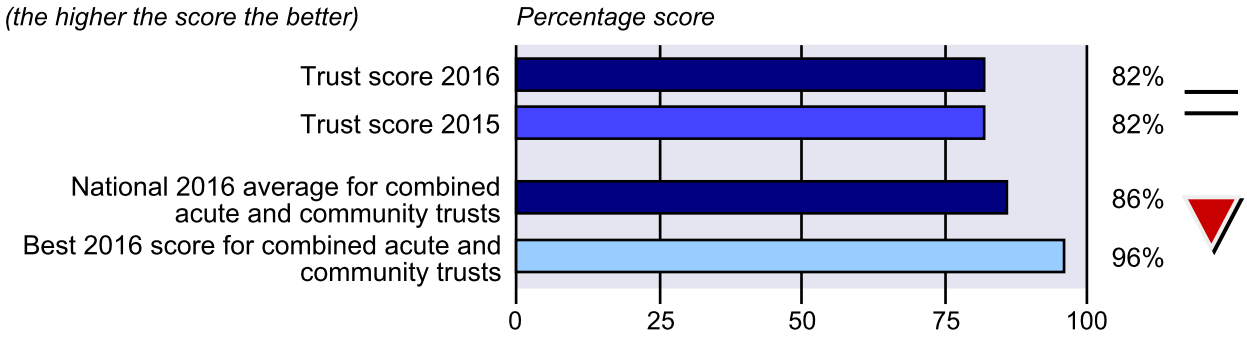
This section presents each of the 32 Key Findings, using data from the trust's 2016 survey, and compares these to other combined acute and community trusts in England and to the trust's performance in the 2015 survey. The findings are arranged under seven headings – the four staff pledges from the NHS 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 2015). 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 2015). An equals sign indicates that there has been no change.

Appraisals & support for development

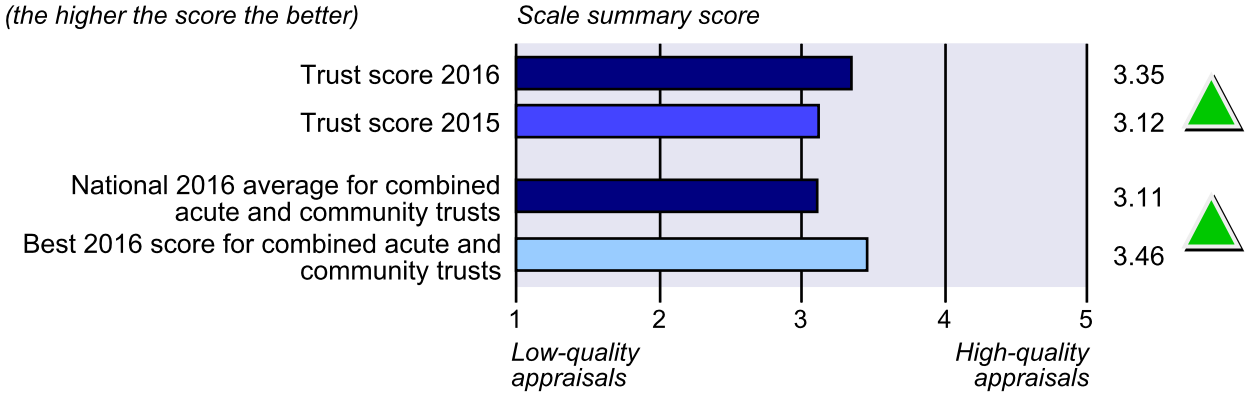
KEY FINDING 11. Percentage of staff appraised in last 12 months

(the higher the score the better)



KEY FINDING 12. Quality of appraisals

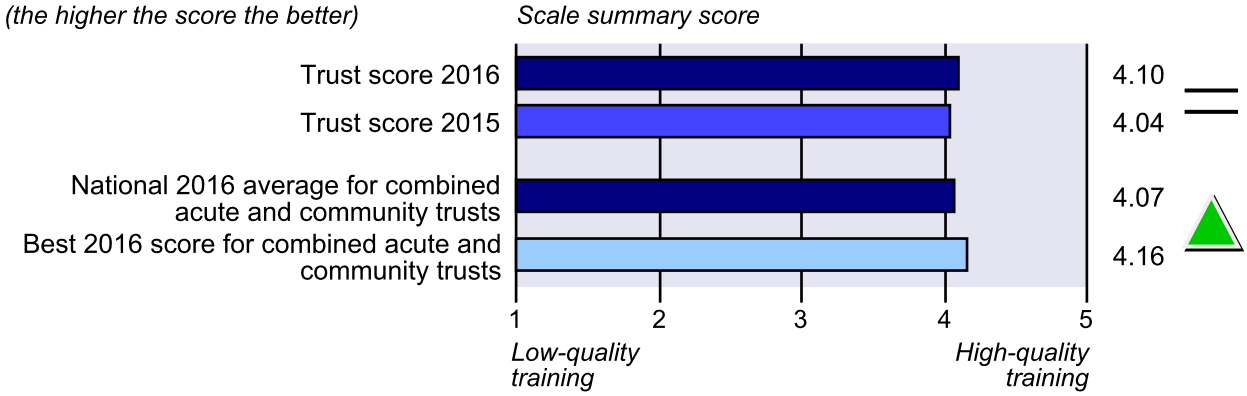
(the higher the score the better)



[1]At the time of sampling, 4065 staff were eligible to receive the survey. Questionnaires were sent to a random sample of 1240 staff. 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 13. Quality of non-mandatory training, learning or development

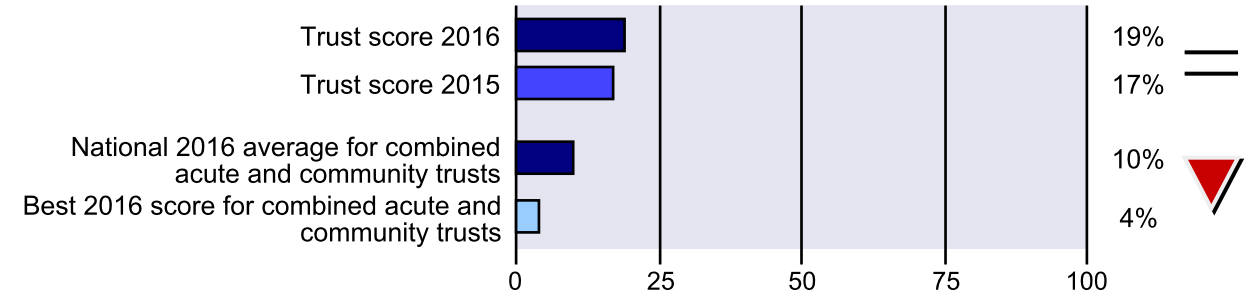
(the higher the score the better)



Equality & diversity

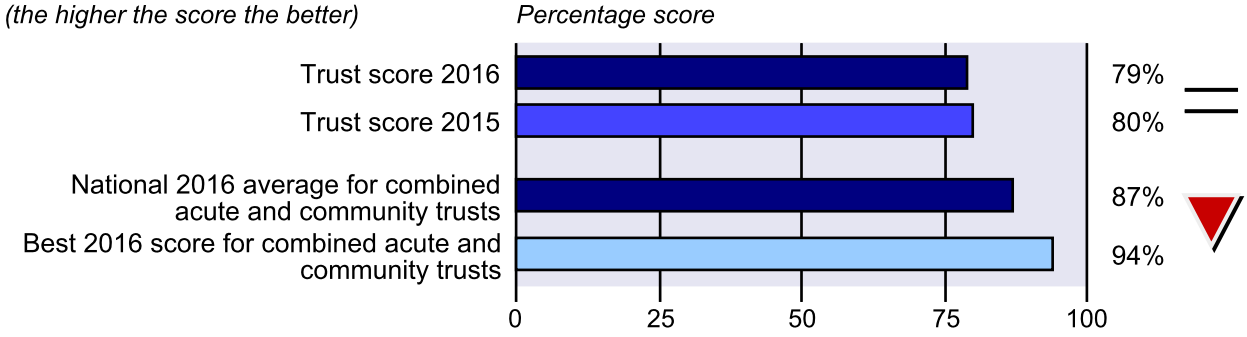
KEY FINDING 20. Percentage of staff experiencing discrimination at work in the last 12 months

(the lower the score the better)



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

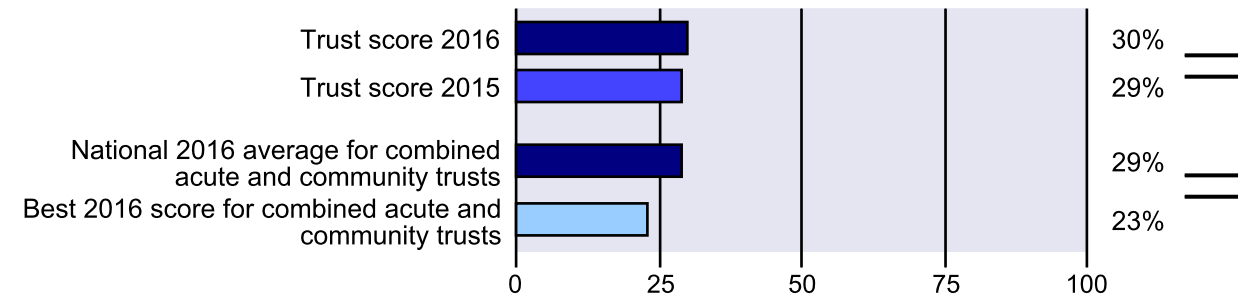
(the higher the score the better)



Errors & incidents

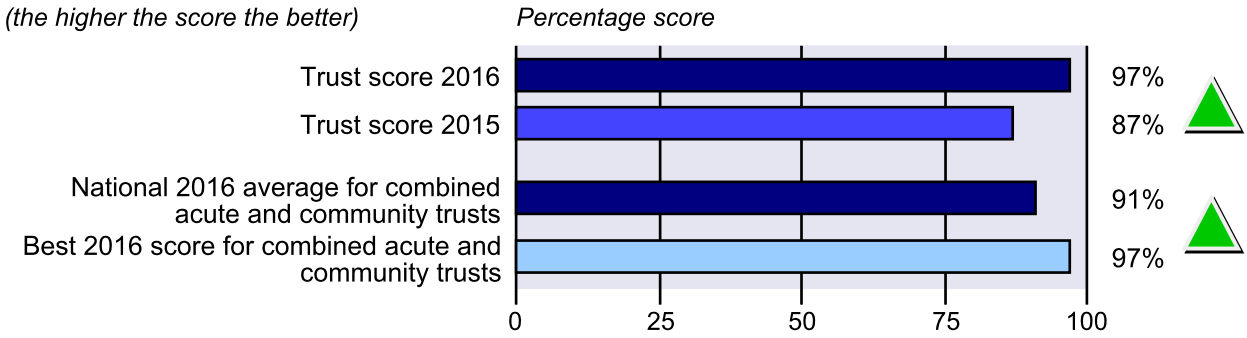
KEY FINDING 28. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month

(the lower the score the better)



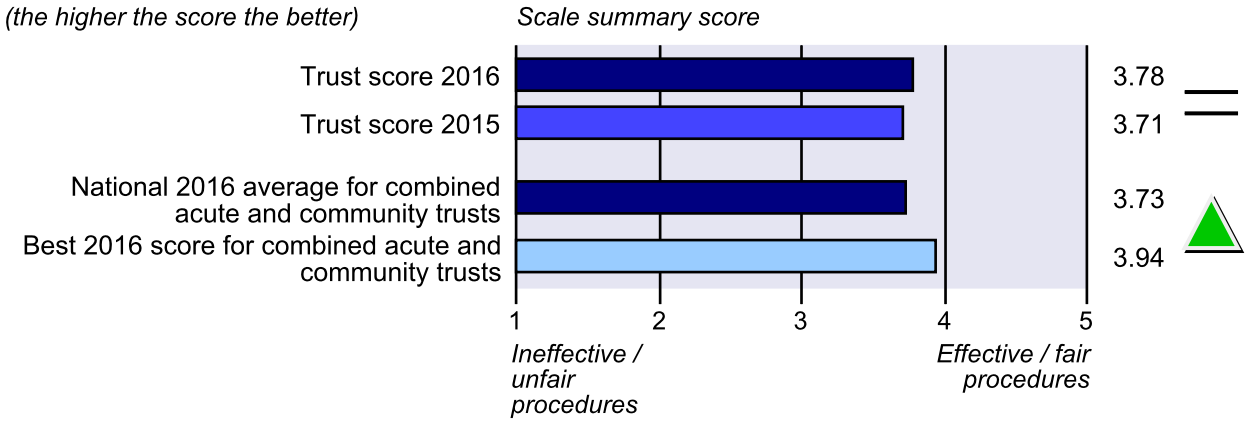
KEY FINDING 29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month

(the higher the score the better)



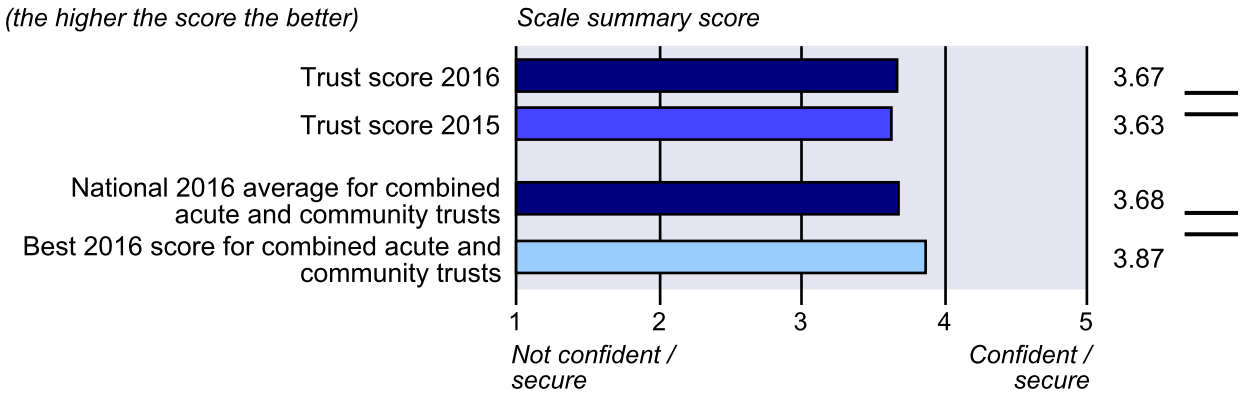
KEY FINDING 30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents

(the higher the score the better)



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

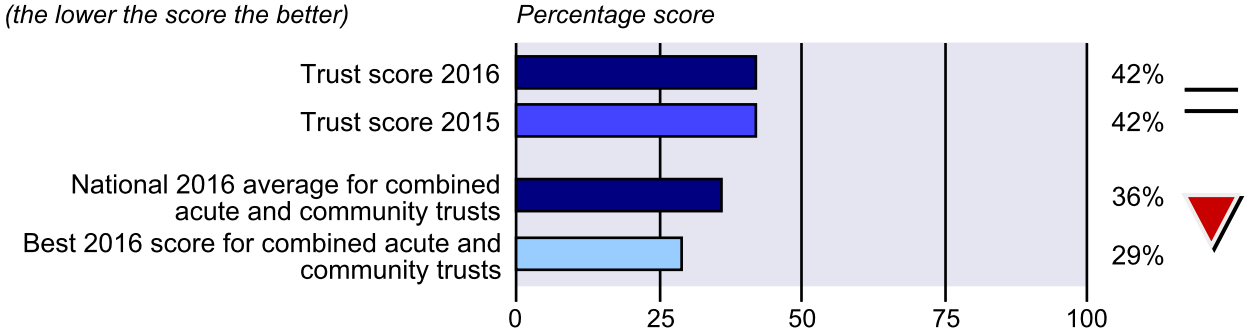
(the higher the score the better)



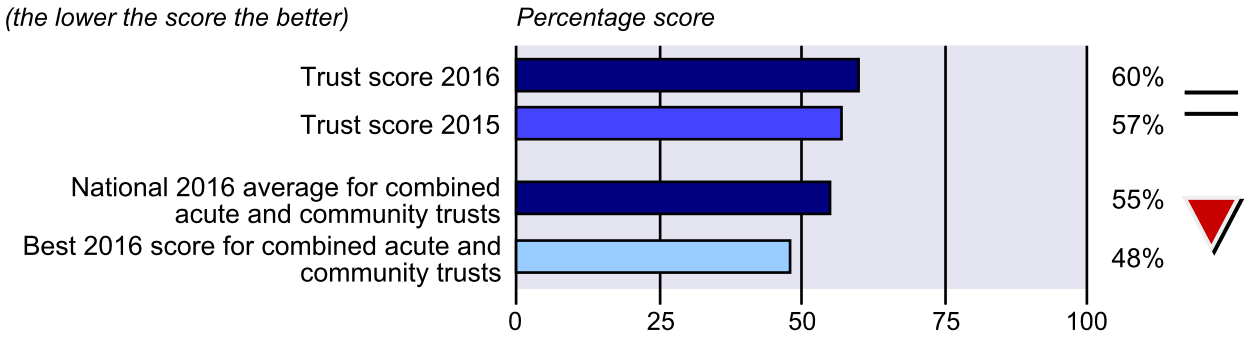
Health and wellbeing

KEY FINDING 17. Percentage of staff feeling unwell due to work related stress in the last 12 months

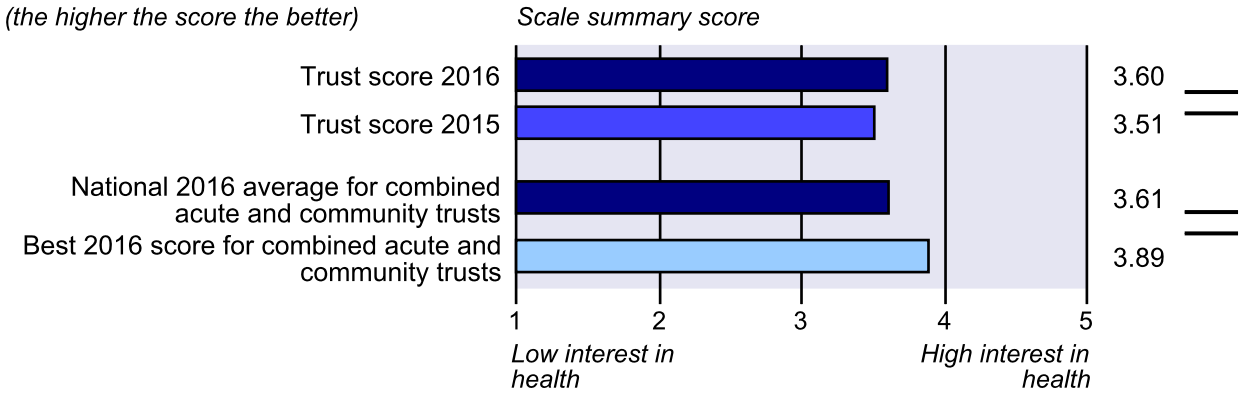
(the lower the score the better)



KEY FINDING 18. Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves

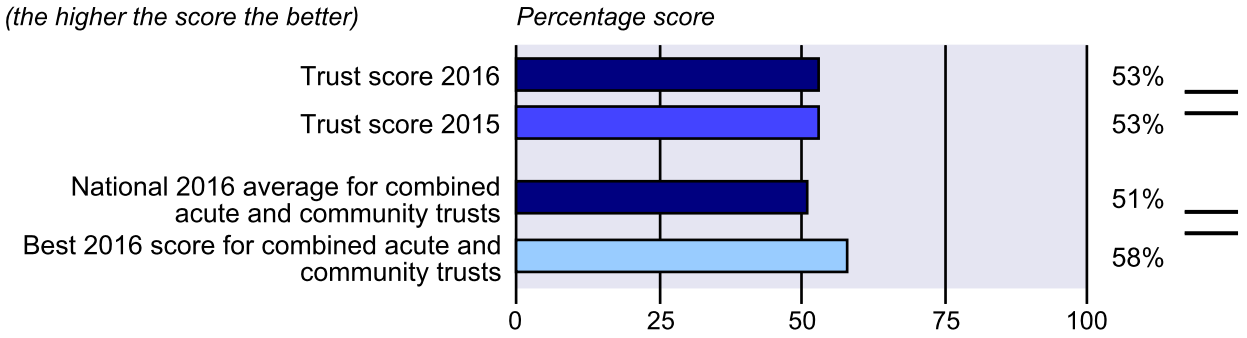


KEY FINDING 19. Organisation and management interest in and action on health and wellbeing

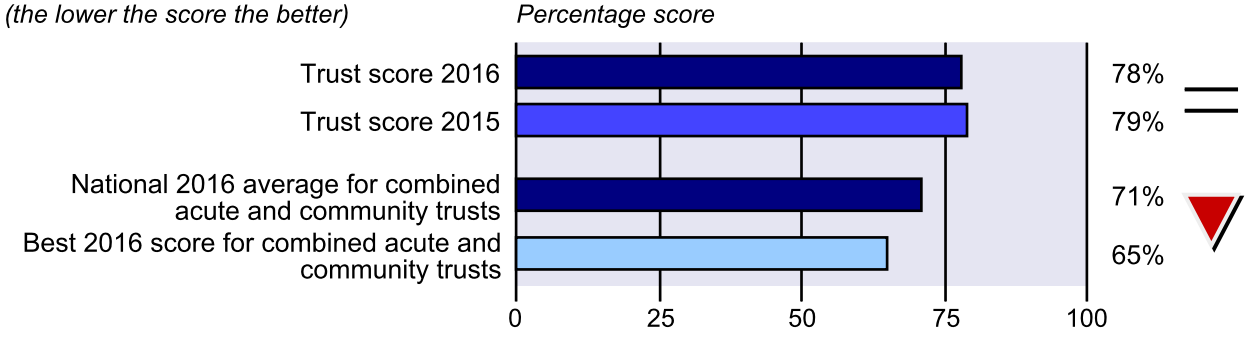


Working patterns

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



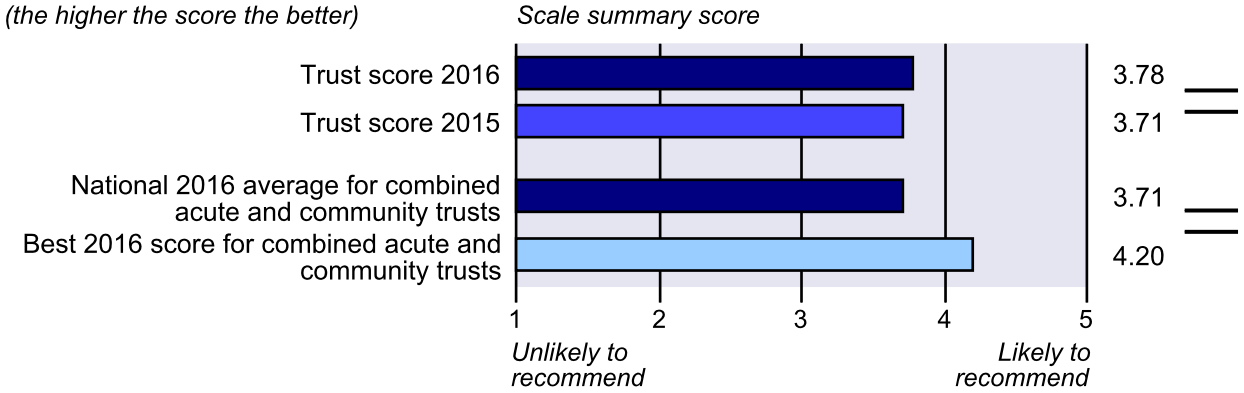
KEY FINDING 16. Percentage of staff working extra hours



Job satisfaction

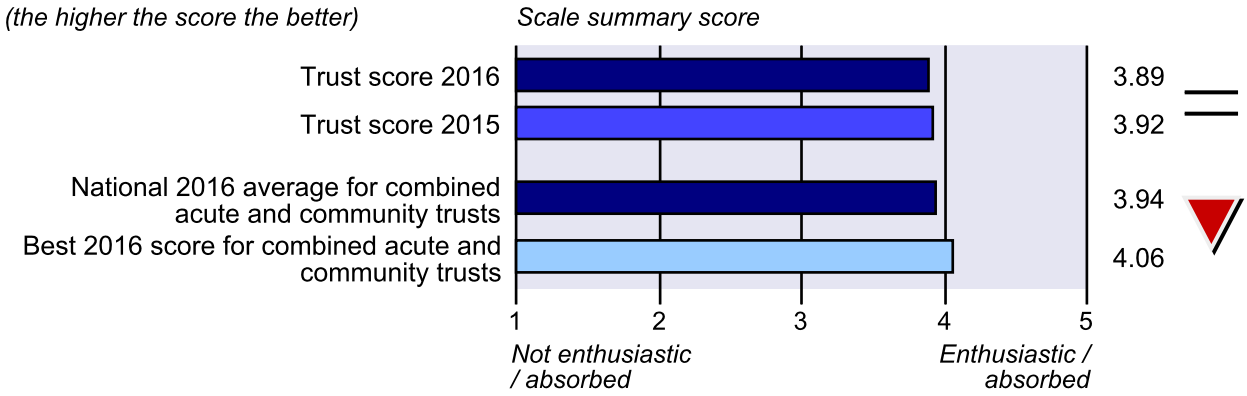
KEY FINDING 1. Staff recommendation of the organisation as a place to work or receive treatment

(the higher the score the better)



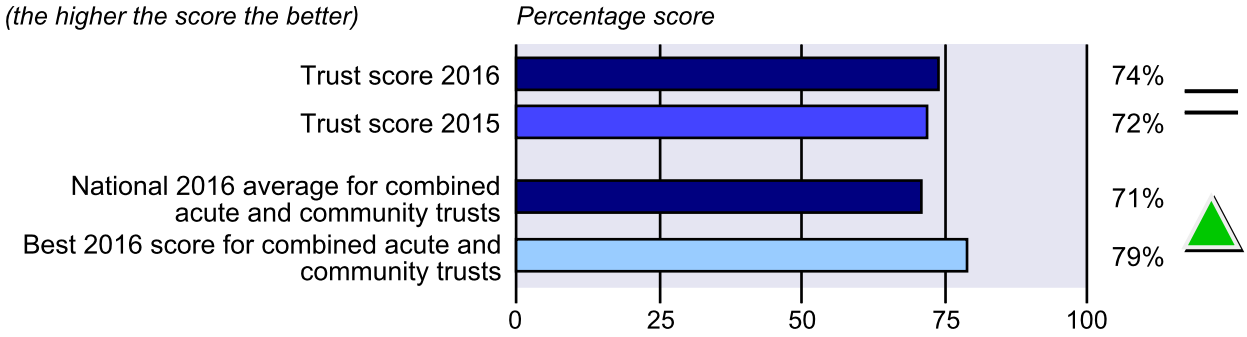
KEY FINDING 4. Staff motivation at work

(the higher the score the better)



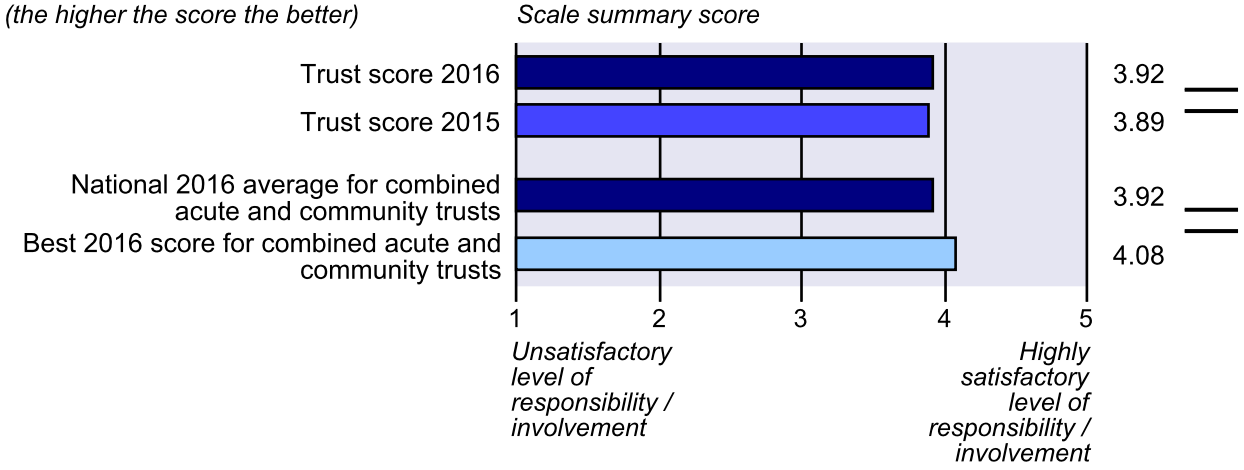
KEY FINDING 7. Percentage of staff able to contribute towards improvements at work

(the higher the score the better)



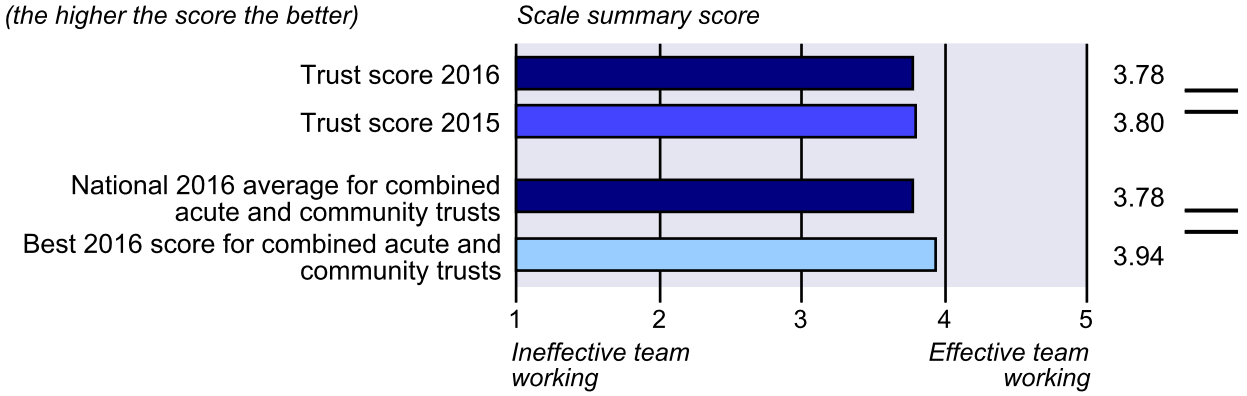
KEY FINDING 8. Staff satisfaction with level of responsibility and involvement

(the higher the score the better)



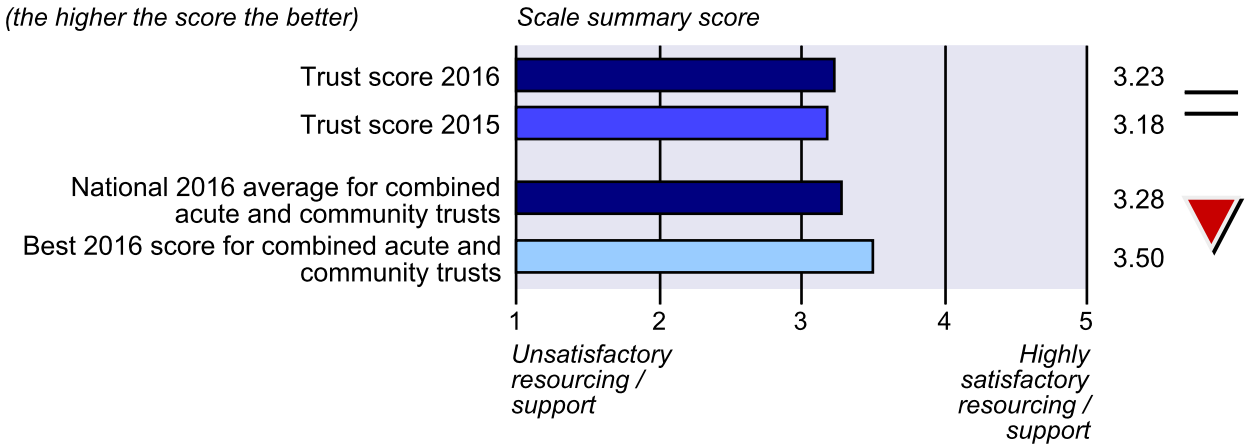
KEY FINDING 9. Effective team working

(the higher the score the better)



KEY FINDING 14. Staff satisfaction with resourcing and support

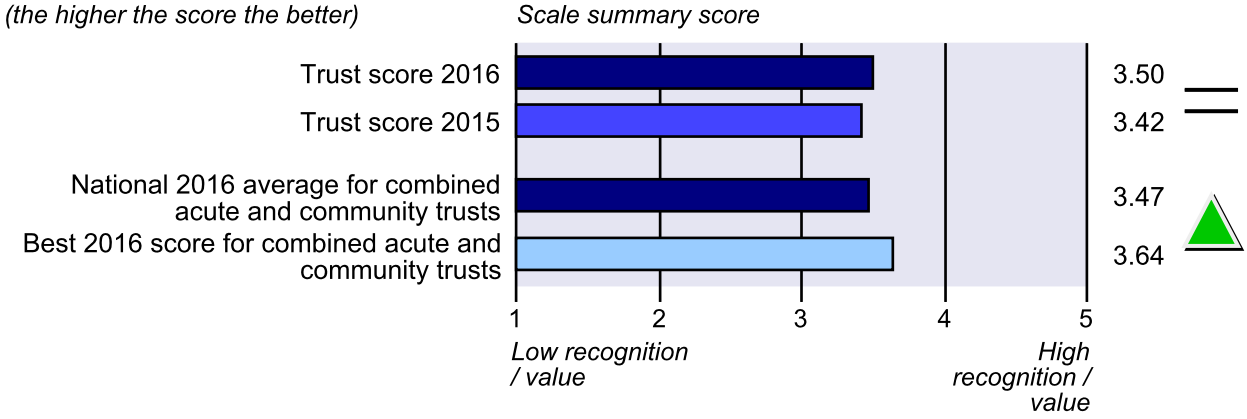
(the higher the score the better)



Managers

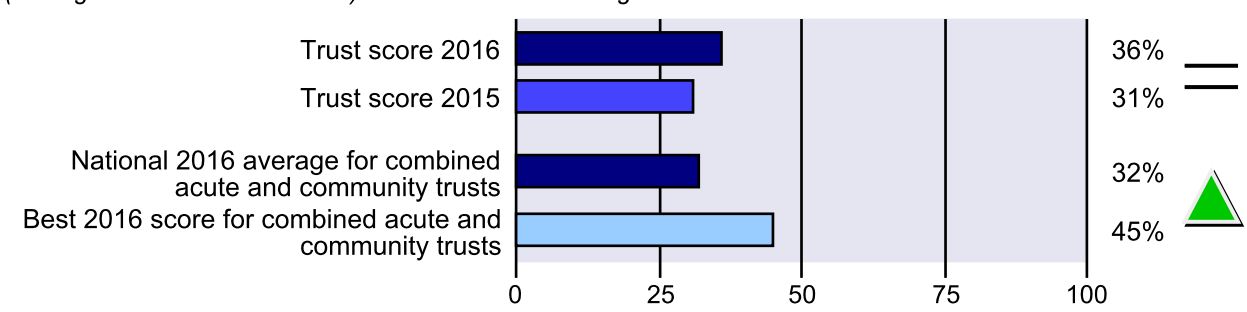
KEY FINDING 5. Recognition and value of staff by managers and the organisation

(the higher the score the better)



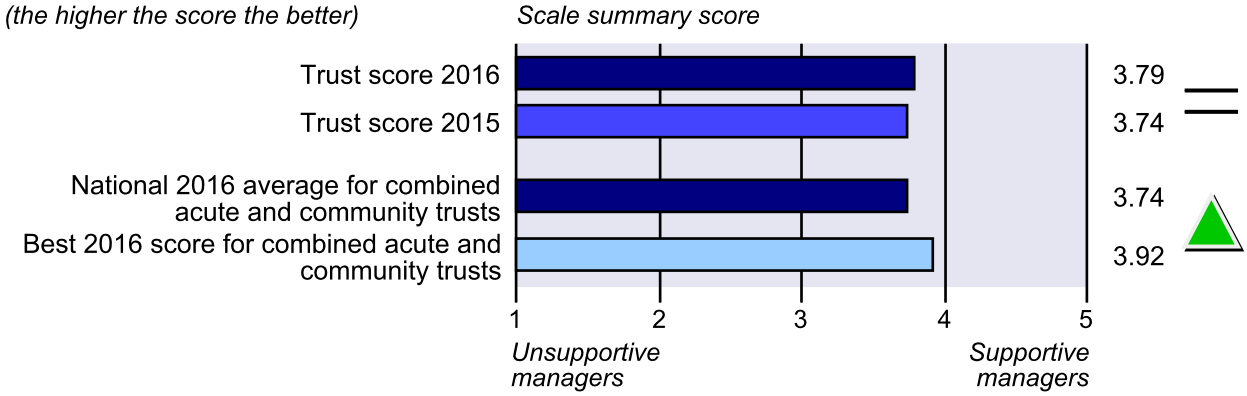
KEY FINDING 6. Percentage of staff reporting good communication between senior management and staff

(the higher the score the better)



KEY FINDING 10. Support from immediate managers

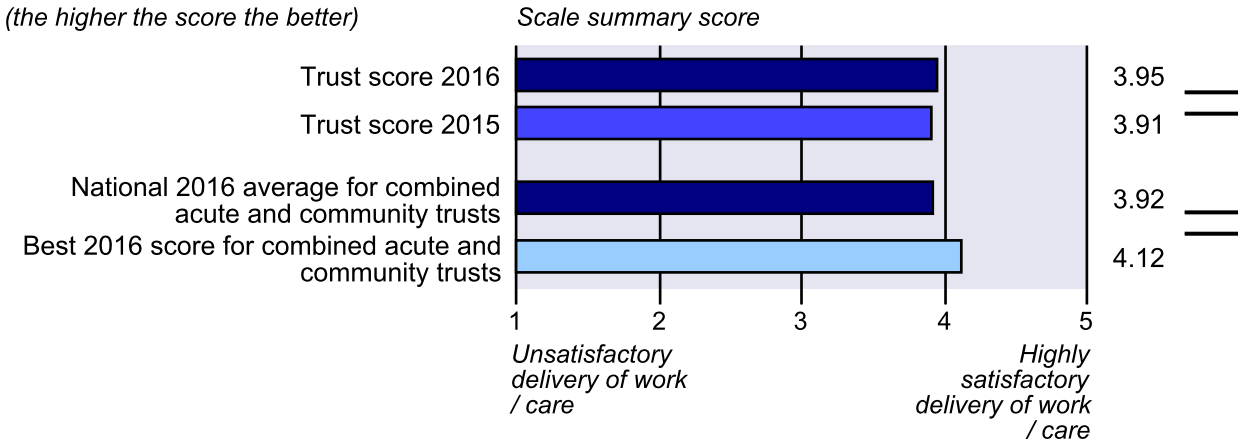
(the higher the score the better)



Patient care & experience

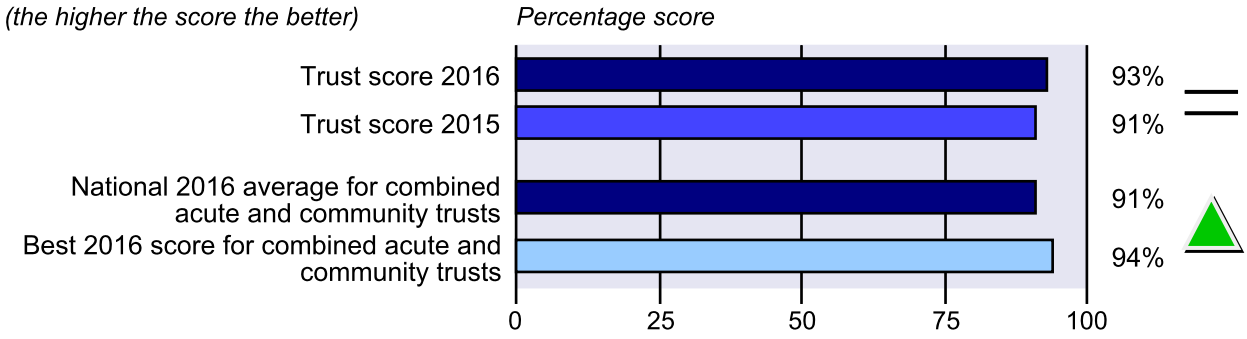
KEY FINDING 2. Staff satisfaction with the quality of work and care they are able to deliver

(the higher the score the better)



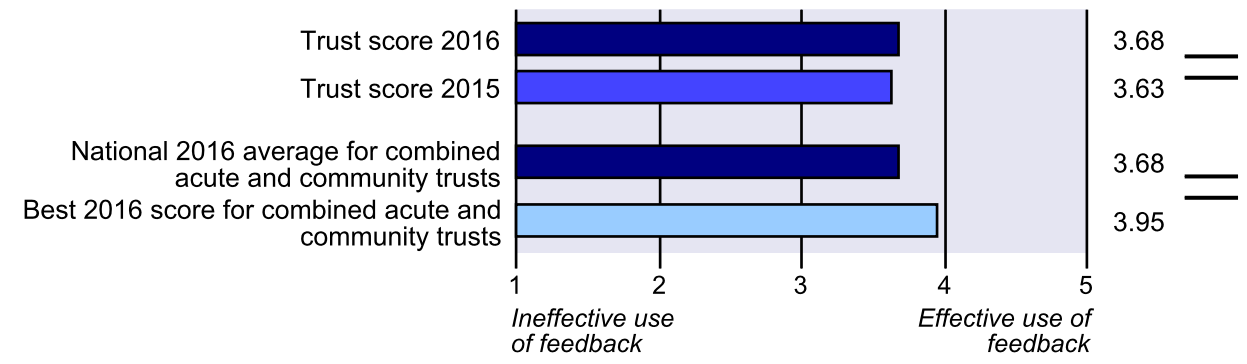
KEY FINDING 3. Percentage of staff agreeing that their role makes a difference to patients / service users

(the higher the score the better)



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

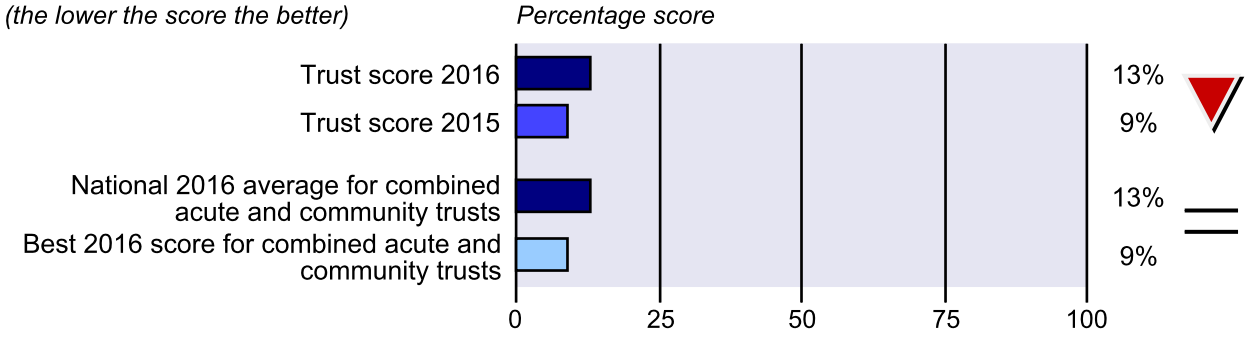
(the higher the score the better)



Violence, harassment & bullying

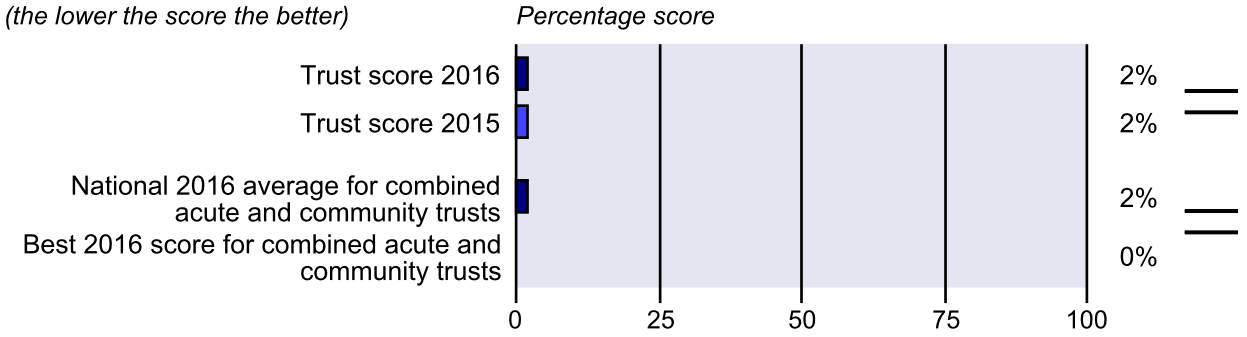
KEY FINDING 22. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months

(the lower the score the better)



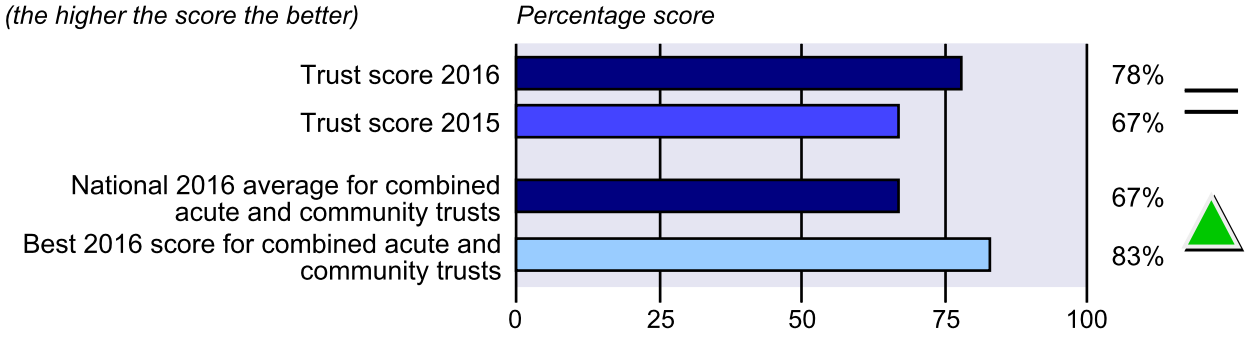
KEY FINDING 23. Percentage of staff experiencing physical violence from staff in last 12 months

(the lower the score the better)



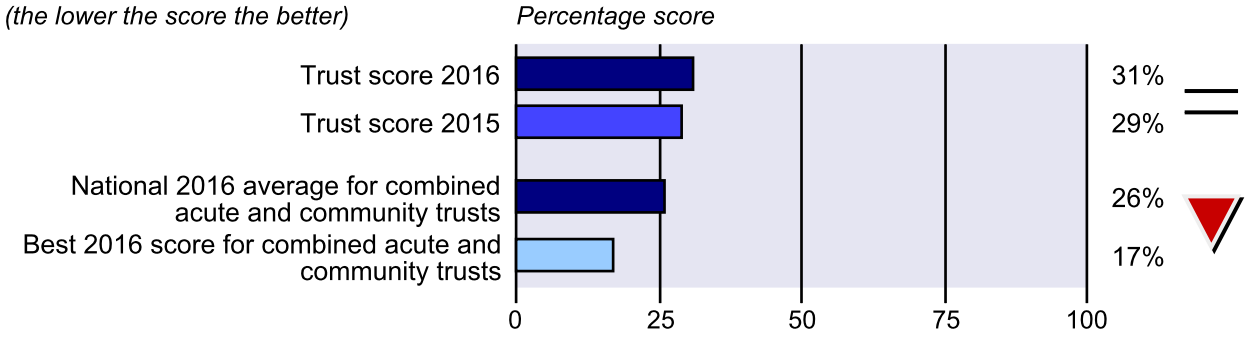
KEY FINDING 24. Percentage of staff / colleagues reporting most recent experience of violence

(the higher the score the better)



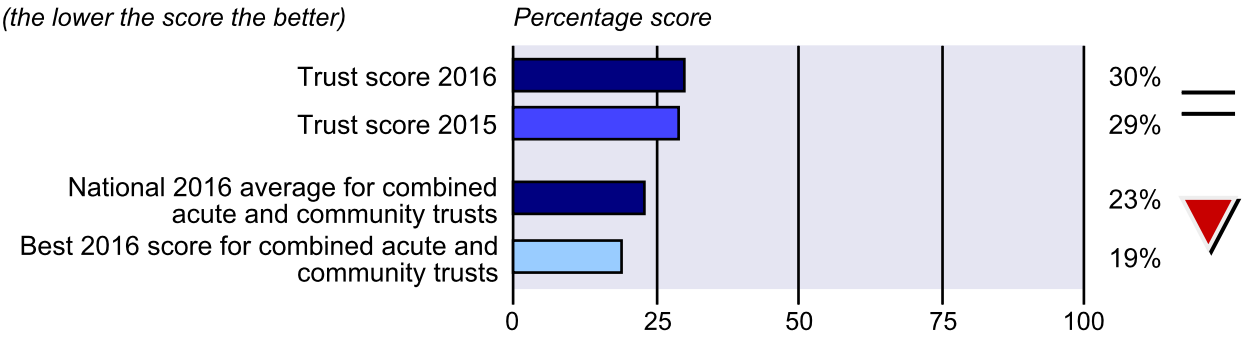
KEY FINDING 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

(the lower the score the better)



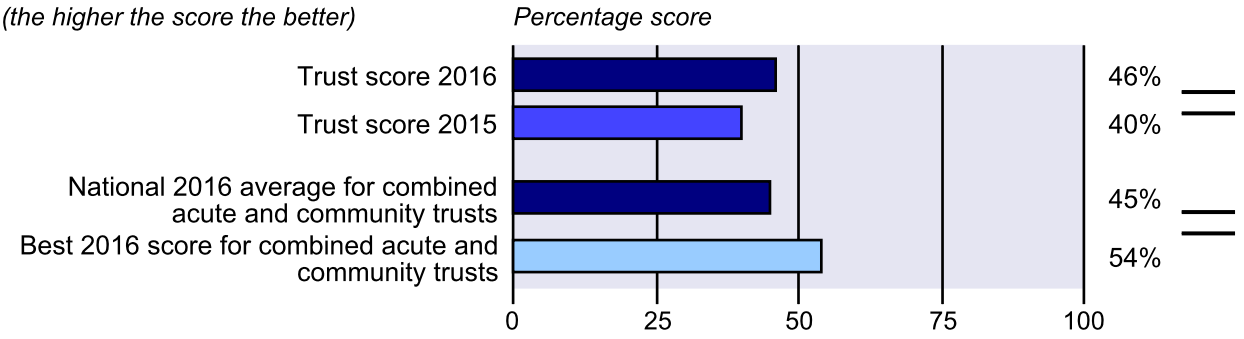
KEY FINDING 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

(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)



Whittington Health NHS

The Whittington Hospital NHS Trust
Magdala Avenue
London N19 5NF

Whittington Health Trust Board

5 April 2017

Title:	**Changes to Standing Orders, Standing Financial Instructions and the Scheme of Delegation**		
Agenda item:	17/054	**Paper**	11
Action requested:	For Decision		
Executive Summary:	This paper was presented to Audit Committee in March, and summarises changes made to the Trust's Integrated Governance paper (comprising Standing Orders, Standing Financial Instructions and the Scheme of Delegation) as part of the 2016/17 annual update. Principal changes include increasing the level of requisition sign-off for Directors from £50,000 to £100,000; and increasing the threshold of expenditure where one quote is needed from £5,000 to £10,000.		
Summary of recommendations:	The Board is asked to approve the revised Standing Orders, Standing Financial Instructions and Scheme of Delegation.		
Fit with WH strategy:	Delivering efficient, affordable and effective services. Meeting statutory duties.		
Reference to related / other documents:			
Reference to areas of risk and corporate risks on the Board Assurance Framework:	BAF6: Failure to maintain liquidity and a sufficient level of working capital.		
Date paper completed:	27 March 2017		

Author name and title:	**Jonathan Ware Head of Financial Services**			**Director name and title:**		**Stephen Bloomer Chief Finance Officer**	
Date paper seen by EC		**Equality Impact Assessment complete?**		**Risk assessment undertaken?**		**Legal advice received?**	

Changes to Standing Orders, Standing Financial Instructions and the Scheme of Delegation

1. Background

1.1 The Trust reviews its governance documentation being Standing Financial Instructions (SFI) and Scheme of Delegation (SD) annually and reports any proposed changes to the Audit and Risk Committee.

1.2 If appropriate the Audit and Risk Committee then recommends them to the Trust Board for adoption.

2. Detail

2.1 The Trust has undertaken its annual review of the current SFIs and scheme of delegation. As part of the process it has benchmarked the scheme of delegation and contracting rules with other NHS Trusts.

2.2 The revised governance documentation was presented at the Audit and Risk Committee on 2nd March 2017. The Committee is recommending the adoption of the revised SFIs and Scheme of Delegation to the Trust Board.

2.3 The following changes to governance documentation are proposed as a result of this process:

- in the scheme of delegation (end of section C, page 57), increasing the level of director sign off of expenditure from £50,000 to £100,000, to ensure that there are no blockages in the authorisation flow, and that there is an appropriate sign off level for Board level Directors;
- in the Standing Financial Instructions (page 69), increasing the expenditure level at which a quote is required from £5,000 to £10,000. The original level of £5,000 was set a number of years ago, is now felt to be too low and is creating an unnecessary administrative burden for little financial benefit. It will therefore increase efficiency in the procurement process and bring the Trust into line with other Trusts using UCLPPS procurement arrangements; and
- ensuring that titles, roles and responsibilities are internally consistent throughout the document.

2.4 The Trust reviewed the NHS England guidance, 'Managing Declarations of Conflicts of Interests' and made some minor changes to the sections on reporting declarations and gifts. These changes are effective from 1 June 2017.

3. Recommendation

3.1 The Trust Board is asked to approve the revised governance documentation.

Whittington Health NHS

Whittington Health

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

- 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
- Review/Updated February 2017

UCL MEDICAL SCHOOL

Helping local people live longer healthier lives

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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 Whittington Health.

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 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). In 2017, the Trust's name became Whittington Health.

(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 Improvement);

(2) Up to 7 non-executive members (6 appointed by the NHS Improvement and one a UCL nominated NED);

(3) Up to 6 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 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 Improvement 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.

2.6 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.

~~a)~~ **2.7 Schedule of Matters reserved to the Board and Scheme of Delegation**

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(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.

2.8 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. Additional papers are at the Chair's discretion.

(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 the minutes and 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 (Mem-

bership, 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. 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;

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

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

~~f)~~g) Interests in pooled funds that are under separate management

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

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(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 (and in any event within 28 days).

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 –

~~1.~~(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.

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(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 Whittington Health ("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 :

~~i)~~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).

~~ii)~~2. The Seven Principles of Public Life as set out by the Nolan Committee and which apply to everyone who works in public services

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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.

~~1.~~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.

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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 that may affect, or be seen to affect, their professional judgement. Gifts from suppliers or contractors doing business (or likely to do business) with the Trust should be declined regardless of value. Low cost branded promotional aids to the value of £6 may be accepted.

(2) Gifts up to the value of £50 from other sources, such as patients, patients' relatives or carers can be accepted, but their senior officer must be informed and a record made. 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.

(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*** ~~15.~~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. ~~16.~~2. Suspend Standing Orders. ~~17.~~3. Vary or amend the SOs. ~~18.~~4. Ratify any urgent decisions taken by the Chairman and Chief Executive in public session in accordance with SO 5.2 ~~19.~~5. Approve a scheme of delegation of powers from the Board to committees**.** ~~20.~~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. ~~21.~~7. Require and receive the declaration of officers' interests that may conflict with those of the Trust. ~~22.~~8. Approve arrangements for dealing with complaints. ~~23.~~9. Adopt the organisation structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications thereto. ~~24.~~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. ~~25.~~11. Confirm the recommendations of the Trust's committees where the committees do not have executive powers. ~~26.~~12. Approve arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust. ~~27.~~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 1. Ratify or otherwise instances of failure to comply with SOs brought to the Chief Executive's attention in accordance with SO 5.6. ~~1.~~2. Discipline members of the Board or employees who are in breach of statutory requirements or SOs.

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REF	THE BOARD	DECISIONS RESERVED TO THE BOARD
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. 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]

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REF	THE BOARD	DECISIONS RESERVED TO THE BOARD
	THE BOARD	**Audit** ~~2.~~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. ~~3.~~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. ~~1.~~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. ~~2.~~3. Receive reports from CFO on financial performance against budget.

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DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES

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

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REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
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 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

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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 (CFO)	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:* ~~1.~~ "have a clear view of their objectives and the means to assess achievements in relation to those objectives ~~2.~~ be assigned well defined responsibilities for making best use of resources ~~3.~~ 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	CHIEF FINANCE OFFICER	Operational responsibility for effective and sound financial management and information.
15	CHIEF EXECUTIVE	Primary duty to see that CFO discharges this function.
16	CHIEF EXECUTIVE	Ensuring that expenditure by the Trust complies with Parliamentary requirements.

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REF	DELEGATED TO	DUTIES DELEGATED
18	CE and CFO	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.

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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; ~~1.~~3. to appoint, appraise and remunerate senior executives; ~~2.~~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; ~~3.~~5. to oversee the delivery of planned results by monitoring performance against objectives and ensuring corrective action is taken when necessary; ~~3~~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.

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REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
1.3.24	BOARD	It is the Board's duty to: 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.
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.

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REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
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.

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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.

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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.

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* 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: ~~a)~~1. Implementing the Trust's financial policies and co-ordinating corrective action; ~~b)~~2. Maintaining an effective system of financial control including ensuring detailed financial procedures and systems are prepared and documented; ~~c)~~3. Ensuring that sufficient records are maintained to explain Trust's transactions and financial position; ~~d)~~4. Providing financial advice to members of Board and staff; ~~e)~~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.
11.1.1	AUDIT COMMITTEE	Provide independent and objective view on internal control and probity.

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SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
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)~~ 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 & 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.
13.4.1	CHIEF FINANCE	Devise and maintain systems of budgetary control.

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SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
	OFFICER	
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 CFO 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.

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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.

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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.

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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; g) Be responsible for ensuring that payment for goods and services is only made once the goods and services are received

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SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
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 CFO 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 CFO 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 CFO.)
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

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SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
24.1.1 & 2	CHIEF EXECUTIVE	Capital investment programme: 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 CFO).
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.
24.4.2	CHIEF FINANCE	Approval of fixed asset control procedures.

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SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
	OFFICER	
24.4.4	BOARD, EXECUTIVE MEMBERS AND ALL SENIOR STAFF	Responsibility for security of Trust assets including notifying discrepancies to CFO, and reporting losses in accordance with Trust procedure.
25.2	CHIEF EXECUTIVE	Delegate overall responsibility for control of stores (subject to CFO 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 CFO 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.

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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 CFO.
26.2.2	CHIEF FINANCE OFFICER	Where a criminal offence is suspected, CFO must inform the police if theft or arson is involved. In cases of fraud and corruption CFO 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 CFO.

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SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
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.
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) CFO 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.

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SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
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 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.

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

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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£100,000	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) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money);

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

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

13.2~~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.

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

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.

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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 within the Public Sector Audit Appointments (PSAA) regime~~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 minimis~~z~~e 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 level 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:

~~(a)~~ the supply of goods, materials and manufactured articles;

~~(b)~~ 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);

~~(c)~~ For the design, construction and maintenance of building and engineering

~~(d)~~ works (including construction and maintenance of grounds and gardens); for disposals.

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THRESHOLDS	
Supplies & Services	
1 quote	1 quote minimum up to £10,000
3 quotes	3 quotes minimum £10,001 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:

~~I.~~(a) the estimated expenditure or income does not, or is not reasonably expected to, exceed **£50,000**;

~~II.~~(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:

~~1.~~I. award direct;
~~2.~~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

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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

~~i.~~1. General Position on quotations

One quotation is required for the initial purchase of items expected to cost up to £10~~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 £10~~5~~,000 but not exceed £50,000.

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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.

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(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 predetermined 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)

~~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.

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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:

~~(a)~~ the standards of service quality expected

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~~(b)~~ the relevant national service framework (if any)

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~~(c)~~ the provision of reliable information on cost and volume of services

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~~(d)~~ the NHS National Performance Assessment Framework

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~~(e)~~ that SLAs build where appropriate on existing Joint Investment Plans

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~~(f)~~ that SLAs are based on integrated care pathways

~~(g)~~ Acceptable levels of risk and performance metrics/non-mandatory penalties

~~(h)~~ The need to maintain adequate cash flow arrangements for the Trust

~~1.~~ that SLAs reflect the advent of the patient–led NHS and practice-based commissioning

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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 en-

sure 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:

~~1.~~(a) verification and documentation of data;

~~2.~~(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:

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(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~~

~~(i)~~**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;

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(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 pre-payment contract are received and they must immediately inform the appropriate Director or Chief Executive if problems are encountered.

21.2.5

~~i.~~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;

~~(1)~~(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;

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(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:

~~(1)~~(i) an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs;

~~(1)~~(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.

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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;

~~(1)~~(c) in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

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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.

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(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.

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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.

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(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.

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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).

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(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.

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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:

- ~~(1)~~ Do you work set hours, or a given number of hours a week or a month?
- ~~(2)~~ Do you have to do the work yourself rather than hire someone else to do the work?
- ~~(3)~~ Can someone tell you at any time what to do, when to do it and how to do it?
- ~~(4)~~ Are you paid by the hour, week or month?

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(5) Do you work at the premises of the person you work for, or at a place or places that they decide?

(6) 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.

(1) Are they hired to undertake a specific project for a finite duration?

(2) Do they decide how, when and where to carry out your services?

(3) Can they make a loss on the contract?

(4) Do they provide the main items of equipment they need to do the job for the Trust?

(5) 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?

(6) Do they have to correct unsatisfactory work in their own time and their own expense?

(7) Do you have a number of customers at the same time?

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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;

~~1.~~a) audit arrangements including; Internal Audit, clinical audit, health and safety review;

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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.~~(1) Trust's may enter commercial arrangements for **insuring motor vehicles** owned by the Trust including insuring third party liability arising from their use;

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~~2.~~(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

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~~3.~~(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.

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33.4 Arrangements to be followed by the Board in agreeing Insurance cover

~~1.~~(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.

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~~2.~~(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

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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.

Executive Offices
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The Whittington Hospital NHS Trust
Magdala Avenue
London N19 5NF

Whittington Health Trust Board

5 April 2017

Title:	Register of Deed of Execution and Seal		
Agenda item:	**17/054**	**Paper**	**12**
Action requested:	Approval for the latest Register of Deed of Execution and Seal		
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 2016 to 31 March 2017		
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 the Trust SOs, SFOs and governance framework		
Reference to related / other documents:	Aligns to the Trust public body statutory requirements and duties		
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:	27 March 2017		

Author name and title:		**Lynne Spencer, Director of Communications and Corporate Affairs**		**Director name and title:**		**Simon Pleydell, Chief Executive**	
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**

Register of Deed of Execution 1 April 2016 to 31 March 2017

Reference	Details	Date
17/01	Community Health Partnerships Limited Under Lease for part of • Kentish town Health Centre NW5 2BX • Bingfield Street PCT • Camden & Islington LIFT underlease for part of Partnership Primary Care Centre • Barnet Enfield and Haringey NHS LIFT underlease for part of Forest Road Health Centre	03.06.16
17/02	Community Health Partnerships Limited Camden & Islington LIFT underlease for part of Hanley Road PCT	06.06.16
17/03	Telcoms Mast Lease – Block K Roof Top Lease	05.07.16
17/04	WH and EE Ltd and Hutchinson 3G UK Agreement to Surrender	05.07.16
17/05	WH and EE Ltd and Hutchinson Waterlow Unit Highgate Hill Deed of surrender	05.07.16
17/06	Unit 1, Whittington Court (Muffin Break) lease	03.08.16
17/07	Unit 3, Whittington Court Lease	04.08.16
17/08	Licence to underlet Forest Road health Centre – ULPA Programme Fund Co consent to CHP granting UCPA to the Trust	24.08.16
17/09	Lease and Deed of Covenant NHS Property Services Ltd relating to Dentist Surgery Ordnance Unity Centre Dental Practice Hertford Road Enfield	04.10.16
17/10	Lease of Premises Hornsey Central Neighbourhood Centre 151 Park Road Hornsey N8 8JD	26.10.16
17/11	St Ann's Hospital SLA re Whittington Occupancy	04.11.16
17/12	Lease renewal units 1,2 &3 Compass Contract Services (UK) Limited FoodCo UK LLP T/A Muffin Break XlNT (Health) Limited	16.01.17
17/13	Deed of variation relating to premises at the Waterlow Unit WH and EE Limited and Hutchison 3G UK Limited	18.01.17
17/14	Contract with LBH/School Nursing Service	09.02.17
17/15	Deed of Variation WH & EE Limited and Hutchison 3G UK Limited	01.02.17
17/16	Nursing Service Contract for Haringey	02.02.17
17/17	Community Health Partnerships Limited with WH – Barnet Enfield and Haringey NHS LIFT – underlease for part of Lordship Lane Health Centre	10.03.17
17/18	1. Forest Vale Fundco Limited 2.Community Health Partnerships Limited 3. Whittington Health Licence to underlet part of Lordship Lane Health Centre	10.03.17

Whittington Health NHS

Board Draft Forward Plan of Business 2017/18 *Version 1* Trust Board - Lynne Spencer, Director of Communications/Corporate Affairs

5th APRIL 2017	3rd MAY 2017	7th JUNE 2017	5th JULY 2017	6th SEPT 2017 & AGM	4th OCTOBER 2017	1st NOVEMBER 2017	6th DECEMBER 2017	3rd JANUARY 2018	7th FEBRUARY 2018	7th MARCH 2018
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
NCL STP updates in Chief Executive report monthly	NCL STP updates in Chief Executive report monthly	NCL STP updates in Chief Executive report monthly	NCL STP updates in Chief Executive report monthly	NCL STP updates in Chief Executive report monthly	NCL STP updates in Chief Executive report monthly	NCL STP updates in Chief Executive report monthly	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)
Wellbeing Programme Islington and Haringey updates in Chief Executive report monthly	5 Yr Capital Programme & Investment Plan update	Strategic Estates Partnership	5 Yr Capital Programme & Investment Plan update		5 Yr Capital Programme & Investment Plan update	Cancer Strategy			5 Yr Capital Programme & Investment Plan update	
Budget Setting 2017/18	Corporate Objectives 2017/18									
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 16/17 and Action Plan 17/18					NHS Staff Survey 16/17 Action Plan update					
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
Medical Director Safer Staffing Report	Medical Director Safer Staffing Report	Medical Director Safer Staffing Report	Medical Director Safer Staffing Report	Medical Director Safer Staffing Report	Medical Director Safer Staffing Report	Medical Director Safer Staffing Report	Medical Director Safer Staffing	Medical Director Safer Staffing	Medical Director Safer Staffing	Medical Director Safer Staffing
	Quality Account 2016-17 (Draft)	Patient Experience (complaints, friends and family test) Annual Report 16/18	H&S (inc fire) Annual Report TBC	Clinical Audit and Effectiveness Annual Report 2016/17 - TBC, Annual report goes to Quality Committee, could be incorporated into MD Q&S report	Safeguarding Adults Annual Report & Safeguarding Children's Annual Report	Mid Year Review of Internal and External Audit		Medical Director Learning from Deaths Q3 Report (new requirement)		Quality Account priorities 2017/18
	Quarterly Quality and Patient Safety Report (Medical Director) (Q4)	Education and Training Annual Report	Medical Director Learning from Deaths Q1 Report (new requirement)	Research and Development Annual Report	Medical Director Learning from Deaths Q2 Report (new requirement)			Quarterly Quality and Patient Safety Report (Medical Director) including Quality Account and Sign up to Safety updates (Q3)		
			Q3 Quality and Patient Safety Report (Medical Director) including Quality Account and Sign up to Safety updates (Q1)		Q2 Quality and Patient Safety Report (Medical Director) including Quality Account and Sign up to Safety updates (Q2)					
Governance	**Governance**	**Governance**	**Governance**	**Governance**	**Governance**	**Governance**	**Governance**	**Governance**	**Governance**	**Governance**
16/17 Seal / Deed Execution - authorised users	Annual refresh of CommitteeTerms of Reference	Annual Governance Statement 16/17	Report on Director's Fit and Proper Person's req'rmts	Section 75 Agreements Update - is this a requirement, did not come in 2016/17	Environmental & Sustainability Annual Report		Board Assurance Framework	Charitable Funds Annual Report 16/17	17/18 budgets to approve	Board Assurance Framework
Annual Refresh SO's, SFI's, Scheme of Delegation	Heatwave Plan 17/18	Annual Accounts/AGS/AR/ Quality Account 16/17	IG Toolkit Compliance Review	Equality and Diversity Annual Report	Winter plan 2017/18		Corporate Risk Register			Corporate Risk Register
		External Audit Letter 16/17	Annual medical appraisal and revalidation annual report 2016/17							Business Conduct and Code of Conduct for Boards & Senior Staff & Register of Board and Senior Manager Interests
		Head of Internal Audit Opinion 16/17	Nursing and midwifery revalidation report 2016/17							IG Toolkit submission & Caldicott
		Board Assurance Framework								Final budget 2017/18
		Corporate Risk Register								
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**
			Updates as required eg comercially sensitive reports	Updates as required eg comercially sensitive reports	Updates as required eg comercially sensitive reports	Updates as required eg comercially sensitive reports	Updates as required eg comercially sensitive reports	Updates as required eg comercially sensitive reports	Updates as required eg comercially sensitive reports	Updates as required eg comercially sensitive reports
Reputation Issues	**Reputation Issues**	**Reputation Issues**	**Reputation Issues**	**Reputation Issues**	**Reputation Issues**	**Reputation Issues**	**Reputation Issues**	**Reputation Issues**	**Reputation Issues**	**Reputation Issues**
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	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

Finance & Business Development Committee, 28th February 2017

Draft Minutes

Attendance: Tony Rice, Steve Hitchins, Deborah Harris-Ugbomah, Steve Bloomer, Carol Gillen, Mark Inman, Jason Burn, John Watson, Adrien Cooper, Paul Attwal & Jit Patel (for Medicine paper 4) & Vivien Bucke (Secretary).

Apologies: Simon Pleydell, Siobhan Harrington and Graham Hart.

1	**Minutes of the previous meeting and Action Notes**	**Action/ Date**
1.1	The minutes of the previous meeting were agreed with the following amendments: 2.1 Item 1. The Trust is £69k ahead of plan *YTD and has consequently qualified for STP funding* 2.1 Item 2. a. Monthly run rate *of loss* is in excess of Plan 2.1 Item 2. b. The Trust has *a disproportionate level of* material non-recurrent benefit. 2.3 TR *pointed out that below par clinical productivity is a major issue* for the Trust and requires further action from the ICSUs. 2.4 *SB expressed a concern that* the Trust will miss the control total …..later. 3. …worst performing trust *in terms of reference costs (itself a proxy for clinical efficiency)* in London… & TR noted that if the Trust brought the references cost down to 100 (for example Kingston are 88) it would eliminate *most if not all of the* deficit. 6.5 TR said he felt the surgeons are not ready at 8.30 a.m. in theatres, while nurses are he believed it would be good to record this for a week *to drive more efficiency measures.* 6.6 It was concluded that to hit the 17-18 target of a cost reduction of £15.5m CIP the Trust *should aim* to have a Pipeline of £20m to allow for slippage.	
	Action Notes	
	6.5 <u>2017/18 Cost Improvement Programme</u> – Update on recording Consultant start times for a week: CG shared print-outs on the Medical productivity programme with the Committee.	
2	**Finance Position Month 10 & Forecast outturn**	
2.1	The members discussed the M10 financial position and the key points: 1. JB reported an in month £800k deficit and a year to date deficit of £5.9m. 2. There is a degree of certainty around the income position together with depreciation and dividend costs and so the key variable is the ICSUs expenditure position. The ICSUs were asked to forecast their best position at month 7, which allowed the Trust to forecast achievement of its control total with some minor additional actions. These forecasts have become the ICSUs control totals, but it was recognised that they were adverse to the budgets. ICSUs have so far	

	failed to deliver on their forecasts. 3. The underlying position has been a £1.5m - £1.8m deficit over the last couple of months with target being £1m. 4. The Trust will require the full £8.9m cash support 5. The Trust will suffer A&E and Cancer fines and will miss the control total by that value but NHSI have stated this will not stop the Trust receiving the remaining STF.	
2.2	SB described the accounting changes and likely challenges to the audit process. These have been discussed with NHSI and will go to the Audit & Risk Committee.	
3.	**Review of the 2016/17 financial position and plans to deliver financial targets & CIP in year and for 2017/18 – Estates and Facilities**	
3.1	AC reported that Estates and Facilities have an overspend of £1.2m against the control total. The challenges are:	
	▪ High vacancy rate ▪ Culture and established working practices particularly around maintenance ▪ Landlord issues ▪ Patient Transport	
3.2	The actions being taken are : ▪ Market testing maintenance contracts ▪ Working with PPS to improve VFM ▪ Managers mapping activity ▪ Heating cost ▪ Food wastage	
3.3	Going forward the Trust is trying to reduce its estate footprint and scrutinising pound for pound what areas are being utilised.	
3.4	DHU asked about the CRC/carbon levy and could this be reduced if things are done in house. AC felt there is a band width of wastage that could be addressed and he wanted to reduce by 3-4% per ward.	
3.5	The Committee discussed the plans for improvement in 2017/18.	
3.6	TR said he found the report clear and readable.	
4.	**Medicine ICSU**	
4.1	PA reported the ICSU had changed the way in which it delivered the service and was seeing a good improvement in costs which would show a £238k improvement in the run rate. The ICSU was undertaking additional work to improve involving: ▪ Dictate IT – service lines were waiting to be completed	

	▪ Better service model with another Nurse Consultant in Endoscopy was planned to bring down the cost base. ▪ A better grip on how to deal with a lot of high level long term sickness ▪ Work around Outpatient activity and Community Cardiology and looking to stop rheumatology where there is a small base. ▪ Looking to improve overseas recruitment to reduce the cost base and have a sustainable workforce ▪ Additional support from the PMO/Allocate to bring the level of PAs down. ▪ ECIP had been in to help with the pressure on Length of Stay and the ICSU will have to maintain within their bed base and only flex up when have funding in the winter period ▪ Additional support from Finance working together with the ICSU to agree assumptions and deliverables.	
4.2	TR asked that PA send a recruitment action plan to the next Committee to get a reduction in the vacancy rate. Culture change is still needed and support from the Medical Director and his deputy should be asked for.	**PA 19 April Committee**
5.	**Financial outlook for 2017-18**	
5.1	JB reported the Trust has accepted its control totals for 2016/17 & 2017/18 and it must achieve an average monthly deficit run rate of £0.5m excluding STF. When discounting non-recurrent mitigations, the underlying monthly run rate has been c. £1.5m to £1.8m deficit. As part of the Trusts 2 year savings programme there is a need to deliver £15.5m of savings in 2017/18. Currently there is a gap of £5.8m. Given that all efficiency schemes will not take effect from 1st April there is a need to make improvements now. JB listed the actions under consideration to reduce the monthly run rate.	
5.2	The committee discussed the challenge of moving from the current run rate to the required run rate in 17/18 and concluded that it was not assured at this point in time the Trust had plans in place to achieve the targets. It also discussed the potential challenges around beds open and winter pressures and how quality is monitored and maintained during the period.	
6.	**2017/18 Cost Improvement Programme**	
6.1	CG outlined current progress on CIP schemes and stated £10,463m schemes are in place towards the target of £15.5m cost out in year target. She explained that BCG are coming in for a challenge round and how the balance will be found.	
6.2	The Committee discussed the medical productivity workstream in detail and will receive further update, including a demonstration on the Qlikview tool.	**CG 19 April Committee**
6.3	2017/18 CIP plans showed a gap of around £7m. The NHSI have asked for weekly submissions from all Trusts which is an increase in their oversight.	

6.4	The Committee discussed implementation of electronic job planning and TR emphasised the need to get this in place by the Summer.	
	Financial Improvement Programme – Wave 2	
	It was agreed a further discussion on this would take place at the Private Trust Board.	
7.	**Business Development Update**	
7.1	MI reported that: ▪ the Trust is working with commissioners to split community spend by service line and individual CCG ▪ following a report on data quality and governance the Trust is currently drawing up an action plan	
7.2	It was agreed the report would return when the Deputy CEO and Director of Strategy was in attendance.	**MI 19 April Committee**
8.	**Risk Register**	
8.1	The Risk Register had been updated to talk about 2017/18 but the risks had not changed.	