East Lancashire Hospitals NHS
NHS Trust

EAST LANCASHIRE HOSPITALS NHS TRUST BOARD MEETING

Safe

Personal

Effective

TRUST BOARD PART 1 MEETING

25 JANUARY 2017, 14:00, SEMINAR ROOM 6, ROYAL BLACKBURN HOSPITAL

AGENDA

v = verbal
p = presentation
d = document
✓ = document attached

OPENING MATTERS				
TB/2017/001	**Chairman's Welcome**	Chairman	v	
TB/2017/002	**Open Forum** To consider questions from the public	Chairman	v	
TB/2017/003	**Apologies** To note apologies.	Chairman	v	
TB/2017/004	**Declarations of Interest** To note any new declarations of interest from Directors.	Company Secretary	v	
TB/2017/005	**Minutes of the Previous Meeting** To approve or amend the minutes of the previous meeting held on 30 November 2016	Chairman	d✓	Approval
TB/2017/006	**Matters Arising** To discuss any matters arising from the minutes that are not on this agenda.	Chairman	v	
TB/2017/007	**Action Matrix** To consider progress against outstanding items requested at previous meetings.	Chairman	d✓	Information
TB/2017/008	**Chairman's Report** To receive an update on the Chairman's activities and work streams.	Chairman	v	Information
TB/2017/009	**Chief Executive's Report** To receive an update on national, regional and local developments of note.	Chief Executive	d✓	Information
QUALITY AND SAFETY				
TB/2017/010	**Patient Story** To receive and consider the learning from a patient story.	Director of Nursing	p	Information/ Assurance
TB/2017/011	**Corporate Risk Register** To receive an update on the Corporate Risk Register and approve revisions based on the Board's insight into performance and foresight of potential and current risks to achieving the strategic and operational objectives.	Medical Director	d✓	Approval
TB/2017/012	**Board Assurance Framework** To receive an update on the Board Assurance Framework and approve revisions based on the Board's insight into performance and foresight of potential and current risks to achieving the strategic objectives.	Medical Director	d✓	Approval
TB/2017/013	**Serious Incidents Requiring Investigation Report** To receive information in relation to incidents in month or that may come to public attention in month and be assured about the associated learning.	Medical Director	d✓	Information/ Assurance
STRATEGY				
TB/2017/014	**Workforce Race, Equality Standard Progress Update Report**	Director of HR and OD	d✓	Information/ Assurance

ACCOUNTABILITY AND PERFORMANCE				
TB/2017/015	**Integrated Performance Report** To note performance against key indicators and to receive assurance about the actions being taken to recover areas of exception to expected performance. The following specific areas will be discussed: • Introduction (Chief Executive) • Performance (Director of Operations) • Quality (Medical Director) • HR (Director of HR and OD) • Safer Staffing (Director of Nursing) • Finance (Acting Director of Finance)	Executive Directors	d✓	Information/ Assurance
GOVERNANCE				
TB/2017/016	**Standing Orders** To approve the revised standing orders	Company Secretary	d✓	Approval
TB/2017/017	**Standing Financial Instructions** To approve the revised standing financial instructions	Company Secretary	d✓	Approval
TB/2017/018	**Finance and Performance Committee Update Report** To note the matters considered by the Committee in discharging its duties (January 2017)	Committee Chair	d✓	Information/ Assurance
TB/2017/019	**Trust Charitable Funds Committee Update Report** To note the matters considered by the Committee in discharging its duties (December 2016)	Committee Chair	d✓	Information/ Assurance
TB/2017/020	**Trust Charitable Funds Committee Terms of Reference** To agree the revised terms of reference for the Committee.	Company Secretary	d✓	Approval
TB/2017/021	**Quality Committee Update Report** To note the matters considered by the Committee in discharging its duties (January 2017)	Committee Chair	d✓	Information/ Assurance
TB/2017/022	**Audit Committee Update Report** To note the matters considered by the Committee in discharging its duties (December 2017)	Committee Chair	d✓	Information/ Assurance
TB/2017/023	**Remuneration Committee Update Report** To note the matters considered by the Committee in discharging its duties (November 2016)	Committee Chair	d✓	Information/ Assurance
TB/2017/024	**Trust Board Part Two Update Report** To note the matters considered by the Committee in discharging its duties (November 2016)	Chairman	d✓	Information
FOR INFORMATION				
TB/2017/025	**Any Other Business** To discuss any urgent items of business.	Chairman	v	
TB/2017/026	**Open Forum** To consider questions from the public.	Chairman	v	
TB/2017/027	**Board Performance and Reflection** To consider the performance of the Trust Board, including asking: • Has the Board focussed on the appropriate agenda items? Any item(s) missing or not given enough attention? • Has the Board agenda the correct balance between formulating strategy and holding to account? • Is the Board shaping a healthy culture for the Board and the organisation? • Is the Board informed of the external context within which it must operate? • Are the Trust's strategies informed by the intelligence	Chairman	v	

	from local people's needs, trend and comparative information? • Does the Board give enough priority to engagement with stakeholders and opinion formers within and beyond the organisation?			
TB/2017/028	**Date and Time of Next Meeting** Wednesday 1 March 2017, 15.00, Seminar Room 6, Learning Centre, Royal Blackburn Hospital.	Chairman	v	

TRUST BOARD REPORT

Item 5

25 January 2017

Purpose Approval

Title	Minutes of the Previous Meeting
Author	Miss K Ingham, Company Secretarial Assistant
Executive sponsor	Professor E Fairhurst, Chairman

Summary:

The draft minutes of the previous Trust Board meeting held on 30 November 2016 are presented for approval or amendment as appropriate.

Report linkages

Related strategic aim and corporate objective	As detailed in these minutes
Related to key risks identified on assurance framework	As detailed in these minutes

Impact

Legal	Yes	Financial	No
Maintenance of accurate corporate records			
Equality	No	Confidentiality	No

Previously considered by: NA

EAST LANCASHIRE HOSPITALS NHS TRUST

TRUST BOARD MEETING, 30 NOVEMBER 2016

MINUTES

PRESENT

Professor E Fairhurst	Chairman
Mr K McGee	Chief Executive
Mr S Barnes	Non-Executive Director
Mrs M Brown	Acting Director of Finance
Miss N Malik	Non-Executive Director
Mrs C Pearson	Director of Nursing
Dr D Riley	Medical Director
Mr P Rowe	Non-Executive Director
Mrs E Sedgley	Non-Executive Director
Mrs G Simpson	Director of Operations
Mr R Slater	Non-Executive Director
Mr D Wharfe	Non-Executive Director

IN ATTENDANCE

Mrs A Bosnjak-Szekeres	Company Secretary	
Mr M Cheyne	Hempsons	Observer/Audience
Mr P Faulkner	That's Lancashire Television	Observer/Audience
Mr K Griffiths	Director of Sustainability	
Mr M Hodgson	Director of Service Development	
Mr J Holden	Member of the Public	Observer/Audience
Mrs C Hughes	Director of Communications and Engagement	
Miss K Ingham	Company Secretarial Assistant	Minute Taker
Mr J Jackson	Porter	For Item TB/2016/319
Ms A Kurvey	Surgery and Anaesthetics Services	Observer/Audience
Mr K Moynes	Director of HR and OD	
Mr R Smyth	Associate Non-Executive Director	
Mr B Todd	Member of the Public	Observer/Audience

APOLOGIES

Professor M Thomas	Associate Non-Executive Director

TB/2016/310 CHAIRMAN'S WELCOME

Professor Fairhurst welcomed Directors and members of the public to the meeting, particularly Mr Griffiths for whom this was his first Board meeting since being appointed to the role of the Director of Sustainability.

TB/2016/311 OPEN FORUM

Mr Todd asked whether there were issues with the discharging of patients from the Trust to residential or nursing care within the Blackburn with Darwen area. Mr McGee confirmed that the Trust was not able to choose the place of discharge for patients; this was in the hands of the patient, their family and social care providers where appropriate.

TB/2016/312 APOLOGIES

Apologies were received as recorded above.

TB/2016/313 DECLARATIONS OF INTEREST

Directors noted that there were no amendments to the Directors' Register of Interests and there were no declarations in relation to agenda items.

RESOLVED: Directors noted the position of the Directors Register of Interests.

TB/2016/314 MINUTES OF THE PREVIOUS MEETING

Directors, having had the opportunity to review the minutes of the previous meeting, approved them as a true and accurate record.

RESOLVED: The minutes of the meeting held on 26 October 2016 were approved as a true and accurate record.

TB/2016/315 MATTERS ARISING

There were no matters arising from the minutes of the previous meeting.

TB/2016/316 ACTION MATRIX

All items on the action matrix were reported as complete or were to be presented as agenda items today or at subsequent meetings.

RESOLVED: The position of the action matrix was noted.

TB/2016/317 CHAIRMAN'S REPORT

Professor Fairhurst reported that she and Mr McGee had been invited to attend a dinner,

hosted by the Care Quality Commission (CQC) for those Trusts who had been in special measures, but went on to achieve significant improvements. She went on to report that Mr McGee had been shortlisted for Chief Executive of the Year award at the recent Health Service Journal (HSJ) awards, but unfortunately had not been the winner on the night. For the first time there was an award category for the NHS workers from the European Union. Professor Fairhurst confirmed that the judges took the decision to recognise all six of the shortlisted finalists and as such it was a testament to the work of the NHS and that the care provided is truly international.

Directors noted that Professor Fairhurst had attended a system design workshop in relation to the Sustainability and Transformation Plan (STP). At the session Professor Fairhurst took the opportunity to provide a vox pop which related to stroke care services and highlighted the health inequalities in the Pennine Lancashire area. In addition to the system design workshop, Professor Fairhurst attended a session focusing on the objectives of the STP and associated local delivery plans. The attendees at the session all recognised the importance of the local delivery aspect of the STP.

RESOLVED: Directors received the report and noted its content.

TB/2016/318 CHIEF EXECUTIVE'S REPORT

Mr McGee presented the report and highlighted a number of the national updates, particularly the current contract negotiations with Commissioners for the next two year period. It is anticipated that the contracts will be agreed and signed in the coming weeks.

Mr McGee reported that the catering services at the Royal Blackburn Hospital and Burnley General Hospital sites had received level five food hygiene standard ratings which was pleasing to note. Directors noted the seasonal flu vaccination rate for staff currently stood at 78% against an internal target of 85% and was likely to be amongst the highest rates for Trusts across the country.

Mr McGee drew Directors attention to a number of key meetings that he had undertaken over the course of the previous two months, including the two Accident and Emergency Delivery Board meetings. Mr McGee provided an overview of the event that had taken place on 4 November with Mr Jim Mackey and Mr Simon Stevens which focused on business planning for the coming two years.

RESOLVED: Directors received the report and noted its contents.

TB/2016/319 PATIENT STORY

Professor Fairhurst introduced Mr Jackson to the Directors. Directors noted that Mr Jackson had been awarded the Kate Granger Award for Compassion in Care at the recent Health

and Care Expo 2016. Mr Jackson gave an overview of his role as a Night Porter in the Trust and the interactions that he has with the patients and their families, as he goes about his business in the Trust. He reported that he is a Bereavement Care Champion for the organisation and works with the families of deceased patients. He provided an outline of the newly developed Bereavement Suite that has been developed within the Trust's Mortuary. He highlighted the decision to make the area less clinical and more comforting for the families whom have lost their loved ones.

He gave a brief story of a patient who had requested a specific song in memory of her husband. He arranged for the song to be played for her whilst on holiday abroad. Mr Jackson reported that he enjoyed his job and was keen to help the Trust to develop and improve further. Mrs Pearson thanked Mr Jackson for sharing his story and confirmed that the nursing teams, with whom he has contact, value greatly the service he and his colleagues provide.

RESOLVED: **Directors thanked Mr Jackson for sharing his experience with the Board and congratulated him on his award.**

TB/2016/320 CORPORATE RISK REGISTER

Dr Riley presented the Corporate Risk Register for approval and gave an overview of the eleven risks on the register. In response to Miss Malik's question, Mrs Simpson reported that the change to the risk rating related to the current inability to temporarily close a ward for a complete refurbishment as there are no spare wards to move patients. She confirmed that partial refurbishment of some areas had taken place. During the summer months it is more likely that an area can be vacated to allow for refurbishment. Mrs Simpson reported that the risk also related to the work that has been carried out in the staff residence. This was close to completion but had not yet been completed. Mr McGee confirmed that there is a programme of refurbishment in place and it is hoped that in the coming months there will be a spare ward to facilitate the refurbishment programme. Directors approved the proposed changes to the register.

RESOLVED: **Directors received the report and approved the changes to the risk ratings.**

TB/2016/321 BOARD ASSURANCE FRAMEWORK (BAF)

Dr Riley presented the report to Directors, for information and approval. Mr McGee commented that the Trust would need to review and refine risk ID BAF/16/06: *The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements* because the organisation is required to undertake

increasing amounts of partnership working and collaboration.

Professor Fairhurst requested that Mr McGee and Executive Director colleagues take the opportunity to revise this risk and the reporting against it prior to the next meeting in January.

RESOLVED: **Directors received the report and noted and approved the BAF.**

Mr McGee and Executive Director colleagues will review and revise risk six: "*The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements"* and the reporting against it prior to the next meeting in January.

TB/2016/322 SERIOUS INCIDENTS REQUIRING INVESTIGATION REPORT

Dr Riley referred Directors to the previously circulated report, and highlighted that there had been no incidents of fractured neck of femur (FNOF) reported since the last meeting. Directors noted the section of the report relating to Duty of Candour and the work required to improve the position. Dr Riley provided an overview of the section of the report relating to the care of the deteriorating patient and reported that the number of cases per month is around 0.5% which is in line with other Trusts.

Dr Riley highlighted the section of the report relating to acute kidney infection (AKI) and Sepsis and reported that significant inroads had been made regarding the treatment of patients suffering from sepsis but there was more to do to improve the treatment of patients with AKI. Dr Riley confirmed that the Trust had pledged to reduce unexpected cardiac arrests by 15% and a pilot scheme was being carried out on ward C11 which would help achieve this reduction. He confirmed that the work was behind schedule; however this was due in part to staffing issues, which are now being managed.

Professor Fairhurst commented that the report was very comprehensive and was the best report on this matter that the Board have had in recent months; it provided evidence of learning across the Trust.

Mr Rowe commented that the Trust had been reactive in the past, but it was now making steps to ensure prevention of problems rather than reaction to them. Mrs Sedgley echoed these comments and stated that the Trust had been on a long journey to get to this point. She went on to request further information about the high rates of incidents in the Family Care Division and asked whether this was due to both mothers and babies being involved in the incidents. Dr Riley confirmed that the majority of the Family Care incidents were recorded in the obstetrics service and therefore were likely to include mothers and their babies, although he stressed that the vast majority of the incidents reported did not result in any harm to the patients.

RESOLVED: **Directors received the report and noted its contents.**

TB/2016/323 SUSTAINABILITY AND TRANSFORMATION PLAN

Mr McGee referred Directors to the slides within the papers and provided an overview of the work and involvement of the Trust in the development of the Sustainability and Transformation Plan (STP) to date. He reported there was a commitment from all organisations across the STP footprint that there was a need to work together to develop high quality and cost effective services for the people of Lancashire and South Cumbria.

Mr McGee highlighted the five 'Local Delivery Plan' (LDP) areas within the STP footprint and the 39 health and social care organisations which make up the LDP areas. He went on to highlight the priorities for the STP area, including the need to address the health and wellbeing gap, mental health services and the need to ensure earlier presentation of patients with a suspected cancer to enable earlier diagnosis and better outcomes.

Directors noted that the development of an NHS Provider Trust Collaborative had been set out in the document and that the Trust was keen to maintain strong and robust District General Hospital services along with the desire to assist with the developments in primary care and the prevention agenda.

Mr Rowe commented that the plan represented a step change in tackling health inequalities and it was the first time that all partners had signed up to work together to address these issues. He commented there was a need to ensure that the work needed to be carried out was completed within the tight financial constraints without detriment to the quality of the services provided. Mr Wharfe asked that the Board spend some time looking at the detailed financial workbook to gain a better understanding of the requirements and the finances available to carry out the work. It was agreed that this would be looked at outside the meeting and would be discussed at a future Board meeting.

RESOLVED: **Directors received the report and noted its content.**
It was agreed to review the narrative of the finance reports.

TB/2016/324 INFORMATION TECHNOLOGY MANAGEMENT STRATEGY IMPLEMENTATION PROGRESS REPORT

Mrs Brown provided a brief presentation to Directors which included an overview of the strategy, an update in relation to progress to date, the key achievements since commencement of the implementation in April 2016 and plans for further development into 2017/18. She reported that, to date, there had been investment of capital totalling £2,635,000 which would rise to £3,125,000 in 2017/18. Directors noted that, of the 98 actions, none were rated as red, 64 were on track or completed and the remaining 29

actions were delayed or required amendment due to changes outside the Trust's control. Work is being undertaken with Leeds Teaching Hospitals NHS Trust to develop an understanding of their technology based issues and learn from their actions in order to avoid similar problems at this Trust.

Mrs Brown provided an overview of activities undertaken, including the roll out of the EMIS system, the accreditation of excellence received by the informatics team by the Informatics Service Development Network (ISDN), the near completion of a project to review and revise discharge letters and the development of the Electronic Patient Record Business Case.

Mr Rowe commended the work to date and asked whether patients receive a copy of their discharge letter. Mrs Simpson confirmed that patients do receive a hard copy of their letter at the point of discharge.

In response to Mrs Sedgley's question, Mrs Brown confirmed that the total capital spend for the Electronic Patient Record System would be in the region of £10,000,000 over five years and could not be completed quicker due to the need to link a number of systems together and resource other activities.

Professor Fairhurst commented that the accreditation for the informatics team that the Trust had recently been awarded must be used to benefit the Trust.

RESOLVED: Directors received and noted the update provided.

TB/2016/325 INTEGRATED PERFORMANCE REPORT

Mr McGee introduced the paper and confirmed that overall performance was good within the Trust with the 18 week referral to treatment target being met, 62 day cancer performance was back on trajectory and good progress was being made towards the financial control total. He reported that the Trust was currently under significant pressure across the emergency care pathway; performance against the four hour standard had suffered as a result and currently stands at 83.1%. Enabling adequate flow throughout the pathway was proving to be difficult and had also had a negative effect on capacity to deliver elective surgery.

Mrs Simpson confirmed that there had been one patient who had waited over 52 weeks for their surgery, but treatment has now been completed. A further two patients have had surgery cancelled on the day due to the pressures being experienced in the Trust. Both cases breached the 28 day limit, but both patients have now been treated. She referred the Directors to the actions within the report that had been implemented to recover performance against the four hour standard.

In the month of October there had been three breaches of the twelve hour standard, all of which were patients requiring the input of mental health services. Directors noted that there

had been a slight improvement in the number of patients suffering a delayed transfer of care in the month.

In response to Miss Malik's question, Mrs Simpson confirmed that the patient waiting over 52 weeks for their surgery had suffered the delay due in part to patient choice, but also due to the complex clinical pathway on which they were.

Mr Rowe asked when the findings from the current review of mental health service provision by the Royal College of Psychiatrists would be available. Mrs Simpson reported that the results of the review would be available in around two months. The report would be issued in draft format for accuracy checking and, following any amendments, would be issued.

Mr Moynes reported that sickness absence levels had increased to 4.95% for the month of September 2016 and confirmed that there were a range of actions in place to manage this issue, including an internal audit of the Trust's sickness absence procedures. Mr Moynes highlighted the completion rate for the NHS National Staff Survey stood at 45% across the Trust and confirmed that the Black and Minority Ethnic (BME) Big Conversation event would take place on 8 December 2016 and currently had over 50 people booked onto the session.

Mrs Sedgley commented that Blackburn with Darwen Local Authority Social Care team seemed to be performing better than Lancashire County Council in relation to facilitating discharges to care/nursing homes for rehabilitation and asked why this was the case. Mrs Simpson confirmed that this was due partly to the availability of social workers to undertake assessments and the availability of beds in care and nursing homes. Mr McGee confirmed that Lancashire County Council were working to improve their performance in relation to this matter.

Mrs Pearson reported that nursing and care staffing had been a challenge in the previous month, but there had been an improvement in the number of areas with staffing with 80% fill rate. Directors noted that the Trust remained within the expected levels in relation to both Hospital Standardised Mortality Indicator (HSMR) and Summary Hospital-level Mortality Ratio (SHMI) indicators; there were five post three day Clostridium Difficile infections reported, which brings the year to date figure to 21 against the annual trajectory of 28 cases. There were no never events reported in the month.

Mrs Brown reported that the Trust had reported a deficit financial position of £2,100,000 at the end of October, which equated to a further deterioration of £300,000 and was in line with the forecast financial position. She reported that the Trust had submitted an appeal to NHS Improvement regarding the sustainability and transformation funding in relation to performance against the four hour standard. Directors noted the increase in the use of agency staff and the associated increase in costs. Mrs Brown highlighted the actions in place to manage this matter. Safely Releasing Costs Programme (SRCP) schemes had

achieved £10,000,000 of the £14,200,000 schemes required to meet the deficit control total of £3,700,000. Directors noted that the Trust had met all four elements of the Better Payment Practice Code.

Mr Wharfe commented that the majority of the new style report works well, but he considered that a simple one page finance overview did not provide the assurance required, particularly in the public part of the meeting. He reported that within the Finance and Performance Committee the report was discussed in detail but more narrative in this paper is required in the future. Professor Fairhurst suggested that Mr Wharfe be included in the development of the finance section of the report.

In response to Mrs Sedgley's question, Dr Riley confirmed that the Trust is not yet seeing an increase in the cost of drugs or medical equipment. There is an expectation that costs for these services will increase in the near future.

In response to Mrs Sedgley's question regarding consultant job planning, Dr Riley provided an overview of the process of ensuring all consultants have a current job plan uploaded to the Allocate System. He confirmed that all new consultants will have an active job plan developed within the first three months of their employment with the Trust. Mrs Bosnjak-Szekeres reported that the Audit Committee monitors this issue closely and confirmed that Mr Hill, Deputy Medical Director for Clinical Performance will be in attendance at the next meeting of the Committee to provide an update to the members.

RESOLVED: **Directors received the report and noted the work undertaken to address areas of underperformance.**

It was agreed that the narrative of the finance section would be more detailed in the future.

Mr Wharfe to be involved in the development of the revised finance section of the report.

TB/2016/326 FINANCE AND PERFORMANCE COMMITTEE UPDATE REPORT

Mr Wharfe presented the report to the Directors and confirmed that is was an accurate reflection of the meeting held in October 2016. He provided an overview of the meeting and highlighted discussions which had taken place in relation to the financial position of the Trust at the end of September, particularly the spend on agency staff and the delivery of the year end control total. He confirmed that the Non-Executive Committee members had sought further assurance that the required reductions in agency spend would be realised.

RESOLVED: **Directors received the report and noted its contents.**

TB/2016/327 QUALITY COMMITTEE UPDATE REPORT

Mr Rowe presented the report to the Directors and confirmed that is was an accurate reflection of the meetings held in October and November 2016. He drew Directors' attention to the range of issues considered at the meetings, particularly the development of the Medicines Optimisation Strategy. Directors noted that the Trust was ahead of most other Trusts in relation to this piece of work. Mr Rowe also highlighted the Trust wide work on organ donation and the need to improve liaison and increase donations from the Black and Minority Ethnic (BME) communities.

RESOLVED: **Directors received the report and noted its contents.**

TB/2016/328 **REMUNERATION COMMITTEE UPDATE REPORT**

The report was presented for information purposes.

RESOLVED: **Directors received the report and noted its contents.**

TB/2016/329 **TRUST BOARD PART TWO UPDATE REPORT**

The report was presented for information purposes.

RESOLVED: **Directors received the report and noted its contents.**

TB/2016/330 **ANY OTHER BUSINESS**

There were no further items of business reported.

RESOLVED: **Directors received the report and noted its contents.**

TB/2016/231 **OPEN FORUM**

Mr Todd reported that he had asked Mr Holden to attend the meeting with him to test the microphone and speaker system. Mr Holden reported that he wore a hearing aid and as such was unable to hear the majority of the meeting, even with the use of the speaker system available. He suggested that a loop system be procured and used in the future. Mr Todd commented that the system which had previously been in place (two large speakers and a number of desk top microphones) had worked much better and suggested that the new system was not fit for purpose and therefore had been a waste of public money. Mrs Bosnjak-Szekeres agreed to source a loop system for the next meeting.

Mr Todd went on to enquire where he could acquire the annexes to the Sustainability and Transformation Plan (STP) as the public had not had the opportunity to see the document in its entirety. Mrs Hughes agreed to provide them to him.

TB/2016/332 **BOARD PERFORMANCE AND REFLECTION**

Professor Fairhurst asked Directors whether there had been appropriate discussion on the

agenda items. Mr Rowe commented that there had been sufficient debate, particularly around the STP.

TB/2016/333 DATE AND TIME OF NEXT MEETING

The next Trust Board meeting will take place on Wednesday 25 January 2017, 14:00, Seminar Room 6, Learning Centre, Royal Blackburn Hospital.

East Lancashire Hospitals NHS
NHS Trust

TRUST BOARD REPORT

Item 7

25 January 2017

Purpose Information

Title	Action Matrix
Author	Miss K Ingham, Company Secretarial Assistant
Executive sponsor	Professor E Fairhurst, Chairman

Summary: The outstanding actions from previous meetings are presented for discussion. Directors are asked to note progress against outstanding items and agree further items as appropriate

Report linkages

Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do Invest in and develop our workforce Work with key stakeholders to develop effective partnerships Encourage innovation and pathway reform, and deliver best practice
Related to key risks identified on assurance framework	Transformation schemes fail to deliver the clinical strategy, benefits and improvements and the organisation's corporate objectives Recruitment and workforce planning fail to deliver the Trust objectives Collaborative working fails to support delivery of sustainable, safe and effective care through clinical pathways Alignment of partnership organisations and collaborative strategies (Pennine Lancashire and Healthier Lancashire) are not sufficient to support the delivery of sustainable services by the Trust The Trust fails to achieve a sustainable financial position and appropriate continuity of service risk rating. The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

ACTION MATRIX

Item Number	Action	Assigned To	Deadline	Status
TB/2016/291b: Workforce And Organisational Development (Workforce Race and Equality Standard report)	Progress reports on the action plan will be presented to the January and April 2017 Trust Board meetings.	Director of HR and OD	January 2017 April 2017	Agenda Items January 2017 April 2017
TB/2016/321: Board Assurance Framework	Mr McGee and Executive Director colleagues will review and revise risk six: "The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements" and the reporting against it prior to the next meeting in January.	Chief Executive and Executive Directors	January 2017	Agenda Item January 2017
TB/2016/325: Integrated Performance Report	It was agreed to review the narrative of the finance reports. Mr Wharfe to be involved in the development of the revised finance section of the report.	Acting Director of Finance Acting Director of Finance	January 2017 January 2017	Agenda Item January 2017 Oral Report
TB/2016/231: Open Forum	Mrs Hughes agreed to provide the whole of the Sustainability and Transformation Plan (STP), including annexes to Mr Todd.	Director of Communications and Engagement	January 2017	Oral Report

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 9

25 January 2017

Purpose Information

Title	Chief Executive's Report
Author	Mr L Stove, Assistant Chief Executive
Executive sponsor	Mr K McGee, Chief Executive

Summary:

A summary of national, health economy and internal developments is provided for information.

Recommendation:

Members are requested to receive the report and note the information provided.

Report linkages

Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do Invest in and develop our workforce Work with key stakeholders to develop effective partnerships Encourage innovation and pathway reform, and deliver best practice
Related to key risks identified on assurance framework	Transformation schemes fail to deliver anticipated benefits The Trust fails to deliver and develop a safe, competent workforce Partnership working fails to support delivery of sustainable safe, personal and effective care The Trust fails to achieve a sustainable financial position The Trust fails to achieve required contractual and national targets and its improvement priorities Corporate functions fail to support delivery of the Trust's objectives

Impact

Legal	Yes	Financial	Yes
Equality	No	Confidentiality	No

Previously considered by: N/A

National Updates

1. **NHS England's Medical Director highlights local plans to improve services for patients -** NHS England's Medical Director, Professor Sir Bruce Keogh, has said that the NHS must embrace common sense changes to prepare for the future. Sir Bruce was speaking as the King's Fund published a new report on local plans to improve services, known as Sustainability and Transformation Plans (STPs). Around a third of the proposals for change have been published, with the remainder set to be shared with the public for discussion over the coming weeks. Sir Bruce called on the public to help shape the plans which he believes will "deliver practical improvements that will really make a difference to people."
2. **NHS England announces six areas to pilot new midwifery supervision model -** NHS England has revealed six maternity pilot sites that will trial new models of midwifery supervision in England ahead of legislative changes due in spring 2017. The new models will look at how midwives can be supported in their role with the aim of improving maternity care and increasing midwives' job satisfaction and development and reducing sickness.
3. **Simon Stevens sets out actions to improve survival and quality of life for people with cancer** - speaking at the Britain Against Cancer Conference, NHS England's Chief Executive, Simon Stevens, announced the first hospitals to benefit from a major investment in NHS radiotherapy machines alongside a £200 million fund to encourage local areas to find new ways to diagnose cancer earlier, improve care for those living with cancer and ensure each cancer patient gets the right care for them.
4. **NHS England announces major extension of national HIV prevention programme** - NHS England will fund a major extension to the national HIV prevention programme led by Public Health England with the aim of supporting those most at risk and reducing the incidence of HIV infection. NHS England will also routinely commission 10 new specialised treatments as part of the annual prioritisation process for specialised treatments. A clinical trial of HIV prevention drugs known as pre-exposure prophylaxis (PrEP), involving at least 10,000 participants over the next three years, will be launched in the next financial year.
5. **NHS England Transformation Fund call to bid -**To support the implementation of the Five Year Forward View's vision of better health, better patient care and improved NHS efficiency, NHS England has created a Transformation Fund. This fund will enable local areas to deliver on key ambitions identified by the independent cancer and mental health taskforces. Additionally NHS England will continue to build

on the transforming care priority for those with learning disabilities and kickstart, at scale, revolutions for diabetes treatment and prevention.

6. **NHS England announces £101 million of new funding for new care model vanguards -** NHS England has announced £101 million of new funding to support the work of the new care model vanguards. The vanguards are partnerships of NHS, local government, voluntary, community and other organisations which aim to improve healthcare people receive. The vanguards will continue to receive support from NHS England and other national bodies to implement their plans.
7. **NHS England to fund ground-breaking new clinical trial -** NHS England has announced it will make up to £8 million available over five years to fund the treatment costs of a five year clinical trial of mitochondrial donation. Mitochondrial donation is a form of IVF in which the future baby's mitochondrial DNA comes from a donor egg, to avoid passing on inherited mitochondrial diseases. This follows the Human Fertilisation and Embryology Authority's decision to start accepting applications for licences to carry out the procedure and the news that Newcastle upon Tyne NHS Foundation Trust will be the first to apply.

Local Developments

8. **Stroke patients sitting comfortably thanks to Al-Imdaad Foundation** - Stroke patients at the Royal Blackburn Hospital are set to benefit after a generous £1,700 donation from Al-Imdaad Foundation towards a hi-tech stroke rehabilitation chair. The donation, presented by Al-Imdaad Foundation Country Director Hafez Abdussamad Mulla, is a big boost for staff and patients on ward B2 at the Hospital. The chair is fully adjustable, giving patients greater support, increased safety and extra mobility as they recover following a stroke. Hafez Abdussamad Mulla, Al-Imdaad Foundation Country Director, said: "It's an honour to be able to support our local hospital. When Muslim Chaplain Fazal Hassan got in touch, we were delighted to get involved and fundraise for this equipment which will really make a difference for local stroke patients."
9. **Lifetime Achievement Award** – Professor Iqbal Singh has received a lifetime achievement award at the BAPIO Annual Conference in London. Professor Singh was given the award for his lifetime contribution to healthcare and medical regulation.
10. **Advanced nurses celebrate graduation success** - Eleven experienced nurses at East Lancashire Hospitals NHS Trust (ELHT) are celebrating after graduating from the University of Central Lancashire (UCLAN) with their Advanced Nurse Practitioner degrees. Advanced Practitioners are qualified, highly experienced nurses who, after

gaining additional qualifications, can now perform extra clinical duties such as taking patient medical history, carrying out physical examinations, requesting investigations, and referring patients directly to other specialists where appropriate.

11. **Inspirational parents fund family quiet room at Burnley General Hospital** - Parents of a baby who was stillborn at have donated an incredible £2,300 to Burnley General Hospital to set up a quiet room for families who need space during tough times. Sarah Bernasconi and Mark Parsons raised the funds through an online auction, which saw the pair being donated an array of goods from guitars to designer handbags, as well as hosting various fun days. The fundraising couple decided on donating towards the creation of a quiet room as they had learnt that one wasn't currently in existence for families that suffer from bad news, such as an early pregnancy loss, or a difficult diagnosis.

12. **Trust rated GOOD overall following CQC Review inspection** - Following a 'well-led review' inspection by the CQC (Care Quality Commission) on 20 and 21 September 2016, East Lancashire Hospitals NHS Trust has received the news it has been waiting for – the Trust has now been rated as 'good' overall. The CQC 'well-led review' was a follow up to the focused inspection conducted in October 2015 which reviewed core services and rated Blackburn and Burnley hospitals 'good'. The review looked at the Trust's responses to the last inspection report and current practice including governance and risk management support for the services inspected to give a revised rating.

Use of the Seal

13. The Trust Seal has been applied on the following occasions:

- On the 15 December 2016 to the Deed of Variation 315 relating to ELHT and Consort Healthcare (Blackburn) Limited. Supplementary Agreement relating to Trust Services. The deed has been signed by the Chief Executive and the Director of Service Development.
- On the 21 December 2016 to Duty of care deed relating to a new hospital and health centre at Chatburn Road, Clitheroe. Parties to the deed are Nightingale Architects Limited, Eric Wright Construction Limited and East Lancashire Hospitals NHS Trust. The deed has been signed by the Director of Service Development and the Acting Director of Finance.
- On the 21 December 2016 Duty of Care Deed relating to Works at Chatburn Road, Clitheroe adjacent to the Clitheroe Community Hospital, Clitheroe. Parties of the deed are Eric Wright Construction Limited, Extruded Window System Limited and

East Lancashire Hospitals NHS Trust. The deed has been signed by the Director of Service Development and the Acting Director of Finance.

- On the 21 December 2016 Duty of Care Deed relating to Works at Chatburn Road, Clitheroe adjacent to Clitheroe Hospital. Parties of the deed are Eric Wright Construction Limited, Kone Public Limited Company and East Lancashire Hospitals NHS Trust. The deed has been signed by the Director of Service Development and the Acting Director of Finance.
- On the 21 December 2016 Duty of Care Deed relating to the new hospital and health centre adjacent to Clitheroe Community Hospital. Parties of the deed are East Lancashire Capital Projects Limited, Eric Wright Construction Limited and East Lancashire Hospitals NHS Trust. The deed has been signed by the Director of Service Development and the Acting Director of Finance.
- On the 21 December 2016 Duty of Care Deed relating to Works at Chatburn Road, Clitheroe adjacent to the Clitheroe Community Hospitals, Clitheroe. Parties of the deed are Eric Wright Construction Limited, Leach Structural Steelwork Limited and East Lancashire Hospitals NHS Trust. The deed has been signed by the Director of Service Development and the Acting Director of Finance.
- On the 21 December 2016 Duty of Care Deed relating to works at Chatburn Road, Clitheroe adjacent to the Clitheroe Community Hospital Clitheroe. Parties of the deed are Eric Wright Construction Limited, The James Mercer Group Limited and East Lancashire Hospitals NHS Trust. The deed has been signed by the Director of Service Development and the Acting Director of Finance.
- On the 21 December 2016 Duty of Care Deed relating to a new hospital and health centre at Chatburn Road, Clitheroe. Parties of the deed are J R B Environmental Design Limited, Eric Wright Construction Limited and East Lancashire Hospitals NHS Trust. The deed has been signed by the Director of Service Development and the Acting Director of Finance.
- On the 21 December 2016 Duty of Care Deed relating to Works at Chaburn Road, Clitheroe. Parties of the deed are Eric Wright Construction Limited, GWN Contracts Limited, Hadley Steel Framing Limited and East Lancashire Hospitals NHS Trust.

Summary and Overview of Board Papers

14. **Patient Story** - These stories are an important aspect for the Trust Board and help to maintain continuous improvement and to build communications with our patients.

Summary of Chief Executive's Meetings for November 2016

01/11/16	Telephone conversation with Sam Nicol from BFWHT - RBH
02/11/16	Telephone conversation with Helen Dabbs from NHSI - RBH
02/11/16	Telephone conversation with Ann Catterson from Common Purpose - RBH
03/11/16	Systems Teleconference - RBH
03/11/16	Meeting between ELHT, ELCCG and GGI – Walshaw House, Nelson
03/11/16	Pennine Lancashire E&D Delivery Board – Walshaw House, Nelson
04/11/16	Jim Mackey and Simon Stevens NHS Planning – Leeds
07/11/16	Systems Teleconference - RBH
08/11/16	Urgent Emergency Care Network Group – Chorley
08/11/16	Telephone conversation with Seamus McGirr - RBH
08/11/16	Telephone conversation with Harry Catherall CEO Blackburn Council - RBH
09/11/16	Systems Teleconference - RBH
10/11/16	Systems Teleconference - RBH
11/11/16	Systems Teleconference - RBH
14/11/16	Systems Teleconference - RBH
14/11/16	Meeting with ELHT, ELCCG and Seamus McGirr - RBH
14/11/16	Health and Wellbeing Board Policy Development Session – Blackburn
15/11/16	A&E Delivery Board Pre Meet with ELCCG – RBH
16/11/16	Systems Teleconference
16/11/16	Meeting with Sally McIvor – RBH
16/11/16	Pennine Lancashire Transformation Programme System Leaders Forum – Blackburn
17/11/16	Systems Teleconference
17/11/16	Action on A&E, Commissioning for Success – Leeds
18/11/16	Teleconference with Brian Saunders from the PFU - RBH
18/11/16	Teleconference with Liam Richardson HSJ – RBH
18/11/16	Teleconference with Bond Dickinson – RBH
21/11/16	Meeting with ELCCG, BwDCCG and ELHT - RBH
21/11/16	System Teleconference - RBH
21/11/16	Meeting with Russ McLean
22/11/16	Meeting to discuss progress in the spending and contracting round/local delivery system – Preston
23/11/16	Systems Teleconference
23/11/16	Teleconference with ELCC, BwDCCG and ELHT – RBH
23/11/16	HSJ Awards - London

28/11/16 Systems Teleconference
28/11/16 Executive Development Session - RBH
29/11/16 Systems Teleconference
29/11/16 Teleconference with Bond Dickinson - RBH
30/11/16 Trust Board

Summary of Chief Executive's Meetings for December 2016

01/12/16 Meeting to discuss SRO – Walshaw House, Nelson
01/12/16 Pennine Lancashire A&E Delivery Board – Walshaw House, Nelson
02/12/16 A&E Summit – Leeds
05/12/16 Meeting with ELCCG, BwDCCG and ELHT - RBH
05/12/16 Hospital Choir Concert – Bridgwater Hall
07/12/16 Systems Teleconference
07/12/16 HLSCCP Programme Board – Leyland
07/12/16 ELHT Contract Negotiations – Fusion House, Blackburn
08/12/16 NHS Improvement System Wide Leadership Seminar – Leeds
09/12/16 Systems Teleconference
09/12/16 Lancashire CEO Meeting – Preston
13/12/16 Systems Teleconference
13/12/16 Health and Wellbeing Board – Blackburn
14/12/16 Systems Teleconference
14/12/16 Board Development
15/12/16 Systems Teleconference
15/12/16 Formal TSG Meeting – Walshaw House, Nelson
16/12/16 Systems Teleconference
16/12/16 CEO Provider Away Day – Chorley
19/12/16 Meeting with Mark Youlton from ELCCG – RBH
19/12/16 Teleconference with Sally McIvor from Pennine Lancashire Transformation Programme – RBH
19/12/16 Meeting with Murray Scott to discuss STP Modelling - RBH
19/12/16 Meeting with LCC and BwD Council – RBH
20/12/16 Systems Teleconference
21/12/16 Systems Teleconference
21/12/16 Meeting with UCLan representatives – RBH
21/12/16 Teleconference with Sally McIvor from Pennine Lancashire Transformation Programme – RBH

21/12/16 Pennine Lancashire Transformation Programme System Leaders Forum – Blackburn

29/12/16 Visit to Clitheroe Hospital

30/12/16 System Teleconference - RBH

Summary of Chief Executive's Meetings for January 2017

03/01/17 Systems Teleconference

03/01/17 Meeting with ELCCG – RBH

04/01/17 Systems Teleconference

04/01/17 Teleconference with Carol Douglas – RBH

05/01/17 Systems Teleconference

05/01/17 Pennine Lancashire A&E Delivery Board – Walshaw House, Nelson

06/01/17 Systems Teleconference

06/01/17 Lancashire CEO Meeting – Preston

06/01/17 Lancashire Systems Winter Call – RBH

09/01/17 Systems Teleconference

09/01/17 Meeting with ELCCG, BwDCCG and ELHT – RBH

09/01/17 Meeting with Mark Youlton from ELCCG – Preston

10/01/17 Systems Teleconference

10/01/17 Meeting with the GGI – Warrington

11/01/17 Systems Teleconference

11/01/17 Board Development Session – RBH

12/01/17 Systems Teleconference

12/01/17 Formal TSG Meeting – Walshaw House, Nelson

12/01/17 Meeting with Ann Catterson from Common Purpose – RBH

12/01/17 Meeting with Sandy Bradbrook – Preston

13/01/17 Systems Teleconference

16/01/17 Systems Teleconference

16/01/17 Meeting with Anne Gibbs from NHSI – RBH

17/01/17 Systems Teleconference

18/01/17 Systems Teleconference

18/01/17 NHS NWLA Board – Manchester

18/01/17 NHS Providers Dinner Programme – London

19/01/17 Systems Teleconference

19/01/17 Pennine Lancashire Solution Design Event – Burnley

20/01/17 Interviews for Estates and Facilities DGM Vacancy – RBH

23/01/17	Systems Teleconference
23/01/17	Meeting with ELCCG, BwDCCG and ELHT – RBH
23/01/17	Meeting with Pam Smith from Burnley Council – RBH
24/01/17	Meeting with Liz Mear from the NWCAHSN – RBH
25/01/17	Systems Teleconference
25/01/17	Trust Board
26/01/17	Systems Teleconference
26/01/17	Meeting with Sharon Robson, Lancashire Director of Procurement – RBH
26/01/17	Meeting with Christian Dingwall from Hempsons Solicitors – RBH
27/01/17	Systems Teleconference
27/01/17	Team Brief – RBH
30/01/17	Systems Teleconference
30/01/17	Newton/LGA Work – Blackburn Council
30/01/17	Meeting with Russ McLean
30/01/17	Meeting with Gary Howe
31/01/17	Systems Teleconference
31/01/17	Pennine Lancashire Transformation Programme Workshop - Blackburn

East Lancashire Hospitals NHS
NHS Trust

TRUST BOARD REPORT

Item 11

25 January 2017

Purpose Approval

Title	Corporate Risk Register
Author	Mr N Smith, Risk Manager
Sponsor	Dr D Riley, Medical Director

Summary:

This report presents the outcome of the most recent review of the Corporate Risk Register by the Patient Safety and Risk Assurance Committee and the Quality Committee.

Recommendation:

It is recommended that the Board:

a) Receive the report noting the assurances provided in relation to the Trust's Corporate Risk Register management processes
b) Approve the proposed changes to the Corporate Risk Register

Report linkages

Related committee aim and duties	Put safety and quality at the heart of everything we do Invest in and develop our workforce Work with key stakeholders to develop effective partnerships Encourage innovation and pathway reform, and deliver best practice
Related to key risks identified on assurance framework	Transformation schemes fail to deliver the clinical strategy, benefits and improvements and the organisation's corporate objectives Recruitment and workforce planning fail to deliver the Trust objectives Collaborative working fails to support delivery of

sustainable, safe and effective care through clinical pathways

Alignment of partnership organisations and collaborative strategies (Pennine Lancashire and Healthier Lancashire) are not sufficient to support the delivery of sustainable services by the Trust

The Trust fails to achieve a sustainable financial position and appropriate continuity of service risk rating.

The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

Impact

Legal	Yes	Financial	Yes
Equality	No	Confidentiality	No

Introduction

1. Monthly Risk Assurance Meetings are undertaken and a review of the Corporate Risk Register is carried out by the Risk Manager in consultation with the Associate Director of Quality and Safety. Since the last report, work has been undertaken to ensure that all risk handlers and executive leads have easier access to risk related information through the Trust's Risk Management system, Datix. Leads have now been provided with access to the Dashboard module which provides a live view of risks within divisions and directorates.
2. The proposed Corporate Risk Register is attached at Appendix 1.
   a) **Risks to be considered for de-escalation within / from the Corporate Risk Register** Nil
   b) **Risks to be included on the Corporate Risk Register** Nil

Update

3. **Risk – 5180** Failure to meet HIMOR standards in staff residences at RBH adversely impacts the financial position and workforce - Work has been undertaken by Estates and Facilities to refurbish staff accommodation with 80% of bathrooms having been replaced, communal areas re-decorated and re-carpeted. Work to replace kitchens is starting in January 2017 and due to finish in March 2017. Mr J Maguire, Acting Director of Estates and Facilities intends to propose the risk is de-escalated through his Directorate Quality and Safety meeting and this risk will be presented at the next possible Patient Safety and Risk Assurance Committee for de-escalation before coming back to the Quality Committee for final approval.

Conclusion

4. Members are asked to note the assurances provided in relation to the ongoing management of the Corporate Risk Register and approve the proposed changes to it. A full review of the Corporate Risk Register will be undertaken with risk leads on a monthly basis.

Appendix 1 – Current Corporate Risk Register

Title:	Failure to meet service needs at times of increased attendance in ED/UCC/MAU impacts adversely on patient care				
ID	1810	Current Status	Live Risk Register – all risks accepted	Opened	05/07/13
Initial Rating	Likelihood: 5 Consequence: 3 Total: 15	Current Rating:	Likelihood: 5 Consequence: 3 Total: 15	Target Rating:	Likelihood: 3 Consequence: 3 Total: 9
Risk Handler:	Jill Wild	Risk Owner:	John Bannister	Linked to Risks:	
What is the Hazard:	• Increases in the volume of attendances in the Emergency Departments can lead to increased and extreme pressure resulting in a delayed delivery of the optimal standard of care across departments. • At times of extreme pressure this increase in the numbers of patients within the emergency pathway makes medical/nursing care difficult and impacts on clinical flow		What are the risks associated with the Hazard:	• Patients being managed on trolleys in the corridor areas of the emergency /urgent care departments impacting on privacy and dignity. • Delay in administration of non-critical medication. • Delays in time critical patient targets (four hour standard, stroke target) • Delay in patient assessment • Potential complaints and litigation. • Potential for increase in staff sickness and turnover. • Increase in use of bank and agency staff to backfill. • Lack of capacity to meet unexpected demands. • Delays in safe and timely transfer of patients	
What controls are in place:	• Daily staff capacity assessment • Daily Consultant ward rounds • Establishment of specialised flow team • Bed management teams • Delayed discharge teams • Bed meetings on a regular basis daily • Ongoing recruitment • Ongoing discussion with commissioners for health economy solutions		Where are the gaps in control:	Trust has no control over the number of attendees accessing ED/UCC services	

	• ED/UCC/AMU will take stable assessed patients out of the trolley space/bed to facilitate putting the unassessed patients in to bed/trolley • ED/UCC/AMU will take stable assessed patients out of the trolley space/bed to facilitate putting the unassessed patients in to bed/trolley		
What assurances are in place:	• Regular reports to a variety of specialist and Trust wide committees • Consultant recruitment action plan • Escalation policy and process • Monthly reporting as part of Integrated Performance Report • Weekly reporting at Exec Team	What are the gaps in assurance:	None identified
Actions to be carried out	Action assigned to	Anticipated completion date	Progress Report
Current planned actions completed			
Notes: Risk reviewed by John Bannister on 29 Dec 2016 and a future review will be conducted on 03 Feb 2017.			

Title:	Aggregated Risk – Failure to meet internal and external activity targets in year will result in loss of autonomy for the Trust				
ID	7017	Current Status	Live Risk Register – all risks accepted	Opened	01/09/16
Initial Rating	Likelihood: 5 Consequence: 3 Total: 15	Current Rating:	Likelihood: 5 Consequence: 3 Total: 15	Target Rating:	Likelihood: 3 Consequence: 3 Total: 9
Risk Handler:		Risk Owner:	John Bannister	Linked to Risks:	1489 (DCS), 2310 (CEO), 4118 (FC), 6487 (ICG), 6509 (FC), 6893 (ICG)
What is the Hazard:	Non achievement of internal and external activity targets will result in increased external scrutiny and potential special measures		What are the risks associated with the Hazard:	• Patient harm due to late/ no treatment • Reputation of the Trust • Special measures • Contractual penalties	
What controls are in place:	• Monitoring at Trust, Divisional, Directorate and service level Reporting to commissioners • Reporting externally to regulators • Data uploads e.g. HED • Strong monitoring of performance standards		Where are the gaps in control:	Demand for non-elective services impacting on planned service delivery	
What assurances are in place:	•Action plans are in place for recovery of exceptions to performance reported on an ongoing basis •Close monitoring of planned actual activity and areas of pressure •Continual monitoring and reporting of exceptions to expected performance •Performance management processes in place to support appropriate escalation of issues and management of exceptions to expected performance •Reviewed at Trust Board meeting and supporting committees •Ongoing review at Executive Team meetings weekly		What are the gaps in assurance:		

Actions to be carried out	Action assigned to	Anticipated completion date	Progress Report
As per individual linked risk actions			
Notes: A review was conducted by John Bannister on 29 Dec 2016 and this risk will be next reviewed on 03 Feb 2017.			

Title:	Aggregated risk – Failure to reduce medical locum costs will adversely impact financial sustainability and patient care				
ID	5790	Current Status	Live Risk Register – All risks accepted	Opened	11/09/15
Initial Rating	Likelihood: 5 Consequence: 3 Total: 15	Current Rating:	Likelihood: 5 Consequence: 3 Total: 15	Target Rating:	Likelihood: 3 Consequence: 3 Total: 9
Risk Handler:	Simon Hill	Risk Owner:	Damian Riley	Linked to Risks:	908 (ICG), 4488 (ICG), 5702 (ICG),5703 (ICG), 6487 (ICG), 6637 (ICG), 6930 (ICG)
What is the Hazard:	Gaps in medical rotas require the use of locums to meet service needs at a premium cost to the Trust		What are the risks associated with the Hazard:	• Escalating costs for locums • Breach of agency cap • Unplanned expenditure • Need to find savings from elsewhere in budgets	
What controls are in place:	• Divisional Director sign off for locum usage • Ongoing advertisement of medical vacancies • Consultant cross cover at times of need		Where are the gaps in control:	Availability of medical staff to fill permanent posts due to national shortages in specialties	
What assurances are in place:	• Directorate action plans to recruit to vacancies • Reviews of action plans and staffing requirements at Divisional meetings • Reviews of action plans and staffing requirements at trust Board meetings and Board subcommittees • Reviews of plans and staffing requirements at performance meetings		What are the gaps in assurance:		
Actions to be carried out		Action assigned to	Anticipated completion date	Progress Report	
Per individual linked risks					
Notes: Reviewed by Damien Riley on 03 Jan 2017. Due for review on 03 Feb 2017.					

Title:	Aggregated risk – Failure to reduce nursing and midwifery agency costs will adversely impact financial sustainability and patient care				
ID	5791	Current Status	Live Risk Register – all risks accepted	Opened	11/09/15
Initial Rating	Likelihood: 3 Consequence: 5 Total: 15	Current Rating:	Likelihood: 3 Consequence: 5 Total: 15	Target Rating:	Likelihood: 4 Consequence: 2 Total: 8
Risk Handler:		Risk Owner:	Christine Pearson	Linked to Risks:	3804 (ICG), 4640 (SAS), 4708 (DCS), 5789 (ICG), 6487 (ICG), 6637 (ICG), 6930 (ICG)
What is the Hazard:	Use of agency staff is costly in terms of finance and levels of care provided to patients		What are the risks associated with the Hazard:	• Breach of agency cap • Agency costs jeopardising budget management	
What controls are in place:	• Daily staff teleconference • Reallocation of staff to address deficits in skills/numbers • Ongoing reviews of ward staffing levels and numbers at a corporate level • 6 monthly audit of acuity and dependency to staffing levels • Recording and reporting of planned to actual staffing levels • E-rostering • Ongoing recruitment campaigns • Overseas recruitment as appropriate • Establishment of internal staff bank arrangements • Senior nursing staff authorisation of agency usage • Monthly financial reporting		Where are the gaps in control:	• Unplanned short notice leave • Non elective activity impacting on associated staffing • Break downs in discharge planning • Individuals acting outside control environment	
What assurances are in place:	• Daily staffing teleconference with Director of Nursing • 6 monthly formal audit of staffing needs to acuity of patients • Exercise of professional judgement on a daily basis to		What are the gaps in assurance:		

	allocate staff appropriately • Monthly report at Trust Board meeting on planned to actual nurse staffing levels • Active progression of recruitment programmes in identified areas		
Actions to be carried out	Action assigned to	Anticipated completion date	Progress Report
Per individual linked risks			
Notes: Reviewed on 3 Jan 2017 by Christine Pearson. Improvements have been made with Healthcare support workers but RN problems remain on-going. Due for review 3 Feb 2017.			

Title:	Aggregated Risk – Failure to meet internal and external financial targets in year will adversely impact the Continuity of Service Risk Rating				
ID	7010	Current Status	Live Risk Register – all risks accepted	Opened	25/08/16
Initial Rating	Likelihood: 3 Consequence: 5 Total: 15	Current Rating:	Likelihood: 4 Consequence: 4 Total: 16	Target Rating:	Likelihood: 4 Consequence: 3 Total: 12
Risk Handler:	Allen Graves	Risk Owner:	Michelle Brown	Linked to Risks:	1487 (DCS), 1489 (DCS), 4118 (FC), 6115 (FC), 6229 (ICG), 6230 (ICG), 6487 (ICG), 6509 (FC), 6868 (FC)
What is the Hazard:	Failure to meet the targets will result in the Trust having an unsustainable financial position going forward and the likely imposition of special measures		What are the risks associated with the Hazard:	• If Divisions deliver their SRCP and meet their Divisional financial plans the Trust will achieve its agreed control total. • Breach of control totals will likely result in special measures for the Trust, adverse impact on reputation and loss of autonomy for the Trust • Sustainability and Transformational funding would not be available to the Trust • Cash position would be severely compromised	
What controls are in place:	• Standing Orders • Standing Financial Instructions • Procurement standard operating practice and procedures • Delegated authority limits at appropriate levels • Training for budget holders • Availability of guidance and policies on Trust intranet • Monthly reconciliation • Daily review of cash balances		Where are the gaps in control:	Individual acting outside control environment in place	

	• Finance department standard operating procedures and segregation of duties		
What assurances are in place:	• Variety of financial monitoring reports produced to support planning and performance • Monthly budget variance undertaken and reported widely • External audit reports on financial systems and their operation • Monthly budget variance undertaken by Directorate and reported at Divisional Meeting • Monthly budget variance report produced and considered by corporate and Trust Board meetings • internal audit reports on financial system and their operation	What are the gaps in assurance:	
Actions to be carried out	Action assigned to	Anticipated completion date	Progress Report
Per individual linked risks			
Notes: Reviewed by Charlotte Henson on 4 Jan 2017. To be next reviewed 4 Feb 2017			

Title:	Failure to meet demand in chemotherapy units due to staffing and accommodation will result in treatment breaches preventing safety and quality being at the heart of everything we do				
ID	3841	Current Status	Live Risk Register – all Risks accepted	Opened	04/08/14
Initial Rating	Likelihood: 3 Consequence: 3 Total: 9	Current Rating:	Likelihood: 5 Consequence: 3 Total: 15	Target Rating:	Likelihood: 2 Consequence: 2 Total: 4
Risk Handler:	Deborah Sullivan	Risk Owner:	John Bannister	Linked to Risks:	
What is the Hazard:	Capacity pressures in the chemotherapy units at both Blackburn and Burnley sites due to staffing and accommodation. Therefore capacity could potentially be unable to meet the demand of the service. This is having a significant effect on staff workload pressures		What are the risks associated with the Hazard:	• Due to the increase in the number of patients requiring chemotherapy the chemotherapy units are at risk of being unable to cope with the demand of treatments required due to capacity issues. This could result in patients breaching and potentially serious errors could occur. In addition to the nursing staff, this presents pressure on the admin/reception support within the unit(s). • Accommodation in both units is not adequate	
What controls are in place:	• All patients are scheduled using the Varian (medonc) oncology computer system to schedule chair and nurse time. • Nursing and clerical staff work across both sites to ensure adequate cover. • Ongoing staff recruitment • Development of business case for consideration 01/09/16		Where are the gaps in control:	• Patient deferrals and unexpected emergency treatment mean the Varian system is not always efficient. • Unplanned leave • Lack of flexibility in accommodation • Lack of suitably qualified/ experienced applicants for recruitment	
What assurances are in place:	• Monitoring of chemotherapy activity is now included in the monthly cancer directorate meeting • Monthly meetings taking place with Business manager cancer services, lead Macmillan cancer nurse, and the 2 chemotherapy sisters.		What are the gaps in assurance:		

Actions to be carried out	Action assigned to	Anticipated completion date	Progress Report
Advertise and interview	Deborah Sullivan	30 Jan 2017	
Recruitment	Deborah Sullivan	01 Feb 2017	
Notes: Reviewed by Deborah Sullivan on 30 Dec 2016. Due for review on 30 January 2017.			

Title:	Failure to meet ICO requirements will lead to ICO intervention and financial penalties				
ID	6912	Current Status	Live Risk Register – all risks accepted	Opened	04/07/16
Initial Rating	Likelihood: 5 Consequence: 4 Total: 20	Current Rating:	Likelihood: 3 Consequence: 5 Total: 15	Target Rating:	Likelihood: 2 Consequence: 4 Total: 8
Risk Handler:	Frances Murphy	Risk Owner:	Michelle Brown	Linked to Risks:	
What is the Hazard:	Insufficient resources to support current demand for Data Protection / Freedom of Information / Information Governance (including potential litigation) requests have resulted in a number of ICO decision notices over the last six months		What are the risks associated with the Hazard:	• Current involvement by ICO in a number of FOI and DPA requests escalates to enforcement action / sanctions resulting in potential fines • Further decision notices being issued due to poor information governance practice across the Trust • Continued decline in IG toolkit score jeopardising contracts	
What controls are in place:	• Temporary support for FOI's from Q&S admin staff - unsustainable due to other duties • IG structure increased - no alignment to FOI function or other departmental SAR / health record / DPA request functions • IG steering group - frequency and attendance are issues • SIRO function		Where are the gaps in control:	• Annual and unplanned leave arrangements • Workload of two staff dealing with FOI does not always allow daily checking and follow up	
What assurances are in place:	• Bi- monthly report to IG Steering Group • Summary report from IG Steering Group to Patient Safety and Risk Assurance Committee • Annual SIRO report to Trust Board on Information Governance • IG Toolkit Audit annually		What are the gaps in assurance:	Occasional cancellation of IG Steering Group	
Actions to be carried out		Action assigned to	Anticipated completion date	Progress Report	
Notes: Reviewed by Frances Murphy on 3 Jan 2017. Due for review on or before 03 Feb 2017.					

Title:	Aggregated Risk - Failure to provide timely Mental Health treatment impacts adversely on patient care & safety and quality				
ID	7067	Current Status	Live Risk Register – all risks accepted	Opened	06/10/2016
Initial Rating	Likelihood: 5 Consequence: 3 Total: 15	Current Rating:	Likelihood: 5 Consequence: 3 Total: 15	Target Rating:	Likelihood: 2 Consequence:3 Total: 6
Risk Handler:	Jill Wild	Risk Owner:	John Bannister	Linked to Risks:	4423 (FC), 2161 (FC) 6095 (ICG)
What is the Hazard:	Mental Health patients with decision to admit may have extended waits for bed allocation.		What are the risks associated with the Hazard:	• Impact on 4 hour and 12 hour standards in ED • Impact on patient care • Risk of harm to other patients • Impact on staffing to monitor/ manage patient with MH needs	
What controls are in place:	• Frequent meetings to minimise risk between senior LCFT managers and Senior ELHT managers to discuss issues and develop pathways to mitigate risk including; • Mental Health Shared care policy, • OOH Escalation pathway for Mental health patients, • Instigation of 24hrs a day Band 3 MH Observation staff. • Ring fenced assessment beds within LCFT bed base (x1Male, x1Female). • In Family Care – liaison with ELCAS		Where are the gaps in control:	• Unplanned demand • ELCAS only commissioned to provide weekday service • Limited appropriately trained agency staff available	
What assurances are in place:	• Ongoing meetings with LCFT and commissioners • Regular review at Divisional and Executive team level		What are the gaps in assurance:		
Actions to be carried out		Action assigned to	Anticipated completion date	Progress Report	
Per linked risks					
Notes: Reviewed by John Bannister on 29 Dec 2016 and next due for review on 03 Feb 2017					

Title:	Aggregated Risk – Failure to deliver stroke care within national guidance will adversely impact patient care and attract financial penalties				
ID	6828	Current Status	Live Risk Register – All risks accepted	Opened	03/05/16
Initial Rating	Likelihood: 5 Consequence: 3 Total: 15	Current Rating:	Likelihood: 5 Consequence: 3 Total: 15	Target Rating:	Likelihood: 2 Consequence: 3 Total: 6
Risk Handler:	Nick Roberts	Risk Owner:	John Bannister	Linked to Risks:	2051 (DCS), 6893 (ICG) 2256 (ICG)
What is the Hazard:	• Lack of capacity combined with a model focused on inpatient care is leaving some patients without the level of quality care expected • Therapy services do not meet the recommended levels of intervention in terms of frequency, intensity and range of service deliveries.		What are the risks associated with the Hazard:	• Compliance against the quality indicators within SSNAP • Care is provided below the standard expected by non-stroke specialists and will impact on patient outcome. • Lack of therapy support leads impacts on outcomes, clinical flow, length of stay & performance	
What controls are in place:	• Ongoing monitoring of SSNAP data • Ongoing identification, and where possible, transfer of stroke patients not on stroke unit. • Prioritisation of stroke services by therapies staff		Where are the gaps in control:	Unplanned demands for service	
What assurances are in place:	• Monitoring through Stroke Steering Group • Reporting to Operational Delivery Board • Reporting to Divisional Quality and Safety Board		What are the gaps in assurance:		
Actions to be carried out		Action assigned to	Anticipated completion date	Progress Report	
Per linked risks					
Notes: Reviewed by Dr Roberts on 03 Jan 2017. Due for next review on 03 Feb 2017 whilst work is on-going.					

Title:	Failure to meet HIMOR standards in staff residences at RBH adversely impacts the financial position and workforce				
ID	5180	Current Status	Live Risk Register – All Risks Accepted	Opened	29/04/15
Initial Rating	Likelihood: 5 Consequence: 4 Total: 20	Current Rating:	Likelihood: 4 Consequence: 4 Total: 16	Target Rating:	Likelihood: 2 Consequence: 4 Total: 8
Risk Handler:	Jim Maguire	Risk Owner:	John Bannister	Linked to Risks:	
What is the Hazard:	Failure to meet the HIMOR (Housing (Management of Houses in Multiple Occupation) Regulations 1990) in the staff residence buildings at Royal Blackburn Hospital will impact on the Trust's achievement of a sustainable financial position and its ability to develop and deliver a safe, competent workforce.		What are the risks associated with the Hazard:	• The current residences do not meet the regulations under which accommodation must be provided to medical students on placement. This could result in • Loss of accreditation to provide medical training • Breach of statutory obligations • Financial penalties • Damage to reputation of the Trust.	
What controls are in place:	• Faults are reported to BBW. • Highlighted to Head of Estates that action needs to be taken to rectify these faults immediately.		Where are the gaps in control:		
What assurances are in place:			What are the gaps in assurance:		
Actions to be carried out		Action assigned to	Anticipated completion date	Progress Report	
Accommodation upgrade		Heather Henderson	November 2016	Funding allocated to achieve priority repairs by November 2016 Work commenced May 2016	
Notes: This risk has been reviewed by James Maguire. 80% of bathrooms are complete. All communal areas re-decorated and re-carpeted. Kitchen work to start January 2017 and be complete by March 2017. This risk will be presented at the next directorate level committee with a proposal for de-escalation. Once ratified it will be presented to the Quality Committee for approval.					

Title:	Failure to provide refurbished ward areas due to delays in refurbishment programme impacting on regulatory, contractual & national performance targets				
ID	1660	Current Status	Live Risk Register – all risks accepted	Opened	17/10/12
Initial Rating	Likelihood: 5 Consequence: 4 Total: 20	Current Rating:	Likelihood: 4 Consequence:4 Total: 16	Target Rating:	Likelihood: 3 Consequence: 4 Total: 12
Risk Handler:	Jim Maguire	Risk Owner:	John Bannister	Linked to Risks:	
What is the Hazard:	• Failure to gain access to patient occupied areas for a set period of time without patients being present will not allow PFI partners access to undertake statutory maintenance work, additional refurbishment work and Trust cleaning programs to be undertaken. • Failure to undertake the refurbishment programme at the Royal Blackburn Hospital site will impact on the Trust's ability to achieve regulatory, contractual and national performance targets and achieve a sustainable financial position.		What are the risks associated with the Hazard:	• Backlog maintenance continues to increase having a long and medium term impact on the physical estate and environment and implications for the PFI contract. • Failure to implement the refurbishment programme may lead to suboptimal environments for the delivery of care and an inability to demonstrate compliance with regulatory and contractual requirements. This will impact on the delivery of care, trust performance, the imposition of financial penalties and reputational damage and may result in a requirement to derogate PFI provider from contractual responsibilities.	
What controls are in place:			Where are the gaps in control:		
What assurances are in place:			What are the gaps in assurance:		
Actions to be carried out		Action assigned to	Anticipated completion date	Progress Report	
Notes: Reviewed by James Maguire on 3 Jan 2017. To be reviewed again on 03 Feb 2017.					

TRUST BOARD REPORT

Item 12

25 January 2017

Purpose Approval

Title	Board Assurance Framework (BAF)
Author	Mrs A Bosnjak-Szekeres, Associate Director of Corporate Governance/Company Secretary
Executive sponsor	Dr D Riley, Medical Director

Summary:
The Executive Directors have reviewed the risks monitored on the BAF and updated the controls, assurances and actions in relation to each risk where appropriate.

As requested by the Board it can be confirmed that, in preparing this report the external context has been taken into account, such as legislative and regulatory requirements placed on NHS providers. Other elements such as local needs, trends and engagement with stakeholders have been considered and have influenced the review of the BAF risks.

Recommendation:

The Board is asked to note the changes and approve the revised Board Assurance Framework, including the reduction in the rating of BAF risk 6 from 20 to 16.

Report linkages

Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do
	Invest in and develop our workforce
	Work with key stakeholders to develop effective partnerships
	Encourage innovation and pathway reform, and deliver best practice

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by: the Executive (17 January 2017) and Operational Delivery Board (18 January 2017).

The Executive Directors have updated the BAF risks and the following changes have been made since the document was last presented to the Board.

a) **Risk 1** – the **risk score remains** 12 (likelihood 3 x consequence 4). New key controls include the two year operational plan linking to the transformational plan that has been agreed and submitted to the regulator and the agreement and signing of the two year contracts with local commissioners. New potential sources of assurance identified include:

   i. The final clinical model at Pennine Lancashire level that will be agreed by system leaders at the end of January and the development of shared business case for consultation.

   ii. The system leaders have committed to work as an Accountable Care System from April 2017.

   iii. The Trust's Director of Sustainability has been appointed to chair the system wide (Pennine Lancashire) Finance and Investment Group.

   iv. Divisional plans are being developed that are linked to the operational and transformational plans.

b) **Risk 2 –** the **risk score remains** 12 (likelihood 3 x consequence 4). The section on potential sources of assurance has been updated to include the increase in the response rate to the national staff survey. Gaps in assurance have been updated to include that assurances are continuing on an ongoing basis through the HR governance processes. Updates on the actions are included on the BAF register.

c) **Risk 3** – the **risk score remains** 9 (likelihood 3 x consequence 3). Key controls now include the development of the Care Professionals Group at STP level and the agreement of improvement priorities for partnership delivery at Pennine Lancashire level. New potential sources of assurance have been added relating to the establishment of health delivery partnerships at Pennine Lancashire level relating to the health improvement priorities and the Trust is initiating a number of provider to provider discussions (eg GP federations) with the aim of refining the clinical pathways. The planned actions section has been updated to reflect the progress made to align the CCG with the priorities for internal pathway redesign for services such as stroke, the Lancashire review of specialist services to serve the population concluding at the end of quarter 4.

d) **Risk 4** – the **risk score remains** 16 (likelihood 4 x consequence 4). The updates include the work being undertaken to complete the solution design

phase and the service model proposal that will be presented to the system leaders at the end of January. Risks regarding the end product of the solution design phase in relation to new models of care have reduced and continuous consultation through the solution design phase has been modified based on public feedback. The gaps in control have been updated to include the recognition that the governance systems for an Accountable Care System across Pennine Lancashire are being developed; however they are still in the early phase. An update in relation to the actions planned includes the commencement of a focused piece of modelling work at Pennine and Healthier Lancashire levels regarding potential service configurations.

e) **Risk 5 –** the **risk score remains** 16 (likelihood 4 x consequence 4). The section on potential sources of assurance has been updated in relation to the regular Performance Review meetings between Executives and Divisions and the development of financial recovery plans which will be presented to the Finance and Performance Committee in February and Board in March for approval. Gaps in assurance have been updated to include the requirement for financial recovery plans to be in place.

f) **Risk 6 –**the **risk score reduced from 20 to 16** (likelihood 4 x consequence 4 – reduction in the likelihood score from 5 to 4). The reduction in score is recommended due to the improvement in the CQC Trust rating to 'good', moving to regulatory segmentation two from segmentation three, the approval of the two year business plan by the regulator, the signing of the two year contracts with the local commissioners and the achievement of the 62 day cancer standard for quarter three.

The section on key controls has been updated to include the establishment of an internal programme board for the emergency pathway improvement programme and the support from NHS Improvement starting during the month of January. Potential sources of assurance include:

i. The commencement of the Cancer 62 day target improvement plan, which is showing a positive impact through enhanced operational meetings.

ii. In quarter 1 approximately six wards will be potentially eligible for silver accreditation under the Nursing Assessment and Performance Framework following three successive 'green' assessments.

iii. An increased number of assessments under the framework are planned and it is envisaged that all wards will have been visited during quarter 1 and 2 in 2017.

iv. The revision of the weekly operational performance meeting and of the Divisional performance meeting framework.

The gaps in control include the need to review the governance of the Divisional performance meetings to reduce gaps between the meetings and achieve better chances of a timely response and actions. The gaps in assurance have been update to reflect the fact that the emergency pathway performance remains a challenge and is putting pressure on the delivery of elective care, particularly referral to treatment targets (RTT).

In relation to the planned actions the expected completion date for the reduction of complaints has been revised due to the increase in the number of complaints and operational pressures, a new completion date had been agreed for the end of March 2017. In addition, there will be enhanced governance around the weekly operational meetings which will be to be put in place by the end of January and improved frequency of the divisional performance meetings will be in place by the end of March.

Angela Bosnjak-Szekeres, Associate Director of Corporate Governance/Company Secretary, 12 January 2017.

Ref	Principle Director	Strategic Risk *What could prevent these objectives being achieved.*	Risk related to strategic objectives	Key Controls *What controls/systems, we have in place to assist in securing delivery of our objective.*	Potential Sources of Assurance *Where we can gain evidence that our controls/systems on which we are place reliance, are effective*	Initial Risk Score	Risk Tolerance Score	Current Risk Score	Likelihood x Consequence	Annual Risk Score 2015/16				Gaps in Control *Where we are failing to put controls/systems in place. Where we are failing in making them effective.*	Gaps in Assurance *Where we are failing to gain evidence that our controls/systems, on which we place reliance, are effective.*	Actions Planned / Update *Dates, notes on slippage or controls/assurance failing.*
										Q1	Q2	Q3	Q4			
BAF/01	Director of Service Improvement	Transformation schemes fail to deliver the clinical strategy, benefits and improvements and the organisation's corporate objectives	Aligned to Strategic Objectives 1,2,3 and 4.	Integrated transformation plans agreed at organisational level, overarching tracker for transformation and SRCP, Transformation Board meetings (internal and external stakeholders), divisional Transformation Boards report into the Transformation Board that reports into the Finance & Performance Committee. Membership of the Pennine Lancashire Transformation Board (6 workstreams). Transformation/business plans linked to the clinical strategy, high level workforce and estate interdependencies identified. Two year operational plan linking to the transformational plan agreed and submitted to the regulator. Two year contract with commissioners (not specialist) agreed and signed.	Monthly report demonstrating progress against key targets reported to the Transformation Board and the Finance & Performance Committee Presentation to the Quality Committee on the quality aspect of the transformation programme Board presentation on individual transformation projects Revised RAG rating should assist with assurance about the delivery. Internal Audit piece on transformation underway and will be presented to the Audit Committee in due course. Final clinical model at Pennine level to be agreed by system leaders at the end of January and the development of shared business case being developed for consultation. System Leaders Forum committed to work as an Accountable Care System from April 2017. Director of Sustainability chairing the system wide (Pennine Lancashire) Finance and Investment Group. Divisional plans are being developed that are linked to the operational and transformational plans.	15	10	12	3x4	12	12	12		Capacity for delivery of transformation programme Service redesign methodology developed by the Trust (accepted by Pennine Lancashire). Workshops held at system level and plans for ownership due to the changed structures at Pennine Lancashire level are now being put in place. Capacity and resilience building in relation to the service redesign is in early phase.	Assurance in place about the process, but assurance about the delivery and benefits is still work in progress at this stage. Dependency on stakeholders to deliver key pieces of transformation. Economic modelling still at high level and linking with new clinical models is still to occur.	New reporting format agreed following meeting with the NED's Using the Transformation Board meetings and our membership on Pennine Lancashire to influence delivery of transformation. Case for change at Pennine Lancashire level agreed, Trust senior leadership involved in the solution design phase. This will be completed at the end of January Resources allocated for the delivery of the transformation programme. PMO infrastructure significantly increased and support to build capacity at Divisional level is ongoing. Plans for the service redesign to be driven by the clinical leadership. Update - methodology presented to the Transformation Board and accepted for inclusion into the Pennine Lancashire Transformation Plan. Management of this issue is still ongoing. Economic modelling to be linked to clinical models in quarter 4. There is a joint clinical leaders event for the Pennine Lancashire health economy held in February. PMO primary focus on emergency pathway currently as it is identified as an increased risk and is highlighted to the Finance and Performance Committee in the last two reports presented. Clinical engagement progressed at both Pennine Lancashire and Healthier Lancashire level and the Care Professionals Board is maturing Work started on 2017/18 transformation programme, within it specifically the SRCP programme for the forthcoming year, to be presented to the Board by the end of the current financial year. Change in Programme Director for Pennine Lancashire in April.
BAF/02	Director of HR/OD	Recruitment and workforce planning fail to deliver the Trust objectives	Aligned to Strategic Objectives 2, 3 and 4.	Transformation plans relating to workforce in place monitored through Transformation Board. Divisional Workforce Plans aligned to Business & Financial Plans, Divisional Performance Meetings, Reports to Finance & Performance Committee, Workforce Controls Group, Population/Person Centric Workforce Planning Methoddology	Performance measures, time limited focus groups with action plans, board and committee reports, regulatory and inspection agencies, stakeholders, internal audit. National staff survey response rate increased in comparison form 2015/16.	16	10	12	3x4	12	12	12		National recruitment shortages, capacity for delivery of transformation programmes, financial restrictions Increase in controls for bank and agency increased in November in line with the national regulatory requirements.	Assurances in place in the IPR, Safer Staffing Report and Quality Dashboard. Assurances continue on an ongoing basis through the HR governance processes.	'Overseas recruitment campaigns, (the Philippines for nurses and India for Doctors) have been successfully completed with a number of new recruits expected to be in place within 4 months. The Trusts recruitment and retention plan continues to be in place. We continue to embed to the 'Retire and Return' approach as a response to those nearing retirement. The Trust ensures that all staff are involved, included and engaged with on key changes within the Trust using the Employee Engagement Strategy. The recent WRES report is being addressed using the agreed action plan and will be reported regularly to the Board. The workforce transformation approach has been discussed and agreed at the Quality Committee in January 2017. The approach aims to understand the future workforce supply pipeline, opportunities to up skill current staff, introducing new roles, e.g. Physicians Associates and Associate Nurses and establishing new ways of working. This approach will direct the Pennine Lancashire approach to workforce transformation. The Finance and HR teams have put in place further controls to reduce bank and agency spend.
BAF/03	Medical Director	Collaborative working fails to support delivery of sustainable, safe and effective care through clinical pathways	Aligned to strategic objectives 3 and 4.	Care Professional Group of Pennine Lancashire reporting to the Transformation Steering Group. Care Professionals Group at STP level now also formed. At Pennine Lancashire level health improvement priorities agreed and there is a proposal for a partnership delivery. Governance controls in place feeding into the Clinical Effectiveness Committee and into the Quality Committee.	Clinical Effectiveness Committee acting as a governance mechanism for the agreement of the internal pathways and guideline. Stroke pathway already included in the transformation programme. ELHT Transformation Board has urgent care and elective care pathway reporting process. Clinical effectiveness review will be carried out during quarter 4. Pennine Lancashire resource in post working on developing models of care against specific improvement priorities (paediatrics, respiratory and frailty). Health delivery partnerships at Pennine Lancashire level to be established under the health improvement priorities. ELHT are initiating a number of provider to provider discussions (eg GP federations with the aim of refining the clinical pathways).	9	6	9	3x3	9	9	9		Not all pathway developments linked in fully with the transformation programme	No separate programme is place to consolidate internal clinical pathways. Mechanism for prioritisation of pathway development not in place at divisional/organisational level; however this will be addressed by the Clinical Effectiveness review in quarter 4 Priorities of CCGs to be aligned with priorities for internal pathway redesign (eg stroke).	Prioritisation mechanism to be resolved at 2 levels - internally as part of the transformation programme & externally as part of the Pennine Lancashire Health improvement priorities initial assessment being reviewed at Care Professionals Board each month as part of the Pennine Lancashire Transformation Programme. This work is ongoing Across the STP footprint the Medical Directors of the four Trusts agreed to focus on urology, vascular services, stroke, emergency department, interventional radiology and gastrointestinal bleed, and neonatology Lancashire review of specialist services to serve the population is hoped to conclude at the end of quarter 4. Some progress made with aligning the CCG with the priorities for the internal pathway redesign (eg Stroke).
BAF/04	Chief Executive/ Director of Finance/ Director of Service Improvement	Alignment of partnership organisations and collaborative strategies (Pennine Lancashire and Healthier Lancashire) are not sufficient to support the delivery of sustainable services by the Trust	3,4,5	Senior Leaders' Forum meets to discuss strategy. Engagement by senior leaders in wider transformation programmes. Regular Board updates and decisions on key actions. Strengthen links between internal transformation and external change processes.	Verbal and written updates, where appropriate Board approvals will be established and permissions will be provided by the Board to let Executives to progress the generations of ideas and options with external stakeholders. At Pennine Lancashire level a Case for Change has been published. The solution design phase is being completed and the service model proposal will be presented to the system leaders at the end of January. Senior leaders from Trust involved at strategic level. Risks regarding the end product of the solution design phase in relation to new models of care reduced. Continuous consultation through the solution design phase and the process has been modified based on public feedback.	16	12	16	4x4	16	16	16		System leaders agreed a process to develop the governance system for an ACS across Pennine Lancashire; however this is still in the early phase.	Governance model at both Pennine Lancashire and STP level are in early phase.	Regular updates provided to Board Pennine Lancashire Memorandum of understanding was presented to the July Trust Board and principles agreed. Pennine Lancashire project solution design phase to be completed and signed off at the end of January. A focused piece of modelling work in progress at Pennine and STP level on potential service configurations to conclude at the end of quarter 4.
BAF/05	Director of Finance	The Trust fails to achieve a sustainable financial position and appropriate financial risk rating in line with the Single Oversight Framework	3,4,5	Ensure suitable controls are in place to maintain budgetary control (income and expenditure). These controls need to extend to effective workforce arrangements. In addition to controls the Trust must ensure that measures are in place to close the financial gap (SRCP), via the Transformation and SRCP schemes effectively monitored by the PMO and the Finance Department and Trust Executives.	Monthly reporting to Finance and Performance reports and the Board to reflect financial position. Separate reporting available to support assurances on the transformation programme. Regular Performance Review meetings between Executives and Divisions. Development of financial recovery plans (detailed draft February to be approved by the Board in March 2017).	16	12	16	4x4	16	16	16		Additional workforce controls to remain in place. policies and procedures may require amendments where they are no longer fit for purpose. Controls around transformation schemes and SRCP to be monitored by the PMO and the Finance Department with Division to be held to account via the PMO. Gaps in control regarding funding for A&E, RTT and STF Funding - recovery plans underway	Utilise the internal audit programme to test for assurance on core controls and SRCP. Financial recovery plans.	Regular updates to Board and Finance and Performance Committee Finance risk around A&E, RTT and STF funding identified and operational plans to recover are underway.
BAF/06	Director of Operations/ Director of Nursing/Medical Director	The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements	Aligned to strategic objectives 1, 3 and 4.	Divisional business plans, weekly operational performance meetings, quarterly divisional performance meetings feeding into the ODB and Finance and Performance Committee, emergency pathway and elective pathway work linking into the broader Trust wide transformation. Engagement meetings with CQC, quality and safety compliance assessed by each division, divisional assurance boards feeding into the operational sub-committees and the Quality Committee. Nursing Assessment Performance Framework System wide approach as part of the new A&E Delivery Board. Established an emergency pathway improvement programme and support from NHSI starting during the month of January.	IPR reporting to the ODB and at Board/Committee level, regular reporting to the NHSI, monthly integrated delivery meeting with the NHSI and A&E Delivery Board. Regular reporting from the divisions into the operational sub-committees and the Quality Committee. Alignment with national priorities through the quality and safety governance mechanisms. Good rating overall received from CQC. ED performance improvement action plan aligned with the NHSI Rapid Improvement Collaborative Cancer 62 day target improvement plan underway and having an impact through enhanced operational meetings. Achieved for quarter 3. In quarter 1 approximately six wards will be potentially eligible for silver accreditation under the Nursing Assessment and Performance Framework following three successive green assessments. Increased number of assessments under the framework planned and envisaged to complete all wards during quarter 1/2 2017. Revision of the weekly operational performance meeting and of the Divisional performance meeting framework.	15	9	16	4x4	15	20	20		Staffing potentially not sufficient to deal with the impact of external environment & high demand, difficulties with discharges. Complaints are a potential source of action by the CQC. Wider system analysis of capacity in primary care and care sector needed. Review of divisional performance meetings governance to reduce gaps between the meetings and achieve better chances of a timely response and action.	Risks around some of the national trajectories identified. Recovery plans are being implemented. Emergency performance continues to be a challenge and is putting pressure on elective care (RTT).	Timeline for the transformation of the emergency pathway plan agreed. Working as part of the Emergency Care Delivery Board to resolve demand issues and participating in the delayed discharge collaborative with the NHSI. Work on reducing the number of complaints, 50+ days complaints, completed at the end of July. Target to clear all 40+ day complaints by the end of October 2016. Completion date planned for the end of December 2016 was revised due to the increase in the number of complaints in November and early December and operational pressures, new completion date agreed for the end of March 2017. Challenges of achieving the four hour standard are being worked on, measures put in place to address performance and action plan has been submitted to NHSI with a view to improve performance and sustain it in the longer term. Board receives regular SRCP and transformation updates Work on the Ambulatory Emergency Care Model and Model Wards continues. Clinical redesign group has been launched in December. Recovery plans being implemented around achievement of national trajectories. Enhanced governance around the weekly operational meetings to be put in place by the end of January. Improved frequency of Divisional performance meetings to be in place by the end of March, linking to the transformational programme for 2017/18.

East Lancashire Hospitals NHS
NHS Trust

TRUST BOARD REPORT

Item 13

25 January 2017

Purpose Information Assurance

Title	Serious Incidents Requiring Investigation Report
Author	Miss S Nosheen, Interim Patient Safety Manager
Executive sponsor	Dr D Riley, Medical Director

Summary: This report provides a summary of the Serious incidents and Duty of Candour requirements that have occurred within the Trust in November and December 2016.

This report also provides a summary themed analysis of "fluid balance and input output charting" and the current quality improvement plans that have either taken place or are in progress aimed at improving fluid balance management

Recommendation: Members are asked to receive the report, note the contents and discuss the findings and receive assurance about the learning across the Trust from the report.

Report linkages

Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do Invest in and develop our workforce Work with key stakeholders to develop effective partnerships Encourage innovation and pathway reform, and deliver best practice
Related to key risks identified on assurance framework	Transformation schemes fail to deliver the clinical strategy, benefits and improvements and the organisation's corporate objectives Recruitment and workforce planning fail to deliver the Trust objectives Collaborative working fails to support delivery of sustainable, safe and effective care through clinical

pathways

Alignment of partnership organisations and collaborative strategies (Pennine Lancashire and Healthier Lancashire) are not sufficient to support the delivery of sustainable services by the Trust

The Trust fails to achieve a sustainable financial position and appropriate continuity of service risk rating.

The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by the Quality Committee (11 January 2017) and the Executive (17 January 2017)

Introduction
This paper provides the Board with:

- **Part 1:**
  An overview of all Serious Incidents Requiring Investigation (SIRIs) that have been reported during November 2016 and December 2016

- **Part 2:**
  A Duty of Candour performance report for November 2016 and December 2016

- **Part 3:**
  Trends, themes and analysis of fluid balance management and input/output charting

- **Part 4:**
  Quality improvement projects taking place/completed which are aimed at improving the fluid balance management

Part 1: Overview of SIRIS Reported

STEIS SIRIs reported in November 2016 and December 2016
There were 14 Strategic Executive Information System (STEIS) events reported in November and December 2016 which is an increase of 5 compared with the last reporting period. All will undergo Root Cause Analysis (RCA) which will be performance managed by the Trust's SIRI Panel and East Lancashire Clinical Commissioning Group.

No	Eir1	Division	Ward/ dept.	Description
1	116456	ICG	UCC	Diagnosis failure/problem
2	116699	ICG	C10	VTE
3	113206	FC	Gynaecology OPD	Failure to act on test results (Diagnosis failure/ problem)
4	117532	SAS	Theatres	Infection Control
5	118306	ICG	Ribblesdale Ward	Fractured Neck of Femur
6	118755	SAS	Cancer OPD	Failure to act on test results (Diagnosis failure/ problem)
7	117520	FC	Birth Suite	Treatment problem/issue
8	115827	FC	Children's Obs Unit	Diagnosis failure/problem
9	119039	FC	Children's Medical Unit	Medical devices and equipment
10	113342	SAS	B24	Hospital acquired G3 PU

No	Eir1	Division	Ward/ dept.	Description
11	116778	SAS	Critical Care	Deteriorating Patient (Treatment problem/issue)
12	109984	ICG	AMU	Diagnosis failure/problem
13	118282	ICG	Ward C7	Deteriorating Patient (Delay in Treatment)
14	116765	ICG	ED	Deteriorating Patient (Treatment problem/issue)

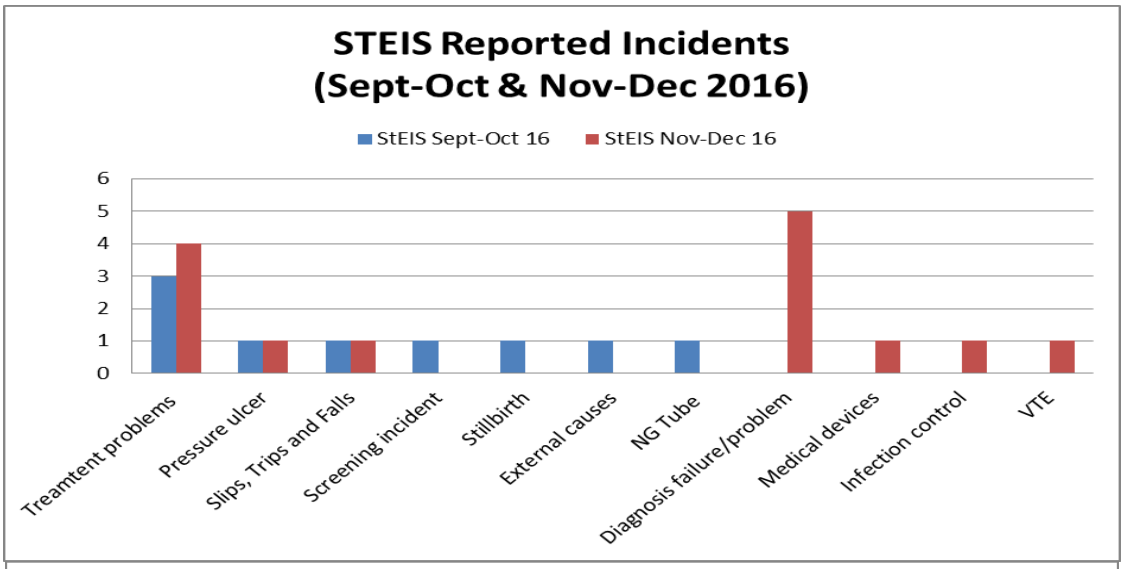
Non STEIS SIRIs reported in November and December 2016

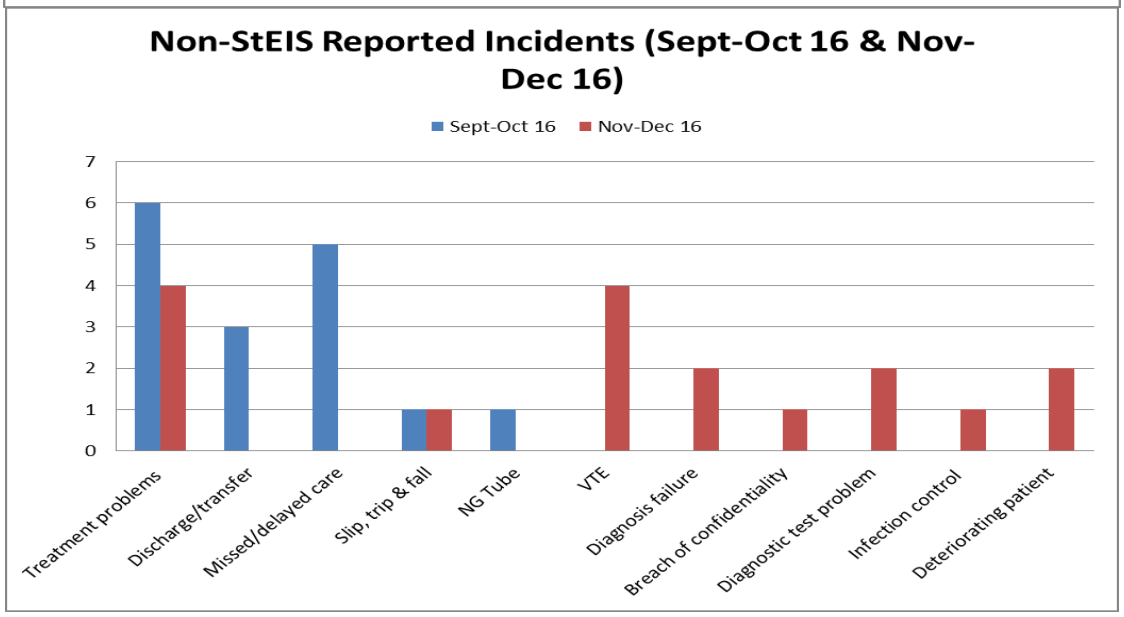
There were 17 non STEIS incidents deemed to be serious incidents requiring investigation in November and December 2016 compared to 16 in the previous reporting period. All will undergo RCA and will be performance managed by the Serious Incident Review Group (SIRG).

No	Eir1	Division	Ward/dept.	Description
1	111589	SAS	B14	VTE (Treatment problem/issue)
2	117150	ICG	ED	Failure diagnosis on X-Ray (Diagnosis failure/problem)
3	105768	FC	Wilson Hey Theatre	Bleeding from port following diagnostic laparoscopy (Treatment failure/problem)
4	115516	SAS	C14	VTE (Treatment problem/issue)
5	110594	SAS	Vascular	Breach of confidentiality – Information Governance
6	110903	DCS	Radiology Dept	CT scan performed on wrong body part (Diagnostic test problem)
7	113946	SAS	T&O on-call AMU	Diagnosis failure
8	115346	SAS	Ward 15	Deteriorating Patient (Diagnosis failure/problem)
9	115707	FC	Paediatrics	Enteral Nutrition (Treatment problem)
10	116378	ICG	AMU A	Slip, trip and fall
11	116450	ICG	C3	Treatment problem/issue
12	117050	FC	Birth Suite	VTE (Treatment problem/issue)
13	117025	ICG	Ward C9	VTE (Treatment problem/issue)
14	117110	FC	Birth Suite	Unexpected deterioration/ transfer to NICU (Diagnosis failure/problem)

No	Eir1	Division	Ward/dept.	Description
15	117888	FC	Ward 12	Delayed response to treatment requirements (Treatment problem/issue)
16	118107	ICG	Endoscopy unit	Infection control of equipment
17	118762	ICG	C2	CT performed on wrong patient (Diagnostic test problem/issue)

STEIS & non STEIS SIRIs reported above compared with previous months





Part 2: Duty of Candour (DOC) Performance Report

There were 39 patient safety incidents graded as moderate or above were reported in November and December 2016 which was an increase on the 31 that were reported in the previous reporting period.

The Duty of Candour completion requires:

1. The patient must be informed of the incident and offered an apology
2. A proposed investigation must be provided to the patient/relative
3. Patient must be offered opportunity to receive outcome of the investigation
4. All Duty of Candour conversations with patient should be documented in casenotes
5. A Duty of Candour letter detailing all the discussions and agreements should be sent to the patient.

All 5 steps must be completed for each incident graded moderate or above for Duty of Candour to be met.

At the time of writing this report (03.01.17) there are 2 incidents where Duty of Candour has not been fully served within the 10 day timeline. The progress of these 2 incidents is as follows:

Ref	Reported	Lead Division	Progress update
eIR1118095	05/12/2016	SAS	Patient has been informed of the incident and apology offered. Awaiting DoC letter, documentation in notes and proposal of investigation to be discussed with Patient/relative - in progress.
eIR1118282	08/12/2016	ICG	Patient has been informed of the incident and apology offered. Phone call with Patient/Relatives taken place, this requires documentation in casenotes before DoC can be closed as complete

These incidents were subject to the DoC regulations which dictate that DoC should be served within a 10 day timeline.

An update report setting out the rationale for the non-completion of DoC is shared with the Deputy Medical Director on a regular basis. The aim of this report is to facilitate a discussion between the Deputy Medical Director and the Senior Lead Clinician responsible for each of the DoC cases to resolve any perceived difficulties

In addition, a weekly meeting is held with the Divisional Governance Leads to review any outstanding DoC cases and to agree plans to bring them back on track.

Part 3: Fluid Balance: Trends, Themes and Analysis

Parts 3 and 4 of this report detail Trust responses to the specific challenge of fluid balance monitoring, including:

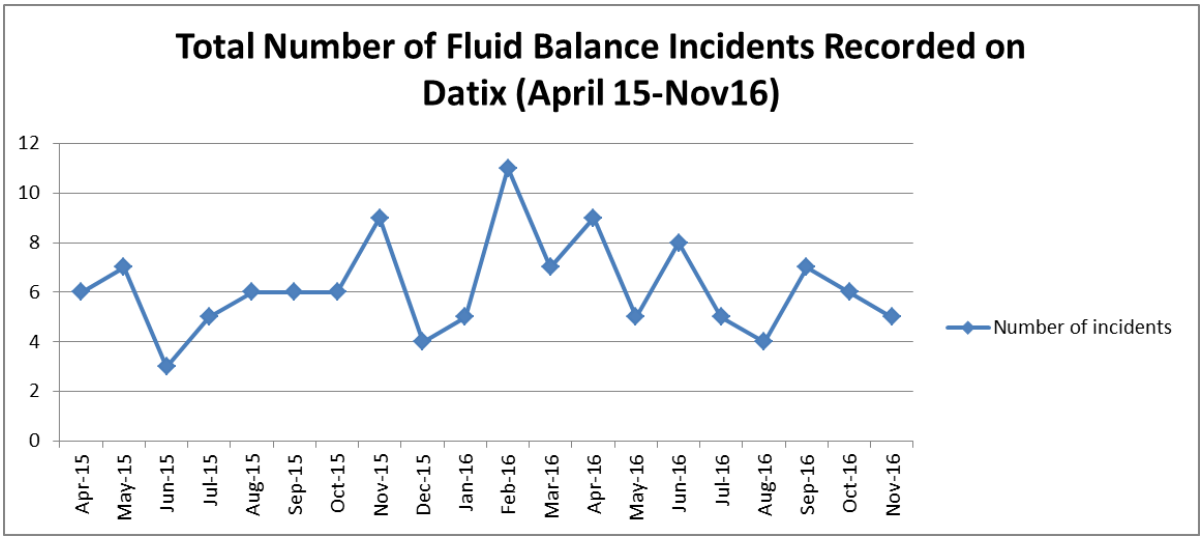
- **A review of incidents relating to fluid balance,**

- **A summary of key causes of incidents,**
- **A description of the actions underway**
- **A review of the current work underway piloting new fluid balance charting and**
- **Handover processes**

Definition: Fluid balance is a term used to describe the balance of the input and output of fluids in the body to allow metabolic processes to function correctly. To make a competent assessment of fluid balance, clinicians need to consider the different fluid compartments within the body and how fluid moves between these compartments. Water is a significant total part of body weight, it is essential to transport systems and perfusion, it helps to regulate body temperature, bolster and support joints and organs. It also facilitates digestion. Fluid balance is part of maintaining salt ("electrolyte") balance in the body. Once consequence of lack of adequate fluid is under-perfusion of the kidneys and this causes "acute kidney injury" ("AKI").

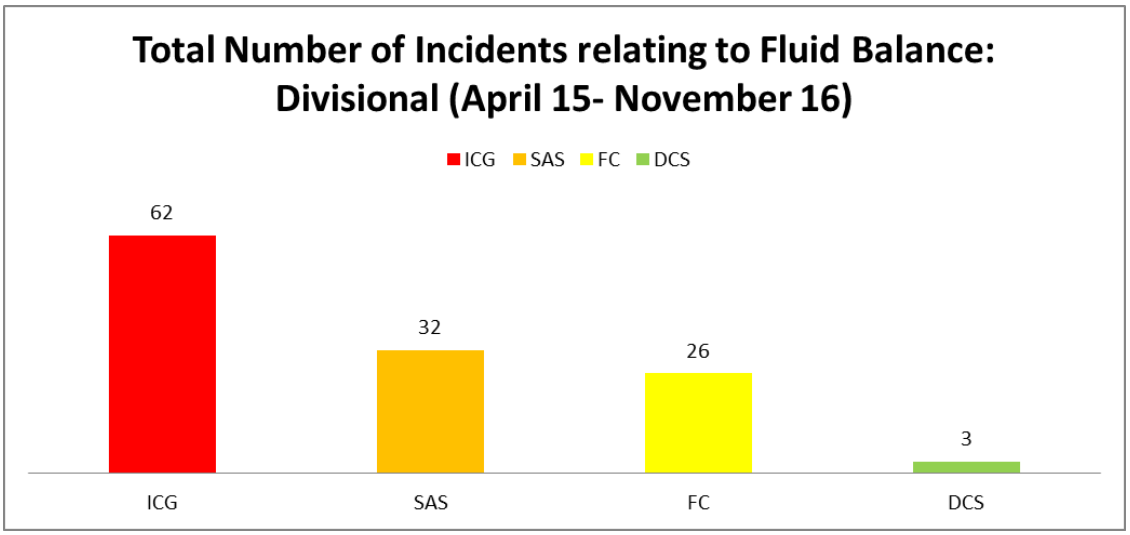
Accuracy in recording fluid intake and output is vital to the overall management of certain patient groups and to facilitate correct prescribing of intravenous and subcutaneous fluids. Prescribing the wrong type or amount of fluid can do harm. Assessment of fluid requirements needs care and attention, with adjustment for the individual patient.

The Datix system at East Lancashire NHS Trust is used to record all incidents that take place across the Organisation. An analysis of incidents relating to fluid balance has taken place from April 2015 to November 2016 and the number of incidents per month is as follows:



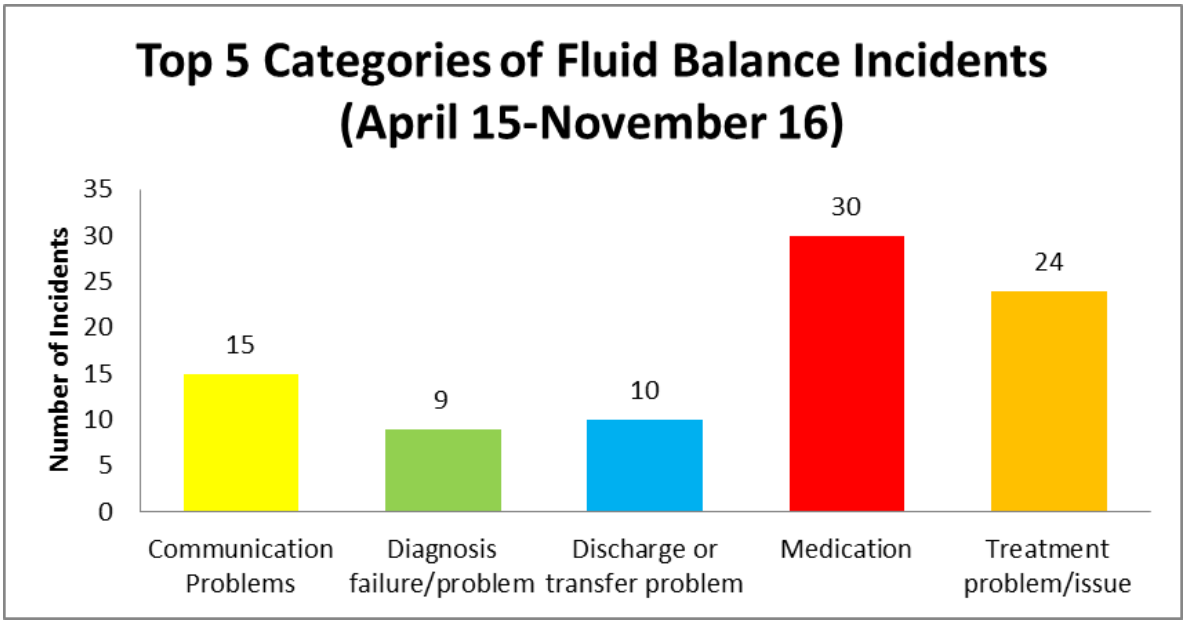
Method: The figures have been extracted from Datix using search criteria for "fluid" "dehydration" and "electrolytes". It is recognised the quality of the data is not all verified and there are potentially other incidents that might have been excluded under this search criteria.

Further analysis of these reported incident rates by Division is on the graph below:



Integrated Care Group (ICG) has the most incidents relating to fluid balance as it is the largest Division. Diagnostic Care Group (DCS) have 3 incidents assigned which are incidents relating to incorrect labelling/storage of fluids that were later used.

Category: Further analysis of the incidents on Datix demonstrated the following categories as the top 5 areas of cause for the incident:



Overall, the highest cause for fluid balance related incidents was medication management in relation to prescription, timing of commencing IV fluids, poor communication at handovers and documentation of input/output

Lessons learnt: Analyses of these incidents showed that lessons could be learnt in the following areas in order to help prevent the same incident occurring again:

Education

- Fluid balance is part of routine induction for medical staff and specific training sessions are provided to junior doctors.

Prescription

- Staff to check prescription rates of fluids
- Ensure treatment is prescribed and administrated before transfers
- Must check dates and times of fluid prescriptions
- Follow prescribed treatment plans without delays

Documentation

- Ensure documentation is accurate, up to date and accessible to all staff
- Ensure Early Warning Score is recorded accurately on charts

Guidelines

- Ensure all staff are aware of IV fluid guidelines
- Ensure all staff are aware of standard bag fluid protocol (120ml/kg)
- Follow the AKI guidelines at East Lancashire NHS Trust

Handovers

- Must be accurate and timely
- Must be updated again if bed is not available straight away (keep handover up to date up until the actual point of transfer)
- Ensure all patient's Early Warning Scores are done prior to transfers and that this information is passed on as part of the handover

Care Plans

- Ensure all staff are aware of the importance of completing care plans. Need More contemporaneous completion
- IV care plans need to be kept up to date
- Accurate intentional-rounding needs to be maintained

Agency Staff

- Ensure all agency staff have induction on the ward
- Ensure all agency staff are aware of procedure and protocols for fluid balance

Conclusion: Overall, the incident analysis shows the common cause for patient safety incidents were relating to the prescription processes, commencement of fluids, continuous documentation of input/output and communication between staff and departments.

Actions Underway: All of these incident causal factors have been reflected in the lessons learnt sections of incident investigations to date and they are identified areas for on-going improvement in the current Deteriorating Patients Quality Improvement Programme. Previous Board reports have emphasised the role of the Deteriorating Patients Faculty. Not only have Fluid Balance Standard Operating Procedures been re-issued in 2016, but also specific actions are underway in relation to fluid balance charting and reviews.

Part 4: Fluid balance guidance and Input/output Charts

Within the Trust, there is a Quality Improvement project underway which is specifically focusing on the improvement of fluid balance guidance and input/output charts. This is being led by the Assistant Divisional Director of Nursing (Jonathon Smith), Surgery Matron (Hillary Wallbank) and Director of Nursing for Surgery (Jarrod Walton-Pollard). Elements of this improvement work also link into the Trust's Deteriorating Patients Programme which is led by Deputy Chief Nurse (Julie Molyneaux).

Some elements of improvement have been tested on a small scale first to ensure the interventions in use actually demonstrate an improvement and are successful in practice before being embedded wider. Some elements of the improvement work have already been tested and spread across the Organisation, in particular relating to new chart design and early warning scores, as well as a review of which patients are monitored on strict "input/output" charting of their fluids. The introduction of the fluid balance SOP aims to provide clear standardised guidance on how to manage this.

Changes are currently piloted on a General Surgery ward which offers care to a variety of patients attending the Trust with conditions needing the input of the Surgical Team. This ward is a 34 bedded unit with a broad mix of conditions with specialist input from the gastro-intestinal surgeons. Other improvements are being incorporated, in particular, how care is escalated in a timely manner; the recording of observations and the standards of documentation needed, the periodic review by staff nurses on the ward, and the "bay nurse handover" procedures (described in greater detail below). These areas are currently being scrutinised and appropriate actions taken to make consistent, sustainable changes.

As with most Quality Improvement projects, learning, recommendations, improvement areas and actions have been applied from a recent Serious Incident investigation relating to a deteriorating patient. The findings were presented in a Root Cause Analysis report which had collaborative input from a wide range of staff and was presented at the Trust's Serious Incident Requiring Investigation (SIRI) panel. Oversight and completion of the action plan relating to this serious incident is being managed by the Assistant Divisional Director of Nursing.

Feedback is provided regularly to the Nursing Management team in Surgery and Anaesthetics Division who in turn provided assurance to the wider audience as-well-as a monthly meeting arranged to track performance against the action plan.

In regards to fluid balance input/output, a drive to improve the completion of all input and output charts is taking place alongside strengthening the documentation of Intentional Rounding. Historically, issues were not identified until the preceding nursing staff had gone for the day.

In order to improve compliance with professional standards and to ensure that all appropriate documentation is complete, the ward has adopted bay handover. All four patients are handed over at the entrance to the bay. The nurse coming onto shift has an opportunity then to check through documentation to ensure that all appropriate components of the nursing documentation are complete and to an acceptable standard. This non-confrontational method of handover and challenge has seen improvements in the standards of all the components above and these continue to improve.

Regular audit of the nursing documentation has shown improvement in compliance around completing fluid balance (input/output) charts. Ad-hoc inspections on the ward by senior managers and clinicians have also demonstrated an improvement.

Whilst standards of nursing documentation have improved on this surgical ward, there needs to be a sustained approach to support and challenge, ensuring that standards are maintained. Senior Nursing colleagues will be expected to undertake more frequent observations of practice and to check documentation to ensure that these meet our expectations. A Trust wide fluid balance audit process is also under development which will aim to ensure the revised fluid balance standard operating procedure is being adhered to in daily practice.

The new approach to handovers will be embedded across the Division of Surgery with an expectation that this is patient focused, involving *them* in the discussion about what their expectations are and what they would like to see take place during the next shift to expedite their care needs. This method of handover means that the patient remains our focus; that issues relating to pressure care, intentional-rounding, input/output charts and again, ensuring care is delivered in a reasonable time-frame – all of which help to prioritise patient's needs. Previously, this was done in isolation between team members distant to the patient environment. Practice has started to change with the aim being to involve the patient in the discussion, keep them informed of what is happening and allow them opportunity to provide input or ask for updates on certain elements of care. This also allows open discussions with members of staff from preceding shifts. This is in progress and continues to be developed.

Sonia Nosheen, Interim Patient Safety Manager
Jonathan Smith, Assistant Divisional Director for Nursing: SAS
3rd January 2017

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 14

25 January 2017

Purpose Information
Assurance

Title	Workforce Race Equality Standard Progress Update Report
Author	Mr N Makda, Equality and Diversity Manager
Executive sponsor	Mr K Moynes, Director of Human Resources and Organisational Development

Summary:
This report provides the Board with an update on the implementation of the Workforce Race Equality Standard (WRES) Action Plan.

Recommendation: the Board is asked to note the progress against the WRES Action Plan and receive assurance that actions are implemented as previously agreed.

Report linkages

Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do Invest in and develop our workforce
Related to key risks identified on assurance framework	Transformation schemes fail to deliver the clinical strategy, benefits and improvements and the organisation's corporate objectives Recruitment and workforce planning fail to deliver the Trust objectives Collaborative working fails to support delivery of sustainable, safe and effective care through clinical pathways Alignment of partnership organisations and collaborative strategies (Pennine Lancashire and Healthier Lancashire) are not sufficient to support the delivery of sustainable services by the Trust

Impact

Legal	Yes	Financial	Yes
Equality	Yes	Confidentiality	No

Previously considered by: NA

Executive summary

1. This report provides the Board with an update on the implementation of the Workforce Race Equality Standard (WRES) Action Plan.

Introduction

2. The National Health Service (NHS) WRES was introduced in April 2015 and for the first time was introduced in the NHS standard contract. The WRES aims to ensure that employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace. Research and evidence nationally strongly suggests that less favourable treatment of BME staff in the NHS, through poorer experience or opportunities, has significant impact on the efficient and effective running of the NHS and adversely impacts the quality of care received by all patients.
3. From 1st July 2015, NHS Trusts submitted their WRES data against nine indicators. The WRES seeks to prompt inquiry to understand why it is that BME staff often receive a poorer staff experience than White staff in the workplace and to facilitate the closing of those gaps.

WRES annual report

4. Following Trusts submissions for the WRES in 2015, a report was published by NHS England on 20th May 2016 showing all NHS Trusts' analyses of the baseline data related to four of the nine WRES indicators – these are the indicators that are reflective of the relevant 2014 NHS staff survey questions.

WRES 2016

5. For the 2016 return, the nine indicators have remained broadly the same, with a minor amendment to indicators 1 and 9. In the 2016 submission, as well as providing data against the nine indicators as at 31st March 2016 the Trust was asked to compare against the 2015 submission and provide progress and future action points.
6. A summary of the results for the 2015, 2016 WRES submission and action plan was provided to the Board on 26th October 2016.

Summary of the Trust's progress against the WRES action plan

7. A WRES working group has been set up and is responsible for the implementation of the WRES action plan.

8. A WRES Big Conversation event specifically for BME staff was held in Dec 2016; with 55 BME staff attending from all groups of staff; the event asked all BME staff about their experience of working in ELHT and the barriers they faced at work.

9. The key barriers identified by BME staff were:
   a) Lack of fairness around career progression/ lack of equal opportunities.
   b) Lack of senior managers from BME backgrounds.
   c) Recruitment process.
   d) Lack of support to progress/ lack of talent management.
   e) Budget for training too small.
   f) More to prove than other counterparts.
   g) More scrutinised.
   h) Fear that others might perceive the "race card" is being used when raising issues, therefore added barrier when raising issues.

10. Suggestions made to remove the barriers by BME staff were:
   a) Independent panel members on recruitment panels.
   b) Talent management programme for BME staff.
   c) Mentorship support to progress.
   d) Promote the Staff Guardian and who else to go to when raising concerns.
   e) Advertise in Asian Image newspaper to increase representation by targeted recruitment.
   f) Unconscious bias training.
   g) BME network forum.
   h) Rotational roles for senior management, e.g. Clinical Director.
   i) Staff ambassadors/champions to increase visibility of role models at ELHT.

11. Based on the above feedback a number of actions have been taken to address the barriers identified:
   a) A summary of the key findings has been shared with stakeholders and stakeholder's have been invited to be involved in various initiatives e.g. the WRES working group, becoming a fair treatment champion, helping to set up a BME network forum.
   b) Ongoing active promotion of Leadership Development (Stepping Up Programme) to BME staff in AFC bands 5-7.
   c) A Bullying & Harassment Task and Finish Group has been set up to promote the Trust's zero tolerance policy towards bullying and harassment.
   d) Quarter 3 monitoring of staff in post data against relevant Census data suggests the BME make up of staff has remained broadly the same at 14%.

e) 2 Senior BME Managers have agreed to become Role Models/Ambassadors.

f) Unconscious bias awareness is to be included in Recruitment & Selection training.

g) Localised advertising of career opportunities in local BME publication i.e. Asian image newspaper.

h) The Trust has agreed to sponsor the Fanshawe Report (Diversity by Design) in collaboration with the Good Governance Institute (GGI).

i) 12 staff have now completed accredited mediation training in December 2016. This means that the new Mediation Service now has 18 fully qualified mediators. The service will significantly help to address conflict and disputes in the workplace.

j) Engagement activities remain ongoing within the local BME communities, schools and colleges to promote career opportunities within ELHT.

k) 3524 staff (48%) have completed the National Staff Survey, our highest ever return. We are expecting to get responses from the survey which relate to the WRES indicators which will allow us to compare against last year's submission and provide progress and future action points.

Conclusion

12. A number of steps have been taken to both understand and address the key issues highlighted in the WRES via a participative and inclusive approach with the workforce. However ongoing work is required to ensure significant improvements are made.

Next steps

13. The next steps are to communicate and publish the WRES submission and action plan both internally and externally. There will also be further developments around specific actions, timescales and lead contacts in relation to each of the WRES objectives and a detailed report in April's Board meeting.

Recommendation

14. The Board is asked to note the progress against the WRES Action Plan, receive assurance that actions are implemented as previously agreed and support the ongoing actions.

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 15

25 January 2017

Purpose Information Assurance

Title	Integrated Performance Report
Author	Mr M Johnson, Associate Director of Performance and Informatics
Executive sponsor	Mr J Bannister, Director of Operations

Summary: This paper presents the corporate performance data at December 16

Report linkages

Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do Invest in and develop our workforce Work with key stakeholders to develop effective partnerships Encourage innovation and pathway reform, and deliver best practice
Related to key risks identified on assurance framework	The Trust fails to deliver and develop a safe, competent workforce Partnership working fails to support delivery of sustainable safe, personal and effective care The Trust fails to achieve a sustainable financial position The Trust fails to achieve required contractual and national targets and its improvement priorities Corporate functions fail to support delivery of the Trust's objectives

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	Yes

Previously considered by: NA

Board of Directors, Update

Corporate Report

Executive Summary

One MRSA infection was reported in December, putting the Trust above the zero threshold. This is the first MRSA infection since December 2015.

Two clostridium difficile post 3 day infections were reported, bringing the trust total to 27 for the year against the annual trajectory of 28.

Nursing and midwifery ward staffing in December 2016 although still challenging, had only five areas falling below an 80% average fill rate for registered nurses on day shifts, this was the same as the previous month of November 2016.

The latest published SHMI mortality indicator has improved to 1.04 from 1.06.

The accident and emergency four hour standard was 77.3%.

The number of ambulance handovers over 30 minutes was 1190

The number of delayed transfers of care remains above threshold at 5.1% which has worsened from 4.3% in November.

Referral to treatment 18 week ongoing pathways continue to achieve at 92.0%, although there is continued pressure in some specialties placing the overall performance at risk. There was one patient still waiting for treatment over 52 weeks at the end of December. The patient has chosen to have the procedure in February.

All cancer targets were achieved in November

The trust sickness absence rate remains above the threshold at 5.1% and the vacancy rate has also remained above the threshold at 6.7% which has worsened from November (5.7%)

The Trust is reporting a deficit of £2.7m for the period ending 31st December 16, a further deterioration of £0.3m, in line with expectations at this stage.

87% of SRCP green schemes have been achieved to date, of which 73% (£10.2m) are recurrent

Introduction

This report presents the data relating to the period April 16 – November 16 and follows the NHS Improvement Single Oversight Framework. The narrative provides details on specific indictors under the five areas; Safe, Caring, Effective, Responsive, Well Led. A summary of performance is included in a scorecard at Appendix A and detailed data behind the narrative is graphed in appendix B and is referenced within the text.

SAFE

Infection Control (Graph 1-3)

Current Position

There was one MRSA infection detected in December post 2 days of admission on the Children's Medical Unit. The year to date total attributed is one, which is above the threshold of zero.

There were two Clostridium difficile toxin positive isolates identified in the laboratory in December which were post 3 days of admission. The year to date cumulative figure is 27 against the trust target of 28.

ELHT ranked 31st out of 154 trusts in 2015-16 with 9.4 clostridium infections per 100,000 bed days. The best performing trust had 0 and the worst performer had 66 infections per 100,000 bed days.

Risks

The MRSA target has now breached the zero threshold.

The cumulative total Clostridium difficile identified is now at 27 which is above the year to date trajectory of 21 and close to breaching the annual trajectory of 28.This puts the year end position at risk. The total number of Clostridium difficile toxin positive results is rising as a health economy with the pre 3 days also rising.

Forecast Position

Currently the year end position is at risk.

Actions

- Post Infection Review (PIR) of all cases undertaken and discussed across health economy
- Themes/trends from PIR fed back to Divisional Meetings and IC Liaison Group
- IR1s generated on all failures to meet infection prevention policy
- Divisional responsibility highlighted
- Mattress audit being completed monthly on wards and reported through Division
- Annual mattress audit completed.
- Actichlor Plus daily cleaning being carried out on high risk areas.
- Monthly hand hygiene audits being undertaken by ICNs

- "Prompt to Protect" is being disseminated to wards, via a rolling programme
- HCAI ward dashboard being published
- Antimicrobial audit being undertaken quarterly and results fed back to Divisions for action
- Surveillance undertaken by ICNs and ribotyping requested on all potential linked cases
- All wards with 2 cases within 28 days supported and closely monitored by ICNs
- New Gastroenterologist appointed as C. difficile Lead and MDT ward rounds to recommence along with the Antimicrobial Pharmacist and ICN.
- Poster put in all toilet areas to highlight for patients to let staff know about any diarrhoea
- New stool chart and SOP devised to monitor all patients bowel habits to be included in new fluid monitoring chart

Harm free Care (Graph 4)

Current Position

The Trust remains consistent with the percentage of patients with harm free care at 98.8% for December 2016 using the National safety thermometer tool.

For December 2016 we are reporting the current position as 6 grade 2 hospital acquired, five grade 2 community acquired, seven grade 3 community acquired and 1 grade 3 hospital acquired pressure ulcers. All pending investigation.

Risks

No risks identified

Forecast Position

Above target for harm free care

Actions

The Trust has a quality improvement approach and an established pressure ulcer steering group meeting monthly, to review performance and progress the initiatives to reduce pressure ulcers. This work is monitored through the patient safety and risk assurance committee.

Never events

Current Position

There were no never events reported to Steis in December. One reported year to date.

Risks

No risks identified

Forecast Position

No further never events anticipated.

Actions

No action required.

Serious Incidents (Graph 6)

Current Position

The Trust unverified position for incidents reported to the Strategic Executive Information System (StEIS) in the month of December was six incidents. These incidents were categorised as two sub-optimal care of the deteriorating patient, one diagnostic incident, one maternity/obstetrics, one slips/trips/falls and one medical equipment/devices.

Risks

At the time of reporting any immediate risks to patient safety have been managed – the Investigations are on-going and any further risk to patient safety and the Trust will be managed and escalated appropriately.

Forecast Position

Current trajectory demonstrates approximately six incidents per month.

Actions

A detailed report providing assurance on the management of each of the STEIS reported incidents is submitted monthly to the Patient Safety and Risk Assurance Committee.

Central Alerting System (CAS) Alerts – non compliance

Current Position

Full compliance reported as all alerts were dealt with within the required timescale.

Risks

None

Forecast Position

100% Compliance

Actions

None required

Safe staffing (Graph 7-8)

Current Position

Nursing and midwifery staffing in December 2016 although still challenging, had only five areas falling below an 80% average fill rate for registered nurses on day shifts, this was the same as the previous month of November 2016.

The causative factors remain as in previous months, compounded by escalation areas being open. Of the 5 areas below the 80% average fill rate, 3 of these wards fell below the 80% due to coordinator unavailability, which is in addition to the agreed safe staffing levels. 1 ward (15 BGH) was due to staff reassigned to an escalation area due to significantly reduced elective activity therefore, staffing remained safe and within agreed levels which left one area of concern.

- Hartley Ward

It should be noted that actual and planned staffing does not denote acuity and dependency or bed occupancy. The divisions consistently risk asses and flex staffing resources to ensure safety is maintained. Of the staffing DATIX incidents reported the divisions have given assurance that that no harm has been identified as a consequence of staffing. Incidents related to staffing are constantly being monitored on a monthly basis by the divisions.

The safer care acuity tool is being utilised much more effectively to support the movement of staff, however it is acknowledged that this remains an iterative process as confidence and ability to use the system embeds.

Actions taken:

- Extra allocations on arrival shifts continue to be booked. Registered and non-registered.
- Safe staffing conference at 10 am followed up with meetings throughout the day where required to ensure safe staffing, with contingencies agreed for weekends and out of hours. The nurse bank team are now part of this process.
- Extra health care assistant shifts are utilised to support registered nurse gaps
- A professional judgment review, triangulating bank and agency usage and the safer care acuity tool is now complete. As part of this process Hartley Ward, Marsden Ward, Reedyford Ward, B22 and B20 may potentially change their model of staffing.

Family Care December 2016

Maternity

Midwifery staffing has been challenging in the month of December due to sickness and maternity leave. Although maternity is staffed to the allocated budget establishment there is still a reliant on the usage of approx. 13 WTE bank shifts weekly to maintain safe staffing levels for safe care and acuity. There is currently a recruitment process on going to backfill to approx. 8WTE maternity leave.

The staffing figures do not reflect how many women were in labour or acuity of areas.

Table outlining the midwife to birth ratios:

Month	Aug 16	Sept 16	Oct 16	Nov 16	Dec16
Staffed to full Establishment	1:30.3	1:30.4	1:30.25	1:30.6	1:30.1
Excluding mat leave and vacancies	1:31.5	1:31.9	1:30.60	1:31.2	1:31
With gaps filled through ELHT Midwife staff bank	1:29.7	1:28.4		1:29.4	1:29.2 Usage 13.31WTE weekly

The midwife/birth ratios calculated using the Birth Rate Plus Tool from the 1st August 2016 to the 31st January 2017 is 1:29.1

Four incidents were reported within Maternity Services as “Red Flag” incidents in December.

Ten Incidents were reported under the staffing issues and of these 3 were recorded as being in relation to midwifery staffing. There was no harm caused as a result of these incidents.

Handlers / team Leaders/ Ward Mangers continue to be reminded to manage incidents in a timely manner.

Maternity Services monitor activity and acuity on a daily basis through the morning huddle on Central Birth Suite which all team leaders / ward managers, matrons attend. Activity and acuity is discussed and services flexed accordingly and staff continue to work flexibly through the obstetric service to maintain safe, personal and effective care and are kept fully informed by their respective line managers on the current issues that the service is experiencing in relation to staffing and the actions being taken to ensure that the services have the correct staffing ratios.

The Matrons and Head of Midwifery / Divisional Director of Nursing liaise closely with the teams in respect of staffing.

NICU

NICU still have challenges recruiting to their full nurse establishment posts and backfill for maternity leave. Processes are in place to address this and they still remain approximately 12 whole time equivalent posts vacant and 6 whole time equivalent on maternity leave. There has also been a high level of sickness in NICU for the month of December. Gaps have been filled by utilising management shifts, transitional care shifts from the postnatal ward, bank and agency going off cap where necessary. Nurse staffing levels for the acuity are monitored on a daily basis and where necessary, the unit closed to external admissions to maintain safety.

Paediatrics

Staffing in paediatrics has been challenging in December caring for a boy with extreme challenging behaviour needing as a minimum 3-1 to restrain him and keep the rest of the children safe on the ward. Social Care are aware of this and plans are in place to support the unit with this. There are currently 6 whole time equivalent nurse vacancies but there are new starters planned in the New Year.

Please see Appendix C for UNIFY data and nurse sensitive indicator report

CARING

Friends & Family (Graph 9-12)

Current Position

These metrics reflect national measurement methodology, which measures the proportion of patients that would recommend the Trust to friends and family. The latest Trust development authority thresholds have been included where available.

In December the number that would recommend A&E to friends and family was slightly up from last month at 76.1%. The proportion that would recommend inpatient services remains high at 98.5%. Community services would be recommended by 92.8% and maternity 98.3%

Risks

The response rate for inpatients in December was 51.2% and the A&E response rate was 19.0% for December, however there are no national targets for this.

Forecast Position

On target

Actions

Volunteer support is now available for inputting responses and matrons are alerted to areas with low response rates.

Complaints (Graph 13)

Current Position

The Trust received 30 new formal complaints in December compared to 46 in November and 20 in October.

The number of complaints closed in December was 28.

ELHT is targeted to achieve a threshold of at or less than 0.4 formal complaints per 1,000 patient contacts – made up of inpatient, outpatient and community contacts. The Trust on average has approximately 115,000 patient contacts per calendar month and reports its performance against this benchmark. For December the number of complaints received is shown as 0.27 Per 1,000 patient contacts.

An external audit on has been completed which gave significant assurance on the Trust's complaint process. All recommendations made in the final report have now been completed.

Risks

No risks identified

Forecast Position

On track

Actions

There is a continued presence of Customer Relations Staff across both sites, in addition to contact by phone, email, letter or face to face being made by the Customer Relations Team to resolve concerns quickly and prevent escalation, where possible.

All complaints are triaged by the Customer Relations Team and, wherever possible, early contact is made. Any issues which can be resolved immediately are identified and dealt with. Any outstanding issues following this are highlighted for investigation and response if necessary. However, a number of complaints have been withdrawn in these circumstances, as once the complainant has the opportunity to discuss issues and immediate concerns are satisfactorily resolved, it is often felt by the complainant to be unnecessary to continue with the formal complaint process.

Weekly complaint monitoring meetings are in progress to review complaint management progress.

Patient Experience Surveys (Graph 14)

Current Position

The table demonstrates divisional performance from the range of patient experience surveys for December 2016. The threshold is a positive score of 90% or above for each of the 4 competencies.

The Divisional performance from the range of patient experience surveys is above the threshold of 90% for all of the 4 competencies in December.

Overall performance by the Integrated Care Group – Acute increased to 97% in December. Performance against the Information and Involvement competencies remain at 99%, performance against the Quality increased to 96%, and performance against the Dignity competency remains at 99% in December.

Overall performance by the Integrated Care Group – Community increased to 100% in December. The performance against Dignity and involvement in December remains at 100%, with performance against Information remaining at 99% alongside Quality at 100%.

The overall performance within Surgery remains at 97% in December. Performance against the Involvement competency remains at 98% in December. Performance for Information decreased to 95%, Quality competency remains at 97%, and Dignity increased to 98%.

The Family Care Division's overall performance increased to 98% in December. Performance against Information increased to 99%, with Dignity remaining at 99%, Involvement increased to 99% and Quality increased to 98% in December.

Overall performance for the Diagnostic and Clinical Care Directorate remains at 95% in December. Performance against the Information competency increased in December to 96. Performance against the Dignity competency remains at 96% in December, with slight decrease in Involvement to 98% and Quality to 95% in December.

Risks

No risks identified

Forecast Position

On track

Actions

Ongoing monitoring of these measures. No specific actions required to improve performance.

EFFECTIVE

Mortality (Graph 15-16)

Current Position

The latest Trust SHMI value as reported by the Health and Social Care Information Centre and Care Quality Commission is within expected levels and has improved again to 1.04, as published in December 2016

The TDA published HSMR is currently within expected levels at 103.03 (July 14 - June 15)

DFI Indicative HSMR - rolling 12 month

The latest indicative 12 month rolling HSMR (October 15 – September 16) is reported 'as expected' at 97.4 against the monthly rebased risk model.

Risks

The diagnostic group 'Peripheral and visceral atherosclerosis' has triggered a CUSUM alert at the highest level (99.9%) which is the level at which the CQC intervene. This group is being investigated through the mortality steering group.

Forecast Position

The SHMI and HSMR trajectories are showing regular improvement and the forecast is for both to remain with expected levels.

Actions

The Trust has an established mortality steering group which meets monthly to review performance and develop specific action plans for any alerting mortality groups identified.

Delayed Discharges (Graph 18)

Current Position

The number of delays reported against the delayed transfers of care standard has deteriorated to 5.1% against the November rate of 4.3% and remains above the threshold of 3.5%.

The failure of this target is multi-factorial, linked to complex discharge processes involving ELHT and partners.

There is now daily reporting at individual patient level in each category of delay so that any trends or specific issues can be escalated for resolution to the relevant partners. The Integrated Discharge Service operational team are attending an allocation meeting at regular

points in the day to progress cases and ensure we are prioritising our work in accordance with organisational clinical flow demands. Progress is reported across the IDS hub as required to expedite any barriers to progressing transfers of care.

Risks

The increase in delayed discharges will add further pressure to patient flow and the 4 hour target as available bed capacity is reduced.

Forecast Position

The actions being taken should reduce the number of delayed discharges.

Actions

A systematic 'micro-management' of all patients who are medically fit for discharge is now well embedded alongside partner agencies with daily meetings taking place to monitor this cohort of patients.

As a health economy, we now have a work stream to develop and implement a fully Integrated Discharge Service (IDS), It requires on-going refinement with partner organisations. This service has been co-produced with our commissioners and partner health and social care provider agencies. It is one of the major facets of our Community Services Transformation Programme alongside Intensive Home Support, Integrated Neighbourhood Teams and Frailty Pathway development. The key strands of work to improve delayed discharges are:

- Integrated discharge service - This will ultimately result in the delivery of a fully integrated discharge service including a trusted assessor role to support ELHT front door areas and wards. The service has been developed to use the 'Assess to Admit' and 'Discharge to Assess' principles of care.
- System Reviews – Audits and improvement events held to identify opportunities for improvement.
- Continuing Health Care – micromanaged to ensure patients are transferred out of hospital as soon as possible when fit for discharge.
- Home of Choice - Our allocation service is supporting families to make timely choices for onward care. Working daily with Care Home Selection service to ensure that we are fully updated on progress and that actions to facilitate discharge are completed in a timely manner.

Emergency Readmissions (Reported 1 month behind - Graph 19)

Current Position

The emergency readmission rate is reported at 12.4% in November 2016 compared with 13.4% in November 2015.

Risks

Readmissions add further pressures to bed capacity and the need to shorten length of stay to release capacity also increases the risk of readmission.

Forecast Position

The current trajectory has shown an improvement over the summer months however winter pressures are a risk for this standard.

Actions

Development of pathways to increase the role of community services, particularly for paediatrics and the elderly.

The Complex Case Management Team work within the ED and assessment units, to ensure that if care in the community has failed this can be reviewed by our duty teams if further admission to the hospital is not required.

Diagnostic Waits (Graph 20)

Current Position

This measures the proportion of patients exceeding the 6 week target for a diagnostic procedure. In December, 0.1% waited longer than 6 weeks.

Nationally, 1.1% of patients were waiting over 6 weeks at the end of November.

Risks

No risks identified

Forecast Position

On track

Actions

Diagnostic patient tracking lists are monitored weekly and any breach risks are escalated to senior managers to ensure all are accommodated where possible.

CQUIN (Graph 21)

Current Position

All quarter 1 CQUIN schemes were achieved and payment received in full. The table shows the Quarter 2 position – Both specialised services and local commissioners have approved the Q2 submissions with the exception of Sepsis due to the data lag.

Antimicrobial resistance 1% reduction in total antibiotic consumption - It has been agreed to use a revised baseline of 2014-15 data for this metric, however there is still a risk to achievement of the 1% reduction.

Risks

Risks have been identified around the following schemes:

- Achievement of the sepsis administration of antibiotics from time of arrival.
- Antimicrobial resistance 1% reduction in total antibiotic consumption
- Hepatitis C

Forecast Position

Achievement of the nationally mandated Quarter 4 milestones for sepsis and reduction in total antibiotic consumption will prove challenging.

Actions

All CQUIN schemes have been assigned clinical and managerial leads and are managed by the divisional teams. Monitoring and updates are provided through the Trust's Clinical Effectiveness Committee and Contract and Data Quality Steering Group.

RESPONSIVE

Accident and Emergency (Graph 22)

Current Position

Overall performance against the Accident and Emergency four hour standard was reported as 77.3%, including Rossendale, below the 95% threshold. The trust did not achieve 95% of any days during December.

The number of attendances during the month was 15,362 compared to 15,507 in December 2015

The latest national performance data showed 88.4% achievement for November, which is lower than 91.3% for the same month last year.

Only 11 out of 138 reporting trusts with type 1 departments achieved the standard on all types for November.

There have been no breaches of the 12 hour standard from decision to admit, in December. Mental Health demand and the timely availability of mental health beds remain an issue. There continues to be significant numbers of attendances in relation to Mental Health which are resource intensive for the emergency department and both of the urgent care centres.

Risks

- Medical staffing gaps continued during the month with sickness and cancellation of locum shifts. This had a serious impact on flow. Support from across divisions continued and alternative internal pathways were put in place where possible although this was limited.
- There was a high level of short notice nurse staffing sickness throughout December which had a significant impact on ED/UCC and on the wards.
- Surges in ambulance attendances have continued with high numbers of arrivals in short period of time leading to delays.
- Mental Health demand and the timely availability of mental health beds remain an issue. There continues to be significant numbers of attendances in relation to Mental Health which are resource intensive for the department. During December there were no 12 hour Mental Health breaches waiting for a MH bed.
- Bed pressures continue. At times admissions have exceeded discharge levels across both surgery and medicine – high acuity patients within medicine and surgery have impacted on the number of discharges which in turn caused delays in bed availability resulting in length of stay in the emergency department extending which has therefore resulted in Delayed First Assessments and overcrowding. Demand has exceeded capacity.
- Increasing patient acuity with patients presenting with complex co-morbidities has continued to place considerable demand on the emergency department. High

numbers of patients needing senior decisions/reviews from Doctors due to acuity. This in turn causes delays at times and has halted flow as each decision needed to go through a Consultant.

- Full receipt of the sustainability and transformational funding of £12.5m is dependent on the 4-hour target, RTT and cancer 62-day target.

Forecast Position

Performance in December has deteriorated and winter pressures now put improvement of this target at risk.

Actions

- Our winter escalation ward is open to support additional demand and is being reviewed in order to plan for the next few weeks.
- Micro-management of clinical flow 24/7 with an 8am cross organisational Operational Performance meeting on a daily basis considering issues from the previous 24 hours.
- Intensive Home Support Teams continue to work daily in the Emergency Department to prevent admissions and have also been deployed across wards to support early discharge.
- Operational times for Ambulatory Care have been increased from November 2016. The service is now provided 10:00-21:00 7 days a week and the impact will is being monitored. A Business Case has also been drafted which supports this continuing going forward.
- Following recruitment, sessional GPs have now commenced shifts in Urgent Care Centre at BGH.
- A Hospital GP commenced in post in December 2016 working across the Urgent Care Centres.
- Overseas recruitment took place in September with 8 potential Doctors recruited. Posts are now being offered and work will continue to ensure that we work with the candidates to secure their services in the near future. .
- A review of the 12 hour Mental Health breaches up to July (17 in total) has been undertaken. A paper and Action Plan has been presented at SIRI panel. There have been 17 further Mental Health Breaches since July and key themes continue to be highlighted. A fishbone analysis was undertaken and the Action Plan updated. The Action Plan will be monitored through the LCFT and ELHT Quality Meetings.
- An external review of the Mental Health Pathway in Pennine Lancashire took place at the end of November. This involved the Royal College of Psychiatrists and the Royal College of Emergency Medicine along with, ELHT and LCFT and commissioners. Formal feedback is due to be received mid-January 2016.
- A review of Core Nurse Staffing in ED/UCC has been undertaken and recruitment has commenced based on initial feedback.

- The Transformation Programme for the Emergency Care Pathway has now been agreed and key projects commenced: including Review of Rapid Assessment and Treatment Model in ED, Review of the Urgent Care Model including Triage, MSK pathway from Triage.
- A stranded patient metric is being used to assess the position in relation to complex discharges and Delayed Transfers of Care.
- The discharge lounge came into operation in July. This facility is available for patients awaiting transport to go home from Emergency Department, Urgent Care Centre, Surgical Triage Unit and Acute Medical Wards.
- A Test of Change has commenced for direct orthopaedic attendances from GPs, Accrington Victoria Hospital Minor Injuries Unit, Burnley Urgent Care and Rossendale Minor Injuries Unit. These will now be reviewed in Ambulatory Care by the Orthopaedic team.
- As part of the Urgent Care Centre improvement plan a streaming model was introduced from Monday 12th December 2016 at Royal Blackburn Hospital. This involves a senior decision maker streaming patients at triage to ensure appropriate and timely treatment
- NHS Improvement visited ELHT on 13th December to offer support in relation to improving performance.

North West Ambulance Service (Graph 23-24)

Current Position

The ambulance handover compliance indicator measures the compliance with PIN entry on completion of patient handover. This was achieved at 91.8% in December, which is above the 90% threshold.

The number of handovers over 30 minutes increased to 1190 for December compared to 954 for November.

The validated NWAS penalty figures for December are not yet available and so are reported as at November;- 170 missing timestamps, 437 handover breaches (30-60 mins) and 167 handover breaches (>60 mins).

Risks

- Royal Blackburn continues to be the busiest site in the North West for ambulance attendances. Surges in ambulance arrivals continue to cause pressure in the department especially in times of limited patient flow due to low bed availability within the Trust.
- Surge patterns continue with high numbers of arrivals in short time periods leading to delays.
- Congestion within the department at time of pressure leads to reduction in space to offload arriving ambulance patients. This impacts handover times.
- Increasing patient acuity with patients presenting with complex co-morbidities continues to place considerable demand on ED.

- Timely availability of medical and surgical beds has impacted on the length of stay in ED which has therefore resulted in Delayed First Assessments and overcrowding. Demand has exceeded capacity.

Actions

- Rapid Handover procedure for UCC patients has been agreed and introduced. This has seen a rise in the number of appropriate patients being taken to UCC.
- Fortnightly operational meetings continue with NWAS/ED/AMU with representation from the CCG.
- The Ambulance Liaison Officer role is now embedded and has been extended for a further 6 months. This role is now being reviewed with NWAS and ELHT clinicians to explore options to expand the role. Evaluation and future options will be provided in January 2017.
- Reception capacity has been increased. Staff are in post and this is supporting timely handovers and more efficient transfer of patients from the department.
- Rapid Assessment of Treatment Process in ED had been reviewed and made leaner to improve the timeliness of assessment and to improve flow to enable an improvement in handover times.

Referral to Treatment (Graph 25-27)

Current Position

The 18 week referral to treatment (RTT) % ongoing position has been achieved with 92.0% patients waiting less than 18 weeks to start treatment at end of December, which is just above the 92% target.

The total number of ongoing pathways has reduced to 26,189 from 26,495 last month. There were with 2089 patients waiting over 18 weeks at the end of the month, up from last month's 1874. The increases are mainly in the surgical specialties and are in part due to lower activity levels in December due to holidays, but compounded by lack of bed capacity, loss of theatre time and higher numbers of cancelled operations.

The median wait has deteriorated in December to 7.3 weeks from 6.4 in November.

There was one General Surgery patient waiting over 52 weeks at the end of December. The pathway was complex involving multiple specialties and outpatient appointments before being listed for surgery. The patient was offered a date in January but has chosen to wait until February for the procedure.

The latest figures from NHS England show a slight improvement of the ongoing standard nationally, with 90.5% of patients waiting less than 18 weeks to start treatment in November.

Risks

Increasingly, routine operations are being cancelled due to lack of beds. Pressures exist in the system with increasing demand and lack of capacity in some areas.

Full receipt of the sustainability and transformational funding of £12.5m is dependent on the RTT, 4 hour and 62 day cancer target. We continue to meet the requirement for 18 week RTT.

Forecast Position

It is anticipated that performance will remain above the national standard of 92%

Actions

Regular monitoring of patient tracking lists is undertaken and risks are escalated to senior managers.

Additional outpatient and theatre sessions are undertaken where possible and subject to bed availability, to manage demand and nurse clinics set up.

Cancer (Graph 28-32)

Current Position

The Trust has successfully achieved all cancer performance targets in November.

The 62 day target is not monitored nationally by tumour group and is included here for information only. At tumour site level, three groups did not meet the 62 day target in November; Lung (83.3%), Upper GI (72.7%) and Head and Neck (78.6%). There were three patients in November treated after day 104 and these will have a detailed root cause analysis undertaken by the clinical director for theatres with the cancer directorate manager liaising with the Consultants involved in the pathway as required.

Risks

Cancer Services are under pressure to manage cancer targets alongside the 18 week referral to treatment target and the 4hr target. The cancer targets are being micromanaged to maintain compliance.

Full receipt of the sustainability and transformational funding of £12.5m is dependent on the cancer 62-day target, the 18 week referral to treatment target and the 4hr target.

Forecast Position

Currently prediction to achieve all cancer targets in December, subject to validation of data.

Actions

Risks are escalated to senior managers and cancer performance is monitored through weekly cancer patient tracking list (ptl) meetings, Surgery and Integrated Care Group (ICG) performance weekly meetings and the director of operations weekly performance monitoring meeting.

Cancelled Operations – 28 Day breach

Current Position

There were no 'on the day' cancelled operations not rebooked within 28 days in December.

Risks

Financial penalties are imposed on the Trust for breaches of the standard at the Payment by Results tariff of the procedure.

Forecast Position

No further breaches anticipated.

Actions

Regular monitoring of patients that had procedures cancelled on the day to ensure dates are offered within the 28 days. Risks are escalated to senior managers and reviewed weekly by the director of operations.

Length of Stay (Graph 33)

Current Position

Trust non elective average length of stay has remained static at 4.7 days in December.

The elective length of stay has increased on last month to 2.5.

Dr Foster benchmarking shows the Trust length of stay to be below the expected when compared to national casemix adjusted, for elective and slightly higher than the expected for non-elective.

Risks

Long length of stay increases bed occupancy which at high levels puts pressure on other standards ie 4hr target and cancelled operations.

Forecast Position

The trend in non-elective length of stay appears to be increasing and is now slightly above the expected according to the DR. Foster casemix adjusted rate.

Actions

The action plan for delayed discharges will also reduce the average length of stay. Divisional monitoring of length of stay and use of benchmarking software to identify outliers.

WELL LED

Sickness (Graph 37)

Current Position

The sickness absence rate reduced slightly to 5.11% in November 2016 from 5.14% in October 2016. This is higher than the previous year (4.9%). Long term sickness currently stands at 2.25% and short term sickness at 2.86%.

Risks

High sickness rates are a financial risk as bank and agency expenditure increases to cover shifts. The level of short term sickness is unusually high. Long Term sickness attributed to anxiety/stress and musculoskeletal problems continue to be the main reasons for sickness absence.

Forecast Position

Improvement due to intervention and actions but countered by expected seasonal increases over the winter period

Actions

- Corporate and Divisional action plans in place
- Sickness Absence Policy review complete and agreed with staff side – trigger levels now more robust and managers have further discretion.
- New Employee Assistance Programme launched
- Divisional sickness clinics and bespoke training taking place
- Internal Audit of Trust sickness absence procedures complete and recommendations being implemented
- Data Analysis of bank holiday sickness underway for Christmas and new year period– trends will be highlighted and data provided to managers for action
- ICG Divisional project aimed at reducing sickness including recruitment of 'Divisional Sickness Absence Taskforce'

Turnover rate and Temporary costs (Graph 38-39)

Current Position

Turnover rate, Vacancy rate and temporary costs

Overall the Trust is now employing 7005 FTE staff in total. This is a net decrease of 19 FTE from the previous month.

The number of nurses in post at December 2016 stood at 2260 FTE which is a net decrease of 27 FTE since last month and a net increase of 206 FTE since 1st April 2013.
The vacancy rate for nurses now stands at 10.4% (263 FTE)

In 2015/16 East Lancashire Hospitals NHS Trust spent £24.6m on temporary staffing. This represented 9% of the overall pay bill. (9% 2014/15; 8% 2013/4; 5.5% 2012/13). For the year ending 2015/16 the Trust has spent £24,607,589 (£16,469,869 agency; £8,137,720 bank).

In December the Trust spent £2,261,798 on bank and agency which represents 9% of the total pay bill.

Risks

Risk of not meeting NHSI targets, impact on staff engagement, attendance and patient care

Forecast Position

No change to vacancy rate. Forecast to not meet NHSI target (£10.5 million)

Actions

- Improving utilisation of Staffflow – now achieved 90%
- Additional eRostering training dates, and on ward training/refresher sessions
- Trust wide agency reduction task groups (medical and Non –Medical) and Executive Oversight Group established
- Each division now has an allocated eRostering expert lead/single point of contact, resulting in increased familiarity with their roster and therefore improved engagement.
- The 16/17 professional judgement meetings were concluded in November 2016. This resulted in required changes to the establishment, which will be documented in a separate paper for agreement.
- A proposal to change the annual leave allowance to a fixed percentage was agreed and so this will come into effect from the 1 April 2017 (updated policy has been agreed). This will have a positive impact in terms of being able to manage/flat line the 22% headroom across the year.
- A 60 unit role out plan has been developed for 2017/18 which will continue to see the Allocate tool being rolled out across the Trust. In December the Domestic workforce (299 WTE) were moved onto the eRoster and are now being paid via this tool. Several more units are now being progressed including, Catering, Portering, Therapies and multiple units within ICG and Family Care.
- A review of the eRoster training modules and the introduction of some eLearning modules are now complete and available via the Learning Hub. Customer feedback has been used to inform this review. This has also included 400 domestics being trained to use Employee on Line.
- Full implementation of the Safecare.
- Reduce additional duties above demand/agreed staffing level. A full reconciliation has been done between the three systems which capturing the establishment (ESR, Ledger and eRoster), demonstrating that all three are aligned. However the actual

levels at which the majority of wards are staffing to, is beyond the budget and the roster template that was agreed. Therefore further work is required in order to understand and address the reasons for this.

- Implementation of the Kendal Bluck recommendations within ED, including the harmonisation of shift patterns and the implementation of a seasonal roster.
- To review the way in which 1:1's are managed, given the month on month increase to establish whether there is a more efficient/cost effective way to identify and manage this required resource.
- Re-introduction of the Nurse Confirm and Challenge meetings (chaired by the Deputy Director of Nursing) to address areas of concern highlighted on the eRostering Dashboard (now that the draft dashboard has been developed). Oversight of this will be via the Executive Oversight Committee from January 2017 onwards.
- Reviewing the way in which the Allocate on Arrival process works to ensure that its managed in the most cost effective and efficient way, now that Safecare has been implemented and can be used to identify and manage the movement of staff.
- Promotion of medical staff bank – 30 more doctors active on bank since April 2016
- Centralisation of all medical locum bookings now complete
- 22 Candidates in the pipeline and have been offered the Intensive ILETS training, 6 of which have passed and are in the CBT process.
- 18 doctors recruited from India in pipeline – 1st doctor to start in February 2017 with rest scheduled to start in Spring
- ED Recruitment national campaign continuing
- Project continuing to look at reducing recruitment time to hire across the Trust to support reducing the vacancy gap and reduction in bank/agency spend
- Social media project group established to support recruitment
- ED and Family Care open day's being planned for Spring 2017
- Attendance at the RCN jobs fair in February

Appraisals & Job Plans (Graph 41-43)

Current Position

The 2015/16 year end job plan completion rate was 80%. The 2016/17 job planning round was re-launched in May, with a window of June to August to undertake the reviews. The current completion figure for 2016/17 at the end of December was 62%, including reviews that have taken place since January 2016. The Deputy Medical Director is working closely with the Divisional Directors to ensure that job plans are undertaken.

A new electronic job planning system has been purchased and is in process of being implemented.

There has been a new system implemented (MyL2P) to capture the appraisal rates for consultants and career grade doctors. The completion rates reported from this system are cumulative year to date, April - December 2016 and reflect the number of reviews completed that were due in this period.

The consultant appraisal rate is currently 95% and the other medical staff appraisal rate is now at 95%.

The AFC appraisal rates continue to be reported as a rolling 12 month figure and are currently at 59% which is below the threshold of 90%

Risks

None identified

Forecast Position

Compliance

Actions

There has been a range of actions to support compliance including:

- Additional PDR and Learning Hub sessions offered to staff from across the organisation
- Bespoke PDR and Learning Hub sessions provided to groups and individual staff undertaken and where requested this had taken place in the workplace.
- A quick PDR Guidance has been made available on the Learning Hub, the Message board and the Learning and Development page of the Intranet
- Flyers have been distributed across the organisation aimed at both Reviewers and Reviewee's detailing what PDR's are and whom to contact for further information
- Staffs are encouraged to consider how PDR's enhance their leadership and management role within their teams/services through various forms of facilitated activities.
- Service support up to the CQC inspection in 2015 was offered to support Divisions in inputting the dates of completed PDRs offered by the Learning and Development department.
- The *Get Ready for Revalidation Awareness Sessions* promotes Personal Development Reviews as a fundamental part of the process
- To promote Talent Management within the organisation we are in the process of implementing a *People Development Strategy* which will incorporate learning and development opportunities accessible to all, integrated within individuals appraisals and enable management of own development in accordance with their aspirations.
- An animated video is being developed which provides an overview of how to carry out an appraisal whilst promoting quality and engagement in the Personal Development Review process
- Work has commenced in making the Appraisal/PDR inputting onto the Learning Hub simpler in readiness for a new template which will be available from 1st January 2017
- *'Have you had the Conversation' campaign* commenced to promote a quality appraisal conversation
- Compliance rates reported and monitored through divisional and directorate management meetings.

Core Skills Training (Graph 45)

Current Position

From April 2016, the core mandatory training has been replaced by a core skills framework consisting of eleven mandatory training subjects. Training is via a new suite of e-learning modules and knowledge assessments on the learning hub. The threshold has been set at 80% for all areas except Information Governance which has a threshold of 95%

All of the eleven areas are currently above target for training compliance, with the exception of three modules which are currently below the threshold 'Basic Life Support' (79%), Information Governance'(92%) and 'Safeguarding adults' (76%).

Risks

No risks identified

Forecast Position

Improvement is noted in all areas and compliance is expected to be achieved in the three areas below target.

Actions

- All new starters complete CST e-learning on induction programme by end of day 2
- Range of communications have continual centrally and via HROD bulletins and within compliance reports and meetings
- Training needs analysis document published on the Trust's intranet further reinforcing the message of who needs to do what training
- Compliance % and divisional trajectory reports are distributed at the beginning of each month centrally.
- Reports training has been implemented from December 2015 and Managers now have direct access to run real time reports for their departments etc.
- All staff have the function available on learning hub to produce red, amber and green compliance reports for their team/area
- Ward and department support and bespoke support sessions in place
- Facilitated Core Skills e-learning sessions running weekly for staff who cannot access this in the workplace or who need additional IT skills support
- Combined IT skills and facilitated Core Skills e-Learning sessions for Estates and Facilities staff
- Learning Hub sends out reminders to individual and their manager at 90, 60 and 30 days prior to expiry date and also once training has expired.
- Staff prompted around CST when attending other courses
- Other controls – compliance checks in place before funded study leave.
- Responsibilities included in new Nursing and Midwifery leadership programme
- Implementation of the Pay progression policy (May 2014)
- Review of improved reports format to divisions
- Compliance rates reported and monitored through divisional and directorate management meetings.

Financial Position (Charts 46-59)

Executive summary

1. The Trust is reporting a deficit of £2.7m at 31st December 2016. This position is within expectations for this point of the year.
2. The Trust has previously reported risk against this position relating to overspending positions in a number of areas. It is pleasing to note that we are now starting to see an improvement to this position overall, despite the Trust being under immense operational pressures. At month 9 we have seen the lowest level of agency usage since month 5 this year. Considerable efforts have resulted in Divisional forecast positions improving by £1.9m from the month 8 position.
3. In addition, we have endeavoured to achieve additional savings to cover the reduction to STF funding that we have seen this year (£1.2m). This has in turn presented an opportunity relating to a newly announced STF incentive scheme which will see the Trust receive an amount equal to this saving to improve its outturn position further, thus improving the cash position in 2017-18.
4. The Trust is continuing to improve its financial controls. A draft Trust financial recovery plan will be presented to the Finance and Performance Committee in February with the aim of achieving the following:
    i. An increase in the recurrent SRCP position for 2016-17
    ii. An improvement in the underlying Trust deficit position
    iii. Reduced reliance on centrally held reserves and one off gains
    iv. An improved agency spend position
    v. Improved financial controls
5. The Trust's Reference Cost Index score [RCI] has been published for 2015-16 which shows an improvement of 0.51 on the previous years reported figures. We have scored an RCI of 98.29. The Trust continues to be more efficient than the average Trust, and on a par with previous years. Table 1 shows the reported RCI by division for 2015-16.
6. It is worthwhile noting at this point this efficiency is inspite of the additional agency costs the Trust incurs to cover vacancies and operational pressures.

Table 1 - Reference Cost Index Score 2015-16

	ELHT cost £000s	Average cost £000s	Total RCI score £000s
Integrated Care Group	169,641	160,882	105.44
Surgery and Anaesthetics	125,356	131,761	95.14
Diagnostic and Clincial Support	63,931	75,194	85.02
Family Care Division	78,819	77,537	101.65
	437,747	**445,374**	**98.29**

7. Key risks to highlight at month 9 include:

- Non achievement of the sustainability funding (minimal)
- Non-achievement of the Safely Releasing Cost Programme (SRCP) (minimal)
- Increased agency and locum staff over and above the resources available (possible)
- The cash impact of any non-delivery (minimal)

Finance and Use of Resources metrics

8. The Trust is scoring a 3 for the Finance and Use of Resources metrics at the end of quarter 3 (potential support need), with risk against the liquidity and agency metrics.
9. The year to date and forecast outturn capital service capacity score of 4 for the Trust, limits the overall score to 3. The high capital service capacity score is heavily influenced by the high borrowing costs attributable to the Trust's PFI scheme. Initial calculations are showing that a small increase in the Trust's EBITDA position will move this score to a 3, however aside from this, we have limited control over this measure.
10. The current forecast for agency is a score of 3, however if the percentage increases by just 3% (from the forecast of 47% to 50%), the Trust will score a 4.

Table 2: Finance and Use of Resources metrics

Area	Metric		Actual YTD Performance	Actual YTD Score	Forecast outturn Performance	Forecast outturn Score
Financial sustainability	Capital service capacity		1.2	4	1.2	4
	Liquidity (days)		(7.1)	3	(13.6)	3
Financial efficiency	I&E margin		(0.8%)	3	(0.8%)	3
Financial control	Distance from financial plan		0.0%	1	0.0%	1
	Agency spend		43.2%	3	47.0%	3
Total				3		3

Break even duty

11. The Trust is reporting a deficit at month 9 of £2.7m, against an initial planned deficit of £2.7m. The Trust has previously reported risk against this position relating to overspending positions in a number of areas across the Trust. It is pleasing to note that we are now starting to see an improvement to this position overall (detailed below), despite the Trust being under immense operational pressures. Divisional forecast positions have improved as per the table below.

Table 3 – Trust forecast position 2016-17 by Division

	Mth 7 £000s	Mth 8 £000s	Mth 9 £000s
Integrated Care Group	(2,010)	(1,700)	(1,150)
Surgery and Anaesthetics	(3,869)	(4,700)	(4,000)
Diagnostic and Clincial Support	289	669	642
Family Care Division	(1,676)	(1,880)	(2,140)
Estates and Facilities	793	201	777
Corporate	1,152	592	962
Total forecast outturn variance	**(5,321)**	**(6,818)**	**(4,909)**
Planned overspend for year	(3,676)	(3,676)	(3,676)
Additional non-recurrent resource	**(1,645)**	**(3,142)**	**(1,233)**
Total Deficit as a % of turnover	-1.13%	-1.45%	-1.04%
Overspend as a % of turnover	-0.35%	-0.67%	-0.26%

12. The position above shows the level of non-recurrent resource required to meet the control total for 2016-17. In addition, the Trust has endeavoured to mitigate the risk of losing £1.2m of STF funding this year by achieving increased savings.
13. For the current forecast position, all areas have reviewed their current and forecast spend. All areas bar Family Care have improved their forecasts. Estates and Facilities, DCS and Corporate are all forecasting stretch targets now to

support the overall position. Surgery are improving their financial control and are forecasting a reduced position as a result. ICG have also improved their position and we have seen this improvement in month 9 with an in-month underspend of £210,000.

14. The Trust has non-recurrent resource to bridge the gap to the control total in year, through a combination of increased savings, reserves and one-off gains relating to accruals no longer required. Further improvement in the financial position will reduce the reliance on this non-recurrent resource. It should be noted that the use of non-recurrent resources is a normal practice and the 2016-17 financial year is no different to previous years.

STF Incentive Scheme

15. Recently, NHSI announced a new 'STF Incentive scheme'. For every £1 improvement to a Trusts control total, NHSI will match this in cash to the Trust on the understanding that it will be used to improve the Trusts outturn position and in turn improve the cash position going into 2017-18.
16. Our planned outturn position is a deficit of £3.7m. This is made up of a control total of a £16.2m deficit and planned STF funding of £12.5m. The first rule in order to achieve STF funding is the 'binary on/off switch' related to the financial control total. In other words, non-achievement of the £16.2m deficit will result in no access to any STF funding.
17. Achievement of the control total deficit of £16.2m 'switches on' access to STF, as follows:

Table 4 – STF finance and operational targets

Financial control total	70.0%
4 hour standard - 95% achievement	12.5%
RTT - 92% achievement	12.5%
Cancer 62 day achievement	5.0%
	100.0%

18. This means that the Trust is not penalised twice for not achieving its outturn position.
19. Current indications are that, in spite of appealing against non-payment, we will see a reduction to STF funding relating the 4 hour standard of £1.2m. As we have endeavoured to bridge this internally in order to sustain our cash position, we are in effect improving our performance against the control total (that is we are forecasting to achieve a £15m deficit against £16.2m).

20. Due to the new incentive scheme, this now means we will be able to access £1.2m of additional funding and will report an improved outturn position as a result. We await further guidance on this from NHSI.

Divisional performance to month 9

21. The divisional performance to the 31st December 2016 is shown in table 5.

Table 5 - Organisational performance

	--------In Month--------			--------Year to date--------		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Income	39.1	39.1	0.0	356.1	356.2	0.1
Expenditure by division:-						
Integrated Care Group	(10.1)	(9.9)	0.2	(86.4)	(86.9)	(0.5)
Surgery and Anaesthetic Services	(7.8)	(8.2)	(0.4)	(68.7)	(72.3)	(3.6)
Diagnostic and Clinical Support	(8.9)	(8.6)	0.2	(73.5)	(72.9)	0.6
Family Care Division	(4.8)	(5.2)	(0.4)	(43.4)	(45.0)	(1.6)
Estates and Facilities	(3.4)	(3.2)	0.2	(28.3)	(28.1)	0.2
Corporate Services	(3.3)	(3.1)	0.2	(27.6)	(26.9)	0.7
Research and Development	(0.1)	(0.1)	(0.0)	(1.1)	(1.1)	0.0
Reserves	1.2	1.3	0.0	(10.6)	(6.6)	4.1
Total Expenditure	(37.2)	(37.2)	0.0	(339.7)	(339.7)	(0.0)
EBITDA : Earnings before interest, taxation, depreciation	1.8	1.9	0.0	16.4	16.5	0.1
PDC/Depreciation/Interest	(2.2)	(2.2)	(0.0)	(19.3)	(19.4)	(0.1)
Impairments	0.2	0.2	(0.0)	0.2	0.2	(0.0)
Retained (Deficit)	(0.1)	(0.1)	0.0	(2.7)	(2.7)	0.0
Impairments	(0.2)	(0.2)	0.0	(0.2)	(0.2)	0.0
Donated assets	0.0	0.0	(0.0)	0.2	0.2	0.0
Break-even duty	(0.3)	(0.3)	0.0	(2.8)	(2.7)	0.0

Divisional Trading Position

22. Charts 46-59 shows the overall trading position for each division, taking account of income, expenditure and efficiency delivery. An extract of the clinical division's performance is shown in Figure 6 below.

Figure 6 - Clinical divisional trading position

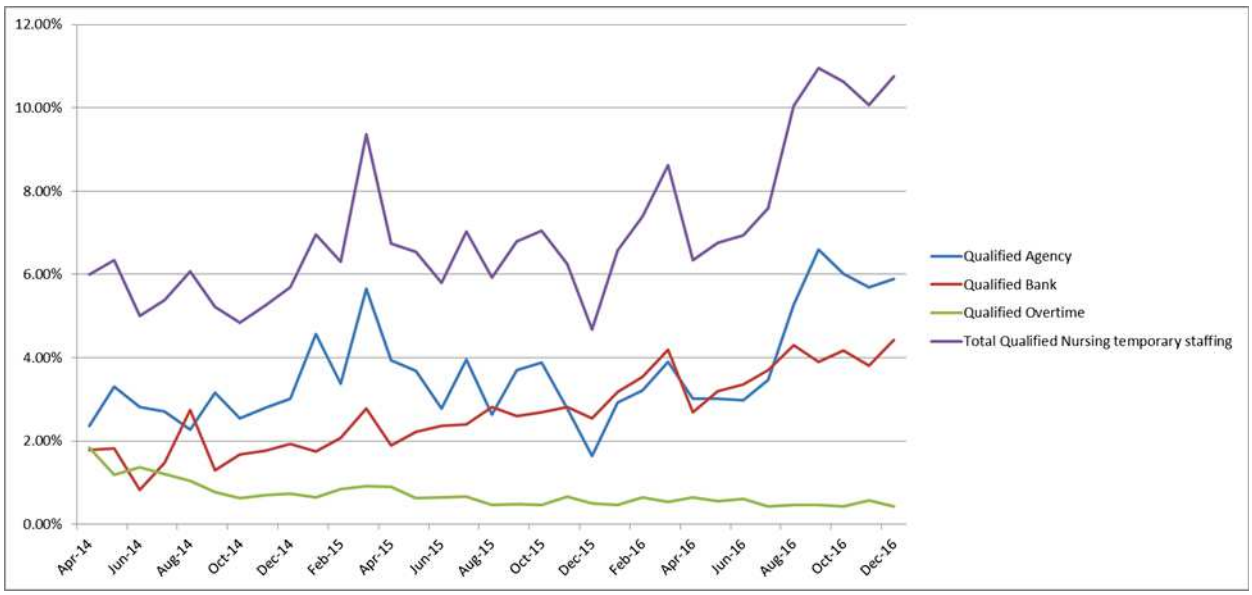
	WTE Variance	Income £000	Pay £000	Non-Pay £000	SRCP £000	Expenditure £000	Total £000
Integrated Care Group	(42)	(194)	(2,909)	2,491	(53)	(471)	**(665)**
Surgery and Anaesthetic Services	(16)	20	(1,792)	(974)	(814)	(3,580)	**(3,560)**
Diagnostic and Clinical Support	63	344	(195)	852	(53)	604	**947**
Family Care Division	26	(27)	(734)	(559)	(273)	(1,566)	**(1,593)**
Sub-total Clinical Divisions	**32**	**143**	**(5,630)**	**1,810**	**(1,194)**	**(5,013)**	**(4,870)**

23. Cumulatively to the end of month 9 the Trust's clinical divisions have a net overspend of £4.9m (previous month £4.4m), with overspends against the non-achievement of the SRCP of £1.2m (previous month £1.3m).

Expenditure

24. Agency staffing spend for month 9 was £1.1m, taking it to a cumulative total of £11.6m over 9 months. This is the lowest monthly level since month 5. We have seen a significant reduction in the use of agency for healthcare assistants but a combination of increased sickness, specialling and vacancies has resulted in an increase to qualified nursing agency and medical agency. We have reduced our administration agency significantly and are working towards zero tolerance for the use of agency for any non-clinical posts.
25. Figure 7 below shows the pressure on qualified nursing agency since April 2014. This shows the demand increasing over this period as a result of vacancies, sickness and specialling, with a resulting pressure on the nurse bank and a continued reliance on agency. Our level of vacancies across our nursing workforce is not unusual and nationally there is an acceptance that more nursing posts are required within the NHS to address these gaps.
26. We are continuing to focus efforts on improving on the position overall through a number of initiatives. These initiatives have Executive oversight with Executive sign off of cap breaches and weekly reporting.

Figure 7: Qualified Nurse spend breakdown



27. Charts 46-59 show spending patterns for temporary bank and agency staff and consultancy within the Trust. The analysis summarised in Appendix E breaks down total staff costs by permanent and temporary staff against the total budget to date. This shows that of the £4.3m overspend on pay;£2.2m is against medical staff (£2.0m previous month), £3.4m is against nursing (£2.9m previous month). Allied Health Professionals, Scientific staff and non-clinical staff are under spending by £1.3m (£0.9m previous month).

Income

28. The Trust's income position is showing a cumulative surplus of £1.9m. An analysis of the Trusts performance by POD shows that the improved position is primarily as a result of the high levels of non-elective activity currently being experienced, with income across the Accident and Emergency and Non-Elective POD's exceeding plan. Other favourable movements include single professional outpatient follow ups, outpatient procedures, day-cases and direct access activity. Areas showing a poor in month performance against plan include elective activity and rehabilitation. Elective activity has been under pressure, in part, as a result of cancelled procedures due to significant operational pressures. Clearly there is a relationship between the increased costs of nursing and medical staff and the increased non-elective activity and associated income.

Safely Releasing Cost Programme (SRCP)

29. The Trust has identified £12.2m (previous month £11.3m) schemes against the annual £14.0m SRCP target (87%). £3.8m of this is non-recurrent. Figure 8 shows the breakdown by Division for 2016-17 and 2017-18.

Figure 8: SRCP Forecast 2016-17 and 2017-18 position statement as at 31st December 2016

Division	2016-17 3% Target £000's	Identified Schemes Green £000's	Amber £000's	Red £000's	Non Rec £000's	Rec £000's	% Total £000's	(Over) / Under £000's	Total Green Schemes %	2016-2017 Recurrent Schemes %
Integrated Care Group	3,951	3,885	200	0	861	3,225	**4,085**	(134)	**98%**	**82%**
SAS	3,243	2,106	602	139	404	2,442	**2,846**	397	**65%**	**75%**
Family Care	1,727	1,338	147	0	811	674	**1,485**	242	**77%**	**39%**
DCS	2,901	2,870	91	0	301	2,659	**2,961**	(60)	**99%**	**92%**
Estates & Facilities	1,293	1,294	57	0	740	611	**1,351**	(58)	**100%**	**47%**
Corporate Services	886	694	0	0	142	552	**694**	192	**78%**	**62%**
Central		0	578	0	578	0	**578**	(578)		
Total	**14,000**	**12,186**	**1,676**	**139**	3,837	10,164	**14,000**	**(1)**		

Division	2017-18 3% Target £000's	Identified Schemes Green £000's	Amber £000's	Red £000's	Non Rec £000's	Rec £000's	% Total £000's	(Over) / Under £000's	Total Green Schemes %	Recurrent Schemes %
Integrated Care Group	3,951	0	0	350	0	350	**350**	3,601	**0%**	**9%**
SAS	3,243	0	0	930	0	930	**930**	2,313	**0%**	**29%**
Family Care	1,727	0	0	413	189	224	**413**	1,314	**0%**	**13%**
DCS	2,901	0	977	2,102	0	3,079	**3,079**	(178)	**0%**	**106%**
Estates & Facilities	1,293	0	0	670	0	670	**670**	623	**0%**	**52%**
Corporate Services	886	0	0	1,000	0	1,000	**1,000**	(114)	**0%**	**113%**
Central		0	0	2,550	0	2,550	**2,550**	(2,550)		
Total	**14,000**	**0**	**977**	**8,015**	189	8,803	**8,992**	**5,008**		

STATEMENT OF FINANCIAL POSITION (SOFP)

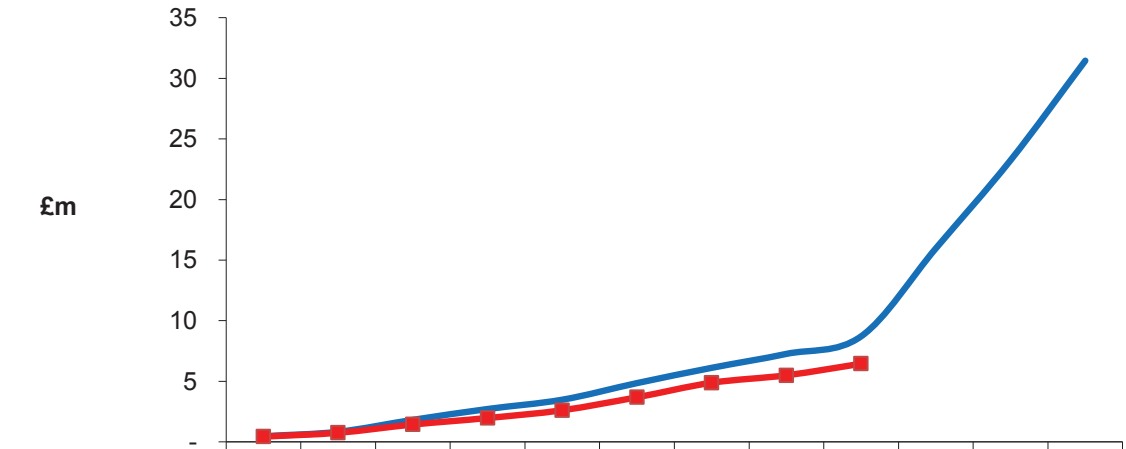
Summary

30. Overall the total assets employed at the end of the reporting month are £166.6m which is a decrease of £0.1m as a result of the in-month retained deficit.

Non-Current Assets, including Capital Expenditure

31. The value of non-current assets has increased by £0.2m to £286.2m, with the £1.0m of capital expenditure in offset mainly by the £1.0m monthly depreciation charge.
32. The Trust has invested £6.5m in capital to the 31st December which represents 74% of the planned expenditure for this period, a fall of 2% from the previous month.

Figure 11 - Capital expenditure



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Revised Plan	0.47	0.83	1.82	2.71	3.48	4.85	6.11	7.26	8.71	15.97	23.24	31.46
Actual	0.43	0.75	1.43	1.97	2.61	3.68	4.88	5.50	6.45			

Current Assets

33. The value of current assets at the end of the reporting month equates to £47.6m, a reduction of £1.5m in month, which is largely due to a £4.0m reduction in cash balances. The main factors contributing to this reduction is the increase in receivables of £2.3m and the £1.3m reduction in payables. While the reduction in payables is not attributable to any significant individual transactions, the increase in receivables is largely due to the prepayment of the £1.8m service payment for the main RBH PFI scheme and a £1.7m increase in system debtors, although this is offset by £1.1m reduction in NHS accrued income, despite the £0.9m increase in the accrual for the quarter three STF allocation.
34. Consequently, there has been a £2.0m increase in the value of debt not yet due, although it is pleasing to report a £0.4m reduction in the value of overdue debt. Within this, while non-NHS debt has remained relatively static, NHS debt overdue by less than 90 days has fallen by £1.2m, although older debt has increase by £0.8m. As a result of these changes, there has been a £0.2m increase in impairment provisions and total net debt overdue by more than 90 days has increased from 42.5% to 65.4%.

Liabilities

35. Current liabilities have fallen by £1.4m, largely due to the reductions in payables referred to in the explanation for the reduction in the cash balance given above. The long term element of the PFI liability, which is the main component of non-current liabilities, has decreased by £0.5m.

Better Payment Practice Code (BPPC)

36. We continue to achieve the BPPC cumulatively and are forecasting to achieve all 4 targets for the year.

Conclusion

37. The Trust is reporting a deficit in line with the planned position for the year to date. This report highlights any risks to this position and remedies being undertaken by the Trust.
38. It is pleasing to note that despite the considerable operational pressure currently being experienced by the Trust, it is forecast that the year-end control total will be achieved.

APPENDIX A – SCORECARD

Safe

		Threshold 16/17	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Monthly Sparkline
M64	CDIFF	28	3	3	1	2	1	2	3	4	1	5	5	4	2	
M65	MRSA	0	1	0	0	0	0	0	0	0	0	0	0	0	1	
M66	Never Event Incidence	0	1	1	0	1	0	0	0	1	0	0	0	0	0	
M67	Medication errors causing serious harm (Steis reported date)	0	0	0	0	0	0	0	1	0	0	0	0	0	0	
C28	Percentage of Harm Free Care	92%	99.2%	99.1%	99.4%	99.1%	99.7%	98.8%	99.1%	99.4%	99.2%	99.1%	99.3%	99.2%	98.9%	
M68	Maternal deaths	0	0	0	0	0	0	0	0	0	0	0	0	1	0	
C29	Proportion of patients risk assessed for Venous Thromboembolism	95%	99.1%	99.4%	99.3%	99.1%	99.1%	99.0%	99.0%	99.2%	98.8%	98.7%	98.3%	97.4%		
M69	Serious Incidents (Steis)		10	7	9	7	10	2	6	5	7	5	4	8	6	
M70	CAS Alerts - non compliance	0	1	0	0	0	0	0	0	0	1	2	0	0	0	
M146	Safer Staffing -Day-Average fill rate - registered nurses/midwives (%)	80%	90%	89%	89%	86%	88%	89%	87%	86%	85%	87%	90%	90%	90%	
M147	Safer Staffing -Day-Average fill rate - care staff (%)	80%	105%	105%	105%	107%	110%	114%	116%	118%	126%	121%	123%	118%	112%	
M148	Safer Staffing -Night-Average fill rate - registered nurses/midwives (%)	80%	97%	97%	97%	97%	97%	99%	98%	99%	98%	99%	101%	99%	97%	
M149	Safer Staffing -Night-Average fill rate - care staff (%)	80%	116%	120%	120%	121%	124%	122%	129%	136%	142%	138%	134%	130%	122%	
M150	Safer Staffing - Day -Average fill rate - registered nurses/midwives- number of wards <80%	0	9	8	12	19	16	11	17	15	21	21	9	5	5	
M151	Safer Staffing - Night -Average fill rate - registered nurses/midwives- number of wards <80%	0	0	0	0	0	0	0	1	1	0	1	1	1	3	
M152	Safer Staffing - Day -Average fill rate - care staff- number of wards <80%	0	2	3	4	3	2	0	0	0	0	0	0	0	0	
M153	Safer Staffing - Night -Average fill rate - care staff- number of wards <80%	0	1	3	2	3	2	1	1	1	1	1	1	1	2	

Caring

		Threshold 16/17	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Monthly Sparkline
C38	Inpatient Friends and Family - % who would recommend	92.07%	98.8%	99.1%	96.9%	98.4%	98.6%	97.9%	98.6%	98.5%	98.2%	98.4%	98.5%	97.7%	98.5%	
C40	Maternity Friends and Family - % who would recommend	91.86%	92.6%	93.4%	95.5%	96.6%	96.4%	96.7%	95.9%	95.8%	97.0%	97.8%	97.3%	96.2%	98.3%	
C42	A&E Friends and Family - % who would recommend	74.90%	85.1%	78.3%	80.8%	76.5%	80.4%	75.7%	76.3%	75.0%	73.9%	75.8%	76.7%	75.7%	76.1%	
C44	Community Friends and Family - % who would recommend	88.62%	93.7%	94.4%	93.7%	93.7%	94.0%	94.9%	94.3%	93.6%	94.3%	93.1%	92.5%	92.8%	92.8%	
C15	Complaints – rate per 1000 contacts	0.4	0.2	0.3	0.3	0.2	0.3	0.2	0.2	0.2	0.3	0.2	0.2	0.4	0.3	
M52	Mixed Sex Breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	0	

Effective

		Threshold 16/17	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Monthly Sparkline
M73	Deaths in Low Risk Categories - relative risk	Outlier	68.5	75.5	75.6	70.4	67.8	71.6	77.3	81.1	85.1	82.7				
M74	Hospital Standardised Mortality Ratio - Weekday (DFI Indicative)	Outlier	98.6	96.4	94.8	94.9	96.1	96.1	95.9	96.3	97.7	97.0				
M75	Hospital Standardised Mortality Ratio - Weekend (DFI Indicative)	Outlier	101.6	101.9	101.7	101.6	106.5	102.0	100.2	98.3	97.7	98.3				
M54	Hospital Standardised Mortality Ratio (DFI Indicative)	Outlier	99.4	97.8	96.6	97.0	99.1	97.6	97.0	96.8	97.7	97.4				
M53	Summary Hospital Mortality Indicator (HSCIC Published data)	Outlier	1.06			1.06			1.04							
C16	Emergency re-admissions within 30 days		13.3%	13.3%	12.6%	12.8%	12.3%	13.0%	13.2%	11.0%	11.6%	12.7%	13.0%	12.4%		
M89	CQUIN schemes at risk	0	3			2			0			3				

Responsive

		Threshold 16/17	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Monthly Sparkline
C2	Proportion of patients spending less than 4 hours in A&E	95%	94.5%	88.2%	90.0%	87.8%	89.3%	86.4%	86.4%	85.2%	79.3%	83.9%	84.1%	79.8%	77.3%	
M62	12 hour trolley waits in A&E	0	2	0	1	0	2	3	3	7	9	2	3	3	0	
C1	RTT admitted: percentage within 18 weeks	95%	86.3%	82.5%	83.2%	81.2%	78.5%	81.8%	79.2%	73.8%	79.0%	76.2%	78.1%	72.5%	75.3%	
C3	RTT non- admitted pathways: percentage within 18 weeks	90%	95.9%	95.3%	95.6%	96.3%	94.4%	94.4%	95.0%	93.8%	92.4%	92.0%	93.9%	92.7%	93.2%	
C4	RTT waiting times Incomplete pathways	92%	93.9%	94.5%	95.2%	95.6%	94.8%	93.7%	94.7%	95.7%	93.9%	93.9%	92.7%	92.9%	92.0%	
C37.1	RTT 52 Weeks (Ongoing)	0	0	0	0	0	1	2	1	1	0	1	1	1	1	
C17	Diagnostic waiting times: patients waiting over 6 weeks for a diagnostic test	1%	0.1%	0.2%	0.2%	0.2%	0.2%	0.1%	0.2%	0.3%	0.3%	0.1%	0.1%	0.2%	0.1%	
C18	Cancer - Treatment within 62 days of referral from GP	85%	91.0%	93.7%	86.6%	88.4%	85.6%	82.8%	81.6%	87.8%	80.8%	86.5%	85.4%	93.6%		
C19	Cancer - Treatment within 62 days of referral from screening	90%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	94.1%	96.4%	96.9%	91.9%	95.8%		
C20	Cancer - Treatment within 31 days of decision to treat	96%	100.0%	98.3%	100.0%	98.9%	100.0%	98.4%	99.1%	99.4%	96.3%	98.9%	99.0%	99.0%		
C21	Cancer - Subsequent treatment within 31 days (Drug)	98%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.5%	100.0%	100.0%	100.0%	100.0%		
C22	Cancer - Subsequent treatment within 31 days (Surgery)	94%	100.0%	99.0%	97.3%	94.1%	97.1%	100.0%	97.8%	97.7%	97.5%	94.3%	100.0%	94.7%		
C24	Cancer - seen within 14 days of urgent GP referral	93%	96.7%	97.6%	95.5%	95.6%	95.2%	95.1%	94.3%	95.4%	93.9%	94.3%	95.1%	95.7%		
C25	Cancer - breast symptoms seen within 14 days of GP referral	93%	97.2%	96.4%	97.3%	93.6%	95.2%	94.1%	93.0%	97.5%	96.6%	98.7%	98.9%	95.6%		
M9	Urgent operations cancelled for 2nd time	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
C27a	Not treated within 28 days of last minute cancellation due to non clinical reasons - actual	0	0	0	0	0	0	1	0	1	1	3	2	1	0	
M55	Proportion of delayed discharges attributable to the NHS	3.5%	4.2%	4.4%	4.8%	4.8%	4.3%	4.4%	4.6%	5.5%	4.5%	5.8%	5.5%	4.3%	5.1%	
M90	Average LOS elective and daycase		2.8	2.9	3.0	2.8	2.8	2.6	2.9	2.3	3.0	2.3	2.9	2.3	2.5	
M91	Average LOS non-elective		4.6	4.6	4.6	4.9	4.8	5.0	5.0	4.5	4.9	5.0	4.7	4.7	4.7	

Well led

		Threshold 16/17	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Monthly Sparkline
C31	NHS England Inpatients response rate from Friends and Family Test	16%	49.8%	48.9%	48.5%	50.1%	45.9%	54.0%	50.5%	47.7%	51.2%	43.3%	43.2%	40.8%	51.2%	
C32	NHS England A&E response rate from Friends and Family Test	4%	23.7%	21.1%	21.7%	22.2%	21.8%	19.8%	19.7%	20.5%	21.5%	21.1%	20.8%	17.9%	19.1%	
M77	Trust turnover rate	12%	9.4%	9.3%	9.2%	8.7%	8.9%	8.9%	9.0%	9.0%	9.4%	9.6%	9.3%	9.2%	9.2%	
M78	Trust level total sickness rate	3.75%	4.74%	4.81%	4.74%	4.45%	4.5%	4.5%	4.9%	4.9%	4.8%	5.0%	5.1%	5.1%		
M79	Total Trust vacancy rate	5%	7.5%	7.8%	7.1%	7.3%	8.0%	6.7%	7.7%	8.0%	7.3%	6.2%	6.1%	5.7%	6.7%	
M80.2	Safeguarding Children	80%	86.0%	87.0%	87.0%	88.0%	88.0%	88.0%	90.0%	91.0%	93.0%	92.0%	91.0%	93.0%	93.0%	
F8	Temporary costs as % of total paybill	4%	8%	8%	9%	9%	7%	7%	8%	9%	10%	10%	9%	10%	9%	
F9	Overtime as % of total paybill	0%	0%	0%	1%	0%	1%	0%	0%	0%	0%	0%	0%	0%	0%	
F1	Cumulative Retained Deficit for breakeven duty (£M)	(3.7)	(10.1)	(10.8)	(11.2)	(11.5)	(0.3)	(0.6)	(0.9)	(1.2)	(1.5)	(1.8)	(2.1)	(2.4)	(2.7)	
F2	SRCP Achieved % (green schemes only)	100.0%	60%	62%	64%	64%	52%	54%	56%	59%	71%	74%	75%	81%	87%	
F3	Liquidity days	>(14.0)	(13.5)	(14.0)	(14.4)	(5.0)	(5.3)	(5.9)	(5.6)	(5.5)	(5.8)	(6.2)	(6.6)	(6.9)	(7.1)	
F4	Capital spend v plan	85%	71%	72%	71%	90%	93%	91%	79%	73%	75%	76%	80%	76%	74%	
F16	Finance & Use of Resources (UoR) metric - overall	3											3	3	3	
F17	Finance and UoR metric - liquidity	3											2	2	3	
F18	Finance and UoR metric - capital service capacity	3											4	4	4	
F19	Finance and UoR metric - I&E margin	3											3	3	3	
F20	Finance and UoR metric - distance from financial plan	1											1	1	1	
F21	Finance and UoR metric - agency spend	1											3	3	3	
F12	BPPC Non NHS No of Invoices	95%	95.9%	95.7%	95.5%	95.5%	96.8%	96.3%	96.0%	96.2%	96.4%	96.3%	96.5%	96.6%	96.8%	
F13	BPPC Non NHS Value of Invoices	95%	95.1%	95.3%	95.2%	95.4%	98.2%	96.7%	95.7%	95.8%	96.2%	96.0%	96.5%	96.6%	96.8%	
F14	BPPC NHS No of Invoices	95%	95.6%	95.2%	95.0%	95.0%	95.3%	95.3%	93.2%	93.7%	93.4%	93.7%	97.0%	96.7%	96.3%	
F15	BPPC NHS Value of Invoices	95%	96.6%	96.6%	96.6%	96.4%	99.5%	95.8%	95.9%	96.6%	96.6%	97.0%	99.2%	99.2%	98.9%	

East Lancashire Hospitals NHS
NHS Trust

APPENDIX B – GRAPHS

Safe | Personal | Effective

Chart 1 - C Difficile actual against threshold

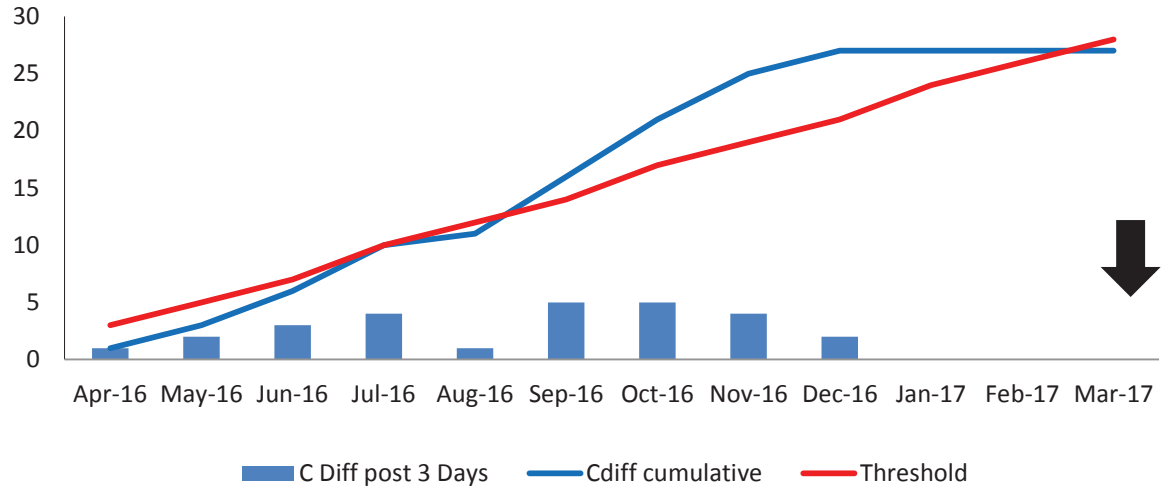


Chart 2 - Safe Infection Control - C Diff per 100,000 occupied bed days

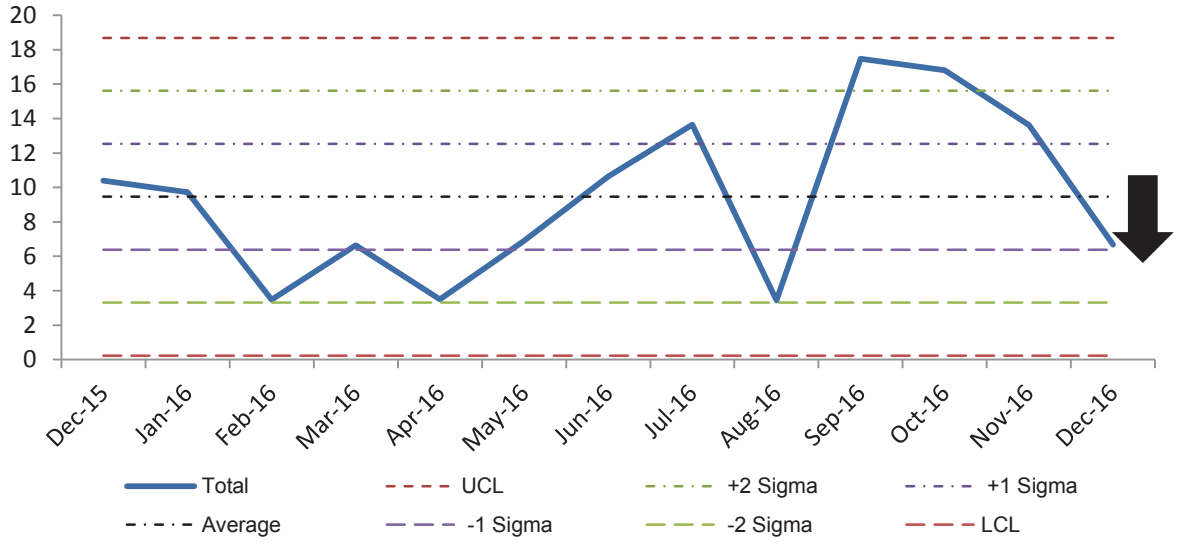


Chart 3 - C Diff benchmarking

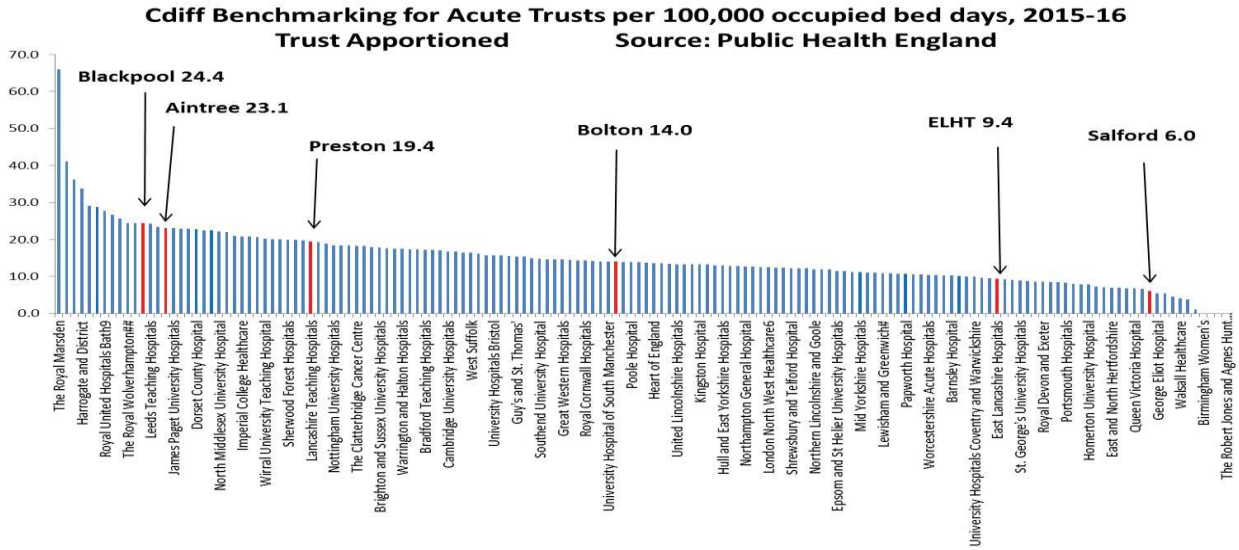


Chart 4 - % Harm Free Care from safety thermometer

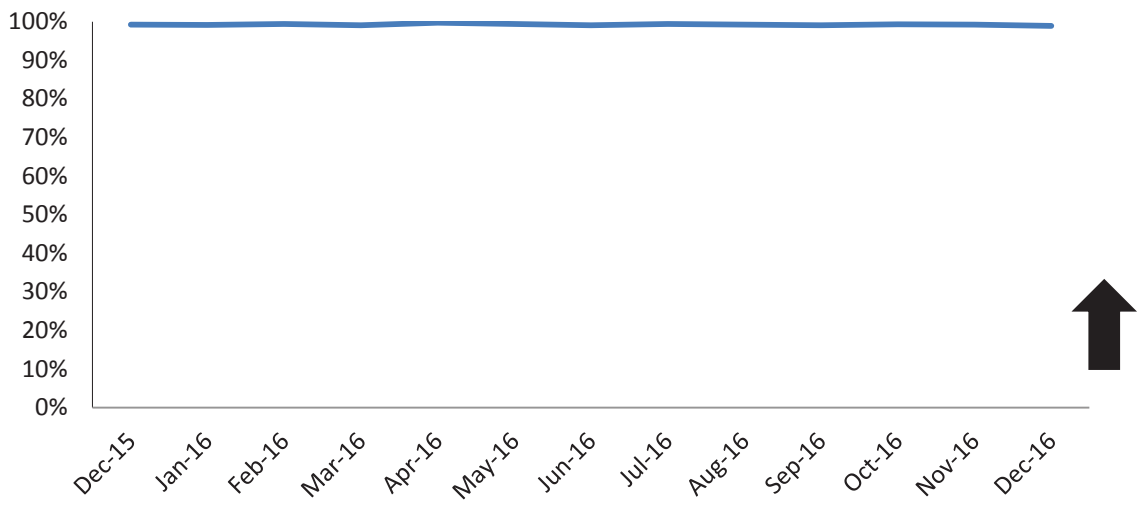


Chart 5 - VTE assessment

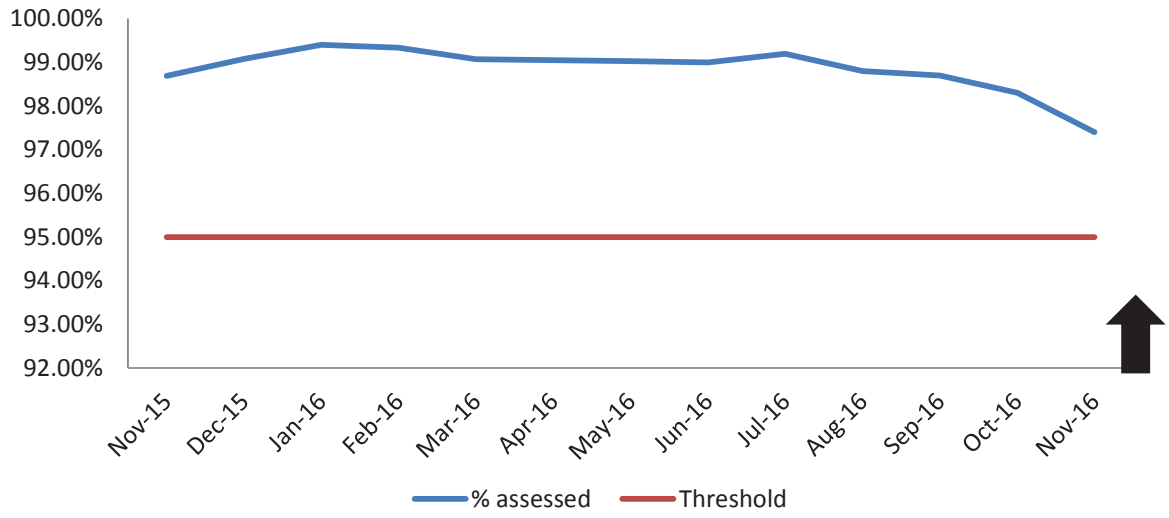


Chart 6 - Serious Incidents

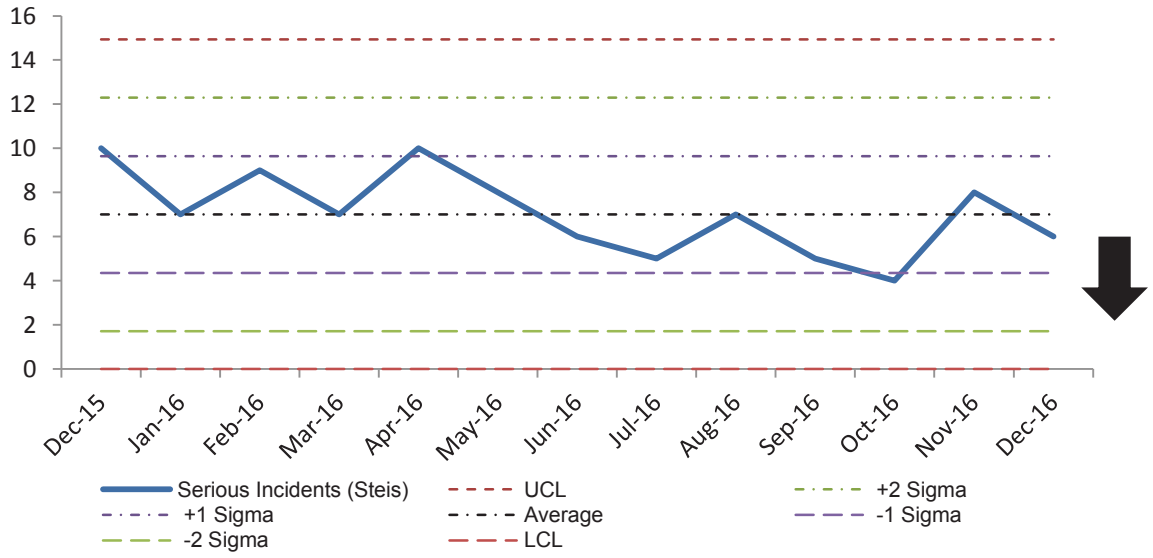


Chart 7 - Registered Nurses/Midwives

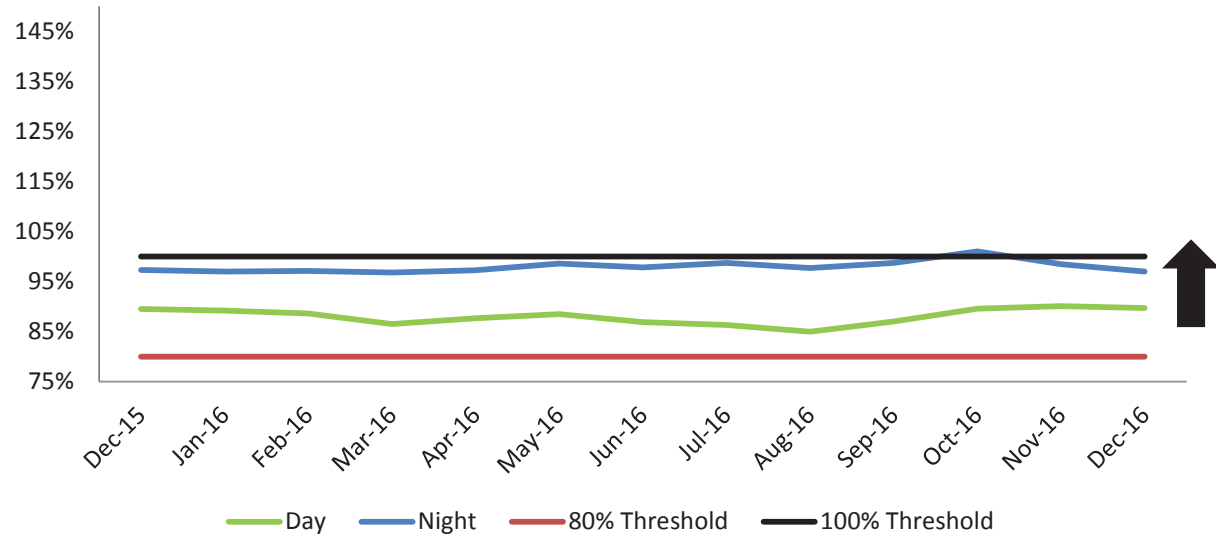


Chart 8 - Care Staff

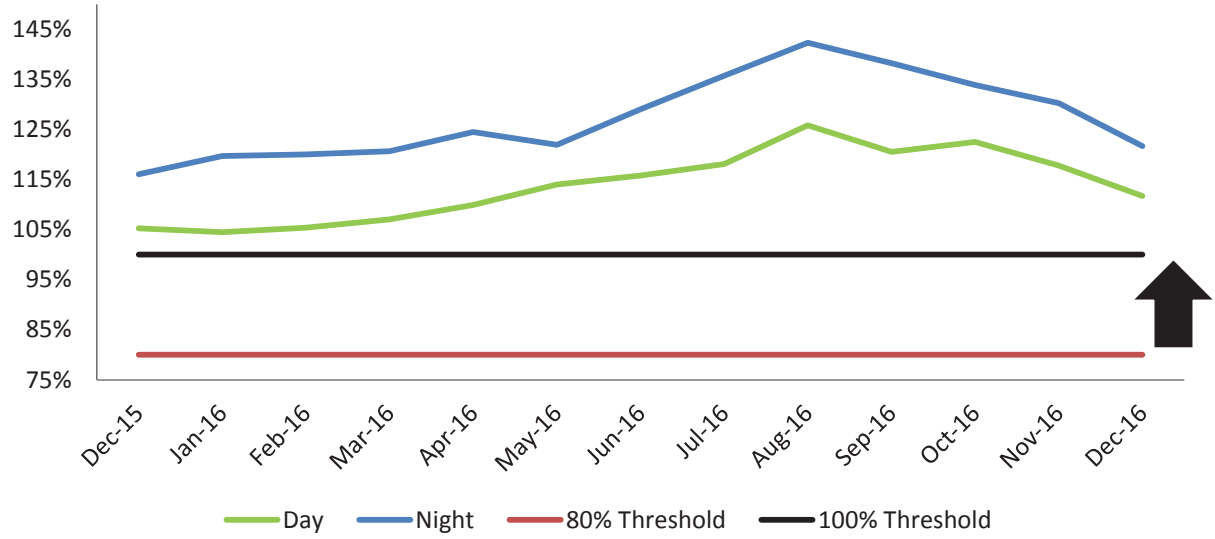


Chart 9 - Friends & Family A&E

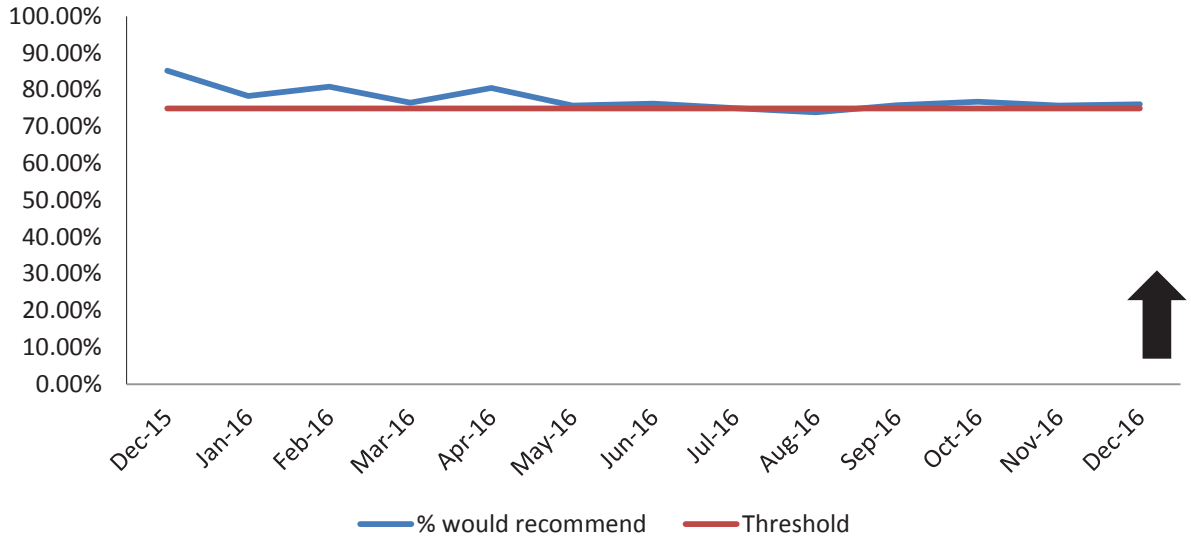


Chart 10 - Friends & Family Community

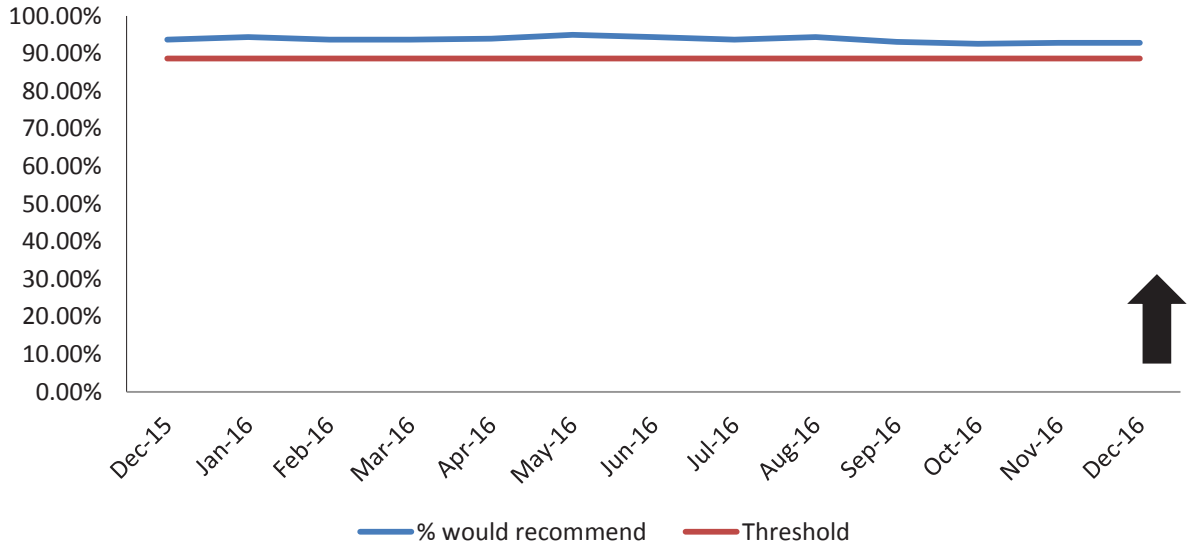
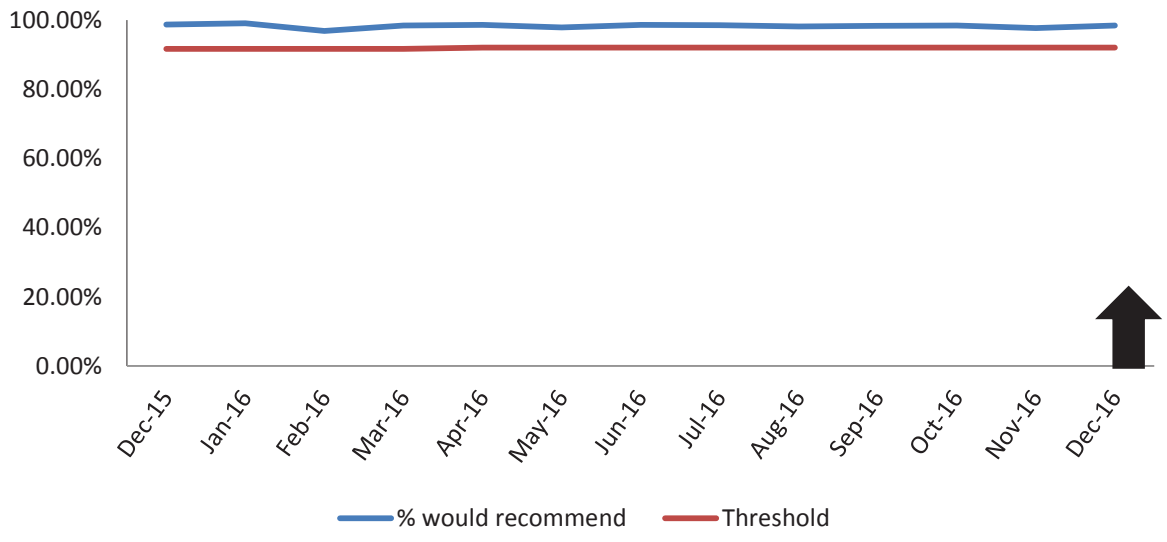


Chart 11 - Friends & Family Inpatient



CARING

Chart 12 - Friends & Family Maternity

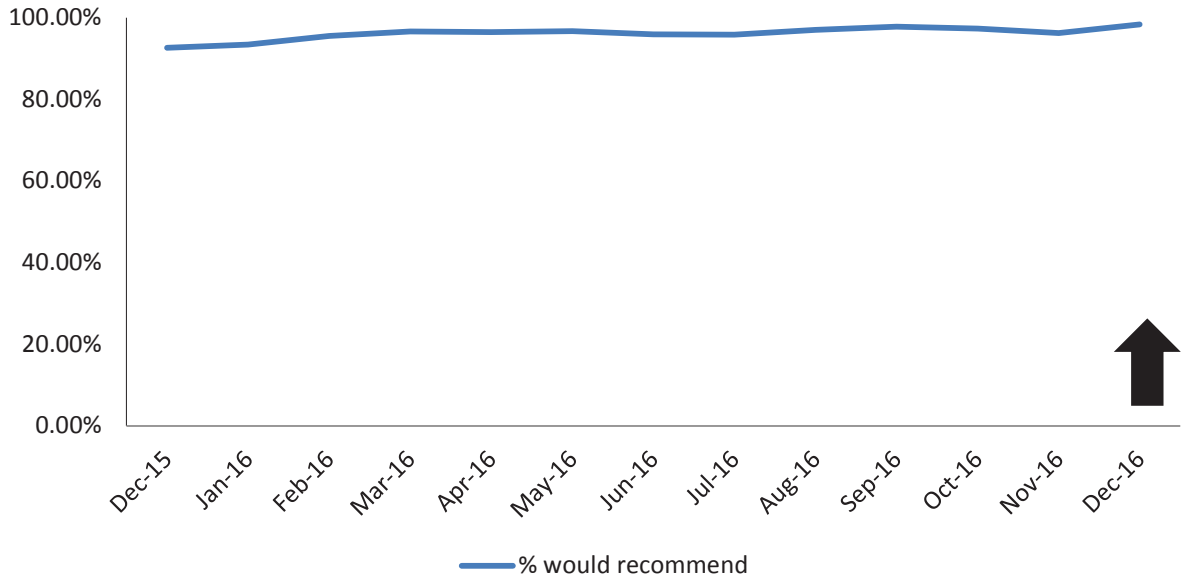


Chart 13 - Complaints per 1000 contacts

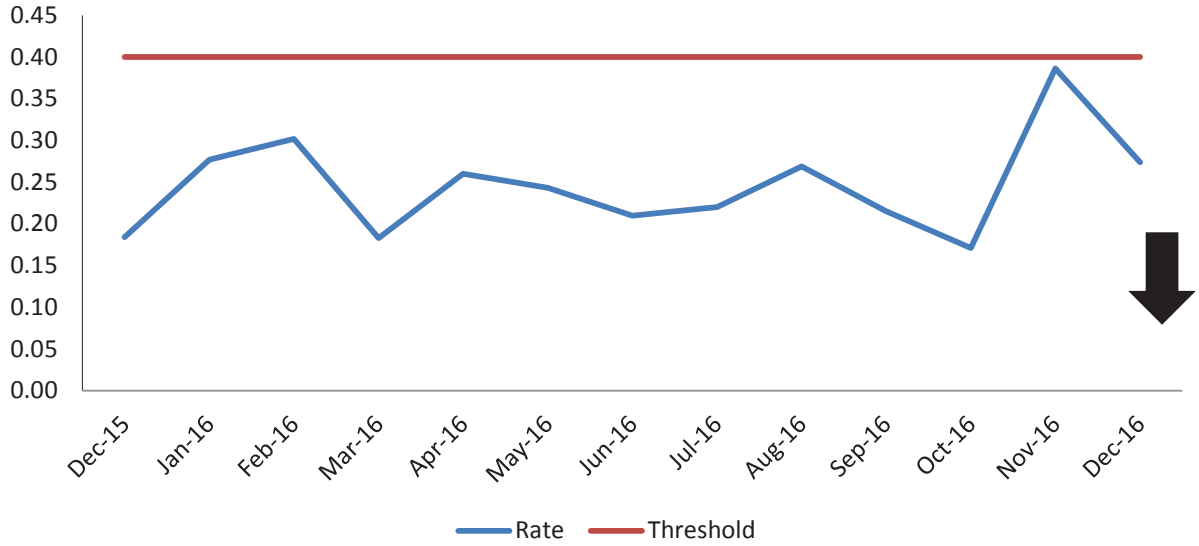


Chart 14 - Patient Experience

December 2016 Totals		Overall	Dignity	Information	Involvement	Quality
	No.	%	%	%	%	%
Trust	1961	97	99	98	99	97
Integrated Care Group - Acute	669	97	99	99	99	96
Integrated Care Group - Comr	260	100	100	99	100	100
Surgery	297	97	98	95	96	97
Family care	404	98	99	99	99	98
Diagnostic and Clinical	318	95	96	96	98	95

Chart 15 - Dr. Foster Indicative HSMR monthly Trend

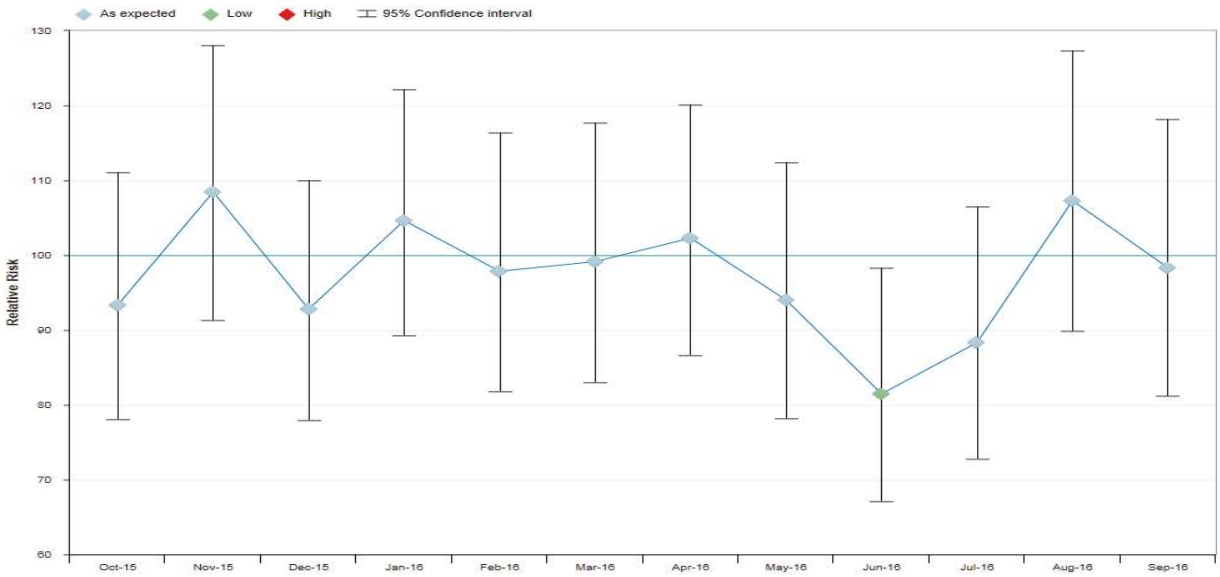


Chart 16 - SHMI Published Trend

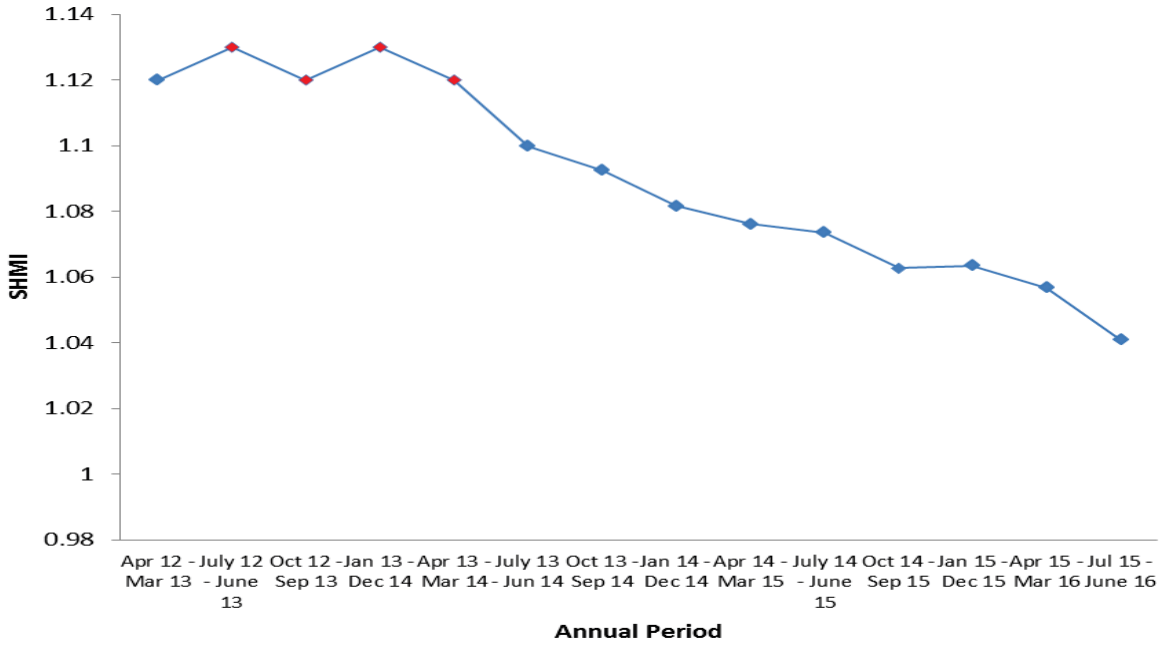


Chart 17 - DFI Indicative HSMR rolling 12 month

	TDA Reported HSMR July 14 – June 15	DFI Rebased on latest month Oct 15 – Sep 16 (Risk model June 16)
TOTAL	103.03	97.4 (CI 92.6 – 102.4)
Weekday		97.0 (CI 91.6 – 102.8)
Weekend	103.94	98.3 (CI 88.9 – 108.5)
Deaths in Low Risk Diagnosis Groups		82.7 (CI 51.2 – 126.4)

Chart 18 - Delayed Discharges per 1000 bed days

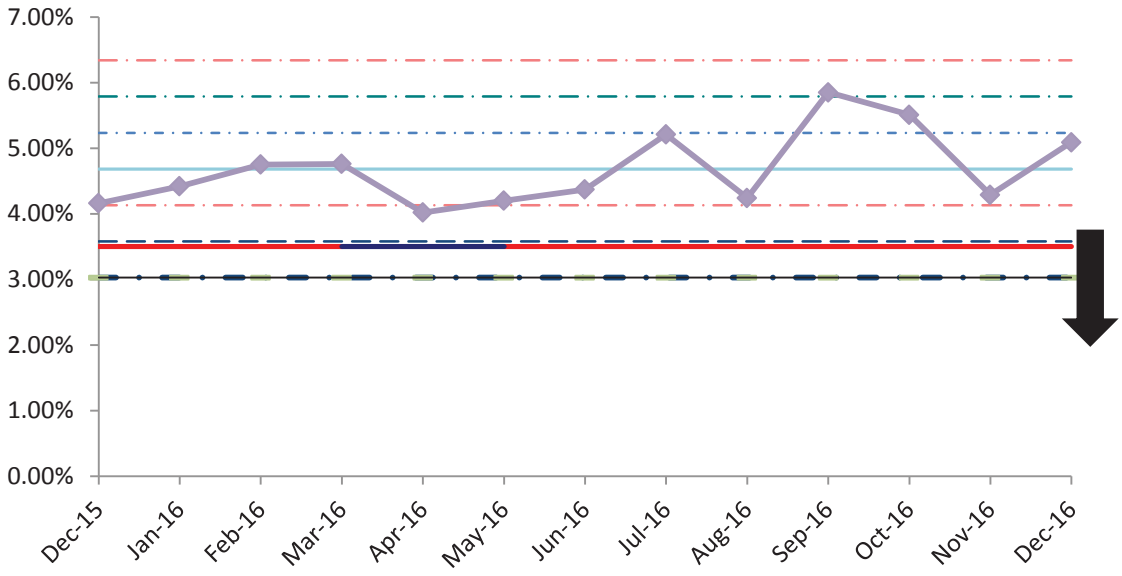


Chart 19 - Emergency Readmissions

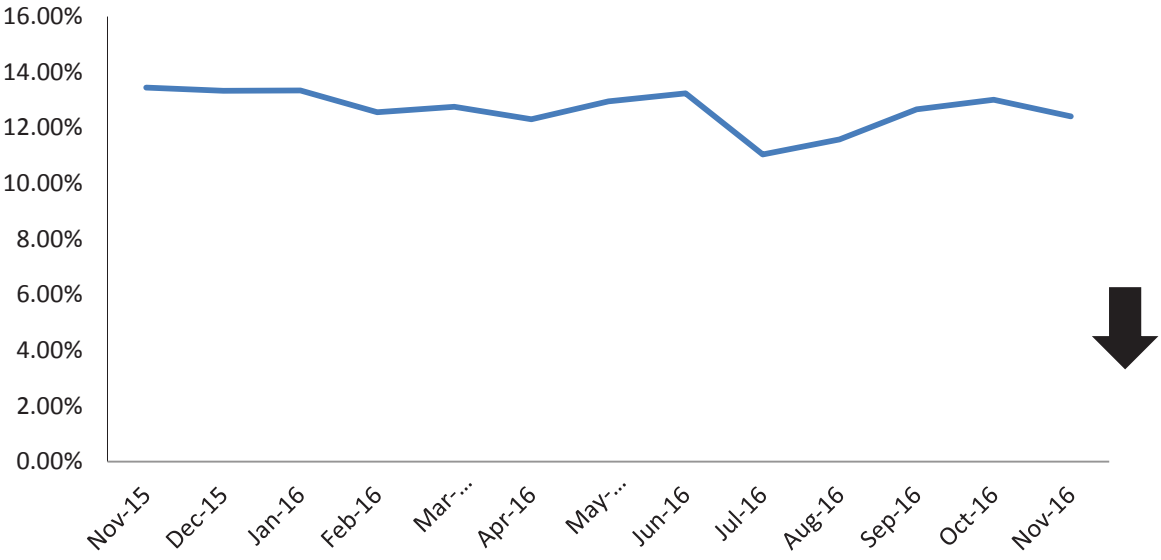
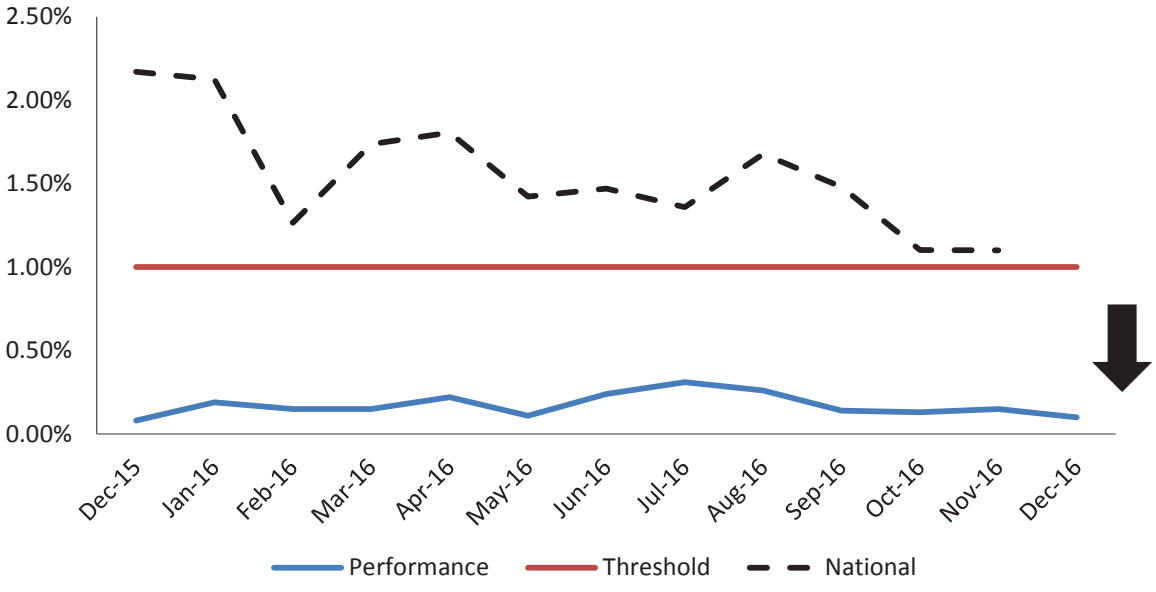


Chart 20 - Diagnostic Waits



EFFECTIVE

Chart 21 - Commissioning for Quality and Innovation (CQUIN)

CQUIN Scheme		Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Q1	Q2
national	**SEPSIS PART A**- screening in **emergency department** - Adult	90.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	- screening in **emergency department** - child	90.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
national	- antiobiotic administration & review - adult - number eligible		4	6	0	4	1	1	10	6
national	- antiobiotic administration & review - adult %		100.0%	66.7%	n/a	50.0%	100.0%	100.0%	80.0%	66.7%
national	- antiobiotic administration & review child - number eligible		0	0	0	0	0	0	0	0
national	- antiobiotic administration & review child %		n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
national	**SEPSIS PART B**- screening in an **inpatient setting** - adult	90.0%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.0%	100.0%
national	- screening in an **inpatient setting** -child	90.0%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.0%	100.0%
national	- antiobiotic administration & review - adult - number eligible		8	5	2	1	1	1	15	3
national	- antiobiotic administration & review - adult %		100.0%	100.0%	50.0%	100.00%	100.00%	100.0%	93.3%	100.0%
national	- antiobiotic administration & review - child - number eligible		0	0	0	0	0	0	0	0
national	- antiobiotic administration & review - child %		n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
national	**ANTIMICROBIAL RESISTANCE PART B** - Empiric Review of antiobiotic prescriptions		84%	78%	74%	80%	82%	70%	79%	77%
local	**SAVING BABIES LIVES** - Induction rate		24.7%	23.9%	25.7%	23.7%	27.7%	25.2%		
local	- Induction rate (FGR/ Reduced fetal movements) **		31.5%	29.3%	30.6%	26.9%	27.9%	26.8%	30.5%	27.2%
local	- No. Stillbirths, TOTAL		1	3	5	5	3	7	9	15
local	- No. Stillbirths, Avoidable			1					1	0
local	- No. Stillbirths, Unavoidable		1	2	5	5	3	7	8	15
local	-Smoking Status at Booking		18.2%	17.7%	17.6%	21.2%	18.0%	19.5%	17.8%	19.6%
local	-Smoking Status at Delivery		15.8%	16.2%	16.1%	17.9%	16.9%	17.7%	16.1%	17.5%
local	-Number of staff who have undertaken PROMPT (CTG training) - rolling 12 months			337			337		337	337
local	-Percentage of staff who have undertaken PROMPT (CTG training) - Rolling 12 months		86.6%	78.0%	76.0%	79.5%	80.9%	73.6%	76.0%	73.6%
local	-Training in the use of customised growth charts		90.2%	103.8%	90.2%	87.6%	80.6%	75.7%	90.2%	75.7%
local	-Feedback from women on information provided on reduced fetal movements		48.7%	47.0%	46.7%	51.8%	59.3%	43.2%	47.5%	51.0%
local	**REFER TO PHARMACY** - Referrals	Q1 1000 Q2 1300 Q3 1600 Q4 2000		1275			2168		1275	2168
Spec Comms	**NEONATAL CRITICAL CARE** - 2 year Outcomes		100%	100%	100%	100%	n/a	100%	100%	100%
Spec Comms	- Hypothermia Prevention - Temperature taken within 1 hr	98.0%	100%	100%	100%	100%	100%	100%	100%	100%
Spec Comms	- Hypothermia Prevention - Temperature >=36 degrees	95.0%	91%	100%	88%	100%	100%	86%	93%	97%
Spec Comms	**CANCER** - Dose Banding			0%			67%		0%	67%

RESPONSIVE

Chart 22 - A&E 4 hour standard % performance, including National average

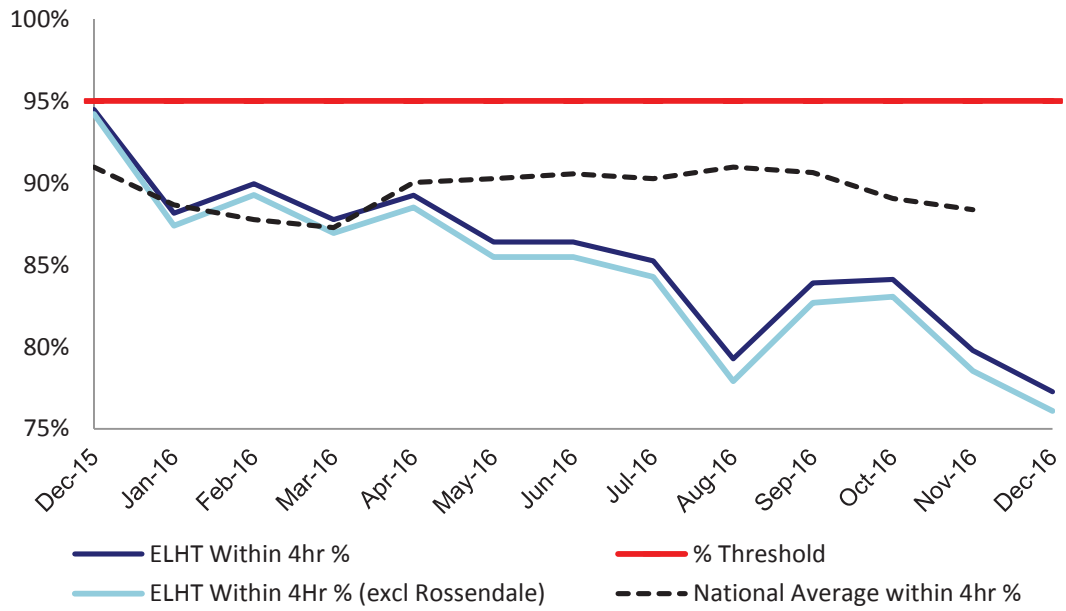


Chart 23 - Handovers

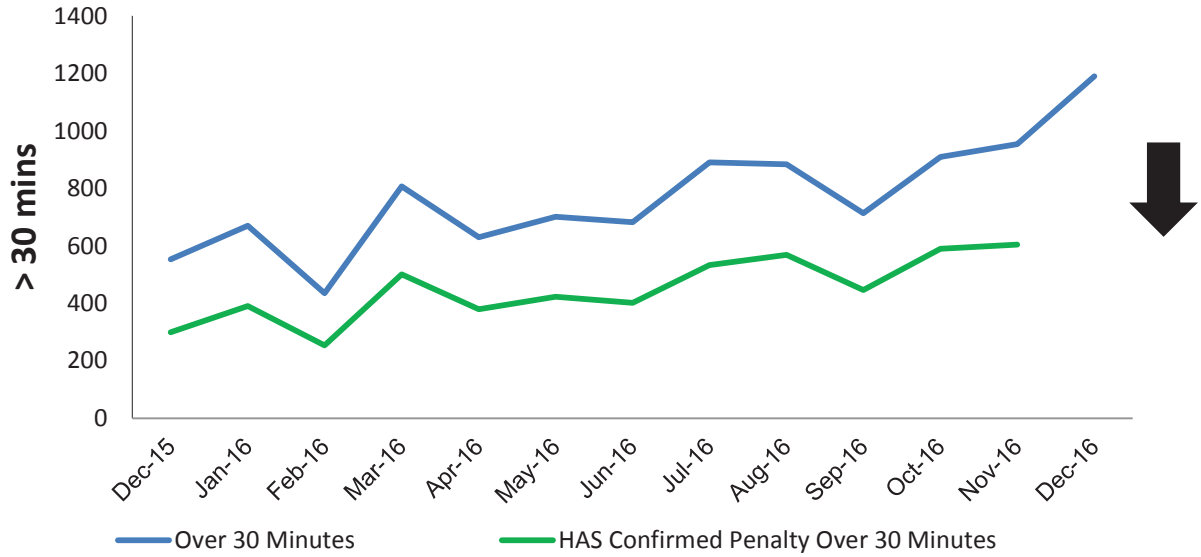


Chart 24 - HAS Compliance

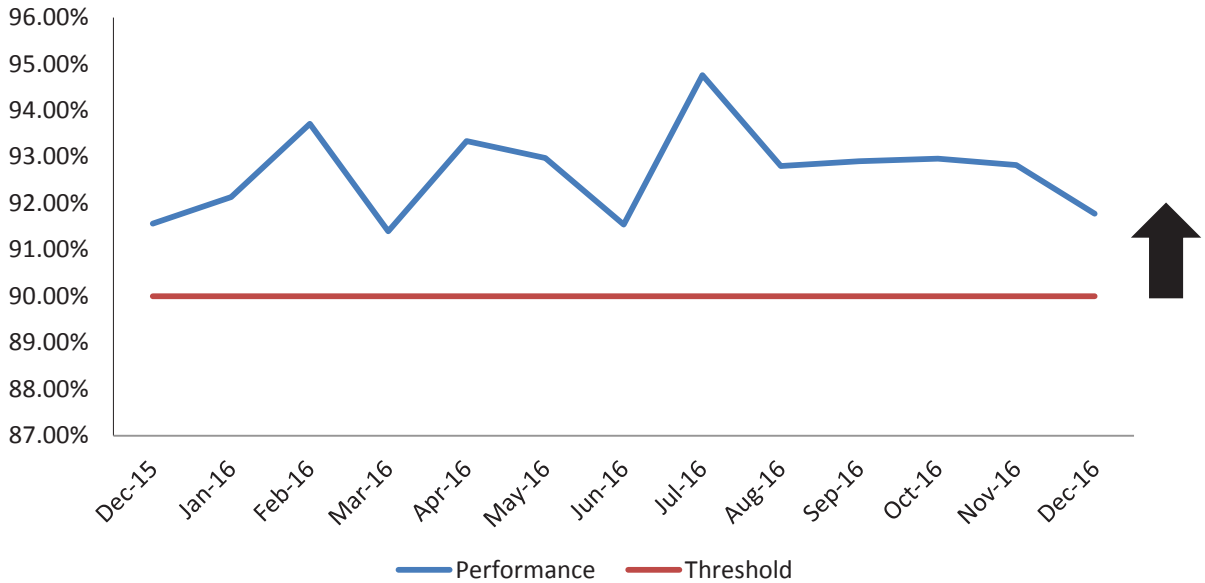


Chart 25 - RTT Ongoing

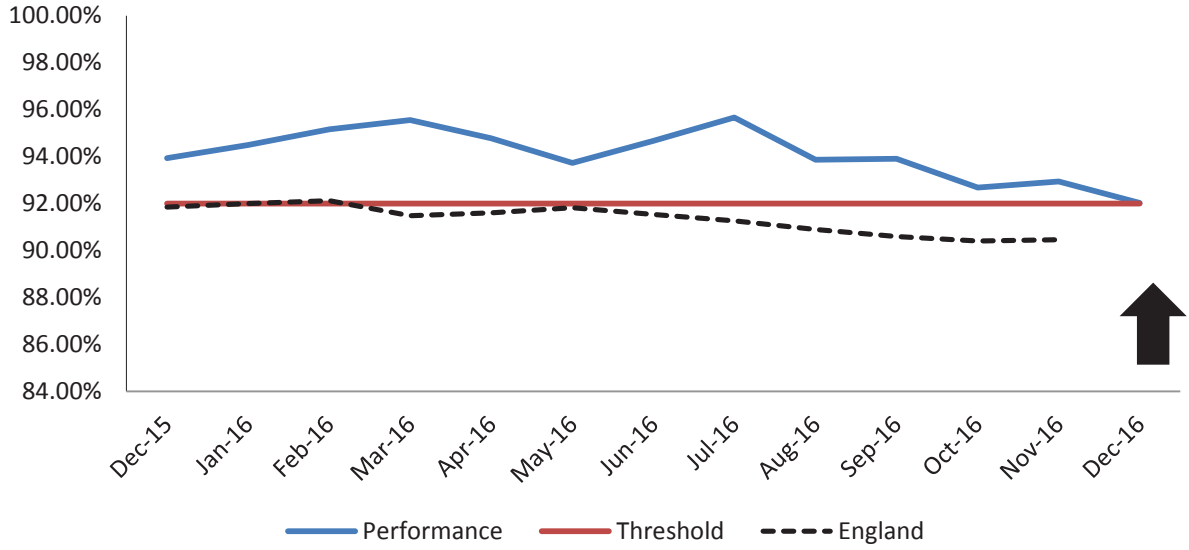


Chart 26 - RTT Ongoing 0-18 Weeks

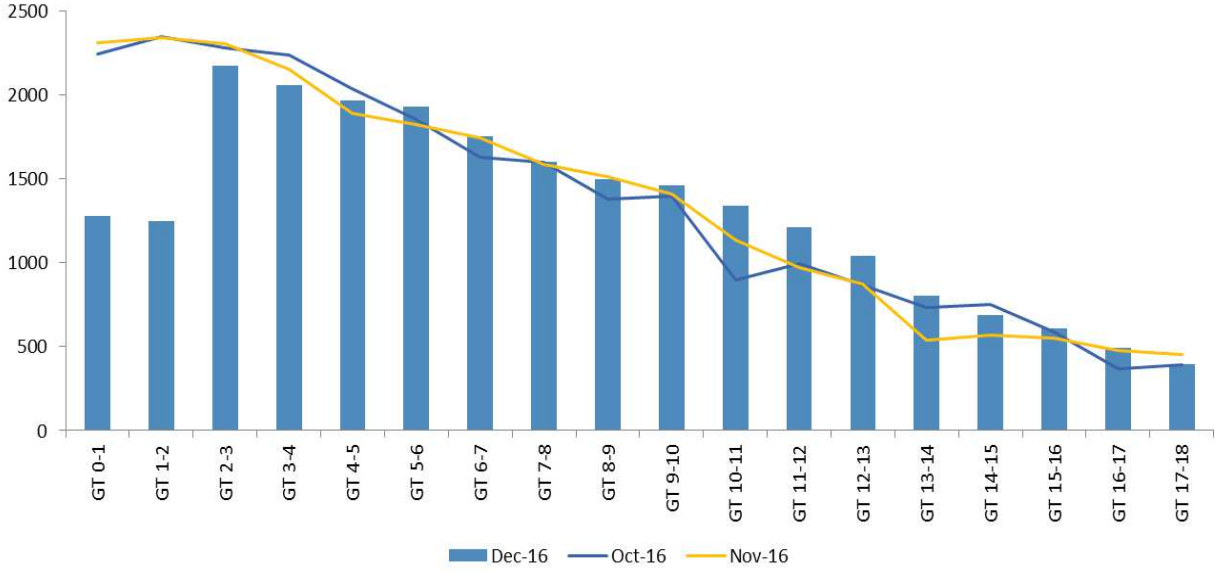


Chart 27 - RTT Over 18 weeks

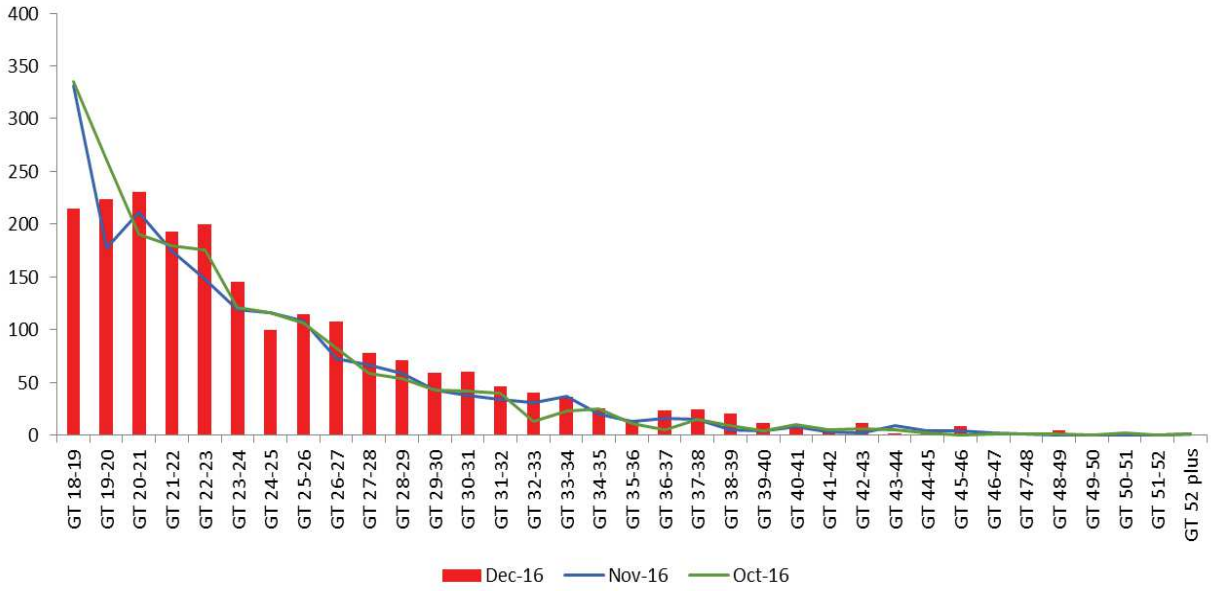


Chart 28 - Cancer 2 Week

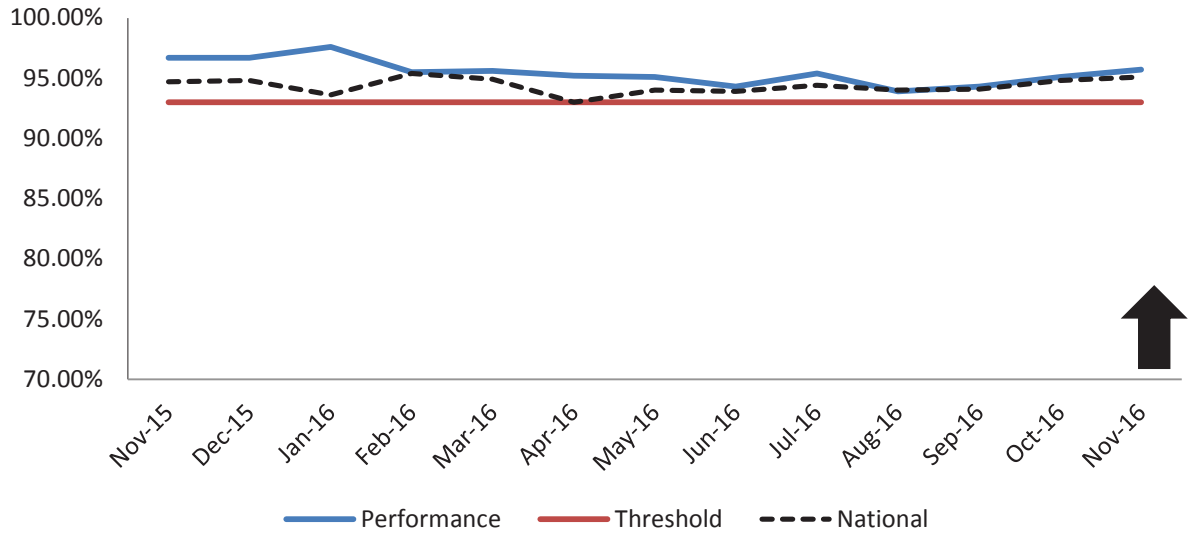


Chart 29 - 62 Day

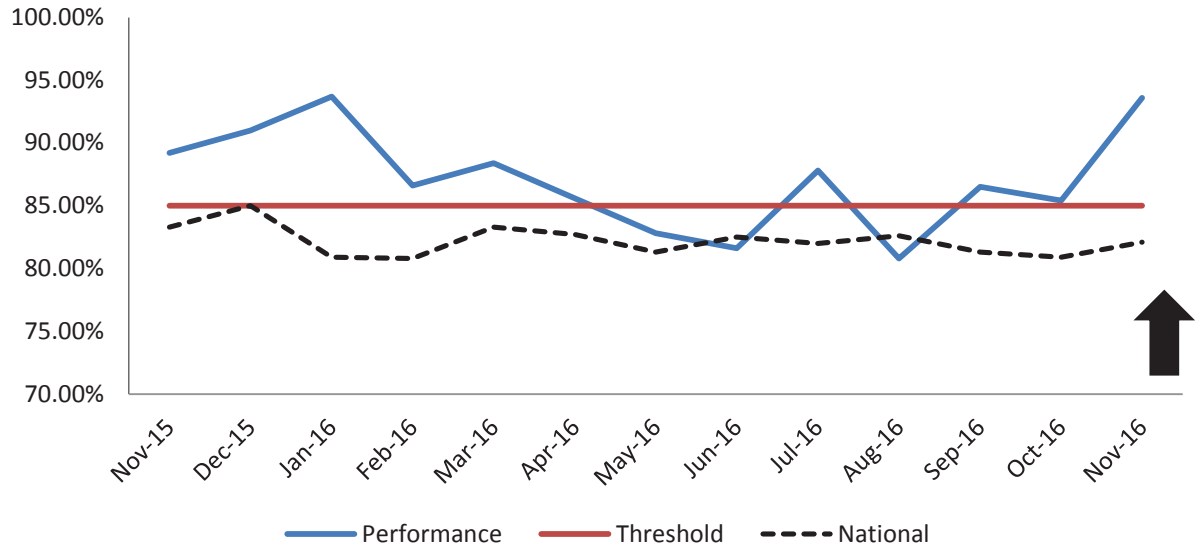


Chart 30 - Cancer Patients Treated > Day 104

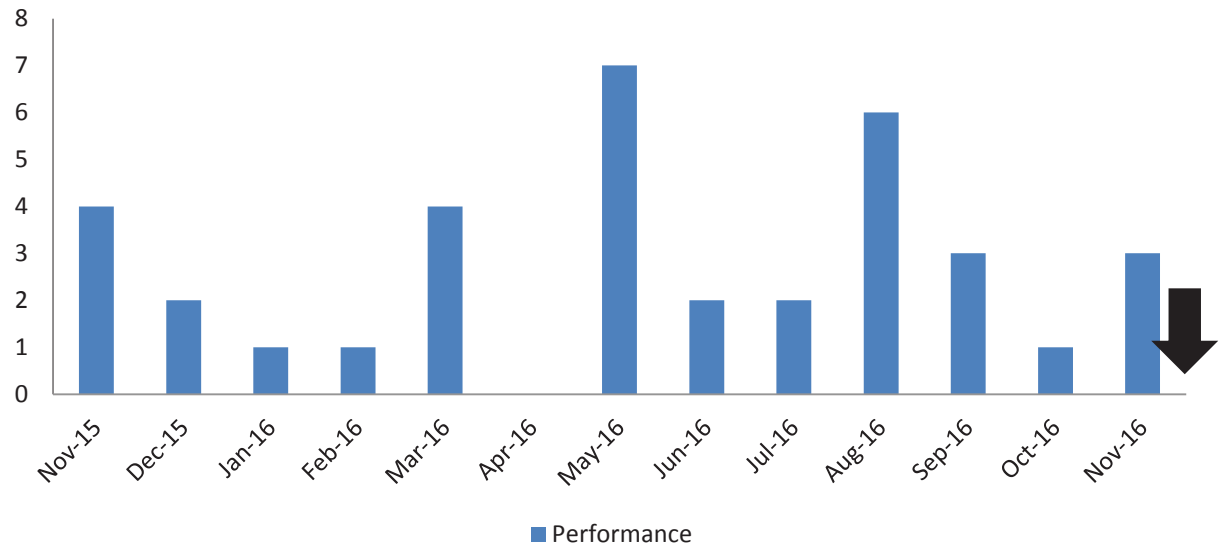
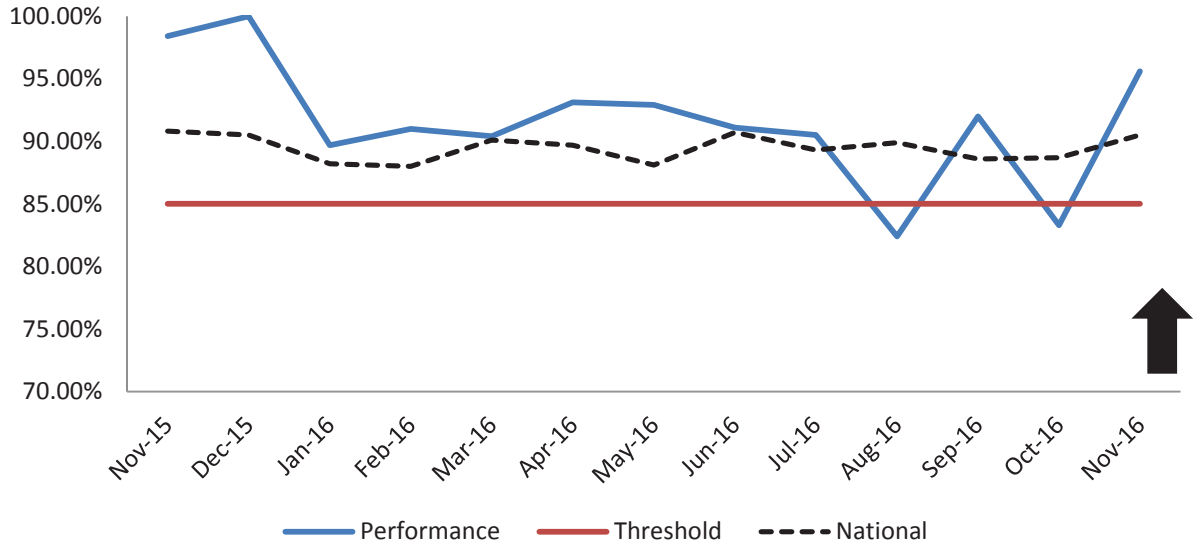


Chart 31 - 62 Day by Tumour Site

Tumour Site	Q1	Q2	Oct-16	Nov-16
Breast	98.1%	100.0%	100.0%	100.0%
Colorectal	71.4%	64.6%	57.1%	100.0%
Gynaecology	86.2%	100.0%	100.0%	100.0%
Haematology	79.3%	84.2%	60.0%	100.0%
Head & Neck	64.9%	78.3%	66.7%	78.6%
Lung	84.9%	89.1%	85.2%	83.3%
Other	100%	100%		
Skin	89.0%	90.3%	95.8%	100.0%
Upper GI	58.5%	82.1%	86.1%	72.7%
Urology	85.0%	76.1%	96.7%	92.3%

Chart 32 - 62 Day Consultant Upgrade



RESPONSIVE

Chart 33 - Average Length of Stay

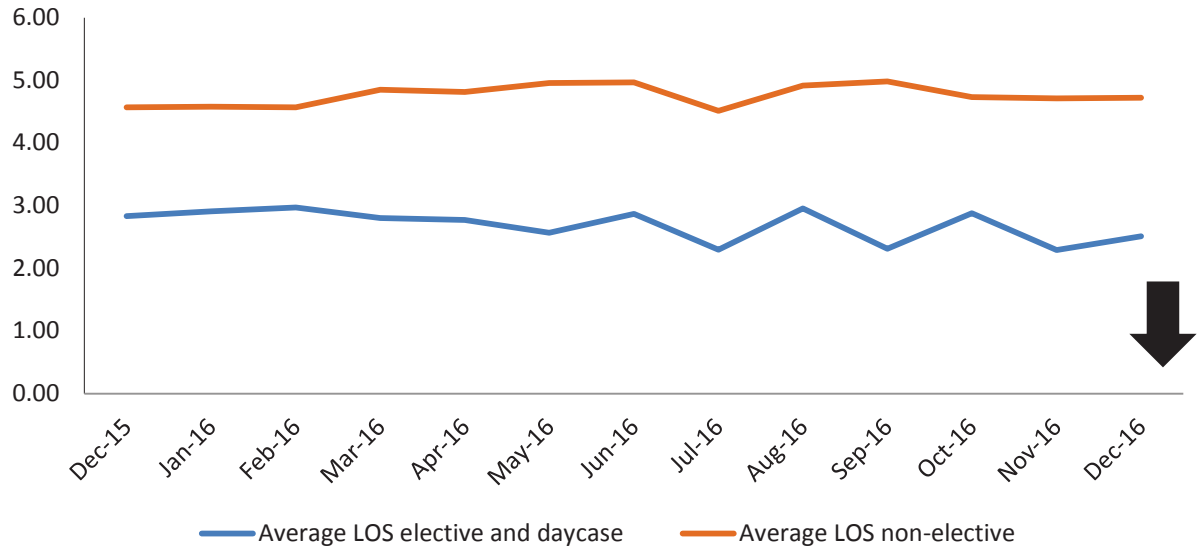


Chart 34 - Average Length of Stay VS expected, October 15 - September 16, Dr. Foster

	Spells	Inpatients	Day Cases	Expected LOS	LOS	Difference
Elective	58,209	10,026	48,183	3.3	2.6	-0.7
Emergency	53,717	53,717	0	4.8	4.9	0.1
Maternity/Birth	14,515	14,515	0	2.1	2.5	0.4
Transfer	187	187	0	10.3	34.6	24.2

Chart 35 - Friends & Family A&E Response Rate

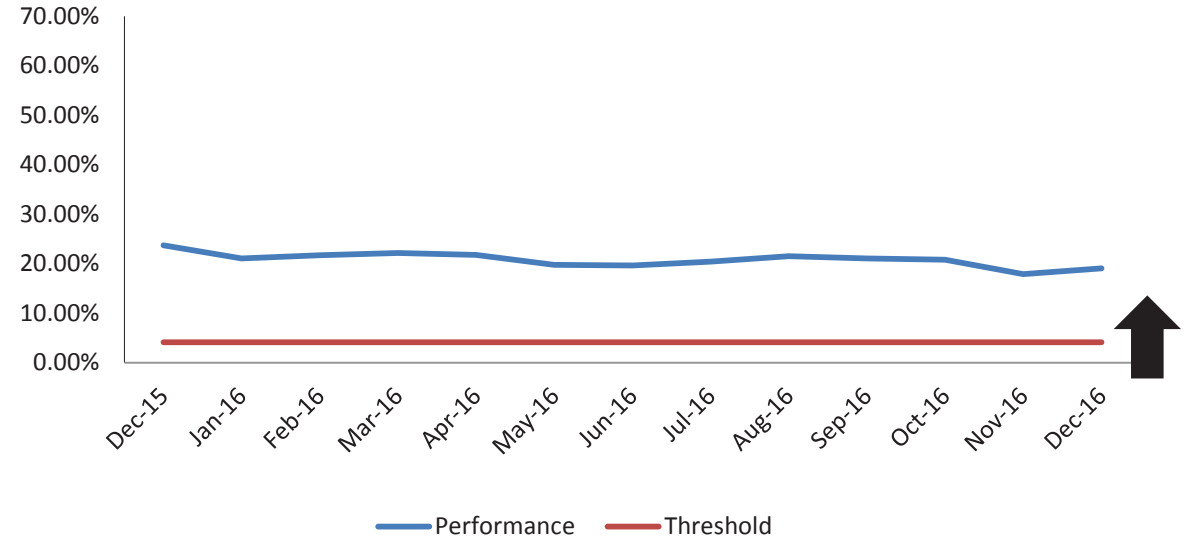


Chart 36 - Friends & Family Inpatient Response Rate

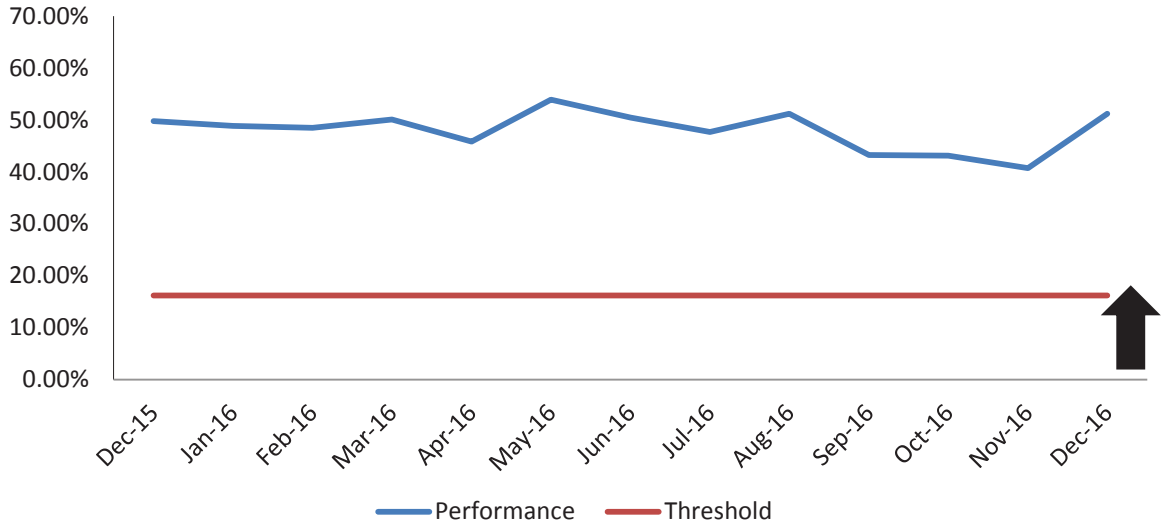


Chart 37 - Sickness

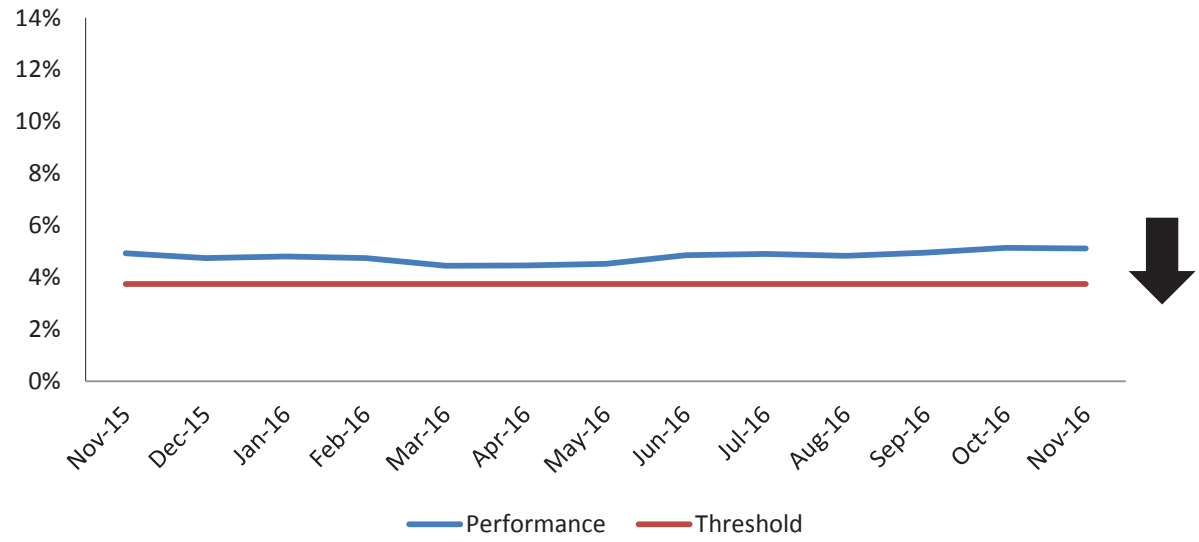


Chart 38 - Turnover Rate

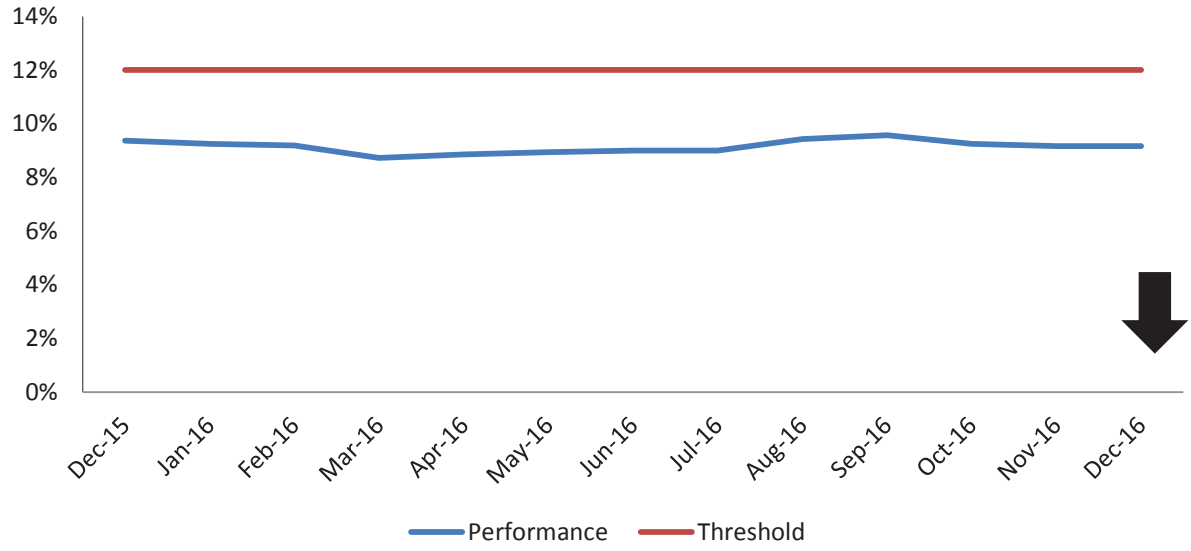


Chart 39 - Temporary costs and overtime as % total paybill

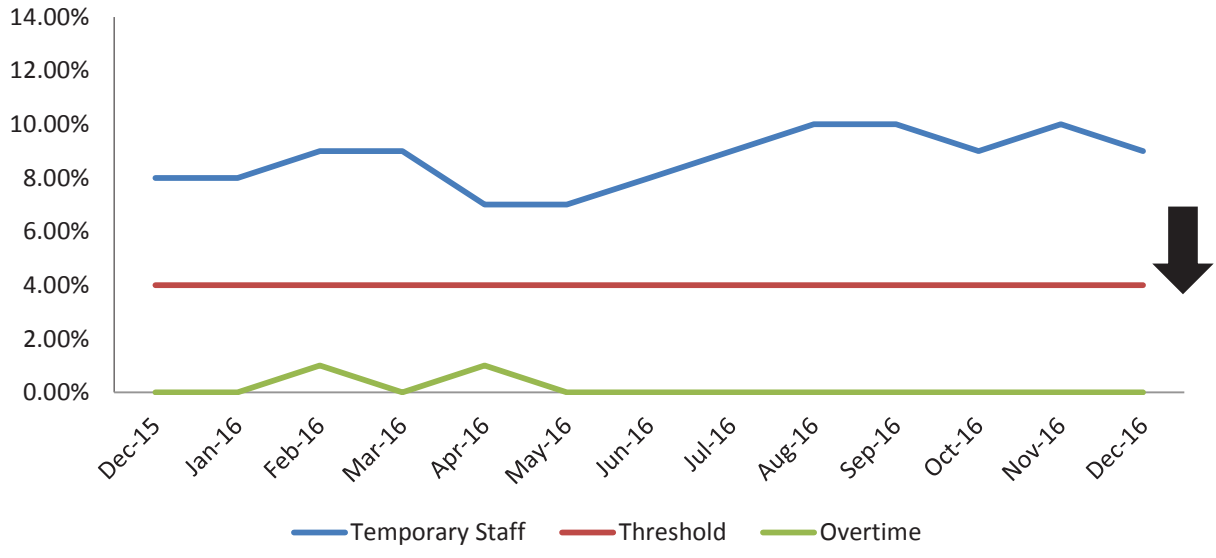


Chart 40 - Vacancy Rate

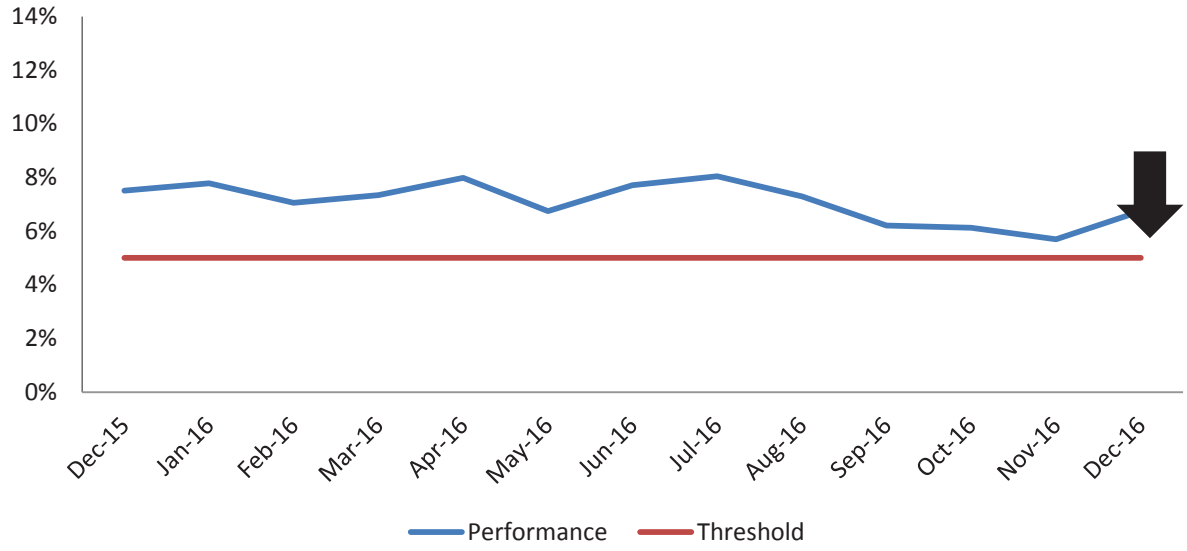


Chart 41 - Appraisals, Consultant & Other Medical

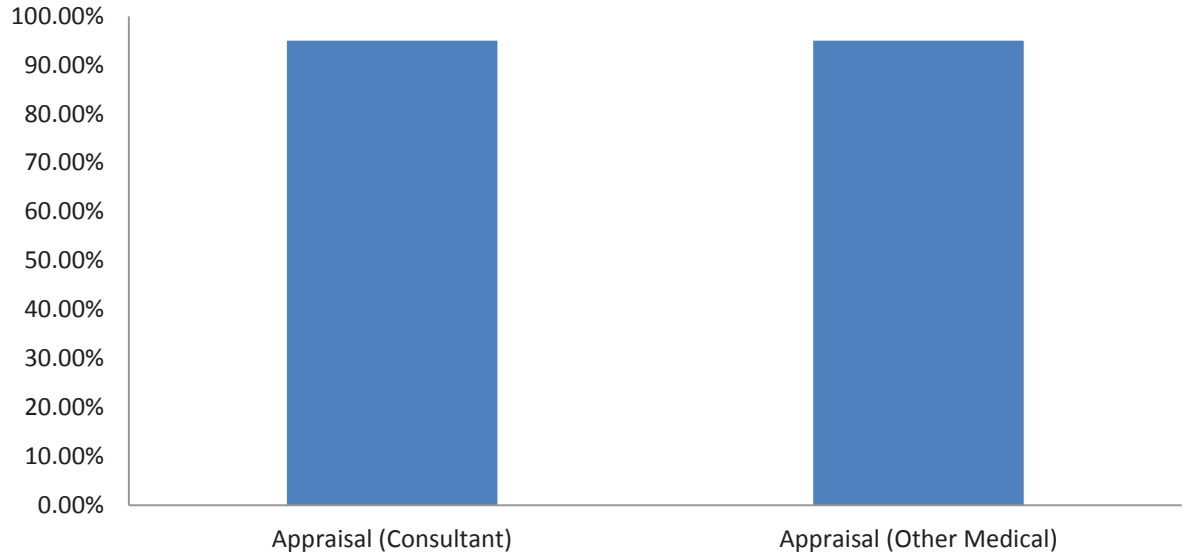


Chart 42 - Appraisals AFC

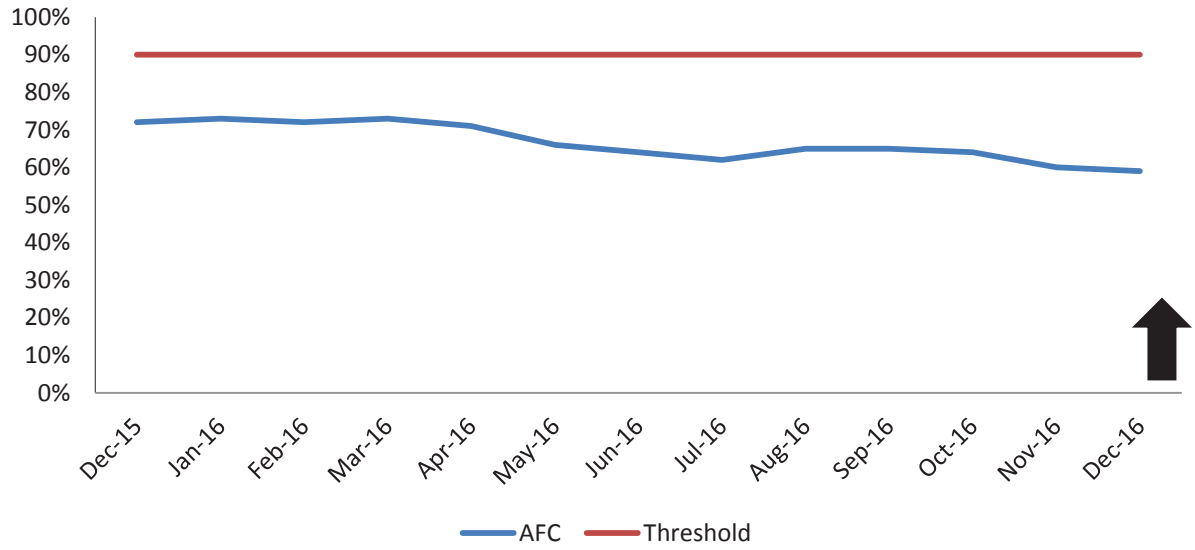


Chart 43 - Job Plans

	2015	2016 (YTD)
Trust Total	80%	62%
Integrated Care Group	66%	3%
Surgery	75%	90%
Family Care	100%	57%
Diagnostics & Clinical Support	84%	80%

Chart 44 - Information Governance Kit

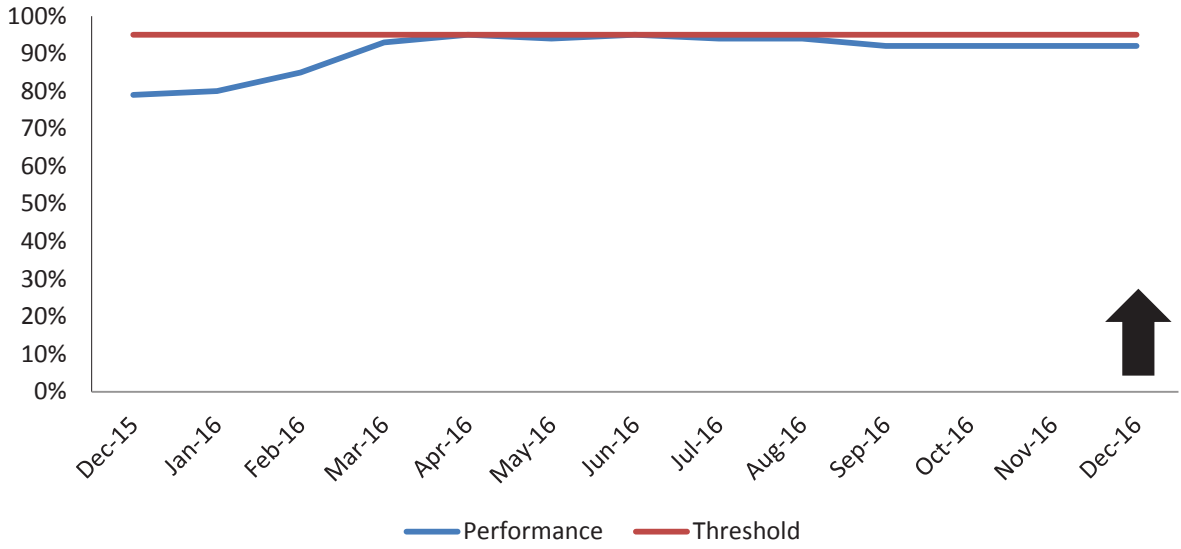


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Chart 45 - Core Skills Training % Compliance

Overall Trust Core Skills Training Compliance End of December 2016 Data includes all staff on ESR (with the exception of bank only staff, FY1 and FY2 doctors)											
	Basic Life Support	Conflict Resolution Training Level 1	Equality, Diversity and Human Rights	Fire Safety	Health, Safety and Welfare Level 1	Infection Prevention	Information Governance	Prevent Healthwrap	Safeguarding Adults	Safeguarding Children	Safer Handling Theory
Target	**80%**	**80%**	**80%**	**80%**	**80%**	**80%**	**95%**	**80%**	**80%**	**80%**	**80%**
Chief Executive	-	85	86	81	72	73	93	90	71	97	85
Diagnostics & Clinical Support	84	94	95	87	84	83	94	90	75	94	94
Estates & Facilities	-	96	94	90	91	91	98	85	90	95	95
Family Care	85	95	96	87	87	86	95	87	78	86	93
Finance & Informatics	-	98	99	94	93	93	94	97	88	98	97
Governance	-	100	100	96	94	94	98	98	94	100	98
HR & OD	83	93	95	87	84	84	98	90	82	93	91
Integrated Care Group	76	91	91	81	80	80	88	80	72	93	92
Research & Development	69	100	100	97	97	95	100	92	89	100	97
Surgical & Anaesthetics Services	73	90	92	82	81	80	91	77	73	92	90
Compliance as at 03 Jan 17	**79**	**93**	**93**	**85**	**84**	**83**	**92**	**84**	**76**	**93**	**93**
Compliance as at 05 Dec 16	**78**	**92**	**93**	**84**	**82**	**81**	**92**	**83**	**74**	**93**	**92**
Trend analysis	⬆	⬆	-	⬆	⬆	⬆	-	⬆	⬆	-	⬆
	1	1	0	1	2	2	0	1	2	0	1

Chart 46 - Finance and Use of Resources metrics

Area	Metric		Actual YTD Performance	Score	Forecast outturn Performance	Score
Financial sustainability	Capital service capacity		1.2	4	1.3	3
	Liquidity (days)		(7.1)	3	(13.6)	3
Financial efficiency	I&E margin		(0.7%)	3	(0.8%)	3
Financial control	Distance from financial plan		0.1%	1	0.0%	1
	Agency spend		43.2%	3	47.0%	3
Total				3		3

Metric	Definition	Weighting	Scoring 1	2	3	4 [1]
Capital service capacity	Degree to which the provider's generated income covers its financial obligations	20%	> 2.5x	1.75 - 2.5x	1.25 - 1.75x	< 1.25x
Liquidity (days)	Days of operating costs held in cash or cash-equivalent forms, including wholly committed lines of credit available for drawdown	20%	> 0	(7) - 0	(14) - (7)	< (14)
I&E margin	I&E surplus or deficit / total revenue	20%	> 1%	1% - 0%	0% - (1%)	<=(1%)
Distance from financial plan	Year-to-date actual I&E surplus / deficit in comparision to year-to-date plan I&E surplus / deficit	20%	>= 0%	(1%) - 0%	(2%) - (1%)	<=(2%)
Agency spend	Distance from provider's cap	20%	<= 0%	0% - 25%	25% - 50%	> 50%

Chart 47 - Break Even Duty

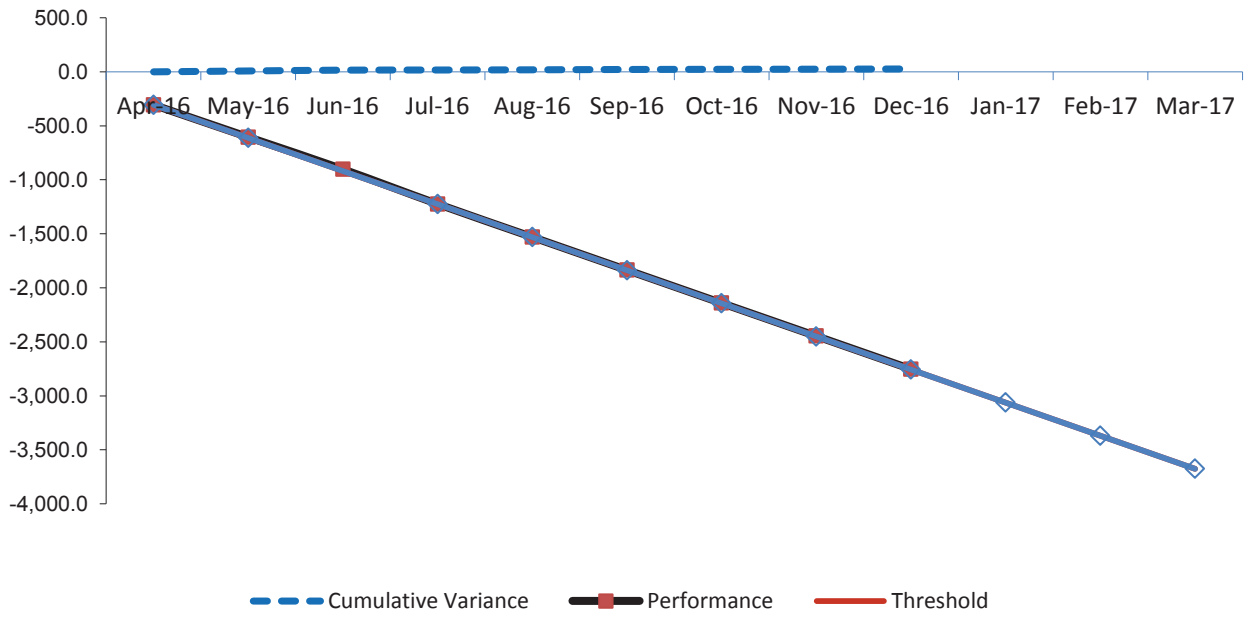


Chart 48 - Income and Expenditure variances

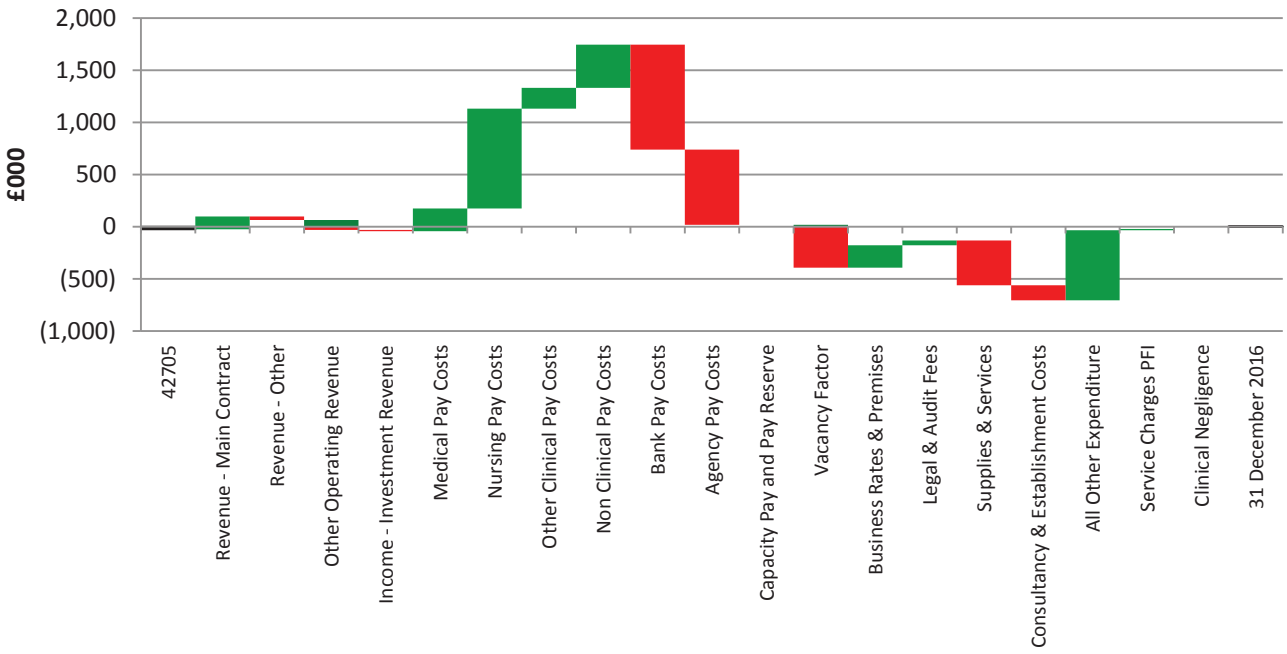


Chart 49 - Better Payment Practice Code (BPPC)

	Performance Target %	Actual in month	Actual YTD	Comments
Non NHS - No. of invoices	95.0%	98.3%	96.8%	Meeting target
Non NHS - Value of invoices	95.0%	98.7%	96.8%	Meeting target
NHS - No. of invoices	95.0%	91.9%	96.3%	Meeting target
NHS - Value of invoices	95.0%	96.7%	98.9%	Meeting target

Chart 50 - Total Trust Savings

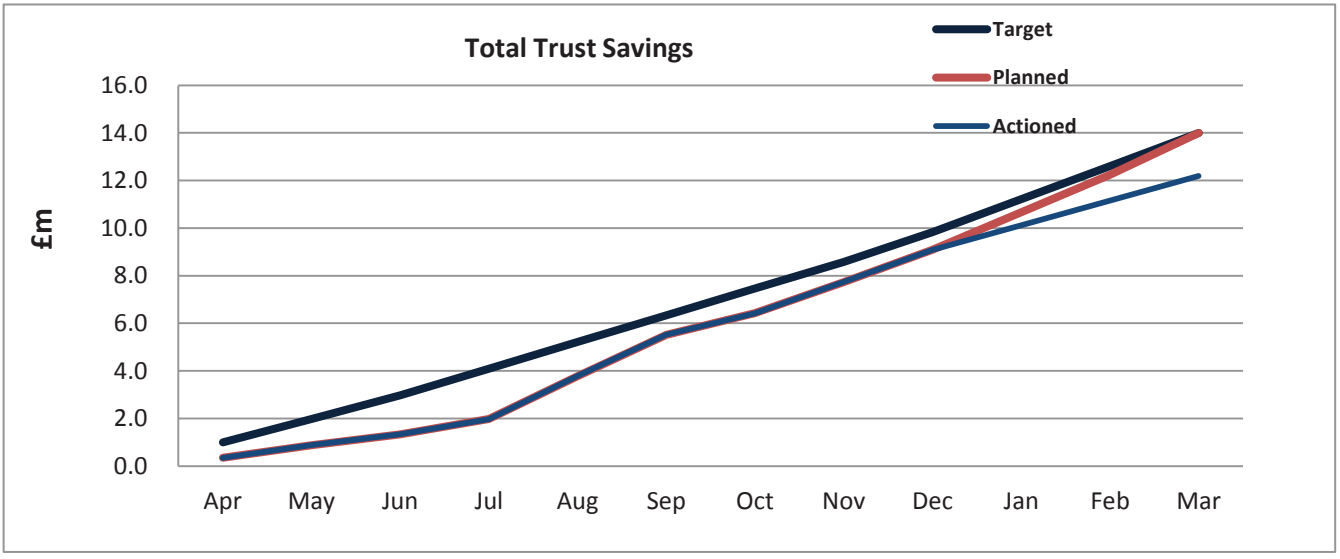


Chart 51 - Statement of Comprehensive Income by Division to 31st December 2016

Statement of Comprehensive Income by division to 31 December 2016

surplus/(deficit)

	In Month			Annual	In Month			Cumulative			Forecast Outturn		
	Est Funded	Wte Worked	Wte Contracted	Budget £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	Planned £000	Likely £000	Worst £000
Income													
Revenue from Patient Care Activities - Main Contract				438,711	36,518	36,641	123	330,370	330,425	55	438,711	439,020	439,020
Revenue from Patient Care Activities - Other				8,881	493	461	(33)	6,987	6,754	(233)	8,881	7,971	7,971
Other Operating Revenue				24,561	2,054	1,957	(97)	18,722	19,010	288	24,561	25,166	25,166
Total Income				**472,153**	**39,065**	**39,058**	**(7)**	**356,079**	**356,189**	**110**	**472,153**	**472,157**	**472,157**
Expenditure													
Clinical Divisions													
Integrated Care Group	2,317.1	2,358.8	2,041.5	(114,630)	(10,120)	(9,910)	210	(86,429)	(86,900)	(471)	(116,713)	(116,713)	(116,713)
Surgery and Anaesthetic Services	1,593.1	1,608.7	1,439.5	(91,462)	(7,788)	(8,232)	(444)	(68,744)	(72,324)	(3,580)	(95,462)	(95,462)	(95,462)
Diagnostic and Clinical Support	1,575.3	1,512.3	1,520.1	(99,145)	(8,873)	(8,629)	244	(73,462)	(72,858)	604	(98,013)	(98,502)	(98,502)
Family Care Division	1,002.9	977.0	891.3	(57,972)	(4,840)	(5,218)	(378)	(43,389)	(44,955)	(1,566)	(60,353)	(60,353)	(60,353)
Sub Total	**6,488.4**	**6,456.8**	**5,892.3**	(363,209)	(31,621)	(31,989)	(368)	(272,023)	(277,037)	(5,013)	**(370,541)**	**(371,030)**	**(371,030)**
Non-Clinical Divisions													
Estates and Facilities	720.6	694.0	643.9	(38,283)	(3,400)	(3,176)	225	(28,284)	(28,100)	185	(37,505)	(37,505)	(37,505)
Corporate Services	497.1	471.7	467.1	(37,097)	(3,307)	(3,148)	159	(27,594)	(26,875)	720	(36,135)	(36,135)	(36,135)
Research and Development	0.0	42.3	33.5	(1,524)	(145)	(145)	(0)	(1,143)	(1,143)	0	(1,524)	(1,524)	(1,524)
Reserves	0.0	0.0	0.0	(10,170)	1,236	1,252	16	(10,647)	(6,554)	4,093	(3,911)	(4,055)	(5,292)
Total Expenditure	**7,706.1**	**7,664.7**	**7,036.8**	**(450,283)**	**(37,237)**	**(37,205)**	**32**	**(339,691.22)**	**(339,708)**	**(16)**	**(449,616)**	**(450,249)**	**(451,486)**
EBITDA : Earnings before interest, taxation, depreciation and amortisation				**21,871**	**1,827**	**1,853**	**25**	**16,388**	**16,481**	**94**	**22,537**	**21,908**	**20,671**
Depreciation				(10,437)	(886)	(886)	0	(7,865)	(7,865)	0	(10,437)	(10,437)	(10,437)
Amortisation				(1,439)	(125)	(125)	(0)	(1,078)	(1,078)	0	(1,439)	(1,439)	(1,439)
Impairments				(7,471)	230	230	(0)	230	230	(0)	(7,471)	(7,471)	(7,471)
Investment Revenue				256	21	10	(11)	192	136	(56)	256	256	256
Other Gains and (Losses)				5	0	0	0	5	6	0	5	6	5
Finance Costs				(9,058)	(703)	(758)	(55)	(6,768)	(6,823)	(55)	(9,058)	(9,096)	(9,058)
Dividends payable on Public Dividend Capital (PDC)				(5,025)	(462)	(419)	43	(3,812)	(3,769)	43	(5,025)	(5,025)	(5,025)
Retained (deficit) for the year				**(11,297)**	**(96)**	**(94)**	**2**	**(2,708)**	**(2,682)**	**26**	**(10,631)**	**(11,297)**	**(12,497)**
Other Adjustments for break-even duty													
Donated asset reserve elimination				150	20	20	(0)	184	184	0	150	150	150
Non IFRIC12 (Impairments)/ Impairment reversals				7,471	(230)	(230)	0	(230)	(230)	0	7,471	7,471	7,471
IFRIC12 (Impairments)/ Impairment reversals				0	0	0	0	0	0	0	0	0	0
Retained (deficit) for Break-even duty				**(3,676)**	**(306)**	**(304)**	**2**	**(2,753)**	**(2,727)**	**26**	**(3,010)**	**(3,676)**	**(4,876)**

Chart 52 - Financial Position by Divisional Variances to 31st December 2016

Division / Directorate	Cumulative Variance						
	WTE Variance	Income	Pay	Non-Pay	SRCP	Expenditure	Total
		£000	£000	£000	£000	£000	£000
Integrated Care Group	(42)	(194)	(2,909)	2,491	(53)	(471)	**(665)**
Surgery and Anaesthetic Services	(16)	20	(1,792)	(974)	(814)	(3,580)	**(3,560)**
Diagnostic and Clinical Support	63	344	(195)	852	(53)	604	**947**
Family Care Division	26	(27)	(734)	(559)	(273)	(1,566)	**(1,593)**
Sub-total Clinical Divisions	**32**	**143**	**(5,630)**	**1,810**	**(1,194)**	**(5,013)**	**(4,870)**
Estates and Facilities	27	(298)	148	109	(73)	185	**(114)**
Chief Executive	(11)	4	13	(55)	29	(13)	**(9)**
Finance, Informatics and Procurement	18	42	643	(198)	(90)	355	**396**
HR and OD	11	146	294	(0)	(84)	209	**355**
Clinical Care & Governance	7	0	155	13	0	169	**169**
Reserves	0	74	0	3,908	0	3,908	**3,983**
Research and Development	0	(0)	0	(0)	0	0	**0**
Sub-total Non-Clinical Divisions	**52**	**(33)**	**1,253**	**3,778**	**(218)**	**0**	**0**
Subtotal	**84**	**110**	**(4,377)**	**5,588**	**(1,412)**	**(201)**	**(91)**
Depreciation	0	0	0	0	0	0	**0**
Amortisation	0	0	0	0	0	0	**0**
(Impairments)/Reversal of Impairments	0	0	0	(0)	0	(0)	**(0)**
Investment Revenue	0	(56)	0	0	0	0	**(56)**
Other Gains and (Losses)	0	0	0	0	0	0	**0**
Finance Costs	0	0	0	(55)	0	(55)	**(55)**
Dividends payable on Public Dividend Capital (	0	0	0	43	0	(55)	**(55)**
Sub-total before Impairments	**84**	**54**	**(4,377)**	**5,576**	**(1,412)**	**(212)**	**(158)**
Other Adjustments for break-even duty						0	**0**
Donated asset reserve elimination	0	0	0	0	0	0	**0**
Non IFRIC12 (Impairments)/ Impairment revers	0	0	0	0	0	0	**0**
IFRIC12 (Impairments)/ Impairment reversals	0	0	0	0	0	0	**0**
Retained Surplus / (Deficit) for Break-even	**84**	**54**	**(4,377)**	**5,577**	**(1,412)**	**(212)**	**(158)**
Planned Deficit	0	0	0	184	0	(212)	**(158)**
Total including planned deficit	**84**	**54**	**(4,377)**	**5,761**	**(1,412)**	**(28)**	**26**

Chart 53 - Expenditure Analysis to 31st december 2016

under / (over) spent

	In Month			Annual	In Month			Year to date		
	Est Funded	Wte Worked	Wte Contracted	Budget £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Pay Expenditure										
Registered Nursing, Midwifery & HV	2,499.0	2,211.2	2,279.2	102,993	8,587	7,629	958	76,900	68,725	8,175
Scientific, Therapeutic & Technical	871.3	827.8	848.2	36,597	3,071	2,951	120	27,407	25,792	1,615
Support to clinical staff - AHP	1,006.0	941.8	977.6	24,398	2,038	1,985	53	18,216	18,020	196
Support to clinical staff - Nursing	303.9	287.3	295.6	7,244	613	590	23	5,444	5,223	221
NHS Infrastructure Support staff	2,232.2	2,070.5	2,103.5	61,916	5,247	4,833	414	46,085	42,535	3,550
Consultants	288.7	271.2	264.5	41,009.7	3,458.6	3,330.9	128	30,695	29,562	1,133
Career and Staff Grades	165.3	132.2	131.2	12,114.3	1,026.4	937.1	89	9,023	8,346	676
Trainee Grades	329.1	322.4	137.0	18,560.1	1,555.9	1,555.8	0	13,922	13,396	526
Bank - Nursing	0.0	87.9	0.0	339.1	45	361	(315)	260	2,790	(2,530)
Bank - Support to Clinical Staff	0.0	253.1	0.0	444.3	84	566	(482)	394	3,956	(3,562)
Bank - NHS Infrastructure Support staff	0.0	99.7	0.0	129.9	14	209	(195)	101	1,915	(1,814)
Bank - Scientific, Therapeutic & Technical	0.0	3.5	0.0	(0.1)	0	12	(12)	(0)	78	(78)
Agency - Nursing Qualified	0.0	80.2	0.0	449	65	610	(545)	402	3,631	(3,229)
Agency - Other Clinical	0.0	19.1	0.0	380	66	12	54	227	1,979	(1,752)
Agency - Non Clinical	0.0	5.1	0.0	309	21	(159)	179	244	323	(79)
Agency - Medical and Dental	10.6	52.8	0.0	2,577	241	651	(410)	1,931	5,665	(3,734)
Capacity Pay and Pay Reserve	0.0	0.0	0.0	0	0	0	0	0	0	0
Vacancy Factor	0.0	0.0	0.0	(4,917)	(409)	0	(409)	(3,689)	0	(3,689)
Total Pay Expenditure	**7,706.1**	**7,665.7**	**7,036.8**	**304,542.1**	**25,724.1**	**26,074.0**	**(350.0)**	**227,559.9**	**231,936.6**	**(4,376.6)**
Non-Pay Expenditure										
Purchase of Healthcare Non-NHS				674	56	43	0	506	608	0
Supplies & Services Clinical				67,826	6,269	6,677	(407)	49,995	52,230	(2,235)
Supplies & Services General				5,714	580	601	(21)	4,239	4,561	(321)
Consultancy Services				262	22	163	(21)	197	333	(321)
Establishment				5,684	487	490	(3)	4,273	4,163	110
Transport				2,062	191	199	(8)	1,587	1,667	(80)
Service Charges PFI				6,392	565	554	(8)	4,827	4,815	(80)
Business Rates				2,658	172	153	12	2,141	2,090	12
Premises				18,083	1,600	1,405	195	13,197	13,006	191
Hospitality				(8)	(1)	(1)	195	(3)	5	191
Legal Fees				598	55	41	0	419	437	(8)
Audit Fees				78	18	(14)	15	164	130	(18)
Clinical Negligence				18,159	1,513	1,513	(0)	13,619	13,619	0
Education and Training				949	122	107	(0)	725	613	0
All Other Expenditure				8,224	1,073	447	626	6,972	2,899	4,073
Research & Development				53	5	5	(0)	40	40	(0)
Total Non-Pay Expenditure				**137,409**	**12,729**	**12,383**	**573**	**102,897**	**101,217**	**1,513**
Reserves & Safely Releasing Cost Programme				4,506	(1,216)	(1,252)	36	9,235	6,554	2,681
Total Expenditure including Reserves & Red Rated saving scheme's				**446,456**	**37,237**	**37,205**	**32**	**339,691**	**339,708**	**(16)**
Operating Expenses - Technical				25,405	1,945	1,957	(12)	19,287	19,299	(12)
Total Expenditure				**471,861**	**39,183**	**39,163**	**20**	**358,978**	**359,006**	**(28)**

Chart 54 - Agency Staffing Costs

2016-17 Agency Staffing Costs

	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Agency 1617 outturn
										£000
Medical staff										
Consultants	200	211	238	220	323	288	229	270	228	2,207
Career and staff grades	78	99	308	263	331	258	320	357	289	2,303
Trainee Grades	311	185	18	94	43	116	86	168	133	1,154
Total Medical	**589**	**495**	**564**	**577**	**697**	**662**	**635**	**795**	**650**	**5,664**
Nursing staff										0
Qualified	248	236	246	282	443	560	511	495	610	3,631
Unqualified	74	87	134	186	231	177	150	40	36	1,115
Total Nursing	**322**	**323**	**380**	**468**	**674**	**737**	**661**	**535**	**646**	**4,746**
Other Clinical/Scientific										0
AHP	132	119	109	80	-22	85	64.5	112	-44	635
Scientific	13	22	27	36	34	18	42	20	19	230
Unqualified clinical / scientific	0	0	0	0	0	0	0	0	0	0
Total Other Clinical	**145**	**141**	**136**	**116**	**12**	**103**	**107**	**132**	**-25**	**866**
Total Clinical	**1056**	**959**	**1080**	**1161**	**1383**	**1502**	**1402**	**1461**	**1271**	**11,274**
Non Clinical										0
Administrative and clerical	39	12	29	6	-5	-8	-3	12	-4	78
Estates	0	0	0	0	0	1	5	3	0	9
Managerial	23	25	21	42	33	17	21	19	1	202
Other	11	4	10	12	-4	0	-6	0	1	27
Total Non clinical	**73**	**41**	**60**	**60**	**24**	**10**	**17**	**34**	**-2**	**316**
Grand Total	**1129**	**1000**	**1139**	**1221**	**1407**	**1512**	**1419**	**1503**	**1269**	**11,598**

Chart 55 - Statement of Financial Position as at December 2016

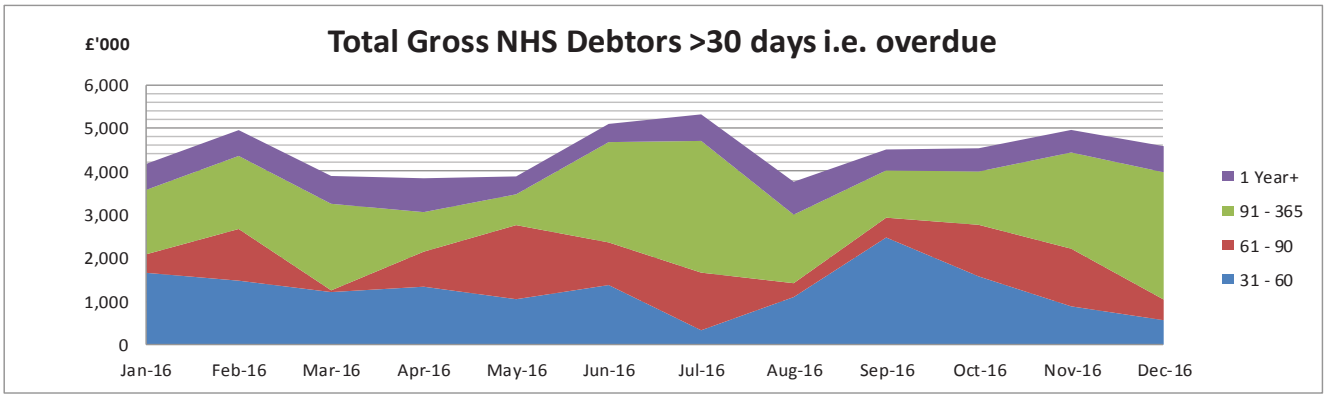
	Year to date movement			In Month		Year end
	Closing 31st March 2016	As at 31 December 2016	Year to date Movement	Prior Month	In-month Movement	Forecast
	£000	£000	£000	£000	£000	£000
Non-Current Assets:						
Property, Plant And Equipment	282,650	281,123	(1,527)	280,833	290	294,690
Intangible Assets	4,605	3,745	(860)	3,870	(125)	4,605
Trade And Other Receivables	1,172	1,299	127	1,297	2	1,172
Total Non-Current Assets	**288,427**	**286,167**	**(2,260)**	**286,000**	**167**	**300,467**
Current Assets:						
Inventories	2,450	2,210	(240)	1,997	213	2,450
Trade And Other Receivables	21,021	29,266	8,245	26,929	2,337	21,021
Cash And Cash Equivalents	32,165	16,116	(16,049)	20,135	(4,019)	21,755
Total Current Assets	**55,636**	**47,592**	**(8,044)**	**49,061**	**(1,469)**	**45,226**
Total Assets	**344,063**	**333,759**	**(10,304)**	**335,061**	**(1,302)**	**345,693**
Current Liabilities:						
NHS Trade Payables	(3,042)	(6,272)	(3,230)	(6,278)	6	(3,042)
Non-NHS Revenue Payables	(45,071)	(41,042)	4,029	(42,420)	1,378	(45,071)
Non-NHS Capital Payables	(4,963)	(788)	4,175	(714)	(74)	(4,963)
Borrowings / DH Loan	(200)	(200)	0	(200)	0	(200)
Other Financial Liabilities - PFI	(3,347)	(3,251)	96	(3,268)	17	(3,202)
Provisions For Liabilities And Charges	(229)	(1,033)	(804)	(1,083)	50	(1,755)
Total Current Liabilities	**(56,852)**	**(52,586)**	**4,266**	**(53,963)**	**1,377**	**(58,233)**
Net Current Assets/(Liabilities)	**(1,216)**	**(4,994)**	**(3,778)**	**(4,902)**	**(92)**	**(13,007)**
Total Assets Less Current Liabilities	**287,211**	**281,173**	**(6,038)**	**281,098**	**75**	**287,460**
Non-Current Liabilities						
Borrowings / DH Loan	(1,600)	(1,500)	100	(1,500)	0	(1,400)
Other Financial Liabilities - PFI	(111,867)	(109,282)	2,585	(109,563)	281	(108,437)
Provisions For Liabilities And Charges	(4,575)	(3,904)	671	(3,453)	(451)	(2,643)
Total Non-Current Liabilities	**(118,042)**	**(114,686)**	**3,356**	**(114,516)**	**(170)**	**(112,480)**
Total Assets Employed	**169,169**	**166,487**	**(2,682)**	**166,582**	**(95)**	**174,980**
Financed By Taxpayers Equity						
Public Dividend Capital	174,173	174,173	0	174,173	0	191,273
Retained Earnings	(44,932)	(47,615)	(2,683)	(47,520)	(95)	(56,221)
Revaluation Reserve	39,928	39,929	1	39,929	0	39,928
Total Taxpayers Equity	**169,169**	**166,487**	**(2,682)**	**166,582**	**(95)**	**174,980**

Chart 56 - Statement of Cash Flows as at 31st December 2016

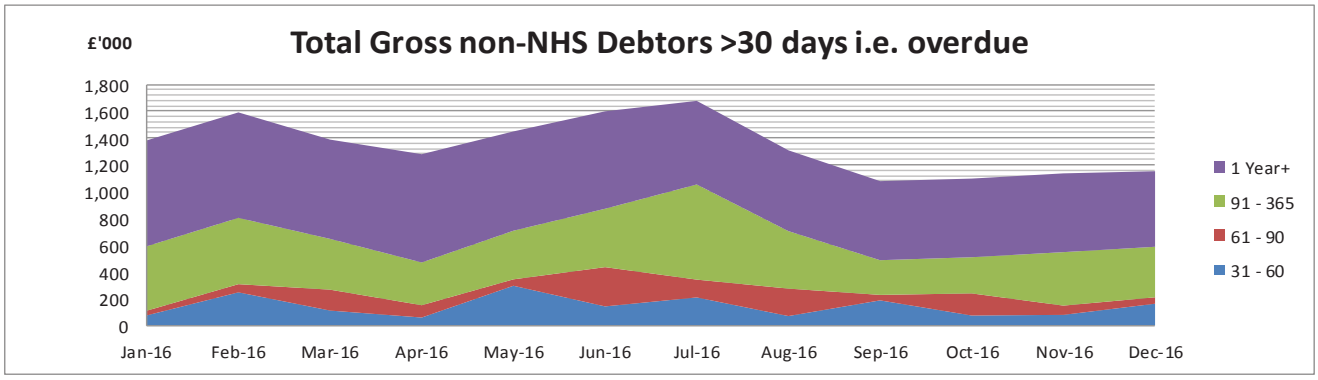
Cash Flow Statement	As at 31st March 2016 £000	Previous month £000	As at 31 December 2016 £000	Forecast £000
Operating Activities				
Operating Surplus/(Deficit)	18,011	6,132	7,768	2,572
Depreciation and amortisation	9,878	6,988	8,943	12,197
Impairments and reversals	3,096	0	(230)	7,471
Donated assets received credited to revenue but non cash	(192)	0	0	(100)
Interest paid	(8,611)	(5,612)	(6,859)	(9,081)
Dividend paid	(5,682)	(1,702)	(1,702)	(5,025)
(Increase) in inventories	(202)	454	240	0
Decrease/(Increase) in trade and other receivables	(6,573)	(7,399)	(10,820)	(3,264)
(Decrease)/Increase in trade and other payables	3,752	5,151	(2,865)	0
(Decrease)/Increase in provisions	1,311	(235)	169	(421)
Net cash inflow from Operating Activities	**14,788**	**3,777**	**(5,356)**	**4,349**
Cash Flows from Investing Activities				
Interest received	178	115	136	256
(Payments) for property, plant and equipment	(7,447)	(7,396)	(8,173)	(26,929)
Proceeds from disposal of property, plant and equipment	137	125	125	0
(Payments) for intangible assets	(129)	0	0	(1,411)
Proceeds from disposal of intangible assets	0	0	0	0
(Payments) for investment with DH	0	0	0	0
(Payments) for other financial assets	0	0	0	0
Proceeds from disposal investment with DH	0	0	0	0
Proceeds from disposal of other financial assets	0	0	0	0
Net cash outflow from Investing Activities	**(7,261)**	**(7,156)**	**(7,912)**	**(28,084)**
Net cash inflow before Financing	**7,527**	**(3,379)**	**(13,268)**	**(23,735)**
Cash Flows from Financing Activities				
Public dividend capital received	30	0	0	17,100
Public dividend capital repaid	(3,700)	0	0	0
New capital investment loans	0	0	0	0
Other capital receipts	0	0	0	0
Capital investment loans repayment of principal	(850)	(100)	(100)	(200)
Capital element of finance lease and PFI	(1,826)	(1,995)	(2,681)	(3,575)
Net cash outflow from Financing Activites	**(6,346)**	**(2,095)**	**(2,781)**	**13,325**
Decrease in cash	**1,181**	**(5,474)**	**(16,049)**	**(10,410)**
Cash at the beginning of the year	**30,984**	**32,165**	**32,165**	**32,165**
Cash at the end of the financial period	**32,165**	**26,691**	**16,116**	**21,755**

Chart 57 - Debtors Report as at 31st December 2016

Gross debtors	Not Due 0 - 30 £'000		No. of days overdue 31 - 60 £000	61 - 90 £000	91 - 365 £000	1 Year+ £000	Total overdue debt M9 £000	M8 £000
NHS	5,876		566	476	2,937	602	4,581	4,955
% of total debt	56.2%		5.4%	4.6%	28.1%	5.8%		
Non-NHS	474		163	48	377	564	1,152	1,136
% of total debt	29.2%		10.0%	3.0%	23.2%	34.7%		
Total gross debtors	**6,350**		**729**	**524**	**3,314**	**1,166**	**5,733**	**6,091**



Top five NHS Gross Debtors by value	No of		No. of days overdue 31 - 60 £'000	61 - 90 £'000	91 - 365 £'000	1 Year+ £'000	Total overdue debt M9 £'000	M8 £'000
Blackburn with Darwen CCG	32		56	49	997	0	**1,102**	1,079
East Lancashire CCG	17		125	131	579	5	**840**	969
Nhs England - 13X - Nth East Comm hub	3		227	147	354	0	**728**	655
Nhs England - Y54 - Cheshire & Mersey - Q75	19		0	0	347	195	**542**	542
Lancashire Teaching Nhs FT	59		48	45	171	60	**324**	340
Balance	224		110	104	489	342	**1,045**	1,370
Total Gross Debtors	**354**		**566**	**476**	**2,937**	**602**	**4,581**	**4,955**



Top five non-NHS Gross Debtors by value	No of		No. of days overdue 31 - 60 £'000	61 - 90 £'000	91 - 365 £'000	1 Year+ £'000	Total overdue debt M9 £'000	M8 £'000
Blackburn With Darwen Borough Council	31		1	0	36	247	**284**	365
Lancashire County Council	7		19	8	55	(10)	**72**	53
Dansac Ltd	2		52	0	0	0	**52**	52
Graham Curran	1		0	0	0	40	**40**	40
Burnley College	2		0	0	34	3	**37**	38
Balance	1,153		91	40	252	284	**667**	588
Total Gross Debtors	**1,196**		**163**	**48**	**377**	**564**	**1,152**	**1,136**

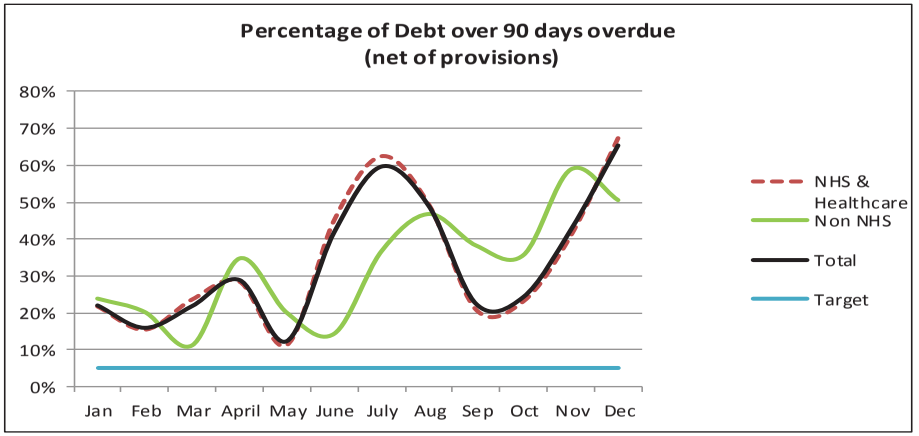
Chart 58 - Debtors Report as at 31st December 2016

Debtors analysis - over 90 days as at 31 December 2016

NHS	M9 2016-17 £	M8 2016-17 £
NHS debtors overdue	4,580,072	4,955,250
Over 90 days	3,538,597	2,739,967
% debt over 90 days	77.26%	55.29%
Total provision *	(1,391,698)	(1,207,393)
Total NHS debt after provision	3,188,374	3,747,857
Net debt over 90 days	**2,146,899**	**1,532,574**
Net % NHS debt over 90 days	**67.34%**	**40.89%**
NHS memorandum items		
Credit notes >90 days	11	72

Non NHS	M9 2016-17 £	M8 2016-17 £
Non NHS debt overdue	1,151,807	1,135,903
Over 90 days	941,486	986,872
% debt over 90 days	81.74%	86.88%
Total provision *	(726,418)	(773,724)
Total Non NHS debt after provision	425,389	362,179
Net debt over 90 days	**215,068**	**213,148**
Net % Non NHS debt over 90 days	**50.56%**	**58.85%**
Non NHS memorandum items		
Awaiting write off	(36,706)	(36,706)
Paying installments	(119,628)	(115,258)

Total		
Total debt after provisions	3,613,763	4,110,036
Total debt overdue by 90 days after provisions	2,361,967	1,745,722
% Net debt over 90 days	**65.36%**	**42.47%**



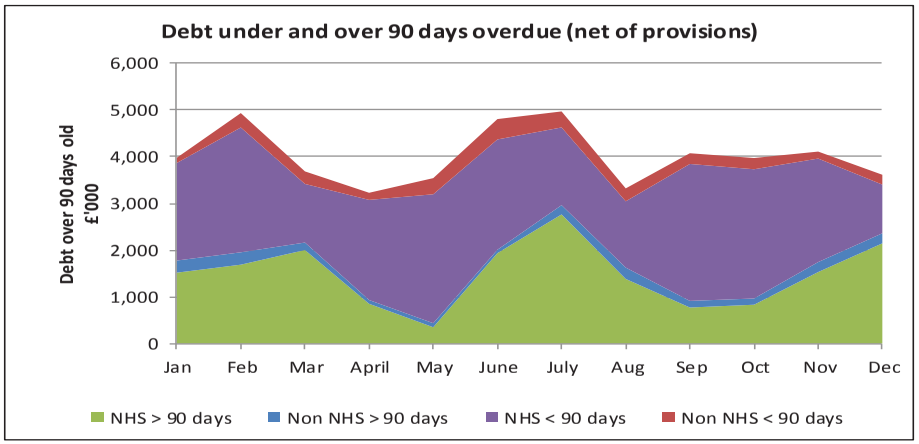


Chart 59 - Capital Spend

East Lancashire Hospitals NHS Trust
Review of 2016/17 Capital Spend to Date as at 31st December (M9)

Scheme	Annual Plan Revised Plan £'000	Actual/Forecast Actual spend to date £'000	Actual/Forecast Forecast Outturn £'000	Under/ (Over) Spend £'000
Total Building Infrastructure Schemes	22,808	1,927	22,851	(42)
Other Schemes	200	(16)	158	42
Total Maintenance and Statutory Compliance	250	135	250	0
Total Equipment	1,755	616	1,755	0
Total Information Technology	2,679	1,016	2,679	0
Total Fees	400	323	400	0
Donated Assets	100	0	100	0
Total Capital Expenditure (Non IFRIC 12)	**28,193**	**4,002**	**28,193**	**0**
Total PFI Life Cycle Costs	3,264	2,448	3,264	0
Charge against Capital Resource Limit including IFRS Impact	**31,457**	**6,450**	**31,457**	**0**

Capital Resource Limit (CRL)	
Capital Resource Limit (CRL)	
Allocation	10,993
PFI Allocation	3,264
Additional CRL required	17,100
Loan re IT	0
TOTAL	**31,357**
Capital Expenditure (Non IFRIC12)	28,193
Capital Expenditure (IFRIC12)	3,264
Less Donated Asset	(100)
Net Book Value of Asset disposals	(125)
TOTAL	**31,233**
(Over) / Under spend against Limit	**124**

Capital Expenditure Performance	**£'000**
Planned expenditure to 31st December 2016	8,709
Actual expenditure to 31st December 2016	6,450
% of plan achieved to date	**74%**

East Lancashire Hospitals NHS
NHS Trust

TRUST BOARD REPORT

Item 16

25 January 2017

Purpose Approval

Title	Standing Orders
Author	Mrs A Bosnjak-Szekeres, Associate Director of Corporate Governance/Company Secretary

Summary: The Company Secretary has undertaken the review of the standing orders, which included separating the Standing Orders and Standing Financial Instructions. It has been agreed at the Audit Committee that they are presented as separate documents going forward. Other changes included:

1. reviewing the composition of the Board,
2. review and consolidation of the section on motions,
3. review of the section on the Trust seal,
4. revising the appointment of Committees of the Board as it included operational committees that are not sub-committees of the Board,
5. review of the quorum requirements,
6. review and consolidation of the section in relation to the press and public.

The first draft of the revised Standing Orders was presented to the Finance and Performance Committee on the 12 September 2016 and subsequently to the Audit Committee on 7 December 2016.

The Audit Committee has revised the Standing Orders and agreed to recommend them to the Board for ratification.

Recommendation: The Board is asked to ratify the revised Standing Orders as per the recommendation of the Audit Committee.

Report linkages

Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do Invest in and develop our workforce Work with key stakeholders to develop effective partnerships Encourage innovation and pathway reform, and deliver best practice
Related to key risks identified on assurance framework	Transformation schemes fail to deliver the clinical strategy, benefits and improvements and the organisation's corporate objectives Recruitment and workforce planning fail to deliver the

Trust objectives

Collaborative working fails to support delivery of sustainable, safe and effective care through clinical pathways

Alignment of partnership organisations and collaborative strategies (Pennine Lancashire and Healthier Lancashire) are not sufficient to support the delivery of sustainable services by the Trust

The Trust fails to achieve a sustainable financial position and appropriate continuity of service risk rating.

The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

Impact

Legal	Yes	Financial	No
Equality	No	Confidentiality	No

Previously considered by: Finance and Performance Committee (12 September 2016) and Audit Committee (7 December 2016).

East Lancashire Hospitals NHS NHS Trust **TRUST WIDE DOCUMENT**	
DOCUMENT TITLE:	**STANDING ORDERS**
DOCUMENT NUMBER:	**ELHT/F15 Version 13**

DOCUMENT PURPOSE:	Identify the standing orders for the Trust.
TARGET AUDIENCE:	All Trust Personnel
DISTRIBUTION:	All Trust policy manuals and intranet
AUTHOR(S):	Associate Director of Corporate Governance/Company Secretary
EXECUTIVE DIRECTOR RESPONSIBLE:	Chief Executive

CONSULTATION VIA	Finance and Performance Committee and Audit Committee
DOCUMENT REPLACES	Version 12
POLICY COUNCIL:	N/A

AUTHORISED BY:	Trust Board
NEXT REVIEW DATE:	December 2017

STANDING ORDERS

1. INTRODUCTION

1.1 Statutory Framework

(1) The East Lancashire Hospitals NHS Trust (the Trust) is a statutory body which came into existence on 1st April 2003 under The East Lancashire Hospitals NHS Trust (Establishment) Order 2002 No. 2073 (the Establishment Order) as amended by the East Lancashire Hospitals National Health Service Trust (Establishment) and the Blackburn, Hyndburn and Ribble Valley Health Care National Health Service Trust and Burnley Health Care National Health Service Trust (Dissolution) Amendment Order 2011 No 2223.

(2) The principal place of business of the Trust is The Royal Blackburn Hospital, Haslingden Road, Blackburn.

(3) 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 and the Health Act 1999 and subsequent amendments.

(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.

(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) 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.

(2) The Code of Accountability requires that Boards, inter alia, 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 prescribe various requirements concerning possible conflicts of interest of Board members.

(3) The Code of Practice on Openness in the NHS and the provisions of the Freedom of Information Act 2000 set out the requirements for public access to information on the NHS.

1.3 Delegation of Powers

The Trust has powers to delegate and make arrangements for delegation. Standing Orders 4 and 5 set out the detail of these arrangements. Delegated powers are covered in the Schedule of Matters reserved for the Board and Scheme of Delegation.

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 National Health Service Trusts (Membership and Procedure) Regulations 1990 and the Trust's Establishment Order as amended by The East Lancashire Hospitals National Health Service Trust (Establishment) and the Blackburn, Hyndburn and Ribble Valley Health Care National Health Service Trust and Burnley Health Care National Health Service Trust (Dissolution) Amendment Order 2011 No 2223, the composition of the Board shall be:

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

(2) 7 Non-Executive Directors (appointed by the Trust NHS Improvement);

(3) 5 Executive Directors including:

- Chief Executive;
- Director of Finance;
- Medical Director
- Director of Nursing
- Director of Service Development

The Trust shall have no more than 13 and no 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).

(4) Other Executive Directors (e.g. Operations, Human Resources and Organisational Development, Sustainability, Communications and Engagement) will also form part of the Board membership but shall have no voting rights.

(5) NHS Improvement or the Trust Board can appoint Associate Members, who shall be Non-Executive Directors that will form part of the Board membership but shall have no voting rights.

2.2 Appointment of Chairman and Members of the Trust Board

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 National Health Service Trusts (Membership and Procedure) Regulations 1990 as amended

2.3 Terms of Office of the Chairman and Members

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 7 to 9 of the National Health Service Trusts (Membership and Procedure) Regulations 1990 as amended.

2.4 Appointment and Powers of the Deputy Chairman

(1) Subject to Standing Order 2.4 (2) below, the Chairman and members of the Trust Board may appoint one of their numbers, who is a Non-Executive member, to be a Deputy 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 Deputy Chairman by giving notice in writing to the Chairman. The Chairman and members may thereupon appoint another member as Deputy Chairman in accordance with the provisions of Standing Order 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 Deputy 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 Deputy Chairman.

2.5 Role of Board Members

The Board will function as a corporate decision-making body, Executive and Non-Executive Members will be full and equal members (provided they have full voting rights). Their role as members of the Trust Board will be to consider the key strategic issues facing the Trust in carrying out its statutory and other functions.

(1) **Executive Members**

Executive Members 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/she 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) **Director of Finance**

The Director of Finance 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/she 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 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 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 Standing Order No. 3.

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

2.8.1 Schedule of Matters reserved for the Board and Scheme of Delegation

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 for the Board' that forms part of the Standing Financial Instructions ' and shall have effect as if incorporated into the Standing Orders. Those powers which it has delegated to officers and other bodies are contained in the Scheme of Delegation.

2.7 Calling meetings

(1) Ordinary meetings of the Board shall be held at regular intervals at such times and places as the Board may determine. The Company Secretary to the Board will publish the dates, times and locations of the meeting of the Board in advance.

(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.

(4) In case of emergencies or the need to conduct urgent business, the Company Secretary shall give to all members as much notice as is considered reasonable by the Chairman or the Deputy Chairman of the Trust, of the date, time and place of the meeting by whatever means of communication is considered appropriate by the Chairman or the Deputy Chairman of the Trust.

(5) In the event of an emergency or the need to conduct urgent business the Chairman, Deputy Chairman or Company Secretary may, in calling the meeting, authorise the

meeting to be held in private as a Part 2 meeting of the Trust Board, if the nature of the business to be conducted is commercially sensitive or would otherwise not be in the public interest to disclose at that time. The fact that such a meeting has been held shall be reported to the next Board meeting.

2.8 Notice of Meetings and the Business to be transacted

(1) Save in the case of emergencies or the need to conduct urgent business, 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. 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 the Standing Orders

(4) A member desiring a matter to be included on an agenda shall make his/her request in writing to the Chairman at least 15 calendar 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 calendar days before a meeting may be included on the agenda at the discretion of the Chairman.

2.9 Agenda and Supporting Papers

The Agenda will be sent to members 7 days before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be dispatched no later than three clear days before the meeting, save in exceptional circumstances

2.10 Notices of Motion

A director desiring to move or amend a motion shall send a written notice thereof at least 10 clear days before the meeting to the Chairman and Secretary, who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations. This paragraph shall not prevent any motion being moved during the meeting, without notice on any business mentioned on

the agenda.

2.11 Withdrawal of Motions or Amendments

A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chairman.

2.12 Motion to Rescind a Resolution

Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding 6 calendar months shall bear the signature of the director who gives it and also the signature of 4 other directors. When any such motion has been disposed of by the Trust, it shall not be competent for any director other than the Chairman to propose a motion to the same effect within 6 months; however the Chairman may do so if he/she considers it appropriate.

2.13 Motions

The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

2.14 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 Deputy Chairman (if the Board has appointed one), if present, shall preside.

(2) If the Chairman and the Deputy Chairman are absent, such member (who is not also an Executive Member of the Trust) as the members present shall choose shall preside.

2.15 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, at the meeting, shall be final.

2.16 Quorum

(1) No business shall be transacted at a meeting unless at least one-third of the whole number (rounded up) of the Chairman and voting members (including at least one member who is also an Executive Member of the Trust and one member who is not) is present.

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

(3) 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.

2.17 Voting

(1) Save as provided in Standing Orders 2.18 - Suspension of Standing Orders and 2.19 - 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 (i.e. the Chairman of the meeting) shall have a second, and casting vote.

(2) 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.

(3) 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).

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

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

(6) A deputy 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.

(7) A deputy attending the Trust Board meeting to represent an Executive 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.

2.18 Suspension of Standing Orders

(1) 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 2.16), 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 voting 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. No formal business may be transacted while the Standing Orders are suspended.

2.19 Variation and amendment of Standing Orders

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

- upon a notice of motion under these Standing Orders
- no fewer than half of the Trust's total Non-Executive Directors in post vote in favour of the amendment; and
- at least two thirds of the voting Board members are present at the meeting where the variation or amendment is being discussed, and
- providing that any variation or amendment does not contravene a statutory provision or direction made by the Secretary of State.

2.20 Record of Attendance

The names of the Chairman and Directors/members present at the meeting shall be recorded.

2.21 Minutes

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

No discussion shall take place upon the minutes except upon their accuracy or where the Chairman considers discussion appropriate.

2.22 Admission of public and the press

(1) Meetings of the Board of Directors will be open to members of the public. At any meeting of the Board of Directors open to members of the public the Chairman may exclude any member of the public if they are interfering with or preventing the proper conduct of the meeting. Members of the public may be excluded from a meeting of the Board of Directors on the grounds that publicity of the matters being reviewed

would be prejudicial to public interest, by reason of the confidential nature of business.

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

3. APPOINTMENT OF COMMITTEES AND SUB-COMMITTEES

3.1 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; or together with one or more health organisations appoint joint committees.

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

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.

3.2 Applicability of Standing Orders to Committees

The Standing Orders of the Trust, as far as they are applicable, shall as appropriate apply to meetings and any committees established by the Trust. (There is no requirement to hold meetings of committees established by the Trust in public.)

3.3 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.

3.4 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.

3.5 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.

3.6 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.

3.7 Committees established by the Trust Board

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

a) Audit Committee and Auditor Panel
b) Remuneration Committee
c) Trust Charitable Funds Committee
d) Finance and Performance Committee
e) Quality Committee

The Board approved the terms of reference for these committees and they are reviewed on annual basis.

3.8 Other Committees

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

4. ARRANGEMENTS FOR THE EXERCISE OF TRUST FUNCTIONS BY DELEGATION

4.1 Delegation of Functions to Committees, Officers or other bodies

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 Standing Order 4, or by an officer of the Trust, or by another body as defined in Standing Order 5.1.2 below, in each case subject to such restrictions and conditions as the Trust thinks fit.

4.2 Emergency Powers and urgent decisions

The powers which the Board has reserved to itself within these Standing Orders (see Standing Order 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.

4.3 Delegation to Committees

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.

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.

4.4 Delegation to Officers

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.

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.

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

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

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.

4.5 Duty to report non-compliance with Standing Orders

If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Trust 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 Company Secretary as soon as possible.

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

5.1 Declaration of Interests

5.2 Requirements for Declaring Interests and applicability to Board Members

The NHS Code of Accountability and the Trust's Standard of Conduct policy 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.

5.3 Interests which are relevant and material

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

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

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

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

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

social care;

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

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

g) Interests in pooled funds that are under separate management.

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 Standing Order 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 Company Secretary as soon as practicable.

5.4 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 Company Secretary.

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.

5.5 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.

5.6 Publication of declared interests in Annual Report

Board members' declarations of interest are entered into the Directors' Register of Interests and should be published in the Trust's annual report. The information should be kept up to date for inclusion in succeeding annual reports.

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.

5.7 Register of Interests

The Company Secretary will ensure that a Directors' 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 which have been declared by executive and non- executive Trust Board members.

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.

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

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

5.9 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:

a) "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);

b) "Contract" shall include any proposed contract or other course of dealing.

c) "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/she, or a nominee of his/her, 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.

Exception to Pecuniary interests

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

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

b) any interest that he/she 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 Standing Orders.

5.10 Exclusion in proceedings of the Trust Board

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.

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 5.11 on the 'Waiver' which has been approved by the Secretary of State for Health).

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.

5.11 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**

The "relevant chairman" is –

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

(b) at a meeting of a Committee –

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

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

(3) **Application of waiver**

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

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

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

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

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

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

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

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

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

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

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

The removal is subject to the following conditions:

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

(b) the relevant chairman must consult the Chief Executive before making a declaration

in relation to the member in question

(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.

5.12 Standards of Conduct

The Trust has adopted the standards of conduct which are applicable to all acting on behalf of the Trust

5.13 Standards of Conduct, Trust Policy and National Guidance

All Trust staff and members of must comply with the Trust's Standards of Conduct and procedures on receipt of hospitality and gifts and the national guidance contained in HSG(93)5 on 'Standards of Business Conduct for NHS staff' and the provisions of the Bribery Act 2010.

(1) **Interest of Officers in Contracts**

i) Any officer 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 has any pecuniary interest, direct or indirect, the Officer shall declare their interest by giving notice in writing of such fact to the Trust's Company Secretary as soon as practicable.

ii) An Officer should also declare to the Trust Company Secretary 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.

(2) **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.

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.

(3) **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' shall apply.

5.14 Fit and Proper Person Declaration

(1) In addition to being of good character, persons appointed to the post of Executive or Non-Executive Director must:

- Have the qualifications, competence, skills and experience necessary to undertake the role
- Be able by reason of their health to properly perform the role's intrinsic tasks after any reasonable adjustment
- Not be prohibited from holding the position under any other legislation

- "not have been responsible for, privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying out a regulated activity"

(S)He must not be:

- an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged.
- subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland.
- a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986
- a person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it.
- a person included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland.

5.15 Declarations

The Board requires Executive and Non-Executive Directors to declare on appointment and thereafter on an annual basis that they remain a Fit and Proper Person to be employed as a Director. If Board members have any doubt about the declaration, this should be discussed with the Chairman of the Trust or with the Trust's Company Secretary.

Failure to comply with this requirement or failure to meet the necessary elements of the Fit and Proper Person test will be addressed under the Trust's HR Policies and Procedures for Executive Directors and will be reported to the Trust Development Authority (TDA)/NHS Improvement for Non-Executive Directors.

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

6.1 Custody of Seal

The common seal of the Trust shall be kept by the Company Secretary in a secure place.

6.2 Sealing of Documents

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

6.3 Register of Sealing

The Company Secretary shall keep a register in which he/she shall enter a record of the sealing of every document.

6.4 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).

7. MISCELLANEOUS (see overlap with SFI No. 19.3)

7.1 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.

Scheme of Reservation and Delegation

The Board	Decision Reserved To The Board
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.
The Board	**Regulations and Control** 1. Approve Standing Orders (SOs), a schedule of matters reserved to the Board and Standing Financial Instructions for the regulation of its proceedings and business. 2. Suspend Standing Orders. 3. Vary or amend the Standing Orders. 4. Ratify any urgent decisions taken by the Chairman and Chief Executive in public session 5. Approve a scheme of delegation of powers from the Board to committees. 6. Require and receive the declaration of Board members' interests that may conflict with those of the Trust and determining the extent to which that member may remain involved with the matter under consideration. 7. Require and receive the declaration of officers' interests that may conflict with those of the Trust. 8. 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. 9. Confirm the recommendations of the Trust's committees where the committees do not have executive powers. 10. Approve arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust. 11. Establish terms of reference and reporting arrangements of all committees and sub-committees that are

The Board	Decision Reserved To The Board
	established by the Board. 12. Approve arrangements relating to the discharge of the Trust's responsibilities as a bailer for patients' property. 13. Receive report on the use of the seal. 14. Ratify or otherwise instances of failure to comply with Standing Orders brought to the Company Secretary's attention 15. Appoint the External Auditors
The Board	**Appointments/ Dismissal** 1. Appoint the Deputy Chairman of the Board. 2. Appoint and dismiss committees (and individual members) that are directly accountable to the Board. 3. Appoint, discipline and dismiss Executive Directors 4. Confirm appointment of members of any committee of the Trust as representatives on outside bodies.
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, or delegate approval to one of its sub-committees, 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 million 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.

The Board	Decision Reserved To The Board
	8. Approve PFI proposals. 9. Approve proposals on individual contracts (other than NHS contracts) of a capital or revenue nature amounting to, or likely to amount to over £1 million 10. Approve proposals in individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive and Director of Finance (for losses and special payments) previously approved by the Board. 11. Approve individual non-clinical compensation payments. 12. Approve proposals for action on non- clinical litigation against or on behalf of the Trust.
The Board	**Annual Reports and Accounts** 1. Receipt and approval of the Trust's Annual Report and Annual Accounts/delegate it to the Audit Committee
The Board	**Monitoring** 1. Receive of such reports as the Board sees fit from committees in respect of their exercise of powers delegated. 2. Continuous appraisal of the affairs of the Trust by means of the provision to the Board as the Board may require from directors, committees, and officers of the Trust as set out in management policy statements. All monitoring returns required by the Department of Health and the Charity Commission shall be reported, at least in summary, to the Board. 3. Receive reports from Director of Finance on financial performance against budget and Trust Annual Business Plan.

Scheme of Delegation Derived From the Accountable Officer Memorandum

Delegated To	Duties Delegated
Chief Executive	Accountable through NHS Accounting Officer to Parliament for stewardship of Trust resources
Chief Executive and Director of Finance	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.
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. Adopt the organisation structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications thereto.
Chief Executive	*Ensure effective management systems that safeguard public funds and assist the Trust Chairman to implement requirements of corporate governance including ensuring managers:* "have a clear view of their objectives and the means to assess achievements in relation to those objectives be assigned well defined responsibilities for making best use of resources have the information, training and access to the expert advice they need to exercise their responsibilities effectively."
Chairman	Implement requirements of corporate governance.
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 External Auditors and the National Audit Office (NAO).
Director of Finance	Operational responsibility for effective and sound financial management and information. Approve the

Delegated To	Duties Delegated
	opening of bank accounts.
Chief Executive	Primary duty to see that DoF discharges this function.
Chief Executive	Ensuring that expenditure by the Trust complies with Parliamentary requirements.
Chief Executive and Director of Finance	Chief Executive, supported by Director of Finance, to ensure appropriate advice is given to the Board on all matters of probity, regularity, prudent and economical administration, efficiency and effectiveness.
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 TDA/HNS Improvement and Department of Health.
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 they are overruled it is normally sufficient to ensure that their advice and the overruling of it are clearly apparent from the papers. Exceptionally, the CE should inform Monitor and the DH. In such cases, the CE should as a member of the Board vote against the course of action rather than merely abstain from voting.

Scheme of Delegation Derived From the Codes of Conduct and Accountability

Delegated To	Authorities/Duties Delegated
The Board	Approve procedure for declaration of hospitality and sponsorship/delegate approval to the Audit Committee.
The Board	Ensure proper and widely publicised procedures for voicing complaints, concerns about misadministration, breaches of Standards of Conduct, and other ethical concerns.
All Board members	Subscribe to Standards of Conduct.
The Board	Board members share corporate responsibility for all decisions of the Board.
Chairman and Non-Executive/Officer Members	Chair and non-executive members are responsible for monitoring the executive management of the organisation and are responsible to the S of S for the discharge of those responsibilities.
The Board	The Board has six key functions for which it is held accountable by the Department of Health on behalf of the Secretary of State: 1. to ensure effective financial stewardship through value for money, financial control and financial planning and strategy; 2. to ensure that high standards of corporate governance and personal behaviour are maintained in the conduct of the business of the whole organisation; 3. to appoint, appraise and remunerate senior executives; 4. to ratify the strategic direction of the organisation within the overall policies and priorities of the Government and the NHS, define its annual and longer term objectives and agree plans to achieve them; 5. to oversee the delivery of planned results by monitoring performance against objectives and ensuring corrective action is taken when necessary;

Delegated To	Authorities/Duties Delegated
	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.
The 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 Standing Orders, 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.
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;

Delegated To	Authorities/Duties Delegated
	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. appoint Non-Executive Board members to an Audit Committee of the main Board; 7. advise the Secretary of State on the performance of Non-Executive Board members.
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.
Non-Executive Directors	Non-Executive Directors are appointed by TDA/NHS Improvement 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.
Chairman and Directors	Declaration of conflicts of interest

Delegated To	Authorities/Duties Delegated
The Board	NHS Boards must comply with legislation and guidance issued by the Department of Health on behalf of the Secretary of State, respect agreements entered into by themselves or in on their behalf and establish terms and conditions of service that are fair to the staff and represent good value for taxpayers' money.

Scheme of Delegation from Model Standing Orders

Delegated to	Authorities/Duties Delegated
Chairman	Final authority in interpretation of Standing Orders (SOs).
The Board	Appointment of Deputy Chairman
Chairman	Call meetings
Chairman	Chair all Board meetings and associated responsibilities
Chairman	Give final ruling in questions of order, relevancy and regularity of meetings
Chairman	Having a second or casting vote
The Board	Suspension of Standing Orders
The Board	Variation or amendment of Standing Orders
The Board	Formal delegation of powers to sub committees or joint committees and approval of their constitution and terms of reference. (Delegation of powers includes approval of corporate policies on behalf of the Board)
Chairman and Chief Executive	The powers which the Board has retained to itself within these Standing Orders may in emergency be exercised by the Chair and Chief Executive after having consulted at least two Non-Executive members
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
All Staff	Disclosure of non-compliance with Standing Orders to the Company Secretary as soon as possible
The Board	Declare relevant and material interests
Company Secretary	Maintain Register(s) of Interests
All Staff	Comply with national guidance contained in HSG 1993/5 “Standards of Business Conduct for NHS Staff”
All Staff	Disclose relationship between self and candidate for staff appointment. (CE to report the disclosure to the Board.

Delegated to	Authorities/Duties Delegated
Company Secretary	Keep seal in safe place and maintain a register of sealing
Chief Executive/ Executive Director	Approve and sign all documents which will be necessary in legal proceedings

East Lancashire Hospitals NHS
NHS Trust

TRUST BOARD REPORT

Item 17

25 January 2017

Purpose Approval

Title	Standing Financial Instructions
Author	Mrs A Bosnjak-Szekeres, Associate Director of Corporate Governance/Company Secretary

Summary: The Finance Team and the Company Secretary have undertaken the review of the standing financial instructions (SFI's), which included separating the Standing Orders and Standing Financial Instructions. The amendments to the Standing Financial Instructions are highlighted by tracked changes and also include the suggested changes recommended by the Finance and Performance Committee and Audit Committee at its meetings on the 7 September 2016 and 7 December 2016 respectively, in particularly in relation to the role of the Remuneration Committee.

Recommendation: The Board is asked to ratify the revised SFI's as per the recommendations of the Audit Committee.

Report linkages

Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do Invest in and develop our workforce Work with key stakeholders to develop effective partnerships Encourage innovation and pathway reform, and deliver best practice
Related to key risks identified on assurance framework	Transformation schemes fail to deliver the clinical strategy, benefits and improvements and the organisation's corporate objectives Recruitment and workforce planning fail to deliver the Trust objectives Collaborative working fails to support delivery of sustainable, safe and effective care through clinical pathways Alignment of partnership organisations and collaborative strategies (Pennine Lancashire and Healthier Lancashire) are not sufficient to support the delivery of sustainable services by the Trust The Trust fails to achieve a sustainable financial position and appropriate continuity of service risk

rating.

The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

Impact

Legal	Yes	Financial	No
Equality	No	Confidentiality	No

Previously considered by: Finance and Performance Committee (12 September 2016) and Audit Committee (7 December 2016)

East Lancashire Hospitals NHS
NHS Trust

TRUST WIDE DOCUMENT

DOCUMENT TITLE:	**STANDING FINANCIAL INSTRUCTIONS**
DOCUMENT NUMBER:	**ELHT/F15 Version 13**

DOCUMENT PURPOSE:	Identify the reservation and delegation of powers and standing financial instructions for the Trust.
TARGET AUDIENCE:	All Trust Personnel
DISTRIBUTION:	All Trust policy manuals and intranet
AUTHOR(S):	Associate Director of Corporate Governance/Company Secretary
EXECUTIVE DIRECTOR RESPONSIBLE:	Director of Finance

DOCUMENT REPLACES	Version 12
POLICY COUNCIL:	N/A
AUTHORISED BY:	Trust Board
NEXT REVIEW DATE:	December 2017

STANDING FINANCIAL INSTRUCTIONS

1. INTRODUCTION

1.1 General

1.1.1 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).

1.1.2 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.

1.1.3 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 Director of Finance.

1.1.4 Should any difficulties arise regarding the interpretation or application of any of the Standing Financial Instructions then the advice of the Director of Finance 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.

1.1.5 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.

1.1.6 **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 Director of Finance as soon as possible.

1.2 Responsibilities and delegation

1.2.1 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.

1.2.2 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 or individuals as indicated in the scheme of delegation or these Standing Financial Instructions.

1.2.3 **The Chief Executive and Director of Finance**

The Chief Executive and Director of Finance 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 and the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

1.2.4 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.

1.2.5 **The Director of Finance**

The Director of Finance 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 Director of Finance 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.

1.2.6 **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.

1.2.7 **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.

1.2.8 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 Director of Finance.

2. AUDIT

2.1 Audit Committee

2.1.1 In accordance with Standing Orders, the Board shall formally establish an Audit Committee, with clearly defined terms of reference and following guidance from the 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) 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;

(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 old and £5,000 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.

(h) Review and approve corporate policies on behalf of the Board

2.1.2 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 Director of Finance in the first instance.)

2.1.3 It is the responsibility of the Director of Finance 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.

2.2 Director of Finance

2.2.1 The Director of Finance 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 must 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.

2.2.2 The Director of Finance 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.

2.3 Role of Internal Audit

2.3.1 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.

2.3.2 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 Director of Finance must be notified immediately.

2.3.3 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.

2.3.4 The Chief Internal Auditor shall be accountable to the Director of Finance. The reporting system for internal audit shall be agreed between the Director of Finance, 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 annually.

2.4 External Audit

The External Auditor is appointed by the Trust Board on the recommendation of the Auditor Panel and 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 Financial Reporting Council if the issue cannot be resolved.

2.5 Fraud and Corruption

2.5.1 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.

2.5.2 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.

2.5.3 The Local Counter Fraud Specialist shall report to the Trust Director of Finance and shall work with staff in the Counter Fraud and Security Management Services (CFSMS) and the Regional Counter Fraud and Security Management Services

(CFSMS) in accordance with the Department of Health Fraud and Corruption Manual.

2.5.4 The Local Counter Fraud Specialist will provide a written report quarterly to the Audit Committee, on counter fraud work within the Trust.

2.6 Security Management

2.6.1 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.

2.6.2 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.

2.6.3 The Trust shall nominate a Non-Executive Director to be responsible to the Board for NHS security management.

2.6.4 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).

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

3.1 Preparation and Approval of Plans and Budgets

3.1.1 The Chief Executive will compile and submit to the Board an Annual Business Plan (ABP) which takes into account financial targets and forecast limits of available resources. The ABP 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.

3.1.2 Prior to the start of the financial year the Director of Finance will, on behalf of the Chief Executive, prepare and submit budgets for approval by the Board. 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.

3.1.3 The Director of Finance shall monitor financial performance against budget and plan, periodically review them, and report to the Board.

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

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

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

3.2 Budgetary Delegation

3.2.1 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.

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

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

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

3.3 Budgetary Control and Reporting

3.3.1 The Director of Finance 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) Balance sheet position showing movement from previous month and movement year to date

(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 Director of Finance's view of whether such actions are sufficient to correct the situation;

(vii) service line reporting information

(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.

3.3.2 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 the Board;

(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.

3.3.3 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the ABP and a balanced budget.

3.4 Capital Expenditure

The general rules applying to delegation and reporting shall also apply to capital expenditure. (The particular applications relating to capital are contained in SFI 22).

3.5 Monitoring Returns

The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to the requisite monitoring organisation.

4. ANNUAL ACCOUNTS AND REPORTS

4.1 The Director of Finance, 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 International Financial Reporting Standards where applicable;

(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.

4.2 The Trust's annual accounts must be audited by an auditor appointed by the Trust Board on the recommendation of the Auditor Panel The Trust's audited annual accounts must be presented to a public meeting and made available to the public.

4.3 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.

5. BANK AND OPG ACCOUNTS

5.1 General

5.1.1 The Director of Finance is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account guidance/ Directions issued from time to time by the Department of Health. In line with 'Cash Management in the NHS' Trusts should minimize the use of commercial bank accounts and consider using Government Banking Service (GBS) accounts for all banking services.

5.1.2 The Board shall approve the banking arrangements.

5.2 Bank and OPG Accounts

5.2.1 The Director of Finance is responsible for:

(a) bank accounts and GBS accounts;

(b) establishing separate bank accounts for the Trust's non-exchequer funds;

(c) ensuring payments made from bank or GBS accounts do not exceed the amount credited to the account 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.

5.3 Banking Procedures

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

(a) the conditions under which each bank and GBS account is to be operated;

(b) those authorised to sign cheques or other orders drawn on the Trust's accounts.

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

5.4 Tendering and Review

5.4.1 The Director of Finance 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.

5.4.2 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.

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

6.1 Income Systems

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

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

6.2 Fees and Charges

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

6.2.2 The Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health/Monitor 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 and the provisions of the Bribery Act 2010 shall be followed.

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

6.3 Debt Recovery

6.3.1 The Director of Finance is responsible for the appropriate recovery action on all outstanding debts.

6.3.2 Income not received should be dealt with in accordance with losses procedures.

6.3.3 Overpayments should be detected (or preferably prevented) and recovery initiated.

6.4 Security of Cash, Cheques and other Negotiable Instruments

6.4.1 The Director of Finance 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.

6.4.2 Official money shall not under any circumstances be used for the encashment of private cheques or IOUs.

6.4.3 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Director of Finance.

6.4.4 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.

7. TENDERING AND CONTRACTING PROCEDURE

The Trust's policy is to seek to maximise value for money in the procurement of goods

and services whilst ensuring that operational requirements are fulfilled and statutory obligations met.

7.1 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 the Standing Orders and the Standing Financial Instructions (except where the Suspension of Standing Orders is applied).

7.2 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.

7.3 Reverse eAuctions

The Trust should have policies and procedures in place for the control of all tendering activity carried out through Reverse eAuctions. For further guidance on Reverse eAuctions refer to www.ogc.gov.uk

7.4 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" and “Estate code” in respect of capital investment and estate and property transactions. In the case of management consultancy contracts the Trust shall comply as far as is practicable with Department of Health guidance "The Procurement and Management of Consultants within the NHS".

7.5 Formal Competitive Tendering

Trust Officers will as a matter of course seek to use NHS or other Public Body Contracts. In cases where they are not available or are inappropriate for use the following rules by value apply. All values are for the total procurement value over the life of the goods/services.

Both quotations and tenders are formal requests from the Trust to potential suppliers to provide prices/costs against a defined procurement.

Tenders representing a value greater that the OJEU level and more complicated procurements will comprise a range of standard documentation as advised by the

Department of Health and Government.

In cases where the Trust, by prior agreement, uses another Public Body to undertake procurement then the Statutory Framework of that Body will apply to the procurement – the Trust having agreed and documented this in advance.

In cases where the Trust, by prior agreement, undertakes procurement on behalf of another Public Body the Trust's Statutory Framework will apply – all parties having agreed and documented this in advance.

7.5.1 **General Applicability**

The Trust shall ensure that competitive tenders are invited for:

- the supply of goods, materials and manufactured articles;
- the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the DH);
- For the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); for disposals.

7.5.2 **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.

7.5.3 **Exceptions and instances where formal tendering need not be applied**

It should be noted that European Procurement Law applies at all times and cannot be waivered. Trust Procurement will advise budget holders as to how compliance can be achieved.

Formal tendering procedures **need not be applied** where:

(a) the estimated expenditure or income does not, or is not reasonably expected to, exceed **£35,000**;

(b) where the supply is proposed under special arrangements negotiated by the DH in which event the said special arrangements must be complied with;

(c) regarding disposals as set out in Standing Financial Instructions No. 23;

Formal tendering procedures **may be waived** in the following circumstances:

(d) in very exceptional circumstances where the Chief Executive decides that formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures, and the circumstances are detailed in an appropriate Trust record;

(e) where the requirement is covered by an existing contract;

(f) where a government agreement is in place and have been approved by the Board;

(g) 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;

(h) 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;

(i) where specialist expertise is required and is available from only one source;

(j) 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;

(k) 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;

(l) for the provision of legal advice and services providing that any legal firm or partnership commissioned by the Trust is regulated by the Law Society for England and Wales for the conduct of their business (or by the Bar Council for England and Wales in relation to the obtaining of Counsel's opinion) and are generally recognised as having sufficient expertise in the area of work for which they are commissioned.

The Director of Finance will ensure that any fees paid are reasonable and within commonly accepted rates for the costing of such work.

The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure. All proposed waivers will be requested by means of the Trust approved formal Waiver Form and in line with the Trust's Scheme of Delegation.

Trust Procurement will consider all requests to waive tendering and quotation requirements as set out in these Standing Orders and Standing Financial Instructions based upon both the information presented and appropriate research. Approval will be granted or declined in the first instance by Trust Procurement and the form will then be submitted to the Director of Finance. If either party declines the waiver request the Trust Procurement Officer will brief and advise the commissioning officer of the reason.

Where it is decided that competitive tendering is not applicable andshould 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 on an annual basis

7.5.4 **Fair and Adequate Competition**

Where the exceptions set out in SFI Nos. 16.1 and 16.5.3 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.

7.5.5 **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. W here in the opinion of the Director of Finance 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 16.6.8 List of Approved Firms).

7.5.6 **Building and Engineering Construction Works**

Competitive Tendering cannot be waived for building and engineering construction works and maintenance (other than in accordance withEU Regulations, Procure21 and Private Finance Initiatives) without Department of Health approval.

7.5.7 **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.

7.6 Contracting/Tendering Procedure

Trust Procurement will support budget holders in sourcing and identifying potential suppliers. Sources of potential suppliers will include but not be limited to:

- NHS or other Public Body Contractors
- Respondents to Notices placed in the Official Journal of the European Union

- Respondents to Notices placed in appropriate Journals
- Those advised by Trust Officers based upon their operational and technical knowledge

A pre-selection process will usually be undertaken including, where appropriate, indicative costing methodologies.

In the case of hard copy paper tenders, a list of the suppliers invited to submit a Tender will be provided for the Director of Finance's office and include the tender reference and the closing date and time for receipt of tenders.

Tender documents will be issued according to one of three methods:

(1) Electronically via the Trust Tender Management (TM) system.

This involves giving Tenderers electronic access to Tender Documents and their return electronically. The Trust may also elect to utilise the Electronic Auction option as part of this method which involves facilitating an online reverse auction where against an agreed range of products/ services tenderers submit prices within a timescale with an expectation that suppliers submitting the lowest prices will achieve the highest score for the pricing elements of the Tender. The trust may also invite non price Tender submissions in addition to the Electronic Auction.

Electronic Auctions will be operated in accordance with the protocols of the TM System provider and the Trust Procurement/E-Commerce Department.

(2) Electronically from an approved Trust Officer email address.

This involves the electronic dissemination of the Tender Documents to the Director of Finance's office and includes the tender reference and the closing date and time for receipt of tenders.

(3) By paper hard copy.

This involves the posting of paper hard copy Tender Documents and the return of the paper hard copy. All invitations to tender shall state the date and time as being the latest time for receipt of tenders. All invitations to tender shall state that no paper hard copy tender will be accepted unless:

(a) submitted in a plain sealed package or envelope bearing a pre- printed label supplied by the Trust (or the word "tender" followed by the subject to which it relates) and the latest date and time for the receipt of such tender addressed to the Chief Executive or nominated Manager;

(b) that tender envelopes/ packages shall not bear any names or marks indicating the sender. The use of courier/postal services must not identify the sender on the

envelope or on any receipt so required by the deliverer.

(iii) Every tender for goods, materials, services or disposals shall embody such of the NHS Standard Contract Conditions as are applicable.

(iv) Every tender for building or engineering works (except for maintenance work, when Estmancode guidance shall be followed) shall embody or be in the terms of the current edition of one of the Joint Contracts Tribunal Standard Forms of Building Contract or Department of the Environment (GC/Wks) Standard forms of contract amended to comply with EU regulations, Procure21 and Private Finance Initiatives; 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.

16.6.2 Receipt and safe custody of paper hard copy and tenders issued electronically from an approved Trust Officer's email address

The Chief Executive or his nominated representative will be responsible for the receipt, endorsement and safe custody of tenders received until the time appointed for their opening.

The date and time of receipt of each tender shall be endorsed on the tender envelope/package.

16.6.3 Opening tenders and Register of tenders

Tenders issued electronically via the TM System should be submitted and opened in accordance with the TM System protocols. These protocols having been agreed with the system provider and having been approved by the Trust's Internal Audit System prior to implementation. The Tenders will remain within the TM System under a password controlled and time locked secure electronic environment.

Tenders issued electronically from an approved Trust Officer email address must be returned addressed to the Director of Finance or delegated officer and submitted in

accordance with the notified tender deadline.

Tenders issued by paper hard copy should be opened:

(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 senior officers/managers designated by the Chief Executive and not from the originating department.

(ii) A member of the Trust Board will be required to be one of the two approved persons present for the opening of 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.

(iii) The 'originating' Department will be taken to mean the Department sponsoring or commissioning the tender.

(iv) The involvement of Finance Directorate staff in the preparation of a tender proposal will not preclude the Director of Finance or any approved Senior Manager from the Finance Directorate from serving as one of the two senior managers to open tenders.

(v) All Executive Directors/members will be authorised to open tenders regardless of whether they are from the originating department provided that the other authorised person opening the tenders with them is not from the originating department.

The Trust's Company Secretary will count as a Director for the purposes of opening tenders.

(vi) Every tender received shall be marked with the date of opening and initialled by those present at the opening.

(vii) A register shall be maintained by the Chief Executive, or a person authorised by him, to show for each set of competitive tender invitations despatched:

- the name of all firms individuals invited;
- the names of firms individuals from which tenders have been received;
- the date the tenders were opened;
- the persons present at the opening;
- the price shown on each tender;
- a note where price alterations have been made on the tender. Each entry to this register shall be signed by those present.

A note shall be made in the register if any one tender price has had so many alterations that it cannot be readily read or understood.

(viii) 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.

Admissibility

If for any reason the designated officers are of the opinion that the tenders received are not strictly competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Chief Executive or Director of Finance.

(ii) Where only one tender is sought and/or received, the Chief Executive and Director of Finance shall, as far practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Trust.

Late Tenders

Tenders received after the due time and date, but prior to the opening of the other tenders may be considered only if the Chief Executive or his nominated officer decides that there exceptional circumstances i.e. dispatched in good time but delayed through no fault of the tenderer.

(ii) Only in the most exceptional circumstances will a tender be considered which is received after the opening of the other tenders and only then if the tenders that have been duly opened have not left the custody of the Chief Executive or his nominated officer or if the process of evaluation and adjudication has not started.

(iii) 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.

(iv) The TM System will require the Trust's authorised Officers to approve the opening of Tenders received past the Tender Return date – until this is agreed they will be stored securely online

Acceptance of formal tenders (See overlap with SFI No. 16.7)

The Tender Document will normally state that the awarded is to be based on the most economically advantageous bid. This will normally include full life cycle costs.

In cases where the EU Thresholds apply, the Award Criteria must be included in either the Notice in the Official Journal of the European Union or in the Tender.

Contract Award criteria are agreed by Trust Officers as part of the procurement process. In projects of significant value/risk this will include budget holders, finance staff and procurement officers along with any other appropriate Trust Officers.

(i) The procurement process must allow sufficient time for pre- offer (tender) engagement with potential suppliers including the application of indicative pricing methodologies. These will be conducted in accordance with Department of Health / Government Guidance. Post tender negotiation /pre contract negotiation is not permitted within the OJEU tendering process. In exceptional cases at the discretion of Trust Procurement it may be undertaken for below OJEU threshold tendering exercises. 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. These clarifications will be conducted in accordance with Department of Health/ Office of Government Commerce Guidance.

(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 factors and their weighting in the award process 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.

16.6.7 Tender reports to the Trust Board

Reports to the Trust Board will be made on an exceptional circumstance basis only.

16.6.8 List of approved firms

(a) **Responsibility for maintaining list**

A manager nominated by the Chief Executive shall on behalf of the Trust maintain lists of approved firms from who tenders and quotations may be invited. These shall be kept under frequent review. The lists shall include all firms who have applied for permission to tender and as to whose technical and financial competence the Trust is satisfied. 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 compiled in accordance with this Instruction or on the separate maintenance lists compiled in accordance with Estmancode guidance (Health Notice HN(78)147).

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 Director of Finance 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.

16.6.9 Exceptions to using approved contractors

If in the opinion of the Chief Executive and the Director of Finance 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.

16.7 Quotations: Competitive and non-competitive

16.7.1 General Position on quotations

Quotations are required where formal tendering procedures are not adopted and where the intended expenditure or income exceeds, or is reasonably expected to exceed £15,000 but not exceed £35,000.

16.7.2 Competitive Quotations

(i) Quotations should be obtained from at least 3 firms/individuals based on specifications or terms of reference prepared by, or on behalf of, the Trust.

(ii) Quotations should be in 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. Quotations will usually comprise a single document.

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.

16.7.3 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;

(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.

16.7.4 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 Director of Finance.

16.8 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 may be decided by the following staff to the value of the contract as follows:

Designated budget holders	up to	£25,000
Divisional General Managers & Other Directors	up to	£75,000
Executive Directors	up to	£250,000
Director of Finance	up to	£500,000
Deputy Chief Executive	up to	£500,000
Chief Executive	up to	£1,000,000
Trust Board	over	£1,000,000

These levels of authorisation may be varied or changed and need to be read in conjunction with the Trust Board's Scheme of Delegation.

Formal authorisation must be put in writing. In the case of authorisation by the Trust Board this shall be recorded in their minutes.

16.9 Instances where formal competitive tendering or competitive quotation is not required

Refer to section 16.5.3

(a) the Trust shall use the NHS Logistics for procurement of all goods and services unless the Chief Executive or nominated officers deem it inappropriate. The decision to use alternative sources must be documented.

(b) If the Trust does not use the NHS Supply Chain - where tenders or quotations are not required, because expenditure is below £15,000, the Trust shall procure goods and services in accordance with procurement procedures approved by the Director of Finance.

16.10 Private Finance for capital procurement (see overlap with SFI No. 22)

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.

16.11 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 Manual, Estate code and guidance on the Procurement and Management of Consultants;

(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.

16.12 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.

16.13 Disposals (See overlap with SFI No. 24)

Competitive Tendering or Quotation procedures shall not apply to the disposal of:

(a) any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or his nominated officer;

(b) obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Trust;

(c) items to be disposed of with an estimated sale value of less than £5,000 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.

16.14 In-house Services

16.14.1 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.

16.14.2 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 Director of Finance representative. For services having a likely annual expenditure exceeding £ 500,000, a Non-Executive member of the Board should be a member of the evaluation team.

16.14.3 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.

16.14.4 The evaluation team shall make recommendations to the Board.

16.14.5 The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.

16.15 Applicability of SFIs on Tendering and Contracting to funds held in trust (see overlap with SFI No. 27.3)

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.

8. NHS SERVICE AGREEMENTS FOR PROVISION OF SERVICES

8.1 Service Level Agreements (SLAs)

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

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

- the standards of service quality expected;
- the relevant national service framework (if any);

- the provision of reliable information on cost and volume of services;
- the NHS National Performance Assessment Framework;
- that SLAs build where appropriate on existing Joint Investment Plans;
- that SLAs are based on integrated care pathways.

8.2 Involving Partners and jointly managing risk

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

8.3 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.

9. TERMS OF SERVICE, ALLOWANCES AND PAYMENT OF MEMBERS OF THE TRUST BOARD AND EXECUTIVE COMMITTEE AND EMPLOYEES

9.1 Remuneration Committee

9.1.1 In accordance with Standing Orders the Board shall establish a Remuneration Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting. (See NHS guidance contained in the Higgsreport.)

9.1.2 The Committee will:

(a) agree the appropriate remuneration and terms of service for the Chief Executive and 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;

(b) Advise the Board of the remuneration and terms of service of the Executive Directors to ensure they are fairly rewarded for their individual contribution to the Trust - having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such members and staff where appropriate;

(c) monitor the performance of individual Executive Directors via the annual appraisal report of the Chief Executive for the Non-Executive Directors and the Chairman's appraisal report for the Chief Executive.

(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.

(e) Carry out duties under the Trust's Fit and Proper Person Test Policy;

(f) The Remuneration Committee and Non-Executive Directors will be involved in the recruitment of Executive Directors through focus groups that form part of the selection process.

9.1.3 The Committee shall report in writing to the Board. The Board shall remain accountable for taking decisions on the remuneration and terms of service of Executive Directors. Minutes of the Remuneration Committee meetings should record such decisions.

9.1.4 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.

9.1.5 The Trust will pay allowances to the Chairman and Non-Executive Directors (including Associate Non-Executive Directors) of the Board in accordance with instructions issued by the Secretary of State for Health.

9.2 Funded Establishment

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

9.2.2 The funded establishment of any department may not be varied without the approval of the Chief Executive.

9.3 Staff Appointments

9.3.1 No officer 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;

(b) Within the limit of their approved budget and funded establishment.

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

9.4 Processing Payroll

9.4.1 The Director of Finance 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.

9.4.2 The Director of Finance will issue instructions regarding:

(a) verification and documentation of data;

(b) the 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.

9.4.3 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 Director of Finance's instructions and in the form prescribed by the Director of Finance;

(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 fulfil obligations in circumstances that suggest they have left without notice, the Director of Finance must be informed immediately.

9.4.4 Regardless of the arrangements for providing the payroll service, the Director of Finance 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.

9.5 Contracts of Employment

The Board shall delegate responsibility to an officer for:

(a) ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation;

(b) dealing with variations to, or termination of, contracts of employment.

10. NON-PAY EXPENDITURE

10.1 Delegation of Authority

10.1.1 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.

10.1.2 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.

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

10.2 Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services (see overlap with Standing Financial Instruction No. 17)

10.2.1 **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 adviser on supply shall be sought. W here this advice is not acceptable to the requisitioner, the Director of Finance (and/or the Chief Executive) shall be consulted.

10.2.2 **System of Payment and Payment Verification**

The Director of Finance 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.

10.2.3 **The Director of Finance will:**

(a) advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in Standing Orders and Standing Financial Instructions and regularly reviewed;

(b) prepare procedural instructions or guidance within the Scheme of Delegation on the obtaining of goods, works and services incorporating the thresholds;

(c) be responsible for the prompt payment of all properly authorised accounts and claims;

(d) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

(i) A list of Board employees (including specimens of their signatures) authorised to certify invoices.

(ii) Certification that:

- goods have been duly received, examined and are in accordance with specification and the prices are correct;
- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;
- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
- the account is arithmetically correct;
- the account is in order for payment.

(iii) A timetable and system for submission to the Director of Finance 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. 19.2.4 below.

10.2.4 **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 3.5%).

(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 Director of Finance will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the EU public procurement rules where the contract is above a stipulated financial threshold);

(d) The budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Chief Executive if problems are encountered.

10.2.5 **Official orders**

Official Orders must:

(a) be in a form approved by the Director of Finance;

(b) state the Trust's terms and conditions of trade;

(c) only be issued to, and used by, those duly authorised by the Chief Executive.

10.2.6 **Duties of Managers and Officers**

Managers and officers must ensure that they comply fully with the guidance and limits specified by the Director of Finance 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 Director of Finance in advance of any commitment being made;

(b) contracts above specified thresholds are advertised and awarded in accordance with EU rules on public procurement;

(c) where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Department of Health;

(d) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:

(i) isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;

(ii) conventional hospitality, such as lunches in the course of working visits;

(This provision needs to be read in conjunction with Standing Orders and the principles outlined in the national guidance contained in HSG 93(5) "Standards of Business Conduct for NHS Staff") and the Bribery Act 2010;

(e) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Director of Finance on behalf of the Chief Executive;

(f) all goods, services, or works are ordered on an official order except works and services executed in accordance with a contract and purchases from petty cash;

(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";

(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 Director of Finance;

(k) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Director of Finance;

(l) petty cash records are maintained in a form as determined by the Director of Finance.

(m) All attempts to bribe or otherwise induce members of staff to procure products or services from a particular supplier are reported immediately to the Director of Finance

10.2.7 The Chief Executive and Director of Finance 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 EU regulations, Procure21, Private Finance Initiative and ESTATECODE. The technical audit of these contracts shall be the responsibility of the relevant Director.

19.3 Joint Finance Arrangements with Local Authorities and Voluntary Bodies (see overlap with Standing Order No. 9.1)

19.3.1 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 Director of Finance which shall be in accordance with these Acts.

11. EXTERNAL BORROWING

20.1.1 The Director of Finance 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 Director of Finance is also responsible for reporting periodically to the Board concerning the PDC debt and all loans and overdrafts.

20.1.2 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 Director of Finance.

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

20.1.4 All short-term borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position, represent good value for money, and comply with the latest guidance from the Department of Health.

20.1.5 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 Director of Finance. The Board must be made aware of all short term borrowings at the next Board meeting.

20.1.6 All long-term borrowing must be consistent with the plans outlined in the current LDP and be approved by the Trust Board.

20.2 INVESTMENTS

20.2.1 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.

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

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

12. FINANCIAL FRAMEWORK

The Director of Finance 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 Trust's. The Director of Finance should also ensure that the direction and guidance in the framework is followed by the Trust.

13. CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

13.1 Capital Investment

13.1.1 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 commissioner(s) support and the availability of resources to finance all revenue consequences, including capital charges.

13.1.2 For every capital expenditure proposal the Chief Executive shall ensure:

(a) that a business case (in line with the guidance contained within the *Capital Investment Manual*) is produced setting out:

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

(ii) the involvement of appropriate Trust personnel and external agencies;

(ii) appropriate project management and control arrangements;

(b) that the Director of Finance has certified professionally to the costs and revenue consequences detailed in the business case.

13.1.3 For capital schemes where the contracts stipulate stage payments, the Chief

Executive will issue procedures for their management, incorporating the recommendations of "Estatecode".

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

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

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

The Chief Executive shall issue to the manager responsible for any scheme:

(a) specific authority to commit expenditure;

(b) authority to proceed to tender (see overlap with SFI No. 16.6);

(c) approval to accept a successful tender (see overlap with SFI No. 16.6).

The Chief Executive will issue a scheme of delegation for capital investment management in accordance with "Estatecode" guidance and the Trust's Standing Orders.

13.1.7 The Director of Finance 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.

13.2 Private Finance

13.2.1 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 Director of Finance 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.

13.3 Asset Registers

13.3.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Director of Finance 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.

13.3.2 Each Trust shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be as specified in the *Capital Accounting Manual* as issued by the Department of Health.

13.3.3 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.

13.3.4 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).

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

13.3.6 Each asset is to be appropriately valued in accordance with agreed accounting policies

13.3.7 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.

13.3.8 The Director of Finance of the Trust shall calculate and pay capital charges as specified by the Department of Health.

13.4 Security of Assets

13.4.1 The overall control of fixed assets is the responsibility of the Chief Executive.

13.4.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Director of Finance. 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.

13.4.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Director of Finance.

13.4.4 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.

13.4.5 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.

13.4.6 Where practical, assets should be marked as Trust property.

14. STORES AND RECEIPT OF GOODS

14.1 General position

23.1 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.

23.2 Control of Stores, Stocktaking, condemnations and disposal

23.2.1 Subject to the responsibility of the Director of Finance 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 Director of Finance. The control of any Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of any fuel oil and coal of a designated estates manager.

23.2.2 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.

23.2.3 The Director of Finance shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

23.2.4 Stocktaking arrangements shall be agreed with the Director of Finance and there shall be a physical check covering all items in store at least once a year.

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

23.2.6 The designated Manager/Pharmaceutical Officer shall be responsible for a system approved by the Director of Finance 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 Director of Finance any evidence of significant overstocking and of any negligence or malpractice (see also overlap with SFI No. 24 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.

23.3 Goods supplied by NHS Logistics

For goods supplied via the NHS Logistics central warehouses, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note before forwarding this to the Director of Finance who shall satisfy himself that the goods have been received before accepting the recharge.

15. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

15.1 Disposals and Condemnations

15.1.1 Procedures

The Director of Finance must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers.

15.1.2 When it is decided to dispose of a Trust asset, the Head of Department or authorised deputy will determine and advise the Director of Finance of the estimated market value of the item, taking account of professional advice where appropriate.

15.1.3 All unserviceable articles shall be:

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

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

15.1.4 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 Director of Finance who will take the appropriate action.

15.2 Losses and Special Payments

15.2.1 **Procedures**

The Director of Finance must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments.

15.2.2 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 Director of Finance or inform an officer charged with responsibility for responding to concerns involving loss. This officer will then appropriately inform the Director of Finance and/or Chief Executive. W here a criminal offence is suspected, the Director of Finance must immediately inform the police if theft or arson is involved. In cases of fraud and corruption or of anomalies which may indicate fraud or corruption, the Director of Finance must inform the relevant LCFS and CFSMS regional team in accordance with Secretary of State for Health's Directions.

The Director of Finance must notify the Counter Fraud and Security Management Services (CFSMS) and the External Auditor of all frauds.

15.2.3 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Director of Finance must immediately notify:

(a) the Audit Committee,

(b) the External Auditor

(c) in the event of theft or arson, the police.

15.2.4 The Director of Finance shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

15.2.5 For any loss, the Director of Finance should consider whether any insurance claim can be made.

15.2.6 The Director of Finance shall maintain a Losses and Special Payments Register in which write-off action is recorded.

24.27 No special payments exceeding delegated limits shall be made without the prior approval of the Department of Health.

24.28 All losses and special payments must be reported to the Audit Committee on an annual basis

16. INFORMATION TECHNOLOGY

16.1 Responsibilities and duties of the Director of Finance

16.1.1 The Director of Finance, 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.

16.1.2 The Director of Finance 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. W here this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

16.1.3 The Company Secretary shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the Information Commissioner.

16.2 Responsibilities and duties of other Directors and Officers in relation to computer systems of a general application

16.2.1 In the case of computer systems which are proposed General Applications (i.e. normally those applications which the majority of Trust's in the Region wish to sponsor jointly) all responsible directors and employees will send to the Director of Finance:

(a) details of the outline design of the system;

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

16.3 Contracts for Computer Services with other health bodies or outside agencies

The Director of Finance shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

Where another health organisation or any other agency provides a computer service for financial applications, the Director of Finance shall periodically seek assurances that adequate controls are in operation.

16.4 Risk Assessment

The Director of Finance 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.

16.5 Requirements for Computer Systems which have an impact on corporate financial systems

Where computer systems have an impact on corporate financial systems the Director of Finance 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) Director of Finance staff have access to such data;

(d) such computer audit reviews as are considered necessary are being carried out.

17. PATIENTS' PROPERTY

17.1 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.

17.2 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.

17.3 The Director of Finance 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.

17.4 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 Director of Finance.

17.5 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.

17.6 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.

17.7 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.

18. FUNDS HELD ON TRUST

18.1 Corporate Trustee

(1) Standing Order No. 2.7 outlines the Trust's responsibilities as a corporate trustee for the management of funds it holds on trust, along with SFI 4.8.3 that defines the need for compliance with Charities Commission latest guidance and best practice. For further information in relation to the requirements in relation to Charitable Funds please see the Standing Orders and Standing Financial Instructions for Charitable Funds.

(2) The discharge of the Trust's corporate trustee responsibilities are distinct from its

responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. Trustee responsibilities cover both charitable and non-charitable purposes.

The Director of Finance 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.

18.2 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 all funds held on trust.

18.3 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.

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 16.16).

(2) The over-riding principle is that the integrity of each Trust must be maintained and statutory and Trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

28 ACCEPTANCE OF GIFTS BY STAFF AND LINK TO STANDARDS OF CONDUCT (see overlap with Standing Orders)

The Director of Finance and Company Secretary 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 the Standing Orders and the Standing Financial Instructions.

29. RETENTION OF RECORDS

29.1 The Chief Executive shall be responsible for maintaining archives for all records

required to be retained in accordance with Department of Health guidelines.

29.2 The records held in archives shall be capable of retrieval by authorised persons.

29.3 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.

30. RISK MANAGEMENT AND INSURANCE

30.1 Programme of Risk Management

The Chief Executive shall ensure that the Trust has a programme of risk management, in accordance with current Department of Health assurance framework requirements, which must be approved and monitored by the Board.

The programme of risk management shall include:

a) a process for identifying and quantifying risks and potential liabilities;

b) engendering among all levels of staff a positive attitude towards the control of risk;

c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

d) contingency plans to offset the impact of adverse events;

e) audit arrangements including; Internal Audit, clinical audit, health and safety review;

f) a clear indication of which risks shall be insured;

g) arrangements to review the Risk Management programme.

The existence, integration and evaluation of the above elements will assist in providing a basis to make a Statement on the effectiveness of Internal Control (SIC) within the Annual Report and Accounts as required by current Department of Health guidance.

30.2 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.

30.3 Insurance arrangements with commercial insurers

30.3.1 There is a general prohibition on entering into insurance arrangements with

commercial insurers. There are, however, **three exceptions** when Trust's may enter into insurance arrangements with commercial insurers. The exceptions are:

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

(2) where the Trust is involved with a consortium in a **Private Finance Initiative contract** and the other consortium members require that commercial insurance arrangements are entered into; and

(3) where **income generation activities** take place. Income generation activities should normally be insured against all risks using commercial insurance. If the income generation activity is also an activity normally carried out by the Trust for a NHS purpose the activity may be covered in the risk pool. Confirmation of coverage in the risk pool must be obtained from the Litigation Authority. In any case of doubt concerning a Trust's powers to enter into commercial insurance arrangements the Finance Director should consult the Department of Health.

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

(1) Where the Board decides to use the risk pooling schemes administered by the NHS Litigation Authority the Director of Finance shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Director of Finance shall ensure that documented procedures cover these arrangements.

(2) Where the Board decides not to use the risk pooling schemes administered by the NHS Litigation Authority for one or other of the risks covered by the schemes, the Director of Finance 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 Director of Finance 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 Director of Finance should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

DETAILED SCHEME OF DELEGATION

Delegated matters in respect of decisions, which may have a far-reaching effect, must be reported to the Chief Executive. The delegation shown below is the lowest level to which authority is delegated. Delegation to lower levels is only permitted with written approval of the Chief Executive who will, before authorising such delegation, consult with other Senior officers as appropriate. All items concerning Finance must be carried out with Standing Financial Instructions and Standing Orders.

	Delegated Matter	**Authority Delegated To**
1	Management of Budgets	Budget holder
a)	Responsibility of keeping expenditure within budgets	Divisional General Manager Director of Finance or
b)	At individual budget level (pay and non-pay)	Appropriate Delegated
	At service level	Manager
c)	For all other areas	
2	Maintenance/ Operation of Bank Accounts	Director of Finance
3	Non - Pay Revenue and Capital Expenditure/Requisitioning/	
a)	Ordering / Payment of Goods and Services Budgets are spent consistent with their purpose	Divisional General Manager or Departmental Manager
b)	Non-Pay Expenditure for which no specific budget has been set up and which is not subject to funding under delegated powers of virement	Chief Executive, Director of Finance or Service Manager
c)	Orders exceeding 12 month period	Director of Finance and
d)	All contracts for goods and Services and subsequent variations to contracts	Divisional General Manager Divisional General Manager or Director of Finance

4 a) b)	Capital Schemes Selection of Architects, Quantity Surveyors, Consultant Engineer and other professional advisors within EU Regulations Financial monitoring and reporting on all capital scheme expenditure	Director of Estates Director of Finance
5 a) b) c) d)	Quotation, Tendering and Contract Procedures Obtaining quotations for goods/ services up to £15,000 Obtaining 3 written quotations for goods/ services from £15,000 to £35,000 Obtaining competitive tenders for expenditure over £35,000 Waiving of Quotations and Tenders subject to SFI's Opening tenders and quotations	Head of Procurement or delegated officer Head of Procurement or delegated officer Head of Procurement or delegated officer Head of Procurement or Director of Finance or Chief Executive Board Director and Senior Manager for paper tenders and Director of Finance/delegated officers for electronic tenders

6 a) b)	Setting of Fees and Charges Private Patients, Overseas Visitors, Income Generation & other patient related services Price of NHS Service Agreements. Charges for all NHS Service Agreements, be they block, cost per case, cost and	 Director of Finance or Nominated Deputy Director of Finance or Nominated Deputy
7 a)	Engagement of staff not on the Establishment Engagement of Trust solicitors Booking of Bank or Agency Staff • Medical Locums • Nursing	Chief Executive/ Director of Finance/ Deputy Chief Executive/ Associate Director of Safety & Quality Divisional General Manager or Nominated
8	Expenditure on Charitable and Endowment Funds Up to £3,000 per request Over £3,000 per request Over £20,000	Departmental Manager/ Directorate Nurse Director of Finance or Executive Director
9 a) b) c) d)	Agreements/ Licenses Preparation and signature of all tenancy agreements/ licences for staff subject to Trust policy on accommodation for staff Extension to existing leases Letting of premises to outside organisations Approval of rent based on professional assessment	 Facilities Manager Director of Finance/ Facilities Manager Director of Finance/ Chief Executive Director of Finance
10 a)	Condemning and Disposals Items obsolete, obsolescent,	

	irreparable or cannot be repaired cost effectively	Supplies Manager Budget Holder
i)	With current/ estimated purchase less than £50	Service Manager – Radiology Service Manager – Radiology
ii)	With current purchase new price greater than £50	Director of Estates
iii)	Disposal of x-ray films (subject to estimated income of less than £1,000 per sale)	Director of Estates and Director of Finance
iv)	Disposal of x-ray films (subject to estimated income exceeding £1,000 per sale)	
v)	Disposal of mechanical and engineering plant (subject to estimated income of less than £3,000 per sale)	

11	Losses, Write Off and Compensation	
a)	Losses and cash due to theft, fraud, overpayment and others up to £50,000	Chief Executive or Director of Finance
b)	Fruitless payments (including abandoned capital schemes) up to £250,000	Chief Executive or Director of Finance
c)	Bad debts and claims abandoned, private patients, overseas visitors and others up to £50,000	Chief Executive or Director of Finance
d)	Damage to buildings, fittings, furniture and equipment and loss of equipment and property in stores and in use due to culpable causes (e.g. fraud, theft, arson) or other up to £50,000	Chief Executive or Director of Finance
	Compensation payments made under legal obligation	Chief Executive or Director of Finance or Deputy Chief Executive
	Extra contractual payments to contractors up to £50,000	Chief Executive or Director of Finance
	Ex-gratia payments to patients and staff for loss of personal effects	
e)	• Less than £500	Budget Holder / Associate Director of Safety & Quality
f)	• Between £500 and £10,000 • £10,000 to £50,000	
g)	For clinical negligence up to £1,000,000(negotiatedsettlements)	Associate Director Safety & Quality / Deputy Chief Executive
	For personal injury claims involving negligence where legal advice has been obtained and guidance applied up to £1,000,000 including plaintiff's costs	Chief Executive / Director of Finance/ Deputy ChiefExecutive
h)	Other, except cases of maladministration where there was no financial loss by claimant £50,000	Chief Executive / Director of Finance/ Deputy Chief Executive
i)	Write off NHS Debtors Write off non NHS Debtors	Chief Executive / Director of Finance/ Deputy Chief Executive

12 a) i) ii) b)	Reporting of Incidents to the Police Where a criminal offence is suspected Criminal offence of a violent nature Other Where fraud is involved	Executive/ Director of Finance/ Divisional Manager Director of Finance
13	Receiving Hospitality Applies to both individual and collective hospitality receipt items, in excess of £25.00 per item received	Declaration required in the Trust's Register
14	Implementation of Internal and External Audit Recommendations	Director of Finance
15	Maintenance & Update on Trust Financial Procedures	Director of Finance
16	Investment of Funds including Charitable and Endowment Funds	Director of Finance

17	**Personnel and Pay**	
	Authority to full funded post on the establishment with permanent staff	Divisional General Manager Director of Finance
	Authority to appoint staff to post not on the formal establishment The granting of additional increments to staff within budget	Director of Finance or Divisional General Manager Chief Executive or Director of Finance
	All requests for upgrading or regarding shall be dealt with in accordance with Trust procedures Establishments	
	Additional staff to the agreed establishment with specifically allocated Finance	Director of Finance Director of Finance
	Additional staff to the agreed establishment without specifically allocated finance	Budget Holder
	Pay	
	Authority to complete standing data forms effecting pay, new starters, variations and leavers Authority to complete and authorise positive reporting forms Authority to authorise overtime	Budget Holder Budget Holder Budget Holder
	Authority to authorise travel and subsistence expenses	
	Leave	Line/ Departmental Manager Line/ Departmental Manager
	Approval of annual leave	
	Annual leave – approval of carry forward up to a maximum of 5 days or as defined in the initial conditions of service	Director of HRand Organisational Development
	Annual leave approval of carry over in excess of 5 days but less then 10 days	
	Annual leave approval to carry forward 10 days or more	
	Compassionate leave up to 5 days Special leave arrangements	

	Study leave • Study leave outside the UK • Medical staff study leave (UK) • All other study leave (UK) Removal expenses, excess rent and house purchases Authorisation of payment of removal expenses incurred by officers taking up new appointments providing consideration was promised at interview. Grievance Procedure All grievance cases must be dealt with strictly in accordance with the Grievance Procedure and the advice of the Head of HR must be sought when the grievance reaches the level of Service Manager Authorised car and mobile phone users Requests for new posts to be authorised as car users Request for new posts to be authorised as mobile telephone users Renewal of Fixed Term contract Staff Retirement Policy Authorisation of extensions of contract beyond normal retirement age in exceptional circumstances Redundancy Ill Health Retirement Decision to pursue retirement on the	Chief Executive or Director of Finance Divisional General Manager Divisional General Manager Divisional General Manger Divisional General Manager Divisional General Manger Divisional General Manager Divisional General Manager Chief Executive Chief Executive and Medical Director Divisional General Manager Director of Finance Director of HR and Organisational Development Director of Finance/ Nominated Officer Director of Finance / Nominated Officer

18	Authorisation of New Drugs £25,000 Estimated total yearly cost above £25,000	Deputy Chief Executive/ Divisional General Manager Drugs Committee & Executive/ Director of
19	Authorisation of Sponsorship Deals	Chief Executive/ Medical Director and Director of
20	Authorisation of Research Projects	Chief Executive / Medical Director and Chairman of Research Committee
21	Authorisation of Clinical Trials	Research & Development Committee, Chief Executive and Medical Director
22	Insurance Policies and Risk Manager	Chief Executive, Director of Finance and Deputy Chief Executive
23	Patients and Relatives Complaints Overall responsibility for ensuring that all complaints are dealt with effectively Responsibility for ensuring complaints relating to a directorate area are investigated thoroughly Medico-legal complaints – coordination of their manager	Deputy Chief Executive and Associate Director of Safety & Quality Divisional General Manager and Associate Director of Safety & Quality Associate Director of Safety & Quality
24	Review Trust compliance with the Access to Records Act	Director of Finance or Nominated Officer
25	Review of the Trust's compliance with the Code of Practice for Handling Confidential Information in the Contracting Environment and	Director of Finance or Nominated Officer
26	The keeping of a Register of Interests	Company Secretary
27	Attestation of Sealings in accordance with Standing Orders	Chief Executive/ Director of Finance/Company
28	The keeping of a Register of Sealings	Company Secretary

29	The keeping of the Hospitality Register	Company Secretary
30	Retention of Records	Chief Executive

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
DIRECTOR OF FINANCE	Approval of all financial procedures.
DIRECTOR OF FINANCE	Advice on interpretation or application of SFIs.
ALL MEMBERS OF THE BOARD AND EMPLOYEES	Have a duty to disclose any non-compliance with these Standing Financial Instructions to the Director of Finance as soon as possible.
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.
CHIEF EXECUTIVE & DIRECTOR OF FINANCE	Accountable for financial control but will, as far as possible, delegate their detailed responsibilities.
CHIEF EXECUTIVE	To ensure all Board members, officers and employees, present and future, are notified of and understand Standing Financial Instructions.
DIRECTOR OF FINANCE	Responsible for: a) Implementing the Trust's financial policies and coordinating corrective action; b) Maintaining an effective system of financial control including ensuring detailed financial procedures and systems are prepared and documented; c) Ensuring that sufficient records are maintained to explain Trust's transactions and financial position; d) Providing financial advice to members of Board and staff; e) Maintaining such accounts, certificates etc as are required for the Trust to carry out its statutory duties
ALL MEMBERS OF THE BOARD AND	Responsible for security of the Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming to Standing Orders, Financial Instructions and financial procedures.

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

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.
AUDIT COMMITTEE	Provide independent and objective view on internal control and probity.
AUDITOR PANEL	Provide advice and recommendation on the appointment of the External Auditor.
BOARD	Appoint External Auditor
CHAIR OF AUDIT COMMITTEE	Raise the matter at the Board meeting where Audit Committee considers there is evidence of ultra vires transactions or improper acts.
DIRECTOR OF FINANCE	Ensure an adequate internal audit service, for which he/she is accountable, is provided
DIRECTOR OF FINANCE	Decide at what stage to involve police in cases of misappropriation and other irregularities not involving fraud or corruption.

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

HEAD OF INTERNAL AUDIT	Review, appraise and report in accordance with NHS Internal Audit Manual and best practice.
AUDIT COMMITTEE	Ensure cost-effective External Audit.
CHIEF EXECUTIVE & DIRECTOR OF FINANCE	Monitor and ensure compliance with SofS Directions on fraud and corruption including the appointment of the Local Counter Fraud Specialist.
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.
CHIEF EXECUTIVE	Compile and submit to the Board an Annual Business Plan (ABP) which takes into account financial targets and forecast limits of available resources. The ABP will contain: • a statement of the significant assumptions on which the plan is based;
DIRECTOR OF FINANCE	Submit budgets to the Board for approval. Monitor performance against budget; submit to the Board financial estimates and forecasts.
DIRECTOR OF FINANCE	Ensure adequate training is delivered on an ongoing basis to budget holders.

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

CHIEF EXECUTIVE	Delegate budget to budget holders.
CHIEF EXECUTIVE & BUDGET HOLDERS	Must not exceed the budgetary total or virement limits set by the Board.
DIRECTOR OF FINANCE	Devise and maintain systems of budgetary control.
BUDGET HOLDERS	Ensure that a) no overspend or reduction of income that cannot be met from virement is incurred without prior consent of Board;
CHIEF EXECUTIVE	Identify and implement cost improvements and income generation activities in line with the Annual Business Plan.
CHIEF EXECUTIVE	Submit monitoring returns
DIRECTOR OF FINANCE	Preparation of annual accounts and reports.

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

DIRECTOR OF FINANCE	Managing banking arrangements, including provision of banking services, operation of accounts, preparation of instructions and list of cheque signatories. Board approves arrangements.
DIRECTOR OF FINANCE	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.
ALL EMPLOYEES	Duty to inform DoF of money due from transactions which they initiate/deal with.
CHIEF EXECUTIVE	Tendering and contract procedure.
CHIEF EXECUTIVE	Waive formal tendering procedures.
CHIEF EXECUTIVE	Report waivers of tendering procedures to the Audit Committee.
DIRECTOR OF FINANCE	Where a supplier is chosen that is not on the approved list the reason shall be recorded in writing to the CE.

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

CHIEF EXECUTIVE	Responsible for the receipt, endorsement and safe custody of tenders received.
CHIEF EXECUTIVE	Shall maintain a register to show each set of competitive tender invitations despatched.
CHIEF EXECUTIVE AND DIRECTOR OF FINANCE	Where one tender is received will assess for value for money and fair price.
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.
CHIEF EXECUTIVE	Will appoint a manager to maintain a list of approved firms.
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.
CHIEF EXECUTIVE	The Chief Executive or his nominated officer should evaluate the quotation and select the quote whichgives the best value for money.

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

CHIEF EXECUTIVE or DIRECTOR OF FINANCE	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.
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.
BOARD	All PFI proposals must be agreed by the Board.
CHIEF EXECUTIVE	The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.
CHIEF EXECUTIVE	The Chief Executive shall nominate officers with delegated authority to enter into contracts ofemployment, regarding staff, agency staff or temporary staff service contracts.
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.
CHIEF EXECUTIVE	The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

CHIEF EXECUTIVE	Must ensure the Trust enters into suitable Service Level Agreements (SLAs) with service commissioners for the provision of NHS services
CHIEFEXECUTIVE	As the Accountable Officer, ensure that regular reports are provided to the Board by the DoFdetailing actual and forecast income from theSLA
BOARD	Establish a Remuneration Committee
REMUNERATION COMMITTEE	Agree the remuneration and terms of service of the CE, and Executive Directors to ensure they are fairly rewarded having proper regard to the Trust's circumstances and any national agreements; NHS Improvement and evaluate the performance of Executive Directors
REMUNERATION COMMITTEE	Report in writing to the Board ~~the bases about remuneration and terms of service of directors.~~ its decisions
BOARD	Approve proposals presented by the Chief Executive for setting of remuneration and conditions of servicefor those employees and officers not covered by the Remuneration Committee.
CHIEF EXECUTIVE	Approval of variation to funded establishment of any department.

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

CHIEF EXECUTIVE	Staff, including agency staff, appointments and re-grading.
DIRECTOR OF FINANCE	Payroll: a) specifying timetables for submission of properly authorised time records and other notifications; b) final determination of pay and allowances;
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.
DIRECTOR OF FINANCE	Ensure that the chosen method for payroll processing is supported by appropriate (contracted) terms andconditions, adequate internal controls and audit review procedures and that suitable arrangement are
	made for the collection of payroll deductions and payment of these to appropriate bodies.
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.
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 forauthorisation above that level.

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

CHIEF EXECUTIVE	Set out procedures on the seeking of professional advice regarding the supply of goods and services.
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.
DIRECTOR OF FINANCE	Shall be responsible for the prompt payment of accounts and claims.
DIRECTOR OF FINANCE	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 regularly reviewed;
	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;
APPROPRIATE EXECUTIVE DIRECTOR	Make a written case to support the need for a prepayment.
DIRECTOR OF FINANCE	Approve proposed prepayment arrangements.

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

BUDGET HOLDER	Ensure that all items due under a prepayment contract are received (and immediately inform DoF if problems are encountered).
CHIEF EXECUTIVE	Authorise who may use and be issued with official orders.
MANAGERS AND OFFICERS	Ensure that they comply fully with the guidance and limits specified by the Director of Finance.
CHIEF EXECUTIVE DIRECTOR OF FINANCE	Ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within EU regulations, Procure21 (P21), Private Finance Initiatives and ESTATECODE. The technical audit of these contracts
DIRECTOR OF FINANCE	Lay down procedures for payments to local authorities and voluntary organisations made under the powers of section 28A of the NHS Act.
DIRECTOR OF FINANCE	The DoF will advise the Board on the Trust's ability to pay dividend on Public Dividend Capital (PDC) and report, periodically, concerning the PDC debt and all loans and overdrafts.
BOARD	Approve a list of employees authorised to make short term borrowings on behalf of the Trust. (This must include the CE and DoF.)

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

DIRECTOR OF FINANCE	Prepare detailed procedural instructions concerning applications for loans and overdrafts.
CHIEF EXECUTIVE OR DIRECTOR OF	Be on an authorising panel comprising one other member for short term borrowing approval.
DIRECTOR OF FINANCE	Will advise the Board on investments and report, periodically, on performance of same.
DIRECTOR OF FINANCE	Prepare detailed procedural instructions on the operation of investments held.
DIRECTOR OF FINANCE	Ensure that Board members are aware of the Financial Framework and ensure compliance
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
DIRECTOR OF FINANCE	Certify professionally the costs and revenue consequences detailed in the business case for capital investment.

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

CHIEF EXECUTIVE	Issue procedures for management of contracts involving stage payments.
DIRECTOR OF FINANCE	Assess the requirement for the operation of the construction industry taxation deduction scheme.
DIRECTOR OF FINANCE	Issue procedures for the regular reporting of expenditure and commitment against authorised capital expenditure.
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.
DIRECTOR OF FINANCE	Issue procedures governing financial management, including variation to contract, of capital investment projects and valuation for accounting purposes.
DIRECTOR OF FINANCE	Demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.
BOARD	Proposal to use PFI must be specifically agreed by the Board.

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

CHIEF EXECUTIVE	Maintenance of asset registers (on advice from DoF).
DIRECTOR OF FINANCE	Approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.
DIRECTOR OF FINANCE	Calculate and pay capital charges in accordance with Department of Health requirements.
CHIEF EXECUTIVE	Overall responsibility for fixed assets.
DIRECTOR OF FINANCE	Approval of fixed asset control procedures.
BOARD, EXECUTIVE MEMBERS AND ALL SENIOR STAFF	Responsibility for security of Trust assets including notifying discrepancies to DoF, and reporting losses in accordance with Trust procedure.
CHIEF EXECUTIVE	Delegate overall responsibility for control of stores (subject to DoF responsibility for systems of control). Further delegation for day-to-day responsibility subject to such delegation being recorded. (Good practice to append to the scheme of delegation document.)

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

DIRECTOR OF FINANCE	Responsible for systems of control over stores and receipt of goods.
DESIGNATED PHARMACEUTICAL OFFICER	Responsible for controls of pharmaceutical stocks
DESIGNATED ESTATES OFFICER	Responsible for control of stocks of fuel oil and coal.
NOMINATED OFFICERS*	Security arrangements and custody of keys
DIRECTOR OF FINANCE	Set out procedures and systems to regulate thestores.
DIRECTOR OF FINANCE	Agree stocktaking arrangements.
DIRECTOR OF FINANCE	Approve alternative arrangements where a complete system of stores control is not justified.

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

DIRECTOR OF FINANCE	Approve system for review of slow moving and obsolete items and for condemnation, disposal and replacement of all unserviceable items.
NOMINATED OFFICERS*	Operate system for slow moving and obsolete stock, and report to DoF evidence of significant overstocking.
CHIEF EXECUTIVE	Identify persons authorised to requisition and accept goods from NHS Supplies stores.
DIRECTOR OF FINANCE	Prepare detailed procedures for disposal of assets including condemnations and ensure that these are notified to managers.
DIRECTOR OF FINANCE	Prepare procedures for recording and accounting for losses, special payments and informing police in cases of suspected arson or theft.
ALL STAFF	Discovery or suspicion of loss of any kind must be reported immediately to either head of department or nominated officer. The head of department / nominated officer should then inform the CE and DoF.
DIRECTOR OF FINANCE	Where a criminal offence is suspected, DoF must inform the police if theft or arson is involved. In cases of fraud and corruption DoF must inform the relevant LCFS and CFSMS Regional Team in line with SoS directions.

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

DIRECTOR OF FINANCE	Notify CFSMS and External Audit of all frauds.
DIRECTOR OF FINANCE	Notify Board and External Auditor of losses caused theft, arson, neglect of duty or gross carelessness (unless trivial).
BOARD	Approve write off of losses (within limits delegated by DH).
DIRECTOR OF FINANCE	Consider whether any insurance claim can be made.
DIRECTOR OF FINANCE	Maintain losses and special payments register.
DIRECTOR OF FINANCE	Responsible for accuracy and security of computerised financial data.
DIRECTOR OF FINANCE	Satisfy himself that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. W here this is undertaken by another organisation assurances of adequacy must be obtained from them prior to implementation.

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

COMPANY SECRETARY	Shall publish and maintain a Freedom of Information Scheme.
RELEVANT OFFICERS	Send proposals for general computer systems to DoF
DIRECTOR OF FINANCE	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.
DIRECTOR OF FINANCE	Ensure that risks to the Trust from use of IT are identified and considered and that disaster recovery plans are in place.
DIRECTOR OF FINANCE	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,
CHIEF EXECUTIVE	Responsible for ensuring patients and guardians are informed about patients' money and property procedures on admission.
DIRECTOR OF FINANCE	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

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

DEPARTMENTAL MANAGERS	Inform staff of their responsibilities and duties for the administration of the property of patients.
DIRECTOR OF FINANCE	Ensure that each trust fund which the Trust is responsible for managing is managed appropriately.
DIRECTOR OF FINANCE	Ensure all staff are made aware of the Trust policy on the acceptance of gifts and other benefits in kind by staff
CHIEF EXECUTIVE	Retention of document procedures in accordance with NHS Code of Practice for Records Management
CHIEF EXECUTIVE	Risk management programme.
BOARD	Approve and monitor risk management programme.
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.

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

*	DIRECTOR OF FINANCE	Where the Board decides to use the risk pooling schemes administered by the NHS Litigation Authority the Director of Finance shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Director of Finance shall ensure that
	DIRECTOR OF FINANCE	Ensure documented procedures cover management of claims and payments below the deductible.

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

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 18

25 January 2017

Purpose Information Assurance

Title	Finance and Performance Committee Update Report (January 2017)
Author	Miss K Ingham, Company Secretarial Assistant
Executive sponsor	Mr David Wharfe, Non-Executive Director

Summary: The report sets out the matters discussed and decisions made at the Finance and Performance Committee meeting held on the 9 January 2017.

Report linkages

Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do Invest in and develop our workforce Work with key stakeholders to develop effective partnerships Encourage innovation and pathway reform, and deliver best practice
Related to key risks identified on assurance framework	Transformation schemes fail to deliver the clinical strategy, benefits and improvements and the organisation's corporate objectives Recruitment and workforce planning fail to deliver the Trust objectives Collaborative working fails to support delivery of sustainable, safe and effective care through clinical pathways Alignment of partnership organisations and collaborative strategies (Pennine Lancashire and Healthier Lancashire) are not sufficient to support the delivery of sustainable services by the Trust The Trust fails to achieve a sustainable financial position and appropriate continuity of service risk rating. The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously Considered by: NA

Finance and Performance Committee Update Report: 9 January 2017

At the last meeting of the Finance and Performance Committee held on 9 January 2017 members considered the following matters.

1. The Committee received the Finance Report which provided an overview of the financial position in the month of November. Members noted the actions that were in place to recover the financial position, particularly those action plans at divisional level and around the use of agency staff. The Non-Executive Committee members expressed their concern at the continued deterioration of financial performance in the Family Care and Surgical and Anaesthetic Services Divisions and requested that the Divisional Management Teams from the two areas attend the next meeting to present their Divisional recovery plans.
2. The Committee received the Integrated Performance Report and the progress report on the work undertaken to address the recommendations in the Lord Carter of Coles review. In addition to the regular report they received an overview of the transformational plans for the Pharmacy Service and Procurement services. The Committee received an overview of the Pharmacy transformation scheme and was pleased to see the positive work that was already in place within the department and the plans to develop this work further.
3. The Committee received an update in relation to the Ward Based Pharmacist pilot that had been running for a number of months on some of the wards. Mr Fletcher provided an overview of the work and highlighted the positive contribution that the individuals involved in the pilot had had on ward teams, the proposed full roll out and the further development of the role. The Committee was supportive of the proposed roll out, pending the presentation of a more in-depth paper to the next meeting.
4. Members of the Committee received the Sustaining Safe, Personal and Effective Care 2016/17 update report and noted the work being undertaken to identify schemes for the forthcoming two years. It was agreed that the development of the Safely Releasing Costs Programme (SRCP) would be discussed further at the Board Development Session. Non-Executive Directors expressed their concerns at the amount of schemes that would release non-recurrent savings as opposed to recurrent savings.
5. The Committee received a report relating to financial planning for 2017/18 and 2018/19. The Committee noted that the contracts with local commissioners had been agreed and signed, however agreement had not yet been reached in relation to specialist commissioning. The initial draft submission of the Business Plan was submitted to NHS Improvement on 24 November and feedback received that was

used to inform the final submission that was approved by the Chief Executive and the Chairman on behalf of the Trust Board prior to submission on 23 December 2016.

6. The Committee received an overview of the GS1 Standard Project and the benefits that it will bring to the Trust; an update on tenders and confirmation that the Single Oversight Framework consultation had closed. In addition, the Committee received the minutes of the Contract and Data Quality Board.

Kea Ingham, Company Secretarial Assistant, 12 January 2017

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 19

25 January 2017

Purpose Information Assurance

Title	Trust Charitable Funds Committee Update Report (December 2016)
Author	Miss K Ingham, Company Secretarial Assistant
Executive sponsor	Mr D Wharfe, Committee Chair

Summary: The report sets out the matters discussed and decisions made at the Trust Charitable Funds Committee meeting held on 7 December 2016

Report linkages

Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do Invest in and develop our workforce Work with key stakeholders to develop effective partnerships Encourage innovation and pathway reform, and deliver best practice
Related to key risks identified on assurance framework	Transformation schemes fail to deliver the clinical strategy, benefits and improvements and the organisation's corporate objectives Recruitment and workforce planning fail to deliver the Trust objectives Collaborative working fails to support delivery of sustainable, safe and effective care through clinical pathways Alignment of partnership organisations and collaborative strategies (Pennine Lancashire and Healthier Lancashire) are not sufficient to support the delivery of sustainable services by the Trust The Trust fails to achieve a sustainable financial position and appropriate continuity of service risk rating. The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously Considered by: NA

Trust Charitable Funds Committee Update: 7 December 2016

1. At the last meeting of the Trust Charitable Funds Committee held on Wednesday 7 December 2016 members considered the following matters and undertook to ensure actions would be taken as outlined in the report.
2. The Committee received the draft annual accounts of the fund and the associated independent report from the external auditors. The Committee members received an overview of the accounts and noted that there had been no requirement for a full audit of the accounts for the year 2015/16, due to the amount held in the funds being just below the threshold for an audit. The independent examination of the accounts had been carried out by Messrs Grant Thornton, who confirmed that the two recommended amendments to the accounts had been completed and as a result the report was ready for issue once the accounts had been approved. The draft accounts were approved by the Committee for presentation to the Corporate Trustee for a final approval before submission to the Charity Commission on the 31 January 2017.
3. The Committee members discussed the benefits and constraints of using an investment advice/management company for the funds and it was agreed that the total amount payable per year to the investment management company would be obtained and shared with the members.
4. The Committee received the draft Annual Report of the charity and were provided with an overview of the content by the Financial Controller. He confirmed that because there had been no need for a full audit of the accounts, the Annual Report did not contain as much information as the report published in the previous year. In addition to the report, the Committee received a proposed Reserves Policy and it was agreed that prior to a contingency/reserve being set, the Charity's deed should be examined and guidance obtained.
5. The Committee received the investment report and noted the overall performance of the funds for the first six months of the year. There was a small increase in the value of the portfolio and it was agreed that a benchmarking exercise would be undertaken in relation to the use of bonds and share based investments.
6. The Committee received a report relating to the performance and utilisation of the funds. It was noted that the utilisation of the fund was £310,000, which was somewhat lower than the planned position. Non-Executive members sought further information regarding the use of the charitable funds for retirement and long service awards. Members discussed the acceptability of financing such staff benefits from the charity and agreed to discuss this matter further at the next meeting.

7. The Committee received the proposed Fundraising Strategy and noted that the majority of the activity would commence once the Fundraising Manager was in post. The Committee noted that it was anticipated that a Fundraising Manager would be in post within the next three months. The Chair of the Committee expressed his disappointment about the length of time that it had taken to get to the current position.
8. The Non-Executive members of the Committee requested a paper that set out the plan for increases in the numbers of staff undertaking fundraising for the charity and the ways in which general fundraising would be undertaken by the Trust.
9. The Committee received the proposed revisions to the Committee's Terms of Reference and approved them for submission to the Trust Board for ratification.
10. The Committee also received the fund consolidation report, a proposed Committee self-assessment tool and the proposed dates of future meetings.

Kea Ingham, Company Secretarial Assistant, 13 January 2017

East Lancashire Hospitals NHS
NHS Trust

TRUST BOARD REPORT

Item **20**

25 January 2017

Purpose Information
Action
Monitoring

Title	Trust Charitable Funds Committee Terms of Reference
Author	Mrs A Bosnjak-Szekeres, Associate Director of Corporate Governance/Company Secretary
Executive sponsor	Mr D Wharfe, Committee Chair

Summary: The Company Secretary has carried out a review of the terms of reference for the Committee. The proposed amendments were presented to the Committee on 7 December 2016. it was agreed at the Committee that the terms of reference should be presented to the Trust Board for ratification.

Recommendation: The Board is asked to consider the document and approve the recommendation from the Committee to ratify the terms of reference.

Report linkages

Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do Invest in and develop our workforce Work with key stakeholders to develop effective partnerships Encourage innovation and pathway reform, and deliver best practice
Related to key risks identified on assurance framework	Transformation schemes fail to deliver the clinical strategy, benefits and improvements and the organisation's corporate objectives Recruitment and workforce planning fail to deliver the Trust objectives Collaborative working fails to support delivery of sustainable, safe and effective care through clinical pathways Alignment of partnership organisations and collaborative strategies (Pennine Lancashire and Healthier Lancashire) are not sufficient to support the delivery of sustainable services by the Trust The Trust fails to achieve a sustainable financial

position and appropriate continuity of service risk rating.

The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

Impact

Legal	Yes	Financial	No
Equality	No	Confidentiality	No

Previously considered by: NA

Charitable Funds Committee Terms of Reference

Constitution

The Trust Board has established this Committee to be known as the Charitable Funds Committee. The Committee will report its actions and decisions to the Trust Board.

The Committee has overarching responsibility for the monitoring and approval of activities relating to charitable fund raising and the uses to which charitable funds are applied providing assurance to Trust Board members in their role of Trustees of the organisation's Charitable Funds.

The Committee has the authority to appoint short term, outcome focused subcommittees but does not routinely receive reports from other subcommittees.

Purpose and Delegated Responsibilities

The Trust receives funds for charitable purposes from a number of sources. The Trust as a corporate body is the Trustee of these funds. The Trust Board must therefore ensure that its duties as a Trustee are discharged correctly taking advice as necessary.

The Board when acting as Trustees of the charitable funds will act in accordance with guidance from the Charities Commission, and will discharge its function as Trustee as far as possible, separately from its duty as a Trust Board. The Trust Board appoints this Committee to discharge this function. In addition the Trust Board delegates to this Committee the authority to examine and recommend for approval to the Corporate Trustee the annual accounts of funds held on trust.

The Committee will oversee the management of funds held on trust and charitable funds. In particular the Committee will:

(a) Set a corporate strategy for the management of funds

(b) Assure the Trust Board and Corporate Trustee that the policies and procedures for the management and administration of Trust funds are adequate, effective and observed

I c) Review the investments held by the Trust at regular intervals

(d) Review the performance of funds on a regular basis

I e) Approve and review the application of funds

(f) Approve, accredit and support fundraising activities in accordance with the Trust's guidelines for fundraising activities

(g) Approve and review the appointment of those managing investments on behalf of the Trustees

(h) Make recommendations regarding the management and performance of funds

(i) Provide an annual report to the Trust Board on the Committee's activities

Membership

At least two Non-Executive Directors/Associate Non-Executive Directors, Director of Finance, Director of Nursing and Director of Communications and Engagement.

Quorum

A quorum of 3 (of which 1 must be a Non-Executive Director and 1 an Executive Director) must be maintained at all meetings. Each member will attend a minimum of 75% of the meetings throughout the year. Members who are unable to attend will arrange for their nominated deputy to attend, their attendance will be recorded in the minutes, making clear on whose behalf they attend.

In Attendance

Any other Executive or Non-Executive Director may be in attendance at meetings in their role as a representative of the Corporate Trustee of the Charitable Funds.
Divisional General Managers will attend meetings where requests for funds from their Division appear as an agenda item.
The Company Secretary, the Charitable Funds Accountant and a Staff Side Representative will normally be in attendance.

Frequency of Meetings

The committee will meet for a minimum of three meetings per year. These will normally be held on a quarterly basis.

Reporting Arrangements

The Committee will provide a summary of its decisions and actions to the next meeting of the Trust Board. The Committee does not regularly receive reports from other subcommittees.

Regular Reports

- Funds' Performance Update Report
- Applications in the form of a business case for the use of funds

Committee Support

Lead Director	- Director of Finance
Agenda and Minute Preparation	- Company Secretary

Review

The effectiveness of the Committee will be reviewed on an annual basis as part of the Trust Board business cycle. The Committee will provide an annual report on its activities to the Trust Board as part of this review.

The annual report will as a minimum report on the Committee's compliance with the reporting arrangements detailed above.

The functioning of the Committee may be assessed within the normal annual cycle of reporting by the Audit Committee through the internal and external auditors and external regulatory bodies.

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 21

25 January 2017

Purpose Information Assurance

Title	Quality Committee Update Report (January 2017 and November 2016)
Author	Miss K Ingham, Company Secretarial Assistant
Executive sponsor	Mr P Rowe, Committee Chair

Summary: The report sets out the matters discussed and decisions made at the Quality Committee meetings held on 11 January 2017 and 9 November 2016)

Report linkages

Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do Invest in and develop our workforce Work with key stakeholders to develop effective partnerships Encourage innovation and pathway reform, and deliver best practice
Related to key risks identified on assurance framework	Transformation schemes fail to deliver the clinical strategy, benefits and improvements and the organisation's corporate objectives Recruitment and workforce planning fail to deliver the Trust objectives Collaborative working fails to support delivery of sustainable, safe and effective care through clinical pathways Alignment of partnership organisations and collaborative strategies (Pennine Lancashire and Healthier Lancashire) are not sufficient to support the delivery of sustainable services by the Trust The Trust fails to achieve a sustainable financial position and appropriate continuity of service risk rating. The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously Considered by: NA

Quality Committee Update: 11 January 2017

1. At the last meeting of the Quality Committee held on Wednesday 11 January 2017 members considered the following matters and undertook to ensure actions would be taken as outlined in the report.
2. The Committee received the Serious Incidents Requiring Investigation (SIRI) Report which focused on fluid balance and the improvements that were being made in this area. Members discussed the importance of accurate recording of fluid intake and balance in patients. It was noted that the Trust had a good reputation of developing the understanding of fluid balance within the FY1 and FY2 students that are on placement with the Trust.
3. The Committee received the Corporate Mortality Report and noted the ongoing good work to ensure that mortality indicators remained within the expected range. The Committee also noted the work that was being undertaken to review all patient deaths from peripheral and visceral atherosclerosis. To date there had been no cases identified as being unexpected deaths.
4. The Committee received the End of Life Care update report and noted the good progress that had been made since the last update to the Committee. Members requested that a further update be provided to the Committee in May 2017 with a revised list of priorities. Following discussion amongst the Committee members, it was agreed that a review of the Pennine Lancashire End of Life Group should be initiated with the stakeholders.
5. The Committee received an update in relation to the development of the Workforce Transformation Strategy, together with the overview of the strategy, including the proposed 'plan on a page'. A more detailed paper will be presented to the next Quality Committee meeting (March 2017).
6. The Committee received, discussed and approved the proposed Quality Committee wrokplan for 2017.
7. The Committee also received the Corporate Risk Register, Quality Dashboard, and summary reports from the following meetings:
   a) Health and Safety Committee
   b) Patient Experience Committee
   c) Internal Safeguarding Board
   d) Infection Prevention and Control Committee
   e) Patient Safety and Risk Assurance Committee
   f) Clinical Effectiveness Committee

Quality Committee Update: 9 November 2016

8. At the meeting of the Quality Committee held on Wednesday 9 November 2016 members considered the following matters and undertook to ensure actions would be taken as outlined in the report.

9. The Committee received the draft Medicines Strategy and were asked to provide comments and feedback to Mr Fletcher, Clinical Director for Pharmacy Services. The draft strategy outlined the seven principles for change required to ensure the delivery of the safe and effective use of medicines. The final strategy will be presented to the Committee in the March 2017.

10. The Committee received a verbal update in relation to the development of the winter resilience plan and the final version will be presented to the Trust Board in November 2016.

11. The Committee received a presentation from the Assistant Director of Nursing for Corporate Services regarding the Nursing Assessment and Performance Framework and the process for achieving Safe, Personal and Effective Care Ward Status. Committee members recognised the importance of the work carried out by the small team and discussed the possibilities of expanding the capacity of the team to carry out an increased number of assessments.

12. The Committee received the Annual Complaints Report and noted the overall reduction in the number of complaints received over the course of the year and a reduction in those complaints being referred to the Ombudsman. Members noted that there were far fewer complaints relating to the attitudes of staff than in previous years, but that complaints relating to 'all aspects of clinical care' had increased.

13. The Committee were presented with the Organ Donation Annual Report and were pleased to note the work that had been carried out with the Asian communities within the area to raise awareness of organ donation. The Committee also noted the difficulties that were experienced in relation to undertaking awareness raising events due to the staffing capacity within the team.

14. The Committee also received the Serious Incidents Requiring Investigation report, Corporate Risk Register, Quality Dashboard and the summary reports from the following sub-committees:

    a) Infection Prevention and Control Committee
    b) Health and Safety Committee
    c) Patient Experience Committee

d) Clinical Effectiveness Committee

Kea Ingham, Company Secretarial Assistant, 17 November 2016

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 22

25 January 2017

Purpose Information Assurance

Title	Audit Committee Update Report (December 2016)
Author	Miss K Ingham, Company Secretarial Assistant
Executive sponsor	Mrs E Sedgley, Non-Executive Director

Summary: The report sets out the matters discussed and decisions made at the Audit Committee meeting held on 7 December 2016.

Report linkages

Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do Invest in and develop our workforce Work with key stakeholders to develop effective partnerships Encourage innovation and pathway reform, and deliver best practice
Related to key risks identified on assurance framework	Transformation schemes fail to deliver the clinical strategy, benefits and improvements and the organisation's corporate objectives Recruitment and workforce planning fail to deliver the Trust objectives Collaborative working fails to support delivery of sustainable, safe and effective care through clinical pathways Alignment of partnership organisations and collaborative strategies (Pennine Lancashire and Healthier Lancashire) are not sufficient to support the delivery of sustainable services by the Trust The Trust fails to achieve a sustainable financial position and appropriate continuity of service risk rating. The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously Considered by: NA

Audit Committee Update: December 2016

1. At the meeting of the Audit Committee held on Wednesday 7 December 2016 members considered the following matters:
2. The Committee received the management responses in relation to the internal audit reports relating to:
    a. cyber security,
    b. service continuity and
    c. consultant job planning
3. The following internal audit reports were presented to the Committee:
    a. IT Service Continuity (limited assurance, see point 2b above)
    b. Nursing and Midwifery Revalidation (high assurance)
    c. Safely Releasing Costs Programme (significant assurance)
    d. Transformational Schemes (significant assurance)
    e. Absence Management (significant assurance)
4. The Committee received the audit opinion and annual report of East Lancashire Financial Services (ELFS) Shared Service report. It was agreed that the Finance and Performance Committee should receive the report for information before the end of the financial year. Members noted that discussions had commenced with ELFS in relation to the provision of assurance. It is anticipated that the majority of assurance related issues can be addressed through the quarterly contracting meetings.
5. The Committee received the Counter Fraud Service progress report and noted the progress being made in relation to the referrals and investigations that were currently underway.
6. The Committee received the closing report in relation to the work undertaken jointly with the Good Governance Institute to improve corporate governance. It was highlighted only one action from over 70 agreed at the beginning of the process has not been completed and it has not commenced due to the lack of resources in this area. It was confirmed that the Trust will consider this matter in the future should resources become available.
7. The Committee received the review of the Trusts Standing Orders and Standing Financial Instructions for discussion and agreement prior to presentation at the January Trust Board for formal approval. Both documents were discussed by the Committee and both were approved for presentation to Trust Board. In relation to the Standing Financial Instructions Mr Barnes, Non-Executive Director commented that the document did not include any mention of the inclusion of Non-Executive Directors in the recruitment process for Executive level posts within the Trust. He suggested

that there should be mention of the formal process that this undertaken in relation to the appointment to such posts. It was agreed that Mr Moynes would be asked to present the current policy for recruitment to the Remuneration Committee with a view to include information about the process in the policy, if it is not already included.

8. The Committee also received the External Audit Progress Plan and Losses and Special Payments Report, the proposed self-assessment of the Committee's effectiveness and proposed future meeting dates.

Kea Ingham, Company Secretarial Assistant, 13 January 2017

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 23

25 January 2017

Purpose Information Assurance

Title	Remuneration Committee Information Report (November 2016)
Author	Ms H Cannon, Personal Assistant
Executive sponsor	Professor E Fairhurst, Chairman

Summary: The list of matters discussed at the last Remuneration Committee is presented for Board members' information.

Recommendation: This paper is brought to the Committee for information.

Report linkages

Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do Invest in and develop our workforce Work with key stakeholders to develop effective partnerships Encourage innovation and pathway reform, and deliver best practice
Related to key risks identified on assurance framework	Transformation schemes fail to deliver the clinical strategy, benefits and improvements and the organisation's corporate objectives Recruitment and workforce planning fail to deliver the Trust objectives Collaborative working fails to support delivery of sustainable, safe and effective care through clinical pathways Alignment of partnership organisations and collaborative strategies (Pennine Lancashire and Healthier Lancashire) are not sufficient to support the delivery of sustainable services by the Trust The Trust fails to achieve a sustainable financial position and appropriate continuity of service risk rating. The Trust fails to earn significant autonomy and

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Equality	No	Confidentiality	No

Previously considered by: N/A

Remuneration Committee Information Report: 30 November 2016

1. At the last meeting of the Remuneration Committee held on Wednesday 30 November 2016 members considered the following matters:
   a) Acting Director of Operations Arrangements
   b) Voting Executive Member of the Board

Hansa Cannon, Personal Assistant, 13 January 2017

East Lancashire Hospitals NHS Trust

TRUST BOARD REPORT

Item 24

25 January 2017

Purpose Information

Title	Trust Board Part Two Information Report
Author	Ms H Cannon, Personal Assistant
Executive sponsor	Professor E Fairhurst, Chairman

Summary: The report details the agenda items discussed in Part 2 of the Board meetings held in November 2016

As requested by the Board it can be confirmed that, in preparing this report the external context has been taken into account, such as regulatory requirements placed on NHS providers. Other elements such as local needs, trends and engagement with stakeholders would not be applicable in this instance.

Report linkages

Related strategic aim and corporate objective	Put safety and quality at the heart of everything we do Invest in and develop our workforce Work with key stakeholders to develop effective partnerships Encourage innovation and pathway reform, and deliver best practice
Related to key risks identified on assurance framework	Transformation schemes fail to deliver the clinical strategy, benefits and improvements and the organisation's corporate objectives Recruitment and workforce planning fail to deliver the Trust objectives Collaborative working fails to support delivery of sustainable, safe and effective care through clinical pathways Alignment of partnership organisations and collaborative strategies (Pennine Lancashire and Healthier Lancashire) are not sufficient to support the delivery of sustainable services by the Trust The Trust fails to achieve a sustainable financial position and appropriate continuity of service risk rating.

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Equality	No	Confidentiality	No

Previously Considered by: n/a

Trust Board Part Two Information Report: 30 November 2016

2. At the meeting of the Trust Board on 30 November 2016, the following matters were discussed in private:

   a) NHS Improvement/NHS England State of the NHS Address
   b) Sustainability and Transformation Plan
   c) Business Planning Submission 2017/18 and 2018/19
   d) Agency Spend
   e) Sustaining Safe, Personal and Effective Care 2016/17 Update Report
   f) Sustaining Safe, Personal and Effective Care 2016/17 Themed Discussion: Family Care and Childrens Services
   g) Trust Specific Communication Strategy (Healthier Lancashire Specific)
   h) Procurement Transformation Plan
   i) Emergency Care Winter Resilience Plan 2016/17
   j) Accident and Emergency Delivery Board Update
   k) Finance Report
   l) Financial Plan and Contracting Offer
   m) Serious Untoward Incident Report
   n) Coronor's Inquest Update
   o) Doctors with Restrictions

3. The matters discussed were private and confidential and/or identified individuals and/or were commercially sensitive at this time and so the decision was taken that these items should not be discussed in the public domain. As these items progress, reports will be presented to Part 1 of Board Meetings at the appropriate time.

Hansa Cannon, Personal Assistant, 13 January 2017