The Princess Alexandra Hospital NHS Trust

AGENDA
Public meeting of the Board of Directors

Date and time: Thursday 2 February 2023 at 09.30 – 13.00
Venue: Kao Park Boardroom

	Item	Subject	Action	Lead	
01 Opening administration					
09.30	1.1	Apologies	-	Chair	
	1.2	Declarations of Interest	-	Chair	
	1.3	Minutes from previous meeting	Approve	Chair	4
	1.4	Matters arising and action log	Review	All	16
09.35	**Staff Story: The role of the Professional Nurse/ Midwifery Advocate**				
02 Chair and Chief Executive's reports					
10.00	2.1	Chair's report	Inform	Chair	17
10.05	2.2	CEO's report including: • COVID-19 update • ICS/ICB update	Inform	Chief executive	20
03 Risk					
10.20	3.1	Significant risk register	Review	Medical director	25
10.30	3.2	Board assurance framework 2022-23 *Diligent Resources: PAHT Board Assurance Framework 2022/23*	Review/ Approve	Head of corporate affairs	32
04 Patients					
10.35	4.1	Report from Quality and Safety Committee 27.01.23: • Part I • Part II – Maternity Oversight	Assure	Committee Chairs	36 41
10.45	4.2	Maternity: • Maternity Incentive Scheme Year 4 Final Report and Evidence Submission • SI report (November data) • Q2 Perinatal Mortality Review Report (PMRT) (quarterly) • Maternity Assurance Report	Approve	Chief nurse/ Director of midwifery	44 72 78 83
11.00	BREAK 1100-1110				
11.10	4.3	Nursing, midwifery and care staff levels including nurse recruitment	Assure	Chief nurse	93
11.20	4.4	Nursing establishment review	Approve	Chief nurse	101
11.30	4.5	New visiting arrangements	Assure	Chief nurse	115

11.40	4.6	Learning from deaths (Mortality)	Assure	Medical director	122
05 People					
11.50	5.1	Report from People Committee 23.01.23	Assure	Committee Chair	125
11.55	5.2	Freedom to speak up report	Assure	Director of people	130
06 Performance/pounds					
12.00	6.1	Report from Performance and Finance Committee 26.01.23	Assure	Chair of Committee	136
12.05	6.2	Finance update	Assure	Director of finance	142
12.15	6.3	Integrated performance report	Discuss	Chief Information Officer	150
07 Strategy/Governance					
12.25	7.1	Report from Strategic Transformation Committee 30.01.23	Assure	Chair of Committee	205
12.30	7.2	Report from Senior Management Team Meetings	Assure	Chair of Committee	208
12.35	7.3	Corporate Trustee: The Princess Alexandra Hospital Charity strategy 2023 - 2028	Approve	Director of people	209
12.45	7.4	PAHT Governance Manual	Approve	Director of Finance/ Head of Corporate Affairs	233
08 Questions from the public					
	8.1	Opportunity for members of the public to ask questions about the board discussions or have a question answered.			
09 Closing administration					
	9.1	Summary of actions and decisions	-	Chair/All	
	9.2	New risks and issues Identified	Discuss	All	
	9.3	Any other business	Review	All	
	9.4	Reflection on meeting *(Is the Board content that patient safety and quality has been considered and there was evidence of good governance)*	Discuss	All	
13.00		Close			

Date of next meeting: 2 March 2023

The Princess Alexandra Hospital NHS Trust

Purpose:

The purpose of the Trust Board is to govern the organisation effectively and in doing so to build public and stakeholder confidence that their health and healthcare is in safe hands and ensure that the Trust is providing safe, high quality, patient-centred care. It determines strategy and monitors performance of the Trust, ensuring it meets its statutory obligations and provides the best possible service to patients, within the resources available.

Quoracy:

One third of voting members, to include at least one Executive and one Non-Executive (excluding the Chair). Each member shall have one vote and in the event of votes being equal, the Chairman shall have the casting vote.

Ground Rules for Meetings:

1. The purpose of the meeting should be defined on the day (set the contract).
2. Papers should be taken as read.
3. The purpose of a paper must be clearly explained and the decision/s to be made must be identified.
4. Members/attendees are encouraged to ask questions rather than make statements and are reminded that when attending meetings, it is important to be courteous and respect freedom to speak, disagree or remain silent. Behaviour in meetings should be in line with the Trust's Behaviour Charter.
5. Challenge should be constructive and a way of testing the robustness of information.
6. Members/attendees are encouraged to support the Chair of the meeting to ensure the meeting runs to time.
7. The use of mobile phones during meetings should be avoided; phones must be set to silent.
8. If the duration of a meeting is likely to exceed 2 hours a break should be taken at a convenient point.

Board Membership and Attendance 2022/23			
Non-Executive Director Members of the Board (voting)		**Executive Members of the Board (voting)**	
Title	**Name**	**Title**	**Name**
Trust Chair	Hattie Llewelyn-Davies	Chief Executive	Lance McCarthy
Vice Chair	Helen Glenister	Director of Nursing & Midwifery and Deputy CEO	Sharon McNally
Non-executive director	George Wood	Chief Operating Officer	Stephanie Lawton
Non-executive director	Colin McCready	Medical Director	Fay Gilder
Non-executive director	Helen Howe	Interim Director of Finance	Tom Burton
Non-executive director	Darshana Bawa	**Executive Members of the Board (non-voting)**	
Associate Non-executive director	Dr. John Keddie	Director of Strategy	Michael Meredith
Associate Non-executive director	Anne Wafula-Strike	Director of People	Gech Emeadi
Associate Non-executive director	Dr. Rob Gerlis	Director of Quality Improvement	Jim McLeish
Associate Non-executive director	Elizabeth Baker	Chief Information Officer	Phil Holland
Corporate Secretariat			
Head of Corporate Affairs	Heather Schultz	Board & Committee Secretary	Lynne Marriott

The Princess Alexandra Hospital NHS
NHS Trust

Minutes of the Trust Board Meeting in Public at Kao Park
Thursday 1 December 2022 from 09:30 to 12:30

Present:	
Hattie Llewelyn-Davis	**Trust Chair (TC)**
Liz Baker (non-voting)	Associate Non-Executive Director (ANED-LB)
Darshana Bawa	Non-Executive Director (NED-DB)
Tom Burton	Director of Finance (DoF)
Ogechi Emeadi (non-voting)	Director of People (DoP)
Rob Gerlis (non-voting)	Associate Non-Executive Director (ANED-RG)
Fay Gilder	Medical Director (MD)
Helen Glenister	Non-Executive Director (NED-HG)
Phil Holland	Chief Information Officer (CIO)
Helen Howe	Non-Executive Director (NED-HH)
John Keddie (non-voting)	Associate Non-Executive Director (ANED JK)
Stephanie Lawton	Chief Operating Officer (COO)
Lance McCarthy	Chief Executive Officer (CEO)
Colin McCready	Non-Executive Director (NED-CM)
Jim McLeish (non-voting)	Director of Quality Improvement (DoQI)
Sharon McNally	Chief Nurse (CN)
Michael Meredith (non-voting)	Director of Strategy (DoS)
Anne Wafula-Strike (non-voting)	Associate Non-Executive Director (ANED-AWS)
George Wood	Non-Executive Director (NED-GW)
In attendance:	
Giuseppe Labriola	Director of Midwifery (DoM)
Laura Warren	Associate Director – Communications (AD-C)
Patient Story:	
Shahid Sardar	Associate Director – Patient Engagement
Emma Harnett	Patient and Macmillan Primary Care Education Lead
Louise Edwards	Head of Cancer Nursing
Cyril Cleary	Patient Panel Member/UCH Cancer Patient Group Lead
Ann Nutt	Chair of Patient Panel
Members of the Public	
Ann Nutt	Chair of Patient Panel
Holly Howlett	Associate Director Operations – Surgery Division
Hannah Milne	NHS Graduate Trainee
Taseen Ahmed	Assistant Service Manager - FAWS
Apologies:	
(None)	
Secretariat:	
Heather Schultz	Head of Corporate Affairs (HoCA)
Lynne Marriott	Board & Committee Secretary (B&CS)

01 OPENING ADMINISTRATION	
1.1	The TC welcomed all to the meeting, particularly those present for the Patient Story. Board members introduced themselves.
1.1 Apologies	
1.2	Apologies were noted as above.
1.2 Declarations of Interest	
1.3	No declarations of interest were made.
1.3 Minutes of Previous Meeting	
1.4	These were agreed as a true and accurate record of that meeting with the following amendments:

	Minute 2.5 The organisation's Infection Prevention & Control (IPC) team was working ~~overtime~~ above and beyond to look at any potential changes to the rules in terms of supporting patient flow and in terms of ongoing transmissions for colleagues. Minute 4.1 Ambulance Handover: The Committee had felt assured about the safety of patients in relation to ~~long waits~~ ambulance handovers. It agreed however that the overall patient experience was impacted by those waits. Minute 4.11 This minute should read as follows: The DoN&M added that whilst there was no longer a national target for CoC, the model remained best practice and the organisation would continue to focus on CoC, with those that were the most vulnerable service users and those at highest risk, being a priority.
1.4 Matters Arising and Action Log	
1.5	There were no matters arising. <u>TB1.06.10.22/27 - Provide the Board with a future update on the community DNACPR concern</u> The Medical Director (MD) was able to update verbally that there was a huge amount of work underway in the community (for example via the End of Life Forum) and this was a focus/priority. She reported that there was not a target date for completion. The TC asked whether this provided assurance. In response Non-Executive Director Helen Howe (NED-HH) stated that the question had been raised by her and she was assured by the response.
Patient Story:	
1.6	The Chief Nurse (CN) introduced the item and welcomed the OSAAT (One Step At A Time) team. She immediately informed Board members that the team had recently won 'RCN Team of the Year' for their collaborative work across Primary Care and she congratulated all those involved.
1.7	The CN then reminded colleagues of a Patient Story in 2018 (Ben's Story) where a young father had spoken about the impact of his cancer diagnosis, particularly in terms of sharing that information with his family and specifically his young son. The OSAAT team had taken that experience and focussed on how that could be improved. She handed over to the team.
1.8	Members were informed that OSAAT had started as a series of helpful and informative videos and literature advising patients on the cancer journey from a patient/carer viewpoint. It was the work of Emma Harnett Patient and Macmillan Primary Care Education Lead (EH), a former cancer patient herself, Ann Nutt Chair of the Patient Panel (CoPP) and Shahid Sardar Associate Director for Patient Engagement (AD-PE), all of whom were passionate about supporting the cancer journey.
1.9	The team had formed in 2020, just before COVID hit, but had now grown beyond its original goal of being a cancer information service. In September 2021 it had held its first cancer conference in Harlow which had been attended by over 100 participants who were either cancer patients, loved ones of patients or those working in the field of cancer. Following the event participants were given an opportunity to provide their comments and address anything relating to cancer that was important to them. This feedback had been developed into an action plan that would shape the future of the cancer journey in West Essex.
1.10	EH then spoke about the fact that cancer information was somewhat fragmented and confusing. OSAAT had set out to change that by producing information in a creative, non-clinical format. But it was not just about how information was provided, it was about the future of the nursing workforce and multi-disciplinary innovation. In terms of her own experience she spoke about how she had accepted a role as Macmillan Primary Care Nurse Facilitator with WECCG which had been an opportunity to improve cancer education and cancer pathways in West Essex. Just seven days after commencing the job she was faced with her own cancer

	diagnosis and the anguish of telling her own family and friends. Returning to the role in January 2020 had given her a new perspective and A chance meeting with CoPP/AD-PE had then been pivotal.
1.11	The Head of Cancer Nursing (HoCN) then informed Board members that she had become involved with the work based on the evidence from the National Cancer Patient Experience Survey (NCPES) which had evidenced poor performance in terms of provision of patient information for cancer.
1.12	The CoPP confirmed that the outputs of the work were evidence of co-production by the team.
1.13	The AD-PE confirmed that Ben's story had driven this programme of work and work would continue to find the right language for patients to share this type of diagnosis.
1.14	In response to the above the Director of Quality Improvement (DoQI) congratulated the team on their amazing work. He asked whether any universities had reached out in terms of including the work in their communications about cancer. In response EH confirmed there had been an opportunity to link with Anglia Ruskin University and share the learning with them.
1.15	Associate NED Anne Wafula-Strike (ANED-AWS) then referenced the fact that due to the work of the team, cancer information was published in the five most common languages used in the UK. She asked whether there were plans to provide cancer information by sign language. In response the AD-PE confirmed there were pockets of good practice in the organisation and sign language was used in Paediatrics but he agreed there was an opportunity now to widen that to other areas. Work was already underway in the ICS to reach vulnerable groups and address health inequalities.
1.16	ANED-AWS then asked whether a different form of text could be used for those who were visually impaired. In response Cyril Cleary Patient Panel Member/UCH Cancer Patient Group Lead (CC) confirmed that was easily done and in the pipeline. 'Zoom' also provided the function of reactive text or subtitles for those with learning disabilities or for those who were visually impaired.
1.17	NED George Wood (NED-GW) then flagged the importance of a patient having someone with them at the time of diagnosis and also the importance of diet and exercise. In response members were informed that the team had links to a local charity which had joined forces with Park Run and it had also just established its own 'Harlow 5K Away' for cancer patients. The HoCN confirmed that patients were encouraged to have someone with them at diagnosis.
1.18	At this point the Director of Finance (DoF) asked whether the team had plans to introduce their work into other hospitals. In response it was confirmed the work had already been shared with Mid & South Essex and the Cancer Alliance. The team took time outside of their roles to share the work locally and across the ICB/other ICBs.
1.19	The Director of People (DoP) then asked if the work could be mirrored in other specialties. In response the team confirmed it absolutely could and the opportunities for that were endless.
1.20	ANED Rob Gerlis (ANED-RG) asked whether the work could make some inroads into the misconceptions around hospice use, and that it was not just there for the end of patient's life. In response the Board was informed that work needed to be done around advanced care planning and needed to be talked through much earlier on in the patient journey. St Clare Hospice had very recently indicated they were very keen to work with the team which would support that. NED-Helen Glenister (ANED –HG) congratulated the team for continuing during COVID and commented that this was a good example of the NHS working with the Charity Sector to deliver benefits to patients.
1.21	The CEO congratulated the team for all their hard work and success with their award. He agreed there was a huge opportunity now to expand the work and he offered the Board's support for anything that was required going forward.
1.22	NED-HH highlighted that it would be important for clinicians to continue to be trained in breaking bad news and to sign-post patients to the team and their work. In response it was confirmed that Clinical Nurse Specialists were experts in having difficult conversations and they sat with the consultant during the consultation and then with the patient afterwards. .

1.23	The CEO then commented this was a great example of talking about place and working differently with multi-disciplinary agencies. It was supporting the local population by working differently and his view was there now needed to be some different thinking about place from a governance perspective.
1.24	As a final point NED Darshana Bawa commented that the work was truly inspirational and she congratulated the team on all that they had achieved.
02 Chair and Chief Executive Reports	
2.1 Chair's Report	
2.1	The TC introduced her report and the paper was taken as read. She highlighted that she had tried to make the update more informative by including the visits undertaken by the NEDs to different areas of the Trust. The next iteration of the paper would provide the actions arising from those visits.
2.2	In response to the above NED-GW asked whether the visits should now be expanded to include Community and other patient services. The TC agreed that it could and she would add that to the list.
ACTION **TB1.01.12.22/30**	**Visits to Community Services and other external areas to be added to the Chair's Update.** **Lead: Trust Chair**
2.3	NED- HG commented that there were visits that happened outside of the Chair/NED visits which should be noted. The TC agreed and highlighted the example of the visits to Maternity by NED-HG/DoP as Maternity Safety Champions.
2.4	The TC agreed to take away the point about local community services.
2.2 CEO's Report	
2.5	This update was presented by the CEO and the key headlines were as follows: • **Urgent and Emergency Care**: The Trust had made strong and sustained improvements against the conditions on its licence through the Section 31 notice and would be writing formally to CQC colleagues in the next day or so to ask for the removal of the conditions. • **Political developments nationally:** The Chancellor had presented his autumn statement which had seen the announcement of an additional £3.3bn being given to the NHS in each of the next two financial years. The statement had also announced additional funding into social care of £2.3bn next year and £4.8bn the following year. In addition, former labour health secretary, Patricia Hewitt, had been asked to review the role and powers of Integrated Care Systems across the country. She would report in to the SoS and the Trust would feed local PAHT/West Essex Health and Care Partnership views into that review. • **General Medical Council (GMC) Enhanced Monitoring:** The organisation had been placed in enhanced monitoring due to concerns that for some doctors-in- training in some specialties, the organisation was not meeting some of the GMC's requirements for training. The Trust was in regular contact with HEE to update them on the progress was being made. • **Industrial Action:** There would not be any strike action from RCN colleagues at PAHT as neither of the two required ballot thresholds had been met. • **Other Headlines:** Andrew Bramidge had been appointed as the new substantive CEO of Harlow Council. Colleagues looked forward to working with Andrew and his team together with the Leader of the Council/other key councillors to support the regeneration of Harlow and reduction of health inequalities across local communities.
2.6	The CEO then handed over to the Chief Operating Officer (COO) to provide an update on winter. The COO then presented key headlines as follows: **Summary of works completed:** As part of the preparation for winter, senior colleagues had agreed a series of ward moves/change of use of some clinical areas to ensure the bed capacity available best met the elective and non-elective activity demands on the hospital. That included therapy services utilising the day room and conservatory area on Gibberd Ward freeing up space in the main hospital building. Plans to create a larger discharge

	lounge for patients, creating space for daily hot clinics to free up capacity in SDEC and co-locating adult and children's UTC thus allowing adult emergency care to reoccupy the clinical decisions unit space. Additional winter funding had been received to support the opening and staffing of 17 beds on Nightingale Ward and four additional spaces on Opal Unit.
2.7	**Site Management and Overview:** A review of the daily patient placement meetings, agenda, format and information required had also been completed. Work to develop a real time bed system using NerveCentre was currently being progressed.
2.8	**Acute Assessment Unit:** To enable assessment capacity to be maintained, all ward areas were supporting the early identification of discharges and patients who could be transferred safely to the discharge lounge. The proposal was to move the discharge lounge into one of the vacated spaces in the main building to develop a "departure lounge" for all patients leaving the hospital. This was planned to be in the vacated space from the therapy gym and minor works would be required.
2.9	**Same Day Emergency Care (SDEC) Capacity:** The conversion rate from the SDEC unit was 1-2 patients per day, and based on their LoS it was not believed there was much scope for a reduction in either the number or the LoS. Many patients who were suitable for SDEC but remained in ED were managed through the non-admitted pathway and did not convert to an admission. Therefore, increasing SDEC capacity would reduce crowding in ED. There had already been a pilot study on the use of AAU and SDEC and early signs of improvement noted.
2.10	In terms of work externally, Strategic Control Centres (SCCs) had gone live in each ICS. Most were virtual but their aim was to coordinate activities across an ICS starting with early intervention to support activity and to then look at elective flow and pressures and how to support patients in an ICS. The second area of work was the implementation of ambulance handover protocols. For acute organisations, when handover extended over four hours, a clear protocol and safety measures were now in place for that.
2.11	In summary the COO reported there were a number of systems and processes being worked through to support demand for both emergency and elective services over the winter period. As those developed and became operational, further updates would be provided.
2.12	ANED-RG asked whether the request to remove the section 31 notice was a risk considering the winter demands at the front door. In response the CEO stated that the notice related to specific conditions on the hospital's licence. Teams had worked very hard to improve care and it was believed the time was now right for the CQC to review that notice. There were pressures in wider parts of the system which were impacting on flow through the ED but the CQC were supportive of the Trust's request to now review the conditions on its licence. The key concerns had been around documentation, triage and risk assessments and his view would be that significant inroads had been made into all of those areas now. .
2.13	The CN added that in terms of the 'safe' domain, Urgent and Emergency Care CQC rating was 'inadequate' and given the improvements made against the conditions placed on the Trust's licence, the view was that this rating had improved.
2.14	In response to a question then from NED-GW around the impact of ambulance strike action on the Trust, the COO confirmed the impact would be managed through the SCCs and the CEO noted that planning for industrial action indicated that urgent and emergency care services would not be impacted. In terms of nursing strike action the COO felt the biggest impact would be in terms of community services provided by Herts Community Trust.
2.15	ANED-AWS then asked for more detail around the provision of 140 additional beds. The COO was able to update that the ask was for 140 beds to be available across the system; the Trust had identified 17 beds on Nightingale Ward and four on Opal.
2.16	In response to a second question from ANED-AWS around support for people with heating during winter, the CEO confirmed there were many actions underway in the community to support vulnerable people. Heating was a community care responsibility but the Trust was working with community colleagues around supporting discharge and getting patients' homes ready for that.

2.17	NED-HG then asked whether the SCCs would also coordinate the discharge process with Social Care. In response the COO confirmed that pathway was being reviewed, not forgetting West Essex also had a Care Coordination Centre.
2.18	In response to a question from NED-HH the DoQI was able to provide assurance that the virtual hospital was part of the organisation's transformation plan. An additional 40 bed spaces would become available over winter increasing to 60 in March and 106 by Christmas 2023. Pharmacy input into that work was currently underway.
2.19	The TC summarised by stating there was assurance on the many actions in place around winter and the Board would look forward to hearing future updates on their impact.
03 RISK/STRATEGY	
3.1 Significant Risk Register (SRR)	
3.1	This update was presented by the Medical Director (MD) who updated there were four new risks scoring 15 (where the risk score had increased) as follows: 1) Haematology staffing impacting the service 2) 24/7 endoscopy service required for JAG accreditation 3) Two-stage consent for surgery and 4) Medical gas training required for porters.
3.2	NED Darshana Bawa (NED-DB) asked for further detail around the risk in maternity related to cross-border working. The Director of Midwifery (DoM) was able to update that there had now been two meetings with ENH Trust. A review of the data was being undertaken and the plan would be to see whether PAHT moved into East Hertfordshire/north of the patch so it could provide care for the whole pathway. The new DoM for ENHT had started the previous week and he would be meeting with her the following week to discuss.
3.3	NED-DB then flagged some of the risks had been on the SRR a long time. The MD provided assurance that the process was to review risks quarterly in the divisions and a review also took place at the Risk Management Group (RMG). The risks were being moved from RiskAssure onto Datix and part of that process would include a robust review of each risk.
3.4	The TC thanked the MD for her update and commented that the paper was becoming much easier to read.
3.2 Board Assurance Framework (BAF) 2022/23	
3.5	This update was presented by the Head of Corporate Affairs (HoCA). Following discussions at Board in October 2022 it was proposed to add a new risk to the Trust's BAF related to resilience during Winter. The risk had been scored at 12 under the patient safety domain, had been discussed at PAF and recommended to Board for approval. .
3.6	She continued that risk 3.2 had been updated with the risk description revised to reflect the impact of system pressures on PAHT and the score remained at 16. It was recommended that this risk be reviewed at Strategic Transformation Committee going forward. The remaining risk scores had not changed that month.
3.7	In line with the recommendation the Board approved new risk around winter resilience and associated scoring and also the rewording of risk 3.2.
04 PATIENTS	
4.1 Reports from Quality & Safety Committee (QSC)	
4.1	Report from QSC.25.11.22 The Committee Chair NED-HG updated that the Trust had not received recent standardised mortality ratios due to a backlog of coding caused by vacancies in coding roles. However assurance had been provided on the plans in place to address that, and work was progressing well. In terms of the August Patient Story the Committee had been assured that there had been both patient and clinical learning and learning to inform the organisation's complaints processes which would be overseen by the Patient Experience Group and reported back to the Committee. QSC had been pleased to receive a draft of the Mental Health Strategy.
4.2	QSC2.25.11.22 (Maternity Oversight) The Committee Chair ANED-RG informed members there had been a robust discussion on the East Kent Hospitals' Report and in particular the requirements for trusts/trust boards

	going forward. The red flags for midwifery staffing continued but strategies were in place to address that and an update was provided in terms of the risk around Maternity Incentive Scheme (MIS) safety action 1. The service was commended for its work to date on improvements related to the Maternity Safety & Support Programme and discussions were beginning around its exit from that.
Break 10:53 – 11:00	
The Director of Midwifery (DoM) came to the table for the following two items.	
4.2 Maternity Updates	
4.3	The CN introduced the item and welcomed the DoM to the meeting. . The papers presented in this section had all been presented previously to Quality & Safety Committee Part II (Maternity Oversight). She handed over to the DoM who updated as per below.
4.4	Q2 Maternity Assurance Report Maternity recruitment was ongoing and good progress was being made with the Maternity Improvement Board (MIB) providing oversight. There had been 23 new joiners which had made a huge impact on rosters. An assurance visit by the ICB was completed in September by the Regional team highlighting positive improvements in the maternity service. Maternity currently had six SIs under investigation. In terms of the Maternity Incentive Scheme (MIS), he was pleased to update there were no longer concerns around safety action 2, but there were now concerns around safety action 1 (Perinatal Mortality Review Tool) and the organisation's input into the national system. The CIO updated that colleagues were working with the current EHR supplier who had agreed to support where they could but the organisation was now out of formal contract with them. The MIS would require Board sign-off in January prior to submission in February.
4.5	The TC summarised by stating that the risks around safety action 1 were noted and would be overseen by QSC (Part II).
4.6	Q1 PMRT Update The DoM informed members that the report updated on the details of the deaths reviewed and the associated action plans. Reviews were under by a multi-disciplinary team with ICS input.
4.7	The TC summarised by confirming the Board was content to note the update.
4.8	Serious Incident (SI) Report The DoM informed members there had been no SIs since the previous report, themes remained the same and there was full oversight of SIs by the MIB and local work-streams.
4.9	The TC summarised by confirming the Board noted the report and the positive position in terms of new no SIs.
4.10	East Kent Hospitals' Report The CN reminded colleagues' that the report had been discussed at November Board's private session but there was a requirement for that now to brought into the public domain bearing in mind its significant impact and what it would mean for maternity services nationally and in terms of trust board responsibilities.
4.11	The report highlighted several underlying issues which had contributed to the cases of avoidable harm it considered, many of which had also been identified in other public enquiries into maternity care. Those were failures of team working, failures in professionalism, failures of compassion, failures to listen, failures after safety incidents and failures in the Trust's response, including at Trust Board level. Another recurring theme highlighted was the failure at a regulatory level to identify those problems, and once identified, to take action to address them.
4.12	The report had also identified four key areas where action was needed to improve patient safety, with accompanying recommendations: Monitoring safe performance (finding signals among noise), standards of clinical behaviour (technical care was not enough), flawed team working (pulling in different directions) and organisational behaviour (looking good while doing badly). She handed over to the DoM.

4.13	The DoM continued that the report had been a distressing read for those accessing care and also for staff providing care. Some listening events had been held and regionally the local LMNS was working on a gap analysis in terms of the findings/recommendations. A single delivery plan for maternity services would be published the following year and the Trust would be able to contribute in terms of what would be included in that. The focus locally would be around improving the culture in the service.
4.14	The CN then commented it would be useful for the Board to reflect on culture and compassion, how the patient voice was being heard, and openness/transparency. There was a significant amount of work already underway around that (Safety & Quality Strategy/Sage & Thyme training) but it would be useful to start the discussion that day and take the Board's thoughts forward to a Board Development session in the new year.
4.15	The MD stated her view would be the themes mirrored those from the Mid Staffs Report. For her, colleagues should take time to consider whether they were comfort-seeking when staff raised concerns to them or problem sensing.
4.16	ANED-RG asked whether staff morale and a tired workforce could have contributed to the failings.
4.17	The DoS flagged that the organisation's/Board's response to staff raising concerns was key. It was about listening rather than apportioning blame in order to develop a culture of transparency.
4.18	The DoQI highlighted that the report highlighted that assurance had been taken from metrics/bench-marking which did not address the underlying issues. His observation therefore would be the Board needed to understand how it was going to measure improvements going forward.
4.19	At this point NED-HH noted that the Board should focus on the 'problem sensing' issues; areas where there was limited progress.
4.20	In response to the above the CEO commented that all the current work around organisational culture should be recognised. Culture was one of the Trust's key priorities and the work had started a good while ago with the values work and now linked to the new on-boarding process. The work around leadership and PAHT2030 should also be recognised but he acknowledged there was still more to do. His view would be that triangulation of information was key. .
4.21	Reflecting on the point made above by ANED-RG, the CEO noted that poor behaviours were not acceptable regardless of pressures and should always be addressed. . He emphasised the PAHT Board did not tolerate poor behaviour and where that existed, it would always be addressed.
4.22	The CN thanked colleagues for the robust discussion above. She summarised some areas that could be discussed further in a development session: - Progression of the Trust's digital strategy and provision of more data/intelligence - How patient feedback and complaints could be used going forward - Hearing the patient voice and being a truly learning organisation.
4.23	In response to the above NED-HG commented it was often difficult to gauge improvements in culture but she very much welcomed that the behaviours in all areas of the organisation would be challenged. The CEO commented there were no real clear KPIs for culture; reliance would be placed on external benchmarking. It linked back to the point around triangulation of data/intelligence and having the headspace to have those conversations.
4.24	The TC thanked colleagues for the update/discussion and agreed there was work to do for herself, the HoCA and CN to draft an agenda for the Board Development session.
ACTION **TB1.01.12.22/31**	**Draft an agenda for a Board Development session in the new year (date to be determined).** **Lead: Trust Chair/Chief Nurse/Head of Corporate Affairs**
4.25	As a final point the DoM flagged that having external colleagues on QSC (Part II) supported the Trust/Board with 'reading the signals'
4.26	The TC stated it would be useful to have a session on culture.
ACTION **TB1.01.12.22/32**	**Undertake a Board Development session around culture.** **Lead: Director of People**

4.27	The TC reiterated there were now some threads to be pulled together for Board Development sessions in the coming year.
4.3 Nursing Midwifery and Care Staff Levels including Nurse Recruitment	
4.28	This update was presented by the CN who informed members that the paper had also been discussed at the People Committee (PC). There had already been some discussion around the section 31 notice and she also drew members' attention to the fact that nursing fill rates in the ED had been dropping off between August and October. Fill rates for night shifts were more consistent, however it was noted that the day shifts fill rate will not capture those additional staff (specialist nurses, matrons, leadership team) who worked a proportion of their day on a shift.
4.29	The Trust continued to support staffing through redeployment of staff to meet acuity and dependency. The data did not capture the moves of bank or agency staff; (including multi post holders) and also excluded were Maternity Wards and the Enhanced Care Team. The accuracy of reports continued to be dependent on the wards and site team redeploying staff, capturing and recording those moves in real-time on e-Roster/SafeCare systems. Whilst essential to ensure safe staffing across the Trust, the impact on moving substantive staff was acknowledged to impact on staff satisfaction and retention rates and therefore was monitored closely to minimise that. The CN informed the Board that a focused piece of work was underway to review the redeployment model.
4.4 Learning from Deaths Update	
4.30	The MD introduced the paper and confirmed the item had been discussed under item 4.1 (QSC Report to Board). In terms of the new mortality outlier – Lymphadenitis – this had related to one patient and the case had been reviewed and it had been agreed there had been a coding error and amended so the organisation was no longer an outlier. She was pleased to report that May data was nearly fully coded at 98.6% so an update on mortality rates should be available for the January Board meeting.
05 PEOPLE	
5.1 Report from People Committee (PC)	
5.1	**Guardian of Safer Working Hours Report**: For the reporting period July to September 2022, 113 exception reports (ERs) had been submitted. PC had been assured around the processes and actions in place to address the issues and the positive culture towards exception reporting was noted. **GMC Enhanced Monitoring Process:** The Committee received assurance on progress being made in relation to the GMC enhanced monitoring process. Support was being received from the GMC/HEE. SMT would receive updates on progress against the action plan. **PAHT2030 Culture Milestones**: PC noted the significant improvement in relation to the six culture related KLOEs. ***This Is Me at PAHT***: The Committee approved the revised approach to performance management (appraisals) - *This is Me @ PAHT*. Changes included a cascade approach, increased frequency of performance conversations and manager accountability for team culture and performance.
5.2	Industrial action and the EDI Annual Report were also discussed.
5.3	In relation to *This Is Me*, the CEO commented that key element of this was the cascade of objectives through the organisation. By definition that started with the Board and ensuring he and his Executive colleagues all had an appraisal and that feedback followed from those.
5.4	The TC commented that she would consider whether *This Is Me* could be adjusted to work for NED colleagues.
ACTION **TB1.01.12.22/33**	**Consider whether '*This Is Me*' could be applied to NED appraisals.** **Lead: Trust Chair**
5.5	As a final point the DoP highlighted there had also been a conversation around quality delivery systems in 2022, how people and patients were treated but from an equity viewpoint

	rather than an equality viewpoint. What was meant by equity was looking at best outcomes for groups and making an individual-based assessment. An EDI strategy was being developed and had been noted at PC (Equity@PAHT).
5.2/5.3 Workforce Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES)	
5.6	This update was presented by the DoP. She clarified that WRES/WDES data came from the electronic staff record (ESR) and the outcomes of the last Staff Survey. From that there had been engagement with the staff networks/Equality Steering Group to establish an action plan.
5.7	In terms of WDES she informed members that there was low reporting in terms of staff declaring a disability. So there was work to do around that which had started (on neuro-diversity) and the TC had put the team in touch with organisations to work with. There was also now a statutory requirement to have statutory/mandatory training on neuro-diversity.
5.8	In terms of WRES, there had been investment in the staff network REACH (Race Equality and Cultural Heritage) and inclusive recruitment training had launched in the organisation and was being very well received.
5.9	At this point the CEO highlighted the improvements being made in terms of WRES, underpinned by the work around culture which was currently underway. He agreed however there was more to do. In terms of WDES Board members were encouraged to declare a disability so that the wider conversation around supporting staff with that could happen.
5.10	The TC summarised by confirming that the Board had noted the two papers and members were encouraged to declare if they had a disability.
5.2 Equality Diversity Inclusion Annual Report	
5.11	This paper was presented by the DoP who informed colleagues the report provided assurance to the Board on the Trust's progress in relation to Equality & Inclusion under the Equality Act 2010.
5.12	The CN commented that she had reflected on the paper in terms of promotional opportunities internally. She was hearing that often colleagues had to leave an organisation to gain a promotion if they were from a BAME background. She asked whether there was any Trust data on that.
5.13	In response the DoP confirmed there was nursing data on that and that had been provided. From what she had seen the position was slowing improving but it linked back to the visibility of roles and opportunities to be developed. The CN then requested that the data start to be tracked for BAME colleagues
ACTION TB1.01.12.22/34	**Track the position in terms of BAME staff and reasons for leaving. Lead: Director of People**
06 PERFORMANCE/POUNDS	
6.1 Report from Performance & Finance Committee (PAF)	
6.1	This update was presented by NED-CM as Chair of PAF. He updated that the M7 position had improved with a large portion of that improvement due to addressing the costs that had been causing the over-run (outsourcing/agency). The Committee had discussed the challenging forecast position which the organisation would struggle to achieve and conversations around that were currently underway with the system. The CIP position was encouraging but the majority of schemes would be non-recurrent. The Moorhouse work currently underway would be looking to support efficiency programmes and behaviours. In summary there was lots more still to do but the organisation was moving in the right direction.
6.2	In response to the above NED-HH asked whether in terms of CIPs, ideas for sustainable change were now slipping as the majority of the schemes were non-recurrent. In response NED-CM confirmed the Moorhouse work would support exactly that in terms of driving recurrent savings and efficiencies.
6.3	The CC summarised by stating that the Board noted the update.
6.2 Finance Update	

6.4	This update was provided by the DoF. The Trust reported a deficit of £0.3m in month 7 and £11.5m Year-to-Date. The anticipated year end forecast was being discussed with regulators; to date a breakeven position had been reported. The financial position in month 7 had started to evidence the actions to reduce and slow down the run rate including the higher levels of expenditure relating to Elective recovery including outsourcing and insourcing and Estates maintenance costs. .
6.5	Some of the drivers of the current position had been discussed. In terms of the elective recovery fund (ERF) this had been set up to incentivise elective recovery. Largely the Trust had achieved the required position but that had come at premium cost (insourcing/outsourcing). As indicated above the Moorhouse work should support recovery of the position.
6.6	The TC summarised by confirming that the Board had noted the position.
6.3 M8 Integrated Performance Report (IPR)	
6.7	This paper was presented by the CIO. He informed members that patient falls had now gone into positive special cause variation which was good news and aligned to the establishment of an organisational falls strategy.
6.8	Performance against the Cancer 2 Week Wait trajectory had dipped in September but improved in October. He drew members' attention to the improvements in the dermatology pathway.
6.9	As a final point he highlighted that the aim for the following month was for the report to contain no acronyms.
6.10	The COO then added that the organisation had no patients waiting over 104 weeks. A piece of work was underway to triangulate the position in terms of referrals, capacity and individual tumour site performance. In terms of elective recovery the organisation's Orthopaedic Lead would be taking the team to Exeter to look at best practice there.
07 STRATEGY/GOVERNANCE	
7.1 Report from Strategic Transformation Committee (STC)	
7.1	This report was presented by ANED Liz Baker (ANED-LB) as Acting Chair of STC. She updated that in terms of PAHT2030, the Committee had agreed an extension to the deadline for completion of all clinical strategies to March 2023 (due to pressures on clinicians' time). The Pathology FBC had been endorsed for Board approval and it was agreed an annual Committee Effectiveness Review would take place in January which would include the focus of the Committee going forward and frequency of meetings.
7.2 Report from Senior Management Team (SMT)	
7.2	The CEO presented this update which detailed the items discussed at the previous two meetings. Members had no comments.
08 QUESTIONS FROM THE PUBLIC	
8.1	The CoPP asked whether the movement of some services to Gibberd Ward was a temporary or permanent measure. In response the COO confirmed it was both, depending on the service. In response to a second question she confirmed that new signage was currently being discussed. The DoS was able to provide assurance that due to a new strategy for this, it was now relatively cost effective to print updates to current signage.
8.2	The CoPP then raised concerns around ambulance handover and the associated protocol. In response the COO was able to provide assurance this was addressed via the daily sitrep, patient placement meetings and patient harm reviews and was a discussion item at the UEC divisional board meeting.
8.3	In response to a final question from the CoPP in relation to communications around the Patient @ Home service, the DoQI was able to confirm that a detailed communication strategy was being developed and colleagues were currently in conversation with the current

	service provider. Some engagement had already taken place with patients and the Patient Panel along with Commissioners and posters were planned.
09 CLOSING ADMINISTRATION	
9.1 Summary of Actions and Decisions	
9.1	These are noted in the shaded boxes above.
9.2 New Issues/Risks	
9.2	It was noted that the new risk around Winter Resilience would now be added to the BAF.
9.3 Any Other Business (AOB)	
9.3	The DoQI updated members that in relation to the Virtual Hospital, the next stage would be a formal consultation with the Patient @ Home team which would begin the following week to develop a new model of care. This would result in the transfer of services out to the community. In response to a question from the MD, it was confirmed there were separate services in West Essex/Hertfordshire.
9.4	The CN was pleased to inform colleagues that a second non-medical consultant had started, and an ED nurse consultant had started the previous week.
9.5	In response to a question from NED-HG it was confirmed that the work around culture/behaviour would be included in the Helen Nellis work.
9.6	As a final point ANED-LB updated that she had attended a recent meeting of the Harlow Growth Board. The Trust was involved in their work and it was a particularly exciting time given the appointment of a new CEO for Harlow Council.
9.7	The TC thanked colleagues for their input that day and the meeting closed at 12:08.
9.4 Reflections on Meeting	
9.8	It was agreed that the Trust's values had been kept at the forefront of discussions that day.

Signed as a correct record of the meeting:	
Date:	02.02.23
Signature:	
Name:	Hattie Llewelyn-Davies
Title:	Trust Chair

ACTION LOG: Trust Board (Public) 02.02.23

The Princess Alexandra Hospital NHS Trust

Action Ref	Theme	Action	Lead(s)	Due By	Commentary	Status
TB1.06.10.22/20	Staff Story: "Asiya's Story"	Consider sharing the Staff Story with the ICS.	TC	TB1.02.02.23	TC meeting with ICS Chair on 02.02.23 to discuss the suggestion.	Open
TB1.01.12.22/30	Chair's Report	Visits to Community Services and other external areas to be added to the Chair's Update.	TC	TB1.02.02.23	To be addressed at item 2.1.	Proposed for closure
TB1.01.12.22/31	Board Development: Learning from East Kent Hospitals' Report	Draft an agenda for a Board Development session in the new year (date to be determined).	TC CN HoCA	TB2.06.07.23	To run in July in conjunction with the session around Culture.	Open
TB1.01.12.22/32	Culture	Undertake a Board Development session around culture.	DoP	TB2.06.07.23	Item not yet due.	Open
TB1.01.12.22/33	NED Appraisals	Consider whether '*This Is Me'* could be applied to NED appraisals.	TC	TB1.02.02.23	The NED annual appraisal process is set out by NHSE on a national basis. However, where possible the values of the '*This is Me'* process will be used throughout the appraisal process this year.	Proposed for closure
TB1.01.12.22/34	BAME Staff Progression	Track the position in terms of BAME staff and reasons for leaving.	DoP	TB1.02.02.23	BAME staff and reason for leaving will be included in reports to the EDI Steering Group on a quarterly basis.	Proposed for closure

The Princess Alexandra Hospital NHS Trust

2.1

Public Meeting of the Board of Directors 2nd February 2023

Agenda item:	2.1								
Presented by:	Hattie Llewelyn-Davies - Trust Chair								
Prepared by:	Hattie Llewelyn-Davies – Trust Chair								
Date prepared:	25th January 2023								
Subject / title:	Chair's Report								
Purpose:	**Approval**		**Decision**		**Information**	**X**	**Assurance**		
Key issues:	To inform the Board and other colleagues about my work; to increase knowledge of the role; to evidence accountability for what I do.								
Recommendation:	The Board is asked to note the report.								
Trust strategic objectives: please indicate which of the five Ps is relevant to the subject of the report	**Patients**	**People**	**Performance**	**Places**	**Pounds**				

Previously considered by:	Not applicable.
Risk / links with the BAF:	
Legislation, regulatory, equality, diversity and dignity implications:	As the NED EDI Champion this continues to guide my work in all the areas noted below.
Appendices:	None

modern • integrated • outstanding

patient at heart • everyday excellence • creative collaboration

1.0 Purpose/issue

This report outlines what is at the top of my agenda and what I have been doing in the last few months. The aim of the report is to make my role as Chair more accountable to my colleagues and more transparent for our partners and local population.

2.0 Succession Planning for Non-Executive Members and Board Development

I am pleased to report to the Board that Anne Wafula Strike has been appointed for a further year as an associate NED. We have begun the process to extend Helen Howe for a further year as a NED.

We are out to advert for a new NED to replace the completely irreplaceable Helen Glenister. We will complete the recruitment process in early March, but if there is a gap before the new NED starts I will chair the Part 1 of the Quality and Safety Committee. Board members ar encouraged to tell anyone who fits the person specification about the recruitment process. We are not using head-hunters on this occasion to see how successful we can be doing it in-house, which if successful will save money in form of their fees.

We have now completed the six month review of the effectiveness of the Strategic Transformation Committee and as a result I am stepping down from being the chair of this committee and Liz Baker will take this over. My thanks to our executive colleagues for their hard work in making this committee develop a useful role so quickly.

The Board had a very successful development day in January facilitated for us by Helen Nellis. As a result of which we are developing a Board Good Practice Charter to guide our work going forward. Once drafted this will come back to the board to approve.

3.0 External Work

On behalf of the NHS Disabled Directors Network, I organised a training course on mentoring for members of the Network. I was delighted that Anne joined the training. We now have a pool of trained mentors we will offer mentoring for any aspiring or newly appointed disabled Director, whether they are a NED or Executive member.

I have taken on a new chair mentee, who is the chair in an acute Trust in the Midlands, as part of the new NHSE scheme providing mentors for newly appointed NEDs and Chairs.

I continue to play an active role in NHS Providers.

On a more local level in addition to the regular meetings of the ICB Chairs, I went to visit our colleagues in Essex Partnership University Trust (EPUT just before Christmas.

I have joined the Members Remuneration Panel for Harlow Council at the Council's request.

4.0 Staff Welfare and Resilience:

One of the issues most concerning to the Board at present is the impact of the issues in relation to the cost of living on our people and our local population. We are developing new services to support our people all the time. I would welcome any ideas from staff about additional things we might do.

The NEDs continue to do regular visits, both as individuals and teams. Actions identified are being addressed through the Trust's quality governance structure.

5.0 The System

I delighted that the ICB Chair and CEO are coming to meet the Board after the Public Board meeting.

The Board is asked to discuss the report, give feedback and note it.

Author: Hattie Llewelyn-Davies - Trust Chair
Date: 25th January 2023

The Princess Alexandra Hospital NHS Trust

2.2

Trust Board (Public) – 2 February 2023

Agenda item:	2.2							
Presented by:	Lance McCarthy - CEO							
Prepared by:	Lance McCarthy - CEO							
Date prepared:	27 January 2023							
Subject / title:	CEO Update							
Purpose:	**Approval**		**Decision**		**Information**	x	**Assurance**	
Key issues: please don't expand this cell; additional information should be included in the main body of the report	This report updates the Board on key issues since the last public meeting: - COVID-19, recovery, vaccination and Urgent and Emergency Care - Winter - EHR FBC - ICS wide pathology procurement - Nitrous Oxide in maternity - Industrial Action risk - Other key headlines / developments for noting							
Recommendation:	The Trust Board is asked to note the CEO report and the progress made on key items.							

Trust strategic objectives: please indicate which of the five Ps is relevant to the subject of the report	**Patients**	**People**	**Performance**	**Places**	**Pounds**
	x	x	x	x	x

Previously considered by:	n/a
Risk / links with the BAF:	CEO report links with all the BAF risks
Legislation, regulatory, equality, diversity and dignity implications:	COVID-19 item - regular clinical reviews of all patients waiting for elective care are undertaken to reprioritise if required and address any potential E&D impact caused by long waits. HCP health inequalities focus supporting EDI.
Appendices:	None

Chief Executive's Report
Trust Board: Part I – 2 February 2023

This report provides an update since the last Board meeting on the key issues facing the Trust.

(1) COVID-19, recovery, vaccination and Urgent and Emergency Care

1.1 COVID-19 Recovery

The number of new COVID positive patients cared for by the Trust increased, as expected, from the middle of December. Over the last 6 weeks, there have been an average of 39 new COVID-positive patients in the hospital every week, with 49 the highest weekly number during this period. At the time of writing this report we had 57 confirmed COVID-positive patient sin the hospital.

We are continuing to work closely with place-based and system colleagues to maximise every opportunity for our longest waiting and most urgent patients to receive the interventions they require in a timely manner, and we are continuing to make strong progress in recovering all of our elective services.

More detail is available in the Integrated Performance Report.

1.2 Flu vaccinations

Our local flu vaccination programme has been running for a couple of months and all colleagues are encouraged to seriously consider having the vaccination. There has been a good uptake.

The number of new 'flu infections increased at the end of December and in to January but has since fallen and at the time of writing this report we had 1 confirmed 'flu patient being cared for in out ITU.

1.3 Urgent and Emergency Care

We continue to see high and sustained demand for our urgent and emergency care (UEC) services. The current challenges in primary care locally, and the challenges that we have as a system with accessing suitable community and social care capacity is putting considerable strain on our Emergency Department and our ability to have as effective and strong flow of patients in to, through and out of the hospital as we would like. This is also causing pressure and backlogs for ambulance waits. Performance against the national standards can also be seen in the Integrated Performance Report.

We continue to make strong and sustained improvements against the conditions on our licence through the CQC Section 31 notice for UEC. Following our formal request to CQC colleagues to ask for the notice to be removed in early December, we have had a number of discussions with CQC colleagues about the next steps. We are awaiting for confirmation of what these will be, aligning with the CQC's new inspection framework and regime.

(2) Winter

Following the previous Board discussions in October and December and winter events and workshops run through the organisation in November, we have implemented all the additional winter initiatives as planned.

These include, amongst many other changes:

- Enhanced model of triage in ED and increased streaming
- Further enhanced use of the Urgent Treatment Centre for appropriate patients
- Reduced ED management of patients and reduced inpatient admissions through greater use of SDEC
- More timely specialty decision making in ED
- Enhanced frailty assessment
- Improved timely daily decision making on inpatient wards to support timely discharge
- Implementation of a continuous flow model from ED to AAU to IP wards
- Expanded use of virtual ward capacity in conjunction with community services colleagues
- Enhanced discussions and decisions for patients no longer meeting the criteria to reside

In addition, there have been a number of wider place and system developments across the health and care system in addition including:

- Use of the HARIS model to support the appropriate reduction in ambulance conveyances
- Expanded number of care packages
- Greater community and social care availability

We have had an enhanced focus on ambulance handover times and on supporting effective and timely discharge and the implementation of the virtual hospital models in Essex and Hertfordshire are starting to support the more effective placement of patients in the most appropriate care setting for their need. As you can see from the IPR, approximately 1/3rd of our ambulances are currently waiting for more than 60 minutes to be offloaded, with approximately 1/3rd between 30 and 60 minutes.

(3) Electronic Health Record Full Business Case (FBC)

I am delighted to formally announce that our EHR FBC was approved by the NHS England Frontline Digitisation EPR Investment Board (EPRIB) on January 18th.

Following a robust review of the business case the EPRIB unanimously approved it. We have subsequently received the letter confirming this decision.

This now enables us to complete our negotiations to agree a contract with Oracle to implement the Cerner Millennium electronic patient record. We will commence detailed preparation and planning shortly, with implementation activities to commence in early summer. We intend to go live across the organisation in the autumn of 2024.

This is a key plank of our Digital strategy, one of our 5 strategic priorities to the delivery of PAHT 2030, and will transform how we capture patient information and data and how we integrate it, enabling us to transform many of our processes to improve the efficiency and effectiveness of our clinical colleagues and speedier decision making for the benefit of our patients.

(4) ICS wide pathology procurement

Following December Board approval of the Full Business Case in December for outsourced pathology services across the ICS, I can confirm that the other 2 acute Trust Boards and in the Integrated Care Board have also now approved the FBC.

A contract with the third-party supplier will be signed by all contracting authorities in February, enabling the commencement of a 9-month mobilisation period. It is expected that services will transfer in late 2023.

(5) Entonox / Nitrous Oxide use in maternity

Following atmospheric testing throughout our maternity unit, we discovered high levels of residual nitrous oxide (gas and air) in a number of locations in our maternity unit on 19 January.

Following discussions with clinical and engineering colleagues we took the difficult decision to temporarily suspend the use of nitrous oxide across the unit to protect and midwifery and medical teams from prolonged exposure. This has been discussed with all staff and support from the Staff Health and Wellbeing team is being provided to colleagues should they want it.

The clinical risk to our women and their babies is low and the full range of other pain relief options are available, with our team are discussing with them on an individual basis.

We have determined a permanent solution to fix the problem of residual high levels which will be in place from the end of February and a temporary solution for a number of birthing rooms which will be in place from the week beginning 6 February. From this we will be able to re-offer nitrous oxide as a form of pain relief for our women.

(6) Industrial Action

As Board members will be aware, most unions, with healthcare workers as members, have either balloted their members or are in the process of balloting their members over industrial action as part of their ongoing disputes with the government over remuneration and pay awards for NHS colleagues.

Locally, the majority of the unions' ballots of PAHT colleagues have not met eligibility to proportion threshold so no PAHT colleagues have yet undertaken strike action.

However, across the country we have seen a number of strikes of nursing, paramedic and AHP colleagues which have impacted on the ability to provide normal full services in many organisations. In the run up to and on strike days themselves, we provide enhanced oversight and command and control incident management structures to minimise any impact from other strikes on our patients, and we will continue to work in partnership with local and regional union representatives to minimise the risk to patients of any potential industrial action from any of the other unions currently balloting their members.

(7) Other key headlines / developments for noting

Other key items of note for the Trust Board include:

- Hattie, myself, Sharon and Steph welcomed Sir Keir Starmer and Angela Rayner to the Trust on 27 January. It was an opportunity for us to talk through the current local, place and system pressures we face, the need for a new hospital and how health and care is developing in Harlow and West Essex. Sir Keir and Angela walked the urgent and emergency care pathway, spending time talking to colleagues and patients in ED and SDEC, before spending time with our EEAST colleagues at Harlow Ambulance Station.

- The NHS planning guidance for 2023/24 was released on 23 December, outlining the high levels plans and expectation for the service over the coming 12 months. A range of more detailed guidance is expected over future weeks, but the headlines / three key areas of focus:
  - Recovering core services and productivity – improving ambulance waits and A&E waiting times; reducing elective waits and cancer backlogs; improving performance against the diagnostic standard; making it easier to access primary care

- Making progress in the delivery of the NHS Long-Term Plan – improving mental health and Learning Disability services; reducing health inequalities; better management of long-term conditions
- Transforming the NHS for the future – increasing the sustainability of the workforce; levelling up the digital infrastructure

Our performance, planning, finance, workforce and clinical teams are working together to produce an integrated realistic plan for submission before the end of March and working with other colleagues across the ICS to enable a coherent system plan to be developed and submitted.

Author: **Lance McCarthy, Chief Executive**
Date: **27 January 2023**

The Princess Alexandra Hospital NHS Trust

3.1

TRUST BOARD
2 FEBRUARY 2023

Agenda item:	3.1
Presented by:	Fay Gilder – Medical Director
Prepared by:	Lisa Flack – Compliance and Clinical Effectiveness Manager Sheila O'Sullivan – Associate Director of Quality Governance
Date prepared:	25 January 2023
Subject / title:	Significant Risk Register

Purpose:	**Approval**		**Decision**		**Information**	√	**Assurance**	√

Key issues:

This paper presents the significant risk register (SRR) for all our services. The significant risk register (SRR) is a snapshot of risks across the Trust and was taken from registers on 4 and 24.1.23.23. This paper includes all items scoring 15 and above.

The overall number of significant risks on the register has reduced to 73, a reduction of 2 from the last paper (table 1 and section 2). With a reduction from 13 to 11 risks scoring 20

The main themes for the 11 risks scoring 20 on the SRR are:

- Seven are our performance risks – five risks covering Emergency department (ED), three for access standards (one has increased score), one new regarding an internal professional standard and new risk for overcrowding when ED is busy. Two further regarding access standards for referrals to treatment and cancer-waiting times, unchanged during 2022.
- One new risk against our patients: regarding patient discharge medication information sent to GPs.
- Two long term risks for our places - regarding refurbishment of the maternity unit and the pharmacy aseptic unit.
- One for our people - consultant cover in obstetrics, unchanged.

Actions and mitigations for each risk are detailed in section three.

One new risk scoring 16 raised since 4.1.23 is:

- medical staffing in acute admission unit

Recommendation: Trust board are asked to review the contents of the significant risk register.

Trust strategic objectives: please indicate which of the five Ps is relevant to the subject of the report	**Patients**	**People**	**Performance**	**Places**	**Pounds**
	√	√	√	√	√

Previously considered by:	Senior Management Team January 2023
	Divisions and corporate teams review their risks at their local governance meetings. Teams escalate new risks and those that they require assistance with for discussion at Risk Management Group on a monthly basis.
Risk / links with the BAF:	There is crossover for the risks detailed in this paper and on the BAF
Legislation, regulatory, equality, diversity and dignity implications:	Management of risk is a legal and statutory obligation. This paper has been written with due consideration to equality, diversity and inclusion.
Appendices:	Nil

The Princess Alexandra Hospital NHS Trust

1.0 Introduction

This paper details the significant risk register (SRR) across the Trust; the registers were taken from the web-based Risk Assure system on 4.1.2023 and reviewed on both Datix and Risk Assure on 24.1.23. The Trust Risk Management Group meets monthly and reviews risks across the Trust, including significant risks.

Each areas risk register is reviewed on rotation at the Risk Management Group according to the annual work plan (AWP).

2.0 Context

The significant risk register (SRR) is a snapshot of risks across the Trust at a specific point and includes all items scoring 15 and above. The risk score is arrived at using a 5 x 5 matrix of consequence x likelihood, with the highest risk scoring 25.

There are 73 significant risks on the risk register, a decrease of two from the paper discussed in November at Risk Management Group and Senior Management team and December 2022 in Trust Board.

The breakdown by service is detailed is in table 1.

Table 1 – Significant Risks	**Risk Score**				
	15	**16**	**20**	**25**	**Totals**
Covid-19	2 (2)	0 (1)	0 (0)	(0)	**2 (3)**
Cancer & Clinical Support	5 (5)	8 (7)	2 (1)	(0)	**15 (13)**
Communications	0 (0)	0 (0)	0 (0)	0 (0)	**0 (0)**
Estates & Facilities	3 (2)	5 (4)	0 (3)	(0)	**8 (9)**
Finance	0 (0)	0 (1)	0 (0)	0 (0)	**0 (1)**
Health Safety and Resilience	0 (0)	0 (0)	0 (0)	0 (0)	**0 (0)**
Information Data Quality and Business Intelligence	0 (0)	1 (1)	0 (0)	0 (0)	**1 (1)**
Information Governance	1 (0)	0 (0)	0 (0)	0 (0)	**1 (0)**
IM&T	1 (1)	1 (2)	0 (0)	0 (0)	**2 (3)**
Integrated Hospital Discharge Team	0 (0)	0 (0)	0 (0)	0 (0)	**0 (0)**
Learning from deaths	0 (0)	1 (1)	0 (0)	0 (0)	**1 (1)**
Nursing	0 (0)	1 (1)	0 (0)	0 (0)	**1 (1)**
Operational	2 (2)	1 (1)	4 (4)	0 (0)	**7 (7)**
Research, Development & Innovation	0 (0)	0 (1)	0 (0)	0 (0)	**0 (1)**
Workforce - training	2 (1)	0 (0)	0 (0)	0(0)	**2 (1)**
FAWs Child Health	1 (2)	4 (4)	0 (0)	0 (0)	**5 (6)**
FAWs Women's Health	5 (4)	5 (4)	2 (4)	0 (0)	**12 (12)**
Safeguarding Adults	1 (1)	0 (0)	0 (0)	0 (0)	**1 (1)**
Safeguarding Children	0 (0)	1 (1)	0 (0)	0 (0)	**1 (1)**
Medicine	0 (0)	1 (1)	0 (0)	0 (0)	**1 (1)**
Surgery	2 (3)	2 (1)	0 (0)	0 (0)	**4 (4)**
Urgent & Emergency Care	3 (3)	3 (5)	3 (0)	0 (0)	**9 (8)**

Totals	**28 (27)**	**34 (36)**	**11 (12)**	**0 (0)**	**73 (75)**

(The scores from paper presented at RMG/ SMT in November and Trust Board in December 2022 are detailed in brackets)

3.0 Summary of risks scoring 20 and above

There are 11 risks with a score of 20. A summary of these risks and mitigations is below, information taken from divisional risk registers:

3.1 Our Patients risk Trust wide

Score increased: Discharge information sent to GPs regarding patients take home medication

- Cosmic and the electronic prescribing and medication administration system (EPMA) do not interface with one another. In the context of discharge information, two discharge summaries are sent, one from Cosmic (medical treatment) and one from EPMA (medication). This is a manual process. Audits reveal that up to 15% of patients are not having EPMA discharge summaries sent meaning that GPs are not getting up to date medication information and this puts patients at risk.
  Action: a task and finish group is working understanding potential solutions prior to the EHR implementation. Education of ward clerks continue. Discharge summaries from wards are being audited monthly.
  Mitigation: Ward clerk education, continued audit and divisional management of staff groups responsible for this task.

3.2 Our People

3.2.1 Obstetric Consultant cover

- Existing consultant cover achieves 90 hours per week. The national requirement of 98 hours consultant cover is required for units with 4,000-5,000 deliveries per annum. (Allocate risk reference: 2020/10/01, Datix reference: 48, raised in December 2020).
  Action: All consultant job plans have been reviewed and changes made to job descriptions. Four consultant posts are out to advert.
  Mitigations: Consultants on call are required to return to site within 30 minutes when called. A hot week consultant role is in place ensuring there are twice daily ward rounds on labour ward as per Ockenden recommendations.

3.3 Our Performance

Emergency department performance

3.3.1 Three risks regarding achieving the four-hour Emergency Department access Standard:

- Compliance with the statutory 4 hour standard for the Emergency department (ED) (Allocate risk reference: 001/2017 raised April 2014, Datix reference: 85).
- Achieving the standard of patients being in ED for less than 12 hours (Risk reference: 002/2016 raised July 2016).
- **Score increased**: Deliver safe high-quality care when not meeting the national four-hour access standard (Risk reference ED012 raised in July 2016 with score amended in December 2022 due to patients in ED for longer and risks detailed in points 3.3.2 and 3.3.3, all of which are resulting in the trust performance deteriorating).

Actions: Complete the accountability and responsibility grid for roles to provide clarity on roles for staff in charge. Expand the skill base of nursing staff through our training programme, expand consultant presence until 22.00 hours, with use of rapid assessment, triage and adult assessment unit. Continuous review of escalation areas.
Mitigations: Daily monitoring of previous days breaches, numbers & patterns of attendance to facilitate changes to ED pathway and improve performance. ED board rounds daily and daily huddle to review treatment plans and pathways (7 days per week). Internal professional performance standards agreed and implemented. Monitoring of performance against internal professional standards and deviations escalated. East of England escalation process in place to reduce ambulance offload delays.

3.3.2 NEW: Length of wait for patients in ED

- Patients are waiting for longer than 60 minutes (our internal professional standard) to be seen by a doctor in the emergency department. (Risk reference ED-LongWaits-01 raised December 2022**).**
  Action: Appropriate use of the Manchester Triage tool to stream patients to the right place. Review and revision of safety huddles, review of medical staffing allocation to particular areas in ED and rota template.
  Mitigation: Direct speciality referrals, movement of medical staff around the department to address patient with longest waits, use of agency and NHSP staff to cover gaps in rota.

3.3.3 Score increased: Risk of overcrowding in the ED

- Risk of overcrowding during busy periods that is caused by lack of capacity within the department. This could result in delays to patient pathways through the ED and onto wards, experiencing longer time in ED, resulting in poor patient experience. A risk the ED is non-compliant with national operating performance standards (Risk reference ED009 raised in June 2026 and score increased December 2022 as a result of new care standards received from NHSE for ambulance off-load to take place within 60 minutes).
  Action: ED overcrowding electronic action cards for staff to use for guidance, full capacity protocol / business continuity plan amended, looking to develop self-assessment kiosks (planned implementation January 2023), recruitment of additional consultant cover.
  Mitigation: Bronze role as point of escalation for speciality delays and overcrowding issues covering seven days per week.

3.3.4 Cancer access standard

- Not achieving 85% of all patients referred by GP to receive treatment within the cancer 62-day standard (Risk reference: 005/2016 on register since July 2016).
  Actions: Tumour site recovery action plans are monitored and tracked.
  Speciality level recovery plan in place monitored daily, and reviewed at tumour site weekly meeting.
  Mitigations: Revised patient target list (PTL) has granular information for oversight of individual patients on cancer pathway to ensure action detailed weekly by patient on the pathway. Revision of the recovery trajectory set for 22/23.

3.3.5 Referral to treatment constitutional standards

- Risk of 52-week breaches because of the pandemic, pauses to OPD clinics and elective surgical activity. The numbers of patients waiting between 40 to 52 weeks is monitored and tracked by operational teams (Risk reference 006/2017 raised February 2017).
  Action: Refreshed PTL meetings with outpatient bookers attending to escalate relevant cases to divisional teams. Patients booked in order of clinical priority, monitoring of PTL continues weekly, with cancer PTL reviewed daily. Working with STP partners to manage paediatric urology and plan to address longer term service provision underway with Addenbrooke's and E&N Herts.
  Mitigation: Weekly recovery performance meeting with executive directors monitors activity levels to improve utilisation and trajectories planned. Detailed monthly dashboards shared.

3.3 Our Places

3.4.1 Maternity Unit

- The maternity unit requires refurbishment which has been highlighted through external visits as part of the Ockenden assurance assessment, reviews within the maternity incentive scheme and from feedback received from service users (Risk reference: 2022/04/01 raised February 2022).
  Action: Development plan and options appraisal has been shared with SMT.
  Mitigations: Estates and facilities are contacted where individual faults are found to complete necessary repairs.

3.4.2 Pharmacy

- Aseptic unit to produce chemotherapy
  The Trust requires a new aseptic unit to comply with routine screening and lack of capacity to obtain chemotherapy from outside the trust. (Risk reference: Pharm/2014/06 on risk register since December 2014, score increased from 16 to 20 in July 2022).
  Action: Building work is in progress and the planned completion of the new aseptic unit is 31/3/23.
  Mitigation: All quality systems ae now in use with staff training up to date on the processes to use within the aseptic unit and a standard operating procedure (SOP) is in place. Business continuity plans in place to manage potential short-term breakdown of the unit and dedicated staff currently manage the work in this unit.

3.5 Our Pounds: Nil

4.0 One new risk with a score of 16 has been raised since 4.1.2023

4.1 Our People

4.1.1 Acute Medicine

NEW: To have sufficient medical staffing numbers working in the acute medicine department (Risk reference: AcuteOps-10 raised November 2022).
Action: Agency assisted recruitment, identify a consultant to be roster lead and put into job planning, ECIST supported demand and capacity peer review of medical rota, internal demand and capacity review of medical staffing needs.

Mitigation: Explore collaboration with educational partners to have joint clinical & educational posts to attract candidates, offer long lines of work for Agency and NHSP staff, offer recruitment packages.

5.0 One new risk with a score of 15 has been raised since 4.1.2023

5.1 Our People

5.1.1 Acute Admissions unit

- **NEW:** High numbers of nursing vacancies can result in delayed care and treatment and poor patient experience in the acute admission unit (Risk reference AAU281122 raised November 2022).
  Action: Recruitment is ongoing and temporary staff obtained through NHSP offering lines of work.
  Mitigation: Rolling programme of nursing adverts, rota completed to ensure balance of skill mix and appropriate numbers of staff per shift.

6.0 Recommendation

Trust board is asked to review the contents of the significant risk register.

Authors: Lisa Flack – Compliance and clinical effectiveness manager
Sheila O'Sullivan – Associate director of quality governance

The Princess Alexandra Hospital NHS Trust

Trust Board – 2 February 2023

3.2

Agenda item:	3.2
Presented by:	Heather Schultz – Head of Corporate Affairs
Prepared by:	Heather Schultz – Head of Corporate Affairs
Subject / title:	Board Assurance Framework 2022/23

Purpose:	**Approval**		**Decision**		**Information**		**Assurance**	

Key issues:	The Board Assurance Framework (BAF) is presented for review and approval. The risks have been updated with executive leads and reviewed at the relevant committees during January 2023. Updates are reflected in red font. It is proposed to add a new risk to the BAF scoring 20. The risk relates to the GMC enhanced monitoring process and is described as: There is a risk that the GMC/HEE will remove the Trust's doctors in training. This is caused by concerns regarding the quality of their experience, supervision and training. Removal of the doctors will result in the Trust being unable to deliver all of its services. The Medical Director is the executive lead for the risk and the People Committee has oversight of the risk. The risk is attached as Appendix C. The remaining risk scores have not changed this month and are summarised in Appendix B. The full BAF is available in the resources section of Diligent.
Recommendation:	The Board is asked to: - Approve the new risk (BAF risk 2.1 GMC enhanced monitoring process). - Note the updates to the remaining risks.

Trust strategic objectives:	**Patients**	**People**	**Performance**	**Places**	**Pounds**
	x	x	x	x	x

Previously considered by:	STC, QSC, PC and PAF in January 2023.
Risk / links with the BAF:	As attached.
Legislation, regulatory, equality, diversity and dignity implications:	NHS Code of Governance in relation to risk management. The controls and mitigating actions outlined in the risks are designed to support delivery of the Trust's strategic objectives and promote an organisational culture that drives improvements in equality, diversity and inclusion.
Appendices:	Appendix B – BAF dashboard Appendix C – BAF risk 2.1 GMC enhanced monitoring process

Board Assurance Framework Summary 2022.23

Risk Ref. Committee	Risk description	Year- end score (Apr 22)	June 22	August 22	Oct 22	Dec 22	Feb 23	Year-end score (Apr 23)	Trend	Target risk score	Executive lead
	Strategic Objective 1: Our Patients - we will continue to improve the quality of care, outcomes and experiences that we provide **our patients**, integrating care with our partners and reducing health inequity in our local population										
1.0 QSC	COVID-19: Pressures on PAHT and the local healthcare system due to the ongoing management of Covid-19 and the consequent impact on the standard of care delivered.	16	12	12	12	12	12		↔	8	CEO/ DoN&M
1.1 QSC	Variation in outcomes resulting in an adverse impact on clinical quality, safety and patient experience.	16	16	16	16	16	16		↔	12	DoN&M/ MD
1.2 STC	EPR: The current EPR has limited functionality resulting in risks relating to delivery of safe and quality patient care.	16	16	16	16	16	16		↔	12	DoIMT/ CIO
1.3 PAF	Recovery programme: Risk of poor outcomes and patient harm due to long waiting times for treatment.	15* New risk	15	15	15	15	15		↔	10	COO
	Strategic Objective 2: Our People – we will support **our people** to deliver high quality care within a compassionate and inclusive culture that continues to improve how we attract, recruit and retain all our people. Providing all our people with a better experience will be evidenced by improvements in our staff survey results.										
2.1 PC	GMC enhanced monitoring: There is a risk that the GMC/HEE will remove the Trust's doctors in training. This is caused by concerns regarding the quality of their experience, supervision and training. Removal of the doctors will result in the Trust being unable to deliver all of its services.						20 New risk		New risk	10	MD
2.3 PC	Workforce: Inability to recruit, retain and engage our people	16	16	16	16	16	16		↔	8	DoP
	Strategic Objective 3: Our Places – Our Places – we will maintain the safety of and improve the quality and look of **our places** and will work with our partners to develop an OBC for a new hospital, aligned with the further development of our local Integrated Care Partnership.										
3.1 PAF	Estates & Infrastructure: Concerns about potential failure of the Trust's Estate & Infrastructure and consequences for service delivery.	20	20	20	20	20	20		↔	8	DoS
3.2 STC	System pressures: Capacity and capability to deliver long term financial and clinical sustainability at PAHT due to pressures in the wider health and social care system	16	16	16	16	16	16		↔	12	DoS
3.5 STC	New hospital: There is a risk that the new hospital will not be delivered to time and within the available capital funding.	16	16	16	16	16	16		↔	9	DoS
	Strategic Objective 4: Our Performance - we will meet and achieve **our performance** targets, covering national and local operational, quality and workforce indicators										
4.1 PAF	Winter resilience: Risk that the Trust will be unable to sustain and deliver safe, high quality care during the Winter period due to the increased demand on its services.					12 New risk	12		↔	12	COO
4.2 PAF	Failure to achieve ED standard resulting in increased risks to patient safety and poor patient experience.	16	16	16	16	16	16		↔	12	COO
	Strategic Objective 5: Our Pounds – we will manage **our pounds** effectively to ensure that high quality care is provided in a financially sustainable way.										

Board Assurance Framework Summary 2022.23

5.1 PAF	Finance – revenue: Risk that the Trust will fail to meet the financial plan due to the following factors: An indicative annual budget for 22/23 has been established. A deficit plan has been submitted but national, allocations are not yet known and are linked to system envelopes. Expenditure plans have been set to deliver a breakeven requirement inclusive of a CIP requirement, with additional deficit expenditure to reflect the current and forecast additional rising Inflation costs in 22/23.	12	12	12	12	12	12		↔	8	DoF

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2022-23**											
Medium Risk		4-6												
Low Risk		1-3												
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead**	**Key Controls**	**Sources of Assurance**	**Positive/negative assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 2: Our People - we will support our people to deliver high quality care within a within a compassionate and inclusive culture that improves engagement, recruitment and retentio													
BAF 2.1		**GMC enhanced monitoring:** There is a risk that the GMC/HEE will remove the Trust's doctors in training. This is caused by concerns regarding the quality of their experinece, supervision and training. Removal of the doctors will result in the Trust being unable to deliver all of its services.	Causes: i) Medical workforce pressures ii) Lack of protected access to training opportunities iii) Inadequate senior supervision in clinical areas iv) Lack of protected time for consultants to train and supervise v) Poor quality of local induction vi) Insufficient numbers of doctors on rotas in specific specialties vii) Reduction in number of HEE funded training posts viii) Not meeting the basic needs of doctors in training, in terms of out of hours provision of hot food, access to rest space, poor IT and car parking	**5 x4 = 20**	Medical Director People Committee	i) An improvement plan that encompasses the HEE quality domains: patient and trainee safety, governance, staffing rota, escalation of concerns, induction and education/clinical supervision ii) Regular meetings with HEE and GMC iii) Enhanced monitoring oversight group iv) Exception reporting v) Medical Education Committee vi) Medical Education Faculty Fora vii) Individual clinical and educational supervisor/trainee meetings	GMC enhanced monitoring group SMT meetings People Committee Trust Board	i) Reports to SMT, People Committee and Trust Board in November 2022 ii) Monthly update to SMT going forward iii) Bi-monthly update to People Committee	**5x4=20**	Providing enough senior medical support in and out of hours Job planning educational supervision time - new job planning round commencing January 2023 Medical workforce planning - external support requested from HEE - awaiting response Recording all meetings between supervisors and trainees Ensuring all trainees attend local induction prior to commencing work in the service Routinely protect training opportunities for all trainees	None noted.	New risk	**N/A**	**5x2 = 10 December 2024**
			Effects: i) Poor trainee experience ii) Poor patient experience iii) Risk to patient safety iv) Provision of poor quality training v) Negative impact on ability to recruit and attract doctors vi) Reputational damage vii) Withdrawal of doctors in training											

BOARD OF DIRECTORS:	**Trust Board (Public) – 2 February 2023**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Helen Glenister - Committee Chair**			
DATE OF COMMITTEE MEETING:	**27 January 2023**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.1 Infection Prevention & Control Update BAF Risk 1.0 - COVID	Y	Y	N	From December data the key issues to note in terms of organisms were low numbers of C. difficile cases, a reduction in E. Coli and confirmation was provided at the meeting that COVID cases were now reducing. Group A Streptococcus had continued to be a national concern in recent weeks, however, with increased support now in place, paediatric ED attendances had lessened. In terms of the COVID BAF risk, it had been discussed in detail at the Infection Prevention and Control Committee and the recommendation was that the risk score should remain at 12.
2.2 Learning from Deaths Update	Y	Y	Y	Mortality indices were still not available due to the delay in coding patient records. Mortality data for the Trust was expected to be available for February QSC.
2.3 Report from Clinical Effectiveness Group (CEG)	Y	Y	N	Items for escalation were: • **National core diabetes audit:** The Trust was currently not participating in this audit due to software issues so CEG had requested confirmation that local audit was taking place and clarity on the plan to participate in future national diabetes audits. • **Audit participation and learning from audit:**

BOARD OF DIRECTORS:	**Trust Board (Public) – 2 February 2023**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Helen Glenister - Committee Chair**			
DATE OF COMMITTEE MEETING:	**27 January 2023**			

Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
				CEG required assurance that divisional teams were addressing the risk that the organisation could not evidence learning from participation in national audits.
2.4 BAF Risk 1.1 Clinical Outcomes	Y	Y	N	In line with the recommendation it was agreed the risk score should remain at 16.
2.5 Quality Programme Management Office (QPMO) Update	Y	Y	N	Confirmation was provided at the meeting that e-consent would now move to amber with S2 (ED 4 Hr standard) and S3/N (Safeguarding Training) remaining red.
2.6 Quality Improvement and Transformation Update	Y	Y	N	Key highlights were: **Sepsis:** The gap in resource and leadership had impacted on the ability to make change at pace. Recruitment to the post of Sepsis Nurse should now work to mitigate the risk. **Patient Initiated Follow-Up (PIFU):** It was estimated there had been circa 6900 saved appointments since PIFU implementation in February 21. **Triage and Streaming:** Since the introduction of the Manchester Triage System, there had been a marked reduction in the average time to triage. **Assessment Recovery (AAU):** With the exception of one week in January, the team had seen a marked increase in the

BOARD OF DIRECTORS:	**Trust Board (Public) – 2 February 2023**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Helen Glenister - Committee Chair**			
DATE OF COMMITTEE MEETING:	**27 January 2023**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
				number of patients flowing through AAU. Going forward the programme will be reframed as the Patient Quality and Productivity Plan
2.7 Report from Patient Safety Group	Y	N	N	EDI data collection/analysis continued but was currently constrained by the multiple different software systems in use by the Trust. Good news stories included 1) The work around antibiotic stewardship which was improving both indication and duration 2) The excellent work of the Anticoagulation Service compared to peers both regionally and nationally and 3) The 'Making Movement Count' initiative which has recently been launched to encourage patients out of bed.
2.8 Report from Vulnerable People Group (VPG)	Y	Y	N	Key points to note were: • Terms of Reference had been reviewed and aligned to the rolling agenda items. • A task & finish group would be set up to establish clear guidance on when dementia and delirium patient screening should take place. • Safeguarding L3 training compliance would be monitored by the VPG and also Senior Management Team. The expansion of the vulnerable groups from the four currently identified will be considered at the request of QSC.

BOARD OF DIRECTORS:	**Trust Board (Public) – 2 February 2023**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Helen Glenister - Committee Chair**			
DATE OF COMMITTEE MEETING:	**27 January 2023**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.9 Patient Safety & Quality Report	Y	Y	N	Key headlines in-month were: 15 open SIs with no new cases reported, three new legal cases opened and five cases closed, no new property claims, two inquests opened (one closed and one reopened) and evidence of improvements in claims' management noted from the GiRFT report. Clinical audit remained a risk in terms of compliance against national audit and NICE guidance (and had been discussed at CEG, see above item 2.3). In terms of External Alerts 87 were open and agreement with the ICB that quality improvement would focus on three main themes (discharge summaries, primary care to carry out referrals that could be done directly and primary care to follow up (and act on) results of tests that had been ordered in hospital). If that focus was in place then there would be an amnesty on external alerts back to 01.10.22.
3.1 M9 Integrated Performance Report	Y	Y	N	It was noted that despite winter, none of the Patient metrics were showing any particular adverse variation. Post-partum haemorrhage (PPH) would be discussed in QSC (Part II).
3.2 Ambulance Handover Deep Dive	Y	Y	N	QSC noted the report and the steps the division was taking to maintain safety and improve handover processes. The organisation remained in a challenged position in delivering the national target for handover delays but was committed to a number of improvement programmes which would help to

BOARD OF DIRECTORS:	**Trust Board (Public) – 2 February 2023**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Helen Glenister - Committee Chair**			
DATE OF COMMITTEE MEETING:	**27 January 2023**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
				either reduce the overcrowding in the ED to enable physical capacity and workforce capacity, both of which would help to achieve the ambulance handover trajectory. QSC will continue to monitor the patient safety element.
3.3 NHS Blood and Transplant Annual Organ Donation Activity Summary	Y	N	N	This was a good news story which had the following key headlines for the year: 2 consented donors, 5 referrals made, 4 met criteria and no missed opportunities.
				Other agenda items were: • Update from Patient Panel • Horizon Scanning Update

BOARD OF DIRECTORS:	**Trust Board (Public) – 2 February 2023**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality & Safety Committee (Part II)**			
REPORT FROM:	**Rob Gerlis - Committee Chair**			
DATE OF COMMITTEE MEETING:	**27 January 2023**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.1 Maternity Report	Y	N	N	The committee noted that midwifery led births had been affected by intermittent closures of the birthing centre (due to staffing issues). Plans are in place to increase midwifery led births. QSC II received an update on staffing actions and the seven transformation workstreams.
2.2 Maternity Incentive Scheme Year 4 – Final Report and Evidence Submission	Y	Y	N	The committee reviewed the evidence of compliance with each of the ten Safety actions, including non-compliance with Safety Action 1. QSC II approved the submission and recommended the Board endorse the decision.
2.3 Quarterly Maternity Assurance Report (including SIs)	Y	N	N	Assurance was provided in relation to SI's, themes identified, minimum staffing in maternity and training compliance. The report is also on the public Board agenda.
2.4 Q2 Perinatal Mortality Review Report	Y			The report provided information on all deaths of babies at PAHT in Quarter 2 July/August/September 2022 and the review process, findings and actions plans arising from the reviews.

BOARD OF DIRECTORS:	**Trust Board (Public) – 2 February 2023**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality & Safety Committee (Part II)**			
REPORT FROM:	**Rob Gerlis - Committee Chair**			
DATE OF COMMITTEE MEETING:	**27 January 2023**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.5 Saving Babies Lives Quarterly Update	Y	N	N	Assurance was provided that the Maternity Service are continually monitoring compliance with Saving Babies Lives Care Bundle V2.
2.6 Quarterly HSIB Update	Y	N	N	A report on maternity referrals to HSIB for the period 1 April 2021 – 30 November 2022. One referral was received from PAHT in Q1 2022/23 which was rejected due to COVID-19 There have been no further referrals. Two reports have been completed by HSIB for 2022/23 with no recommendations for the organisation. Top recommendations for PAHT are guidance, clinical assessment and clinical oversight in line with national and regional recommendations.

BOARD OF DIRECTORS: Trust Board (Public) – 2 February 2023 **AGENDA ITEM: 4.1**

REPORT TO THE BOARD FROM: Quality & Safety Committee (Part II)

REPORT FROM: Rob Gerlis - Committee Chair

DATE OF COMMITTEE MEETING: 27 January 2023

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
2.7 Maternity and Neonatal Safety Champions' Report	Y	N	N	The regular report was noted. An update on Entonox was noted. Following atmospheric testing throughout the maternity unit, high levels of residual nitrous oxide (gas and air) were discovered on 19 January. A decision was taken to temporarily suspend the use of nitrous oxide across the unit to protect midwifery and medical teams from prolonged exposure. This has been discussed with all staff and support from the Staff Health and Wellbeing team is being provided. The clinical risk to women and their babies is low and other pain relief options are available. A permanent solution is underway with an anticipated date of the beginning of March. A temporary solution which will enable the use of Entonox within some birthing units within 2 – 3 weeks is being scoped. QSC II noted that this is becoming a national issue with oversight at national and regional level.

Trust Board (Public) – 2 February 2023

Agenda item:	4.2
Presented by:	Giuseppe Labriola – Director of Midwifery
Prepared by:	Erin Walters – Head of Maternity Governance and Assurance
Date prepared:	10.01.2023
Subject / title:	Maternity Incentive Scheme Year 4 – Final Report and Evidence Submission

Purpose:	**Approval**	x	**Decision**	x	**Information**	x	**Assurance**	x
Key issues:	This is the fourth year that NHS Resolution are operating the Clinical Negligence Scheme for Trusts (CNST) to support the delivery of safer maternity care. The Trust must demonstrate achievement of all the 10 safety actions to recover the element of the CNST maternity incentive fund contribution. This paper outlines the requirements of the scheme, assurance framework and summarises the evidence of achievement against each standard, including non-compliance with Safety Action 1.							
Recommendation:	It is requested that the Board accepts the report and the evidence that has been submitted to demonstrate compliance with the Ten Maternity Safety Actions and the Trust Board Declaration Form is signed.							

Trust strategic objectives: please indicate which of the five Ps is relevant to the subject of the report	**Patients**	**People**	**Performance**	**Places**	**Pounds**
	x	x	x	x	x

Previously considered by:	QSC2.27.01.23 To be considered at Divisional Board 15.2.23 To be considered at Local Maternity and Neonatal System Programme Board 25.1.23
Risk / links with the BAF:	BAF 1.1
Legislation, regulatory, equality, diversity and dignity implications:	To be compliant with Year 4 of the Maternity Incentive Scheme which was published in August 2021
Appendices:	Appendix 1 – Summary of evidence

1.0 Purpose

This paper outlines the requirements required to achieve the NHS Resolution Maternity Incentive Scheme payment for 2021/22 and provides evidence for each safety action. The Maternity Incentive Scheme requires the Board to declare that they are satisfied with the evidence provided to NHS Resolution and meets the required standards as set out in the guidance. This report provides a summary of the evidence which is required as per Appendix 1.

2.0 Background

This is the fourth year that NHS Resolution are operating the Maternity Incentive Scheme to support the delivery of safer maternity care. Under the Clinical Negligence Scheme for Trusts only trusts that meet all 10 maternity safety actions will be eligible for a partial refund of approximately 10% of their initial contribution. For PAHT this equates to approx. ≥£1.8m minimum.

The maternity service have been working towards achievement of all 2021/22 safety actions and meeting the evidence submission requirements so that the Trust is eligible for the rebate. The Division meet weekly to collate evidence with support from Trust Executives and monthly reporting at Divisional Performance Review Meeting.

Due to the importance of delivering the safety elements for our mothers and babies as well as achieving the rebate the oversight of delivery it is recommended that Quality and Safety Committee (QSC) oversee the delivery programme.

3.0 Analysis

The maternity incentive scheme applies to all acute Trusts that deliver maternity services and are members of the CNST. As in previous years, members contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund. As in year three, the scheme incentivises ten maternity safety actions. Trusts that can demonstrate they have achieved all of the ten safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds.

Year 4 was launched in August 2021 with the required minimal evidential standards updated and distributed in October 2022.

The 10 Safety Actions have not changed since last year's scheme however there has been inclusion of further evidence required.

The 10 maternity safety actions are framed as questions:

Safety action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?

Safety action 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

Safety action 3: Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?

Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?

Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

Safety action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?

Safety action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?

Safety action 8: Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4?

In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, multi-professional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and newborn life support, starting from the launch of MIS year 4?

Safety action 9: Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?

Safety action 10: Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) scheme for 2021/22?

Each question has a required standard and minimal evidential requirement to demonstrate compliance. The document also details an assurance framework with timescales on the evidential standards that require Board sign off. Table 1 provides a summary of our compliance.

Table 1. MIS Progress Yr 4

MIS Progress Yr 4			
SA 1	Non-Compliant – agreed by ICB	SA 6	Signed off by ICB
SA 2	Signed off by ICB	SA 7	Signed off by ICB
SA 3	Signed off by ICB	SA 8	Signed off by ICB
SA 4	Signed off by ICB	SA 9	Signed off by ICB
SA 5	Signed off by ICB	SA 10	Signed off by ICB

Safety Action 1

Evidence
The Perinatal mortality review processes have been embedded within the service since March 2018.

A monthly multi-disciplinary Perinatal Mortality Review Team (PMRT) meeting is held each month at which all cases that meet the criteria are reviewed by a multi-disciplinary panel including external parties from across the LMNS.

The parents are informed the PMRT meeting will take place and feedback is shared with them either via a face to face meeting or at the Sensitive clinic meeting. Parents concerns are sought and these are addressed at the PMRT.

The Trust completed a review and assurance deep dive into our PMRT processes in October 2022. It was at this point, there were identified discrepancies to what had been completed locally and what was documented on the MBRRACE PMRT reporting page. At this time there were 7 reportable cases and although immediate reviews of the care had been undertaken as per the recommended process, this was not submitted within the reported timeframes to the MBRRACE PMRT tool which then reflects to state we are non-compliant. All deaths were reported within the 7 day timescale and all cases have had an MDT review and report generated and published within 6 months of the death. There were a number of mitigating factors during this time period; change in bereavement lead, Trust wide IT issues and the need to prioritise clinical care, all of these situations led to the online system not being updated correctly despite in person reviews being undertaken.

Quarterly reports have continued to be presented at QSC giving details of deaths and associated actions that occurred between the designated timeframes of MIS year 4. This is 100% of deaths that meet the criteria and within the timescale. This is a rolling agenda item and will continue to be presented quarterly.

A panel was held with Executive and ICB colleague oversight on 03rd January 2023 and following review of evidence the Trust will be declaring non-compliance with Safety Action 1.

Recommendation: Standard will not be met

Safety Action 2

Evidence
The Digital Strategy has been completed and was approved by the ICB and LMNS in October 2022. This was also presented to Board as per the requirements of the scheme.

Data was submitted to the Maternity Services Data Set for July 2022 which demonstrated compliance with the associated requirements, the scorecard was received from NHS Digital.

A panel was held with Executive and ICB colleague oversight on 23rd November 2022 and following review of evidence the Trust will be declaring compliance with Safety Action 2.

Recommendation: Standard met

Safety Action 3

Evidence
There is a local policy available which is based on the British Association of Perinatal Medicine principles regarding transitional care which has been coproduced between maternity and neonatal services, this is audited on a monthly basis. All audits are shared within the division, with the Maternal and Neonatal Safety Champions, the LMNS and the ICS. Reviews are undertaken on all unexpected admissions to NICU by a multi-disciplinary team including the Neonatal and Midwifery Governance Leads from the LMNS. The Neonatal Safety Champion is also a key member of the review panel. There is a recording process in place for both long term and short stay admissions to the neonatal unit. Again, this is shared with all relevant parties.
Data is available on transitional care activity via the National BadgerNet System this also includes data for commissioner returns for Healthcare Resource Groups (HRG) activity. An action plan has been developed and approved by Trust Board and the LMNS and shared as per the requirements of the scheme. The Operational Delivery Network have reviewed this within the required timeline. The action plan is available as a separate document. The action plan has been shared with the safety champions and LMNS and discussed at the ICS meetings. Transitional care is now part of the maternity transformation board and a quality improvement project is ongoing – bays D & E on the postnatal ward are now utilised for transitional care and

a workforce model is currently under review. This does not impact on the scheme itself but has been implemented with the aims of strengthening the processes that are already embedded.

A panel was held with Executive and ICB colleague oversight on 03rd January 2023 and following review of evidence the Trust will be declaring compliance with Safety Action 3.

Recommendation: Standard met

Safety Action 4

Evidence
All Obstetric Consultants have agreed to the RCOG document and would attend for any of the situations detailed within the paper. This was approved at the Consultant meeting on 11th March 2022. This is monitored on a monthly basis via the Datix system. Since the start of MIS year 4 there has been one incidence of Consultant non-attendance where required, this has been reviewed within the Division and was due to a miscommunication of the gestational age. There was no harm to the mother or baby as a result of this.

Rotas are available to demonstrate that obstetrics have a dedicated Duty Anaesthetist available 24 hours a day. There are clear lines of communication with a Consultant Anaesthetist should they be required to attend or for advice.

The neonatal unit meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing.

The Neonatal Nursing workforce are currently under template for QIS staffing. This is on the Divisional Risk Register. An action plan has been developed and shared with the ODN, RCN and the LMNS.

A panel was held with Executive and ICB colleague oversight on 03rd January 2023 and following review of evidence the Trust will be declaring compliance with Safety Action 4.

Recommendation: Standard met

Safety Action 5

Evidence
The service has recently had a Birthrate+ assessment undertaken which showed a deficit in staffing. A staffing paper went to Board and was accepted, this is on the work plan for 6 monthly reporting. The service is currently employing >20 registered midwives who are at varying stages in the recruitment process, all will be joining the Trust by January 2023. All vacancies are out to advert with a rolling advert for Band 6 midwives.The service has electronic rosters which shows planned vs actual staffing, this is reviewed on a daily basis by the Staffing Coordinator and the Senior Management Team.
The Labour Ward Coordinator supernumerary status is recorded on the Birthrate Plus tool. This is a live reporting system that shows all red flags and includes escalation, delays in care and supernumerary status including where mitigation is required to maintain supernumerary status. This is reported on a monthly basis to the committee. All women and birthing people have had 1:1 care in labour and Labour Ward Coordinators do not take a caseload. There is a robust escalation plan in place which enables the Labour Ward Coordinator to remain supernumerary.

A panel was held with Executive and ICB colleague oversight on 23rd November 2022 and following review of evidence the Trust will be declaring compliance with Safety Action 5.

Recommendation: Standard met

Safety Action 6

Evidence

The service has fully committed to implementing all elements of Saving Babies Lives Care Bundle v2. This is demonstrated through the compliance as outlined below.

Quarterly reports are submitted to this committee to provide updates against each element and to ensure ongoing oversight. This includes submitting a monthly survey to the National Team. These were paused for part of this year's MIS due to the pandemic but all surveys have been completed and submitted following reinstatement of the National Surveys.

Element 1 – reducing smoking in pregnancy

All women/pregnant people are offered CO monitoring at booking which is recorded on the electronic patient record. Additional screening is offered as appropriate throughout the pregnancy journey with a recorded CO monitoring at 36 weeks gestation.

Women/pregnant people who are identified as smokers are placed on the smoking pathway. This means all smokers are offered further scans at 32, 36, 38-40 weeks gestation and are referred and provided support with smoking cessation throughout their pregnancy.

Audits are ongoing to measure the compliance with CO monitoring currently at ≥80%, compliance level for Trusts is ≥95%. The healthy lifestyle midwife is currently undertaking targeted work with community teams to increase compliance. The service have an action plan in place to further improve the compliance with the aim of reaching the national trajectory of ≥95%. The service can still declare compliance as long as 80% of monitoring is undertaken and an action plan is in place.

All community teams have been allocated their own CO monitors and for heavy smokers individual monitors are being provided for self-testing.

The service also now has a Band 4 stop smoking advisor who will assist the Healthy Lifestyle Midwife in ensuring ongoing compliance and training.

Element 2 – fetal growth restriction

All women/pregnant people have a risk assessment undertaken at the booking appointment to determine their requirement for Aspirin, this is documented both electronically on the patient record and as an integral part of the hand held notes.

Women/pregnant people who have an increased risk of/or previous fetal growth restriction are referred to the Fetal Medicine Consultants and Midwife. As per the local guidance these service users will have serial growth scans undertaken throughout the 3rd semester. Where concerns are noted with fetal growth a plan of care is initiated including induction of labour where indicated as per the care bundle following discussion with the woman/pregnant person. The last audit undertaken demonstrated 98% compliance for service users being on the correct pathway, compliance level for Trusts is ≥95%.

Fetal growth restriction is monitored through the Perinatal Mortality Review Tool and is not currently showing as theme for stillbirths and neonatal deaths.

All women/pregnant people who have multiple pregnancies are under the care of the Fetal Medicine Consultants and Midwife. PAHT does not currently participate in the Gap/GROW programme and are auditing on a rolling quarterly basis babies that are born under the 10th and 3rd centile. All audits have been presented at the Divisional Audit meeting and shared with the Maternity and Neonatal Safety Champions.

A work-stream has been developed after a review of antenatal services and the Division are re-looking at fetal growth pathways and service provision to ensure women/pregnant people are receiving the most evidence based care available.

Fundal height charts were utilised in 98% of cases and currently 96% of staff have a recorded competency assessment for fundal height measurement.

The service is compliant in terms of NICE guidance for growth monitoring in multiple pregnancies.

Element 3 – reduced fetal movements

All women/pregnant people have the reduced fetal movements leaflet provided to them at booking, this is an integral part of the hand held maternity notes. Fetal movements are also documented at every antenatal contact.

An audit has been undertaken with women/pregnant people who have attended with reduced fetal movements having a computerised CTG undertaken. The audit has demonstrated 95% compliance, compliance level for Trusts is ≥95%.

Element 4 – fetal monitoring

PAHT have a 1 WTE fetal monitoring midwife and a Lead obstetrician in post.

All midwives and obstetric doctors are required to attend an in-house fetal monitoring training day on an annual basis this includes use of CTG machines, intermittent auscultation, electronic fetal monitoring, human factors, situational awareness and escalation. Compliance has met the requirement of >90% attending a study day and completing a competency assessment. A full breakdown is available under Safety Action 8.

Element 5 – reducing preterm birth

Element 5 of the care bundle is reliant on manual audits as the SNOMED-CT coding is unable to pull from Cosmic, the Trusts Electronic Patient Record System, directly to the Maternity Dataset. Compliance with all elements is set at 80% however a Trust will not fail if ≤80%. An action plan should be developed in these cases and agreed by the Trust Board. Due to difficulties in obtaining the data at ease, a new work stream has been added to the Maternity Improvement Board in January 2023 to strengthen the data collection and submissions to the Regional and National Team.

An audit has been completed in relation to administration of antenatal steroids which showed 88.5% compliance (National Target 85%). Compliance is monitored through a variety of means such as electronic prescription, hand held notes and through both Cosmic and Badgernet. The audit must include 40 cases of notes where women/pregnant people have birthed prior to 34 weeks gestation.

An audit was undertaken for administration of Magnesium Sulphate (MgSo4) for neuroprotection. The audit demonstrated 95% compliance of which 1 case was considered avoidable.

Where babies are born at less than 27 weeks gestation an exception report is completed and submitted through the LMNS/ICS to share learning where appropriate, excluding mitigating cases (born within 1 hour of arrival or obstetric emergencies) 100% of babies were born in the appropriate care setting.

All women/pregnant people at risk of preterm birth have access to transvaginal ultrasound cervical length measurement which is performed by designated Obstetric Consultants within the department.

An audit has been undertaken on 40 consecutive cases to ensure that women are risk assessed at booking and placed onto the appropriate pathway, current compliance is 100%.

The service is compliant in terms of NICE guidance for preterm risk assessments in multiple pregnancies.

A panel was held with Executive and ICB colleague oversight on 03rd January 2023 and following review of evidence the Trust will be declaring compliance with Safety Action 6.

Recommendation: Standard met

Safety Action 7

Evidence
The Trust has a Terms of reference for the Maternity Voices partnership that is embedded within the service. All meetings are minuted and available as evidence. West Essex MVP has two co-chairs, both of which have been offered remuneration and expenses, this has also been agreed by the CCG and signed by both of the chairs. There is a work programme that has been agreed and ratified by the LMNS board. The MVP is working closely with the local community to co-produce services alongside women from Black, Asian and Minority Ethnic backgrounds. PAHT currently does not have areas of high deprivation as per the national standards. The MVP chairs are invited to and attend the Divisional Governance meeting which includes discussions of complaints and PALs within the service.

A panel was held with Executive and ICB colleague oversight on 23rd November 2022 and following review of evidence the Trust will be declaring compliance with Safety Action 7.

Recommendation: Standard met

Safety Action 8

Evidence
A training plan has been developed and shared across the LMNS/ICS with regards to the core competency framework. This is under continuous development and review to ensure that all appropriate clinicians are attending the training.

In-house Maternity Emergency Training (PROMPT) is above 90% for all staff groups:
Obstetric Consultants – 100%
Junior Doctors (Obstetrics) – 91%
Midwives – 98%
Maternity Care Assistants/Maternity Support Workers – 97%
Maternity Nurses – 100%
Nursery Nurses – 100%
Anaesthetic Consultants – 100%
Junior Doctors (Anaesthetics) – 93%
Operating Department Practitioners – 100%

Training continued throughout December due to clinical activity with compliance met by the end of December 2022.

Fetal Monitoring Training is above 90% for all staff groups:
Obstetric Consultants – Study day attendance 100%. Competency assessment 92%.
Junior Doctors (Obstetrics) – Study day attendance 95%. Competency assessment 90%.
Midwives – Study day attendance 94%. Competency assessment 95%.

Training continued throughout December due to clinical activity with compliance met by the end of December 2022.

Neonatal Life Support Training is above 90% for all staff groups:
Neonatal Consultants – 100%
Junior Doctors (Neonatal) – 97%
Advanced Neonatal Nurse Practitioners – 100%
Neonatal Nurses – 100%
Midwives – 98%

Training continued throughout December due to clinical activity with compliance met by the end of December 2022.

The Division are now a recognised provider of NLS training following observation of the Resus Council UK

A panel was held with Executive and ICB colleague oversight on 03rd January 2023 and following review of evidence the Trust will be declaring compliance with Safety Action 8.

Recommendation: Standard met

Safety Action 9

Evidence

The pathway from year 3 has been reviewed in line with the perinatal surveillance model and describes how information is shared from floor to board, this also includes the regional meetings from the LMNS and ICS. The regional team are key members of this Committee and all information is shared as part of this.

New posters have been placed around the unit detailing the maternity and neonatal safety champions and there are monthly meetings to gain staff feedback.

The safety champions report back to this committee on a monthly basis relating to staff feedback and action log. Monthly walkthroughs/feedback sessions have also been recommenced post pandemic. The claims information is submitted via a quarterly maternity assurance paper as well as the Trust Patient Safety Group paper.

The continuity of carer action plan has been to Board for sign off with a workplan of further roll out. Following the Ockenden report this was revisited and a revised plan was presented and agreed. This plan detailed women/pregnant people from socially deprived areas and those of Black, Asian, Minority Ethnicity.

There has been attendance from the Safety Champions at National MatNeoSIP meetings as part of the safety networks that are organised regionally.

A panel was held with Executive and ICB colleague oversight on 23rd November 2022 and following review of evidence the Trust will be declaring compliance with Safety Action 9.

Recommendation: Standard met

Safety Action 10

Evidence
There is a local process in place for ensuring every baby that meets qualifying incidents to NHS Resolution Early Notification Scheme are reported. All families that meet the criteria for referral are contacted by the Governance Team to gain consent and an information leaflet is sent to them alongside the Duty of Candour Letter. Current figures state that we are fully compliant with this safety action. These are reported at the monthly Divisional Governance meeting. Legal Services also disseminate this data to Trust Patient Safety Group. Duty of Candour is reported via the Quarterly Assurance Report that comes to this forum.

A panel was held with Executive and ICB colleague oversight on 23rd November 2022 and following review of evidence the Trust will be declaring compliance with Safety Action 10.

Recommendation: Standard met

4.0 Oversight

All highlighted concerns have been escalated at divisional board. The service are have achieved compliance with 9/10 Safety Actions of MIS Year 4 and continue to monitor compliance with SBLCBv2 and the Ockenden IEA. Escalation will occur through board where non-compliance is anticipated or found to occur.

5.0 Recommendation

It is requested that the Board accepts the report with the evidence provided and the ongoing work for assurance of compliance with local and national standards of Maternity Incentive Scheme Year 4. It is requested that following ICB review and the evidence within the paper that the Trust declare compliance with Safety Actions 2, 3, 4, 5, 6, 7, 8, 9 and 10. It is recommended that the Trust declare non-compliance with Safety Action 1 due to the data variance in the reporting to the live MBRRACE PMRT tool, and the action plan which will be provided in mitigation to NHS Resolution.

The board declaration form will require signing by the Chief Executive Officer and the ICB Accountable Officer.

Author: Erin Walters - Head of Maternity Governance and Assurance
Date: 10.01.2023

APPENDIX 1: Copy of Maternity Incentive Scheme Action Plan and Evidence Submitted

Blue - Fully Embedded
Green – completed but yet to be embedded
Amber – on track but not complete
Red - Insufficient progress to meet planned timeframe

SA 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?

Relevant time period - 6th May 2022- 05th December 2022				
No:	Description	Minimum evidential requirement for Trust Board	RAG rating	Evidence
Ai	All perinatal deaths eligible to be notified to MBRRACE-UK from 6 May 2022 onwards must be notified to MBRRACE-UK within seven working days and the surveillance information where required must be completed within one month of the death. Deaths where the surveillance form needs to be assigned to another Trust for additional information are excluded from the latter.	Notifications must be made and surveillance forms completed using the MBRRACE-UK reporting website. The perinatal mortality review tool must be used to review the care and reports should be generated via the PMRT. A report has been received by the Trust Board each quarter from 6 May 2022 onwards that includes details of the deaths reviewed and the consequent action plans. The report should evidence that the PMRT has been used to review eligible perinatal deaths and that the required standards a), b) and c) have been met. For standard c) for any parents who have not been informed about the review taking place, reasons for this should be documented within the PMRT review.		MBRRACE Surveillance spreadsheet
Aii	A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 6 May 2022 will have been started within two months of each death. This includes deaths after home births where care was provided by your Trust.			MBRRACE Surveillance spreadsheet
B	At least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from 6 May 2022 will have been reviewed using the PMRT, by a multidisciplinary review team. Each of these reviews will have been completed to the point that at least a PMRT draft report has been generated by the tool within four months of each death and the report published within six months of each death.			MBRRACE Surveillance spreadsheet
C	For at least 95% of all deaths of babies who died in your Trust from 6 May 2022, the parents will have been told that a review of their baby's death will take place, and that the parents' perspectives and any questions and/or concerns they have about their care and that of their baby have been sought. This includes any home births where care was provided by your Trust staff and the baby died either at home or in your Trust. If delays in completing reviews are anticipated parents should be advised that this is the case and be given a timetable for likely completion. Trusts should ensure that contact with the families continues during any delay and make an early assessment of whether any questions they have can be addressed before a full review has been			MBRRACE Surveillance spreadsheet PAHT Parent Feedback Form PAHT Perinatal Mortality Review Tool SOP

	completed; this is especially important if there are any factors which may have a bearing on a future pregnancy. In the absence of a bereavement lead ensure that someone takes responsibility for maintaining contact and for taking actions as required.			
D	Quarterly reports will have been submitted to the Trust Board from 6 May 2022 onwards that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety and Board level safety champions.			Quarterly Reports: QSC 26.11.2021 (Q1) QSC 25.2.2022 (Q2,Q3) QSC 29.07.2022 (Q4) QSC 28.10.2022 (PMRT Deep Dive, Q1) Trust Board (June 2022) Trust Board (December 2022)

SA 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?				
Relevant time period - 6th May 2022- 05th December 2022				
No:	Description	Minimum evidential requirement for Trust Board	RAG rating	Evidence
1	By 31st October 2022, Trusts have an up to date digital strategy for their maternity services which aligns with the wider Trust Digital Strategy and reflects the 7 success measures within the What Good Looks Like Framework. The strategy must be shared with Local Maternity Systems and be signed off by the Integrated Care Board. As part of this, dedicated Digital Leadership should be in place in the Trust and have engaged with the NHSEI Digital Child Health and Maternity Programme.	Criteria 1 will be reported to NHS Resolution as part of trusts' self-declaration using the Board declaration form.		Digital Strategy QSC 30.09.2022 Trust Board (06.10.2022)
2	Trust Boards to assure themselves that at least 9 out of 11 Clinical Quality Improvement Metrics (CQIMs) have passed the associated data quality criteria in the "CNST Maternity Incentive Scheme Year 4 Specific Data Quality Criteria" data file in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2022. The data for July 2022 will be published during October 2022.	For criteria 2 to 7, the "CNST Maternity Incentive Scheme Year 4 Specific Data Quality Criteria" data file in the Maternity Services Monthly Statistics publication series displays whether trusts have passed the requisite data quality thresholds.		NHSD Trust Score Card (July)
3	July 2022 data contained height and weight data, or a calculated Body Mass Index (BMI), recorded by 15+0 weeks gestation for 90% of women reaching 15+0 weeks gestation in the month.			NHSD Trust Score Card (July)
4	July 2022 data contained Complex Social Factor Indicator (at antenatal booking) data for 95% of women booked in the month.			NHSD Trust Score Card (July)
5	July 2022 data contained antenatal personalised care plan fields completed for 95% of women booked in the month. (MSD101/2)			NHSD Trust Score Card (July)
6	July 2022 data contained valid ethnic category (Mother) for at least 90% of			NHSD Trust Score Card (July)

	women booked in the month. Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001)			
7	Trust Boards to confirm to NHS Resolution that they have passed the associated data quality criteria inthe "CNST Maternity Incentive Scheme Year 4 Specific Data Quality Criteria" data file in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2022 for the following metrics: Midwifery Continuity of carer (MCoC) i. Over 5% of women who have an Antenatal Care Plan recorded by 29 weeks and also have the CoC pathway indicator completed. ii. Over 5% of women recorded as being placed on a CoC pathway where both Care Professional ID and Team ID have also been provided. iii. At least 70% of MSD202 Care Activity (Pregnancy) and MSD302 Care Activity (Labour and Delivery) records submitted in the reporting period have a valid Care Professional Local Identifier recorded. Providers submitting zero Care Activity records will fail this criterion. Criteria i and ii are the data quality metrics used to determine whether women have been placed on a midwifery continuity of carer pathway by the 28 weeks antenatal appointment, as measured at 29 weeks gestation. Criteria iii are fundamental building blocks and a necessary step towards measuring whether or not women have received midwifery continuity of carer (though it is not the complete measurement). The data for July 2022 will be published in October 2022. If the data quality for criteria 7 are not met, trusts can still pass safety action 2 by evidencing sustained engagement with NHS Digital which at a minimum, includes monthly use of the Data Quality Submission Summary Tool supplied by NHS Digital (see technical guidance for further information).			NHSD Trust Score Card (July)

SA 3: Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?				
Relevant time period - 6th May 2022- 05th December 2022				
No:	Description	Minimum evidential requirement for Trust Board	RAG rating	Evidence

A	Pathways of care into transitional care have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care.	Evidence for standard a) to include: • There is evidence of neonatal involvement in care planning • Admission criteria meets a minimum of at least one element of HRG XA04 but could extend beyond to BAPM transitional care framework for practice • There is an explicit staffing model • The policy is signed by maternity/neonatal clinical leads and should have auditable standards. • The policy has been fully implemented and quarterly audits of compliance with the policy are conducted.		TC Guideline Monthly Exception Audit
B	The pathway of care into transitional care has been fully implemented and is audited quarterly. Audit findings are shared with the neonatal safety champion, LMNS, commissioner and Integrated Care System (ICS) quality surveillance meeting each quarter.	Evidence for standard b) to include: • An audit trail is available which provides evidence that ongoing audits from year 3 of the maternity incentive scheme of the pathway of care into transitional care are being completed as a minimum of quarterly. If for any reason, reviews have been paused, they should be recommenced using data from quarter 1 of 2022/23 financial year. • Audit findings are shared with the neonatal safety champion on a quarterly basis. Where barriers to achieving full implementation of the policy are encountered, an action plan should be agreed and progress overseen by both the board and neonatal safety champions.		Neonatal Safety Champion and LMNS Maternity and Neonatal Leads are key members of ATAIN Meetings LMNS Safety Forum Information Monthly Exception Audit
C	A data recording process (electronic and/or paper based for capturing all term babies transferred to the neonatal unit, regardless of the length of stay, is in place)	Evidence for standard b) to include: • An audit trail is available which provides evidence that ongoing audits from year 3 of the maternity incentive scheme of the pathway of care into transitional care are being completed as a minimum of quarterly. If for any reason, reviews have been paused, they should be recommenced using data from quarter 1 of 2022/23 financial year. • Audit findings are shared with the neonatal safety champion on a quarterly basis. Where barriers to achieving full implementation of the policy are encountered, an action plan should be agreed and progress overseen by both the board and neonatal safety champions.		ATAIN Tracker (Long and Short Stay Admissions)
D	A data recording process for capturing existing transitional care activity, (regardless of place - which could be a Transitional Care (TC), postnatal ward,	Evidence for standard d) to include: • Data is available (electronic or paper based) on transitional		Available on Badgernet

	virtual outreach pathway etc.) has been embedded. If not already in place, a secondary data recording process is set up to inform future capacity management for late preterm babies who could be cared for in a TC setting. The data should capture babies between 34+0-36+6 weeks gestation at birth, who neither had surgery nor were transferred during any admission, to monitor the number of special care or normal care days where supplemental oxygen was not delivered.	care activity (regardless of place - which could be a TC, postnatal ward, virtual outreach pathway etc.). • Secondary data is available (electronic or paper based) on babies born between 34+0-36+6 weeks gestation at birth, who did not have surgery nor were transferred during any admission, to monitor the number of special care or normal care days where supplemental oxygen was not delivered to inform future capacity management for late preterm babies who could be cared for in a TC setting.		
E	Commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data set (NCCMDS) version 2 are available to be shared on request with the operational delivery network (ODN), LMNS and commissioners to inform capacity planning as part of the family integrated care component of the Neonatal Critical Care Transformation Review and to inform future development of transitional care to minimise separation of mothers and babies.	Evidence for standard e) to include: • Commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data Set (NCCMDS) version 2 are available to share on request, for example to support service development and capacity planning, with the LMNS, ODN and/or commissioner		HRG Codes Report
F	Reviews of babies admitted to the neonatal unit continue on a quarterly basis and findings are shared quarterly with the Board Level Safety Champion. Reviews should now include all neonatal unit transfers or admissions regardless of their length of stay and/or admission to BadgerNet. In addition, reviews should report on the number of transfers to the neonatal unit that would have met current TC admissions criteria but were transferred or admitted to the neonatal unit due to capacity or staffing issues. The review should also record the number of babies that were transferred or admitted or remained on Neonatal Units because of their need for nasogastric tube feeding, but could have been cared for on a TC if nasogastric feeding was supported there. Findings of the review have been shared with the maternity, neonatal and Board level safety champions, LMNS and ICS quality surveillance meeting on a quarterly basis.	Evidence for standard f) to include: • An audit trail is available which provides evidence that ongoing reviews from year 3 of the maternity incentive scheme of term admissions are being completed as a minimum of quarterly. If for any reason, reviews have been paused, they should be recommenced using data from quarter 1 of 2022/23 financial year. • If not already in place, an audit trail is available which provides evidence that reviews from Monday 18 July 2022, now include all term babies transferred or admitted to the NNU, irrespective of their length of stay, are being completed as a minimum of quarterly. If your reviews already included all babies transferred or admitted to the NNU then this should continue using data from quarter 1 of 2022/23 financial year. • Evidence that the review includes: the number of transfers or admissions to the neonatal unit that would have met current TC admission criteria but were transferred or admitted to the neonatal unit due to capacity or staffing issues and the number of babies that were transferred or		Dashboard Shared with Safety Champions and Board Neonatal Safety Champion and LMNS Maternity and Neonatal Leads are key members of ATAIN Meetings RPQOG Safety Highlight Reports

		admitted to, or remained on NNU because of their need for nasogastric tube feeding, but could have been cared for on a TC if nasogastric feeding was supported there. • Evidence that findings of all reviews of term babies transferred or admitted to a neonatal unit are reviewed quarterly and the findings have been shared quarterly with the maternity and neonatal safety champions and Board level champion, the LMNS and ICS quality surveillance meeting.		
G	An action plan to address local findings from the audit of the pathway (point b) and Avoiding Term Admissions Into Neonatal units (ATAIN) reviews (point f) has been agreed with the maternity and neonatal safety champions and Board level	Evidence for standard g) and h): • An audit trail is available which provides evidence and rationale for developing the agreed action plan to address local findings from the pathway audit (point b) and the ATAIN reviews (point f).Evidence that progress with the action plan has been shared with the neonatal, maternity safety champion, and Board level champion, LMNS and ICS quality surveillance meeting each quarter.		Copy of Action Plan Safety Champion Minutes and Agendas LMNS Safety Forum
H	Progress with the revised ATAIN action plan has been shared with the maternity, neonatal and Board level safety champions, LMNS and ICS quality surveillance meeting.			Safety Champion Minutes and Agendas LMNS Safety Forum RPQOG submissions

SA 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?				
Relevant time period - 16th June 2022-05th December 2022				
No:	Description	Minimum evidential requirement for Trust Board	RAG rating	Evidence
A1	**Obstetric medical workforce** The obstetric consultant team and maternity senior management team should acknowledge and commit to incorporating the principles outlined in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service: https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/	**Obstetric medical workforce** Sign off at Trust Board level acknowledging engagement with the RCOG document along with an action plan to review any non-attendance to the clinical situations listed in the document. Trusts should evidence their position with the Trust Board, Trust Board level safety champions and LMNS meetings at least once from the relaunch of MIS year 4 in May 2022. **Anaesthetic medical workforce** The rota should be used to evidence compliance with ACSA standard 1.7.2.1. **Neonatal medical workforce** The Trust is required to formally record in Trust Board minutes whether it meets the		Consultant Meeting Minutes (11.03.2022) RCOG Roles and Responsibilities Document MIS Interim Report - QSC 13.04.2022 MIS Interim Report - QSC 27.05.2022 MIS Interim Report - QSC 30.09.2022
A2	Units should monitor their compliance of consultant attendance for the clinical situations listed in this document when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance. Trusts' positions with the requirement should be shared with the Trust board,			Paweb117233

	the board-level safety champions as well as LMNS.	recommendations of the neonatal medical workforce. If the requirements are not met, Trust Board should evidence progress against the action plan developed in year 3 of MIS to address deficiencies. **Neonatal nursing workforce** The Trust is required to formally record to the Trust Board minutes the compliance to the service specification standards annually using the neonatal clinical reference group nursing workforce calculator. For units that do not meet the standard, the Trust Board should evidence progress against the action plan developed in year 3 of MIS to address deficiencies. A copy of the action plan, outlining progress against each of the actions, should be submitted to the Royal College of Nursing (cypadmin@rcn.org.uk), LMNS and Neonatal Operational Delivery Network (ODN) Lead.		
B	**Anaesthetic medical workforce** A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients (ACSA standard 1.7.2.1)			Anaesthetic Rotas (April 2022 - October 2022)
C	**Neonatal medical workforce** The neonatal unit meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing. If the requirements had not been met in both year 3 and year 4 of MIS, Trust Board should evidence progress against the action plan developed in year 3 of MIS as well include new relevant actions to address deficiencies. If the requirements had been met in year 3 without the need of developing an action plan to address deficiencies, however they are not met in year 4, Trust Board should develop an action plan in year 4 of MIS to address deficiencies.			Neonatal Medical Rotas (Aug 2021 - Nov 2022) Email Confirmation from Clinical Director of Meeting Requirements MIS Interim Report - QSC 13.04.2022 MIS Interim Report - QSC 30.09.2022
D	**Neonatal nursing workforce** The neonatal unit meets the service specification for neonatal nursing standards. If the requirements had not been met in both year 3 and year 4 of MIS, Trust Board should evidence progress against the action plan developed in year 3 of MIS as well include new relevant actions to address deficiencies. If the requirements had been met in year 3 without the need of developing an action plan to address deficiencies, however they are not met in year 4, Trust Board should develop an action plan in year 4 of MIS to address deficiencies and share this with the Royal College of Nursing, LMNS and Neonatal Operational Delivery Network (ODN) Lead.			Neonatal Nursing Workforce Plan Neonatal Nuring Workforce Calculator Email to RCN Email to ODN/LMNS MIS Interim Report - QSC 27.05.2022 MIS Interim Report - QSC 30.09.2022

SA 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?				
Relevant time period – August 2021- 02nd February 2023				
No:	Description	Minimum evidential requirement for Trust Board	RAG rating	Evidence
A	A systematic, evidence-based process to calculate midwifery staffing establishment is completed.	The report submitted will comprise evidence to support a, b and c progress or achievement. It should include: • A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how		Midwifery Workforce (Jan 22)
B	Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above.			Midwifery Workforce (Jan 22) Board Minutes Extract (April 2022)
C	The midwifery coordinator in charge of labour ward must have supernumerary			Local Birthrate+ Audit

	status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service	the required establishment has been calculated • In line with midwifery staffing recommendations from Ockenden, Trust Boards must provide evidence (documented in Board minutes) of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations. • Where Trusts are not compliant with a funded establishment based on BirthRate+ or equivalent calculations, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls. • The plan to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent undertaken, where deficits in staffing levels have been identified must be shared with the local commissioners. • Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall in staffing. -The midwife to birth ratio -The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives. • Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator status and the provision of one-to-one care in active labour. Must include plan for mitigation/escalation to cover any shortfalls.		
D	All women in active labour receive one-to-one midwifery care			Maternity Dashboard
E	Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year four reporting period.			Mcoc (QSC 28.01.2022) Maternity Staffing Update (QSC 27.05.2022) Mid-Year Staffing Update (QSC 30.09.2022) Trust Board (09.06.2022) Trust Board (06.10.2022)

SA 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version two?				
Relevant time period - 6th May 2022- 02nd February 2023				
No:	Description	Minimum evidential requirement for Trust Board	RAG rating	Evidence
1	Trust Board level consideration of how its organisation is complying with the Saving Babies' Lives care bundle version two (SBLCBv2), published in April 2019.			QSC 29.04.2022 QSC 29.07.2022 QSC 28.10.2022 QSC 27.01.2023

	Note: Full implementation of the SBLCBv2 is included in the 2020/21 standard contract.			Trust Board June 2022 Trust Board August 2022 Trust Board October 2022 Trust Board December 2022
2	Each element of the SBLCBv2 should have been implemented. Trusts can implement an alternative intervention to deliver an element of the care bundle if it has been agreed with their commissioner (CCG). It is important that specific variations from the pathways described within SBLCBv2 are also agreed as acceptable clinical practice by their Clinical Network.			QSC 29.04.2022 QSC 29.07.2022 QSC 28.10.2022 QSC 27.01.2023 Trust Board June 2022 Trust Board August 2022 Trust Board October 2022 Trust Board December 2022
3	The quarterly care bundle survey should be completed until the provider Trust has fully implemented the SBLCBv2 including the data submission requirements. The survey will be distributed by the Clinical Networks and should be completed and returned to the Clinical Network or directly to England.maternitytransformation@nhs.net from May 2022 onwards. Evidence of the completed quarterly care bundle surveys should be submitted to the Trust board.			SBLCBv2 Survey 6 SBLCBv2 Survey 7
Element 1 Reducing Smoking in Pregnancy				
A	Percentage of women where Carbon Monoxide (CO) measurement at booking is recorded.	The relevant data items for these process indicators should be recorded on the provider's Maternity Information System (MIS) and included in the MSDS submissions to NHS Digital in an MSDSv2 Information Standard Notice compatible format, including SNOMED-CT coding. The Trust board should receive data from the organisation's MIS evidencing an average of 80% compliance over a four month period (i.e. four consecutive months in during the MIS year 4 reporting timeframe). If there is a delay in the provider Trust's ability to submit these data to MSDS then compliance can be determined using their interim data recording method. The denominator should still be the total number of women at booking or 36 weeks gestation, as appropriate for each process indicator If the provider Trust is unable to record these data on their maternity information system an audit of 60 consecutive		Audit Smoking insert from handheld notes Smokerlyzer SOP Smoking Cessation Pathway
B	Percentage of women where CO measurement at 36 weeks is recorded.			Audit Smoking insert from handheld notes Smokerlyzer SOP Smoking Cessation Pathway

		cases would be acceptable evidence to demonstrate >80% of women having a CO measurement recorded at 36 weeks. The denominator for the audit should be 60 consecutive women at 36 weeks gestation, whereas the denominator for the electronic audit would be the total number of women at 36 weeks gestation. In addition to this, the audit should be accompanied by a brief description of the stop smoking strategy within the Trust and any plans for improvement. A Trust will fail Safety Action 6 if the process indicator metric compliance is less than 80%. If the process indicator scores are less than 95% Trusts must also have an action plan for achieving >95%. In addition, the Trust board should specifically confirm that within their organisation they: 1) Pass the data quality rating on the National Maternity Dashboard for the 'women who currently smoke at booking appointment' Clinical Quality Improvement Metric. 2) Have a referral pathway to smoking cessation services (in house or external). 3) Audit of 20 consecutive cases of women with a CO measurement ≥4ppm at booking, to determine the proportion of women who were referred to a smoking cessation service. 4) Have generated and reviewed the following outcome indicators within the Trust for four consecutive months within the MIS year 4 reporting period: • Percentage of women with a CO measurement ≥4ppm at booking. • Percentage of women with a CO measurement ≥4ppm at 36 weeks. • Percentage of women who have a CO level ≥4ppm at booking who subsequently have a CO level <4ppm at the 36 week appointment. Additional information If your Trust is planning on using the maternity dashboard to evidence an average of 80% compliance over four months, please be advised		

		that there is a three month delay with MSDSv2 data, for example data submitted at the end of August 2022 will be published on the dashboard at the end of November 2022. If your Trust does not have an in house stop smoking service or a pathway to an external service, please contact your local authority stop smoking service or escalate to your local maternity system to enable the Trust to ensure provision is in place. Percentage of women where Carbon Monoxide (CO) measurement at booking is recorded. Women declining CO testing at booking / 36 weeks appointment Standard A and B of element 1 require Trusts to demonstrate that 80% of women had CO testing at booking and at 36 weeks respectively and that this is recorded in the Trusts' information system. In the event of a high number of women declining CO testing a Trust would be at risk of failing standard A and B by not reaching the 80% testing rate. We suggest Trusts proactively monitor their testing rate and consider interventions to maintain adequate compliance.		
Element 2 Risk Assessment, Prevention and Surveillance of Pregnancies at Risk of Fetal Growth Restriction (FGR)				
1	1) Percentage of pregnancies where a risk status for fetal growth restriction (FGR) is identified and recorded using a risk assessment pathway at booking and at the 20 week scan (e.g. Appendix D).	Note: The relevant data items for these indicators should be recorded on the provider's Maternity Information System and included in the MSDS submissions to NHS Digital in an MSDSv2 Information Standard Notice compatible format, including SNOMED-CT coding. The Trust board should receive data from the organisation's MIS evidencing 80% compliance. If there is a delay in the provider Trust Maternity Information System's ability to record these data at the time of submission an in house audit of 40 consecutive cases of women at 20 weeks scan using locally available data or case records should have been undertaken to assess compliance with this indicator. A Trust will fail Safety Action 6 if the process indicator metric compliance is less than 80%. If the process indicator scores are less than 95% Trusts must		Fetal Growth Audit Obesity Guideline Ultrasound Guideline Quarterly Audits MIB Workstream

		also have an action plan for achieving >95%. In addition the Trust board should specifically confirm that within their organisation: 2) Women with a BMI>35 kg/m2 are offered ultrasound assessment of growth from 32 weeks' gestation onwards 3) In pregnancies identified as high risk at booking uterine artery Doppler flow velocimetry is performed by 24 completed weeks gestation 4) There is a quarterly audit of the percentage of babies born <3rd centile >37+6 weeks' gestation. 5) They have generated and reviewed the percentage of perinatal mortality cases for 2021 where the identification and management of FGR was a relevant issue (using the PMRT). 6) Their risk assessment and management of growth disorders in multiple pregnancy complies with NICE guidance or a variant has been agreed with local commissioners (CCGs) following advice from the Clinical Network. 7) They undertake a quarterly review of a minimum of 10 cases of babies that were born <3rd centile >37+6 weeks' gestation. The review should seek to identify themes that can contribute to FGR not being detected (e.g. components of element 2 pathway and/or scanning related issues). The Trust board should be provided with evidence of quality improvement initiatives to address any identified problems. Trusts can omit the above mentioned quarterly review of a minimum of 10 cases of babies that were born <3rd centile >37+6 weeks' gestation for quarter 3 of this financial year (2021/22) if staffing is critical and this directly frees up staff for the provision of clinical care.		
Element 3 Raising Awareness of Reduced Fetal Movements				
A	Percentage of women booked for antenatal care who had received reduced fetal movements leaflet/information by 28+0 weeks of pregnancy	Note: The SNOMED CT code is still under development for RFM and therefore an in-house audit of two weeks' worth of cases or 20 cases of women attending with RFM whichever is the smaller to assess compliance with the		Reduced Fetal Movements Leaflet from Notes
B	Percentage of women who attend with RFM who have a computerised CTG (a computerised system that as a			Audit

	minimum provides assessment of short term variation).	element three process indicators. A Trust will fail Safety Action 6 if the process indicator metric compliance is less than 80%. If the process indicator scores are less than 95% Trusts must also have an action plan for achieving >95%.		
Element 4 Effective Fetal Monitoring During Labour				
A	There should be Trust board sign off that staff training on using their local CTG machines, as well as fetal monitoring in labour are conducted annually. The fetal monitoring sessions should be consistent with the Ockenden Report recommendations, and include: intermittent auscultation, electronic fetal monitoring with system level issues e.g. human factors, escalation and situational awareness.			Fetal Monitoring Study Day Programme
B	The Trust board should specifically confirm that within their organization 90% of eligible staff (see Safety Action 8) have attended local multi-professional fetal monitoring training annually as above.			Fetal Monitoring Compliance Spreadsheet
Element 5 Reducing Preterm Birth				
A	Percentage of singleton live births (less than 34+0 weeks) receiving a full course of antenatal corticosteroids, within seven days of birth.	The relevant data items for these process indicators should be recorded on the provider's Maternity Information System and included in the MSDS submissions to NHS Digital in an MSDSv2 Information Standard Notice compatible format, including SNOMED-CT coding. If there is a delay in the provider Trust MIS's ability to record these data then an audit of 40 cases consisting of 20 consecutive cases of women presenting with threatened preterm labour before 34 weeks and 20 consecutive cases of women who have given birth before 34 weeks using locally available data or case records should have been undertaken to assess compliance with each of the process indicators. The Trust board should receive data from the organisation's Maternity Information System evidencing 80% compliance with process indicators A, C and D. The percentage for process indicator B should be as low as possible and can be reported as the proportion. A Trust will not fail Safety Action 6 if the process indicator scores are less than 80%. However, Trusts must		Audit Multiple Pregnancy Guideline Preterm Birth Guideline
B	Percentage of singleton live births occurring more than seven days after completion of their first course of antenatal corticosteroids			Audit Multiple Pregnancy Guideline Preterm Birth Guideline
C	Percentage of singleton live births (less than 30+0 weeks) receiving magnesium sulphate within 24 hours prior birth.			Audit Multiple Pregnancy Guideline Preterm Birth Guideline
D	Percentage of women who give birth in an appropriate care setting for gestation (in accordance with local ODN guidance).			Audit Multiple Pregnancy Guideline Preterm Birth Guideline

		have an action plan for achieving >80%. In addition, the Trust board should specifically confirm that within their organisation: • They have a dedicated Lead Consultant Obstetrician with demonstrated experience to focus on and champion best practice in preterm birth prevention. (Best practice would be to also appoint a dedicated Lead Midwife. Further guidance/information on preterm birth clinics can be found on https://www.tommys.org/sites/default/files/2021-03/reducing%20preterm%20birth%20guidance%2019.pdf • Women at high risk of preterm birth have access to a specialist preterm birth clinic where transvaginal ultrasound to assess cervical length is provided. If this is not the case the board should describe the alternative intervention that has been agreed with their commissioner (CCG) and that their Clinical Network has agreed is acceptable clinical practice. • An audit of 40 consecutive cases of women booking for antenatal care has been completed to measure the percentage of women that are assessed at booking for the risk of preterm birth and stratified to low, intermediate and high risk pathways, and the percentage of those assessed to be at increased risk that are referred to the appropriate preterm birth clinic and pathway. The assessment should use the criteria in Appendix F of SBLCBv2 or an alternative which has been agreed with local CCGs following advice from the Clinical Network. • Their risk assessment and management in multiple pregnancy complies with NICE guidance or a variant that has been agreed with local commissioners (CCGs) following advice from the provider's clinical network.		

SA 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?
Relevant time period - 6th May 2022 - 05th December 2022

No:	Description	Minimum evidential requirement for Trust Board	RAG rating	Evidence
1	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership(MVP) to coproduce local maternity services?	Terms of Reference for your MVP. They reflect the core principles for Terms of Reference for a MVP as outlined in annex B of Implementing Better Births: A resource pack for Local Maternity Systems		ToR
		Minutes of MVP meetings demonstrating how service users are listened to and how regular feedback is obtained, that actions are in place to demonstrate that listening has taken place and evidence of service developments resulting from coproduction between service users and staff.		Meeting Minutes
		Written confirmation from the service user chair that they are being remunerated as agreed and that this remuneration reflects the time commitment and requirements of the role given the agreed work programme. Remuneration should take place in line with agreed Trust processes.		Renumeration Signed Documents
		The MVP's work programme, minutes of the MVP meeting which agreed it and minutes of the LMNS board that ratified it		Work Programme MVP Chair Agenda Feb 22 HWE LMNSPB Minutes May 2022 LMNS Six Monthly Coproduction Report Apr 22 - Sep 2022 draft 3 LMNS Six Monthly Coproduction Report Oct 21 - Mar 2022
		Written confirmation from the service user chair that they and other service user members of the MVP committee are able to claim out of pocket expenses, including travel, parking and childcare costs in a timely way.		Expenses Documents Signed
		Evidence that the MVP is prioritising hearing the voices of women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation, given the findings in the MBRRACE-UK reports about maternal death and morbidity and perinatal mortality.		Twitter Feedback Work Programme
		Evidence that the MVP Chair is invited to attend maternity governance meetings and that actions from maternity governance meetings, including complaints' response processes, trends and themes, are shared with the MVP.		Diary Invite Agenda Minutes

SA 8: Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4? In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, multi professional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and newborn life support, starting from the launch of MIS year 4

Relevant time period - Any 12 consecutive months within the period: 1st August 2021 until 5th January 2023				
No:	Description	Minimum evidential requirement for Trust Board	RAG rating	Evidence
A	A local training plan is in place to ensure that all six core modules of the Core Competency Framework, will be included in your unit training programme over 3 years, starting from the launch of MIS year 4 in August 2021.			Training Needs Analysis Study Day Agendas
B	90% of each relevant maternity unit staff group have attended an 'in house' one day multi-professional training day, that includes maternity emergencies starting from the launch of MIS year four in August 2021?			PROMPT Compliance Tracker
C	90% of each relevant maternity unit staff group have attended an 'in-house' one day multi-professional training day that includes antenatal and intrapartum fetal monitoring, starting from the launch of MIS year four in August 2021.			Fetal Monitoring Compliance Tracker
D	Can you evidence that 90% of the team required to be involved in immediate resuscitation of the newborn and management of the deteriorating newborn infant have attended in-house neonatal life support training or a Newborn Life Support (NLS) course starting from the launch of MIS year four in August 2021.			NLS Compliance Tracker

SA 9: Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?				
Relevant time period - 16th June 2022-02nd February 2023				
No:	Description	Minimum evidential requirement for Trust Board	RAG rating	Evidence
A	The pathway developed in year 3, that describes how safety intelligence is shared from floor to Board, through local maternity and neonatal systems (LMNS), and the Regional Chief Midwife has been reviewed in line with the implementing-a-revised-perinatal-quality-surveillance-model.pdf (england.nhs.uk) The revised pathway should formalise how Trust-level intelligence will be shared with new LMNS/ICS and regional quality groups to ensure early action and support is provided for areas of concern or need.	Evidence for points a) and b) • Evidence of a revised pathway which describes how frontline midwifery, neonatal, obstetric and Board safety champions share safety intelligence between a) each other, b) the Board, c) new LMNS/ICS quality group and d) regional quality groups involving the Regional Chief Midwife and Lead Obstetrician to ensure early action and support is provided for areas of concern or need in line with the perinatal quality surveillance model. • Evidence that a clear description of the pathway and names of safety champions are visible to maternity and neonatal staff. • Evidence that discussions regarding safety intelligence, including; the number of incidents reported as serious harm, themes identified and actions being taken to address any issues; staff feedback from frontline champions and engagement sessions;		Maternity Safety Intelligence Pathway Perinatal Quality Surveillance Model Divisional Meeting Structure Safety Champion Poster Quarterly Assurance Papers (QSC 29.10.21, 28.01.2022, 29.04.22, 29.07.2022, 28.10.22) Board (04.08.22)
B	Board level safety champions present a locally agreed dashboard to the Board quarterly, including; the number of incidents reported as serious harm, themes identified and actions being taken to address any issues; staff feedback from frontline champions and walk-abouts; minimum staffing in maternity services and training			Quarterly Assurance Papers (QSC 29.10.21, 28.01.2022, 29.04.22, 29.07.2022, 28.10.22) Board (04.08.22)

	compliance are taking place at Board level no later than 16 June 2022. NB, The training update should include any modifications made as a result of the pandemic / current challenges and a rough timeline of how training will be rescheduled later this year if required. This additional level of training detail will be expected by 16 June 2022.	minimum staffing in maternity services and training compliance are taking place at Board level no later than 16 June 2022. NB- The training update should include any modifications made as a result of the pandemic / current challenges and a rough timeline of how training will be rescheduled later this year if required. This additional level of training detail will be expected by 16 June 2022. • Evidence of the engagement sessions (e.g. staff feedback meeting, staff walkaround sessions etc.) being undertaken by a member of the Board. • Evidence of progress with actioning named concerns from staff workarounds are visible to both maternity and neonatal staff and reflects action and progress made on identified concerns raised by staff and service users. • Evidence that the Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level safety champions to help target interventions aimed at improving patient safety at least twice in the MIS reporting period at a Trust level quality meeting. This can be a board or directorate level meeting.		Safety Champion Meetings and Agendas
C	Trust Boards have reviewed current staffing in the context of the letters to systems on 1 April 2022 and 21 September 2022 regarding the roll out of Midwifery Continuity of Carer as the default model of care. A decision has been made by the Board as to whether staffing meets safe minimum requirements to continue rollout of current or planned MCoC teams, or whether rollout should be suspended	Evidence for point c): This is to be evidenced by a minuted Board level discussion and decision since 1 April 2022 on how a Trust's current workforce position should determine current and future rollout of MCoC. Where more than one discussion has taken place, the most recent evidence should be submitted.		MCoC Paper (QSC 27.05.2022) Trust Board 09.06.2022
D	Board level and maternity safety champions are actively supporting capacity and capability building for staff to be involved in the Maternity and Neonatal Safety Improvement Programme (MatNeoSIP)	Evidence for point d): Evidence of how the Board and Safety Champions have supported staff involved in part d) of the required standard and specifically in relation to: • active participation by staff in contributing to the delivery of the collective aims of the MatNeo Patient Safety Networks, and undertaking of specific improvement work aligned to the MatNeoSIP national driver diagram and key enabling activities • engagement in relevant improvement/capability building initiatives nationally, regionally or via the MatNeo Patient		Safety Champion Exception Reports Internal Staff Survey Results

		Safety Networks, of which the Trust is a member • support for clinicians identified as MatNeoSIP Improvement Leaders to facilitate and lead work through the MatNeo Patient Safety Networks and the National MatNeoSIP network • utilise insights from culture surveys undertaken to inform local quality improvement plans • maintain oversight of improvement outcomes and learning, and ensure intelligence is actively shared with key system stakeholders for the purpose of improvement		

SA 10: Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) scheme for 2021/22?				
Relevant time period - 1ST April 2021 - 05TH December 2022				
No:	Description	Minimum evidential requirement for Trust Board	RAG rating	Evidence
A	Reporting of all qualifying cases to HSIB from 1 April 2021 to 5 December 2022	Trust Board sight of Trust legal services and maternity clinical governance records of qualifying HSIB/EN incidents and numbers reported to HSIB and NHS Resolution. Trust Board sight of evidence that the families have received information on the role of HSIB and EN scheme. Trust Board sight of evidence of compliance with the statutory duty of candour.		Badger Net Reporting HSIB Final Case Reviews
B	Reporting of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 1 April 2022 until 5 December 2022			Badger Net Reporting HSIB Final Case Reviews External validation by NHSR
C1	For all qualifying cases which have occurred during the period 1 April 2021 to 5 December 2022, the Trust Board are assured that: the family have received information on the role of HSIB and NHS Resolution's EN scheme.			HSIB Family Leaflet
C2	For all qualifying cases which have occurred during the period 1 April 2021 to 5 December 2022, the Trust Board are assured that: there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.			Quarterly Assurance Papers (QSC 29.10.21, 28.01.2022, 29.04.22, 29.07.2022, 28.10.22) Board (04.08.22)

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 2 February 2023

4.2

Agenda item:	4.2							
Presented by:	Giuseppe Labriola, Director of Midwifery							
Prepared by:	Erin Harrison, Head of Maternity Governance and Assurance							
Date prepared:	02nd December 2022							
Subject / title:	Overview of Serious Incidents within maternity services							
Purpose:	**Approval**		**Decision**		**Information**	x	**Assurance**	x
Key issues:	The Ockenden Report, published in December 2020, recommended that all maternity Serious Incidents (SI's) reports and a summary of the key issues are shared with Trust boards. There were 0 new maternity incidents declared since the last report There were 1 maternity incident closed since the last report Maternity services currently have 5 SI's under investigation (0 HSIB).							
Recommendation:	To provide assurance to the Board that the maternity service is continually monitoring compliance and learning from Serious Incidents.							

Trust strategic objectives:	**Patients**	**People**	**Performance**	**Places**	**Pounds**
	x	x	x	x	x

Previously considered by:	Patient Safety Group 13.12.22 Quality & Safety Committee (Part II) – 23.12.22
Risk / links with the BAF:	BAF 1.1
Legislation, regulatory, equality, diversity and dignity implications:	To be compliant with the Ockenden report that was published in December 2020 with recommendations for maternity services.
Appendices:	1. Open Serious Incidents under investigation

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The Princess Alexandra Hospital NHS Trust

1.0 Purpose

This paper outlines the open and recently closed Serious Incidents within Maternity services with concerns, themes, areas of good practice and shared learning identified.

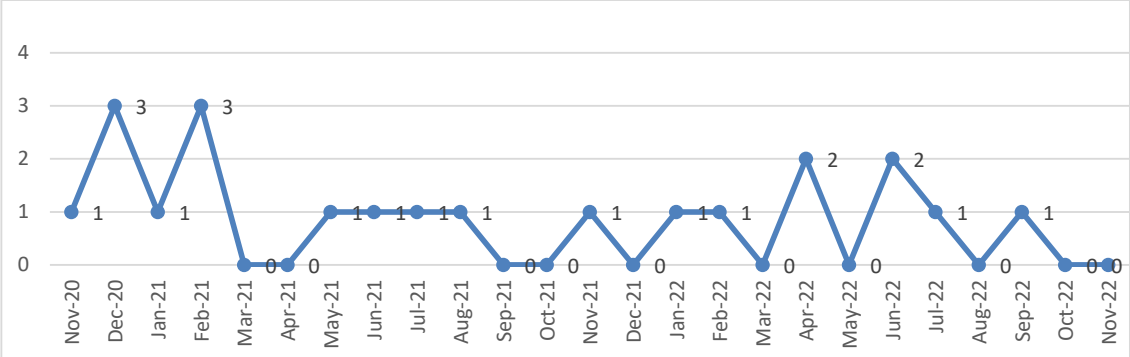
2.0 Background

The Ockenden Report, published in December 2020, recommended that all maternity Serious Incidents (SI's) reports and a summary of the key issues are shared with Trust boards.

3.0 Analysis

Maternity currently have 5 SI's under investigation, 0 of which are being investigated by Healthcare Safety Investigation Branch (HSIB), the detail can be found in Appendix 1. Table 1 details the trend of declared SI's within the last 24 months to November 2022.

Table 1. Comparison of SI's reported for Maternity in last 24 months (to November 2022)



There were 0 new serious incidents declared in November 2022.

Table 2. Serious Incidents declared, submitted and closed for November 2022

Serious Investigations		
Number Declared for November 2022		**0**
Number Submitted for November 2022		**1**
Number Past CCG Deadline as of November 2022 (Not including HSIB/Approved Extensions)		**0**
New Serious Investigations declared		
Ref	**Summary**	**Learning Points**
Closed Serious Investigations		
Paweb 107031	35 weeks pregnant with a history of reduced fetal movements and COVID-19. On arrival intrauterine death diagnosed and disseminated intravascular coagulation. Post-mortem consistent with COVID-19 placentitis. Complex case involving a multi-agency approach including PAHT, East and North Hertfordshire NHS Trust (ENHT),	• Cross border working with reviewing results – discussions ongoing with ENHT • Communication barriers due to language barrier

	General Practitioner and East of England ambulance service.	

4.0 Themes

Table 3 details the top themes identified in maternity SI's within the last 24 months to November 2022

Table 3. Top Themes

Total Number of SI's	Theme	Number
21	Cardiotocograph (CTG) interpretation	7
	Obstetric Haemorrhage	6
	Neonatal death	4
	Delay in care	4
	Compliance with guidance	3
	Hypertension	3
	Intrauterine death	3
	Escalation	3
	Hypoxic ischaemic encephalopathy	3
	Laceration at caesarean	1
	Fetal growth	1
	Cross Border Working	1
	Medical Equipment	1

5.0 Oversight

All highlighted concerns have been escalated at Divisional level. All incidents are discussed at the Women's Weekly Assurance Meeting, Divisional Governance Meeting and Trust Incident Management Group and escalated where relevant for further investigation. A maternity assurance committee has been established to provide assurance for quality and safety of the maternity service.

The Maternity Improvement board continues to drive change within the service.

Current work streams include:

- Maternity Triage and Telephone Helpline
- Induction of Labour
- Transitional Care
- Fetal Growth
- Diabetes
- Caesarean Booking Process
- Culture
- Antenatal Care – Booking Pathway
- Antenatal Care – Antenatal Clinic Demand and Capacity

Each work stream has an identified lead and progress is reported back to the Maternity Improvement Board. This reports into the monthly executive Maternity Assurance Committee.

There are three work streams that are subject to closure following extensive work and evidence of improvement:

- Massive Obstetric Haemorrhage/Post-Partum Haemorrhage
- Huddles, Handover and Ward Rounds
- Fundamentals of Care

All evidence will be bought through the Maternity Improvement Board and close by the Multidisciplinary Team.

6.0 Recommendation

It is requested that the Board accepts the report with the information provided and the ongoing work with the investigation process.

Author: Erin Harrison – Head of Maternity Governance and Assurance
Date: 02nd December 2022

The Princess Alexandra Hospital NHS Trust

4.2

APPENDIX 1

Open SI's under Investigation (excluding in month new declaration)

Ongoing Serious Investigations			
Ref	**Date Reported on STEIS and STEIS Code**	**Summary**	**Learning Points**
Paweb 113165 **Awaiting SIAP**	**25/04/2022** 2022/8111	Woman attended another Trust with history of bleeding and infertility. Hysteroscopy undertaken which identified a man-made foreign object in the cervix and uterus. Unable to remove so booked for laparoscopy/laparotomy for removal.	• Round table held with Trust and notes/images received. • Surgical procedure has confirmed a retained object – investigation ongoing.
Paweb 111144 **Awaiting SIAP**	**01/06/2022** 2022/11147	Woman attended at 26+2 gestation with abdominal pain and amniotic fluid leaking. The birth was imminent and the baby required extensive resuscitation at birth. After 52 minutes a decision was made to stop of resuscitation.	• Room layout in rooms 7,8 & 9. In cases of preterm birth resuscitaire needs to be used via piped gases. • Neonatal Consultant to be called at earliest opportunity
Paweb 115539 **Awaiting SIAP**	**13/06/2022** 2022/11968	A woman in her fourth pregnancy attended the emergency department at 22+1 weeks gestation with a history of abdominal pain, dizziness and feeling unwell for 3 days. The mother collapsed whilst in the emergency department and was clinically unstable with a Hb of 30g/L. The baby was born with signs of life and passed to the midwife and neonatal consultant who was present for the birth. Neonatal resuscitation was not commenced for approximately 10 minutes. A 2222 neonatal emergency call was placed and resuscitation equipment was brought up to main theatre including a resuscitaire. The baby responded well to resuscitation, was intubated and transferred to the neonatal intensive care unit (NICU). The Paediatric and Neonatal Decision Support and Retrieval Service (PANDR) declined transfer as the baby had not had any resuscitation for >10 minutes (transfer criteria not met).The baby died approximately 4 hours later.	• Case to be used for Perinatal Mortality and Morbidity Meeting • Review of gestation and pathways between ED and Maternity • Communication between ED and Labour Ward

Paweb 117972 **Awaiting SIAP**	**27/07/2022** 2022/16043	Baby boy born via vaginal birth following induction of labour due to irregular maternal antibodies (Anti-C and Anti-E). Baby was diagnosed as DAT positive (risk that he/she could develop anaemia due to maternal antibodies) and was discharged home on day 1 with a prescription for folic acid. The mother called the community team on day 12 to report concerns regarding abnormal skin colour, behaviour and feeding. She was advised baby is well and discharged from community care. The mother attended a clinic on day 17 to report her concerns and was immediately advised to attend the emergency department. Baby was diagnosed with haemolytic disease of the newborn and required urgent admission, a total of 5 blood transfusions and treatment for low saturations and tachycardia.	• Communication surrounding paediatric plan • Communication between the midwifery team and the family • Case booked for perinatal mortality and morbidity review
Paweb 119843	**16/09/2022** 2022/20047	Mixing wireless telemetry Cardiotocograph (CTG) and wired CTG recording. Patient was on CTG and then discontinued to go to toilet but the CTG was still recording from fetal monitoring in adjacent room.	• Escalated to MHRA and Manufacturer to review • Quick escalation at time of incident by midwife • Wireless telemetry recording suspended • Escalated to national maternity team

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 2 February 2023

4.2

Agenda item:	4.2							
Presented by:	Giuseppe Labriola – Director of Midwifery							
Prepared by:	Kate Boxall – Bereavement Midwife							
Date prepared:	10.01.2023							
Subject:	Perinatal Mortality Review Tool (PRMT) Quarter 2 2022/23							
Purpose:	**Approval**		**Decision**		**Information**	x	**Assurance**	x
Key issues:	This report provides information on all deaths of babies at The Princess Alexandra Hospital NHS Trust (PAHT) in Quarter 2 July/August/September 2022 and the review process, findings and actions plans arising from the reviews. The service will be declaring non-compliance with Safety Action 1 of Year 4 Maternity Incentive Scheme. It has been identified that despite a review of the care had been undertaken as per the normal process this was not submitted within the reported timeframes to the PMRT tool which then reflects to state we are non-compliant.							
Recommendations:	To note this report and the further detail which is provided in the final Maternity Incentive Scheme Paper to Board							

Trust strategic objectives:	**Patients**	**People**	**Performance**	**Places**	**Pounds**
	x	x	x		x

Previously considered by:	To be considered at Divisional Board 15.02.23 Quality & Safety Committee (Part II) – 27.01.23
Risk / links with the BAF:	BAF 1.1
Legislation, regulatory, equality, diversity and dignity implications:	Maternity Incentive Scheme – Year 4
Appendices	Appendix 1: Criteria for PMRT Appendix 2: MDT Panel composition

The Princess Alexandra Hospital NHS Trust

4.2

1.0 Purpose

As part of the NHS Resolution Maternity Incentive Scheme: Safety Action One, the maternity service is required to provide a quarterly update to the board of all perinatal deaths in the preceding quarter, detailing the death review process to confirm they have been reviewed using the Perinatal Mortality Review Tool (PMRT) and any consequent action plans as a result of the review. This paper provides this information.

2.0 Background

The required standards for meeting Safety Action One have been updated in May 2022:

a) All perinatal deaths eligible to be notified to MBRRACE UK from 6th May 2022 onwards must be notified to MBRRACE-UK within seven working days and the surveillance information where required must be completed within one month of the death.

A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 6th May 2022 will have been started within two months of each death. This includes deaths after home births where care was provided by the Trust.

b) At least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in the Trust, including home births, from 6th May 2022 will have been reviewed using the PMRT, by a multidisciplinary review team. Each review will have been completed to the point that at least a PMRT draft report has been generated by the tool within four months of each death and the report published within six months of each death. How are we detailing in the analysis below that we have met this section?

c) For at least 95% of all deaths of babies who died in the Trust from 6th May 2022, the parents will have been told that a review of their baby's death will take place, and that the parents' perspectives and any questions and/or concerns they have about their care and that of their baby have been sought. This includes any home births where care was provided by Trust staff and the baby died either at home or in the Trust. If delays in completing reviews are anticipated parents should be advised that this is the case and be given a timetable for likely completion. Trusts should ensure that contact with the families continues during any delay and make an early assessment of whether any questions they have can be addressed before a full review has been completed; this is especially important if there are any factors which may have a bearing on a future pregnancy. In the absence of a bereavement lead ensure that someone takes responsibility for maintaining contact and for taking actions as required.

Quarterly reports will have been submitted to the Trust Board from 6th May 2022 onward that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety and Board level safety champions. How are we detailing that we have met this standard. Agenda item at next meeting etc.

3.0 Analysis

Since the commencement of the Maternity Incentive Scheme in 2018 there have been ninety eight (98) cases reported (Stillbirths/Neonatal Deaths) that adhere to the PMRT criteria

Year	Number of cases reported
2018	17
2019	17
2020	19
2021	26
2022	19

There were four deaths, notified to MBRRACE during July-September 2022 Q2.

Report ID	Date of death	Date notified (within 7 days)	Date surveillance complete (within 1 month)	Review started (within 2 months)	Review completed (within 6 months)
82356	01/07/2022	05/07/2022	27/9/2022	28/10/2022	02/11/2022
82597	15/07/2022	19/07/2022	21/07/2022	17/10/2022	17/11/2022
82756	27/07/2022	01/08/2022	01/08/2022	20/10/2022	07/12/2022
82966	07/08/2022	11/08/2022	27/09/2022	17/10/2022	17/11/2022
Completed on PMRT system within timeframe		Not completed on PMRT system within timeframe		Not yet due	

The PMRT meetings take place on a monthly basis as part of a multidisciplinary panel details of eligible cases can be found in Appendix 1. There is one consultant neonatologist and one neonatal nurse who routinely attend for all neonatal death reviews as per national requirements (Appendix 2). All neonatal deaths are also reviewed at the Perinatal Morbidity and Mortality Meeting, which has a larger attendance. There have been recent improvements in having an external panel member – which is now achieved by the attendance of the Local Maternity Neonatal Systems (LMNS) Quality and Safety Governance Midwife, the LMNS Neonatal lead and representation from bereavement midwives in our LMNS.

There were no cases where issues identified were likely to have made a difference to the outcome of the case.

Data and themes identified from cases are provided in Table 1

Table 1. Data and themes from PMRT reviews

Ethnicity	
White British	2
Black African	1
White Other	1

Gender of Baby	
Male	3
Female	1

Gestation	
22+0 – 24+0	1
24+1 – 28+0	1
28+1 – 34+0	0
34+1 – 36+6	1
37+0 – 40+	1

Mode of Birth	
Spontaneous Vaginal Birth	2
Emergency Caesarean Section	2

Actions	
Partogram incomplete or not used	1
No issue identified	1
Risk Assessment not undertaken	2

Cause of Death	
Extreme Prematurity	1
Placental Abruption	1
Not able to confirm	2

Grading of the mother and baby up to the point that the baby was confirmed as having died	
The review group concluded that there were no issues with care identified up the point that the baby was confirmed as having died	0
The review group identified care issues which they considered would have made no difference to the outcome for the baby	3
The review group identified care issues which they considered may have made a difference to the outcome for the baby	1
The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0
Grading of care of the mother following confirmation of the death of her baby	
The review group concluded that there were no issues with care identified for the mother following the death of her baby	2
The review group identified care issues which they considered would have made no difference to the outcome for the mother	2
The review group identified care issues which they considered may have made a difference to the outcome for the mother	0
The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother	0

4.0 Recommendation

The service will be declaring non-compliance with Safety Action 1 of Year 4 Maternity Incentive Scheme. The service completed a review and assurance deep dive into our PMRT processes in October 2022. It was at this point we identified disparity to what had been completed locally and what was documented on the MBRRACE PMRT reporting page. At this time, there were 7 reportable cases and although immediate reviews of the care had been undertaken as per the usual process, this was not submitted within the reported timeframes to the MBRRACE PMRT tool, which then reflects to state we are non-compliant. All deaths were reported within the 7 day timescale and all cases have had an MDT review and report generated and published within 6 months of the death. There were a number of mitigating factors during this time period; change in bereavement lead, Trust wide IT issues and the need to prioritise clinical care, all of these situations led to the online system not being updated correctly despite in person reviews being undertaken. The service has an action plan in place to address the shortfalls which will provide a more robust governance and assurance process within the Division as well as Board Level oversight. This will be addressed in the final Maternity Incentive Scheme Paper to Board.

Author: Kate Boxall – Bereavement Midwife
Date: 10.01.2023

Appendix 1: The PMRT has been designed to support the review of the following perinatal deaths

Deaths eligible for notification from 1st January 2018 onwards are:
Late fetal losses – the baby is delivered between 22+0 and 23+6 weeks of pregnancy (or from 400g where an accurate estimate of gestation is not available) showing no signs of life, irrespective of when the death occurred. Stillbirths – the baby is delivered from 24+0 weeks gestation (or from 400g where an accurate estimate of gestation is not available) showing no signs of life. Early neonatal deaths – death of a live born baby (born at 20 weeks gestation of pregnancy or later or 400g where an accurate estimate of gestation is not available) occurring before 7 completed days after birth. Late neonatal deaths – death of a live born baby (born at 20 weeks gestation of pregnancy or later or 400g where an accurate estimate of gestation is not available) occurring between 7 and 28 completed days after birth. Post-neonatal deaths – We are no longer collecting information for post-neonatal deaths because of the difficulty in ensuring complete data collection from the wide variety of places of death for these cases.

Appendix 2. Recommended composition of the local perinatal mortality review group

Core membership	Additional members
Roles within the group: Chair and Vice-Chair Scribe/Admin support PMRT/Maternity Safety Champion Minimum of 2 of each of the following: Obstetrician Midwife Neonatologist and Neonatal Nurse: (All cases where resuscitation was commenced / All neonatal deaths) Bereavement team (1 acceptable) Risk manager/governance team member (1 acceptable) External panel member (1 acceptable) Other members as appropriate to the organisation of care in the Trust/Health Board e.g. service manager	Named and invited to attend or contribute where applicable: Pathologist GP/Community healthcare staff Anaesthetist Sonographer/radiographer Safeguarding team Service manager Any other relevant healthcare team members pertinent to case

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 2 February 2023

Agenda item:	4.2
Presented by:	Giuseppe Labriola – Director of Midwifery
Prepared by:	Erin Walters – Head of Maternity Governance and Assurance
Date prepared:	12.01.2023
Subject / title:	Maternity Assurance Report – Quarterly review Oct- Dec 2022 (Q3)

Purpose:	**Approval**		**Decision**		**Information**	x	**Assurance**	x

Key issues:	The recent Maternity Incentive Scheme (MIS) Year 4, published in October 2021 has issued the requirement for quarterly reporting to Board including details on number of serious harm incidents, themes identified and actions being taken to address any issues, minimum staffing in maternity services and training compliance. The expectation is that the paper will be presented by the Board Level Safety Champions moving forward to be in line with the national requirements.
Recommendation:	To provide assurance to the Trust Board that the maternity service ise continually monitoring compliance and learning from complaints and incidents.

Trust strategic objectives: please indicate which of the five Ps is relevant to the subject of the report	**Patients**	**People**	**Performance**	**Places**	**Pounds**
	x	x	x	x	x

Previously considered by:	To be considered at Divisional Board 15.02.23 Quality & Safety Committee (Part II) 27.01.23
Risk / links with the BAF:	BAF 1.1
Legislation, regulatory, equality, diversity and dignity implications:	To be compliant with Year 4 of the Maternity Incentive Scheme which was published in October 2021
Appendices:	N/A

The Princess Alexandra Hospital NHS Trust

4.2

1.0 Purpose/issue

This paper is to provide assurance to the Board

2.0 Background

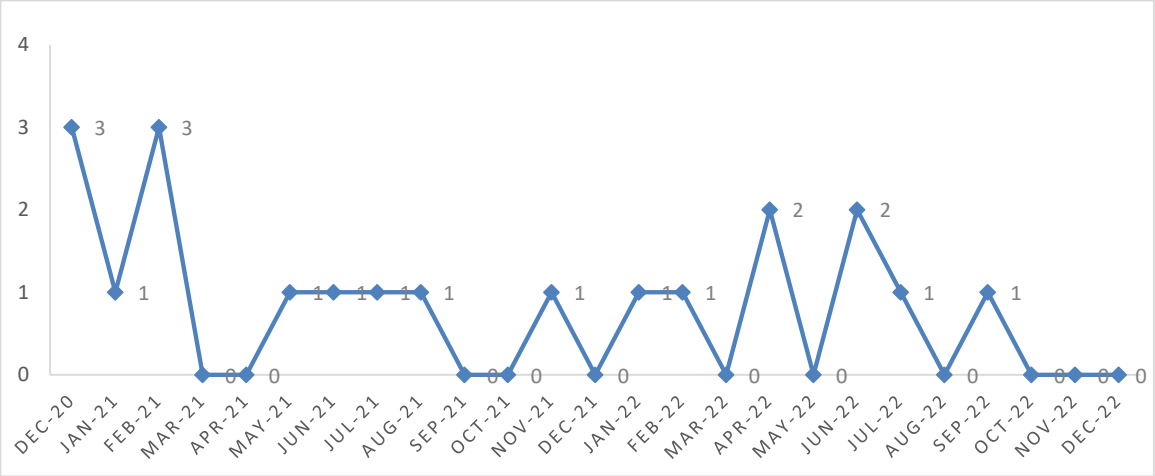
NHS Resolution is operating year four of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care.
The maternity incentive scheme applies to all acute Trusts that deliver maternity services and are members of the CNST. As in previous years, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund. As in year three, the scheme incentivises ten maternity safety actions. Trusts that can demonstrate they have achieved all of the ten safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds.

3.0 Analysis

Serious Incidents

Maternity currently have 5 SI's under investigation, 0 of which is being investigated by HSIB, the detail can be found in Table 2. Table 1 details the trend of declared SI's within the last 24 months to December 2022.

Table 1. Comparison of SI's reported for Maternity in last 24 months (to December 2022)



There were 0 new serious incidents declared in Quarter 3 of 2022/23.

Table 2. Serious Incidents declared and submitted for October-December 2022 (Q3)

	Serious Investigations	
	Number Declared for Q3 2022/23	**0**
	Number Submitted for Q3 2022/23	**1**
	Number Past CCG Deadline as of December 2022 (Not including HSIB/Approved Extensions)	**0**
	Total Open SIs for Maternity to date (including HSIB)	**5**

New Serious Investigations declared			
Ref	**Date Reported on STEIS and STEIS Code**	**Summary**	**Learning Points**
All open serious incidents			
Paweb 113165 **Awaiting SIAP**	**25/04/2022** 2022/8111	Woman attended another Trust with history of bleeding and infertility. Hysteroscopy undertaken which identified a man-made foreign object in the cervix and uterus. Unable to remove so booked for laparoscopy/laparotomy for removal.	• Round table held with Trust and notes/images received. • Surgical procedure has confirmed a retained object – investigation ongoing.
Paweb 111144 Awaiting SIAP	**01/06/2022** 2022/11147	Woman attended at 26+2 gestation with abdominal pain and amniotic fluid leaking. The birth was imminent and the baby required extensive resuscitation at birth. After 52 minutes a decision was made to stop of resuscitation.	• Room layout in rooms 7,8 & 9. In cases of preterm birth resuscitaire needs to be used via piped gases. • Neonatal Consultant to be called at earliest opportunity
Paweb 115539 Awaiting SIAP	**13/06/2022** 2022/11968	A woman in her fourth pregnancy attended the emergency department at 22+1 weeks gestation with a history of abdominal pain, dizziness and feeling unwell for 3 days. The mother collapsed whilst in the emergency department and was clinically unstable with a Hb of 30g/L. The baby was born with signs of life and passed to the midwife and neonatal consultant who was present for the birth. Neonatal resuscitation was not commenced for approximately 10 minutes. A 2222 neonatal emergency call was placed and resuscitation equipment was brought up to main theatre including a resuscitaire. The baby responded well to resuscitation, was intubated and transferred to the neonatal intensive care unit (NICU). The Paediatric and Neonatal Decision Support and Retrieval Service (PANDR) declined transfer as the baby had not had any resuscitation for >10 minutes (transfer criteria not met).The baby died approximately 4 hours later.	• Case to be used for Perinatal Mortality and Morbidity Meeting • Review of gestation and pathways between the emergency department (ED) and Maternity • Communication between ED and Labour Ward
Paweb 117972 Awaiting SIAP	**27/07/2022** 2022/16043	Baby boy born via vaginal birth following induction of labour due to irregular maternal antibodies (Anti-C and Anti-E). Baby was diagnosed as DAT positive (risk that they could develop anaemia due to	• Communication surrounding paediatric plan

		maternal antibodies) and was discharged home on day 1 with a prescription for folic acid. The mother called the community team on day 12 to report concerns regarding abnormal skin colour, behaviour and feeding. She was advised baby is well and discharged from community care. The mother attended a clinic on day 17 to report her concerns and was immediately advised to attend the emergency department. Baby was diagnosed with haemolytic disease of the newborn and required urgent admission, a total of 5 blood transfusions and treatment for low saturations and tachycardia.	• Communication between the midwifery team and the family • Case booked for perinatal mortality and morbidity review
Paweb 119843 **Agreed deadline 01.02.2023**	**16/09/2022** 2022/20047	Concern with wired and wireless telemetry Cardiotocograph (CTG). Patient was on CTG and this was discontinued to go to attend the bathroom. The CTG continued to record fetal monitoring in adjacent room.	• Escalated to Medicines and Healthcare products regulatory agency (MHRA) and Manufacturer to review • Prompt escalation of incident by midwife • Wireless telemetry recording suspended • Escalated to national maternity team

Clinical Incidents

There is a daily Datix review meeting undertaken by the Senior Midwifery Team and the Governance Consultant to ensure that any incidents requiring escalation are identified immediately.

There has been an 8% decrease in the amount of open incidents at the end of Q3. All moderate harm incidents have had a review and all relevant concerns have been escalated through the Trust Governance processes, all relate to post-partum haemorrhages.

Table 3. Current Clinical incidents open and closed

Clinical Incidents (DATIX)	
Number of Incidents Submitted Last Quarter	366 (94% low or no harm)
Number of Incidents Moderate Harm or Above	11↓
DoCs Outstanding	None
Number of Open Incidents	102 (4 moderate harm or above)
Number of Incidents Submitted for last financial year April 2021 – March 2022	1262
Percentage of Open Incidents	28%↓

Table 4. Legal Cases Received over October-December 2022 (Q3)

Legal Cases			
	New	Closed	NHSR (Early Notification Scheme)
Oct 2022	0	1	0
Nov 2022	0	0	0
Dec 2022	0	0	0

Perinatal Mortality Review Tool Summary

PMRT was launched in January 2018 with the aim of standardising perinatal reviews across NHS maternity and neonatal units in England, Wales and Scotland. The tool is used to support a systematic, multidisciplinary, high quality review and to ensure that parents are involved in the process. This enables a structured process of review, learning, reporting and actions to improve future care and to come to a clear understanding of why each baby died, accepting that this may not always be possible even when full clinical investigations have been undertaken which in turn involves a grading of the care provided. Reports will be published and shared with the family and placed in the medical notes.

PAHT perform a review of cases on a monthly basis which is undertaken as a multidisciplinary panel including midwives, obstetricians, neonatologists and external experts. Table 5 shows the current open cases for PAHT. All cases are within the reportable time frames for MIS Yr 4.

Table 5. Perinatal Mortality Review Tool Open Cases

Perinatal Mortality Review Tool Summary
7 open cases for PAHT 2 open with other Trusts All cases are scheduled for review

MBRRACE-UK Real Time Data Modelling for past 6 months

The MBRRACE-UK reporting system is in use across England, Scotland and Wales. The system is used to report all cases of maternal death, late fetal losses, stillbirths and neonatal deaths. PAHT is are compliant with all reporting requirements, Table 6 shows reported cases over the last 6 months.

Table 6. MBRRACE Reportable Cases

MBRRACE-UK Real Time Data Modelling for Past 6 Months

6 reported deaths to MBRRACE which included:

4 Antepartum stillbirths
0 Intrapartum stillbirth
1 Neonatal death
1 Medical Termination of Pregnancy

Ethnicity:

White British	3
Black or Black British African	1
Indian	1
Any other mixed	1

External Reviews and External Scrutiny

Table 7. External Reviews and Scrutiny

External Reviews and External Scrutiny
• *HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust* • *Coroner Reg 28 made directly to Trust*
PAHT currently have 0 cases that are under investigation by HSIB as per Table 1. Below shows the status of all reported cases to HSIB.

Cases to date	
Total referrals	15
Referrals/cases rejected	7
Total investigations to date	8
Total investigations completed	8
Current active cases	0
Exception reporting	0

No inquests undertaken for maternity care.

Staffing

Table 8. Current staffing across Maternity, Neonatal and Obstetric Workforce

Staffing

Staff feedback from frontline champions and walk-abouts:

Staffing remains a key area of concern across the service. There continues to be ongoing recruitment planning. A lead recruitment and retention midwife is now in post which will assist with the outstanding vacancies, retention and wellbeing.

The service is still actively recruiting international midwives with the support of the Preceptor Support Midwife.

IT issues in community and inpatient areas have been escalated formally through both the Division and the Safety Champions. There is ongoing consultations with the IT team to remedy the situation.

Consultant Obstetric Cover on the Labour Ward	87 hours cover (RCOG recommendation is 98 hours)
Junior Doctor Rota Gaps	No rota gaps – Currently recruiting to implement a 2 tier rota (2 registrars per shift)

Midwifery and Neonatal Staffing

	Sep	Oct	Nov
Overall Sickness (<3.7%)	4.87%	5.60%	6.02%
Short Term Sick	2.81%	3.30%	2.93%
Long Term Sick	2.06%	2.30%	3.09%
Turnover (voluntary) (<12%)	18.07%	17.80%	18.25%

Proportion of midwives responding with 'Agree or Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment (Reported annually)	**Proportion of speciality trainees responding with 'excellent or good' on how they would rate the quality of clinical supervision out of hours (Reported annually)**
Workshops have been booked with the Senior Leadership Team to discuss results	Awaiting Staff Survey

and implement changes. Monthly feedback sessions in place via multiple sources	

Training Compliance

With the pandemic a decision was made to suspend all training to support safe staffing. PROMPT, Neonatal Life Support and Fetal Monitoring study days have continued to be compliant with Maternity Incentive Scheme Year 4. From July 2022 the Fetal Monitoring Study day went back to face to face training.

Table 9. Training Compliance

	Oct-22	Nov-22	Dec-22
SFH	100%	95%	96%
PROMPT	93%	96%	97%
NLS	96%	98%	98%
Appraisals	75.6%	83.53%	85.23%
BLS	72%	72%	70%
FAWS	87%	85%	82%

MIS Progress

The maternity incentive scheme applies to all acute Trusts that deliver maternity services and are members of the CNST. As in previous years, members contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund. As in year three, the scheme incentivises ten maternity safety actions. Trusts that can demonstrate they have achieved all of the ten safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds.

Year 4 was launched in August 2021 with the required minimal evidential standards updated and distributed in October 2022.

The 10 Safety Actions have not changed since last year's scheme however there has been inclusion of further evidence required.

Once all evidence has been collated the Board will be required to sign off the scheme which will be submitted in February 2023.

Table 10. MIS Progress Yr 4

MIS Progress Yr 4			
SA 1	Non-Compliant – agreed by ICB	SA 6	Signed off by ICB
SA 2	Signed off by ICB	SA 7	Signed off by ICB
SA 3	Signed off by ICB	SA 8	Signed off by ICB
SA 4	Signed off by ICB	SA 9	Signed off by ICB
SA 5	Signed off by ICB	SA 10	Signed off by ICB

Safety Action 1 will be declared as non-compliant. Although reviews of care have taken place in house these reviews were not reflected in real time onto the national reporting system. The service have contacted both NHS Resolution and the Team at MBRRACE and unfortunately the dates cannot be altered. There is now a weekly review of all perinatal deaths by the bereavement midwife and the bereavement matron to ensure that data is accurately reflected within the appropriate timescales.

All Safety Actions were reviewed and signed off by the ICB and Trust on 23.11.2022 and 9.1.2023. Following ICB approval, the scheme declaration form will be submitted to Trust Board in January 2023.

Ockenden

Following the publication of Donna Ockenden's first report: Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trust on 11 December 2020, all Trusts providing maternity services were required to undertake an immediate response looking at 7 immediate and essential safety actions (IEA) and workforce planning (WF).

The IEA are:

1. Enhanced safety
2. Listening to women and their families
3. Staff training and working together
4. Managing complex pregnancies
5. Risk assessment throughout pregnancy
6. Monitoring fetal wellbeing
7. Informed consent

The final report was released in March 2022, the service is currently in the process of reviewing the 15 new Immediate and Essential Safety Actions. This will be monitored via the revised maternity improvement board – with a focus monthly on regulatory requirements.

Table 11. Immediate and Essential Safety Actions outcome

IEA Progress			
IEA 1	94%	IEA 5	93%
IEA 2	100%	IEA 6	77%
IEA 3	75%	IEA 7	57%
IEA 4	100%	WF	100%

Saving Babies Lives Care Bundle v2 (SBLCBV2)

'Saving Babies' Lives is a care bundle designed to support providers, commissioners and professionals take action to reduce stillbirths. The guidance was developed with clinicians, commissioners, charities and royal colleges and is based on the best available evidence. It supports the delivery of safer maternity care, as described by the National Maternity Review, in Better Births' 2016.

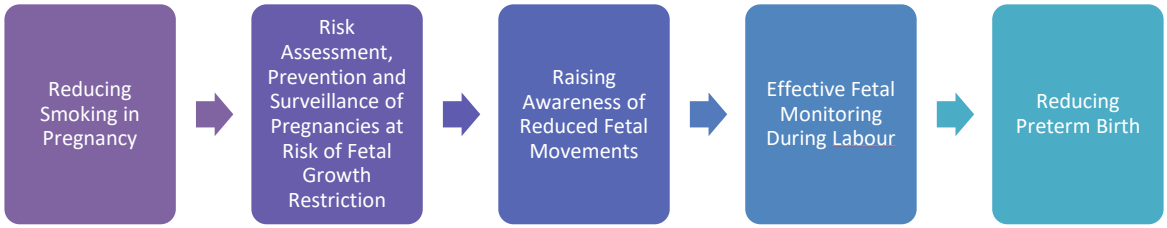


Table 12. Saving Babies Lives Score Card Summary

Saving Babies Lives Score Card Summary
Compliant with all elements. No areas of concern identified. Awaiting national update with regards to elements of SBLCB v3 which will be launched in 2023.

Complaints/PALS

Table 13. Current open complaints/PALs and Service User Feedback

Complaints	Pals	Compliments
October – 4 November – 4 December – 0	October – 11 November – 9 December – 15	October – 3 November – 3 December – 1
Themes		
All complaints received over Q3 related to direct care provided and communication. Pals themes were surrounding communication and delay. No Change since Q2		
Service User Feedback		
"Throughout the whole experience they made me & my partner feel comfortable, calm, reassured & cared for. They ensured that my "ideal" birthing plan was met by opening a room on the birthing centre. This made me feel at ease as I felt in control. Arriving in the birthing centre, we were amazed at the setting and facilities; the candles, the lights & the whole atmosphere! I would recommend anyone who is low risk, to birth in the birthing centre!" *"Just wanted to say thank you again for everything! I gave birth to my baby daughter at the labour ward, every single member of staff involved in our care was absolutely brilliant. We were so pleased and left the hospital well informed and confident should we need any further help!"*		

4.0 Oversight

All highlighted concerns have been escalated at Divisional board. All incidents are discussed at the Divisional Patient Safety and Quality Group and Trust Incident Management Group and escalated where relevant for further investigation. Staffing is assessed on a daily basis and the directorate are currently out to advert for all vacancies.

The service are continuing to work towards the requirements of MIS yr 4, SBLCBv2 and the Ockenden IEA. Escalation will occur through board where non-compliance is anticipated or found to occur.

The Princess Alexandra Hospital NHS Trust

5.0 Recommendation

It is requested that the Board accepts the report with the information provided and the ongoing work for assurance of compliance with local and national standards.

Author: Erin Harrison – Head of Maternity Governance and Assurance
Date: 12.01.2023

Trust Board (Public) – 2 February 2023

Agenda item:	4.3
Presented by:	Sharon McNally – Chief Nurse and Deputy CEO
Prepared by:	Sarah Webb – Deputy Chief Nurse
Date prepared:	16.1.2023
Subject / title:	Report on Nursing and Care Staff Levels for December 2022– Hard Truths Report

Purpose:	**Approval**		**Decision**		**Information**	x	**Assurance**	x
Key issues: please don't expand this cell; additional information should be included in the main body of the report	The overall fill rates for December were 89.7%. RN fill rate decreasing by 5.5% to 85.2% and care staff fill rates also decreased by 5.4% to 89.7%in line with additional escalation areas being opened and increased sickness from Covid and flu like symptoms							
Recommendation:	The Board is asked to note the information within this report.							

Trust strategic objectives: please indicate which of the five Ps is relevant to the subject of the report	**Patients**	**People**	**Performance**	**Places**	**Pounds**
	x	x	x		x

Previously considered by:	PC.23.01.23
Risk / links with the BAF:	BAF: 2.1 Workforce capacity All Divisions have both recruitment and retention on their risk registers
Legislation, regulatory, equality, diversity and dignity implications:	NHS England and CQC letter to NHSFT CEOs (31.3.14): Hard Truths Commitment regarding publishing of staffing data. NHS Improvement letter: 22.4.16 NHS Improvement letter re CHPPD: 29/6/18
Appendices:	**Appendix 1:** Registered fill rates by month against adjusted standard planned template. RAG rated. **Appendix 2a:** Ward staffing exception reports.

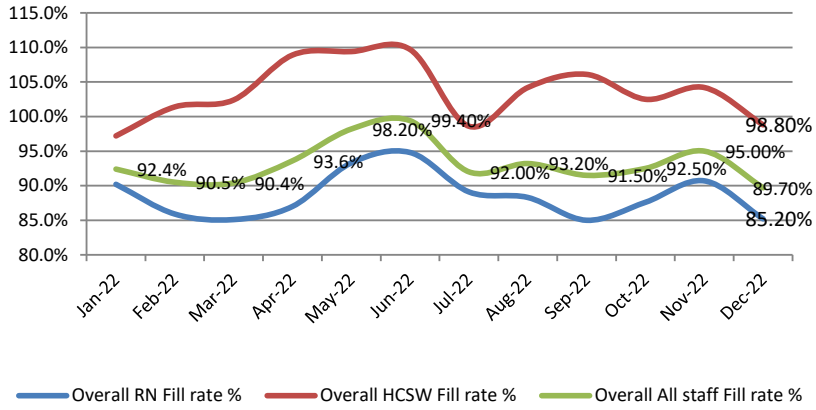
There was a downward trend in average fill rates in December; with the overall fill rates for December were 89.7%. RN fill rate decreasing by 5.5% to 85.2% and care staff fill rates also decreased by 5.4% to 89.7%. Nightingale ward continues to be open as part of winter escalation plans and additional surge areas were staffed to support flow in December such as PACU and ADSU.

AAU is an emerging risk with a 39% Band 5 vacancy rate. The ward is being supported and prioritised for new starters from International pipeline and as well a number of other measures to ensure fill rates and skill mix meet demand and acuity.

ED fill reduced in December due to vacancies and increased sickness. Recruitment activity continues. Overall vacancy in ED is 12% (10.95WTE) Across nursing there are 23 new international nurses staring in January with a further 48 before the end of March. Details on pipeline for 2023/24 will be provided in next report.

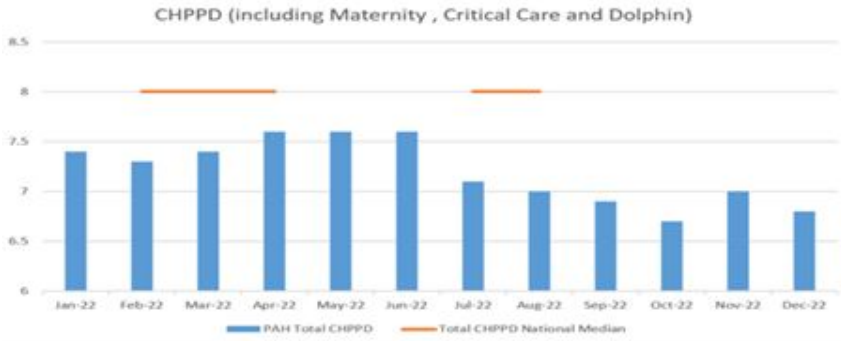
Overall Care Hours Per Patient Day (CHPPD) was 6.8 for December. The Model Hospital data for October 2022 shows the Trust with a CHPPD of 6.8 against the national median of 7.9. CPPD has fallen in line with additional escalation ward Nightingale opening.

Nursing and midwifery fill rate



ED Fill rate

A&E Nursing	Day		Night	
	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
October 2022	81.9%	77.2%	90.9%	75.7%
November 22	86.6%	80.6%	91.9%	79.0%
December 22	77.2%	79.3%	84.3%	73.9%



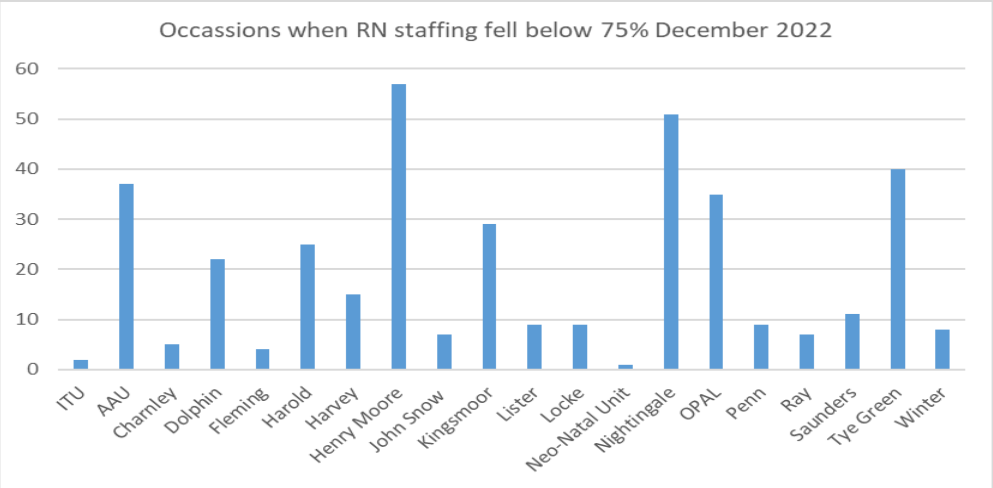
The number of occasions/shifts where the reported fill rate has fallen below 75% across the wards (excluding Maternity) increased to 383 (↑262) against November. If a nursing red flag event occurs for number of staff on duty to meet the care needs of patients, staff escalate the situation and if appropriate complete a Datix.

The trend in reports completed in relation to nursing and midwifery staffing is included below and shows that the number of incidents recorded had increased in month to 75 (↑31),

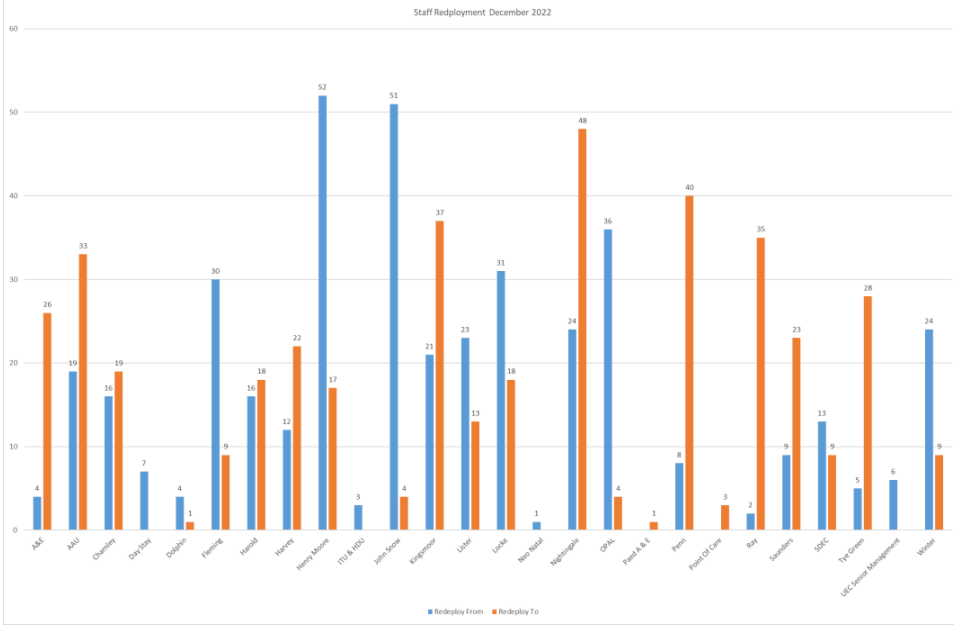
Tye Green raised 14, AAU 11, Kingsmoor 7 and A&E 6 Datix reports in relation to staffing levels where RN staffing has fallen below 75% across the wards (excluding Maternity) increased to 383 (↑262) against November. If a nursing red flag event occurs for number of staff on duty to meet the care needs of patients, staff escalate the situation and if appropriate complete a Datix.

Nightingale, Henry Moore, Tye Green and Dolphin reported average fill rates below 75% for RN against the standard planned template during December. This is the fourth consecutive month overall fill rates have been below 75% for Tye Green. Details on the impact on care can be found in below

Redeployment of staff continues to be undertaken to support SafeCare as part of the daily huddles. In December staff were moved from elective surgical wards (JSU and HMU) followed by Opal and Fleming both wards that have very low vacancies or are over establishment. Highest net receivers of staff were Nightingale (winter escalation), Penn and Kingsmoor. Work will commence in February on creating buddy wards to minimise impact on staff of having to move to an unfamiliar area.



Redeployment



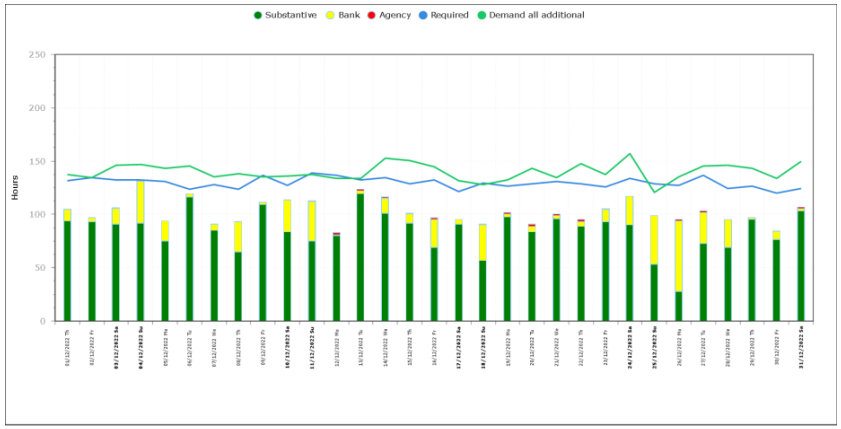
Appendix.1. Ward level data: fill rates December 2022. *(Adjusted Standard Planned Ward Demand)*

	Day		Night				
Ward name	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	% RN overall fill rate	% overall HCSW fill rate	% Overall fill rate
ITU & HDU	95.3%	49.0%	94.8%	54.1%	95.1%	51.5%	87.8%
Saunders Unit	84.8%	106.7%	82.0%	136.5%	83.6%	118.0%	95.9%
Nightingale	70.4%	75.2%	68.9%	95.1%	69.7%	84.7%	75.7%
Penn Ward	83.7%	108.0%	85.5%	152.3%	84.5%	124.8%	98.9%
Henry Moore Ward	69.8%	50.1%	65.6%	43.3%	67.8%	46.9%	59.4%
Harvey Ward	77.4%	105.0%	94.8%	112.4%	84.5%	108.5%	93.2%
John Snow Ward	97.5%	40.9%	91.9%	49.8%	94.8%	43.7%	72.7%
Charnley Ward	83.4%	106.5%	85.8%	107.7%	84.5%	107.0%	91.0%
AAU	75.5%	135.4%	76.5%	125.7%	75.9%	130.8%	87.7%
Harold Ward	69.1%	65.6%	91.4%	114.2%	78.2%	85.4%	80.6%
Kingsmoor General	64.4%	110.7%	90.4%	120.5%	74.3%	115.4%	89.6%
Lister Ward	82.8%	98.3%	100.2%	123.5%	90.2%	110.4%	98.2%
Locke Ward	89.9%	84.9%	79.3%	113.3%	84.8%	98.5%	89.9%
Ray Ward	83.0%	85.9%	92.7%	133.4%	87.1%	103.9%	93.1%
Tye Green Ward	62.4%	94.1%	72.3%	116.6%	66.7%	103.2%	80.9%
OPAL	88.3%	92.8%	74.4%	101.6%	81.6%	97.0%	87.8%
Winter Ward	81.1%	92.1%	88.0%	113.6%	84.0%	102.4%	91.3%
Fleming Ward	81.8%	110.8%	91.3%	105.2%	85.8%	108.2%	92.7%
Neo-Natal Unit	104.4%	83.9%	95.6%	112.9%	100.0%	98.4%	99.7%
Dolphin Ward	72.4%	96.7%	76.2%	88.9%	74.1%	94.1%	79.1%
Total	70.1%	90.2%	85.6%	109.0%	76.6%	98.5%	83.4%

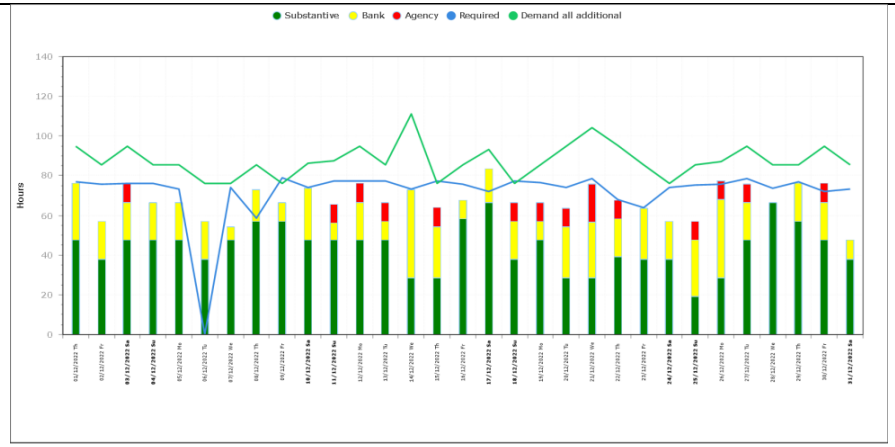
Appendix.2. Ward staffing exception reports for 4 areas where fill was below 75% NB In graphs below bars = staff on shift; blue line = staffing required based on acuity and dependency recorded twice a day and the green line = demand template based on establishment review.

Report from the Associate Director of Nursing for the Division							
Ward	Analysis of gaps			Impact on Quality / outcomes			Actions in place
This is the fourth consecutive month that Tye Green overall RN fill rate has been below 75%	RN overall Fill: 66.7% HCSW Overall Fill: 103.2% Overall Fill: 80.9%			Quality metrics remain static in month – risk recognised regarding pressure area care. Positive feedback from patients from FFT			Ward Manager worked within the numbers Practice Development Team support that is not captured in Safecare- working alongside staff in their preceptorship period. Support from Out Patients (going forward captured in Safecare). Regular Safety Huddles to review patient acuity and dependency and assign staff accordingly. Cohorting of patients based on enhanced care need to mitigate risk of falls and pressure injuries. Matron support in relieving staff for breaks and delivering patient care.
Quality Metric	PU	Falls	Staffing Datix	SIs	Drug Errors	Complaints	PALS
Number in month	10	1	14	0	0	0	1

Required vs Actual Day

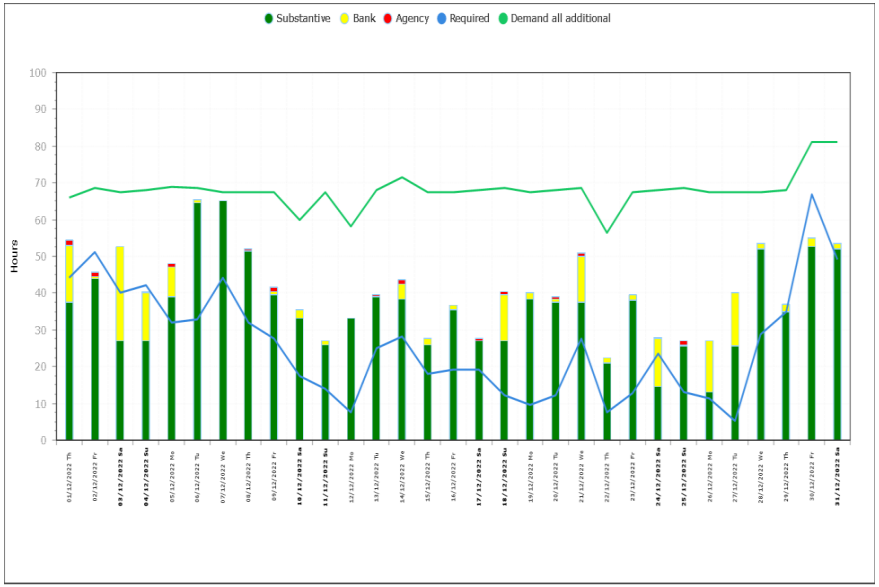


Required vs Actual Day

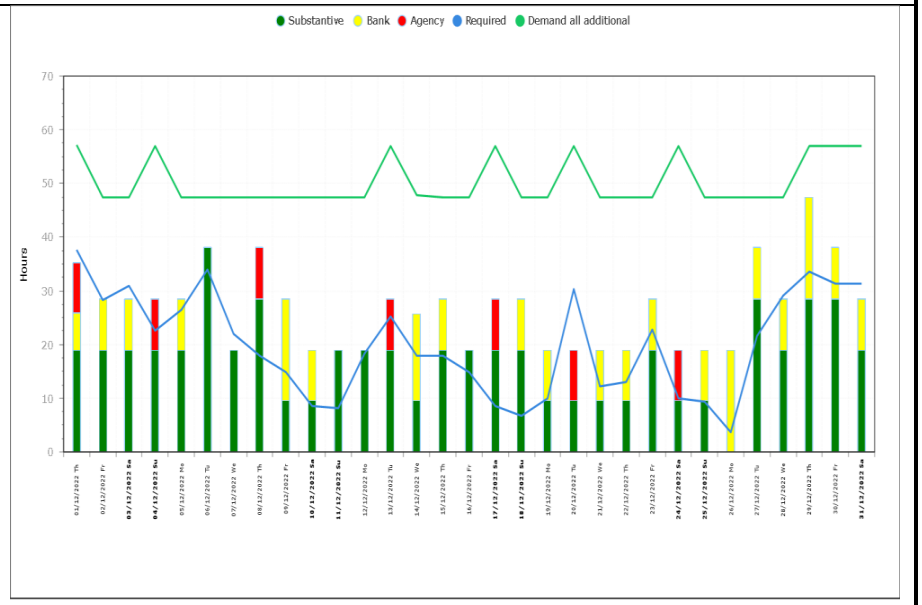


Report from the Associate Director of Nursing for the Division							
Ward	Analysis of gaps			Impact on Quality / outcomes			Actions in place
Henry Moore	Fill rates below template staffing: RN fill 67.8% HCSW Fill =46.9% Overall fill 59.4%.			Nil			A review of bed capacity and staffing is being undertaken by the surgical Division Graphs below demonstrate the actual number of staff on shift (bars) was ABOVE that required by the acuity and dependency of patients including numbers of patients during December (blue line) The green line is the template numbers on shift (the plan) Fill rates are calculated on blue line minus green line.
Quality Metric	PU	Falls	Staffing Datix	SIs	Drug Errors	Complaints	PALS
Number in month	0	0	0	0	0	0	0

Required vs Actual Day

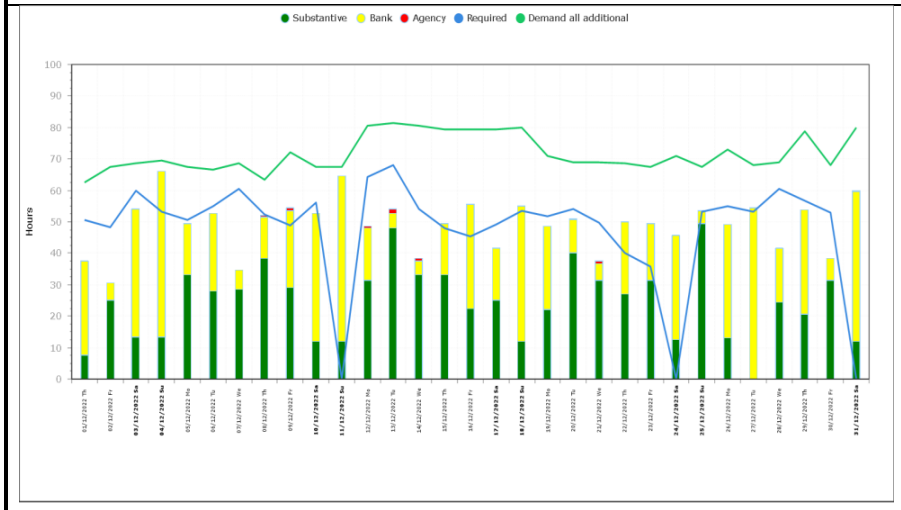


Required vs Actual Day

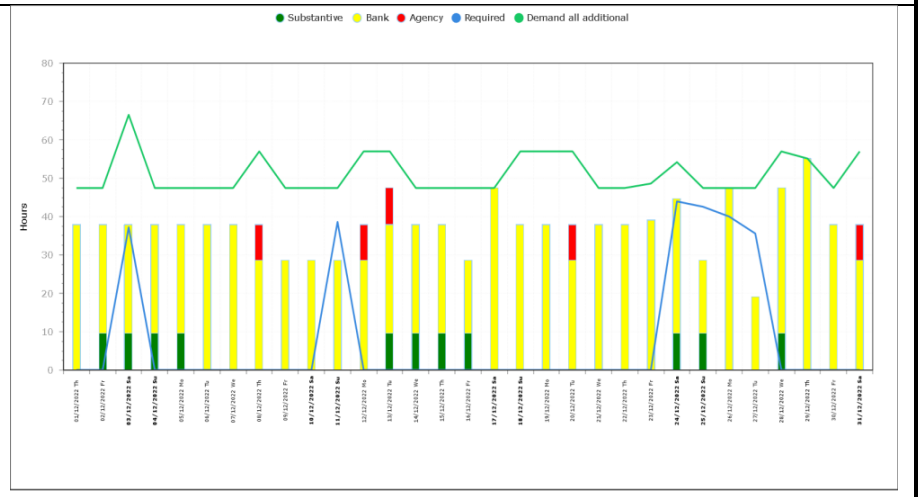


Report from the Associate Director of Nursing for the Division							
Ward	Analysis of gaps				Impact on Quality / outcomes		Actions in place
Nightingale	RN Fill = 69.7% HCSW fill = 84.7% Overall fill = 75.7%				Quality outcomes remain in line with expected with good mitigation to meet patient needs.		Ward Manager worked on the ward which is not reflected on Safecare Support from Outpatients nursing Practice Development team support Regular patient safety huddles to support prioritising patient care needs and utilisation of staff. Daily matron support and oversight.
Quality Metric	PU	Falls	Staffing Datix	SIs	Drug Errors	Complaints	PALS
Number in month	2	4	3	0	0	1	2

Required vs Actual Day

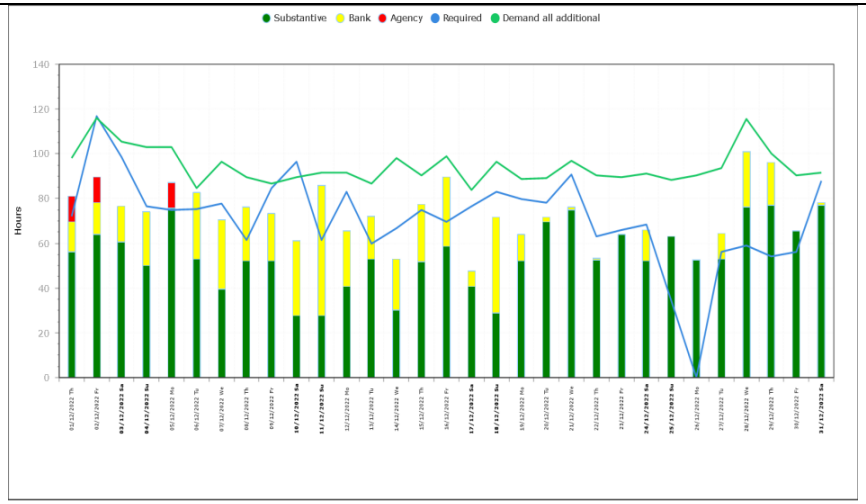


Required vs Actual Day

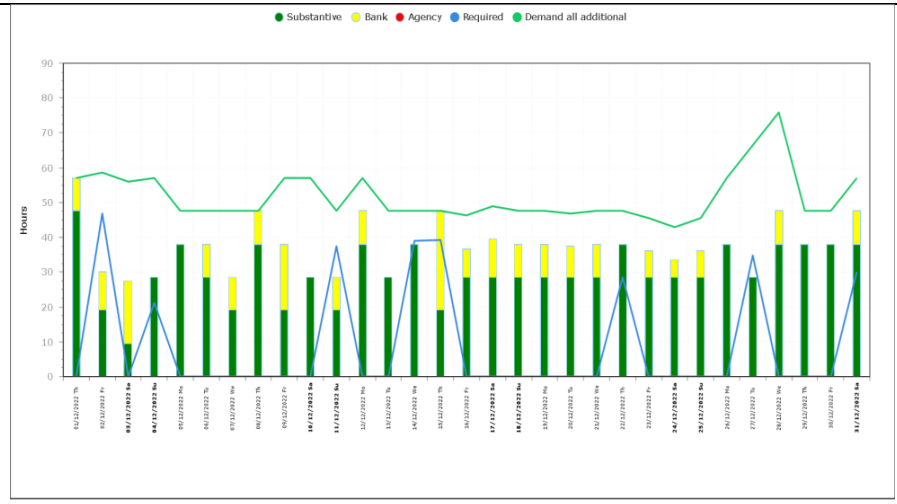


Report from the Associate Director of Nursing for the HCG							
Ward	Analysis of gaps			Impact on Quality / outcomes			Actions in place
Dolphin	RN overall fill: 74.1% HCSW fill: 94.1% Overall 79.1%			Nil			Nil Required
Quality Metric	PU	Falls	Staffing Datix	SIs	Drug Errors	Complaints	PALS
Number in month	0	0	0	0	0	0	0

Required vs Actual Day



Required vs Actual Day



The Princess Alexandra Hospital NHS
NHS Trust

Trust Board (Public) – 2 February 2023

4.4

Agenda Item:	4.4							
Presented by:	Sharon McNally, Director of Nursing and Midwifery							
Prepared by:	Shaheen Hosany, Polly Read and Jo Ward, Associate Directors of Nursing							
Date prepared:	30th December 2022							
Subject / Title:	Nursing Establishment Review							
Purpose:	Approval	x	Decision		Information		Assurance	x
Executive Summary:	This paper reports the recommendations following the nursing establishment review (September 2022). The review recommends changes in demand for qualified nurses (reduction of 8.62WTE) and an increase in demand for healthcare support workers (HCSW) (4.8 WTE), (details in section 5, and recommendations under section 9). In line with changes to the national role profile and banding of HCSWs, the paper recommends the net savings (£244k) be used to part fund the required uplift from Band 2 to Band 3 for HCSWs. A paper detailing the proposed changes and full costings will be presented through the appropriate channels.							
Recommendation:	The Board is are asked to support the outcome and recommendations of the nursing establishment review.							

Trust strategic objectives: [please indicate which of the 5Ps is relevant to the subject of the report]	Patients	People		Places	Pounds
	■	■	■		■

Previously considered by:	EMT 5th January: ITU recommendation added and business plan noted. SMT 17th January: supported with no changes People Committee 23d January: supported with no change.
Risk / links with the	BAR Risk 2.1 Nurse Recruitment
Legislation, regulatory, equality, diversity and dignity	NHSE: How to ensure the right people with the right skills in the right place at the right time (2014). Expectation one. NQB guidance (2013, 2016)
Appendices:	Appendix 1: Summary of Nurse Sensitive Indicators for each in-patient area Appendix 2: Emerging questions from 2021 review Appendix 3 Progress against Nursing Workforce Intentions 2021/22 Appendix 4: Enhanced care pool Appendix 5: CHPPD Appendix 6 Results of establishment review Bibliography

1. Purpose

The National Quality Board (NQB) in their publication 'Developing workforce safeguards' (2018), clearly sets out a requirement for the Board of Directors to receive a report outlining the assessment or resetting of the nursing establishment and skill mix by ward or service area at least annually.

Part A of this report details the results of the establishment review, which was undertaken in September 2022 and provides assurance that the review was undertaken in line with regulatory requirements. It outlines a series of recommendations following the review and details the nursing workforce intentions for 2023/24.

Part B outlines the financial impact of the recommendations.

A separate report for maternity staffing will be presented to the Board by the Director of Midwifery in conjunction with this paper.

Part A

2. Background and context

The NQB guidance (2014, 2018) and NICE (2014) set out clear expectations for boards in relation to staffing:

> *Boards are required to take full responsibility for the quality of care provided to patients, and as a key determinant of quality, take full and collective responsibility for nursing, midwifery and care staffing capacity and capability. Boards are required to ensure there are robust systems in place to assure themselves that there is sufficient capacity and capability to provide high quality care to patients on all wards, departments, services or environments day or night, every day of the week.*

This was reiterated in the RCN Nursing Workforce Standards (Supporting a safe and effective nursing workforce) 2021 Standard 1**:** Executive nurses are responsible for setting nursing workforce establishment and staffing levels. All members of the corporate board of any organisation are accountable for the decisions they make and the action they do or do not take to ensure the safety and effectiveness of service provision.

Post publication of the Francis Report 2013 and Safe Staffing in adult inpatient wards in acute hospital (NICE, 2014) the National Quality Board (NQB July 2016) has defined a framework and set of expectations (July 2016) to achieve the "right staff, with the right skills, in the right place at the right time", including the responsibilities of Trust Boards.

The fundamental aims of each of the safe nurse staffing guidance are set out as three main principles, right care, minimising avoidable harm and maximising the value of available resources.

NHS organisations have a responsibility to undertake an annual comprehensive nursing and midwifery skill mix review to ensure that there are safe staffing levels and to provide assurance to the Board and stakeholders. The yearly skill mix review should be "followed with a comprehensive staffing report to the board after six months to ensure workforce plans are still appropriate" (NQB 2016).

Lord Carter's report, 'Operational Productivity and Performance in English Acute Hospitals: Unwarranted variations' (revised February 2016), identified efficiency opportunities and the requirement for organisations to meet the challenges of maintaining and improving quality, operational performance, finance and efficiency. The latest CQC Consultation document outlines how effectively

a provider uses its resources is one of the factors that determines the quality and responsiveness of its care.

The principles set out by the NQB are further supplemented by a suite of nationally driven guidance documents, and speciality specific recommendations, which further inform the governance required to demonstrate the application and delivery of safe staffing in practice. A selection are included in the Bibliography

3. Process

The last establishment review was conducted in May 2021, gaining Board approval in January 2022. An interim review was undertaken and reported to Board in March 2022.

The data collection for this nursing establishment review was undertaken in September 2022 for the following areas, utilising approved acuity and dependency tools.

Adult Inpatient Wards	Safer Nursing Care Tool Adult Inpatient Areas
AAU and OPAL	Safer Nursing Care Tool Adult Inpatient Areas and Assessment Areas
Dolphin	Safer Nursing Care Tool Children's Inpatient Areas
Emergency Department – Adults and Paediatrics	Safer Nursing Care Tool Emergency Department

The data collection process consisted of collecting patient dependency/acuity data once a day for a minimum of 12 days to determine our Trust specific dependency mix. Data collection was in line with Shelford recommendations.

In previous staffing establishment reviews, we have used the BEST audit tool for the Emergency Departments; however, an SNCT tool has been specifically developed for the Emergency Department and this was the first year we have used this tool for both Adults and Paediatrics.

The Emergency Department Safer Nursing Care Tool (ED SNCT) is a safer staffing decision support tool, which uses the principles and framework of the Safer Nursing Care Tool for Adult Inpatients in Acute Hospitals. It was developed by the Shelford Group Chief Nurses, licenced by Imperial College London and supported by the Chief Nursing Officer for England.

The ED SNCT calculates nurse staffing requirements for the Emergency Department based on patients' needs (acuity and dependency), together with professional judgement, to inform evidence-based decision making on setting nursing establishments for the Emergency Department. The descriptors were agreed by senior nurses working/managing ED services in England, followed by an extensive data collection exercise, which included auditing quality standards, staff activity, patient acuity/dependency scoring and the tool was tested in practice with Trusts that were not part of the initial development for validity, reliability and usability. The Emergency Departments involved in this project included large acute trusts, as well as those with major trauma centres, and district general hospitals caring for adults only or adults and children. It is therefore suitable for determining nurse-staffing establishments for all Emergency Departments.

The SNCT calculation is based upon a funded headroom allowance of 22% (leave allowance including annual, study, sickness etc.), our trust allowance is currently 20%, it should be noted that the Royal College of Nursing (RCN) recommends 25%.

The Ward Manager role has been fully supervisory since the establishment review in 2019.

Whilst the establishment reviews focus on the acuity/dependency results, these were not reviewed in isolation. Experience and best practice identify that a wider suite of quality indicators must be considered to allow more informed approaches in respect of assuring the Trust that staff are in place

to provide high quality, safe and compassionate care. Therefore, in addition to the acuity/dependency results professional judgement, peer group validation, review of e-roster data and nurse sensitive indicators were incorporated into the review process.

A full breakdown of the nurse sensitive indicators that were reviewed when considering the SNCT results are in Appendix 1. Additional local information related to the ward layout, and professional judgement supplemented the outcome of the SNCT findings. Recommendations were then triangulated with the themes that emerged from the 2022/3 establishment review (Appendix 2).

4. Care Hours Per Patient Day (CHPPD)

CHPPD has been a regular method of measuring available capacity for several years. It is a mandated monthly report and provides local and central information regarding the average amount of care delivery time each patient receives per day. Lord Carter (2016) as part of his unwarranted variation review indicated that an overall average CHPPD of 7.5 or less could contribute to increase risk of patient harm. Furthermore, the patient to staff ratio's currently in place for general inpatient areas suggest that registered nurse establishment should provide approximately 3 hours CHPPD.

Appendix 5 shows a breakdown by ward during the census period of CHPPD and identifies that no area was below 2.9 hours CHPPD of registered nurse during this time.

5. Findings

A full breakdown of the findings from the establishment review can be found in Appendix 6. Wards which require a change in establishment are as follows:

Division	Ward	Change
Urgent and Emergency Care	AAU	No change
	SDEC	No change
	Charnley	No change
	ED	No change
Surgery Surgery savings in elective nursing demand (due to lower acuity of patients and efficient utilisation of day case pathways) will fund uplift in non-elective surgery increases.	Henry Moore	Reduce by 2.3WTE RN and 1.7HCSW
	John Snow Unit	Reduce by 2.3WTE RN
	Penn	Increase RN 2.47WTE
	Saunders	Increase RN 2.47WTE
	Harvey	No change
	Critical Care	No change at present. Based on the current GPICS (Guidelines for the Provision of Intensive Care Services) the nursing staffing levels for critical care are set in accordance with the current capacity for five level 2 patients and five level 3 patients. A business case is being written to request for additional funding to increase the capacity across critical care based on predicted demand and this will include an uplift in nursing establishment based on the proposed increased patient capacity.
Medicine	Fleming	Reduce establishment in line with SNCT by RN 1.7WTE and Band 2/3 0.4WTE
	Tye Green	No change
	Harold	Increase establishment in line with SNCT Band 5 Registered Nurses by 5.2 WTE and increase HCSW's by 3.5 WTE. Harold Ward is now the respiratory ward and was relocated from Locke Ward. The patient acuity is high as the ward

		support patients requiring NIV. There are 4 more beds on Harold than on Locke Ward.
	Winter	Decrease establishment in line with SNCT Band 5 RN by 1.66 WTE
	Lister	Decrease establishment in line with SNCT Band RN/NA by 2.42 WTE
	Locke	Reduce establishment in line with SNCT Band 5 RN by 4.9 WTE and Band 2/3 by 0.8 WTE. Locke Ward relocated from Harold Ward and reduced the bed base by 4.
	Ray	Increase establishment in line with SNCT by Band 5 2.0 and 2.0WTE Band 2/3 health care assistants
	Kingsmoor	Previously run as an unfunded escalation area the substantive funding introduced in financial year 2022/23 was based on the establishment required for a respiratory ward. Included as part of the September SNCT review the modelling has recommended an increase in RN numbers by 2.7WTE and increase the Band 2/3 numbers by 3.5 WTE.
	Opal	New area opened in September 2021. Establishment agreed as part of business case and predicated activity through the unit. Included as part of the September 2022 SNCT review with the recommendation to decrease the RN numbers by 5.64WTE and decrease Band 2/3 by 1.3WTE
CSS	Outpatients	There is not a nationally recognised tool to support calculating nursing workforce demand in outpatients. However, the CSS nursing leadership team will be reviewing capacity and demand modelling for outpatients staffing within the next 6 months and this will be reported in the next establishment review paper.
	William's Day Unit (Chemotherapy unit	There is not a nationally recognised tool to support calculating nursing workforce demand for chemotherapy units. However, the CSS nursing leadership team led by the Head of Nursing for Cancer will be reviewing capacity and demand modelling for chemotherapy nursing within the next 6 months and this will be reported in the next establishment review paper.
CHAWs NICU and Maternity staffing will be presented in the Maternity Establishment review paper	Paediatric ED:	SNCT data showed that the staffing for the core paediatric ED footprint was covered by the current budget. This excluded PACU and the triage model. The financial impact of the staffing model for triage and Paediatric Ambulatory Care unit will be brought as a separate business case when the final paediatric UTC model has been agreed.
	Dolphin:	No additional funding requests
Unfunded Areas	Nightingale	Open as an unfunded medical escalation area and not included in the September SNCT review. Anticipate this ward will be open till the end of March 2023.
	Point of Care Team (POCT)*	Remains unfunded, staffed by a Band 2 24/7 equating to 5.38WTE.

	Paediatric Ambulatory care	A business case will be required. Current staffing is pulled from the Children's ED establishment however this establishment is only sufficient to meet BEST safe staffing for Children's ED.

NB: there may be further recommendations when the model for CDU has been finalised as these patients were excluded from the ED BEST modelling. There continues to be cost pressures with the increased staffing demand for Red RD and POCT* team for SAMBA testing

6. Summary table of recommendations

	2021	2021	2021	2021	2022	2022	2022	2022	2022
	Recommended		2021 Template		Recommended		New Template		
Ward Name Est review Oct 2022	RN	HCSW	Day	Night	RN	HCSW	Day	Night	New Template WTE
Fleming	25	10.7	6+2	4+2	23.3	10.3	5+2	4+2	33.6
AAU	38.8	10.3	8+2	7+2	38.8	10.3	8+2	7+2	49.1
Charnley	26	10.3	5+2	5+2	25.8	10.3	5+2	5+2	36.1
Ray	23.3	10.3	5+2	4+2	22.4	14.9	5+3	4+2	37.3
Locke	28.4	18.1	6+4	5+3	23.3	15.5	5+3	4+3	38.8
Harvey	18.1	10.3	4+2	3+2	18.1	10.3	4+2	3+2	28.4
Lister	25.8	15.5	5+3	5+3	23.3	15.5	5+3	4+3	38.8
Harold	28.4	10.3	6+2	5+2	33.6	15.5	7+3	6+3	49.1
Winter	23.3	15.5	5+3	5+3	23.3	15.5	5+3	4+3	38.8
Kingsmoor	23.3	10.3	5+2	4+2	26	15.5	6+3	4+3	41.4
Tye Green	28.4	18.1	6+4	5+3	28.4	18.1	6+4	5+3	46.6
OPAL	21.14	11.6			15.5	10.3	3+2	3+2	25.8
John Snow	12.6	8	20.6		10.3	7.8	2+2	2+1	18.1
enry Moor	17.8	12	19.8		15.5	10.3	3+2	3+2	25.8
Saunders	20.83	13	5+3	3+2	23.3	13	5+3	4+2	36.3
Penn	20.83	13	5+3	4+2	23.3	13	5+3	4+2	36.3
OPAL	21.14	11.6	3+2	3+2	15.5	10.3	3+2	3+2	25.8
Total	403.14	208.9			389.7	216.4			

7. Workforce Intentions

A number of workforce intentions underpin the nurse staffing recommendations for 2023/24 which have been refreshed from last year. Progress against these ongoing intentions is on Appendix 3

These are to:

- Continue to reduce our vacancy rate against establishment to less than 1%
- Following changes to the national job roles for healthcare support workers uplift all Band 2 HCSW to Band 3. A paper will be brought through normal approval process detailing rationale, proposal and full costings

- Expand our nursing and midwifery Consultant Nurse/Midwife posts to including a Nurse /Practitioner Consultant post for older people's care
- Continue the programme of inclusion of Nursing Associates within the skill mix on care of the elderly wards
- Continue to establish the enhanced care team who are able to respond to meet patients' additional requirements for observation and support due to increased risk of fall, behaviour or mental health including substantive recruitment of RMNs
- Continue with our programme of growing our own workforce in conjunction with the ICS and NHSE/I 50K target by supporting 10 new Nursing Associate Apprenticeships and providing ongoing support to 47-degree nurse apprenticeships which are in progress
- Secure funding for medical escalation area (Nightingale ward) that enables an adaptive and sustainable staffing model.
- Review how the new regulatory requirement for dedicated off rota time for Professional Nurse Advocates can be met.
- Fund the Lead Professional Nurse Advocate /Professional Midwifery Advocate post.
- Recruit a Lead Nurse for Mental Health for adults

Part B

8. Net benefit of: £244,138.72

Based on midpoint pay of Band 5 decrease and Band 2 increase. Actual budgets changes mapped against current budgets.

In-patient wards

Band	PAYE total 1 WTE	NI	Pension	Annual Cost	WTE	Total cost
Band 2	20,935	1,698	4,329	26,962	4.8	129,418
Band 3	22,866	1,964	4,729	29,559	0	-
Band 4	26,126	2,414	5,403	33,943	0	-
Band 5	33,111	3,378	6,847	43,336	-8.62	-373,557
Band 6	35,881	3,760	7,420	47,061	0	-
Band 7	43,882	4,865	9,075	57,821	0	-
						-244,138

9. Recommendations

To note the recommendations within this report, and the methodology used to inform the establishment setting process:

Overall decrease of 8.62 WTE Band 5 and increase in Band 2/3 by 4.8 WTE

- To approve the uplift in templates for Harold, Kingsmoor, Penn and Saunders Wards
- To approve the reduction in template for Fleming, OPAL, Locke, Lister, Winter, Henry Moore and John Snow Wards.
- It is recommended that the staffing templates are adjusted in the adult inpatient areas in line with the recommendations with immediate effect to support safe staffing.
- To approve using the underspend to fund the uplift for care support workers who have completed their Health Care Certificate from a Band 2 to Band 3 (AFC). This will support the recruitment and retention of health care support workers and is in line with the priorities set out in the nursing workforce intentions for 2023/24.
- To note the unfunded areas across the nursing establishment as detailed in section 5 and consider future funding of establishment to enable a more responsive and flexible workforce.
- To note the funding of the establishment headroom at 20%, against national recommendations of 22 – 25%, to give consideration for future investment in an uplift to funded headroom.
- Nurse Sensitive Indicators will continue to be reviewed by exception reports on a monthly basis to ensure safe staffing levels.
- A further establishment review will be completed in March 2023 in line with the NQB guidance and report to Board in June 2023. It is not anticipated that there will be any additional recommendations for Board from this report.

Appendix 1: Summary of Nurse Sensitive Indicators for each in-patient area

Ward	PALS (Inc bereavement, GP queries)	PALS queries referred to complaints	Compliments	New complaints	Pressure ulcers (All categories reported)	Falls	Sis	Staffing levels	Medication errors
A&E	20	2	7	6	-	7	-	-	14
AAU	1	-	1	-	-	7	-	12	5
Charnley Ward	3	-		-	7	4	-	-	5
Dolphin Ward	1	-	1	-	-	-	-	-	1
Fleming Ward	2	-	-	-	4	2	-	-	1
Harold Ward	2	-	-	1	4	7	-	3	2
Harvey	3	-	4	1	3	5	-	1	-
Henry Moore Ward	1	-	2	-	-	-	-	1	2
John Snow Ward	-	-	-	-	-	-	-	1	3
Kingsmoor Ward	4	-	6	1	4	13	-	4	4
Lister Ward	3	-	1	1	5	6	-	2	-
Locke Ward	2	1	-	1	5	6	-	-	-
Nightingale Ward	1	-		-	-	2	-	-	2
OPAL	4	-	2	1	3	4	-	2	-
Paediatric ED	3	-	3	2	-	-	-	2	3
Penn Ward	1	-	--	1	4	1	-	3	6
Ray Ward	2	-	-	-	7	5	-		5
Saunders	-	-	1	-	1	8	-	3	2
SDEC	6	-	2	-	-	-	-	2	-
Tye Green Ward	4	1	-	2	8	3	-	6	2
Winter Ward	-	1	5	2	7	6	-	5	-

Appendix 2: Emerging questions from 2021/22 review

Many of the ward budget names and correlating budgets have not been changed following the ward moves. It is recommended that when the final ward move has been completed with opening of refurbished Saunders ward in January 2022 that the budget name changes are completed to avoid further confusion. **From Month 8 2022 the budget names have now all been changed.**

Kingsmoor ward is currently running as escalation area for Covid and does not have a budgeted establishment- **The nursing establishment on Kingsmoor Ward has now been substantively funded for 2022/23**

Once the ward refurbishments have been completed Nightingale will be an escalation ward and does not have a budgeted establishment- **Part of emerging questions for 2023/24 is to consider funding Nightingale as a winter pressures ward.**

Appendix 3 Progress against Nursing Workforce Intentions 2021/22

Priority	Intention	Rationale	Progress
1.	Continue to reduce our vacancy rate against establishment to less than 1%	Improve patient outcomes reducing mortality and better patient flow	Partially achieved rate at 12% in M7 2022/23
2.	Improve the skill mix of the nursing teams to 70/30 for those wards with a higher level of acuity or requirement for nurse assessment including Fleming (cardiology), Charnley (short stay), AAU and Locke (respiratory/ NIV) and 60/40 for all other general wards as indicated in 2019 review.	Improve patient outcomes reducing mortality and better patient flow	Achieved
3.	All ward based HCSW inc ED to be re-banded as Band 3 in line with national job profiles	Support retention and recruitment of skilled care support staff. Improve patient outcomes reducing mortality and better patient flow	Not achieved- need to submit develop and submit business case in 2023/24
4.	Continue the programme of inclusion of Nursing Associates within the skill mix on care of the elderly wards	Improve skill mix, improve patient outcomes on care of the wards.	Partially achieved.
5	Develop Nurse/ Practitioner Consultant posts including a Nursing Professor post with ARU for older people's care	Improve care for older people by supporting with senior clinical specialist who will inform the strategy in line with best practice and support with training and development in line with this.	Not achieved
6	Continue with our programme of growing our own workforce in conjunction with the ICS and NHSE/I 50K target by supporting 10 new Nursing Associate Apprenticeships and providing ongoing support to 47 degree nurse apprenticeships which are in progress	Improve patient outcomes reducing mortality and better patient flow. Improving recruitment and retention of nursing staff.	Partially achieved
7	Expand the clinical practice educator team to include additional post for assessment and short stay (funded from establishment review	Support with training and education of nursing staff.	Achieved
8	Develop a sustainable model for safe staffing of escalation areas including funding	Kingsmoor Ward funded. Need to consider budget for Nightingale in the future to support planning workforce for winter pressures to support patient flow, safety and staff morale.	Achieved

9	Review how the new regulatory requirement for dedicated off rota time for Professional Nurse Advocates can be met.	Staff who are completing the PNA/PMA have an agreement to have off rostered time to do PNA/PMA role- however we have not funded the backfill of this time. Consider factoring in to unavailability uplift	Partially achieve
10	Establish an enhanced care team who are able to respond to meet patients' additional requirements for observation and support due to increased risk of fall, behaviour or mental health.	9 HCSWS in post and pipeline recruitment to have 15 HCSWS in post. Working to recruit RMNs substantively.	Achieved

Appendix 4: Enhanced care pool

In May 2021 the enhanced care policy was implemented. The policy sets out the how patients who are identified as having additional care needs should be managed. Patients who require enhanced care include some mental health patients, those at very high risk of falling and those have dementia and delirium and are restless or agitated. The policy is in line with evidence based best practice and work undertaken at other similar Trusts. The policy includes a standardised risk assessment and matrix for establishing need, definition of what enhanced care(amber) or 1:1 (red) care is, how and who can provide care and core care plans.

In many cases the ward establishment will be able to provide enhanced care or a 1:1 from their establishment but due to the unpredictability of the requirement additional staff are required to meet the need.

In 2022/23 the enhanced care pool was established and we have successfully recruited 9 HCSWs with a pipeline to recruit 15 in total. Workforce intentions for 2023/24 are to recruit substantive RMNs and a Lead Mental Health nurse for adults to support.

Number of patients per month who are identified as having an enhanced care need

	Day		Night	
	Amber Day	Red Day	Amber Night	Red Night
Apr-22	13.1	5.3	13.1	5.3
May-22	13.5	5.5	11.9	5.2
Jun-22	12.2	7.2	12.7	7.7
Jul-22	14.2	7.2	12.6	7.2
Aug-22	11.1	6.3	9.9	7.7
Sep-22	7.4	3.8	6.4	4.2

Appendix 5: CHPPD

Ward name	Registered Nurses/Midwives	Non-registered Nurses/Midwives	Overall
Saunders Unit	3.2	2.6	5.8
Penn Ward	3.2	2.4	5.6
Henry Moore Ward	5.3	2.8	8.1
Harvey Ward	3.6	2.5	6.2
John Snow Ward	4.9	1.8	6.7
Charnley Ward	3.6	2.2	5.8
AAU	6.2	2.2	8.4
Harold Ward	3.9	2.3	6.1
Kingsmoor General	2.9	3.0	5.8
Lister Ward	3.1	2.7	5.8
Locke Ward	3.3	2.1	5.6
Ray Ward	3.4	2.1	5.6
Tye Green Ward	3.0	2.8	5.8
OPAL	3.7	3.3	7.0
Winter Ward	3.3	2.6	5.9
Fleming Ward	3.5	2.3	5.9
Dolphin Ward	10.2	3.0	13.2

The Princess Alexandra Hospital NHS
NHS Trust

Appendix 6 Results of establishment review

			2021	2021	2021	2021	2022	2022	2022	2022	2022	2022	2022
Ward Name - establishment review 2021	HCG	Ward Name Est review Oct 2022	Recommended		New Template		Recommended		New Template			RN Budgeted change WTE	HCSW Budgeted change
			RN	HCSW	Day	Night	RN	HCSW	Day	Night	New Template WTE		
Fleming	CCCS	Fleming	25	10.7	6+2	4+2	23.3	10.3	5+2	4+2	33.6	0	0.4
AAU	UEC	AAU	38.8	10.3	8+2	7+2	38.8	10.3	8+2	7+2	49.1	0	0
Charnley	UEC	Charnley	26	10.3	5+2	5+2	25.8	10.3	5+2	5+2	36.1	0	0
Ray	Medicine	Ray	23.3	10.3	5+2	4+2	22.4	14.9	5+3	4+2	37.3	0	2
Harold	Medicine	Locke	28.4	18.1	6+4	5+3	23.3	15.5	5+3	4+3	38.8	0	3.5
Harvey	Medicine	Harvey	18.1	10.3	4+2	3+2	18.1	10.3	4+2	3+2	28.4	0	0
Lister	Medicine	Lister	25.8	15.5	5+3	5+3	23.3	15.5	5+3	4+3	38.8	0	0
Locke	Medicine	Harold	28.4	10.3	6+2	5+2	33.6	15.5	7+3	6+3	49.1	0	-0.8
Winter	Medicine	Winter	23.3	15.5	5+3	5+3	23.3	15.5	5+3	4+3	38.8	0	0
Nightingale	Medicine	Kingsmoor	23.3	10.3	5+2	4+2	26	15.5	6+3	4+3	41.4	0	3.5
Tye Green	Medicine	Tye Green	28.4	18.1	6+4	5+3	28.4	18.1	6+4	5+3	46.6	0	0
		OPAL	21.14	11.6			15.5	10.3	3+2	3+2	25.8	0	-1.3
John Snow	Surgery	John Snow	12.6	8	20.6		10.3	7.8	2+2	2+1	18.1	-2.3	0
Henry Moore	Surgery	Henry Moore	17.8	12	19.8		15.5	10.3	3+2	3+2	25.8	-2.3	-1.7
Ray	Surgery	Saunders	20.83	13	5+3	3+2	23.3	13	5+3	4+2	36.3		
Saunders	Surgery	Penn	20.83	13	5+3	4+2	23.3	13	5+3	4+2	36.3	2.4	0
		OPAL	21.14	11.6	3+2	3+2	15.5	10.3	3+2	3+2	25.8		
Dolphin	FAWS	Total	403.14	208.9			389.7	216.4				0	0
Total												-8.62	4.8

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NHS Improvement (2018) Care hours per patient day (CHPPD): guidance for acute trusts

NHS Improvement (2018) Nursing and midwifery e-rostering: a good practice guide.

Royal College of Emergency Medicine and Royal College of Nursing (2020) Nursing Workforce Standards for Type 1 Emergency Departments

Core Standards for Intensive Care Units (2013) Faculty of Intensive Care Medicine

The Princess Alexandra Hospital NHS NHS Trust

4.5

Trust Board (Public) – 2 February 2023

Agenda item:	4.5
Presented by:	Sharon McNally - Chief Nurse and Deputy CEO
Prepared by:	Sarah Webb - Deputy Chief Nurse
Date prepared:	11th January 2023
Subject / title:	Introduction of new visiting arrangements and a new Visitors Charter

Purpose:	**Approval**	**x**	**Decision**		**Information**		**Assurance**	

Key issues: please don't expand this cell; additional information should be included in the main body of the report	Post pandemic the visiting arrangements on the adult inpatient areas are fragmented and subject to local variation which is causing unwarranted communication issues. The senior nursing leadership team agreed that a return to pre-pandemic visiting hours of 3-5 and 7-8pm did not meet our aim of putting the patient at heart, improving communication with next of kin & relatives and was too restrictive. An engagement programme was undertaken to scope new visiting arrangements and this paper describes this and the recommendations.
Recommendation:	To agree the new Visitors Charter which sets out a shared agreement for supporting patients and visitors between staff and visitors and agree the new arrangements of visiting between 9am and 8pm in line with AAU and Charnley.

Trust strategic objectives: please indicate which of the five Ps is relevant to the subject of the report	**Patients**	**People**	**Performance**	**Places**	**Pounds**
	x				

Previously considered by:	Senior Nursing, Midwifery and AHP Leadership Group 9th January 2023 Executive Management Team 11th January 2023 Senior Management Team 17th January 2023 People Committee 23rd January 2023
Risk / links with the BAF:	BAF 1.1: Clinical outcomes. Poor patient survey, high complaints relating to communication
Legislation, regulatory, equality, diversity and dignity implications:	The proposed changes and charter will improve our compliance with EDI regulations and requirements.
Appendices:	Appendix 1: Slide pack from Engagement Session

1.0 PURPOSE

This paper outlines work that has been undertaken to engage with staff and patients to shape new adult inpatient visiting arrangement at PAHT that puts Patients at the Heart and recognises the enormous benefits to patients of having open visiting has on patient care and outcomes.

The purpose of the review was:

- To have a clear and consistent approach to visiting times across similar ward areas/departments.
- No patient who is at the end of life or who has a carer, is prevented from having a visitor, even outside of agreed visiting hours.
- Our people are able to confidently include relatives and visitors in delivering patient centred care, decision making and treatment plans.
- Patients, relatives and visitors are able to easily find information about visiting times and that the information reflects their experience.

2.0 BACKGROUND AND NATIONAL CONTEXT

During the Covid pandemic visitors were restricted onsite due to risks of transmission both to the public and our patients. As the pandemic unfolded visitor restrictions were amended in recognition of the negative impact on patients, decreasing risk of transmission when IPC precautions were followed and the immunisation programme.

Our current adult inpatient visiting arrangements are subject to local arrangements in each ward and department which has enabled flexibility in line with local outbreaks, size of the ward etc but has led to confusion for patients and relatives as well as staff.

One of the consistent PALS and Complaints and our In-patient survey is poor communication. Further information on the impact and themes from the medicine division can be found in the slides in Appendix 1.

There is a wealth of evidence and information available which highlights the benefits of open visiting on patient care and outcomes and a national drive with Johns Campaign that promote open visiting and the participation of relatives in care and decision making.

John's Campaign (johnscampaign.org.uk)

A realist evaluation of the implementation of open visiting in an acute care setting for older people | BMC Health Services Research | Full Text (biomedcentral.com)

University Hospitals Birmingham NHS Foundation Trust | Open visiting already having positive impact as Trust looks for feedback (uhb.nhs.uk)

3.0 PROCESS

In order to address these issues and to come to a consensus on visiting times, the ward managers were consulted on a range of options. This resulted in a consensus for open visiting but it was recognised that engagement with a wider group of staff would be beneficial as open visiting does require staff working on wards to think and work differently.

An engagement session was held on the 2.12.2022 with a whole Trust invite. Staff were encouraged to share their views directly bother before and after the engagement session and the link to the session was shared by the Communications team.

As AAU have already implemented open visiting for 2 visitors at a time from 9am to 8pm the AAU Ward manager and a HCSW spoke about their experience of the change including how initial concerns were quickly overcome and the overwhelming positive impact on patient care, communication and reduction in PALS and complaints.

Emerging themes from the engagement session and staff who have contacted have been:

Overwhelming positive response for standardising visiting hours with those of AAU

However there were some concerns including:

- Bed spaces in the wards in the main block are small and view of ward managers of these wards is that 2 visitors by every bed will be very difficult
- Visitors and relatives will impede staff in undertaking essential care such as medicine rounds
- Patient confidentiality at handover if visitor are still on the ward
- Managing ‘difficult’ visitors

To address these concerns the new open visiting hours will support 2 visitors’ in the larger wards and 1 visitor (2 at the nurse in charges discretion) on the smaller wards.

The visiting hours of 9am to 8pm will enable continuation of handover at the bedside and support confidentiality as well as enable the ward teams to ‘start the day’ before visitors are welcomed

It was recognised that the concerns raised regarding interrupting essential care or being ‘disruptive’ will happen on occasion regardless of the visiting hours and so a Visiting Charter has been developed based on the national charter and incorporating points from our maternity charter and feedback from staff.and patient panel (appendix 1).

New visiting arrangements

Proposed the new visiting arrangements will be as follows:

Visitors over 12 years will be able to visit from 9am to 8pm everyday

Two visitors at a time will be able to visit patients on the following wards: AAU, Charnley, Nightingale, Kingsmoor, Harold, Henry Moore, John Snow, Tye Green and Fleming.

On our older wards (lister, Locke, Winter, Ray, Penn and Saunders) due to space around the bedside one visitor at a time will be able to visit. Two visitors at the discretion of the nurse in charge.

Visitors should follow the latest IPC advice which currently advises face coverings to be worn at all times on the hospital site and they should not visit if they are feeling unwell.

Visiting continues without restrictions:

- For end-of-life patients
- Where assistance is being provided for communication e.g. for patients with learning disabilities, dementia, mental health, emotional, religious, spiritual or compassionate care needs.
- Where the visitor is an unpaid or paid carer or personal assistant.

The IPC Cell have approved the following guidance when a Covid, Flu or Norovirus outbreak has been declared:

Visiting hours will remain 9am to 8pm but visiting will be restricted to one visitor per day. Visitors will be asked to sign in and out of the ward.

This may be applied to the whole ward or a designated bay.

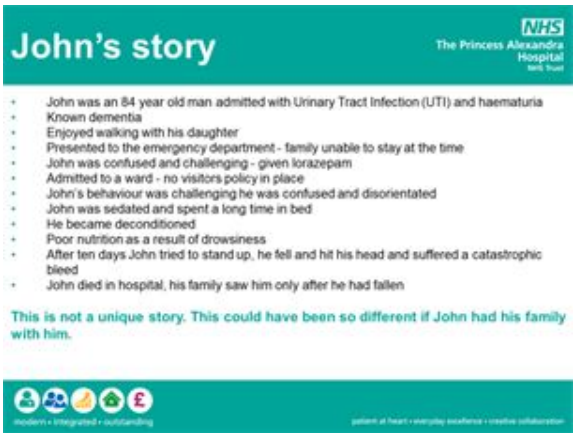
There is no change to visiting arrangements for critical care, maternity or children's areas.

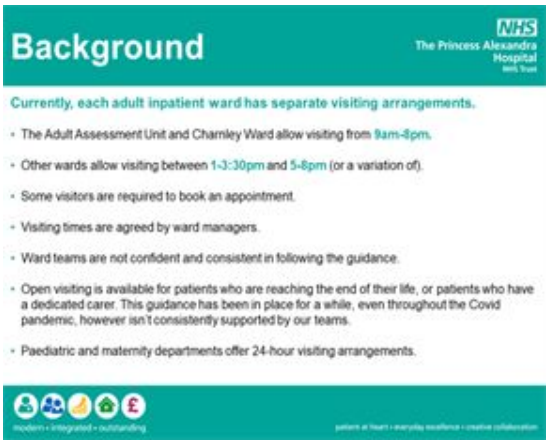
4.0 Recommendation

That the new visiting arrangements and Visitors Charter is accepted for implementation across the Trust and following a communication strategy for patients, Visitors and Staff the new visiting times and charter are launched on Monday 30th January.

The Princess Alexandra Hospital NHS
NHS Trust

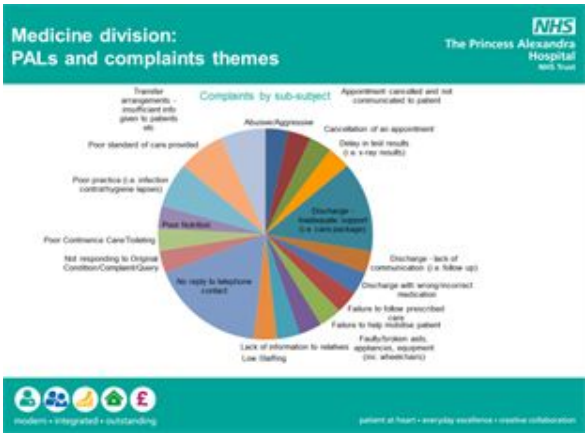
Appendix 1 Engagement Session 2/12/2022 Slide Pack

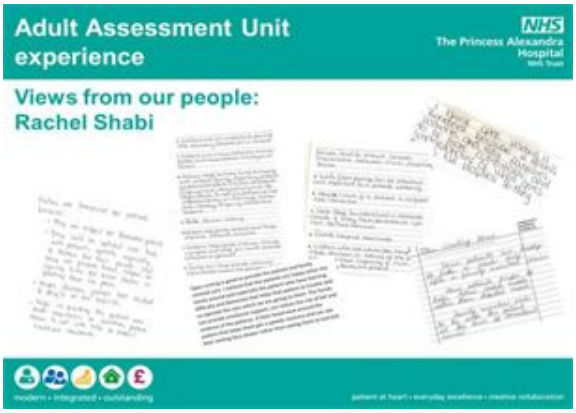


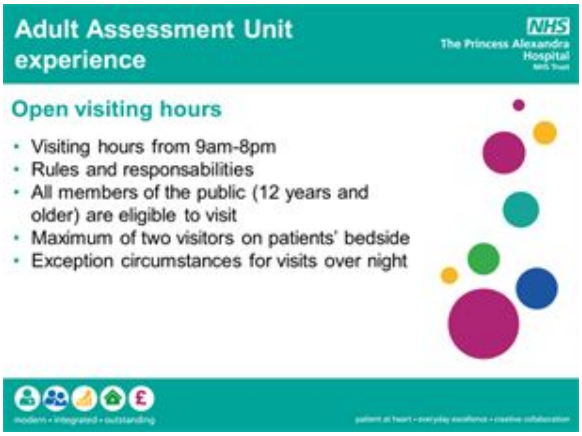


The Princess Alexandra Hospital NHS
NHS Trust

4.5







Visitors' charter

NHS
The Princess Alexandra Hospital
NHS Trust

We have a policy of open visiting on our wards from **9am to 8pm***.
We recognise the important role that loved ones, friends and carers play in supporting patients in their recovery.
We have developed this charter in order to ensure that open visiting is beneficial to everyone.

We ask our people to:	We ask you to:
Be polite and welcoming to everyone.	Be polite to everyone.
Be supportive of visitors who wish to participate in the care of their relative or loved one.	Let the nurses know if you would like to help deliver care. If you would like to help your friend or relative at mealtimes, please ask the ward team about times. Provide your loved one with their toiletries, dentures, glasses, suitable clothing and footwear.
Keep each patient's next-of-kin/named contact well informed (with the patient's permission). Talk to visitors about how to make the most of their time on the ward.	Remember that our people may not give out information about a patient without the patient's permission. Agree visiting times with other family or friends, so that patients do not have more than two visitors at a time. Some wards can only support one visitor at a time - please check the website and with ward staff. Take breaks away from the bedside, to allow the patient time to rest – don't feel you have to be there all the time.
Do our best to create a calm, restful environment to help patients recover.	Keep noise levels low and speak quietly.
Put patient care first, which might mean sometimes asking visitors to leave the bedside or finish a visit early.	Avoid disturbing our people doing important work, such as giving out medicine. Please be aware that you will be asked to leave the ward if a medical emergency occurs. Support our people to deliver care or treatment to your friend or relative without delay e.g. physiotherapy or an X-ray.
Protect patients from infections and diseases by washing our hands, and following infection prevention and control policy.	Wash your hands on entering and leaving the ward by using the alcohol gel provided, and follow all hygiene rules. Stay at home if you are unwell.

*Our Critical Care and High Dependency Unit retain visiting hours restrictions in the interest of patient safety and recovery.

Our team are committed to providing high quality care. If you have any queries or concerns, please speak to the ward manager or matron. If you are in a clinic, ask for help at reception. In most cases, our people will be able to address your concerns at the time. If this is not possible, or your concerns are not resolved after talking to our people, please contact the patient advice and liaison service (PALS) and they will work with you to try to resolve your concerns as quickly as possible.

PALS are located in the main corridor. **Email: paht.pals@nhs.net or telephone: 01279 827111.**

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 27 January 2023

4.6

Agenda item:	4.6							
Presented by:	Fay Gilder | Medical Director							
Prepared by:	Nicola Tikasingh | Lead Nurse for Quality and Mortality Information Team							
Date prepared:	January 2023							
Subject / title:	Learning from Deaths and Mortality Update – December 2022 data							
Purpose:	**Approval**		**Decision**		**Information**		**Assurance**	x
Key issues:	This paper provides assurance on the learning from death process and highlights key pieces of learning and updates on the current programme of work to improve clinical practice and patient outcomes.							
Recommendation:	To note the progress being made on the learning from death process and the improvement work to address this.							

Trust strategic objectives: please indicate which of the five Ps is relevant to the subject of the report	**Patients**	**People**	**Performance**	**Places**	**Pounds**
	✓	✓	✓		

Previously considered by:	Strategic Learning From Death Group QSC.27.01.23
Risk / links with the BAF:	BAF 1.1 Variation in outcomes resulting in poor clinical quality, safety and patient experience.
Legislation, regulatory, equality, diversity and dignity implications:	*'Learning from Deaths'* - National Quality Board, March 2017 *This paper has been written with due consideration to equality, diversity and inclusion in respect of our patients, people and potential providers.*
Appendices:	

The Princess Alexandra Hospital NHS Trust

4.6

1.0 Purpose/issue

The purpose of this paper is to provide bimonthly assurance on the learning from death process to the quality and safety committee. The paper will highlight key pieces of learning and provide progress updates on the current programme of work to improve clinical practice and patient outcomes

2.0 Background

PAHT has a learning from death process that meets the national requirements. The risks associated with this are captured on the learning from death risk register.

3.0 Current Telstra/ NHS Data Headlines

Due to the delay in coding patient records, the mortality data for the trust was put on hold until coding had completed >95% of the backlog to ensure that mortality data was accurate. This means that there is currently no current mortality indices data for the trust. The coding department has now achieved >95% and a report ie expected in time for the Strategic Learning from Deaths Forum in February 2023.

4.0 Mortality Programme Updates

4.1 Sepsis

New innovations:
Sepsis function to be implemented on nerve centre which will improve the accuracy of the data. Aim to launch in January 2023.
Appointment of AKI/Sepsis Nurse.

4.2 Respiratory

New Innovations:
Ward based NIV can now be delivered to three patients' at a time, compared with one previously.
NIV has now been deemed a non-aerosol generated pressure and can be delivered in bay areas, whereas side rooms only were previously used.
Pilot study is being undertaken by Speech and Language Therapy Team by undertaking bedside swallow assessments using ITU fibre-optic assessment equipment. Avoids in-patient delays in waiting video-fluoroscopy assessments.

4.3 Acute Kidney Injury

New Innovations:
Appointment of AKI/Sepsis Nurse and AKI Deputy Clinical Lead.
New project launched to develop an e-referral system for patients to the Renal Team at Lister Hospital.

4.4 End of Life:

New Innovations:
Preferred place of Care and Preferred place of Death now being logged onto nerve centre to ease identification and standardise approach.
Funds available to appoint an End of Life Care Discharge Coordinator for winter pressures – out to advert.

5.0 Learning from deaths process update

5.1 Mortality Narrative

There were 123 deaths in December 2022.

38 cases referred for SJR's.

There are 91 outstanding SJRs (over 6 weeks of the patients' death.) The divisional directors for medicine, urgent and emergency care and surgery are working to confirm a proposed trajectory for completion.

There were 11 Covid related deaths. 3 of which were nosocomial case (1 x definite and 2 x probable) – to be reviewed by Respiratory Lead.

There were no cases presented to the second review panel.

5.2 Key Learning from Structured Judgement Reviews

The importance of balancing sedatives in elderly patients with postictal confusion as they are vulnerable to fall – shared at local M&M meeting.
Early cancer screening might have helped treat the cancer – learning shared with the GP.

6.0 Medical Examiner (ME) Headlines

100% of deaths scrutinised between 10 Medical Examiners.

27 cases referred to the Coroner, with 11 post mortems requested and 4 inquests logged.

87.5% of MCCDs were completed within 72 hours due to delays in doctors' availability to complete the Medical Certificate of Causes of Death (MCCD). (National Target 95%).

Ongoing Developments:
Community death pilot with St Claire Hospice.
GP death scrutiny is being expanded with further meetings pending.
Quality First improvement project in process to improve the timely completion of MCCD's.

7.0 Risks

No changes identified for the Learning from Deaths risk register. The risk register is in the process of being moved from Allocate to Datix.

8.0 Recommendation

For the Board to provide feedback on the contents of the paper to ensure a dynamic development of the information provided so that assurance can be provided.

BOARD OF DIRECTORS: Trust Board (Public) 2 February 2023 **AGENDA ITEM: 5.1**

REPORT TO THE BOARD FROM: People Committee (PC)

REPORT FROM: Helen Howe – Committee Chair

DATE OF COMMITTEE MEETING: 23 January 2023

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
2.1 People Report	Yes	Y	N	The following was highlighted; Trust wide vacancy rate remained static, decrease in agency spend, sickness/absence also remained static and rolling turnover was slowly decreasing. It was agreed to cover retention in greater detail at the next meeting.
2.2 Freedom to Speak Up Report	Yes	N	N	The Committee received an update on Freedom to Speak Up data. It was highlighted that behaviours continued to be the highest reason for staff speaking up and patient safety reason the lowest reason – this is being looked into to determine whether this is due to safety incidents being recorded on Datix. The 11 new freedom to speak up ambassadors were highlighted.
2.3 PAHT2030 Culture Milestones & Deloitte Well Led Review Update	Yes	N	N	The Committee noted the position in regards to the 5 culture related KLOEs. It was noted the recommendation relating to Equality, Diversity and Inclusion would be moved to Amber due to the long term absence of the EDI Lead.
2.4 Guardian of Safer Working Hours Report	Yes	N	N	For the reporting period October to December 2022, 90 exception reports (ERs) were submitted, most were for working over hours but there was an increase in those reporting missed educational opportunities. PC was assured around the processes and actions in place to address the issues and noted divisional directors now had oversight of the data and issues being raised.

BOARD OF DIRECTORS: Trust Board (Public) 2 February 2023 **AGENDA ITEM: 5.1**

REPORT TO THE BOARD FROM: People Committee (PC)

REPORT FROM: Helen Howe – Committee Chair

DATE OF COMMITTEE MEETING: 23 January 2023

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
2.5 GMC Survey	Yes	Y	N	An update was received on the 2022 GMC survey results. The Trust was amongst the worst scoring Trusts in the region. The DME was in continuous discussions with Junior Doctors reps, Divisional Directors and Royal College/Specialty Tutors concerning the effectiveness of actions taken to address the outlying areas in the GMC survey and HEE visits. Progress would be monitored via the Junior Doctors Committee, the Medical Education Committee and the GMC enhanced monitoring group.
2.6 GMC Enhanced Monitoring Process	Yes	Y	N	The Committee received assurance on progress being made in relation to the GMC enhanced monitoring process. Funding had been received from HEE to support a workforce and educational review, project management support and additional development of clinical leadership. It was noted the outcome of HEE review of recently submitted improvement plan was awaited. An update will be received at every meeting.
2.7 New BAF risk: GMC enhanced monitoring	Yes	N	N	The Committee noted the new BAF risk relating to the GMC enhanced monitoring process. The score was rated at 20 with a target score of 10 to be achieved by December 2024. PC recommended the risk to Board for approval.
2.8 Safer Nurse Staffing Report	Yes	N	N	PC were assured in regards to the provision of safer nurse and midwifery staffing and that processes are in place for managing and monitoring staffing levels. The paper will be discussed at Board.

BOARD OF DIRECTORS: Trust Board (Public) 2 February 2023 **AGENDA ITEM: 5.1**

REPORT TO THE BOARD FROM: People Committee (PC)

REPORT FROM: Helen Howe – Committee Chair

DATE OF COMMITTEE MEETING: 23 January 2023

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
2.9 Nursing Establishment Review	Yes	N	N	The report detailed the recommended changes following the nursing establishment review. This included a reduction of qualified nurses by 8.62WTE and an increase in demand for healthcare support workers (4.8 WTE). The Committee recommended the paper to Board for approval.
2.10 Nursing Midwifery and Allied Health Professionals Strategy	Yes	N	N	The Committee noted the continuing work being undertaken to deliver the objectives set out in the Nursing, Midwifery & AHP strategy. Of note was the successful appointment of the Associate Director of Allied Health Professionals. The key risks included; reciprocal mentorship, access to on-site Simulation Training rooms was affecting progress with the training programme.
2.11 BAF Risk 2.3 (Workforce)	Yes	N	N	Risk score to remain unchanged at 16; the controls had been updated.
2.12 Health and Wellbeing Report	Yes	N	N	Recent health and wellbeing initiatives were noted including; re-established Schwartz rounds, working towards a disability confident employer status. An update was provided on the Entonox position and it was noted support was being offered to staff; blood tests and a dedicated Shaw helpline had been arranged.
3.1 Communications Update	Yes	N	N	PC noted the recent communications activities including; make movement count campaign, #PAHTPeople in action campaign and the ICS pathology programme communications.

BOARD OF DIRECTORS: Trust Board (Public) 2 February 2023 **AGENDA ITEM: 5.1**

REPORT TO THE BOARD FROM: People Committee (PC)

REPORT FROM: Helen Howe – Committee Chair

DATE OF COMMITTEE MEETING: 23 January 2023

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
4.1 Learning and OD Update	Yes	N	N	PC were assured in regards to the measures being taken to address statutory and mandatory training compliance. The introduction of This is Me @ PAHT was highlighted including: ○ increasing frequency of key performance conversations, ○ introducing an appraisal cascade approach ○ increasing manager accountability for team culture and performance ○ enhancing appraisal planning ○ digitally modernising performance conversations The Committee congratulated the Associate Director of Patient Experience for receiving the Dean's award from the University of Hertfordshire.
4.2 Staff Survey	Yes	N	N	The report detailed the 2022 staff survey results. It was noted the response rate had improved (49.5%, a 2.2% increase compared with 47.3% in 2021). The new response plan approach was discussed. The proposed new approach was centred around the implementation of a 'feedback to action' programme, a structured process for divisions to follow, with support and guidance primarily from the OD team.
4.3 Horizon Scanning	Yes	N	N	PC noted the emerging people issues including; the DHSC consultation on proposed changes to the NHS Pension Scheme, NHSE was commissioning an independent report to review disciplinary cases from the last three years to be used to

BOARD OF DIRECTORS: Trust Board (Public) 2 February 2023				AGENDA ITEM: 5.1
REPORT TO THE BOARD FROM: People Committee (PC)				
REPORT FROM: Helen Howe – Committee Chair				
DATE OF COMMITTEE MEETING: 23 January 2023				
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
				identify improvement opportunities, contingency planning for the impending industrial action would form part of the Trust's winter plans and HWE ICS People strategy approval supported the people agenda at the Trust.
4.4 Voluntary Services Report	Yes	Y	N	The Committee noted the current activities within the Voluntary Services. The draft Voluntary services strategy was under review and due to be shared for approval in March 2023.

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 2 February 2023

5.2

Agenda item:	5.2							
Presented by:	Lindsay Hanmore – Lead Freedom to Speak Up Guardian							
Prepared by:	Lindsay Hanmore – Lead Freedom to Speak Up Guardian							
Date prepared:	5th January 2023							
Subject / title:	Freedom to Speak up Report							
Purpose:	**Approval**		**Decision**		**Information**	x	**Assurance**	x
Key issues:	The purpose of this paper is to update and provide analysis on the Trust's freedom to speak up data. It will highlight themes of concerns raised up to Q3, attempt to identify any gaps in groups not speaking up, what actions are being taken to address concerns and triangulate information from other feedback mechanisms.							
Recommendation:	For the Board to give feedback on the contents of this report to ensure it provides the details and assurance required. For members of both the People Group and the People Committee to review the training on the FTSU page on AlexNet "follow up".							

Trust strategic objectives: please indicate which of the five Ps is relevant to the subject of the report	**Patients**	**People**	**Performance**	**Places**	**Pounds**
	√	√			

Previously considered by:	Staff Health and Well Being Group – January People Group – January 2023 People Committee (PC) 23.01.23.
Risk / links with the BAF:	
Legislation, regulatory, equality, diversity and dignity implications:	Freedom to speak up principles are contained with the NHS Contract
Appendices:	

The Princess Alexandra Hospital NHS Trust

1.0 Purpose/issue

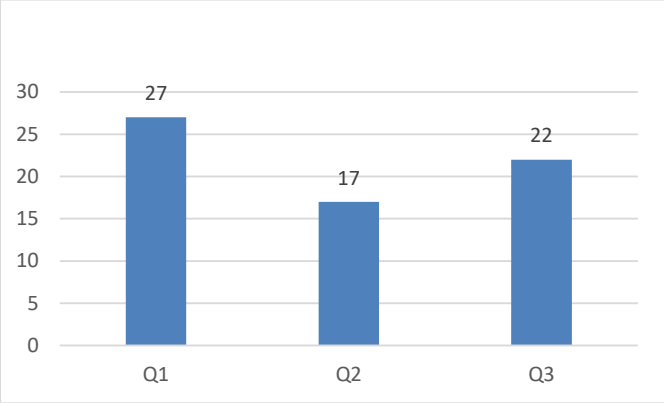
The purpose of this paper is to update and provide analysis on the Trust's freedom to speak up data. It will highlight themes of concerns raised up to end of quarter 3, attempt to identify any gaps in groups not speaking up, what actions are being taken to address concerns and triangulate information from other feedback mechanisms.

2.0 Background

2.1 Freedom to speak up principles are contained with the NHS Contract. Good "speak up" cultures are linked with improved patient safety and quality, higher staff well being and retention with lower levels of dissatisfaction.

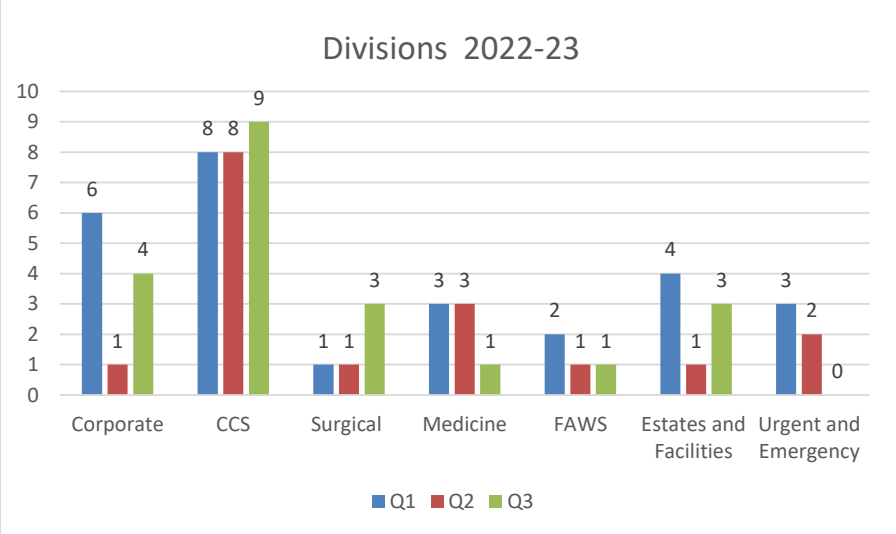
3.0 Data and analysis

3.1 Number of referrals 2022-23



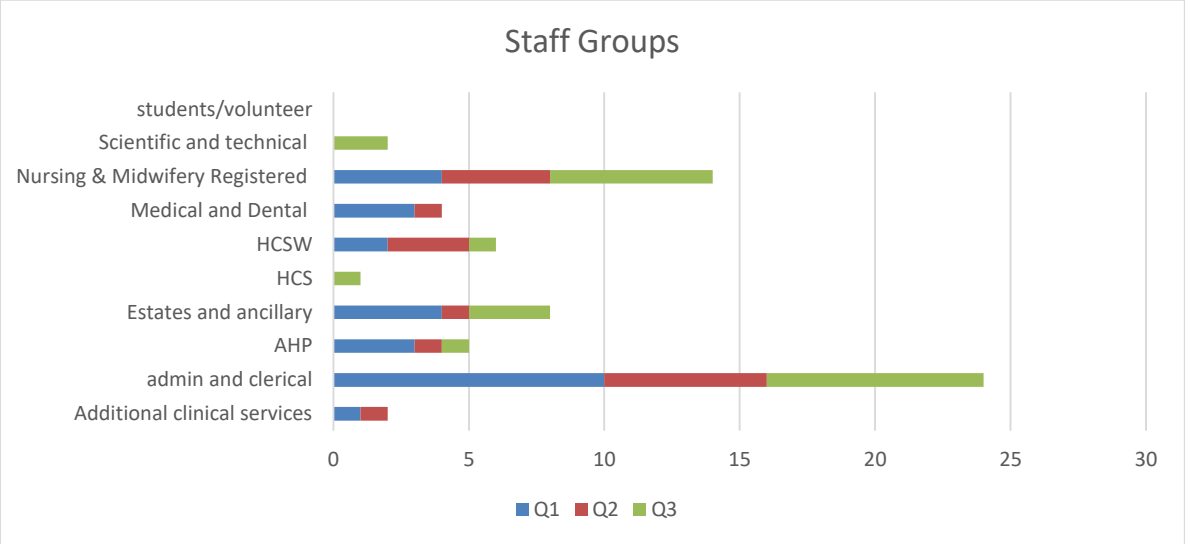
Numbers of referrals do appear to be reducing and the team continue to raise awareness through a number of forums.

3.2 Breakdown of referrals for Quarter 1-3 2022-23



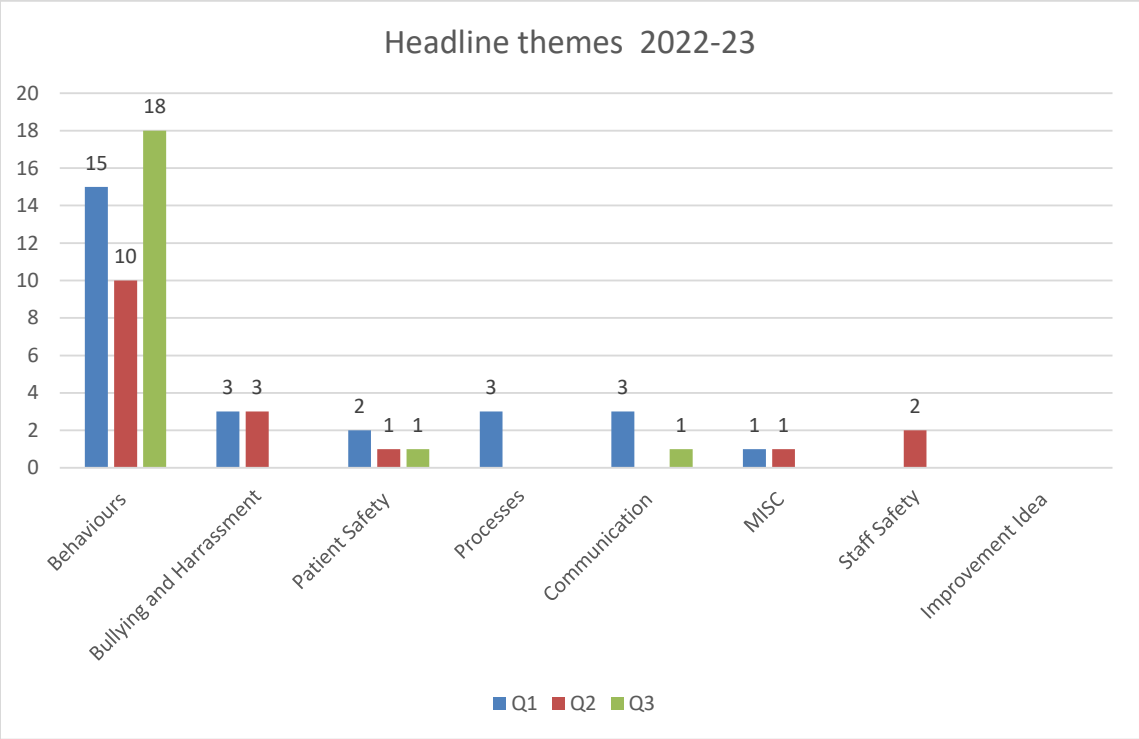
modern • integrated • outstanding

patient at heart • everyday excellence • creative collaboration



It is acknowledged that doctors in training are not using the service to raise concerns and it is unclear where they feel most comfortable to speak up other than once they have left and feed back on their training experience. The two consultant guardians attend the Junior Doctor Committee and we are developing a poster to improve signposting to the service for those that do not feel comfortable speaking up to their educational supervisor. We would like to have a more proactive response to their concerns and continue to reach out to them and their representatives to explore how we can improve this.

3.3 Themes 2022-23



Poor behaviours continue to be the highest reason staff speak up and it is usually that they feel undervalued and do not have effective communication roots in place with their line

managers and teams. The local actions usually involve facilitating this communication and feedback on how some actions are making individuals feel.

Very few patient safety issues are raised through the guardian root and these tend to be either brought up via datix or whistleblowing cases.

3.4 Equality, Diversity and Inclusion of Referrers Q1-3

We now aim to collect data to capture and promote inclusiveness for those who speak up. So far this information is quite sparse but to date 3 x black/black British and 3 x Asian/Asian British members of staff have been recorded as making referrals. Unfortunately, many of the details of the referrers are unknown or not asked and there is no record of anyone with a disability or an alternative sexuality other than heterosexuality using the service.

Of the 69 referrals this year the majority were classified as workers x 48, managers x 18 and 3 as senior leaders.

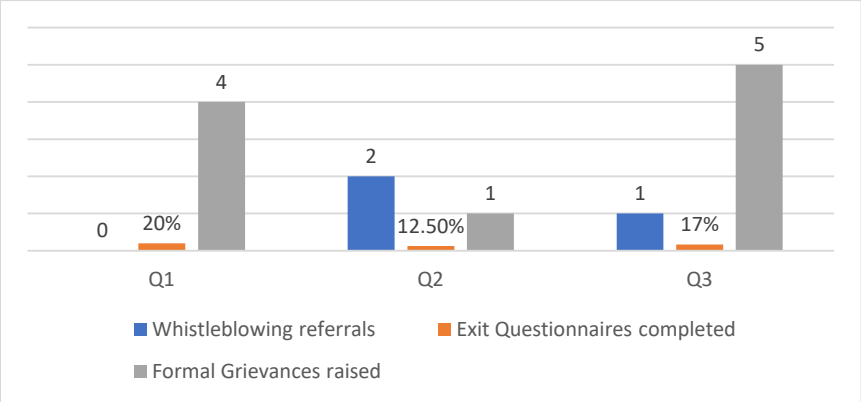
3.5 Referrer Feedback from Quarters 1 & 2

The following are just some of the positive feedback quotes from those who have spoken to a guardian.

- "*I feel I have been heard and understood", "I feel very reassured and valued by the Guardian that my concern was dealt with quickly and resolved quickly", "I felt a lot better after I spoke to the speak up guardian although one issue hasn't been resolved due to complications so may have to wait", "I would encourage anybody who feels things are not right or may be being bullied to talk to a guardian even if it's just for a bit of advice", "Everything was resolved".*

However, one referrer suggested that although the issue had now been resolved by speaking up to a guardian they didn't like being questioned by their management team to find out who had spoken up. The lead guardian continues to monitor this situation with the individual to ensure this does not impact negatively on them.

3.6 Other Feedback Data



4.0 Actions

4.1 Freedom to Speak up Ambassadors

On 29th November 2022 11 ambassadors were trained from a wide range of roles across the organisation. They will increase accessibility to staff being able to speak up, they will raise the profile and importance of speaking up across the organisation and be a point of contact for colleagues to reach out to ensure they are signposted to the correct support. These are the first FTSU ambassadors in the Trust and the Freedom To speak up guardians will be supporting their ongoing development and assessing the impact of the role.

4.2 Some Improvements following feedback

- Listening events have been facilitated with groups of staff to ensure everyone has a voice
- Individuals have been supported to discuss and raise their concerns locally to achieve resolution
- Facilitated team building workshops
- Raised awareness of staff visa rules and to break myths about what can impact their visas
- Plans to ensure improved development opportunities for our overseas employees
- Listen up training delivered to key groups of staff to ensure they can support their teams.

4.3 Raising Awareness

- The guardians continue to meet all new starters and deliver an awareness session on Trust Induction
- Bimonthly newsletters are shared physically and via In Touch and Communications
- Lead Guardian raised awareness through Lance's Digital Diary
- Alex.net pages updated

4.4 Professional Nurse/Midwife Advocates

The lead freedom to speak up guardian and the lead professional nurse/midwife advocate will now triangulate information about registered nurses and midwives accessibility to speak up and raise concerns. This is another supportive network for these practitioners to speak up to and may account for lower numbers of this professional group needing to speak up to guardians.

Although there has been a small increase in the number of nurses/midwives speaking up using the guardian service there have also been a total of 69 1:1 restorative clinical supervision sessions and 28 group sessions with professional nurse/midwife advocates. There have also been 86 career/development conversations.

5.0 Risks

The main risk to developing a safe speaking up culture in the Trust appears to be either the fear of repercussions or the fact that nothing appears to happen. In an aim

to address this a wide range of communication tools will be utilised to provide assurance to those speaking up that they will be supported through the whole process and to share examples of changes put in place to address feedback.

6.0 Next Steps

- Support and mentoring of ambassadors
- Collaboration with other support networks ie SHAW, People Team, ED&I lead, JSCC and professional nurse/midwife advocates to obtain rich feedback information to inform health and well being requirements.
- Links into health Divisions and corporate team meetings to feedback themes and required actions
- Consultant Guardians have close links with Junior Doctor Committee to ensure they feel supported to feedback safely without impact on their training.

7.0 The impact will be monitored Trust wide by:

- Annual staff survey results – in particular with the key questions focused on staff reporting concerns and feeling they are treated fairly.
- Numbers of FTSU referrals and themes
- Feedback from those who have spoken up
- Grievances – numbers and themes
- Exit interviews – numbers and themes
- Staff retention rates
- Patient and staff safety incidents
- Number of issues raised externally ie directly to CQC or NHSE/I
- National benchmarking data from National Guardian's office

8.0 Recommendation

For the Board to give feedback on the contents of this report to ensure it provides the details and assurance required. For members of both the People Group and the People Committee to review the training on the FTSU page on AlexNet "follow up".

Author: Lindsay Hanmore
Date 5th January 2023

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS:	**Trust Board (Public) – 2 February 2023**	**AGENDA ITEM: 6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**	
REPORT FROM:	**Colin McCready - Committee Chair**	
DATE OF COMMITTEE MEETING:	**26 January 2023**	

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
2.1 M9 Financial Results	Y	Y	N	The Trust reported a deficit of £1.6m in-month and £14.5m YTD. The financial position in M9 has started to evidence the actions to reduce and slow down the run rate including the higher levels of expenditure relating to elective recovery including outsourcing\insourcing and estates maintenance costs. The Trust's agency costs, particularly for medical staff, remain at levels higher than in previous years. These are not being helped by current operational pressures and are in line with pressures elsewhere within the NHS.
2.2 Financial Forecast	Y	Y	Y	At M9 the Trust has a deficit of c. £14.5m. Whilst the run-rate has recently slowed, it is becoming increasingly difficult to foresee the Trust achieving financial balance without external assistance. The presentation at the meeting initiated a detailed discussion around medical agency spend.

BOARD OF DIRECTORS:	**Trust Board (Public) – 2 February 2023**			**AGENDA ITEM: 6.1**
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DATE OF COMMITTEE MEETING:	**26 January 2023**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.3 Capital Update	Y	N	N	The Trust's total CRL 2022-23 is £14.2m. The Trust has been awarded additional capital funding from the centre to the value of £3.9m. This has increased the available capital resources for the year to £18.1m. As at M9, YTD capital spend totals £8.9m and this includes the external funding spend. The spend profile YTD gives the Trust a requirement to deliver spend of £9.2m in the final 3 months of 22/23.
2.4 CIP Update	Y		N	The 22/23 CIP target is £11.7m with savings now identified to the value of the full year plan, YTD M9 savings are £7.5m. The Trust has re-energised the CIP work programme, re-naming as Patient Quality & Productivity, being supported by an external consultancy for a further 2 months to establish the 23/24 work programme. The detail of the second phase of the consultancy work was shared with PAF members. PAF felt assured the approach and underpinning governance framework now appeared more robust and the organisation was in a better place than it had been six months previously. The detailed schedule will be presented in March 2023.
2.5 Planning Guidance 23/24	Y	N	N	The '23/24 Priorities and Operating Guidance' was published on 23.12.22 and it approaches the year's planning by combining the acknowledgment of an anticipated complex and pressured year and aiming to continue implementing the NHS

BOARD OF DIRECTORS:	**Trust Board (Public) – 2 February 2023**			**AGENDA ITEM: 6.1**
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DATE OF COMMITTEE MEETING:	**26 January 2023**			

Agenda Item:	**Committee assured** **Y/N**	**Further work** **Y/N**	**Referral elsewhere for further work** **Y/N**	**Recommendation to Board**
				Operating framework new ways of working. Three focused national aims have been set: 1. Recover core services and productivity 2. Deliver the key ambitions in the Long Term Plan 3. Continue transforming the NHS for the future. The guidance requires locally set ambitions in addition to these three national aims, with the ICB funding allocations and performance objectives being set out.
2.6 BAF Risk 5.1 (Finance/Revenue)	Y	N	N	In line with the recommendation it was agreed the risk score would remain at 12.
2.7 Nursing Establishment Review	Y	Y	N	The review (Sept 2022) recommended changes in demand for qualified nurses (reduction of 8.62WTE) and an increase in demand for healthcare support workers (HCSW) (4.8 WTE). It was noted that the national role profile and banding of HCSWs has changed, requiring an uplift from Band 2 to Band 3 for HCSWs. A paper detailing the proposed changes and full costings would be presented through the appropriate channels prior to being presented to PAF. In line with the recommendation, PAF supported the outcome and recommendations of the nursing establishment review.

BOARD OF DIRECTORS:	**Trust Board (Public) – 2 February 2023**	**AGENDA ITEM: 6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**	
REPORT FROM:	**Colin McCready - Committee Chair**	
DATE OF COMMITTEE MEETING:	**26 January 2023**	

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
2.8 Finance Modernisation Programme Update	Y	Y	N	PAF received an update on finance modernisation including options being considered as part of the ledger upgrade.
3.1 M9 Integrated Performance Report	Y	Y	N	Key headlines at M9 were that diagnostic performance was back in common cause variation but some improvement being seen in Cancer 2WW performance, particularly in Dermatology. Emergency Department indicators were evidencing the impact of winter. Additional data for UTC streaming will be added as more is collected and theatre productivity was performing at 68% against a target of 85%. This was only 3%-4% behind pre-COVID performance despite data to show that procedures were taking longer. Clear KPIs were now in place for the UTC Provider and the organisation was on track to achieve the requirement to have all 78 week waiters booked by the end of January with a TCI date before the end of March.
3.2 BAF Risk 4.1 Winter Resilience	Y	Y	N	In line with the recommendation it was agreed the risk score would remain at 12.
3.3 BAF Risk 1.3 Recovery Programme	Y	Y	N	In line with the recommendation it was agreed the risk score would remain at 16.

BOARD OF DIRECTORS:	**Trust Board (Public) – 2 February 2023**	**AGENDA ITEM: 6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**	
REPORT FROM:	**Colin McCready - Committee Chair**	
DATE OF COMMITTEE MEETING:	**26 January 2023**	

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
3.4 BAF Risk 4.2 ED 4 Hour Emergency Department Constitutional Standard	Y	Y	N	In line with the recommendation it was agreed the risk score would remain at 20.
4.1 New Hospital Update	Y	Y	Y	The second national Programme Business Case (PBC) was submitted to Major Projects Review Group (MPRG) in December 2022. Further work has been requested on the PBC to include details of the RAAC schemes. A further update is not anticipated until at least March 2023. Until the outcome of the latest PBC is known, PAH remains uncertain on the next steps and the timeline for the delivery of the new hospital.
4.2 BAF Risk 3.1 Estate and Infrastructure	Y	Y	N	In line with the recommendation it was agreed the risk score would remain at 20.
4.3 Health & Safety Update	Y	Y	N	The key point to note was the external audit by Essex County Fire and Rescue service on 10/11/13 January. There were a number of recommendations which the team is following up with respective departments. A non-conformance letter was received in respect of Fleming Ward evacuation route and the issue has been addressed.

BOARD OF DIRECTORS:	**Trust Board (Public) – 2 February 2023**			**AGENDA ITEM: 6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**			
REPORT FROM:	**Colin McCready - Committee Chair**			
DATE OF COMMITTEE MEETING:	**26 January 2023**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
4.4 Estates & Facilities Quarterly Update (including Trust's Sustainable Development Plan)	Y	Y	N	The report summarised the performance of Estates and Facilities services covering the period M5 to M9 FY 22/23. Areas highlighted to PAF included key staffing gaps in the team, the suspension of Entonox in maternity and actions being taken to address the issue as well as the risk relating to the organisation being unable to substantively recruit and retain catering staff. PAF noted that business continuity planning was in place to support the management and repair of the cracked main water pipe on the hospital site; the Trust was on major incident standby with all relevant partners engaged. *Following the meeting the water pipe issue was resolved and the major incident stood down.*

The Princess Alexandra Hospital NHS Trust

Trust Board – 02 February 2022

Agenda item:	6.2
Presented by:	Tom Burton, DoF
Prepared by:	Mark Pockett, DDoF and Wole Ajiboye, Head of FM
Date prepared:	16th November 2022
Subject / title:	Month 9 Financial Performance

Purpose:	**Approval**		**Decision**		**Information**		**Assurance**	**X**	
Key issues: please don't expand this cell; additional information should be included in the main body of the report	This report provides an update on the Trust's financial performance for to December 2022 (Month 9). The Trust reported a deficit of £1.6m in month and £14.5m YTD. The financial position in month 9 has started to evidence the actions to reduce and slow down the run rate mainly due to stopping or heavily reducing outsourcing\ insourcing and Estates maintenance costs. The Trust's agency costs, particularly Medical staff, remain at levels higher than previous years. These are not being helped by current operational demand pressures and are in line with pressures elsewhere within the NHS. To land a position in line with the forecast of £14.2m, significant non-recurrent support will need to be used in year.								
Recommendation:	The Board is asked to note the month 9 financial results.								
Trust strategic objectives: please indicate which of the five Ps is relevant to the subject of the report	**Patients**	**People**	**Performance**	**Places**	**Pounds**				
	X	**X**	**X**	**X**	**X**				

Previously considered by:	PAF on 26th January 2023
Risk / links with the BAF:	BAF risks 5.1 and 5.2
Legislation, regulatory, equality, diversity and dignity implications:	No impact on EDI identified.
Appendices:	See finance report attached

modern • integrated • outstanding

patient at heart • everyday excellence • creative collaboration

The Princess Alexandra Hospital NHS Trust

Summary finance notes

- Nationally Trust's are being tasked with reducing patient waiting times and delivering elective recovery activity. The Trust has seen a significant reduction in income from the previous years but also seen it's operating costs grow in response to the elective recovery challenges.

- PAHT has reported a deficit of £1.6m in month and £14.5m YTD. There have been minimal non recurrent flexibilities played in at Month 9 but this is being analysed and further release of prior year adjustments will be made in order to achieve our financial forecast.

- We continue to work with each divisional team to review and challenge the assumptions of the Trust's underlying deficit and reflect these within the forecast position. There has been a comprehensive review of the forecasts with Budget Holders at Month 9 and renewed oversight of the current deficit drivers is being undertaken as part of our wider financial transformation work.

- The monthly financial position indicated the actions to reduce and slow down the run rate have reduced the deficit. These include Elective recovery activity including stopping outsourcing\insourcing and Estates maintenance costs.

- The Trust's agency costs, particularly Medical staff, remain at the levels seen in previous months. This month's report includes an analysis of some of the drivers of the underlying price and volume variance around pay spend.

- Pay is overspent by £1.1m in month and £11.5m year to date against plan. The pay award for months 1-6 was paid in September to all staff. The initially anticipated 2% pay award was not included in our reported financial position in previous months, the arrears adversely impacted the month 6 pay spend by £1.5m. The substantive pay spend has been increasing recently reflecting increased recruitment but has not been tempered by equivalent reductions to agency and bank spend in this time.

- Cash balance is £29.9m as at month 9. The movement from the closing 21/22 cash balance reflects the Trust's YTD deficit together with working capital movements. Overall, the Trust is still in a position to meet its short term cash obligations but with an increasing deficit, additional oversight is being provided of the cash balance in this time.

Trust Board

NHS
The Princess Alexandra Hospital
NHS Trust

December - Month 9

Financial Performance

Summary financial results

The Princess Alexandra Hospital NHS

	FY Budget	Month 9			YTD - Dec		
		Budget	Actual	Variance	Budget	Actual	Variance
	£'m	£'m	£'m	£'m	£'m	£'m	£'m
Income							
NHS Clinical SLA Income	318.4	26.5	26.0	(0.5)	238.8	238.4	(0.4)
Non NHS Clinical Income	12.4	1.0	1.2	0.2	9.3	11.2	1.9
Non Clinical Income	1.2	0.1	0.6	0.5	0.9	1.9	1.0
Income Total	**332.0**	**27.7**	**27.8**	**0.1**	**249.0**	**251.5**	**2.5**
Pay							
Substantive	(203.2)	(17.0)	(15.3)	1.7	(152.3)	(138.9)	13.3
Bank	(5.0)	(0.4)	(2.3)	(1.8)	(3.8)	(21.1)	(17.4)
Agency	(5.9)	(0.5)	(1.4)	(1.0)	(4.6)	(12.1)	(7.5)
Pay Total	**(214.2)**	**(17.9)**	**(19.0)**	**(1.1)**	**(160.6)**	**(172.1)**	**(11.5)**
Non-Pay							
Drugs & Medical Gases	(28.1)	(1.9)	(2.1)	(0.1)	(20.8)	(19.8)	1.1
Supplies & Services - Clinical	(19.3)	(1.7)	(1.8)	(0.1)	(14.5)	(15.5)	(1.0)
Supplies & Services - General	(5.1)	(0.4)	(0.6)	(0.1)	(3.9)	(4.0)	(0.2)
All other non pay costs	(46.9)	(3.7)	(4.7)	(1.0)	(35.2)	(42.2)	(7.0)
Non-Pay Total	**(99.4)**	**(7.7)**	**(9.1)**	**(1.3)**	**(74.4)**	**(81.4)**	**(7.0)**
Financing & Depn							
Non NHS Clinical Income	(4.7)	(0.4)	(0.3)	0.1	(3.6)	(3.1)	0.5
All other non pay costs	(14.0)	(1.2)	(1.0)	0.1	(10.5)	(9.4)	1.1
Financing & Depn Total	**(18.7)**	**(1.6)**	**(1.3)**	**0.2**	**(14.0)**	**(12.5)**	**1.6**
Grand Total	**(0.3)**	**0.50**	**(1.6)**	**(2.1)**	**(0.0)**	**(14.5)**	**(14.5)**

Summary financial results

Monthly Summary

- As reported in previous months the YTD deficit has been driven by the higher staffing cost, insourced and outsourced activity related to elective recovery and 104 week waits, continuing Covid-19 related expenditure and higher estates costs.

- Working with the Trust and operational colleagues the level of overspend has been discussed and challenged at various forums including the weekly PRMs .The financial position has started to evidence the ongoing actions to reduce and slow down the run rate.

Workforce

The Princess Alexandra Hospital NHS Trust

	FY Budget	Month 9 Budget £'000	Month 9 Actual £'000	Month 9 Variance £'000	YTD - Dec Budget £'000	YTD - Dec Actual £'000	YTD - Dec Variance £'000
Pay							
Substantive	203,186	16,985	15,293	(1,692)	152,267	138,921	(13,346)
Bank	5,043	419	2,259	**1,839**	3,785	21,137	**17,352**
Agency	5,948	464	1,420	**956**	4,570	12,068	**7,497**
Total Pay Cost	**214,177**	**17,869**	**18,972**	**1,103**	**160,622**	**172,126**	**11,504**

	Month 9 Permanent £'000	Month 9 Bank £'000	Month 9 Agency £'000	Month 9 Total £'000	YTD - Dec Permanent £'000	YTD - Dec Bank £'000	YTD - Dec Agency £'000	YTD - Dec Total £'000
Pay								
Medical	4,413	668	1,081	**6,161**	40,675	6,539	8,172	**55,385**
Nursing	5,591	1,097	64	**6,752**	51,380	10,282	1,715	**63,376**
Scientific, Therapeutic & Tech	1,904	98	132	**2,135**	17,144	792	1,175	**19,112**
Ancillary	623	209	52	**884**	5,782	2,120	47	**7,949**
Admin & Clerical	1,640	187	91	**1,918**	14,719	1,405	958	**17,082**
Snr Managers	1,068	0	0	**1,068**	8,814	0	0	**8,814**
Maintenance & Works Staff	54	0	0	**54**	408	0	0	**408**
Total Pay Cost (Actual)	**15,293**	**2,259**	**1,420**	**18,972**	**138,921**	**21,137**	**12,068**	**172,126**

- Total staff cost of £19.0m in month and £172.1m year to date
- Substantive Pay continues to underspend due to vacancies, these are backfilled using bank and agency staff often at higher costs .
- Medical staffing accounts for £8.2m (67.7%) of the total agency staff cost of £12.1m year to date.

Statement of Financial Position

The Princess Alexandra Hospital NHS Trust

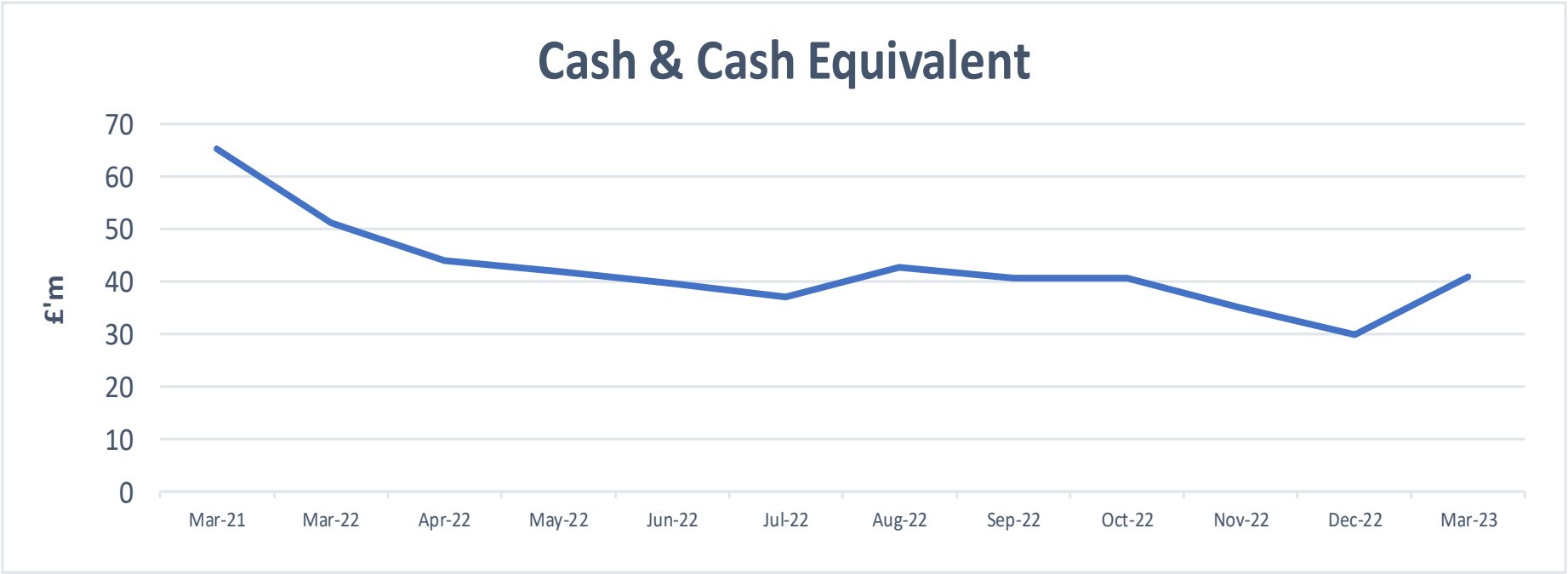
Statement of Financial Position	30 November 2022 £m	31 December 2022 £m	In Month Variance £m	YTD Variance £m
Non-current assets				
Property, plant & equipment	148.6	149.9	1.3	0.8
Intangible assets	9.9	9.8	(0.2)	(1.2)
Trade & other receivables	0.6	0.6	0.0	0.0
Total non-current assets	**159.1**	**160.3**	**1.1**	**(0.5)**
Current assets				
Inventories	5.2	5.2	0.0	0.0
Trade & other receivables	13.7	13.3	(0.4)	1.3
Cash & cash equivalents	35.1	29.9	(5.2)	(21.1)
Total current assets	**54.0**	**48.4**	**(5.5)**	**(19.8)**
Total assets	**213.1**	**208.7**	**(4.4)**	**(20.2)**
Current liabilities				
Trade & other payables	(42.6)	(39.7)	2.8	6.0
Provisions	(1.3)	(1.3)	0.0	0.3
Borrowings	0.0	0.0	0.0	0.0
Total current liabilities	**(43.9)**	**(41.1)**	**2.8**	**6.3**
Net current assets/ (liabilities)	**10.1**	**7.4**	**(2.7)**	**(13.5)**
Total assets less current liabilities	**169.2**	**167.6**	**(1.6)**	**(13.9)**
Non-current liabilities				
Trade & other payables	0.0	0.0	0.0	0.0
Provisions	(1.0)	(1.0)	0.0	0.5
Borrowings	0.0	0.0	0.0	0.0
Total non-current liabilities	**(1.0)**	**(1.0)**	**0.0**	**0.5**
Total assets employed	**168.2**	**166.6**	**(1.6)**	**(13.4)**
Financed by:				
Public dividend capital	327.7	327.7	0.0	(0.1)
Income and expenditure reserve	(160.7)	(162.3)	(1.6)	(14.5)
Revaluation reserve	1.2	1.2	0.0	1.2
Total taxpayers' equity	**168.2**	**166.6**	**(1.6)**	**(13.4)**

- **Non Current Assets** have increased in month by £1.1m representing additions to capital expenditure.
- **Trade and Other Receivables**, the reduction is due to payment of backlog invoices
- **Cash balances** remains at £29.9m.
- **Trade and Other Payables** have decreased, we have processed and paid a number of our older invoices during the month.

Cashflow

The Princess Alexandra Hospital NHS Trust

Mar-21	Mar-22	<----------YTD---------->								Fcast	1 month trend
		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Mar-23	
65,242	51,075	44,051	42,022	39,522	37,129	42,725	40,667	40,741	35,112	29,943	40,795	↑



The Princess Alexandra Hospital NHS Trust

Public Trust Board – 2 February 2023

Agenda item:	6.3
Presented by:	Phil Holland – Chief Information Officer
Prepared by:	Phil Holland – Chief Information Officer
Date prepared:	27 January 2023
Subject / title:	M9 2022/23 Integrated Performance Report (IPR)

Purpose:	Approval		Decision		Information	x	Assurance	x

6.3

Key issues:

Patients		
Patients	**Complaints**	Fourth successive month of reduction in complaints and below the mean for the first time since July. Remains in common cause variation
	Falls per 1000 bed days	Performance is now at the lower control limit and returned to positive special cause variation
People		
People	**Appraisals**	Remains in common cause variation due to an increase in compliance to 83%
	Statutory and Mandatory Training	In special cause variation, however, performance has improved to 88%, up from 85% two months ago
	Sickness Absence	Has returned to special cause variation due to a second data point in three months being at the upper control limit
Performance		
Performance	**RTT**	Performance remains in special cause variation, and seen a slip dip in December, but recovery actions continue to be in place, with patients being treated in clinical priority.
	Cancer 2 week wait	Remains in common cause variation and performance has returned to the mean with the highest performance since June 2022
	Cancer 62 day pathway	Returned to common cause variation for the last two months and for the first time since September 2021. Focus is being placed on the long wait patients, which is having an impact on the overall performance
	Four hour standard	Remains in special cause variation. A number of indicators are in special cause variation highlighting the continued winter pressure on the service
	Diagnostics	Whilst performance remains in common cause variation, we are seeing a downward trend with performance now near the lower control limit
	52 week waits	Still is special cause variation, with a continued focus on clinical priority patients. The volume of patients waiting 52 weeks has remained relatively constant for the last five months following a small increase in July. After 5 months of reduction in 78 week patients, we have seen a small increase in December
	Stranded Patients	The number of patients with a length of stay over 7 days continues to be at or near the upper control limit for the last six months and remains in special cause variation
Pounds		
Pounds	Surplus	The Trust reported a deficit of £1.6m in December (Month 9) and year to date deficit of £14.5m. We continue to work with each divisional team to review and challenge the assumptions of the Trust's underlying deficit and reflect these within the forecast position.
	CIP	The 22/23 CIP target is £11.7m with a YTD planned savings at month 9 of £7.6m. The FY forecast waste\efficiency is currently £11.7m with the YTD indentified savings at £7.5m, of which £6.7m are non-recurrent. Work continues within each divsion to deliver additional schemes and savings.
	Capital Spend	The Trust total revised Capital resourcing for 2022/23 is £16.9m, this includes external PDC including the new hospital project. As at Month 9 the year to date capital spend total is £8.9m, excluding the impact of IFRS 16. Whilst further national support will be available to the Trust, it is fully anticipated the capital programme will be fully utilised in 22/23. Note: some additional PDC may be made available for digital programmes but this will be confirmed in due course
	Cash	The Trust's cash balance is £29.9m. The cash reserves which were boosted due to the national Covid support received by the Trust have started reducing as we continue to run with a deficit in 2022/23. There remains focus on the level of unpaid invoices and maintaining the Trust's improved 30 day BPPC performance.
Places		
Places	Domestic Services (cleaning) high risk	Performance has reduced towards the lower control limit for October and November

The Princess Alexandra Hospital NHS Trust

Recommendation:	The Board is asked to discuss the report and note the current position and further action being taken in areas below agreed standards.				
Trust strategic objectives: please indicate which of the five Ps is relevant to the subject of the report	Patients	People	Performance	Places	Pounds
	x	x	x	x	x

Previously considered by:	PAF.26.01.23 and QSC.27.01.23
Risk / links with the BAF:	
Legislation, regulatory, equality, diversity and dignity implications:	No regulatory issues/requirements identified, the IPR demonstrates a full view of service delivery to ensure we take into account equality, diversity and dignity
Appendices:	

6.3

NHS
The Princess Alexandra Hospital
NHS Trust

Integrated Performance Report for December 2022

modern • integrated • outstanding

patient at heart • everyday excellence • creative collaboration

Performance Summary

Patients		
Patients	**Complaints**	Fourth successive month of reduction in complaints and below the mean for the first time since July. Remains in common cause variation
Patients	**Falls per 1000 bed days**	Performance is now at the lower control limit and returned to positive special cause variation

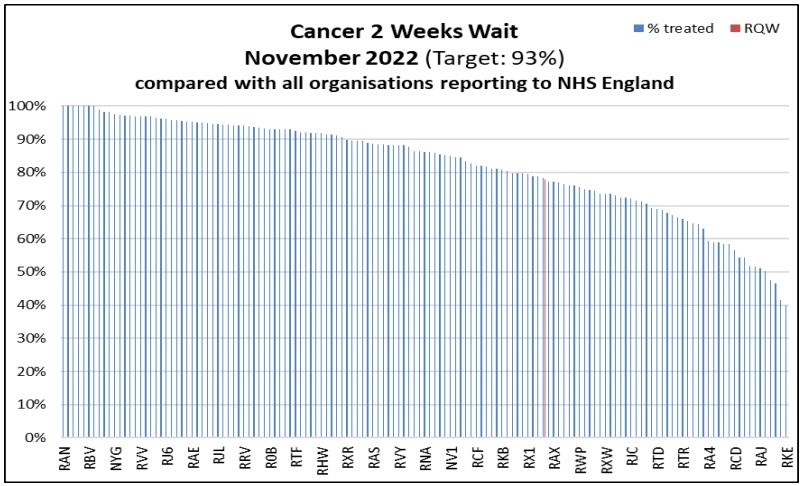
Pounds		
Pounds	**Surplus**	The Trust reported a deficit of £1.6m in December (Month 9) and year to date deficit of £14.5m. We continue to work with each divisional team to review and challenge the assumptions of the Trust's underlying deficit and reflect these within the forecast position.
Pounds	**Cost Improvement Programme**	The 22/23 CIP target is £11.7m with a YTD planned savings at month 9 of £7.6m. The FY forecast waste\efficiency is currently £11.7m with the YTD indentified savings at £7.5m, of which £6.7m are non-recurrent. Work continues within each divsion to deliver additional schemes and savings.
Pounds	**Capital Spend**	The Trust total revised Capital resourcing for 2022/23 is £16.9m, this includes external PDC including the new hospital project. As at Month 9 the year to date capital spend total is £8.9m, excluding the impact of IFRS 16. Whilst further national support will be available to the Trust, it is fully anticipated the capital programme will be fully utilised in 22/23. Note: some additional PDC may be made available for digital programmes but this will be confirmed in due course
Pounds	**Cash**	The Trust's cash balance is £29.9m. The cash reserves which were boosted due to the national Covid support received by the Trust have started reducing as we continue to run with a deficit in 2022/23. There remains focus on the level of unpaid invoices and maintaining the Trust's improved 30 day BPPC performance.

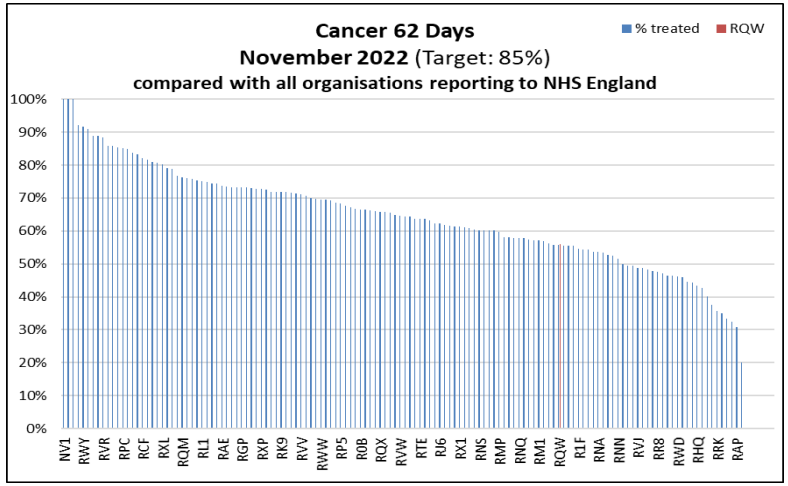
Places		
Places	**Domestic Services (cleaning) high risk**	Performance has reduced towards the lower control limit for October and November

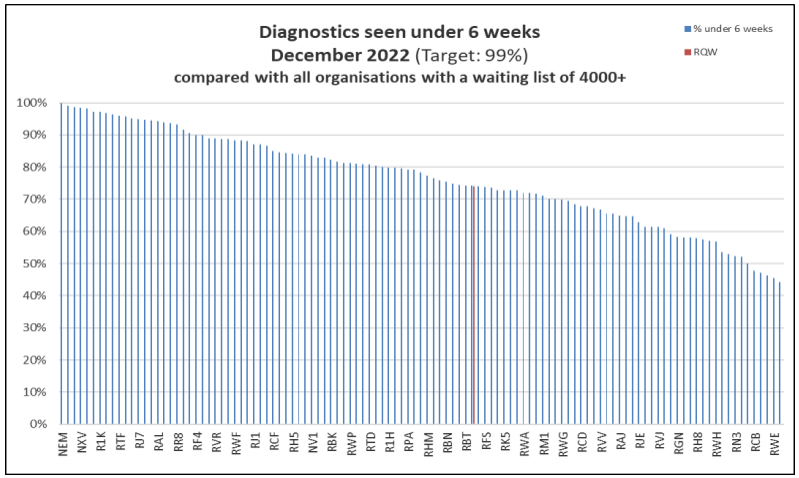
People		
People	**Appraisals**	Remains in common cause variation due to an increase in compliance to 83%
People	**Statutory and Mandatory Training**	In special cause variation, however, performance has improved to 88%, up from 85% two months ago
People	**Sickness Absence**	Has returned to special cause variation due to a second data point in three months being at the upper control limit

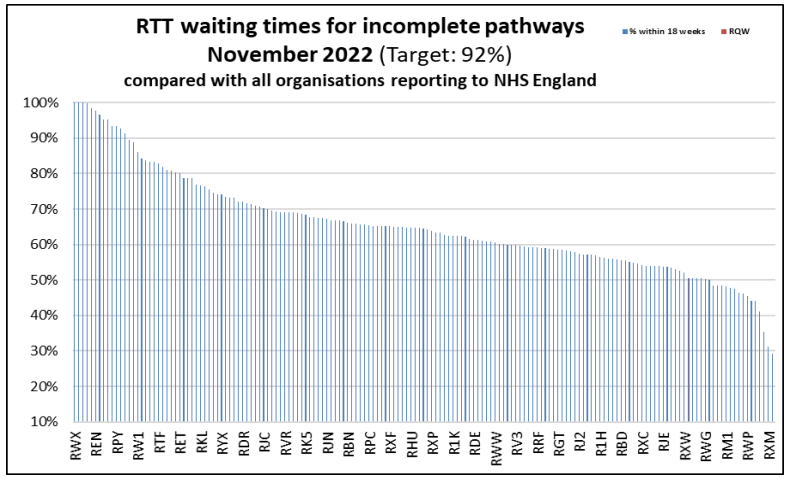
Performance		
Performance	**Referral to Treatment**	Performance remains in special cause variation, and seen a slip dip in December, but recovery actions continue to be in place, with patients being treated in clinical priority.
Performance	**Cancer 2 week wait**	Remains in common cause variation and performance has returned to the mean with the highest performance since June 2022
Performance	**Cancer 62 day pathway**	Returned to common cause variation for the last two months and for the first time since September 2021. Focus is being placed on the long wait patients, which is having an impact on the overall performance
Performance	**Four hour standard**	Remains in special cause variation. A number of indicators are in special cause variation highlighting the continued winter pressure on the service
Performance	**Diagnostics**	Whilst performance remains in common cause variation, we are seeing a downward trend with performance now near the lower control limit
Performance	**52 week waits**	Still is special cause variation, with a continued focus on clinical priority patients. The volume of patients waiting 52 weeks has remained relatively constant for the last five months following a small increase in July. After 5 months of reduction in 78 week patients, we have seen a small increase in December
Performance	**Stranded Patients**	The number of patients with a length of stay over 7 days continues to be at or near the upper control limit for the last six months and remains in special cause variation

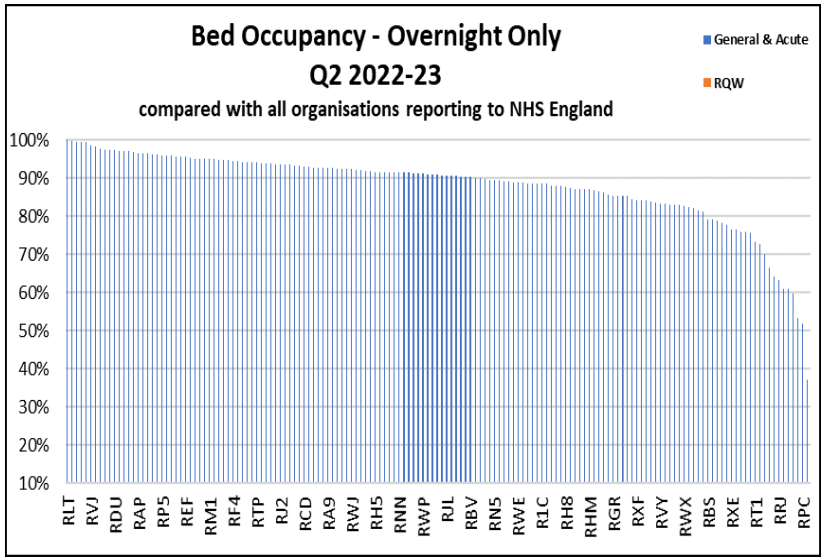
National Benchmarking

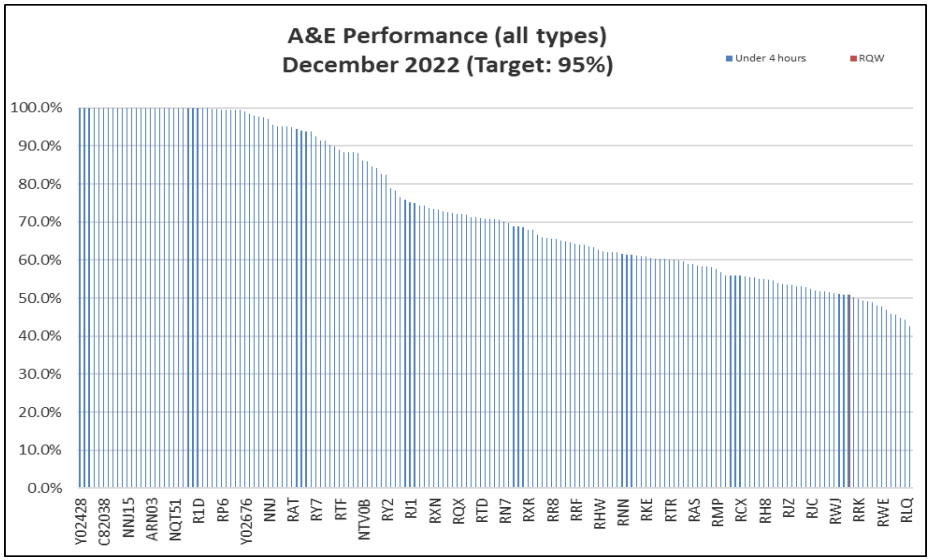









Bed Occupancy - Overnight Only
Q2 2022-23
compared with all organisations reporting to NHS England
General & Acute
RQW
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
RLT RVJ RDU RAP RP5 REF RM1 RF4 RTP RJ2 RCD RA9 RWJ RH5 RNN RWP RJL RBV RN5 RWE R1C RH8 RHM RGR RXF RVY RWX RBS RXE RT1 RRJ RPC


A&E Performance (all types)
December 2022 (Target: 95%)
Under 4 hours
RQW
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
Y02428 C82038 NNJ15 ARN03 NQT51 R1D RP6 Y02676 NNJ RAT RY7 RTF NTV0B RY2 RJ1 RXN RQX RTD RN7 RXR RR8 RRF RHW RNN RKE RTR RAS RMP RCX RH8 RJZ RJC RWJ RRK RWE RLQ


Benchmarking

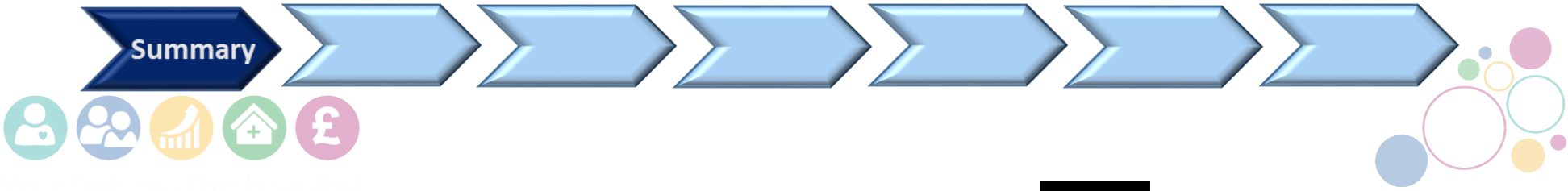
The difference between common and special cause variation

Common Cause Variation

- Is inherent in the design of the process
- Is due to regular, natural or ordinary causes
- Shows that a process is stable and overall predictable
- Also known as random or unassignable variation
- Shown as grey line with grey markers on our SPC charts

Special Cause Variation

- Is due to irregular causes that are not inherent in the design of the process
- Results in an unstable process that is not predictable
- Also known as non-random or assignable variation
- Shown as blue or orange markers on our SPC charts



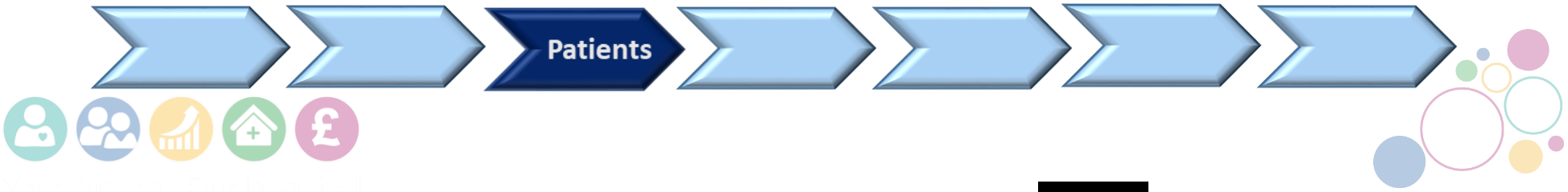
How is special cause variation defined and identified

It can be positive and improving (identified by blue markers), or negative and deteriorating (orange markers). The following factors identify special cause variation in our SPC charts

- A single point outside of the upper or lower control limits
- A run of points above or below the average (mean) line.
- Six consecutive points increasing or decreasing
- Two consecutive points near the upper or lower process control limits

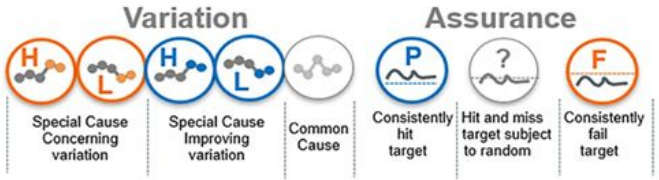
Patients

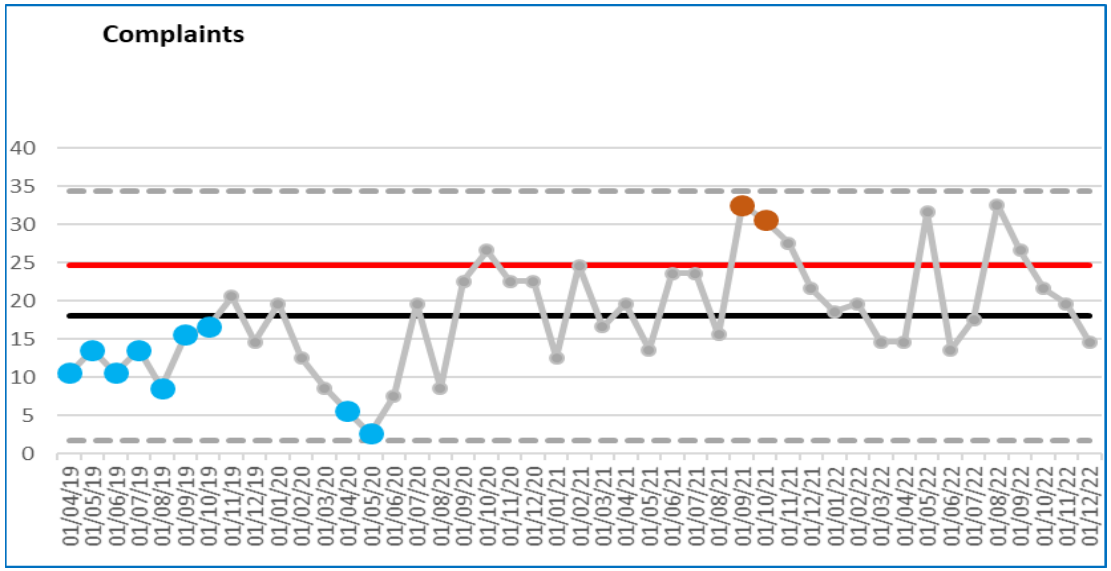
*We will continue to improve the quality of care, outcomes & experiences that we provide **our patients**, integrating care with our partners & reducing health inequity in our local population*



KPI	Latest month	Measure	Target	Perfomance	Assurance	Mean	Lower process limit	Upper process limit
Group 1 metrics								
Complaints	Dec 22	15	25			18	2	35
Compliments	Dec 22	68	50			112	-81	306
PALS	Dec 22	287	none			291	149	433
Complaints closed within target	Dec 22	9	none			6	-3	14
% of complaints where an extension has been agreed	Dec 22	54%	none			44%	13%	75%
Mixed Sex Accommodation Breach	Dec 22	2	0			7	-4	19
Serious Incidents	Dec 22	0	none			4	-4	12
MSSA	Dec 22	3	none			1	-1	3
CDIFF	Dec 22	2	none			5	-3	13
Hand Hygiene	Dec 22	93%	none			92%	78%	107%
eColi	Dec 22	0	3			1	-2	4
Klebsiella	Dec 22	1	2			1	-1	3
Pseudomonas	Dec 22	2	1			0	-1	2
Falls per 1000 bed days	Dec 22	5	9			8	5	11
Falls total minor, moderate & severe	Dec 22	15	13			24	10	38
Pressure Ulcers per 1000 bed days	Dec 22	4	3			4	1	7
Pressure Ulcers: grade 3, 4 & unstageable	Dec 22	6	3			5	-3	12
Total number of mothers delivering in birthing unit/home	Dec 22	5%	20%			10%	-2%	22%
Number of mothers delivering in Labour Ward/Theatres	Dec 22	96%	75%			89%	76%	102%
Number of women due to deliver at PAH adjusted for misc/TOPs	Dec 22	301	375			329	272	386
Smoking rates at booking	Dec 22	7%	none			9%	3%	14%
Smoking rates at delivery	Dec 22	6%	6%			9%	5%	14%
Breast feeding rates at delivery	Dec 22	73%	74%			75%	67%	84%

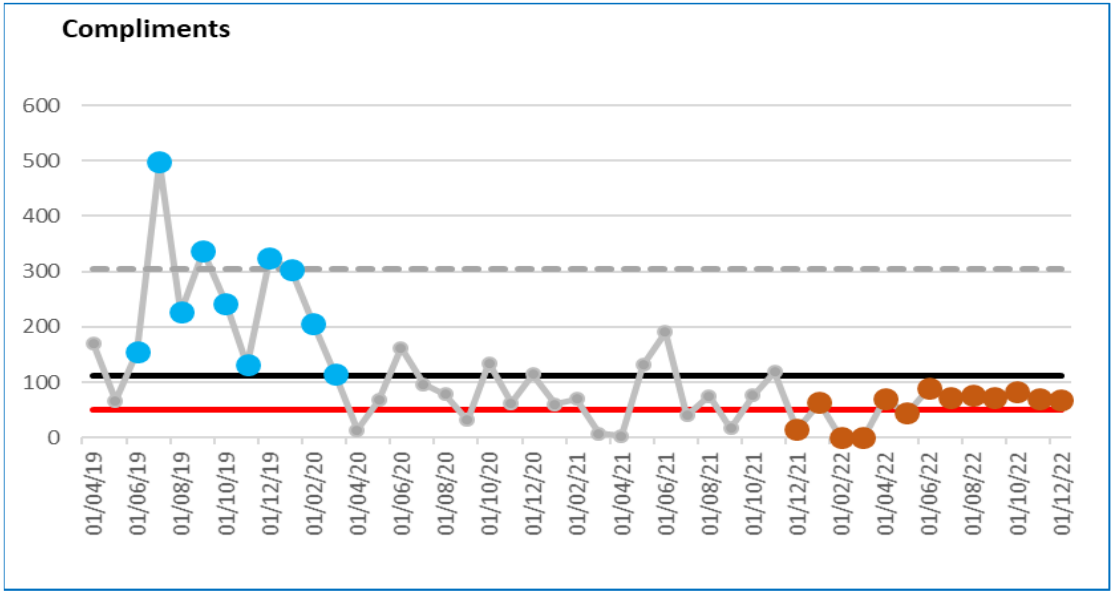
KPI	Latest month	Measure	National target	Performance	Assurance	Mean	Lower process limit	Upper process limit
Group 2 metrics								
Postpartum Haemorrhage over1500 mls	Dec 22	5%	none			4%	1%	7%
CTG training compliance midwives	Dec 22	96%	85%			74%	56%	91%
CTG training compliance doctors	Dec 22	91%	85%			75%	51%	99%
Still births	Dec 22	0	none			1	-1	3
Patients detained under MHA	Dec 22	0	none			0	-1	2
Patients detained under section 136	Dec 22	2	none			1	-2	4
Mental health patient incidents	Dec 22	9	none			12	-1	25
Mental health patient complaints	Dec 22	0	none			0	-1	1
Mental health patient PALS	Dec 22	2	none			2	-1	5
Patients with LD and Autism accessing inpatient services	Dec 22	29	none			26	6	45
C-DIFF Hospital onset healthcare associated	Dec 22	1	none			2	-3	7
C-DIFF Community onset healthcare associated (Acute Admissio	Dec 22	0	none			1	-1	3
C-DIFF Community onset indeterminate association (Acute Adm	Dec 22	0	none			1	-1	3
C-DIFF Community onset community associated (No acute conta	Dec 22	1	none			1	-3	5
Covid-19 new positive inpatients	Dec 22	165	none			136	-99	372
MRSA	Dec 22	0	0			0	0	0
Births	Dec 22	288	none			320	265	375
Instrumental births	Dec 22	35	none			25	6	45
Pre- term births	Dec 22	21	none			21	3	40
Continuity of carer	Dec 22	9%	none			22%	11%	33%
Women booked in month	Dec 22	387	none			363	295	431





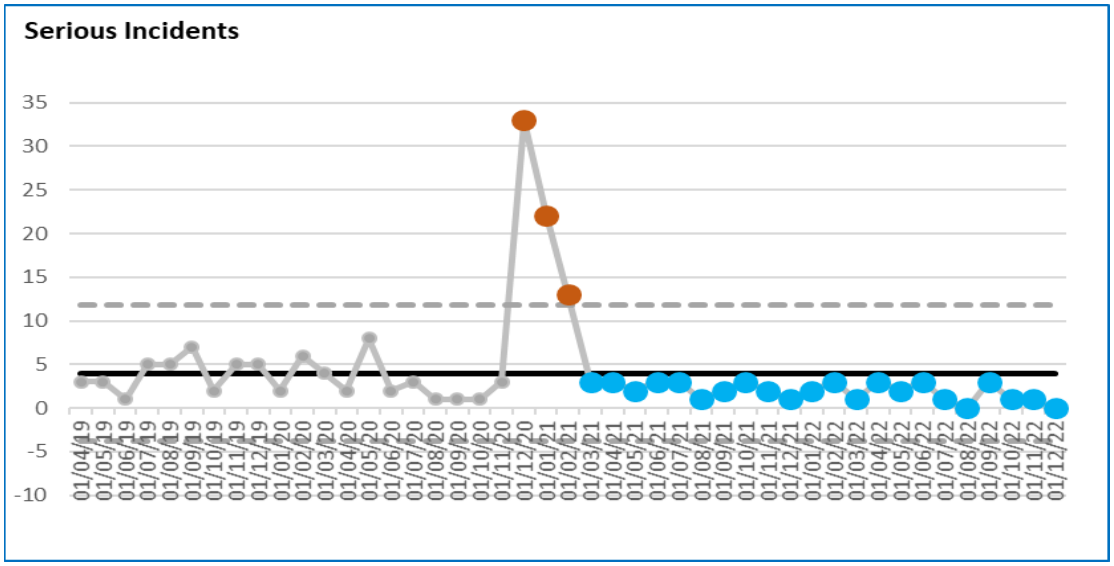
15
Variance Type
Common cause variation
Target
25
Target Achievement
Hit & miss target subject to random variation

Background	What the chart tells us	Issues	Actions	Mitigation
Complaints	Common cause variation	Complaints increases reflects operational issues.	Objective to return to pre-pandemic levels. Case management support. Process workshops and divisional PSQ recruitment ongoing.	No cases older than 6 months by March 2023.



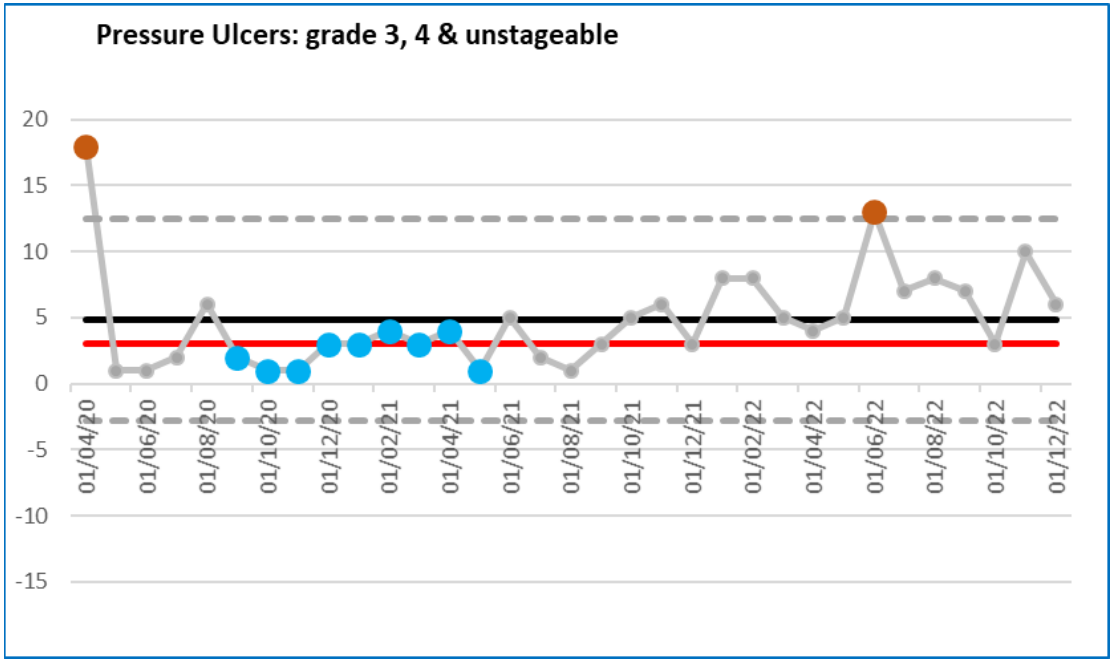
Dec-22
68
Variance Type
Special cause variation
Target
50
Target Achievement
Hit & miss target subject to random variation

Background	What the chart tells us	Issues	Actions	Mitigation
Compliments	Special cause concerning variation while hit & missing the target	During the last 12 month compliments have seen a decline due to staffing pressures.	Will return to recording this data when staffing issues resolved. Keeping staffing gap under regular review.	Continuing to receive and hold feedback and data in preparation for return to normal staffing and encourage staff to return compliements despite the data delay.



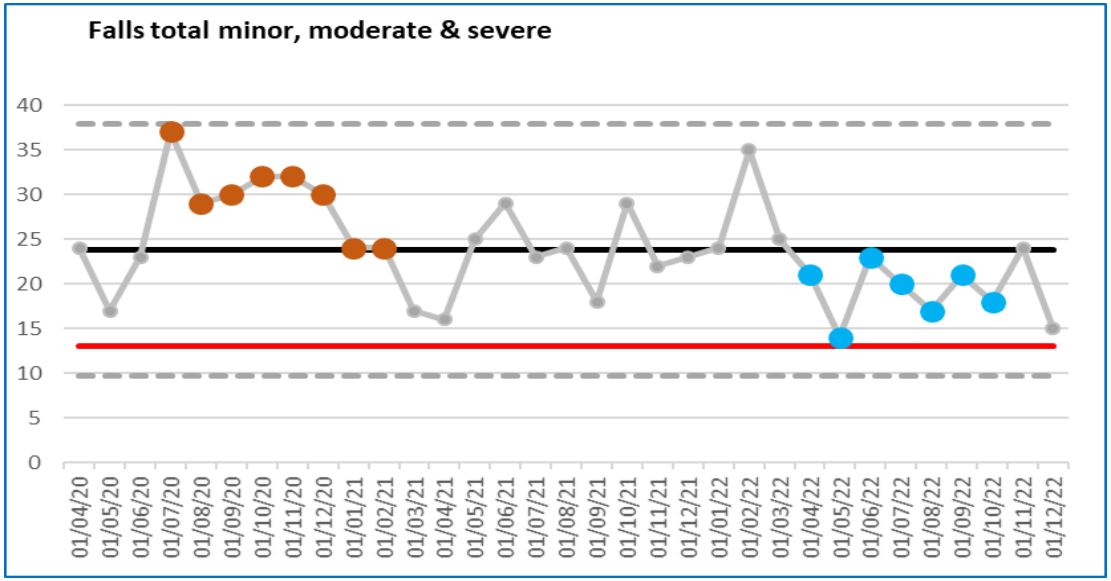
Dec-22
0
Variance Type
Special cause improving variation
Target
The trust does not have a target submission no. for SIs each month
Target Achievement
Our level of serious incidents reported per month is consistent

Background	What the chart tells us	Issues	Actions	Mitigation
Serious Incidents (SIs)	Trust reporting numbers for serious incidents raised each month is consistent & month on month	Where an incident meets the national reporting criteria to be raised externally as a serious incident (SI) it will be raised. There is no internally set target		Daily local review of incidents by each divisional team is completed with appropriate second stage review at the incidents management group. IMG submits a monthly report on both incident themes & serious incidents onto the Patient Safety Group.



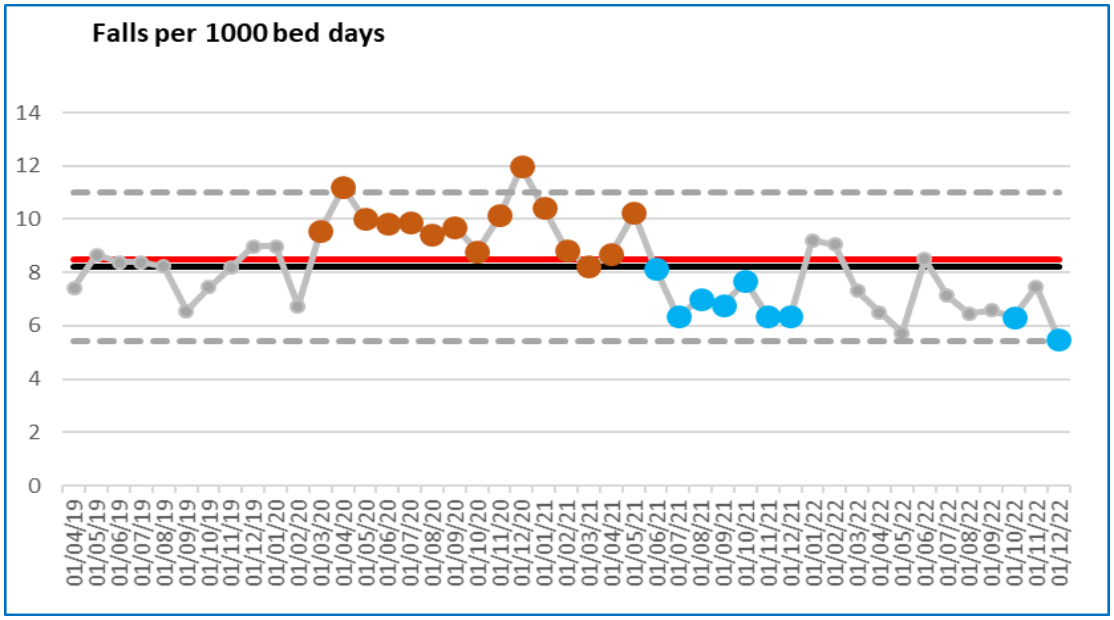
Dec-22
6
Variance Type
Common cause variation
Target
3
Target Achievement
Hit & missing target subject to random variation

Background	What the chart tells us	Issues	Actions	Mitigation
Pressure Ulcers: grade 3, 4 & Unstageable	Common cause variation while hit & missing the target			



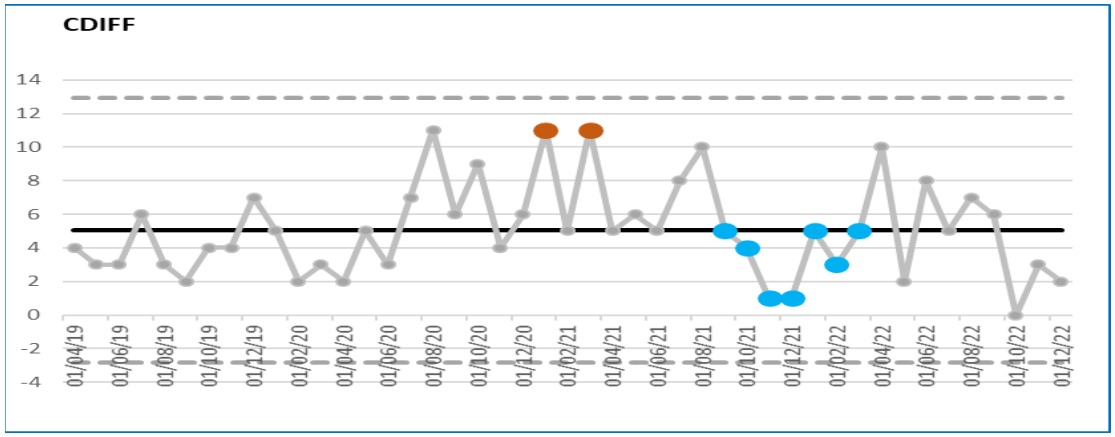
01/15/2022
24
Variance Type
Common cause variation
Target
13
Target Achievement
Hit & miss target subject to random variation

Background	What the chart tells us	Issues	Actions	Mitigation
Falls total minor, moderate & severe	Common cause variation & hit and miss target subject to random variation	A new falls prevention strategy has been developed for the financial year 2022/23. The Trust remains committed to reducing falls with harm by 50% by the end of 2022/23	New falls strategy in place for 2022/23.New method for validating falls with harm is in place	Nil at this point



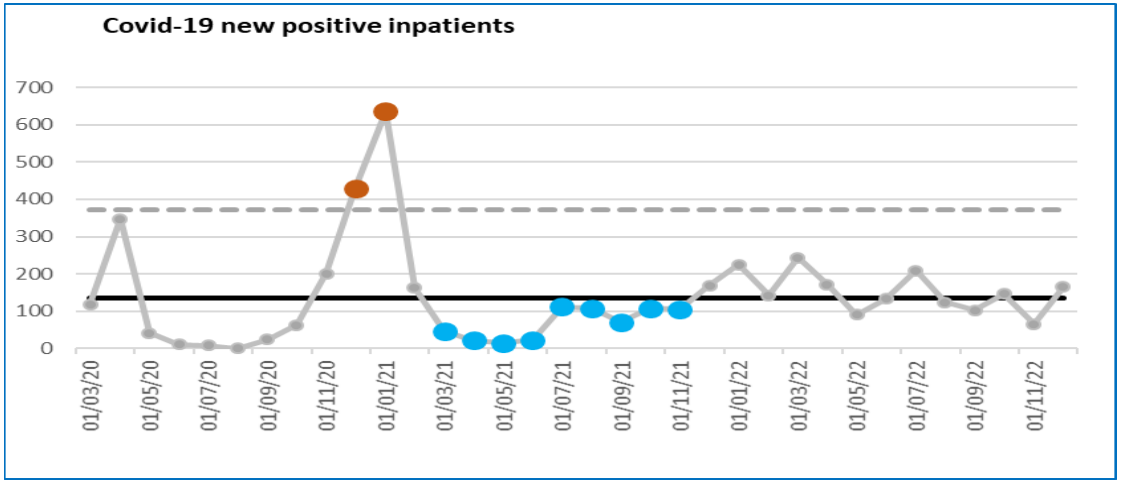
Dec-22
5.48
Variance Type
Common cause variation
Target
8.5
Target Achievement
Hit & miss target subject to random variation

Background	What the chart tells us	Issues	Actions	Mitigation
Falls per 1000 bed days	Common cause variation & hit and miss target subject to random variation		Please see Falls by Harm narrative	



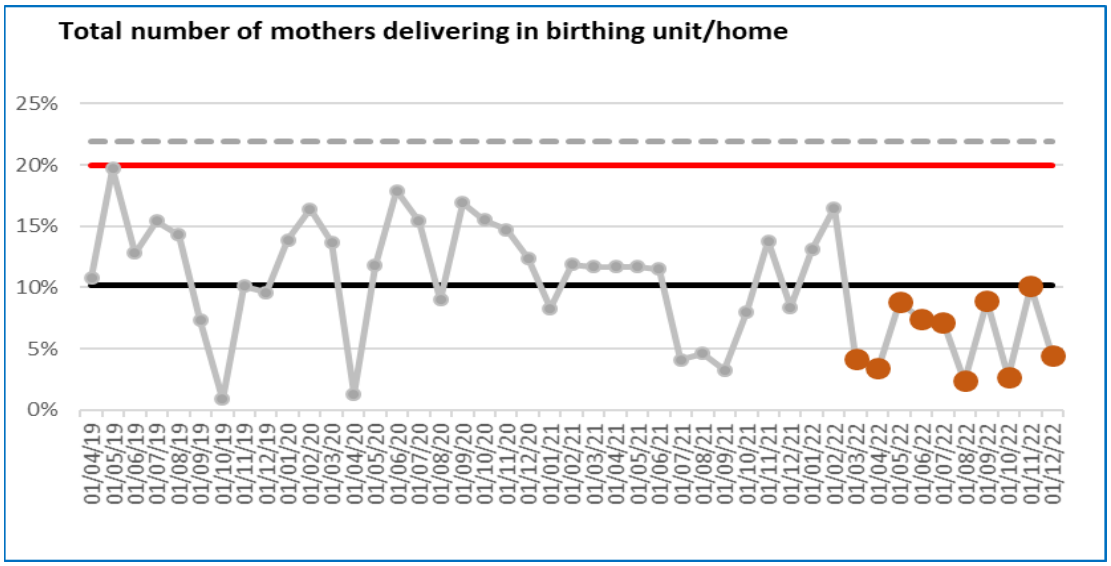
Dec-22
2
Variance Type
Common cause variation
Target
Not Set
Target Achievement
N/A

Background	What the chart tells us	Issues	Actions	Mitigation
C.difficile	Common cause variation	1.The Trust is the highest prescriber of antibiotics per 1000 admissions in the East of England (EoE). Although it is acknowledged there are multi-factorial root causes of C.difficile cases, reductions in overall and broad-spectrum antibiotic use should help reduce cases, which is monitored through the Antimicrobial Stewardship (AMS) meetings. The AMS team are considering reducing the use of Co-amoxiclav and Piperacillin- tazobactam by stating alternatives in the Trust antibiotic policy at the next update over the next few months. 2. incident reviews have highlighted that there are some practices which require improvement, including documentation of duration and indication of antibiotics, inappropriate use of antibiotics and below the expected standards of compliance (95%) for PPE, hand hygiene and environmental audits.	Focus of actions: 1.Antimicrobial prescribing 2.Environment /cleanliness 3.Prompt isolation 4.Hand hygiene 5.PPE 6.Prompt stool specimen collection 7.Commode & dirty utility audits 8.Increased teaching / cascading of key messages /attending ward manager meetings/ IPC Associates 7.Introduction of sporicidal wipes for commode cleaning in all clinical areas 8.Ribo-typing of C.difficile specimens to support in detecting possible outbreaks or clusters of infection 9.RCA process (Incident Panel) to review cases and shared learning .	1. Monitoring of cases (Infection Prevention & Control Committee & Trust Dashboard) 2. RCA reviews of all cases; this is undertaken by the IPC Team, DIPC/Microbiology Consultant, Antimicrobial pharmacist, senior medical & nursing colleagues caring for the patient - shared learning is achieved through the reviews 3. Antimicrobial Stewardship Committee is responsible for the monitoring of antibiotic prescribing 4. IP&C Associate team in place who are supporting the IPC team in delivering the key messages 5. Appeals panel in place (led by CCG) to appeal against cases that have been considered to be 'unavoidable' 5. Although cases increased, severity of infection did not; there have not been any deaths where C.difficile has been the cause of death



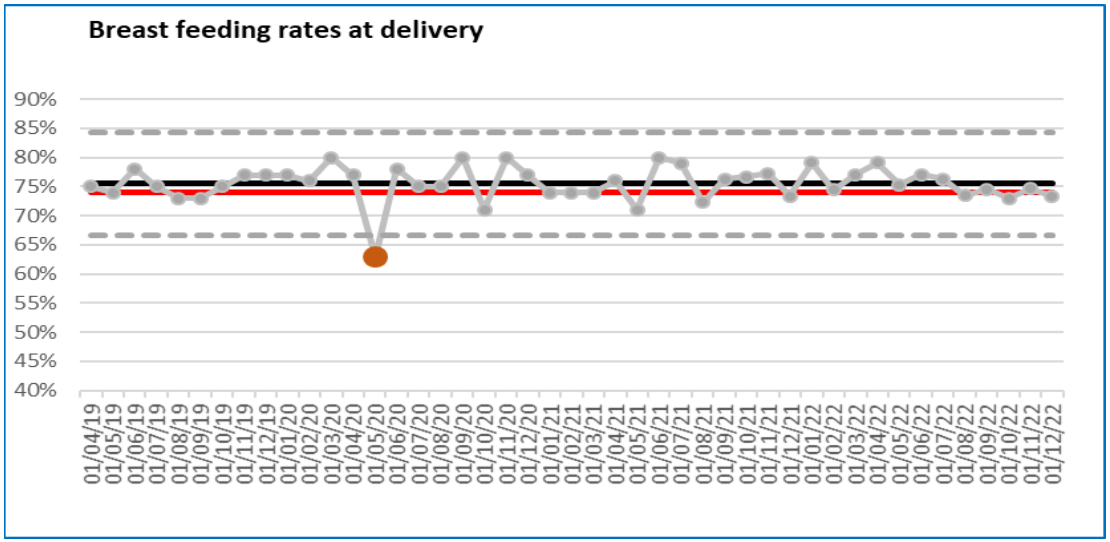
Dec-22
165
Variance Type
Common cause variation
Target
Target Achievement
Hit & miss target subject to random variation

Background	What the chart tells us	Issues	Actions	Mitigation
Covid-19 new positive inpatients	Common cause variation & inconsistently hit & missing target	Due to the Omicron being the dominant strain of SARS-CoV-2 (COVID-19) in the country, which was driving the peak in community cases, the Trust also saw a significant increase in the number of nosocomial COVID-19 cases in January. There were four outbreaks in January.	IPC Cell meets weekly; reviews data/trends/new guidance/pathways Outbreak meetings held wth representation for regional and CCG colleagues. IPC audits continue and reviewed at Cell IPC Team collecting data on all cases related to vaccination status. Visitor restrictions in place	1. All measures in place relating to screening on admission & every 48 hours thereafter & monitoring for signs & symptoms of COVID-19 2. All other IPC measures in place, e.g screens between beds, patients encouraged to wear masks, standard precautions, restricted visiting, cleaning protocols 3. Regular outbreak meetings following declaration of outbreak to agree & monitor actions including: Screening of staff and patients, increased observations/audits of practice, emphasis on hand hygiene, decontamination, cleaning & restricted visiting.



Dec-22
4.5%
Variance Type
Common cause variation
Target
20%
Target Achievement
Hit & miss target subject to random variation

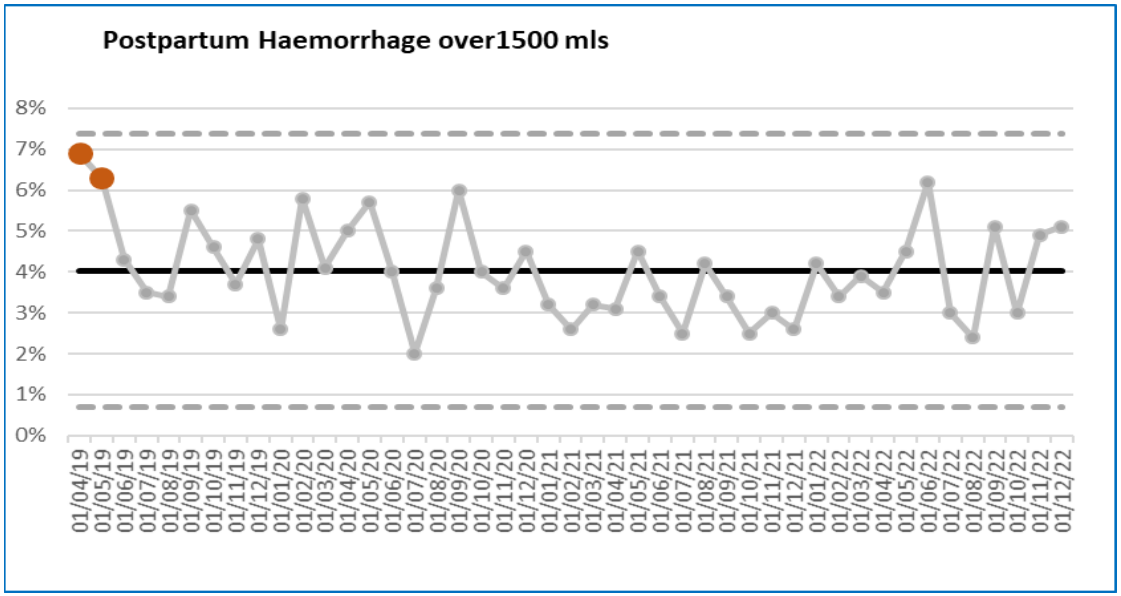
Background	What the chart tells us	Issues	Actions	Mitigation
Total no. of mothers delivering in birthing unit/home	Common cause variation & hit & missing target	Mothers delivering in birthing unit/home		Midwives are being re-deployed to the most appropriate area in terms of maintaining safe staffing levels – resulting in periodic closure of the Birth Unit to maintain safe staffing



Dec-22
73.4%
Variance Type
Common cause variation
Target
74%
Target Achievement
Hit & miss target subject to random variation

Background	What the chart tells us	Issues	Actions	Mitigation
Breast feeding rates at delivery	Common cause variation & inconsistently hit & missing target	Breast feeding rates at delivery	A 'Baby Friendly Strategic Group has been established, chaired by the Head of Midwifery. PAH is working towards the BFI Gold standard Award.	Recent initiative include; to reduce the number of unknown method of baby feeding at delivery alongside other Baby Feeding data quality initiatives

Patients



Dec-22
5.10%
Variance Type
Common cause variation
Target
Not set
Target Achievement

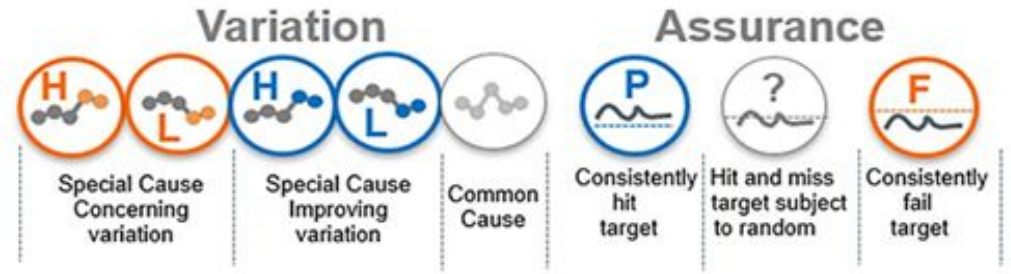
Background	What the chart tells us	Issues	Actions	Mitigation
PPH over 1500mls	Common cause variation	PPH over 1500mls	All massive obstetric haemorrhages are reviewed to ensure the appropriate management was followed, including a thematic review of high risk factors	The labour admission risk assessment tool has been reviewed to ensure it is as effective as possible and a new PPH checklist has recently been approved

Places

*We will maintain the safety of & improve the quality & look of **our places** & will work with our partners to develop an OBC for a new hospital, aligned with the development of our local Integrated Care Partnership.*

Places Summary		Board Sub Committee: Performance and Finance Committee	
Focus Area	**Description and action**	**Reason for Inclusion**	**Target Date for Resolution if applicable**
Estates	The new system MICAD is currently being implemented, once this is up and running we will be able to report the required figures	For information	
Catering	Increase in meals due to the hospital patient numbers. Currently using the Cook Chill whilst the kitchen was refurbished. In house meal preparation restarted beginning of December.	For information	
Facilities	The current monitoring system for the domestics which produces the NSC scores has being failing regularly, the decision has been made to give notice and to move to a new system which encorporates Domestics, Portering and Catering. This new system will be ensure that all areas have a full auditing too	For information	

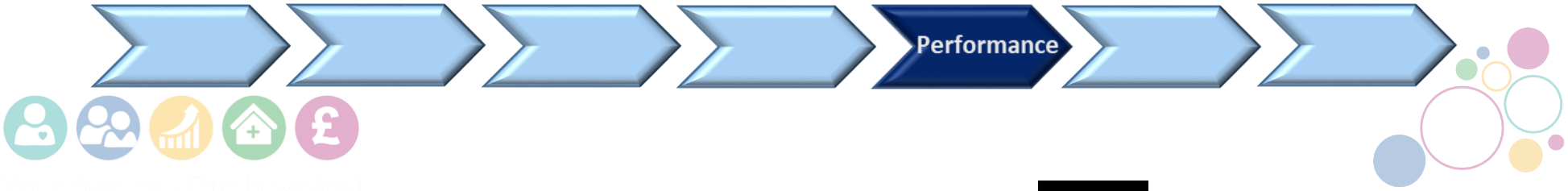
KPI	Latest month	Measure	National target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Estates Responsiveness (Priority 2 - Urgent)	Sep 22	93%	95%			95%	91%	99%
Meals Served	Nov 22	50170	42120	H		38705	27190	50221
Catering Food Waste	Sep 22	2%	4%	L		5%	-1%	10%
Domestic Services (Cleaning) Very High Risk	Oct 22	97.6%	98.0%			97.7%	94.7%	100.7%
Domestic Services (Cleaning) High Risk	Oct 22	93.4%	95.0%			96.7%	93.2%	100.1%



Performance

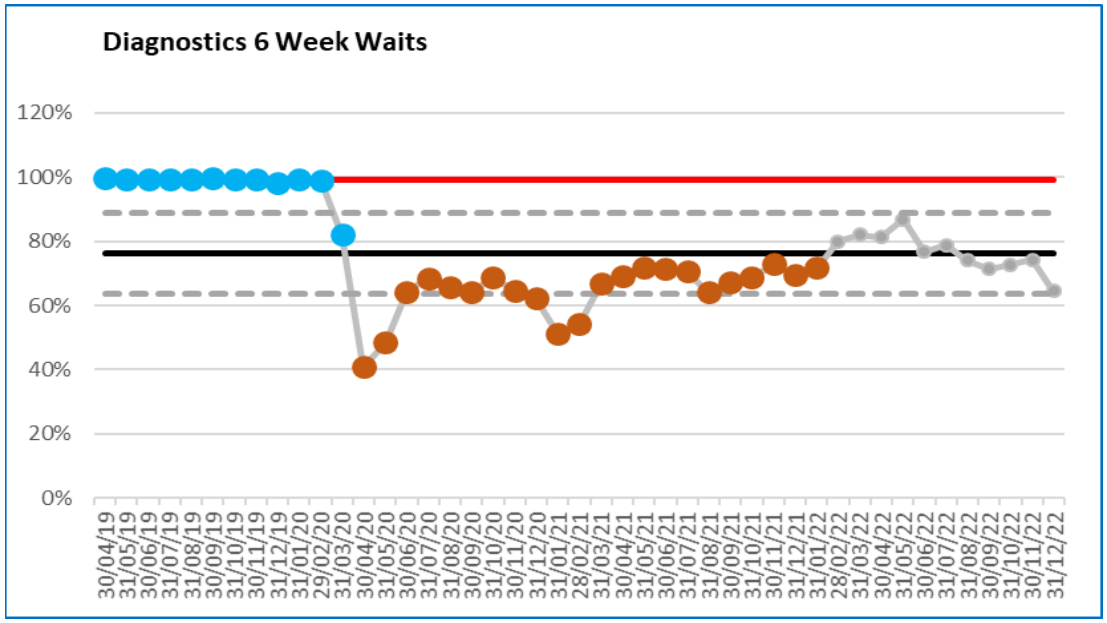
*We will meet & achieve **our performance** targets, covering national & local operational, quality & workforce indicators.*

Performance	Board Sub Committee: Worforce Committee		
Focus Area	**Description and action**	**Reason for Inclusion**	**Target Date for Resolution if applicable**
Emergency Care	Continued increased attendances through the emergency department and decreased flow through the hospital impacting all the key standards. We have included the shadow new emergency standarda of 12 hours in the department in the IPR this month.	For increased visibility and awareness	31/03/2023
RTT/18 weeks	The number of patients waiting over 52 weeks has started to decrease this month and the Trust is ahead of the 78 week recovery trajectory. The Trust is well paced across the region in this performance.	For recognition	31/03/2023
Diagnostics	CT is achieveing the national standard of 95% by 31/3/23 and MRI is close at 92.4%. Most specialities improving performance, but audiology has poor performance and a detailed acion plan is being put in place.	For increased visibility and awareness	31/03/2023
Cancer	Significant increases in referrals over the past few months and staff vacancy have impacted the first appointment standard. 28 day diagnosis standard is steady and an action plan is in place to improve this alongside the CQUIN. Continued focus on diagnosing and treating the patients that have waited the longest. The Trust is making some of the best progress in the Region.	For increased visibility and awareness	31/03/2023



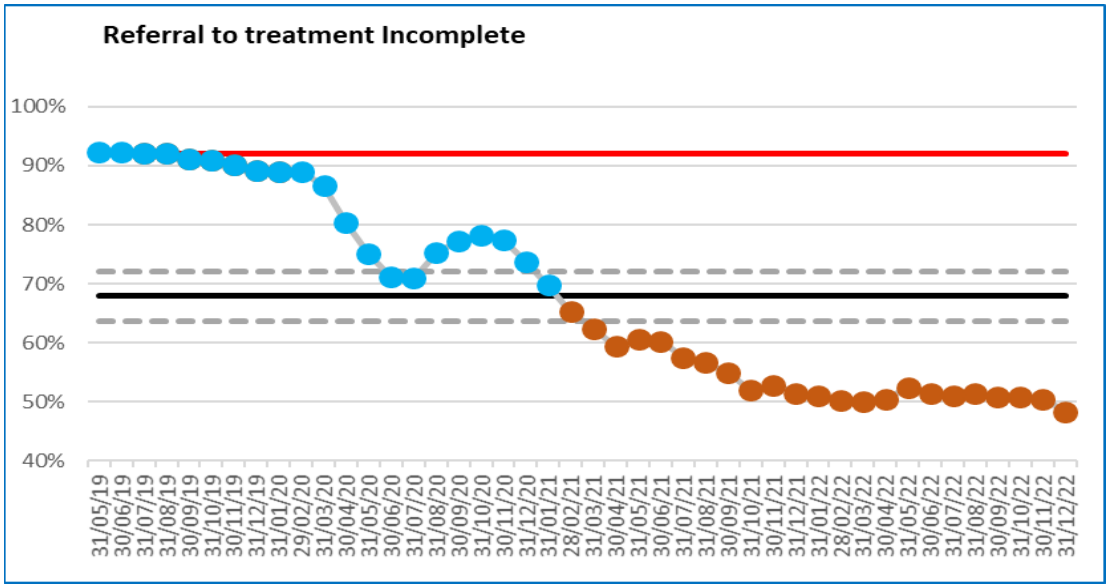
KPI	Latest month	Measure	Target	Perfomance	Assurance	Mean	Lower process limit	Upper process limit
Performance Group 1 metrics								
Referral to treatment Incomplete	Dec 22	48%	92%			68%	64%	72%
Referral to treatment Admitted	Dec 22	39%	90%			50%	27%	73%
Referral to treatment Non-Admitted	Dec 22	65%	95%			85%	81%	88%
RTT PTL vs RTT PTL & ASIs	Dec 22	83%	none			91%	88%	94%
Cancer 31 days First	Nov 22	89%	96%			93%	83%	102%
Cancer 31 days Subsequent Drugs	Nov 22	100%	98%			98%	91%	106%
Cancer 31 days subsequent surgery	Nov 22	83%	94%			91%	54%	128%
Cancer 2 Week Wait	Nov 22	78%	93%			80%	60%	100%
Cancer 62 day shared treatment	Nov 22	56%	85%			65%	42%	88%
Cancer 62 day screening	Nov 22	27%	90%			64%	6%	121%
Cancer 62 Day Consultant Upgrade	Nov 22	76%	90%			81%	58%	104%
Cancer 28 day faster diagnosis	Nov 22	74%	75%			67%	52%	82%
4 Hour standard	Dec 22	51%	95%			71%	63%	79%
Emergency Department attendances	Dec 22	12024	none			9455	7412	11499
Emergency Department Admitted performance	Dec 22	40%	95%			43%	27%	58%
Emergency Department non admitted performance	Dec 22	56%	95%			79%	71%	87%
Emergency Department Arrival to Triage	Dec 22	41	15			46	27	64
Emergency Department Triage to examination	Dec 22	163	60			112	70	153
Emergency Department Examination to referral to specialty aver	Dec 22		45			101	82	120
Seen by specialty to Decision to Admit	Dec 22	134	60			100	77	123
Decision to Admit to departure	Dec 22	404	30			244	114	374
Ambulance handovers less than 15 minutes	Dec 22	9%	100%			23%	12%	34%
Ambulance handovers between 15 and 30 mins	Dec 22	25%	0%			39%	30%	48%
Ambulance handovers between 30 and 60 mins	Dec 22	26%	0%			23%	13%	33%

KPI	Latest month	Measure	National target	Perfomance	Assurance	Mean	Lower process limit	Upper process limit
Performance Group 2 metrics								
Ambulance handovers > 60 mins	Dec 22	40%	0%			14%	4%	25%
Diagnostics 6 Week Waits	Dec 22	65%	99%			76%	64%	89%
Patients with a Length of Stay more than 7 days	Dec 22	208	80			159	107	211
Bed occupancy	Dec 22	91%	85%			89%	82%	96%
Discharges between 8am and 5pm	Dec 22	800	none			717	480	955
Discharges between 5pm and 8am	Dec 22	830	none			716	475	956
Length of Stay non elective	Dec 22	5.7	5.1			4.2	3.3	5.0
Length of Stay elective	Dec 22	3.3	4.2			2.5	1.0	4.0
Out Patient new to follow up ratio	Dec 22	2.4	2.3			2.1	1.8	2.5
Out Patient Did Not Attend Rate	Dec 22	7.0%	8.0%			5.1%	4.0%	6.2%
Referral to treatment 52 week waits	Dec 22	1773	0			972	697	1246
Proportion of Majors Patient treated within 4 hours in ED Paeds	Dec 22	32%	95%			73%	57%	89%
Patients with a Length of Stay more than 21 days	Dec 22	65	25			48	24	72
12 Hour waits in ED from Arrival	Dec 22	1818	0			673	312	1034
12 Hour Trolley waits in ED from DTA	Dec 22	139	0			91	-3	186
% seen by UTC	Dec 22	39%	none			#DIV/0!	#DIV/0!	#DIV/0!



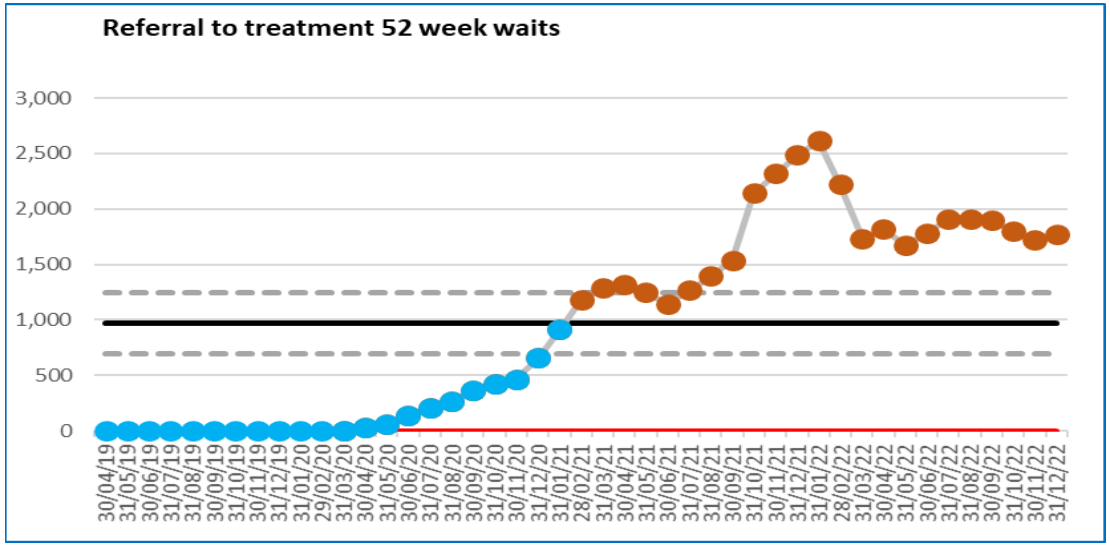
Dec-22
64.53%
Variance Type
Special cause variation
Target
99.00%
Target Achievement
Consistently failing target

Background	What the chart tells us	Issues	Actions	Mitigation
Diagnostics 6 week wait	Special cause concerning variation and consistently failing target	There is a backlog of diagnostic requests which have built up as a result of covid restrictions. Increased referral levels (+20%) continuing.	Additional capacity is being delivered as extra sessions & use of independent sector providers. "Smart" booking of longest waiting patients. Additional temporary staff being sourced to support additional capacity.	Clinical prioritisation (99%) of waiting list & review of long waiting patients on DM01 waiting list. A number of modalities are improving month by month, eg Ultrasound should achieve standard next month



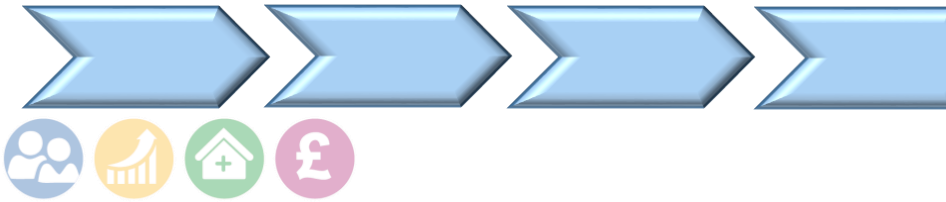
Dec-22
48.4%
Variance Type
Special cause variation
Target
92%
Target Achievement
Consistently failing target

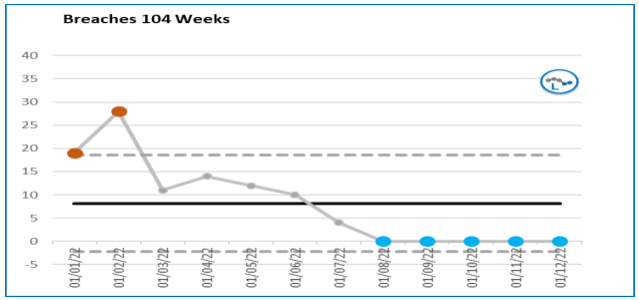
Background	What the chart tells us	Issues	Actions	Mitigation
RTT Incomplete	Special cause concerning variation and consistently failing target	The performance against the RTT standard has been below the target and statistical mean for 12 months as a result of covid activity pressure pausing elective activity which created a backlog of patients waiting longer than 18 weeks for first definitive treatment. The balance of emergency, elective and recovery remains an ongoing challenge	Admitted backlog being booked & treated in clinical order not chronological. Elective bed capacity has increased with the opening of an Orthopaedic ward. Insourcing operating in Urology & General Surgery has commenced. Virtual & face to face clinics & additional sessions being put on where possible including insourcing at PAH. Weekly oversight from healthcare groups. All specialties remain under constant review	Admitted backlog clinically prioritised. Non admitted - clinical priority booking at sub specialty level. Clinical Reviews of long waiting patients & harm reviews being put into place.

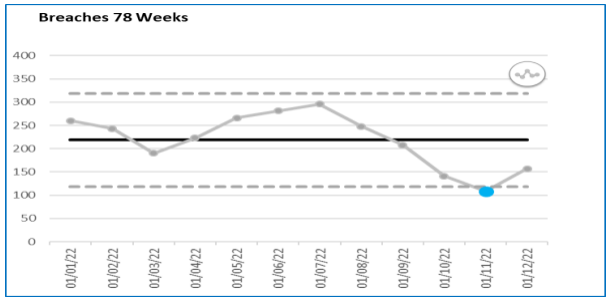


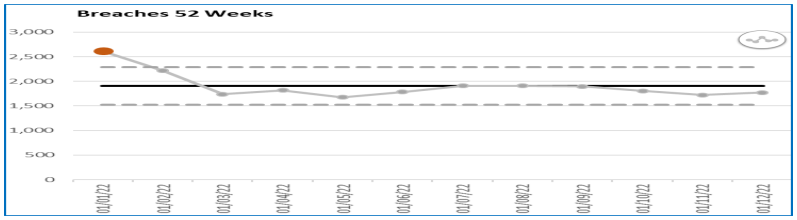
Dec-22
1773
Variance Type
Special cause variation
Target
0
Target Achievement
Consistently failing target

Background	What the chart tells us	Issues	Actions	Mitigation
52 week waits	Special cause concerning variation and consistently failing target	Booking in clinical priority order instead of chronological order has led to increasing numbers of long waiting lower priority patients. Balance between emergency & elective capacity is an ongoing challenge. Challenge of anaesthetic workforce availability restricting the number of elective lists.	Patients that will be over 104 weeks by 31/3/22 booked along with urgent & cancer patient as a priority. Ongoing outsourcing of lower clinical priority patients to Independent sector. ICS bid for 22/23 elective recovery capital accepted an two options for a segregated elective hub being drawn up. Elective ward capacity increased to 2 wards. Admitted & non admitted demand & capacity work commenced to inform recovery plan for 22/23.	Clinical review of long waiting patients being implemented with interim & treatment harm review process to monitor for potential harm. Numbers of patients over 78 weeks reducing & potential patients over 104 weeks all have appointments/treatment plans.





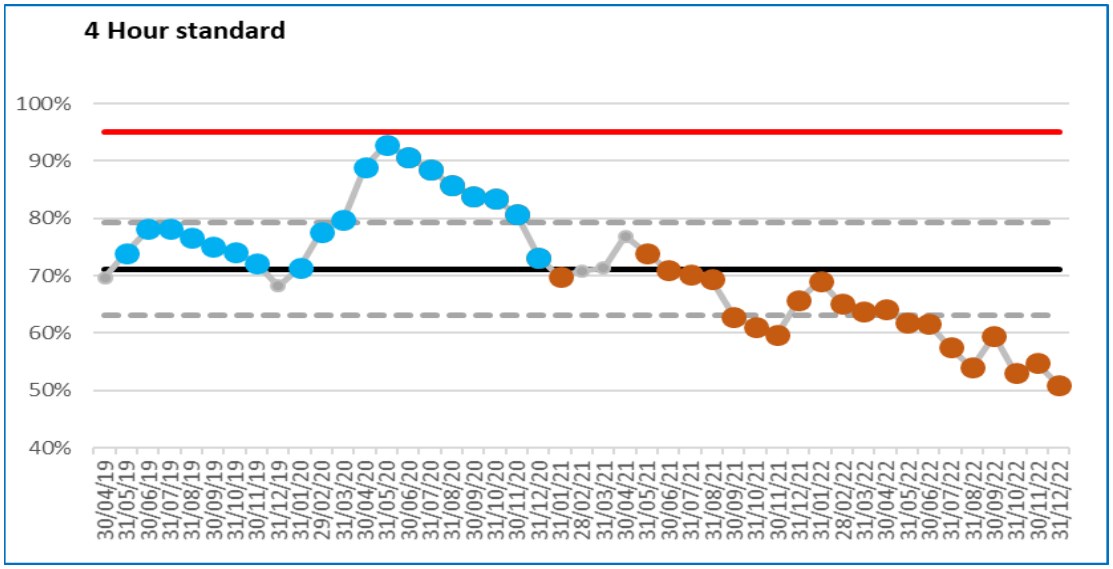




Dec-22

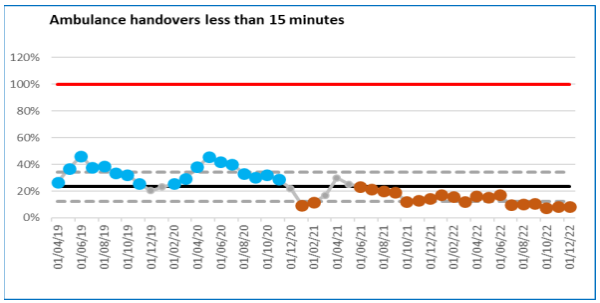
Variance Type
Special cause variation
Target
0
Target Achievement
Consistently failing target

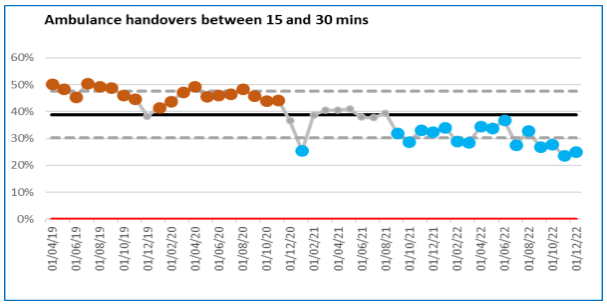

Background	What the chart tells us	Issues	Actions	Mitigation
Breaches	Special cause concerning variation and consistently failing target			

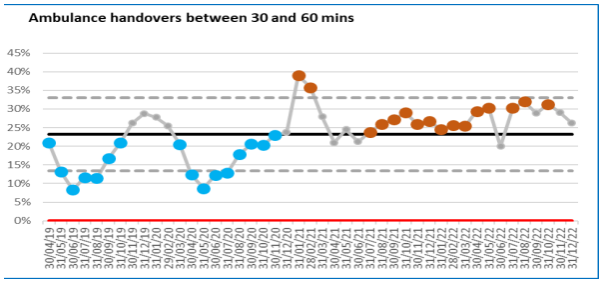


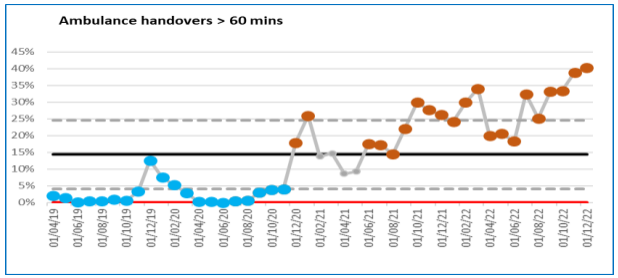
Dec-22
50.86%
Variance Type
Special cause variation
Target
95%
Target Achievement
Consistently failing target

Background	What the chart tells us	Issues	Actions	Mitigation
Four hour standard	Special cause concerning variation and consistently failing target	The performance against the four hour standard has been consistently below the statistical mean for four months & close to the lower control limit. Significant increases in attendances has exacerbated the pressure on the emergency pathways.	Executive and divisional oversight continues through the Urgent Care Board & CQC Quality Project workstream. Internal, Regional and national discharge projects in place. Response to the national "100 day challenge" being prepared to improve flow and ED performance.	Safety huddle in ED 3 times a day to review safety and pressure in the department and to escalate where additional support is required. Additional UTC hours & services. Weekly regional discussion on pressure points. Evening ICS system call to support emergency areas out of hours.



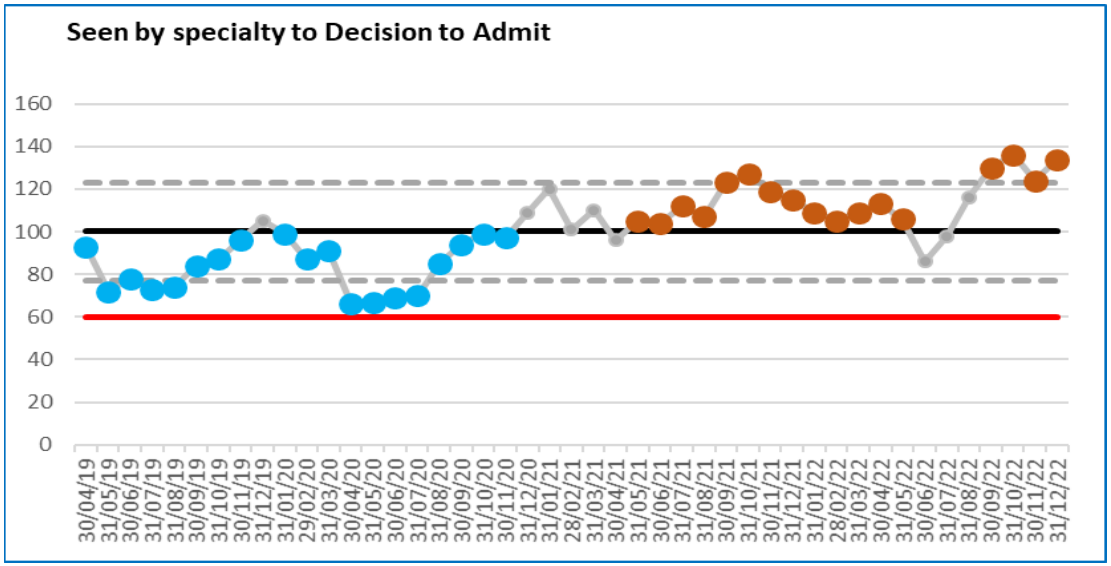






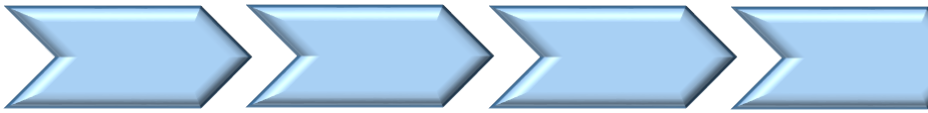
Dec-22
26.2% 30-60 min
Variance Type
Special cause variation
Target
0%
Target Achievement
Consistently failing target

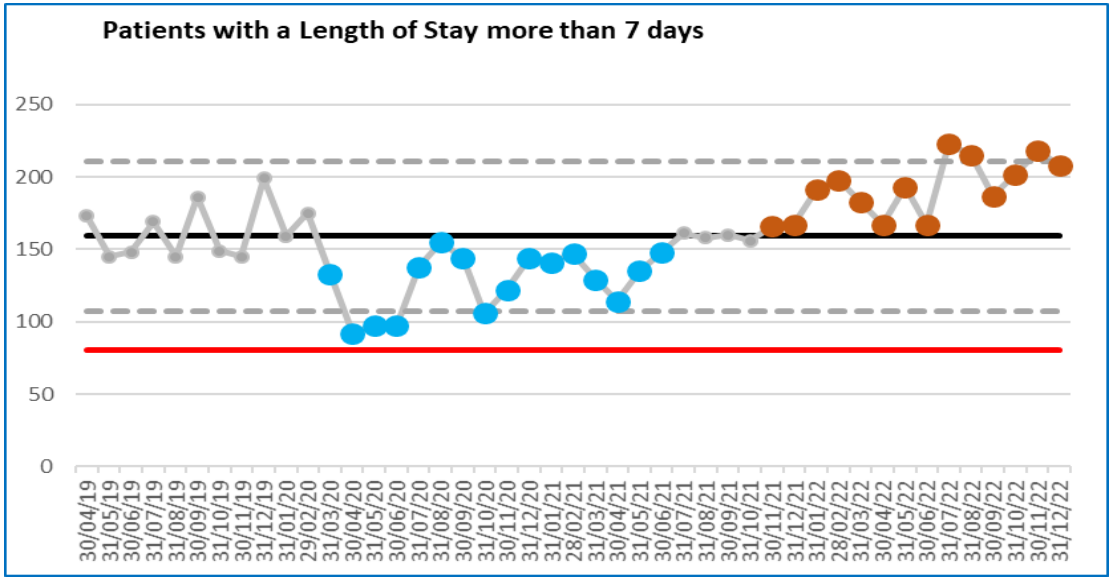
Background	What the chart tells us	Issues	Actions	Mitigation
Ambulances handovers between 30 and 60 minutes	Special cause concerning variation and consistently failing target	The % of ambulance conveyances over 30 minutes has increased above the statistical average. Increased ambulance activity, increased attendances and delays in bed availability for admissions from the emergency department.	Ongoing improvement programme monitored through Urgent Care Board. Daily system call with EEAST to enact load levelling and manage volume across the acute Trusts. Drop & Go service maintained despite extreme pressure. Improved staffing enabling the 4th Rapid Assessment & Triage team to assess faster	Safety huddle led by EPIC and NIC to review entire department 6 times a day. SOP in place for ambulance patients. Ongoing review of capacity across the emergency department



Dec-22
134 minutes
Variance Type
Special cause variation
Target
60 minutes
Target Achievement
Consistently failing target

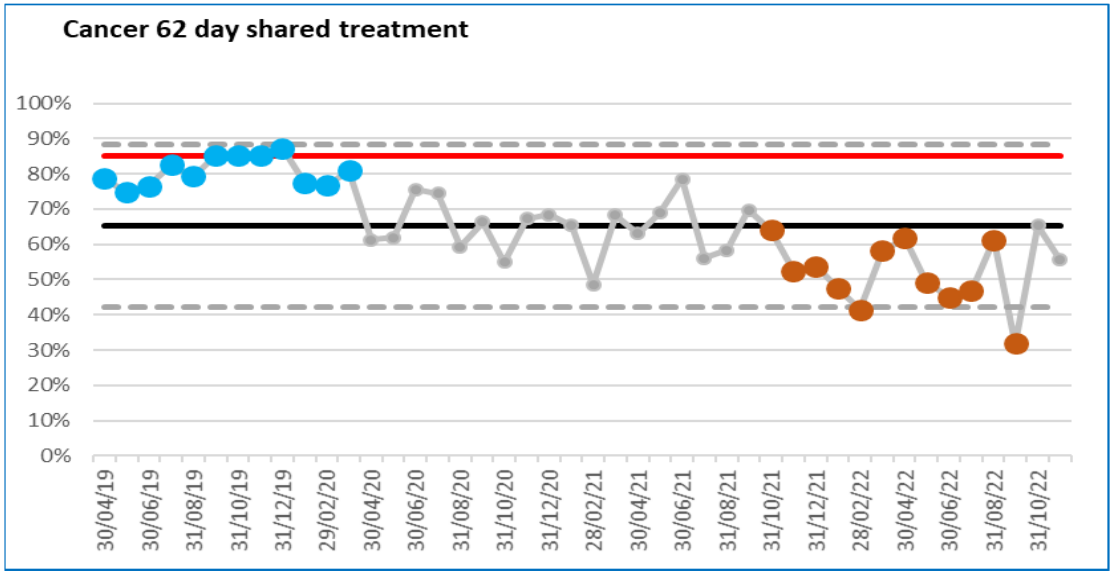
Background	What the chart tells us	Issues	Actions	Mitigation
Seen by specialty to DTA	Special cause concerning variation and consistently failing target	The average time from being seen by specialty to decision to admit has been consistently increased over the statistical average for 9 months	Internal Professional Performance Standards being monitored by Urgent Care Board and actions to improve being developed. Focus on increasing attendance at Emergency Department huddles from specialities to ensure clear & rapid communication of delays. Divisional directors accountable for direct discussions across clinical teams	Close review through breach analysis &at Urgent Care Board





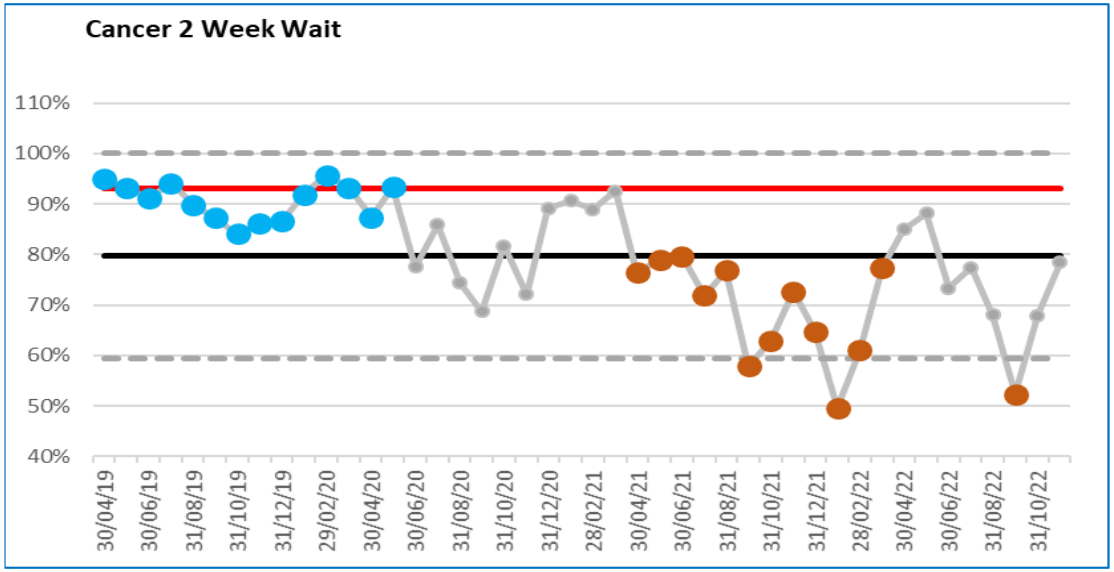
Dec-22
208
Variance Type
Special cause concerning variation
Target
80
Target Achievement
Consistently failing target

Background	What the chart tells us	Issues	Actions	Mitigation
Occupied beds with stranded patients	Special cause concerning variation & consistently failing target	The performance against the target for stranded patients has failed consistently, however, we have shown common cause variation for the last 12 months	Daily patient panel review to understand discharge constraints. HIT Team review of patients appropriate for discharge extended across weekends. Close working with community bed providers & commissioners ensuring effective bed usage. Closure of Gibberd ward compensated by bridging capacity. National improvement programme continues, with focus on partner organisations including ambulance trust in April.	Review via daily bed meetings, daily system meetings & weekly capacity planning meetings. EDD review underway. Use of nerve centre to track patient EDDs & support for discharge in place.



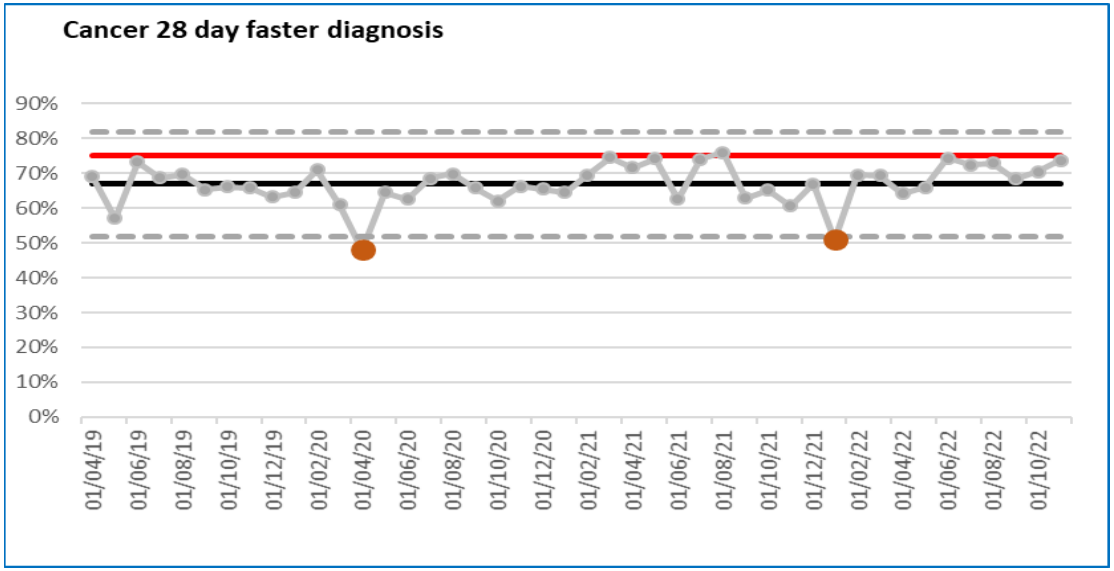
Nov-22
55.65%
Variance Type
Common cause variation
Target
85%
Target Achievement
Consistently failing target

Background	What the chart tells us	Issues	Actions	Mitigation
Cancer 62 day shared treatment	Common cause variation and hitting and missing target radomly	The performance against the target has failed for over 12 months.	The Trust has continued to focus on diagnosing & treating the backlog of patients that developed over the Covid period & the 62 day performance reflects the increased numbers of patients treated after 62 days in their pathway. The backlog of patients over 62 days continues to decrease and is close to the submitted trakectorry. Theatre capacity is due to ncrease in July & August which will enable more diagnostics and treatment capacity.	Weekly tracking meetings and review of performance at Elective Care Operational Group in addition to executive reporting. Prioritisation of cancer patients in booking diagnostics & treatments. Clinician discussions at Cancer Board to escalate concerns and review cancer conversion rates which remain steady.



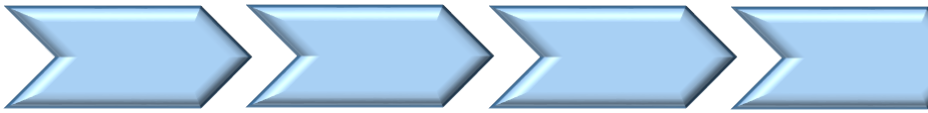
Nov-22
78.44%
Variance Type
Special cause concerning variation
Target
93%
Target Achievement
Inconsistently passing and falling short of target

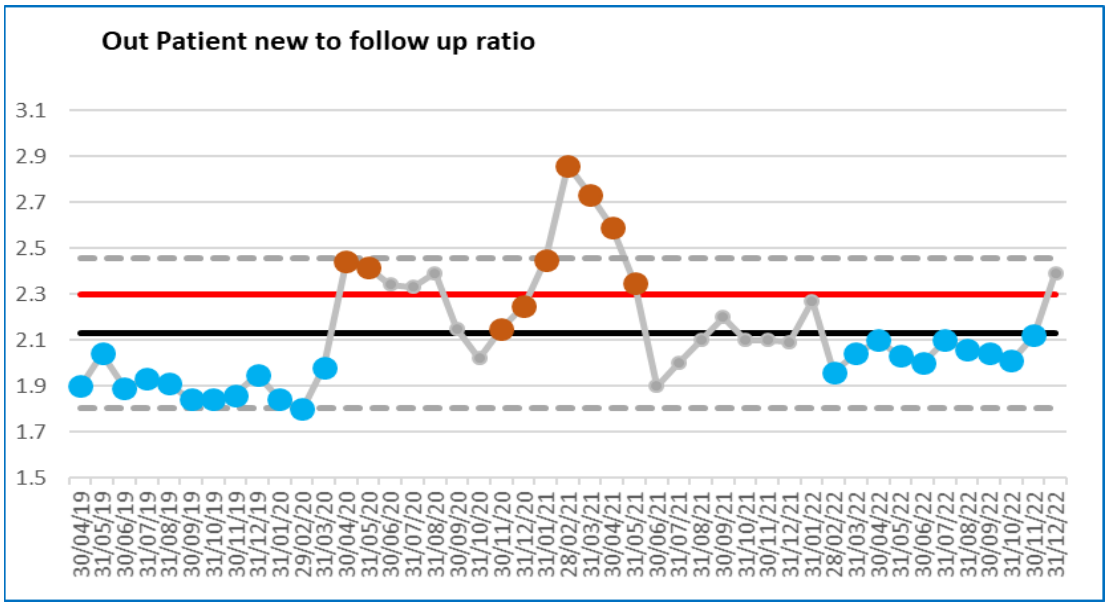
Background	What the chart tells us	Issues	Actions	Mitigation
Cancer 2 week wait	Special cause concerning variation & inconsistently passing and falling short of the target			Close review of 28 day diagnosis standard for each tumour site failing 2ww. Dermatology achieving 62 day performance. Weekly tracking meetings and review of performance at Elective Care Operational Group in addition to Cancer Board & executive reporting.



Nov-22
73.67%
Variance Type
Common cause variation
Target
Target Achievement
Consistently failing target

Background	What the chart tells us	Issues	Actions	Mitigation
Cancer 28 day faster diagnosis	Common cause variation and hitting and missing target radomly	The performance against the target has failed for over 12 months.	28 day Faster Diagnosis Improvement Manager delivering Frailty pathway, success with Lower GI triage process and improved data recording following clarification of CWT Guidance. Development of Lung, Upper GI and Prostate faster diagnosis pathways with the CQUIN work commencing.	Weekly tracking meetings and review of performance at Elective Care Operational Group in addition to executive reporting. Prioritisation of cancer patients in booking diagnostics & treatments. Clinician discussions at Cancer Board to escalate concerns and review cancer conversion rates which remain steady.





Dec-22
2.40
Variance Type
Common cause variation
Target
2.3
Target Achievement
Inconsistently passing and falling short of target

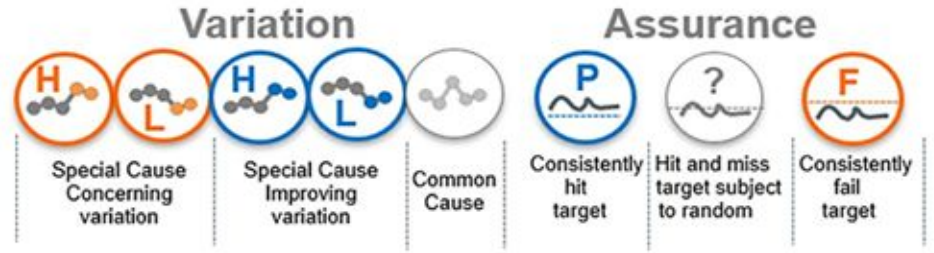
Background	What the chart tells us	Issues	Actions	Mitigation
OP new to follow up ratio	Common cause variation and inconsisrtently passing and falling short of the target	Additional insourcing to clear the overdue follow-up appointments is impacting the ratio.	Ongoing monitoring & increased volumes of activity to support recovery.	Not required - clearance of additional follow-up activity expected to increase ratio.

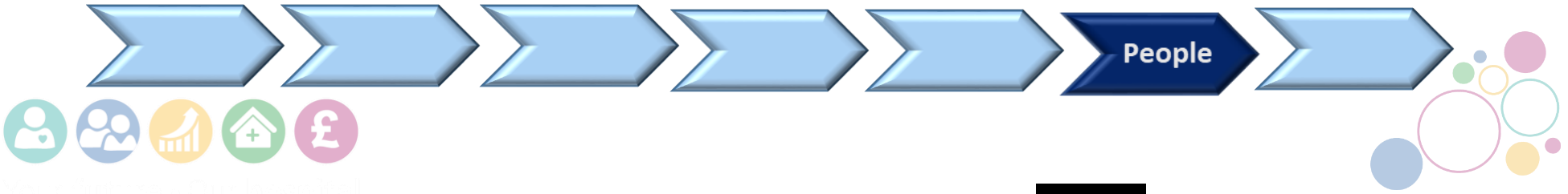
People

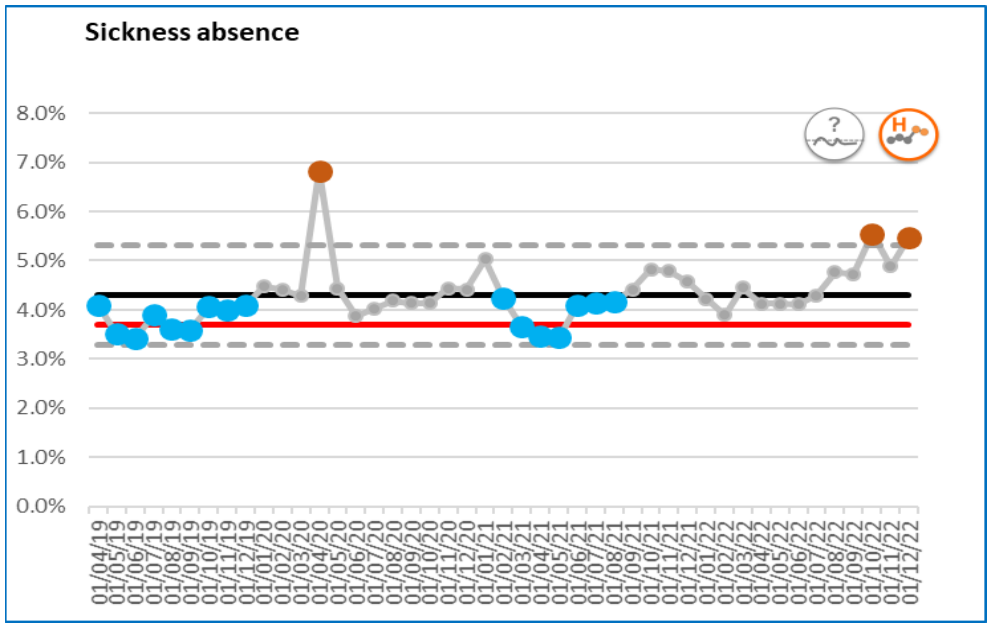
*We will support **our people** to deliver high quality care within a culture that continues to improve how we attract, recruit & retain all our people. Providing all our people with a better experience will be evidenced by improvements in our staff survey results.*

People Summary	Board Sub Committee: People Committee		
Focus Area	**Description and action**	**Reason for Inclusion**	**Target Date for Resolution if applicable**
Sickness	Sickness absence workshops for managers are scheduled and taking place within divisions. Individual long term cases and actions discussed at management level	For information	Q2
Appraisal	Time constraints cites as reasons for non-compliance. Individualised reports sent to triumvirate and managers. Managers asked to book outstanding appraisals within the next month Compliance rates are addressed at PRMs	For information	Q2
Stat and Mand Training	Compliance remains static, challenges of protected time to complete training cited. There is a blended approach to training, delivered both via teams and face to face in the learning and education facility.	For information	Q2
Vacancy	Vacancy rate impacted by high level of vacancies within Nursing & Midwifery, Estates & Ancillary and A&C staff groups. Recruitment action plans continue to be agreed with divisions; recruitment team attending local job centre to highlight working for the Trust and to promote vacancies.	For information	Q3
Turnover	Leaving reasons are being linked to relocation due to cost of living and health and wellbeing. There is continued promotion of the trusts health and wellbeing offer including sessions on budgeting and access to Citizen's Advice sessions held on site. The trust have also undertaken a number of cost of living initiatives such as continuing free parking and access to Harlow community hub and food back. PAHT are part of the retention pathfinder programme within the ICS	For information	Q3

KPI	Latest month	Measure	National target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Appraisals - non medical	Dec 22	83.0%	90.0%		F	81.4%	76.8%	86.0%
Agency staffing spend	Nov 22	7.7%	15.0%	H	P	5.4%	2.5%	8.3%
Bank staffing spend	Nov 22	12.5%	15.0%		P	11.8%	9.5%	14.2%
Vacancy Rate	Dec 22	10.4%	8.0%	H	F	9.4%	8.0%	10.9%
Staff turnover - voluntary	Dec 22	17.0%	12.0%	H	?	12.7%	11.8%	13.6%
Sickness absence	Dec 22	5.5%	3.7%	H	?	4.3%	3.3%	5.3%
Statutory and Mandatory training	Dec 22	88.0%	90.0%	L	?	88.1%	85.3%	90.9%



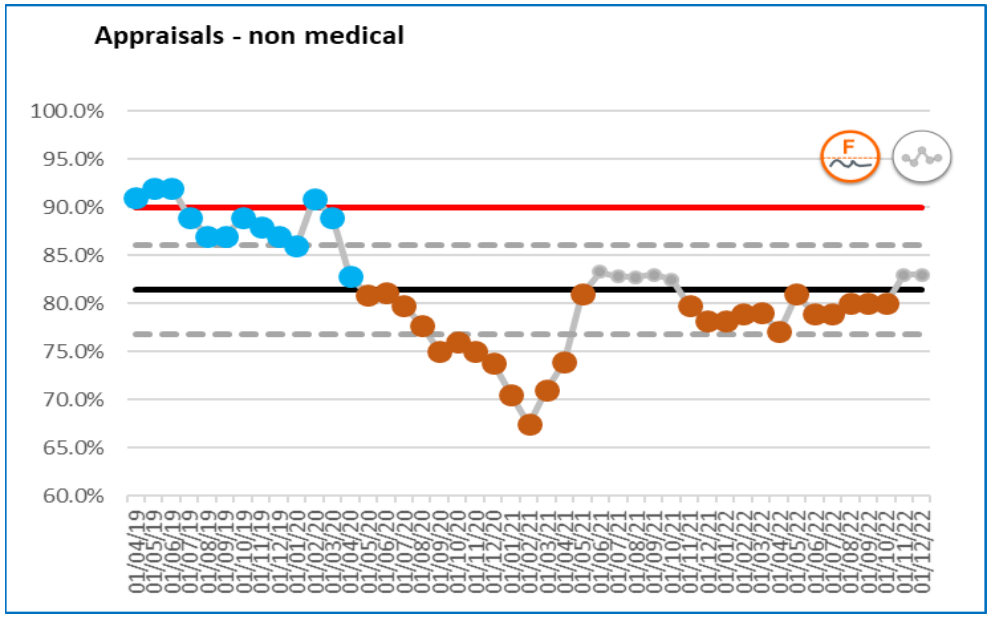




Dec-22
5.46%
Variance Type
Common cause variation
Target
4%
Target Achievement
Inconisistently passing & falling short of the target

Background	What the chart tells us	Issues	Actions	Mitigation
Sickness absence	Variation indicates inconsistently passing & falling short of the target	Sickness absence rates across the trust remain static. Reasons for absense continue to be linked to mental health and MSK	Sickness absence worshops currently taking place within divisions. Individual long term cases and actions discussed at management level	Absences recorded contemporaneously and advice & guidance to managers on COVID & testing guidelines

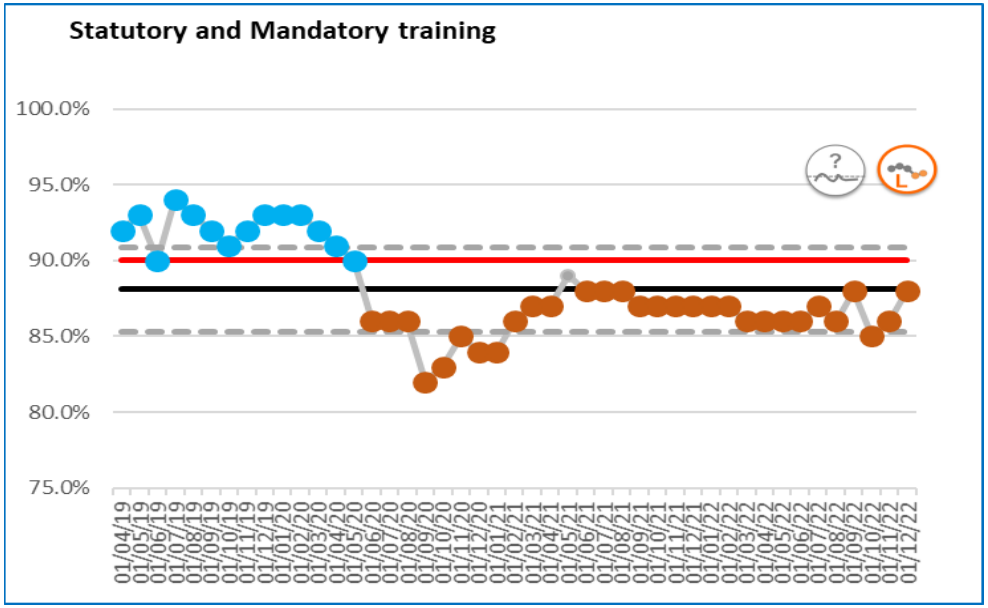
People



Dec-22
83.00%
Variance Type
Common cause variation
Target
90%
Target Achievement
Consistently failing target

Background	What the chart tells us	Issues	Actions	Mitigation
Appraisal non medical	Common cause concerning variation & consistently falling short of target	Overall appraisal rates are improving	Individualised reports sent to triumvirate and managers. Managers asked to book outstanding appraisals within the next month Compliance rates are addressed at PRMs	Compliance rates discussed at monthly divisional board meetings & performance review meetings with actions agreed. People information team able to support any challenges with MyESR

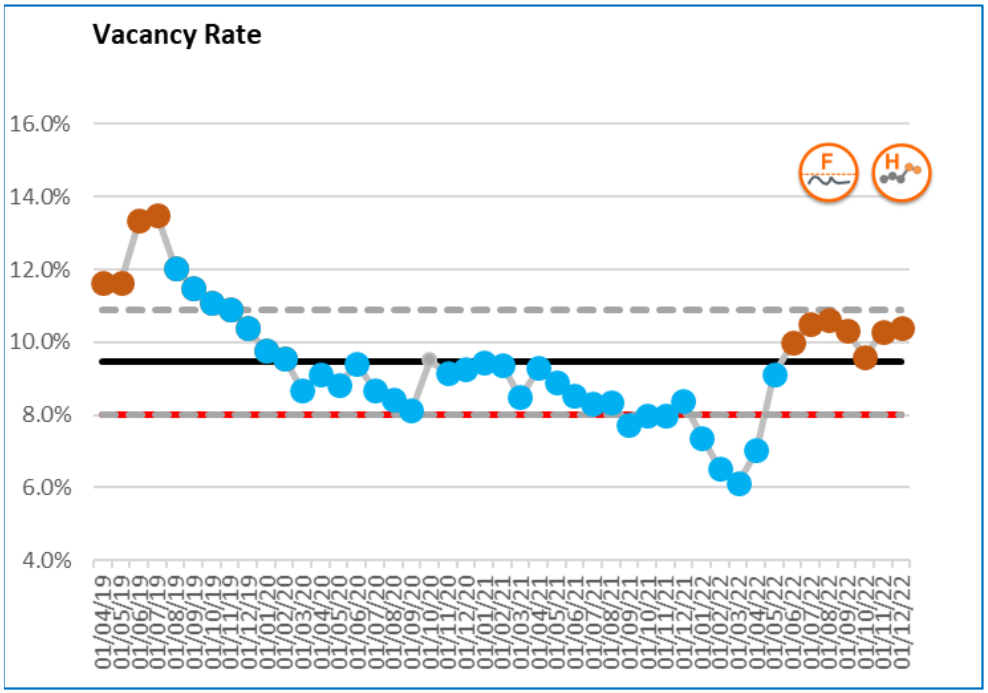
People



Dec-22
88%
Variance Type
Special cause variation
Target
90%
Target Achievement
Consistently failing target

Background	What the chart tells us	Issues	Actions	Mitigation
Statutory and Mandatory Training	Special cause concerning variation & consistently failing target	Compliance remains static, challenges of protected time to complete training cited.	There is a blended approach to training, delivered both via teams and face to face in the learning and education facility.	Compliance rates are addressed at PRMs

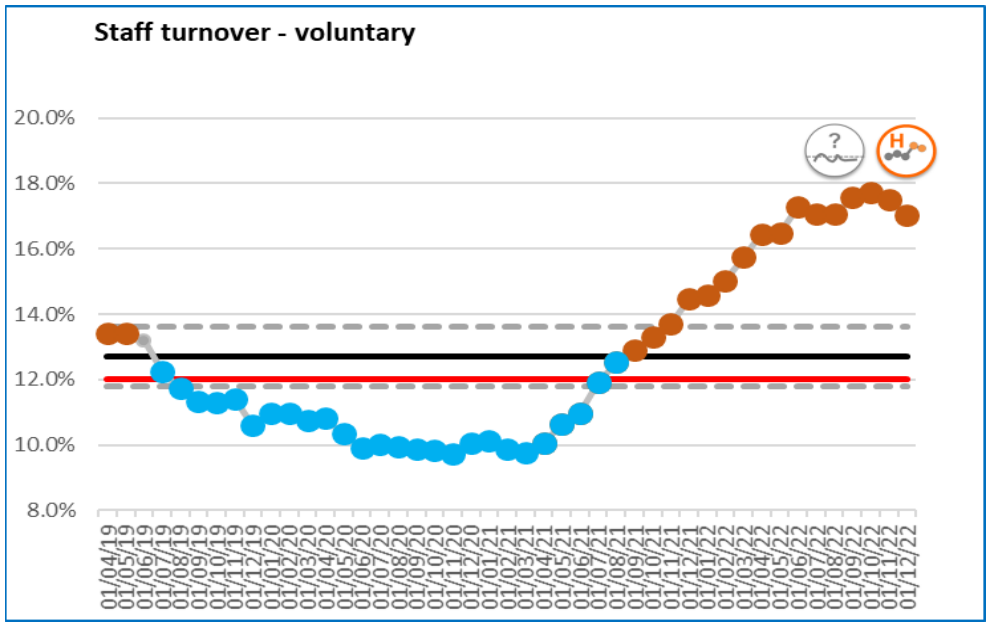
People



Dec-22
10.40%
L
Variance Type
Special cause variation
Target
8.00%
Target Achievement
Consistently failing
F

Background	What the chart tells us	Issues	Actions	Mitigation
Vacancy Rate	Special cause improving variation & consistently failing target	Over all trust establishment has increased by approx 20 posts. Increase in vacancy rate is reflected by the overall establishment increase. Midwifery, Nursing and A&C hold the highest vacancy rates	Recruitment days planned for ED and Estates and Facilities	Vacancy rates are discused in monthly divisional meetings and PRMs

People



Dec-22
17.03%
Variance Type
Special cause variation
Target
12.00%
Target Achievement
Consistently failing

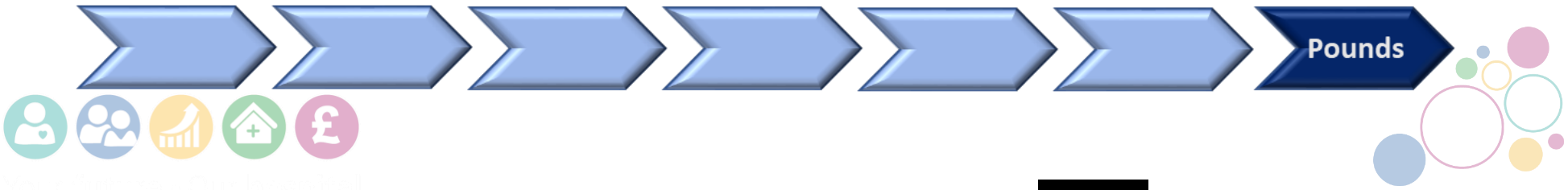
Background	What the chart tells us	Issues	Actions	Mitigation
Vacancy Rate	Special cause improving variation & consistently failing target	The trust voluntary turnover has been ibcreasing over the last 12 months. This is reflected across both EoE and the ICS. Leaving reasons are linked to health and wellbeing/ fatigue, promorion and moving area for a better cost of living	There are a number of initialtives in place to address these. Continued promotion of the trusts health and wellbeing offer including sessions on burnout and sleep hygiene. The recruitment and L&OD team are organising an in house recruitment and development fair for August. PAHT are part of the retention pathfinder programme within the ICS	Retention initiatives are discussed at recruitment and retention steering groups. Staff survey action plans in place for divisions

People

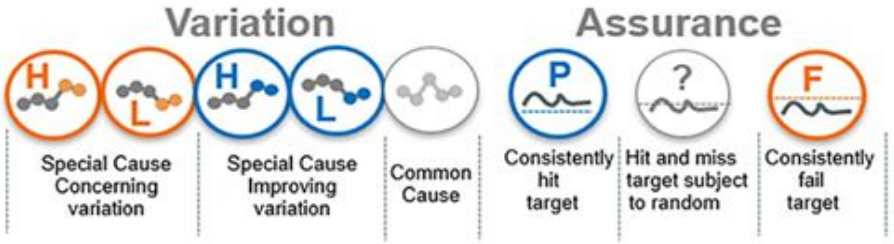
Pounds

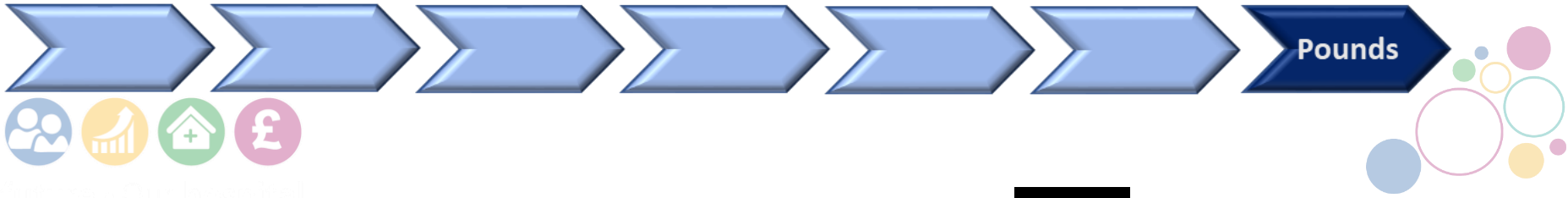
*We will manage **our pounds** effectively to ensure that high quality care is provided in a financially sustainable way*

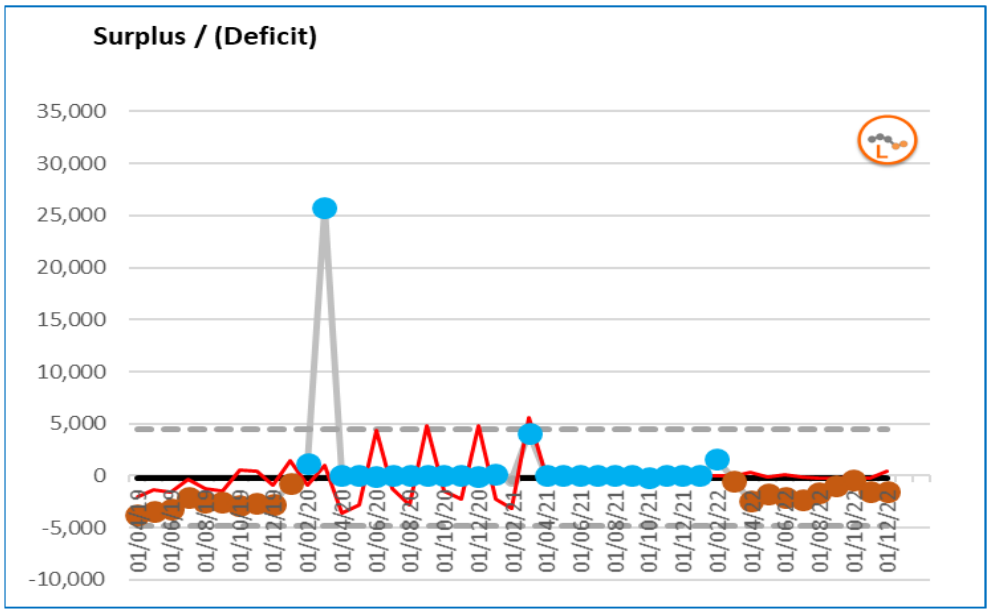
Pounds Summary		Board Sub Committee: Performance and Finance Committee	
Focus Area	**Description and action**	**Reason for Inclusion**	**Target Date for Resolution if applicable**
Surplus \ Deficit	The Trust reported a deficit of £1.6m in December (Month 9) and year to date deficit of £14.5m. We continue to work with each divisional team to review and challenge the assumptions of the Trust's underlying deficit and reflect these within the forecast position.	For information	
CIP	The 22/23 CIP target is £11.7m with a YTD planned savings at month 9 of £7.6m. The FY forecast waste\efficiency is currently £11.7m with the YTD indentified savings at £7.5m, of which £6.7m are non-recurrent. Work continues within each divsion to deliver additional schemes and savings.	For information	
Capital Spend	The Trust total revised Capital resourcing for 2022/23 is £16.9m, this includes external PDC including the new hospital project. As at Month 9 the year to date capital spend total is £8.9m, excluding the impact of IFRS 16. Whilst further national support will be available to the Trust, it is fully anticipated the capital programme will be fully utilised in 22/23. Note: some additional PDC may be made available for digital programmes but this will be confirmed in due course	For information	
Cash	The Trust's cash balance is £29.9m. The cash reserves which were boosted due to the national Covid support received by the Trust have started reducing as we continue to run with a deficit in 2022/23. There remains focus on the level of unpaid invoices and maintaining the Trust's improved 30 day BPPC performance.	For information	



KPI	Latest month	Measure	National target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Surplus / (Deficit)	Dec 22	-1558	0			-198	-4851	4455
CIP	Dec 22	148	0			640	-774	2053
Income	Dec 22	27798	0			26717	17508	35927
Operating Expenditure	Dec 22	-28033	0			15270	6229	24311
Bank Spend	Dec 22	-2259	0			1127	148	2105
Agency Spend	Dec 22	-1420	0			422	-212	1056
Capital Spend	Dec 22	2171	0			2262	-3407	7932
Cash Balance Actual	Dec 22	29943	75000000			4064010	-1248669	9376689



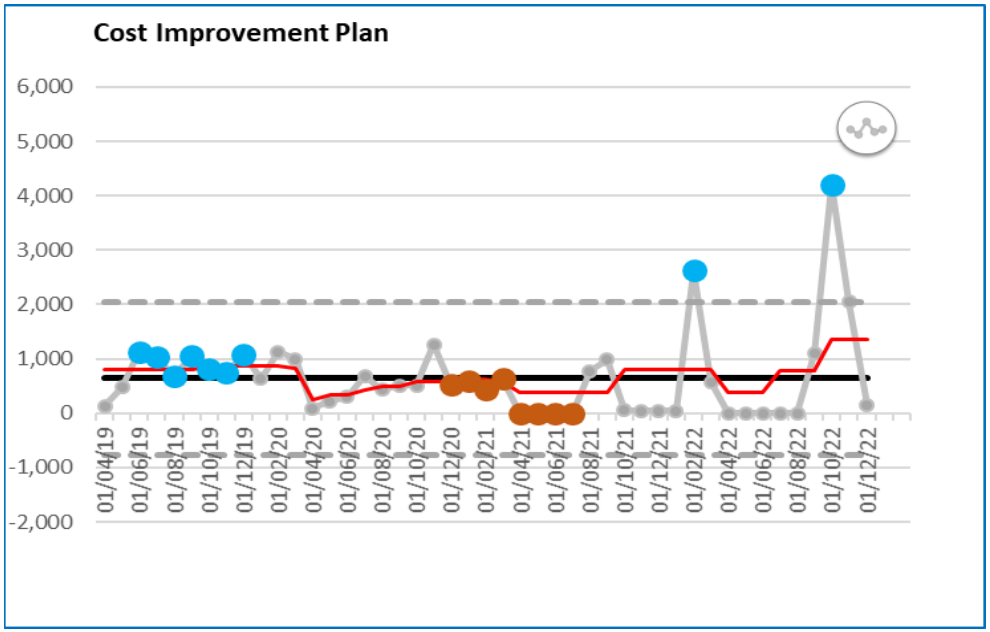




Dec-22
-1558
Variance Type
Special cause concerning variation
Target
0
Target Achievement
Consistently failing target

Background	What the chart tells us	Issues	Actions	Mitigation
Surplus/Deficit	Special cause concerning variation & inconsistently passing and falling short of the target			

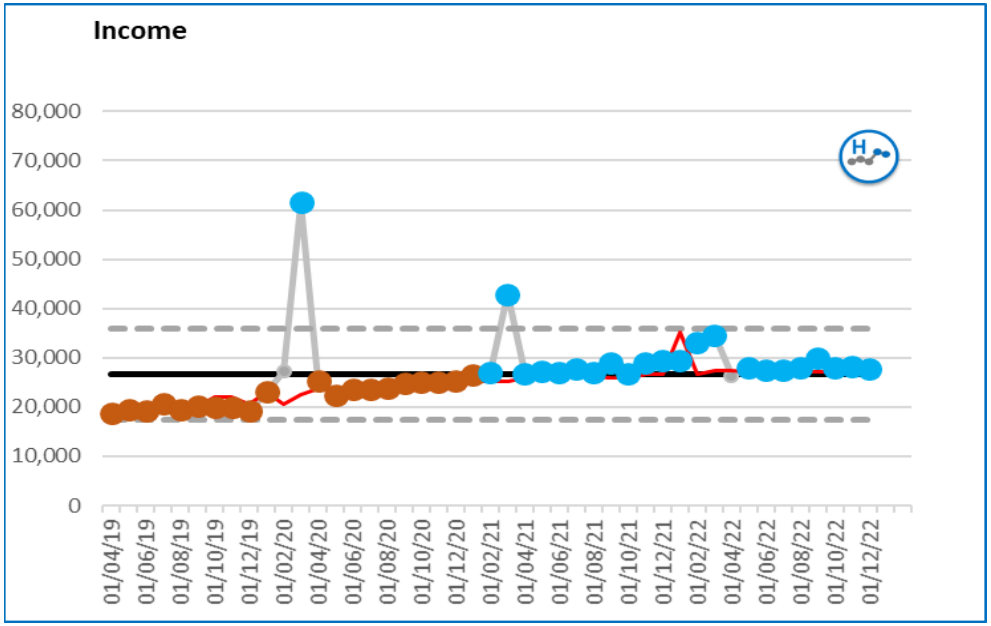
Pounds



Dec-22
148
Variance Type
Common cause variation
Target
801
Target Achievement
Inconsistently passing and falling short of the target

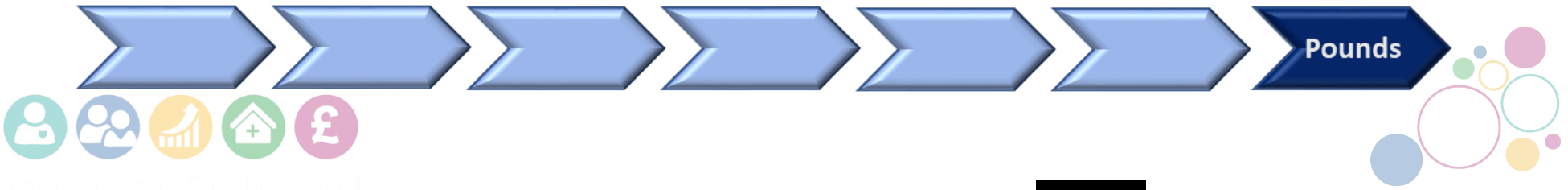
Background	What the chart tells us	Issues	Actions	Mitigation
CIP	Common cause variation and inconsistently passing and falling short of the target			

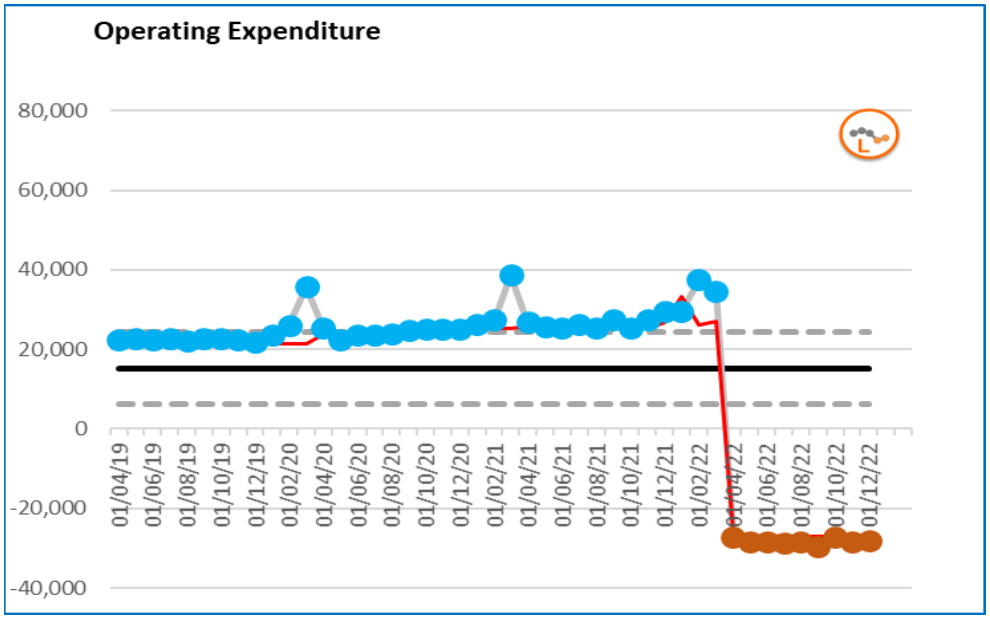
Pounds



Dec-22
27798
Variance Type
Special cause improving variation
Target
26684
Target Achievement

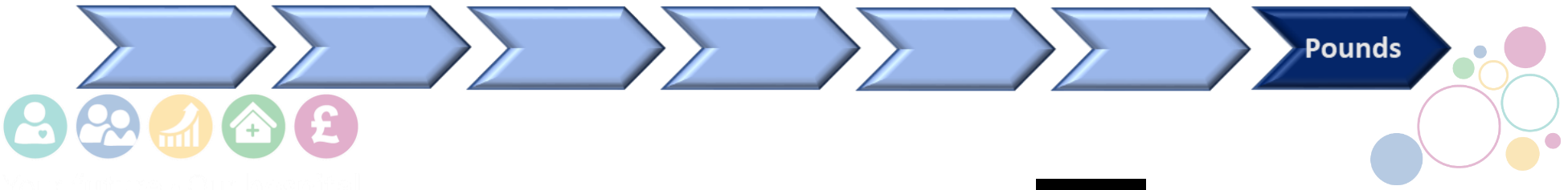
Background	What the chart tells us	Issues	Actions	Mitigation
Income	Special cause improving variation			

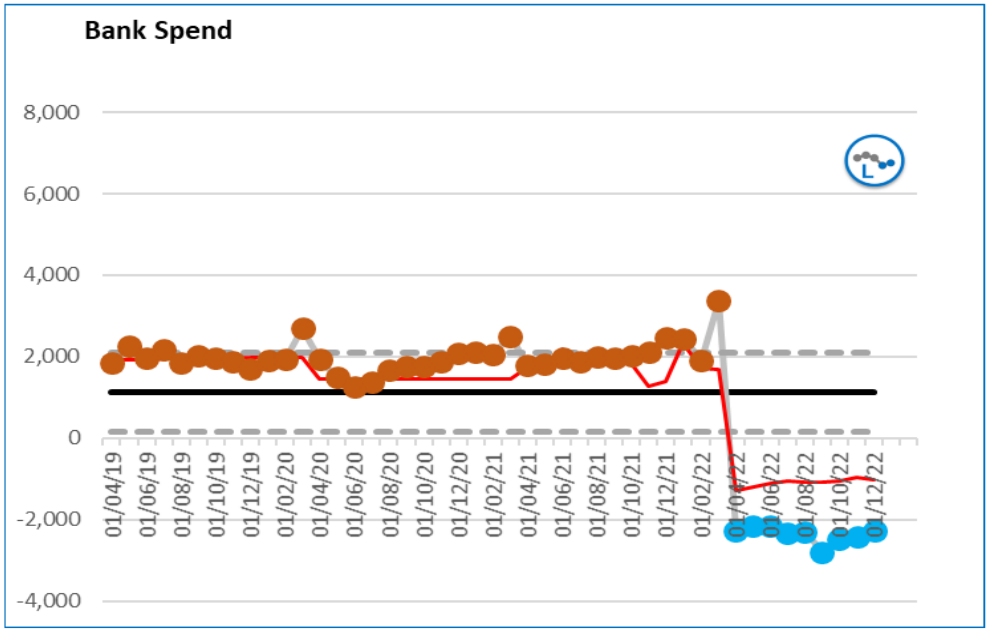




Dec-22
-28033
Variance Type
Common cause variation
Target
26709
Target Achievement

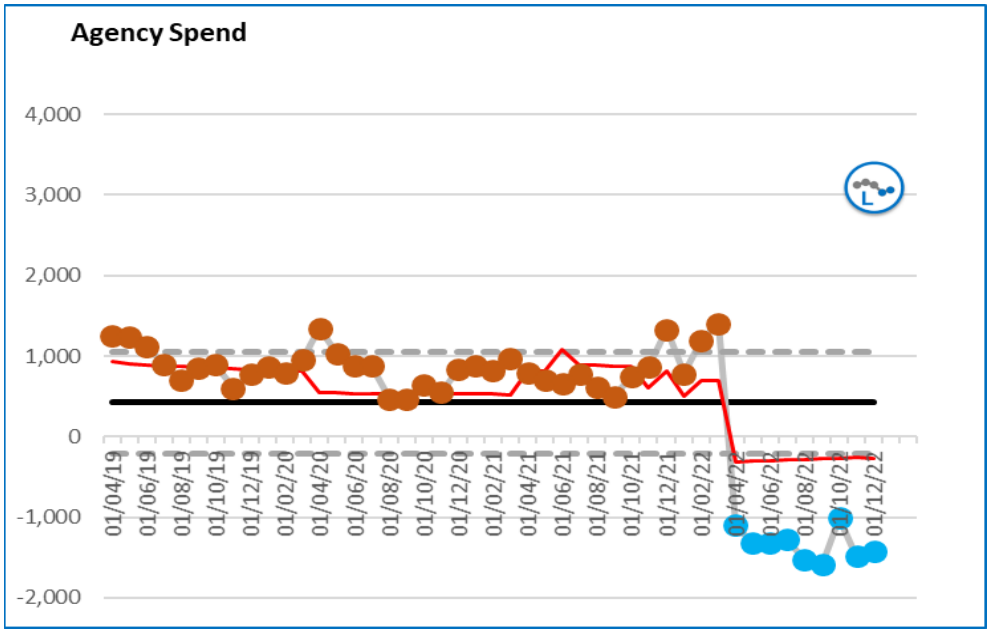
Background	What the chart tells us	Issues	Actions	Mitigation
Operating Expenditure	Common cause variation			





Dec-22
-2259
Variance Type
Special cause variation
Target
1110
Target Achievement
Inconsistently passing and falling short of the target

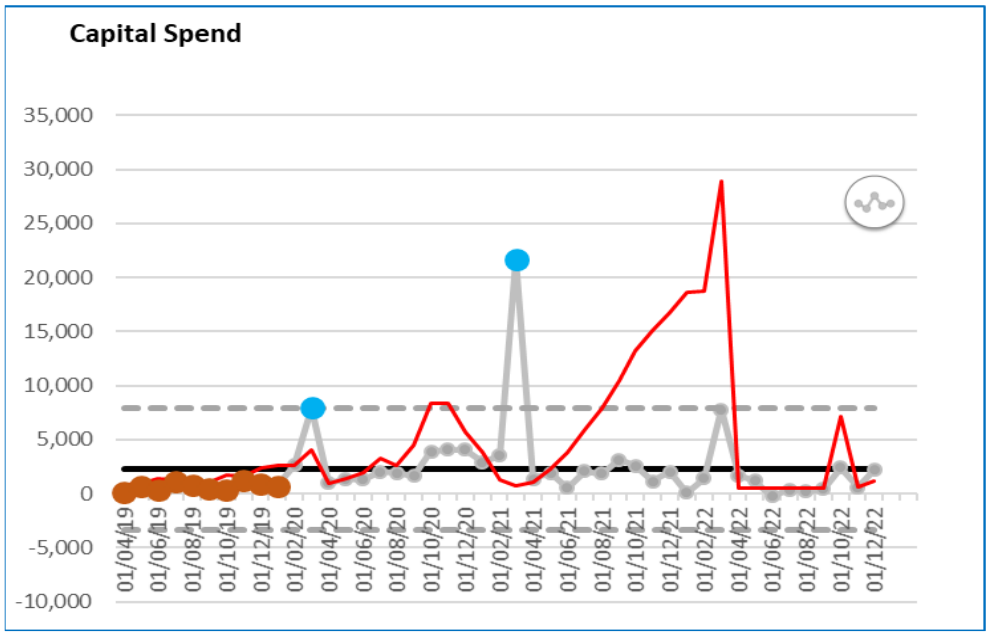
Background	What the chart tells us	Issues	Actions	Mitigation
Bank Spend	Common cause variation & inconsistently passing and falling short of the target			



Dec-22
-1420
Variance Type
Common cause variation
Target
1107
Target Achievement
Inconsistently passing and falling short of the target

Background	What the chart tells us	Issues	Actions	Mitigation
Agency Spend	Common cause variation & inconsistently passing and falling short of the target			

Pounds



Dec-22
2171
Variance Type
Common cause variation
Target
18682
Target Achievement
Inconsistently passing and falling short of the target

Background	What the chart tells us	Issues	Actions	Mitigation
Capital Spend	Common cause variation and inconsistently passing and falling short of the target			

Pounds

The Princess Alexandra Hospital NHS Trust

BOARD OF DIRECTORS:	**2 February 2023**	**AGENDA ITEM: 7.1**
REPORT TO THE BOARD FROM:	**Strategic Transformation Committee (STC)**	
REPORT FROM:	**Elizabeth Baker – Committee Chair**	
DATE OF COMMITTEE MEETING:	**30 January 2023**	

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
1.6 STC Annual Committee Effectiveness Review	Y	Y	N	STC discussed the effectiveness review and recommendations. It was agreed to meet bi-monthly with immediate effect and the next meeting will take place in March 2023. Further discussions are to take place regarding the attendance by Place directors at STC meetings going forward. The Terms of Reference will be updated on completion of these discussions.
2.1 PAHT2030 Update	Y	Y	N	The Digital Health and Our Culture strategic priorities are meeting their delivery plan actions and are RAG rated (GREEN). The Transforming Our Care and Corporate Transformation strategic priorities are at risk of delivering within the original timescales and rated (AMBER). The Our New Hospital strategic priorities carry significant risk of delivery within the original timescales and are rated (RED). Going forward the committee will receive updates on PQP.
2.2 New Hospital Update	Y	Y	N	The second national Programme Business Case (PBC) was submitted to Major Projects Review Group in December 2022. Further work has been requested on the PBC to include details of the RAAC schemes. A further update is not anticipated until at least March 2023. Until the outcome of the latest PBC is known, PAH remains uncertain on the next steps and the timeline for the delivery of the new hospital.
2.3 BAF Risk 3.5 (New Hospital)	Y	N	N	In line with the recommendation it was agreed that the risk score should remain at 20.

The Princess Alexandra Hospital NHS Trust

BOARD OF DIRECTORS:	**2 February 2023**			**AGENDA ITEM: 7.1**
REPORT TO THE BOARD FROM:	**Strategic Transformation Committee (STC)**			
REPORT FROM:	**Elizabeth Baker – Committee Chair**			
DATE OF COMMITTEE MEETING:	**30 January 2023**			

Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.4 Digital Transformation Update/EHR Update	Y	N	N	Approval of the full business case was noted. Going forward the committee will focus on digital transformation.
2.5 BAF Risk 1.2 (EHR)	Y	N	N	In line with the recommendation it was agreed the risk score should remain at 16.
3.1 Strategic/System Update including: Report from West Essex Health Care	Y	Y	N	Feedback from the ICB Board meeting was noted including approval of the Pathology FBC and system wide strategy. Discussions that took place at the Partnership Board were noted along with a stakeholder update. Board members will receive a similar briefing in Part II of the Board meeting.

The Princess Alexandra Hospital NHS Trust

BOARD OF DIRECTORS:	**2 February 2023**			**AGENDA ITEM: 7.1**
REPORT TO THE BOARD FROM:	**Strategic Transformation Committee (STC)**			
REPORT FROM:	**Elizabeth Baker – Committee Chair**			
DATE OF COMMITTEE MEETING:	**30 January 2023**			

Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
Partnership (WEHCP), Stakeholder Update and Hewitt Review				
3.5 BAF Risk 3.2 System Pressures	Y	N	N	In line with the recommendation the risk score remained at 16.
4.1 Well-Led Review Update (KLOE's assigned to STC)	Y	N	N	In line with the recommendation KLOE9 is to remain closed/complete (blue) following review and assurances provided. KLOE15 to be closed/complete (blue) following PMO review and assurance provided around delivery.

The Princess Alexandra Hospital NHS
NHS Trust

Trust Board – 2 February 2023 **Item No: 7.2**

REPORT TO THE BOARD FROM: Senior Management Team (SMT)
CHAIR: Sharon McNally
DATE OF MEETINGS: **17.01.23**

ITEMS FOR THE BOARD'S INFORMATION AND ASSURANCE

The following items were discussed at the SMT meeting in January:

17 January 2023:

- Quality Briefing
- Quality PMO report
- New visiting arrangements – approved
- PIFU Update
- Medicines Optimisation Strategy – approved in principle (subject to amendments)
- Nursing Establishment Review - approved
- Healthcare Support Worker Band Alignment
- Annual Staff Survey 2022 Trust Level Results and Response Plan
- This is Me @ PAHT Implementation Timeline
- Freedom to Speak Up Report
- Planning Guidance
- Recovery Dashboard
- Significant Risk Register
- AOB:
    - The Infection Prevention Control team will move from CSS to Corporate Nursing in April 2023
    - Finance Update

7.2

The Princess Alexandra Hospital Charity

NHS
The Princess Alexandra Hospital
NHS Trust

Trust Board (Public) – 2 February 2023

Agenda item:	7.3
Presented by:	Gary Taylor, head of charity
Prepared by:	Gary Taylor, head of charity
Date prepared:	16 December 2022
Subject / title:	Charity strategy

Purpose:	**Approval**	X	**Decision**	X	**Information**	X	**Assurance**	

Key issues: please don't expand this cell; additional information should be included in the main body of the report	Following presentation of the draft strategy at the September/December Charitable Funds Committees, the Board is asked to review and approve the final version.
Recommendation:	That the strategy be approved by the Board.

Trust strategic objectives: please indicate which of the five Ps is relevant to the subject of the report	**Patients**	**People**	**Performance**	**Places**	**Pounds**
	X	X	X		X

Previously considered by:	CFC.16.12.22
Risk / links with the BAF:	PAHC risk register in separate document
Legislation, regulatory, equality, diversity and dignity implications:	Charity commission guidance Fundraising regulator NHS charities guidance
Appendices:	None

7.3

The Princess Alexandra Hospital Charity
Registered Charity Number: 1054745

NHS
The Princess Alexandra Hospital
NHS Trust

The Princess Alexandra Hospital Charity strategy 2023-28

modern • integrated • outstanding

patient at heart • everyday excellence • creative collaboration

The Princess Alexandra Hospital Charity
Registered Charity Number: 1054745

NHS
The Princess Alexandra Hospital
NHS Trust

Contents

The Princess Alexandra Hospital Charity
Registered Charity Number: 1054745

NHS
The Princess Alexandra Hospital
NHS Trust

Introduction

In January 2022, a head of charity was appointed. The head of charity is in the early stages of developing the charity, including improving processes, developing relationships and establishing the profile of the charity post-pandemic. This strategy represents an opportunity for a fresh start for the charity post-COVID-19.

The charity has sought wide engagement in the production of this strategy including the Charitable Funds Committee, Executive Directors, Non-executive Directors, and charity fundholders.

Charitable objects

The Princess Alexandra Hospital NHS Trust Charitable Fund (the Charity), was formed under a trust deed dated 21 March 1996, and is registered with the Charity Commission, registration number 1054745. Our official charitable objects are:

For any charitable purpose or purposes relating to the National Health Service.

In practice, this means the charity supports a wide range of charitable and health related activities benefitting both patients and the people of The Princess Alexandra Hospital NHS Trust.

In general, they are used to purchase the very varied additional goods and services that the NHS is unable to provide.

Our vision and mission

Our vision is:

To enhance the experience of patients, visitors and people, being cared for and working at The Princess Alexandra Hospital NHS Trust.

Our mission is:

We will work in partnership with our local community to become recognised as a charity of choice in our community.

The Princess Alexandra Hospital Charity

The Princess Alexandra Hospital NHS Trust

Over-arching goals – what do we want to achieve?

- Increase the charity's ability to impact patients, people, visitors through spending down existing funds and by increasing its income from £373,000 to over £1,000,000 (exact target £1,069,000).
- Raising the profile of the charity locally and in PAHT to support an increase in income, and enable our people to more easily access funds.

Objectives – how will we achieve our goals?

To achieve our key goals, we will work in partnership with our community, our people and our supporters. As such, the key objectives for this strategy will be:

Key objectives for this strategy period will be:

- Community – we will work in partnership with local people, businesses and groups to promote the impact of our work and ensure we make supporting our charity as simple as possible.
- Our people – we will create a thriving community of 'Charity Champions' (fundholders and other key people) to support the embedding of the charity as a key part of the Trust.
- Supporters – we will create a supporter panel to champion the work of our charity and will increase overall number of donors from c.350 to c.1,800.

Our strengths, weaknesses, opportunities and threats

This strengths, weaknesses, opportunities and threats (SWOT) analysis supports the development of the charity strategy.

The Princess Alexandra Hospital Charity

NHS
The Princess Alexandra Hospital
NHS Trust

Strengths

- ✓ National support for NHS post-COVID
- ✓ Established oversight via charitable funds committee
- ✓ Strong financial and legal governance in place
- ✓ Experienced charity professional leading strategic direction and day to day operations
- ✓ A significant monetary sum held by the Trust to be utilised for the benefit of patients, visitors and our people.

Weaknesses

- Sole member of staff causing inability to sufficiently cover all fundraising disciplines and exploit all opportunities
- Lack of historical donor information
- Lack of awareness of charity locally and within the Trust

Opportunities

- ✓ A large local community served by the Trust which is largely untapped
- ✓ Support from the voluntary services team which could lead to a committed charity volunteer base.

Threats

- Post-COVID NHS support reducing
- Local competitor charities e.g. St Clare Hospice, Harlow Food Bank, St Francis Hospice
- Difficulty in conveying to the public why NHS charities exist
- Cost of living crisis will affect all audiences and potential donors

PESTLE analysis

P	E	S	T	L	E
Political	**Economic**	**Societal**	**Technological**	**Legal**	**Environmental**
Part of NHS – key consideration in how we can spend our funds	Impact of higher cost of living	People want to give, if they can	We need to ensure it is as easy as possible to donate	Charity Commission Fundraising Regulator	Support green agenda

The SWOT and PESTLE analyses will be revisited each 12 months.

The Princess Alexandra Hospital Charity
Registered Charity Number: 1054745

NHS
The Princess Alexandra Hospital
NHS Trust

Where we are now

Whilst the charity has existed since 1996, in recent years it has operated without significant investment in senior leadership for the charity. This has now changed and a head of charity started in post in January 2022. They have initiated a large amount of improvement work to improve the day to day operations of the charity, in particular the relationship with the finance team. Investigations are currently on-going regarding the procurement of a dedicated charity database and a plan is being prepared to embark on a managed spend-down of existing funds held by the charity and managed by individual fundholders.

This focus on processes underpins a stronger, more robust fundraising infrastructure on which we are now building with a range of fundraising activities to grow income and, as a consequence, grow expenditure on charitable activities to support the trust.

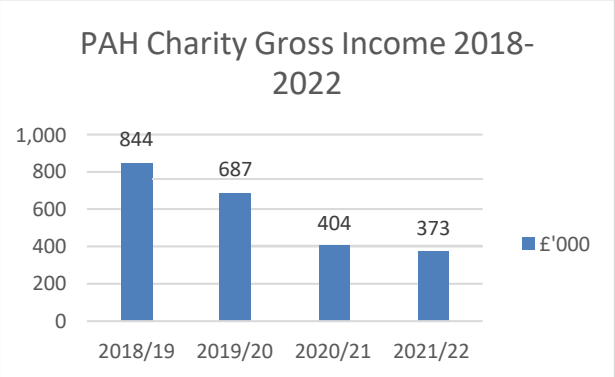
The next five years (2023-28)

This strategy outlines the expectations of and targets for the level of growth possible between 2023 and 2028. The below highlights our main actions, covering this period:

- Increase overall charity gross income to £1,069,000 by March 2028.
- A specialist charity database will be in place and established and will operate seamlessly alongside the finance charity system, our cashier's officer and third-party integrations such as JustGiving.
- Monthly charity management accounts will be produced, enabling the charity team, finance team and the charitable finds committee to regularly and pro-actively manage charity performance.
- Fundholders will be fully informed of their fund balances on a live basis and will utilise consistent procedures to request the utilisation of the funds.
- The charity team will work directly with fundholders to raise funds for special projects, planning actions across the range of fundraising disciplines to ensure these needs are met.
- Increased level of awareness of the charity both locally and within the Trust.

Recent income trends

The below shows charity income over the past four years.



The above shows a significant reduction in income over the past four years. This does of course coincide with the pandemic and, as such, was largely to be expected.

Donor database

At present, the charity does not benefit from the use of a fundraising database. This is vital for an organisation of our size to allow us to manage our donor information in a secure, GDPR compliant manner and to allow us to easily access donor information, fully assess and report on the success of our fundraising initiatives, plan and implement individual stewardship journeys for our donors and work in a clearer, more efficient way.

A database will be purchase before the end of the financial year 2022-23, in place for the start of this strategic period.

Individual income streams

Trusts and foundations

The head of charity's area of expertise, trusts and foundations, is one we could be very successful in. Reseach is ongoing into potential hospital supporters in the local area and working on packaging our work into an attractive case for support. Despite a growing number of people within the trust fundraising community advocating for more core or unrestricted funding and a distinct move in this direction over the past

few years, many grant-making organisations do, and always will, prefer (or insist) on funding something tangible. This is why, alongside the fact that some individual donors will insist on supporting the ward/service that supported them or their loved one, we will always retain the ability to restrict income – though our focus will be on the general fund where possible. We will therefore work to ensure we do establish some tangible, fundable projects available to support our fundraising. The new hospital presents an opportunity to apply for some larger grants which we will begin investigating.

Corporate

The Hospital Hundred
Beginning with those who choose to host a collection tin we will engage with local businesses in a range of ways. To tie this together, we will launch The Hospital Hundred, bringing together 100+ local businesses who will pledge to each raise £1,000 over a year, encouraging friendly competition between them.

A fundraising pack with ideas including: a collection tin, sponsorship a tap to donate machine for a year, asking for donations to round up purchases to the nearest £1, dress down days, sponsoring our events etc will be provided.

Solicitors and accountants
For local solicitors and accountants, we will ask if they would be willing to donate their unclaimed client funds to us. This is a common fundraising initiaitve, but will require input from our legal team as we may be required to indemnify against a client claiming the funds at a later date.

Right: an example from another charity.

Individual giving

Following or first direct mail appeal in spring 2022, we will be working with our planning partner to fully assess the outcome and determine the value of further such campaigns.

A new database, improved income processing procedures and the future addition of a senior individual giving manager will provide us with the ability to dedicate more time and resource to this fundraising discipline.

Community

It is vital that to achieve our aim of becoming the charity of choice locally, we work with all aspects of the local community to raise our profile and ultimately increase income to the charity.

Three **tap to donate** console machines were installed in October on site at Princess Alexandra Hospital. These should produce a far higher return on investment than traditional colleciton tins, based on the simple fact that many people no longer carry cash. If successful, these consoles will be rolled out to other areas across the Trust, including our periphery sites, and can be used as a tool within corporate fundraising, as mentioned above.

We will launch a **supporter panel** incuding some of our most committed local fundraisers to brainstorm and consult on fundraising ideas and generally champion our work locally. This will be created with input from the volunteering team. Clincial input will be vital, as we need to ensure that any suggestions made will prove beneficial in practice.

We will work with local groups and schools, to create income generation opportunies and increase our brand awareness locally.

Legacies/in-memory

Due to the nature of our work, legacies and in-memory gifts is a very imporant area of income generation for us and is one where we need to ensure we strike the correct tone in the use of our language and promotion. We will build a collaborative relationship with the hospital bereavement team, to ensure we understand the most appropriate way to connect with bereaved families. We will also review our policy for managing large legacies, which may take some time to spend, or may not be able to be spent entirely to support the desired restriction.

Will-writing
Many charities work with local solicitors to offer will-writing services at low or no cost, with the option (but no requirement or expectation) to leave a gift to us.

Funeral directors
We will work with local funeral directors regarding how they may be able to support us in making families with no existing charity of choice aware that we are here, again, in the most responsible and considerate manner.

Major donors

Major donor, or philanthropy fundraising involves indentifying potential high net worth individuals who may have an affinity with your cause, and over time, planning how best to involve them with your work with a view to making a financial or other ask at

an appropriate time in the future. This process can take a number of years, however it represents a vital element of the fundriasing mix due to the level of income that can be generated. In addtion, many major donors are well-conneted and influential members of society and as such can contribute in many other ways.

Research
We will research potential major donors and plan the most approriate way of initaiting contact. This will involve a process of network mapping, particularly involving our executive and non-executive directors (NEDs).

Involvement
It is vital that we make the most of all opportunites to involve potential high net worth supporters, such as by making sure we network effectively at all events, including ensuring members of our board are present at key gatherings.

Understanding our current donor base
There is a fundraising adage that your next major donor is often already in your database and as such, ensuring excellent income processing, gift acknowledgments and stewardship of all donors will be vital, as will spending time analysing our gifts to see which supporters may require more individual stewardship paths.

As ever, correctly stewarding existing donors is more vital than securing new donors and as such the head of charity will ensure that existing major donors are in no doubt they represent some of our most valued supporters. Through the pandemic, the sector has seen that engaging with major donors was one of the least considered fundraising areas, as shown by the below quote taken from ***Are major donors the answer to Covid-19 deficits?*, Third Sector, February 2021:**

'Anecdontally, my overall impression is that major donors have not stopped giving, but they have stopped being asked.'

Lesley Alborough, research fellow at the Centre for Philanthropy at the University of Kent

The charity aims between 2023 and 2025 to have working relationships with between five and ten committed major donor supporters, with this growing by 2028 to between 15 and 20.

Events

Challenge events
Challenge events, such as marathons, abseils etc. are an excellent way of raising funds and engaging a large number of members of the community, via sponsorship of our fundraisers.

This area of fundraising is already operating well and generating income and we will look to increase participation over the next five years. Our close relationship with the voluntary services team will prove vital, as we will require volunteer support as we increase the number of events we take part in.

Challenge events will provide the charity with experience in event management, which will be vital as we look to the longer-term goal of launching special events, which is discussed below.

Special events

Special events fundraising can be incredibly succcessful in terms of income generation and also in raising brand awareness. Special events can act as a forum to effectively steward corporates, trusts and major donors and involve celebrities and our ambassadors (see below). Events fundraising is a specialist fundraising discipline and as such the charity will, in time, benefit from the addition of an events fundraiser to the charity team. As this is not a priority area, we do not anticipate adding this role until the second half of this strategy period. This does not however mean that we will not investigate such opportunites, utilising the support of volunteers in any events we do hold.

New fundraising opportunities

For any new fundraising opportunites, we will balance the potential net income to the charity with any potential repuational concerns.

Crypto philanthropists

Connecting with crypto currency philanthropists, could provide a new and lucrative income stream, not currently being considered by many. The opportunity is highlighted in the below quote from ***How To … use cryptocurrencies,*** **Jason Shaw and Annie Connelly, *Fundraising Magazine*, May 2021:**

'For crypto philanthropists, it's simply that they aren't being asked to give.

'I'm well-known in the crypto space,' says a donor who wished to remain anonymous. 'It wouldn't be hard for a charity to predict my ability to give a big gift in crypto. But I never get asked.'

This is a great example of why it is important we move with the times and do not miss an opportunity to diversify our income generation portfolio.

Gaming

Fundraising via gaming is a relatively new concept but can be very lucrative and engage a younger audience. The below screenshot shows an event for this year which raised nearly £100,000.

Some charities are already advertising for posts specifically managing this area of fundraising, and JustGiving have a dedicated platform: *Gaming for Social Good* showing that its potential is widely recognised.

It is important that alongside ensuring we have a wide mix of fundraising activities, we look to stay current in terms of fundraising trends.

Celebrity patrons and ambassadors

It is very important for our brand awareness, social media profile etc. to secure the support of a number of celebrity supporters. Celebrities can support with hosting events, offering auction prizes, or simply sharing social media posts – with their reach far greater than anything we could otherwise achieve.

There is also an opportunity to appoint patrons and ambassadors of the charity, who would operate in a similar way, but with an offically recognised and well defined role supporting the charity.

The charity has identified a number of local celebrities, whom we will consider looking to work with.

Fundraising targets

Appendix A sets out all income targets for the period. The target for 2023/24 is a rough average of the past two years, and the five-year period aims to surpass the level we achieved in 2016/17, and the £1m mark.

These targets will be regularly re-forecast throughout the period.

Equality, diversity and inclusion

The charity will mirror the corporate approach and responsibility in terms of equality, diversity and inclusion. Supporting the charity is open to all and funds are used to support patient care and also our people.

The charity will remain committed to working across the community and involving those who we care for and their family and friends.

Fundraising events that are not inclusive will not be endorsed by or receive funds for the charity.

Charity spending

The charity holds monies across a number of internal funds, managed by fundholders from across the organisation. At the time of writing, we are working with the finance team to initiate contact with all fundholders, understand their requirements and plans for any funds held. We will work with them on spending plans.

It is clear that a new, clearly defined process is required regarding how funds are accessed by fundholders, with committee approval where required. It is proposed that the charity, PAHT finance team and charitable funds committee work together to develop a formal process whereby fundholders can apply for funds, including a framework by which approvals may or may not be made, based upon the strategic priorities of the charity and PAHT as a whole.

In addition to the above, the head of charity will work alongside fundholders to ensure they have the skills and knowledge to successfully and impactfully manage the funds they are responsible for.

The head of charity will arrange presentations with all divisions, to re-introduce the charity, and ensure all staff feel comfortable talking with patients and visitors about the impact of our work and how they can support us.

Following on from this, we will look to create a number of 'charity champions' in areas across PAHT, to help raise our profile internally.

Impact monitoring

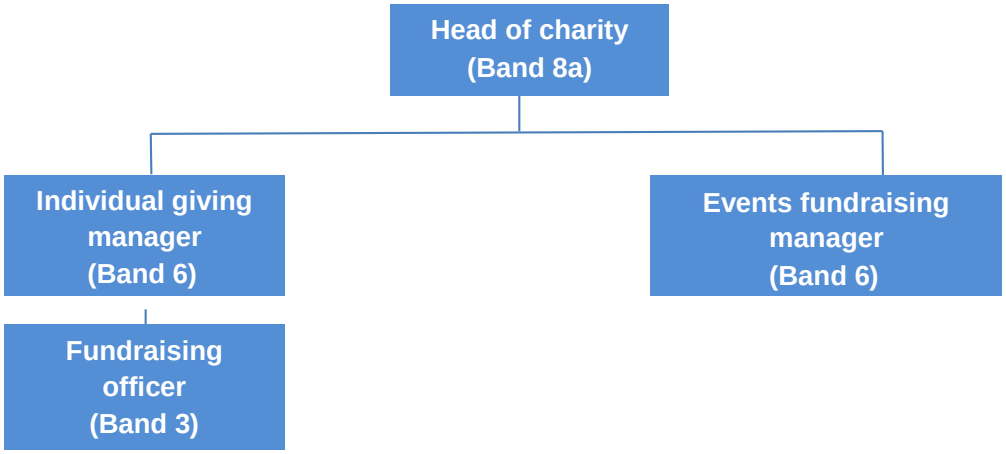
It is vital for any charity that we determine what we want to achieve and regularly measure performance against this, alongside measuring the impact of our work.

Appendix A shows our targets in full, however these can be reviewed and adjusted throughout the strategy period, as required. We intend to ultimately produce an annual impact report, alongside our annual report and accounts, to highlight our achievements, key facts and figures, case studies and beneficiary surveys.

Future charity structure

It is clear that to manage and operate the charity effectively, professionally and to grow, additional resource will be required. The ideal size of the team and the areas of specialty that will be required are shown below. During the next two years, it is proposed that consideration is given to the addition of a fundraising officer (2023-24) and individual giving manager (2024-25). The events fundraising manager role is anticipated to be added between 2025 and 2028.

At present, the fundraising officer role is being fulfilled in part by volunteer support, however it would be preferable for this position to be a salaried role.



Head of charity
Strategic direction and management of charity
Major donors
Large corporate
Trusts and foundations

Senior individual giving manager
Individual giving
Legacies
In-memory
Charity data security lead
Overall responsibility for income processing within the charity team

Events fundraising manager
Management of all events (special, in-aid of, challenge)
Main point of contact with Mr Patel

Fundraising officer
First line of contact (phone and emails)
Daily income processing, thanking donors etc.
Reports to senior individual giving manager (head of charity in first instance)

Costs of the above (based on 2022/23 bandings)

Role (band)	2023/24	2024/25	2025/2026	2026/27	2027/28
Head of charity (8a)	£63,350	£63,350	£63,350	£63,350	£63,350
Individual giving manager (6)	£0.00	£0.00	£44,140	£44,140	£44,140
Events fundraising manager (6)	£0.00	£0.00	£0.00	£44,140	£44,140
Fundraising officer (3)	£0.00	£28,030	£28,030	£28,030	£28,030
Total	**£63,350**	**£91,380**	**£135,520**	**£179,660**	**£179,660**

As can be seen in Appendix A, whilst the above will increase charity expenditure, income is forecast to grow as a result of the addition of these income generating roles.

Alongside this structure, we will continue to work closely with the voluntary services team to identify potential voluntary support for the charity, in particular individuals with transferrable experience such as those who have worked in events.

The Princess Alexandra Hospital Charity
Registered Charity Number: 1054745

NHS
The Princess Alexandra Hospital
NHS Trust

Marketing and communications

The charity will continue its excellent working relationship with our communications team, to raise the profile of the charity with PAHT people; patients: visitors; local people; businesses and stakeholders.

As outlined in this strategy, there will be a wide range of fundraising campaigns to establish and, alongside, these will be tailored attention to the audience that the campaign is going to benefit and those with an interest. For example, this will include everything from the challenge events such as the London Marathon and Royal Parks Run to fundraising for music therapy for patients with dementia.

The awareness raising will also be part of a rich range of stories about what current funds have been spent on and how the purchase or investment in expertise will benefit our patients; their carers or our people.

Where needed, fundraising materials will be designed and purchased to draw the eye to the charity brand and this will build into a recognition and validation of the charity when the charity brand assets are used and seen by potential donors. People will be clear what the fundraising is for and the charity leading on the charitable funds and their use.

Examples of where the communications and marketing will play an important role includes:

- Printing a marketing brochure created from a synopsis of the front pages of the charity annual report
- Designing a campaign and assets for the Hospital Hundred including fundraising packs for the members
- Issuing news releases publicising the work, successes and who is benefitting from the use of charity funds to purchase equipment etc
- Highlighting fundraising opportunities via social media, especially challenge event opportunities and inviting patients; their families and local people to get involved and charting their experience in preparing and taking part in the event
- Promoting the charity and how to access funds across the main sites and maximising the use of digital information screens and tap to donate machines as part of that awareness
- Feature articles in In Touch magazine to give an opportunity to share how much the charity is supporting our patients and people and the benefits of this support
- Sharing wider promotion across local communities and linking with external charity events
- Making donating to the charity very visible, straight-forward and welcomed.

These activities will use the current social media platforms and charity pages of the PAHT website. In time, consideration will be given to creating a stand-alone charity website to provide a dedicated site and tailored content.

Conclusion

Our charity benefits from a huge amount of goodwill locally and it is clear we are not currently taking full advantage of the range of opportunities available to us. By growing our team and investing in new income streams, we plan to increase gross income to £1,069,000 by March 2028, enabling us to provide more of our excellent work in supporting the patients, people and visitors at Princess Alexandra Hospital NHS Trust.

The Princess Alexandra Hospital Charity
Registered Charity Number: 1054745

NHS
The Princess Alexandra Hospital
NHS Trust

Appendix A – income and donor targets

The below is a summary of our initial targets for each income stream, comprising both income and number of donors. The highlighted sections represent an increase in dedicated resource in this area.

	£	£	£	£	£
Source	**2023/24**	**2024/25**	**2025/26**	**2026/27**	**2027/28**
Individual giving	6,000.00	9,000.00	24,000.00	30,000.00	36,000.00
Legacies	10,000.00	20,000.00	30,000.00	40,000.00	50,000.00
In-memory	20,000.00	22,000.00	24,000.00	26,000.00	28,000.00
Community	15,000.00	25,000.00	35,000.00	50,000.00	75,000.00
Local business (Harlow Hundred)	56,250.00	75,000.00	93,750.00	112,500.00	150,000.00
Large corporate	10,000.00	25,000.00	50,000.00	75,000.00	100,000.00
In aid of	10,000.00	15,000.00	20,000.00	25,000.00	30,000.00
Challenge events	75,000.00	90,000.00	105,000.00	130,000.00	165,000.00
Trusts	50,000.00	75,000.00	100,000.00	150,000.00	200,000.00
Major donors	0.00	0.00	20,000.00	40,000.00	60,000.00
Special events	100,000.00	100,000.00	100,000.00	150,000.00	175,000.00
	352,250.00	**456,000.00**	**601,750.00**	**828,500.00**	**1,069,000.00**

The Princess Alexandra Hospital Charity
Registered Charity Number: 1054745

NHS
The Princess Alexandra Hospital
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	2023/24	2024/25	2025/26	2026/27	2027/28
Individual giving	200	300	800	1,000	1,200
Legacies	1	3	5	8	10
In-memory	20	22	24	26	28
Community	10	15	20	25	35
Local business (Harlow Hundred)	75	100	125	150	200
Large corporate	2	5	10	15	20
In aid of	10	15	20	25	30
Challenge events	25	30	35	50	75
Trusts	5	7	10	15	20
Major donors	0	0	1	2	3
Special events	0	0	0		200

The Princess Alexandra Hospital Charity
Registered Charity Number: 1054745

NHS
The Princess Alexandra Hospital
NHS Trust

Appendix B – timing of key events

The below is a summary of our current plan to when key events will take place. This is a fluid document and will change depending on a range of factors over the strategy period.

***appointments pending confirmation**

	Pre-strategy period	2023/24	2024/25	2025/26	2026/27	2027/28
Income	N/A	**Gross income £352,250**	**Gross income £456,000**	**Gross income £601,750`**	**Gross income £828,500**	**Gross income £1,069,000**
Communication	Launch strategy and present to divisional boards		Launch patron and ambassador programme	Continue to support charity with day-to-day and strategic communications		
	Launch charity champions campaign					
Trusts	Research suitable grant-making organisations	Following review of current funds and charity requirements, begin to approach grant-making organisations				
		Target Trust donors: 5	**Target Trust donors: 10**	**Target Trust donors: 15**	**Target Trust donors: 20**	**Target Trust donors: 25**
Corporate/ community	Evaluate tap to donate pilot (from Feb 2023)	Expand tap to donate programme				
	Research potential local businesses to approach	Following review of current funds and charity requirements, begin to approach corporates.				
		Launch Hospital Hundred (corporate club)	Gradual growth and stewardship of club members			

modern • integrated • outstanding

patient at heart • everyday excellence • creative collaboration

The Princess Alexandra Hospital Charity
Registered Charity Number: 1054745

NHS
The Princess Alexandra Hospital
NHS Trust

	Pre-strategy period	2023/24	2024/25	2025/26	2026/27	2027/28
Corporate/ community		**Target corporate donors: 77**	**Target corporate donors: 105**	**Target corporate donors: 135**	**Target corporate donors: 165**	**Target corporate donors: 220**
		Target community donors: 10	**Target community donors: 15**	**Target community donors: 20**	**Target community donors: 25**	**Target community donors: 35**
Major Donor	Begin research into potential major donors, working with Trust board			**Target: 1 donor**	**Target: 2 donors**	**Target: 3 donors**
Individual giving	Review spring 2022 direct mail appeal	Potential direct mail appeals (dependent on review of spring 2022)		Individual giving programme (direct mail appeals etc.) to grow following team expansion		
		Target IG donors: 200	**Target IG donors: 300**	**Target IG donors: 800**	**Target IG donors: 1,000**	**Target IG donors: 1,200**
Legacy/in-mem		Write legacy and in-mem strategy	Work with PAH bereavement team, local funeral directors etc and communications team to launch strategy	Gradual growth as a result of continued promotion and partnership work with PAH bereavement team and local funeral directors etc.		
		Target legacy donors: 1	**Target legacy donors: 3**	**Target legacy donors: 5**	**Target legacy donors: 8**	**Target legacy donors: 10**
		Target in-mem donations: 20	**Target in-mem donations: 22**	**Target in-mem donations: 24**	**Target in-mem donations: 26**	**Target in-mem donations: 28**
Events/in aid of	Gradual growth of challenge events (marathons, abseils, sky dives etc.)				Special events fundraising to grow following team expansion	
		Target event donors: 35	**Target event donors: 45**	**Target event donors: 55**	**Target event donors: 170**	**Target event donors: 300**

	Pre-strategy period	2023/24	2024/25	2025/26	2026/27	2027/28
Operational	Complete review of current funds and agree formal process for fundholders to access funds	Begin spending down existing funds	TBC			
	Donor database in place	TBC				
Opportunities	Day to day research of new opportunities	Investigate crypto philanthropy and gaming	Day to day research of new opportunities		Investigate potential addition of retail post 2028	Day to day research of new opportunities
Team	Volunteer support begins	Expand volunteer support				
			Fundraising officer appointed*	Individual giving manager appointed*	Events fundraising manager appointed*	Review resourcing requirements post 2028

The Princess Alexandra Hospital Charity
Registered Charity Number: 1054745

Meeting your needs

We can provide information about our services in different formats and adapt the ways we communicate with you - depending on your needs. For example, we can use Braille, large print or different languages.

Please let us know what your particular needs are and we will do our best to help. You can contact us about accessibility by calling **01279 82 7211**.

The Princess Alexandra Hospital NHS Trust, Hamstel Road, Harlow, Essex, CM20 1QX
01279 44 44 55

Keep up to date with our latest news via social media:

@NHSHarlow

@princessalexandranhs

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The Princess Alexandra Hospital

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 2nd February 2023

Agenda item:	7.4							
Presented by:	Tom Burton, Director of Finance							
Prepared by:	Samuel Owusu-Ansah, Head of Financial Services							
Date prepared:	25th January 2023							
Subject / title:	Governance Manual							
Purpose:	**Approval**	**x**	**Decision**		**Information**	**x**	**Assurance**	
Key issues: please don't expand this cell; additional information should be included in the main body of the report	This paper highlights the proposed changes to the Trust's Governance Manual and these are in section 3. All Trust spend goes through our central procurement teams before we fully commit to spend and make payment for services or goods received							
Recommendation:	To note the updates to the Governance Manual and recommend to Board for approval							

Trust strategic objectives: please indicate which of the five Ps is relevant to the subject of the report	**Patients**	**People**	**Performance**	**Places**	**Pounds**
			x		X

Previously considered by:	N/A
Risk / links with the BAF:	The NHS code of governance requires NHS trusts to follow standing orders, SFIs and standards of business conduct that follow best practice
Legislation, regulatory, equality, diversity and dignity implications:	NHS code of conduct and accountability
Appendices:	Appendix 1 - Governance Manual updates tables

7.4

The Princess Alexandra Hospital NHS Trust

1.0 Purpose

The paper sets out the changes made to the Governance Manual following review by members of the finance team and the Head of corporate affairs. Prior to submission of the updated Governance Manual to the Trust Board, the Audit Committee is asked to consider the changes and comment as appropriate.

2.0 Context

A Trust's Governance Manual is a key part of its corporate governance arrangements and regulates the proceedings and business of the Trust.

The Governance Manual contains a number of sections which together provide the regulatory framework for the business conduct of the Trust. They fulfil the dual role of protecting the Trust's interests and protecting staff from possible accusation that they have acted less than properly.

3.0 Changes to the SFIs

- Job titles and names of regulatory bodies have been updated, throughout the document

- **Pages 22-23 & 34-36** - Further clarification of Audit Committee and the role of the Internal Audit duties and responsibilities
- **Page 37** - Additional interpretation of Security Management roles and responsibilities
- **Page 38-39** - Budgetary Control and reporting have been updated to include the No PO No Pay policies
- **Page 43** - Tender & Contracts procedures have been updated to reflect the Public Contract Regulations 2015 (PCR) which govern public procurement
- **Page 46 –** Director of Procurement refers to as ICS Director of Procurement
- **Page 72 -** Following discussions at the last Charitable Funds Committee, Fund Managers will now have a delegated approval limits up to £2,500
- **Page 75** - Losses and Special payments approval limes have been updated
- **Page 86** - Strengthening approval limits on capital projects in line with Business Cases process
- **Page 86** - Strengthening approval limits on expenditure projects in line with Business Cases process
- **Page 86** - Strengthening the Scheme of Delegation (SoD)
- **Page 86** - Scheme of delegation on expenditure and capital approval limits have been simplified to reflect the various levels of approvers and type of spend
- **Page 85** - Value of Order / Contract Goods & Services and works contracts and Waiving of Standing orders have been updated to reflect the PCR limits.
- **Page 117 - 118** - A waiver form has been added

4.0 Changes to the Standing Orders and Standards of Business Conduct

- The content of these two sections has not changed significantly; job titles, names of regulatory bodies and formatting have been updated.
- Following Audit Committee the role of the NEDs was enhanced.

The Princess Alexandra Hospital NHS Trust

5.0 Recommendation

The Board is asked to:

- To note the updates to the Governance Manual and recommend to the Board for approval

Author: Samuel Owusu-Ansah, Head of Financial Services
Heather Schultz - HoCA

Date: 25th January 2023

The Princess Alexandra Hospital NHS Trust

Appendix 1 – January 2022 Governance Manual schedule of updates

Value of Order / Contract Goods & Services and Works Contracts

Process	Goods & Services	Works	Contrcts for Social and other specific services
I written quotation	Up to £10,000	Up to £10,000	Up to £10,000
Minimum of 3 written quotations	Over £10,000 to £25,000	Over £10,000 to £25,000	Over £10,000 to £25,000
Mininmum of 3 tenders invited	Over £25,000 to £123,796	Over £25,000 to £4,733,252	Over £25,000 to £663,540
Public Contrct Regulations	Over £123,796	Over £4,733,252	Over £663,540
Full Process under Thresholds for Utilities Contract Regulations	Over £378,660	Over £4,733,252	Over £884,720

7.4

Acceptance of Tenders / Quotes

Financial Limit	Opened by	Adjudicated by	Accepted by
Quotations			
£5,000 - £25,000	Originating Dept. (Estates or Supplies).	Representative from user department and senior manager from Supplies or Estates.	Supplies Services Manager or Director of Estates & Redevelopment/Head of Estates.
Tenders			
£25,001 - £50,000	Executive Director and Deputy Director of Finance	Representative from user department and senior manager from Supplies or Estates.	Supplies Services Manager or Director of Estates & Redevelopment/Head of Estates. Reported to the Chief Financial Officer.
£50,000 +	Executive Director and Deputy Director of Finance	Representative from user department and senior manager from Supplies or Estates.	Supplies Services Manager or Director of Estates & Redevelopment/Head of Estates. Reported to Board.

Waiving of Standing Orders

Financial Limit	Approved by	Reported to
Quotations		
Up to £25,000	Deputy Director of Finance or Director of Finance and Budget Holder	Audit Committee
Tenders		
£25,001 to £250,000;	Director of Finance	Audit Committee
£250,001 - £500,000	Director of Finance and Chief Executive	Audit Committee
£500,000 +	Trust Board	N/A

The Princess Alexandra Hospital NHS Trust

Scheme of Delegation: Expenditure Approval Limits (Revenue, Charitable Funds and Capital expenditure)

Funded revenue expenditure (including full cost of all contracts entered into)				
Description	**Approval and Requisition limit**		**Approval**	**Receipting**
Requisitioner	-	-	✓	✓
Band 7	£2,500	£2,500	✓	✓
Band 8a	£2,501	£5,000	✓	✓
Band 8b	£5,001	£7,500	✓	✓
Band 8c	£7,501	£19,999	✓	✓
Band 8d and 9	£20,000	£49,999	✓	✓
Exec Director or DoF	£50,000	£100,000	✓	✓
Exec Director and Director of Finance	£100,000	£250,000	✓	✓
Chief Executive and Director of Finance	£250,001	£1,000,000	✓	✓
Trust Board	£1,000,000+	£1,000,000+	✓	✓

7.4

Business cases approval limits - Capital	Required Approval
Up to £75,000	CWG chaired by DoF
£75,000 to £500,000	SMT, with subsequent recommendation by Performance and Finance Committee & Trust Board approval
£500, 001 to £14,999,999	Trust Board (Following recommendation from Finance and Performance Committee)
£15,000,000	ICB
Any expenditure the breaches the Trust CRL will need to be approved by the highest level which is the ICB	

Business cases approval limits - Revenue	Required Approval
Up to £250,000 and with budget	DMB, with subsequent recommendation to SMT
UP TO £250,000 and not within budget	SMT (Following recommendation by Divisional Board and EMT
£250,000 to £500,000 whether within budget or without	SMT (Following recommendation by Divisional Board and EMT
£500, 001 to £14,999,999	Trust Board (Following recommendation from Performance and Finance Committee)
£15,000,000	ICB – Any expenditure that is above this level will need to be approved first by the Trust Board prior to escalation to the ICB/NHSE.

Governance Manual
Contents

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FOREWORD

A Trust's Governance Manual is a key part of its corporate governance arrangements and regulates the proceedings and business of the Trust.

The Governance Manual contains a number of sections which together provide the regulatory framework for the business conduct of the Trust. They fulfil the dual role of protecting the Trust's interests and protecting staff from possible accusation that they have acted less than properly.

The Governance Manual provides a comprehensive business framework that is to be applied to all activities, including those involving the Trust's charitable funds. Members of the Trust Board and all members of staff should be aware of the existence of and work to these documents.

OVERVIEW

The Corporate Governance Manual sets out the rules by which The Princess Alexandra Hospital NHS Trust is run. These rules are in line with its responsibilities as a public body and ensure that it is run in an open, honest and proper way. They consider best practice set out by the Department of Health & Social Care which in turn derives from good practice developed in the Companies Act and elsewhere.

The Legal Framework

The Princess Alexandra Hospital NHS Trust was established as an NHS Trust in 1994 to provide health care to the public. NHS Trusts are public bodies set up under the National Health Service and Community Care Act 1990 and subsequent Acts and amendments, and are subject to guidance and directions from the Secretary of State for Health & Social Care.

The Board

The Trust is run by a Board of Directors, which is answerable to the Secretary of State for Health & Social Care, regarding the quality of services and for healthcare performance. The Chair and Non- Executive Directors of the Trust are appointed by NHS Improvement; and they in turn appoint the Executive Directors. The Board meets regularly in public.

The Board has the following key functions:

- Exercise the functions of the Trust effectively, efficiently and economically.
- Comply with legislation and other duties imposed on it by the Department of Health & Social Care.
- Ensure that high standards of governance and personal behaviour are maintained in line with national best practice.
- Ensure that it complies and delivers its healthcare services to standards specified in contracts.
- Develop the strategic direction of the organisation within the overall policies and priorities of the Government and its commissioners.
- Oversee the delivery of planned results by monitoring performance against objectives and agreeing plans to achieve them.
- Ensure effective dialogue between the Trust and its stakeholders.
- Shape organisational culture.

The Chair has five key responsibilities:

- Strategic: ensuring the board sets the trust's long-term vision and strategic direction and holding the chief executive to account for achieving the trust's strategy
- People: creating the right tone at the top, encouraging diversity, change and innovation, and shaping an inclusive, compassionate, patient-centred culture for the organisation

- Professional acumen: leading the board, both in terms of governance and managing relationships internally and externally
- Outcomes focus: achieving the best sustainable outcomes for patients/ service users by encouraging continuous improvement, clinical excellence and value for money
- Partnerships: building system partnerships and balancing organisational governance priorities with system collaboration; this role will become increasingly more important as local organisations move to delivering integrated care, prioritising population health in line with the NHS Long Term Plan.

Non-Executive Directors (NEDs) are accountable for:

Formulate plans and strategy:

- Bring independent judgement, external perspectives and advice on issues of strategy, vision, performance, resources and standards of conduct and constructively challenge, influence and help the executive board develop proposals on such strategies to enable the organisation to fulfil its leadership responsibilities to patients, for healthcare of the local community.
- Assist fellow directors in setting the trust's values and standards and ensure that its obligations to its stakeholders and the wider community are understood and fairly balanced at all times.
- Ensure accountability
- Ensure that the board sets challenging objectives for improving its performance across the range of its functions.
- Hold the executive to account for the delivery of strategy.
- Provide purposeful, constructive scrutiny and challenge.
- Chair or take part as a member of key committees that support accountability.
- Contribute to the determination of appropriate levels of remuneration for executive directors.
- Being accountable individually and collectively for the effectiveness of the board.
- Accept accountability to NHS Improvement for the delivery of the organisation's objectives and ensure that the board acts in the best interests of patients and its local community.
- Shape culture and capability
- Ensure that patients and service users are treated with dignity and respect at all times, and that the patient is central to trust decision-making.
- Actively support and promote a healthy culture for the organisation which is reflected in their own behaviour.
- Ensure that the organisation values diversity in its People and demonstrates equality of opportunity in its treatment of staff and patients and in all aspects of its business.
- Provide visible leadership in developing a healthy culture so that staff believe non-executive directors provide a safe point of access to the board for raising concerns.
- Ensure the directors of the board are 'fit and proper' for the role and champion an open, honest and transparent culture within the organisation.

Context

- As a member of board committees, appoint, remove, support, encourage and where appropriate 'mentor' senior executives.
- Mentor less experienced non-executive directors where relevant.

Process, structures and intelligence

- Commit to working to, and encouraging within the trust, the highest standards of probity, integrity and governance and contribute to ensuring that the trust's internal governance arrangements conform with best practice and statutory requirements.
- In accordance with agreed board procedures, monitor the performance and conduct of management in meeting agreed goals and objectives and statutory responsibilities, including the preparation of annual reports and annual accounts and other statutory duties
- Ensure that financial information is accurate, that financial controls and risk management systems are robust and defensible, and that the board is kept fully informed through timely and relevant information
- Satisfy themselves of the integrity of reporting mechanisms, and financial and quality intelligence

including getting out and about, observing and talking to patients and staff.
- Provide analysis and constructive challenge to information on organisational and operational performance.

Engagement
- Ensure that the board acts in best interests of patients and the public.
- Show commitment to working with key partners.
- Act as an ambassador for the trust in engagement with stakeholders including patients and the local community, dealing with the media when appropriate.

Chief Executive is accountable for:

- Performing the duties of the Trust's accountable officer as set out in the 'Accountable Officer' memorandum.
- Organising, managing and staffing of The Princess Alexandra Hospital NHS Trust.
- Risk Management for the Trust.
- Protecting the Trust's reputation and integrity, by ensuring the Trust is open and honest in its communications, and through the development of strong partnerships with its stakeholders.

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

Unless a contrary intention is evident or the context requires otherwise, words or expressions contained in this document shall have the same meaning as set out in the National Health Service Act 2006 and the Health & Social Care Act 2012 or any secondary legislation made under the National Health Service Act 2006 and the Health & Social Care Act 2012. References to legislation include all amendments, replacements or re-enactments made and include all subordinate legislation made thereunder.

Words importing the masculine gender only shall include the feminine gender; words importing the singular shall import the plural and vice versa.

Headings are for ease of reference only and are not to affect interpretation.

DEFINITIONS
The following defined terms shall have the specific meanings given to them below:

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

Trust Board Advisor means an independent person who supports the Trust Board but has no voting rights and does not influence decisions of the Trust Board. A Trust Board Advisor is usually a specialist in their own right and is brought in with a specific brief and for a defined time period.

Trust Board means the Chair, Executive Members and Non-Executive Members of the Trust collectively as a body.

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

Budget Holder means the Officer with delegated authority to manage finance (income and/or expenditure) for a specific area of the Trust.

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

Chief Executive means the Chief Executive Officer of the Trust.

Director of Finance means the Executive Director with responsibility for the finances of the Trust.

Clear Day means a day of the week not including a Saturday, Sunday or public holiday.

Close Family Member means either a:
a) Spouse;
b) Person whose status is that of “Civil Partner” as defined in the Civil Partnerships Act 2004 or a co-habitee;
c) Parent;
d) Child, step child or adopted child;
e) Sibling;
f) Nephew, niece or first cousin; or
g) Spouse, Civil Partner or co-habitee of any of (c) to (f) listed above.

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

Committee means a Committee created and appointed by the Trust Board, which reports to the Trust Board.

Committee Member means a person formally appointed by the Trust Board to sit on or to chair a specific Committee.

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

Corporate Trustee means that the Trust Board members are jointly responsible for the management and control of the charitable funds and are accountable to the Charity Commission.

Director means a member of the Trust Board and any other Officer employed as a Director.

Employee means a person paid via the payroll of the Trust, or for whom the Trust has responsibility for making payroll arrangements but excluding Non-Executive Directors.

Executive Director means an Executive member of the Trust Board of the Trust who has voting rights.

Executive Team means the Chief Executive's direct reports.

Charitable Funds means those funds which the Trust holds on date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under powers derived under S.90 of the NHS Act 1977, as amended.

Member means a Non-Executive Member or Executive Member of the Trust Board as the context permits. Member in relation to the Trust Board does not include its Chair.

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

Meeting Chair means the person presiding over a meeting, committee or event.

Motion means a formal proposition to be discussed and voted on during the course of a meeting of the Trust Board.

Nominated Officer means an Officer charged with the responsibility for discharging specific tasks within the Standing Orders and Standing Financial Instructions.

Non-Executive Director (NED) means a Non-Executive Director and Member of the Trust Board.

Non-Executive Director (NED) Designate or Associate means a NED who has been identified by NHS Improvement (NHSI) to fulfil a NED vacancy on the Trust Board when a vacancy arises.

Director of Procurement refers to the ICS Director of Procurement

Officer means an Employee of the Trust or any other person holding a paid appointment or office with the Trust.

NHSE/I means NHS England/Improvement

Secretary or Head of Corporate Affairs means a person appointed to act independently of the Trust Board to provide advice on corporate governance issues to the Trust Board and the Chair and

monitor the Trust Board's compliance with the law, Standing Orders, and guidance issued by the Secretary of State and Department of Health and Social Care.

Secretary of State for Health and Social Care means the UK Cabinet Minister responsible for the Department of Health and Social Care.

Senior Independent Director means the non-executive director appointed by the Chair to be available to members of the Board if they have concerns which they have failed to resolve through the normal channels of communication with the Chair, Chief Executive or Director of Finance or for which such contact is inappropriate.

SFIs mean Standing Financial Instructions.

SOs means Standing Orders.

Trust means The Princess Alexandra Hospital NHS Trust.

Vice-Chair means the non-executive director member appointed by the Trust Board to take on the Chair duties if the Chair is absent for any reason.

STANDING ORDERS

1. INTRODUCTION

1.1 Statutory Framework

The Princess Alexandra Hospital NHS Trust (the Trust) is a statutory body which came into existence on 01 April 1995 under the National Health Service Trust (Establishment) Order 1995 No 3149 (the Establishment Order).

(1) The principal place of business of the Trust is Hamstel Road, Harlow, Essex CM20 1QX.

(2) NHS Trusts are governed by Acts of Parliament, mainly the National Health Service (NHS) Act 1977, the NHS and Community Care Act 1990 as amended by the Health Authorities Act 1995, the Health Act 1999, the NHS Act 2006 and the Health and Social Care Act 2012 and any secondary legislation.

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

(4) 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. Furthermore, the Trust has delegated powers under the NHS Act 2006 as amended by the Health and Social Care Act 2012 and any secondary legislation.

(5) The Code of Accountability requires the Trust to adopt Standing Orders for the regulation of its proceedings and business. The Trust must also adopt Standing Financial Instructions (SFIs) as an integral part of Standing Orders setting out the responsibilities of individuals. The proceedings shall not however be invalidated by any vacancy of its membership, or defect in a Director's appointment.

(6) 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 and Social Care issues further directions and guidance. These are normally issued under cover of a circular or letter.

(2) The Code of Accountability requires that, inter alia, Trust Boards draw up a schedule of decisions reserved to the Trust 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 Code of Conduct requires a register of possible and actual conflicts of interest of members of the Trust Board and how those conflicts are addressed.

(3) The Freedom of Information Act 2000 sets out the requirements for public access to information held in the Public Sector.

1.3 Delegation of Powers

(1) The Trust has powers to delegate and make arrangements for delegation. These Standing Orders set out the detail of these arrangements. Under the Standing Order relating to the Arrangements for the Exercise of Functions (Standing Order 5) the Trust is given powers to "make arrangements for the exercise, on behalf of the Trust of any of their functions by a committee, sub-committee or joint committee appointed by virtue of Standing Order 4 or by an officer of the Trust, in each case subject to such restrictions and conditions as the Trust thinks fit or as the Secretary of State may direct". Delegated Powers are covered in a separate document (Matters Reserved to the Trust Board and Scheme of Delegation).

(2) Delegated Powers are covered in a separate document entitled *Matters Reserved to the Trust Board and Scheme of Delegation* and have effect as if incorporated into the Standing Orders and Standing Financial Instructions.

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

2.1 Composition of the Membership of the Trust Board

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

(a) The Chair of the Trust (appointed by NHSI/E);

(b) Up to five non-executive directors (appointed by NHSI/E);

(c) Up to five executive directors (but not exceeding the number of non-executive directors) including:
(i) The Chief Executive;
(ii) The Director of Finance

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

(3) In line with the expectations of the sector regulator for health services in England, the Trust will also have amongst its officer members:
(a) One Executive Director who is to be a registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984);
(b) One of the Executive Directors is to be a registered nurse or a registered midwife.

2.2 Appointment of Chair and Non-Executive Directors of the Trust

(1) Appointment of the Chair and Non-Executive Directors of the Trust is by NHSI/E or successor body.

2.3 Terms of Office of the Chair and Members

(1) The terms of office of the Chair and Non-Executive Directors are determined by NHSI.

2.4 Appointment and Powers of Vice-Chair

(1) Subject to Standing Order 2.4 (2) below, the Chair and Members of the Trust Board may appoint one of their numbers, who is not also an Officer Member, to be Vice-Chair, for such period, not exceeding the remainder of his/her term as a member of the Trust Board, as they may specify on appointing him/her.

(2) Any member so appointed may at any time resign from the office of Vice-Chair by giving notice in writing to the Chair and the Secretary. The Chair and Members may thereupon appoint another Member as Vice-Chair in accordance with the provisions of Standing Order 2.4 (1).

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

2.5 Joint Members

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

(2) Where the office of a member of the Trust Board is shared jointly by more than one person:
(a) either or both of those persons may attend or take part in meetings of the Trust Board;
(b) if both are present at a meeting they should cast one vote if they agree;
(c) in the case of disagreements, no vote should be cast;
(d) The presence of either or both of those persons should count as the presence of one person for the purposes of Standing Order 3.8 (Quorum).

2.6 Role of Members

The Trust Board will function as a corporate decision-making body, executive and Non-executive directors will be full and equal members. Their role as members of the Trust Board will be to consider the key strategic and managerial issues facing the Trust in carrying out its statutory and other functions. The Trust Board will operate as a Unitary Board: that means all members of the Trust Board have joint responsibility for every decision of the Trust Board regardless of their individual skills or status. All Directors must take decisions objectively and in the best interests of the Trust and must avoid conflicts of interest.

(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) Chair

(a) The Chair shall be responsible for the operation of the Trust Board and chair all Trust Board meetings when present. The Chair has certain delegated executive powers. The Chair must comply with the terms of appointment and with these Standing Orders.
(b) The Chair shall liaise with NHSI/E 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 and removal where required.
(c) The Chair shall work in close harmony with the Chief Executive and shall ensure that key and appropriate issues are discussed by the Trust Board in a timely manner with all the necessary information and advice being made available to the Trust Board to inform the debate and ultimate resolutions.

2.7 Corporate Role of the Trust Board

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

(2) All Charitable Funds received shall be held in the name of the Trust as Corporate Trustee. Directors acting on behalf of the Trust as Corporate Trustees are acting as quasi-trustees.

(3) In relation to Charitable Funds, powers exercised by the Trust as Corporate Trustee shall be exercised separately and distinctly from those powers exercised as the Trust. Accountability for Charitable Funds is to the Charity Commission.

(4) The powers of the Trust established under statute shall be exercised by the Trust Board meeting in public session except as otherwise provided for in Standing Order 3.16.

(5) The Trust Board has resolved that certain powers and decisions may only be exercised or made by the Trust Board in formal session. These powers and decisions are set out in the *Matters Reserved to the Trust Board and Scheme of Delegation.*

(6) The Trust Board and each Director individually shall at all times seek to comply with the Trust's Standards for Business Conduct and the NHS Foundation Trust *Code of Governance*, (updated July 2014) in the extent to which it applies. The Trust Board should also comply with the 7 Principles of Public Life (Nolan Principles).

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

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

(1) The Trust Board resolves that certain powers and decisions may only be exercised by the Trust Board in formal session. These powers and decisions are set out in the *Matters Reserved to the Trust Board and Scheme of Delegation* 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.

2.9 Lead Roles for Trust Board Members

(1) The Chair will ensure that the designation of Lead roles or appointments of Trust Board members as required by the Department of Health and Social Care or as set out in any statutory or other guidance will be made in accordance with that guidance or statutory requirement (e.g. appointing a Lead Trust Board Member with responsibilities for Infection Control or Safeguarding etc.).

3. MEETINGS OF THE TRUST BOARD

3.1 Calling meetings

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

(2) The Chair, or the Secretary, of the Trust may call a meeting of the Trust Board at any time.

(3) One third or more members of the Trust Board may requisition a meeting by giving written notice to the Secretary specifying the business to be carried out. The Secretary shall send a written notice to all Directors as soon as possible after receipt of such a request. If the Chair refuses, or fails, to call a meeting within seven days of a requisition being presented, the members signing the requisition may forthwith call a meeting.

3.2 Notice of Meetings and the Business to be transacted

(1) Before each meeting of the Trust Board, the Secretary shall give notice of the meeting, specifying the business proposed to be transacted at it and authorised for issue by the Chair. The notice shall be delivered or sent to every Director and 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 Chair, those Directors calling the meeting shall authorise that no business shall be transacted at the meeting other than that specified on the agenda, or emergency motions allowed under Standing Order 3.5.

(3) Before each meeting of the Trust Board a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed at the Trust's principal offices at least three clear days before the meeting, (required by the Public Bodies (Admission to Meetings) Act 1960 Section 1 (4) (a)). Details will also be displayed on the Trust's website.

(4) If, in exceptional circumstances, a decision or assurance is required outside the schedule of Trust Board or associated Committee meetings, the Chair (or Meeting Chair) has the authority from the Trust Board with two other members of the Trust Board or relevant Committee to take Chair's action and report back to the next meeting of the Trust Board or Committee.

3.3 Agenda and Supporting Papers

Supporting papers will be sent with the agenda and will be dispatched no later than three clear days before the meeting, save in emergency. Whenever possible, the agenda and supporting papers will be sent to members five Clear Days before the meeting. If sent by electronic transmission, dispatch prior to 12 noon will count as one Clear Day.

3.4 Setting the Agenda

(1) The Trust Board may determine that certain matters shall appear on every agenda for a meeting as "Standing Items".

(2) A Director desiring a matter to be included on an agenda shall make his/her request in writing to the Trust or Meeting Chair (as the case may be) and the Secretary at least 15 Clear Days before the meeting. In the case of Trust Board meetings, 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 Clear Days before a meeting may be included on the agenda at the discretion of the Trust or Meeting Chair.

(3) No business may be transacted at any meeting of the Trust Board which is not specified in the notice of that meeting unless the Trust or Meeting Chair, as the case may be, in his absolute discretion, agrees that the item and (where relevant) any supporting papers should be considered as a matter of urgency. The matter shall be recorded in the minutes of that meeting.

(4) Where a petition has been received by the Trust, the Chair shall include the petition as an item for the agenda of the next meeting.

3.5 Petitions and Motions

Petitions

(1) Where a petition has been received by the Trust, the Chair shall include it as an item for the agenda of the next meeting of the Trust Board. Any petitions received shall be given to the communication team and the item on the agenda shall be led by the Director with responsibility for public relations.

Motions

(2) A Director desiring to move or amend a motion shall send a written notice thereof at least ten Clear Days before the meeting to the Chair, who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations.

This Standing Order shall not prevent any motion being moved during the meeting, without notice, on any business mentioned on the agenda.

(3) A member of the Trust Board may give written notice of an emergency motion after the issue of the notice of meeting and agenda, and up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency and whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. If in order, it shall be declared by the Chair at the commencement of the business of the meeting as an additional item included in the agenda. The Chair's decision to include the item shall be final.

(4) At a meeting of the Trust Board, a motion, or an amendment to a motion, may be proposed by the Chair of the meeting or any member of the Board of the Directors present. It must also be seconded by another member.

(5) When a motion is under discussion or immediately prior to discussion, it shall be open to a member of the Trust Board to move:

(a) an amendment to the motion;
(b) the adjournment of the discussion, or the meeting;
(c) that the meeting proceed to the next business (to ensure objectivity, this motion may only be put by a member of the Trust Board who has not previously taken part in the debate and who is eligible to vote);
(d) that the motion should be now voted on (to ensure objectivity, this may only be put forward by a member of the Trust Board who has not previously taken part in the debate and who is eligible to vote);
(e) the appointment of an 'ad hoc' Committee to deal with a specific item of business;
(f) that a member/director be not further heard;
(g) a motion under Standing Order 3.16 to exclude the public, including the press.

(6) No amendment shall be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the motion. The Chair shall put such proposals to the vote without debate. If there are a number of amendments, they shall be considered one at a time. When a motion has been amended, the amended motion shall become the substantive motion before the meeting, upon which any further amendment may be moved.

(7) 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 Chair.

(8) The Chair should give the mover of the substantive motion under debate a right of reply, if not already exercised, if it is carried that:
(a) the meeting proceeds to the next business; or
(b) the motion should now be voted on; or
(c) the discussion on the matter is closed; or
(d) the motion is amended.

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

(10) A notice of a motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the member of the Trust Board who gives it and also the signature of three other members of the Trust Board who support it.

3.6 Adjournment

(1) Any meeting of the Trust Board may be adjourned by the Chair (whether or not it has

commenced) where, acting reasonably, it appears to the Chair that:
(a) any Directors wishing to attend the meeting cannot be properly or conveniently accommodated in the place appointed for the meeting;
(b) the conduct of the persons present prevents, or is likely to prevent, the orderly continuation of the business of the meeting; or
(c) an adjournment is otherwise necessary so that the business of the meeting may be properly conducted; and
(d) any business remaining on the agenda shall stand adjourned until that adjourned meeting to such time and place as the Chair shall state.

(2) In addition, the Chair may at any time adjourn the meeting where a quorum is present to another place and time with the consent of the meeting and shall be obliged to do so if directed by a majority of those present at the meeting.

(3) Notice of the adjourned meeting shall be dispatched to all Directors not present at the Trust Board meeting as soon as possible, but in any event no later than two days prior to the date of the adjourned meeting (if possible).

(4) No business other than that properly remaining on the agenda shall be discussed at the adjourned meeting.

3.7 Chair of Meeting and Chair's Ruling

(1) At any meeting of the Trust Board the Chair, if present, shall preside. If the Chair is absent from the meeting, the Vice-Chair (if the Trust Board has appointed one), if present, shall preside. If the Chair and Vice-Chair are absent, another Member of the Trust Board (who is not also an Officer Member of the Trust) as the members present shall choose shall preside.

(2) If the Chair is absent temporarily on the grounds of a declared conflict of interest the Vice Chair, if present, shall preside. If the Chair and Vice Chair are absent, or are disqualified from participating, such Non-Executive Director as the Directors present shall choose shall preside.

(3) All meetings shall be controlled by the Chair or the designated Meeting Chair and any ruling made by the person presiding over the meeting in relation to the conduct of the meeting shall be final.

(4) At the meeting, the decision of the Chair or the designated Meeting Chair on questions of order, relevancy and regularity and any other matters (including procedure on handling motions and interpretation of the Standing Orders) shall be final.

(5) Statements of Directors made at meetings of the Trust Board shall be relevant to the matter under discussion at the material time. The decision of the Chair of the meeting on questions of order, relevancy and regularity (including procedure on handling motions) and their interpretation of the Standing Orders and Standing Financial Instructions, at the meeting, shall be final.

3.8 Quorum

(1) No business shall be transacted at a meeting unless at least one-third of the whole number of the Chair and Members (including at least one Member who is also an Officer 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 Chair 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 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.

(4) The Trust Board may agree that its Directors can participate in its meetings by telephone, video or computer link. Participation in a meeting in this manner shall be deemed to constitute presence in person at the meeting.

(5) The requirement for at least two executive Directors to form part of the quorum shall not apply where the Executive Directors are excluded from a meeting (for example when the Trust Board considers the recommendations of the Remuneration and Nomination Committee).

3.9 Voting

(1) When an issue at a meeting of the Trust Board requires a vote, each voting member of the Trust Board shall have one vote each.

(2) Every motion or question put to a vote at a meeting shall be determined by a majority of the votes of the Chair of the meeting and Directors present and voting on the motion or question. In the case of the number of votes for and against a motion being equal, the Chair of the meeting shall have a second and casting vote.

(3) All questions put to the vote shall, at the discretion of the Chair or Meeting Chair, be determined by oral expression or by a show of hands. A paper ballot may also be used if Chair directs it or it is proposed, seconded and carried that a vote should be taken in this way.

(4) 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).

(5) If a member so requests, their vote shall be recorded in the minutes by name (other than by paper ballot).

(6) A Director may only vote if present at the time of the vote on which the question is to be decided. In no circumstances may an absent Member vote by proxy. Absence is defined as being absent at the time of the vote.

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

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

(9) For the voting rules relating to joint members see Standing Order 2.5.

(10) No resolution of the Trust Board shall be passed or opposed by a majority composed only of Executive Directors or Non-Executive Directors.

3.10 Suspension of Standing Orders

(1) Except where this would contravene any statutory provision, any direction made by the Secretary of State or the rules relating to quorum, any one or more of the Standing Orders may be suspended or waived at any meeting, providing that the meeting is quorate and that a majority of those present vote in favour of the suspension (including at least one member who is an Officer Member of the Trust and one member who is not). The reason for the suspension shall be recorded in the Trust Board's minutes.

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

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

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

3.11 Variation and Amendment of Standing Orders

(1) These Standing Orders shall not be varied except in the following circumstances:
   (a) that two thirds of the Trust Board members are present at the meeting where the variation or amendment is being discussed, and that at least half of the Trust's Non-Officer members vote in favour of the amendment;
   (b) providing that any variation or amendment does not contravene a statutory provision or direction made by the Secretary of State.

3.12 Waiver, variation and amendment of Standing Orders

(1) These Standing Orders shall not be waived or varied except in the following circumstances:
   a) Upon a notice of motion under SO 3.5;
   b) Upon a recommendation of the Chair or Chief Executive included on the agenda for the meeting;
   c) That two thirds of the Trust Board members are present at the meeting where the variation or amendment is being discussed, and that at least half of the Trust's Non-Executive directors vote in favour of the amendment;
   d) Providing that any variation or amendment does not contravene a statutory provision or direction made by the Secretary of State.

3.13 Reporting of Waivers of Standing Orders and Standing Financial Instructions

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

3.14 Record of Attendance

(1) The names of the Chair and Directors/Members present at the meeting shall be recorded.

3.15 Minutes

(1) The minutes of the proceedings of a meeting shall be drawn up and maintained as a record by the Secretary and submitted for agreement at the next ensuing meeting where they shall be signed by the person chairing the meeting.

(2) No discussion shall take place upon the minutes except upon their accuracy or where the Trust Chair or Meeting Chair (as the case may be) considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

(3) Minutes shall be circulated in accordance with Directors' wishes. Minutes of meetings shall be made available to the public except for minutes relating to business conducted when members of the public are excluded.

(4) A record of matters discussed in private will be drawn up and maintained as a record by the Secretary and approved by the Trust Board.

3.16 Admission of the Public and the Press

(1) The public and representatives of the press shall be afforded facilities to attend all formal meetings of the Trust Board but shall be required to withdraw upon the Trust Board resolving as follows:

"That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest."
Or
"That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Trust Board to complete business without the presence of the public."

(2) The Chair shall give such directions as he/she thinks fit in regard to the arrangements for meetings and accommodation of the public and the representatives of the press. This shall include deciding to expel or exclude any member of the public and/or press if the individual in question is interfering with or preventing the proper conduct of the meeting.

(3) Nothing in these Standing Orders shall require the Trust Board to allow members of the public or representative of the press to record proceedings in any manner whatsoever, other than in writing, or to make any oral report of proceedings as they may please without the prior agreement of the Trust Chair or Meeting Chair.

(4) Matters to be dealt with by the Trust Board following the exclusion of the public and representatives of the press above shall be confidential to the Directors. Members of the Trust Board and others in attendance at the request of the Trust Chair or Meeting Chair shall not reveal or disclose the content of papers or reports presented, or any discussion on these generally, which take place while the public and press are excluded, without express permission from the Chair. For the avoidance of doubt, this means that Members and Officers or any employee of the Trust in attendance shall not reveal or disclose the contents of papers marked 'In Confidence'. This also applies to minutes headed 'Items Taken in Private' outside of the Trust and this prohibition shall apply equally to the content of any discussion during the Trust Board meeting which may take place on reports or papers.

(5) The reasons for passing such a resolution shall be due to the sensitive or confidential nature of the discussion which might include information relating to:
a) employees, former employees or applicants;
b) occupiers or former occupiers of accommodation provided by or at the expense of the Trust;
c) patients or service users;
d) information relating to the financial or business affairs of a particular person;
e) the interests of public order, the meeting should be adjourned, for a reasonable, specified period, to enable the meeting to complete business without the presence of the public or the press;
f) publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted;
g) there is another special reason, which shall be stated in the resolution, which requires that members of the public and representatives of the press be excluded.

3.17 Observers at Trust Board meetings

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

4. APPOINTMENT OF COMMITTEES AND SUB-COMMITTEES

4.1 Committees of the Trust Board

(1) The Trust Board is required to establish an Audit Committee and a Committee dealing with Executive remuneration and nomination. The Trust Board shall also have a Charitable Funds Committee and further Committees dealing with Quality and Finance.

(2) The Trust Board may also establish (or dissolve) other formal Committees, sub-committees or working groups (collectively referred to as "Committees") consisting wholly or partly of the Chair and Directors as required to discharge the responsibilities of the Trust Board. The Trust

Board may elect to change the Committees of the Trust Board without requirement to amend these Standing Orders.

(3) There is no requirement to hold meetings of these Committees, sub-committees or working groups in public.

4.2 Terms of Reference of Committees

(1) Each such Committee, sub-committee or working group shall have such terms of reference and powers and be subject to such conditions the Trust Board shall decide. Such terms of reference shall be in accordance with the NHS Framework and any directions and guidance issued by the Secretary of State and shall have effect as of incorporated into the Standing Orders.

4.3 Appointment of Committees

(1) A Committee appointed under this Standing Order may, subject to such directions and guidance as may be given by the Trust Board, appoint sub- committees or working groups consisting wholly or partly of members of the Committee.

(2) Committees will normally only make recommendations and provide advice to the Trust Board unless the Trust Board has specifically delegated powers to the Committee.

(3) Where Committees are authorised to establish sub-committees or working groups, they may not delegate their powers to the sub-committees or working groups unless expressly authorised by the Trust Board.

4.4 Approval of Appointments to Committees

(1) The Trust Board shall approve the appointments of each of the Committees that it has formally constituted.

(2) The Trust Board shall elect one of the Directors to chair each of its Committees.

(3) Where the Trust Board determines, and legislation, regulations and directions or guidance issued by the Secretary of State permit that persons who are not members of the Trust Board shall be appointed to a Committee, the terms of such appointment shall be determined by the Trust Board. The Trust Board shall define the powers of such appointees and shall agree allowances and/or expenses. Save where permitted under legislation, persons who are not Directors will not have a vote.

4.5 Applicability of Standing Orders and Standing Financial Instructions to Committees

(1) The Standing Orders and Standing Financial Instructions of the Trust, as far as they are applicable, shall as appropriate apply to meetings and any Committees established by the Trust Board. In which case the term “Chair” is to be read as a reference to the Chair of the Committee as the context permits and the term “member” is to be read as a reference to a member of the Committee as the context permits.

4.6 Confidentiality

(1) A member of a Committee shall not disclose a matter dealt with by, or brought before, the Committee without its permission until the Committee shall have reported to the Trust Board or shall otherwise have concluded on that matter.

(2) A Director shall not disclose any matter reported to the Trust Board or otherwise dealt with by a Committee, notwithstanding that the matter has been reported or action has been concluded, if the Trust Board or Committee shall resolve that it is confidential.

5. ARRANGEMENTS FOR THE EXERCISE OF TRUST FUNCTIONS BY DELEGATION

5.1 Delegation of Functions to Committees, Officers or other Bodies

(1) Subject to such directions as may be given by the Secretary of State, the Trust Board may make arrangements for the exercise, on behalf of the Trust 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.

(2) The National Health Service Act 2006 as amended by the Health and Social Care Act 2012 allows for regulations to provide for the functions of Trust's to be carried out by third parties. In accordance with the Trust (Membership, Procedure and Administration Arrangements) Regulations 2000, the functions of the Trust may also be carried out in the following ways:
(a) by another Trust;
(b) jointly with any one or more of the following: NHS trusts, NHS Improvement (NHSI) or Clinical Commissioning Groups (CCGs);
(c) by arrangement with the appropriate Trust or CCG, by a joint committee or joint sub-committee of the Trust and one or more other health service bodies;
(d) in relation to arrangements made under S63 (1) of the Health Services and Public Health Act 1968, jointly with one or more NHSI, NHS Trusts or CCG.

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

5.2 Emergency Powers and Urgent Decisions

(1) The powers which the Trust Board has reserved to itself within these Standing Orders may, in emergency or for an urgent decision, be exercised by the Chief Executive and the Chair after having consulted at least one Non-Executive Director and one Executive Director. The exercise of such powers by the Chief Executive and Chair shall be reported to the next formal meeting of the Trust Board in public session for formal ratification.

5.3 Delegation to Committees

(1) The Trust Board shall agree from time to time to the delegation of executive powers to be exercised by Committees which it has formally constituted in accordance and which are comprised of members of the Executive Team. The constitution and terms of reference of such Committees and their specific executive powers shall be approved by the Trust Board.

(2) When the Trust 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.

(3) When the Trust Board is meeting or gathering but not in its capacity as the Trust Board, these Standing Orders shall not apply to any such meeting or gathering and no business shall be transacted or decisions made.

5.4 Delegation to Officers

(1) Those functions of the Trust which have not been retained as reserved by the Trust Board or delegated to other Committees shall be exercised on behalf of the Trust by the Chief Executive. The Chief Executive shall determine which functions he will perform personally and shall nominate Officers to undertake the remaining functions for which he will still retain accountability to the Trust.

(2) The Chief Executive shall prepare a Scheme of Reservation and Delegation *Matters Reserved to the Trust Board and Scheme of Delegation* identifying his proposals which shall be considered and approved by the Trust Board, subject to any amendment during the discussion. The Chief Executive may periodically propose amendment to the *Matters Reserved to the Trust Board and Scheme of Delegation* which shall be considered and approved by the Trust Board.

(3) Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to

the Trust Board of the Chief Executive, the Director of Finance, Executive Directors and other members of the Executive Team to provide information and advise the Trust Board in accordance with statutory or Department of Health and Social Care requirements. Outside these statutory requirements the roles of the Director of Finance, other Executive Directors and members of the Executive Team shall be accountable to the Chief Executive.

(4) The arrangements made by the Trust Board as set out in the *Matters Reserved to the Trust Board and Scheme of Delegation* shall have effect as if incorporated in these Standing Orders.

5.5 Over-riding Standing Orders (and Standing Financial Instructions)

(1) 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 Head of Corporate Affairs or the Chief Executive as soon as possible.

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

6.1 Policy Statements: General Principles

(1) The Trust will from time to time agree and approve policy statements/procedures which will apply to all or specific groups of staff employed by the Trust. The decisions to approve such policies and procedures will be recorded in the minutes of an appropriate Committee and will be deemed to be part of the Trust's Governance Manual.

(2) The Trust's Standing Orders and Standing Financial Instructions must be read in conjunction with the Governance Manual and the Trust's staff disciplinary and appeals procedures both of which shall have effect as if incorporated in these Standing Orders.

6.2 Standing Financial Instructions

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

6.3 Specific Guidance

(1) Notwithstanding the application of Standing Order 6 (1) above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following guidance and any other issued by the Secretary of State for Health and Social Care:
- (a) Caldicott Guardian 1997;
- (b) Human Rights Act 1998;
- (c) Freedom of Information Act 2000.
- (d) General Data Protection Regulations/Data Protection Act 2018;
- (e) Nolan Committee's First Report on Standards in Public Life (Seven Principles of Public Life) 1994

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

7.1 Declaration of Interests

(1) The Trust has a duty to have in place principles and procedures to minimise, manage and register potential conflicts of interests, which could be deemed, or assumed, to affect the decisions made by those involved in the business of the Trust.

(1) 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 shareholdings 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 Trust as soon as practicable

(2) If Trust Board members have any doubt about the relevance of an interest, this should be discussed with the Chair of the Trust or with the Secretary.

(3) When assessing the relevance of an interest, influence as well as the immediacy of the relationship is an important consideration. Therefore interests conferred through close family members are also to be disclosed.

(4) Financial Reporting Standard No 8 (issued by the Accounting Standards Board), superseded by FRS 102, specifies that influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

7.2 Exclusion of Chair and Members in Proceedings on Account of Pecuniary Interest

(1) A Director shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:
(a) of his membership of a company or other body, if he has no beneficial interest in any securities of that company or other body; or
(b) of an interest in any company, body or person with which he is connected which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a Director in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

(2) A Director has a duty not to accept a benefit from a third party by reason of being a Director or doing (or not doing) anything in that capacity.

7.3 Declarations by Directors

(1) Directors have a duty to inform the Head of Corporate Affairs in writing within seven Clear Days of becoming aware of the existence of a relevant or material interest.

(2) If a Director is present at a meeting of the Trust Board and has an interest of any sort in any matter which is the subject of consideration, the Director shall at the meeting and as soon as practicable after its commencement, disclose the fact. At the time the interest is declared, it should be recorded in the minutes of the meeting.

(3) Unless in the case of a Director, the conflict of interest has been authorised by the Trust Board, the Director concerned shall withdraw from the meeting and play no part in the relevant discussion or decision. For the avoidance of doubt, this includes voting on such an issue where a conflict is established. If there is a dispute as to whether a conflict of interest does exist, a majority will resolve the issue with the Chair having the casting vote.

(4) Any changes in interests should be officially declared at the next relevant meeting of the Trust Board following the change occurring.

(5) Relevant and material interests of Directors, including interests with companies, bodies or organisations likely or possibly seeking to do business with the NHS should be published in the Annual Report. The information should be kept up to date for inclusion in succeeding Annual Reports.

(6) The Head of Corporate Affairs shall be responsible for compiling and maintaining a Register of Interests to formally record interests of Trust Board members.

(7) These details will be kept up to date by means of an annual review of the Register and by virtue of a Standing Agenda item requiring Trust Board and Committee members to declare any relevant interests at the start of each meeting, following which the Register of Interests will be updated.

7.4 The Register of Interests

The register will be kept up to date and available to the public.

7.5 Standards of Business Conduct

(1) All Trust staff and members of the Trust Board must comply with the Trust's Standards of Business Conduct, based on the national guidance contained in HSG(93)5 on "Standards of Business Conduct for NHS Staff" and Conflicts of Interest Policy both of which are set out in the Governance Manual.

7.6 Interests of Officers in Contracts

(1) 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 has any pecuniary interest, direct or indirect, the Officer shall declare their interest by giving notice in writing of such fact to the Chief Executive or Trust's Head of Corporate Affairs as soon as practicable.

(2) An Officer should also declare to the Chief Executive or Director responsible for People any other employment or business or other relationship of a Close Family Member that conflicts, or might reasonably be predicted, could conflict with the interests of the Trust.

(3) The Trust will require interests, employment or relationships so declared to be entered in a Register of Interests of staff.

7.7 Canvassing of, and recommendations by, Members in Relation to Appointments

(1) Canvassing of members of the Trust or 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 shall be included in application forms or otherwise brought to the attention of candidates.

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

(3) Informal discussions outside appointments panels or Committees, whether solicited or unsolicited, should be declared to the panel or Committee in question.

7.8 Relatives of Members or Officers

(1) Insofar as they are aware of any such application, Directors and Officers of the Trust should ensure that relatives applying for positions within the Trust complete the section disclosing the relationship. They should also ensure relatives are made aware that failure to disclose such a relationship shall disqualify them as a candidate and, if appointed, render the individual liable to instant dismissal.

(2) The Chair, every other member of the Trust Board and Officer of the Trust shall disclose to the

Trust Board any relationship between himself and a candidate of whose candidature that Trust Board member or Officer is aware. It shall be the duty of the Chief Executive to report to the Trust Board any such disclosure made.

(3) Prior to appointment and acceptance of appointment, a new member of the Trust Board should disclose to the Trust Board if they are related to any Officer in the Trust.

7.9 Waiver of Standing Orders made by the Secretary of State for Health and Social Care

(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 Chair 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 „Chair" for the purpose of interpreting this waiver. For the purposes of paragraph 7.9(3) (below), the "relevant Chair" is:
- a) At a meeting of the Trust, the Chair of that Trust;
- b) At a meeting of a Committee:
  - i) In a case where the member in question is the Chair of that Committee, the Chair of the Trust;
  - ii) In the case of any other member, the Chair 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:

a) A member of Princess Alexandra Hospital NHS 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:
   i) Services under the National Health Service Act 1977; or
   ii) 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.

b) Where the "pecuniary interest" of the member in the matter which is the subject of consideration at a meeting at which he is present:
   i) 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;
   ii) Has been declared by the relevant Chair 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 Chair must consult the Chief Executive before making a declaration in relation to the member in question pursuant to paragraph 7.9(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.

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

8.1 Custody of Seal

(1) The Common Seal of the Trust shall be kept by the Chief Executive or Head of Corporate Affairs or other nominated Officer in a secure place.

8.2 Sealing of Documents

(a) The Trust Board shall nominate Officers with power to sign and or seal documents on their behalf and report such use to the Trust Board.

(b) Where it is necessary that a document be sealed, the seal shall be affixed in the presence of two Officers, duly authorised, and shall be attested by them. The two Officers shall not be from the originating department.

(c) A document purporting to be duly executed under the Trust's seal or to be signed on its behalf is to be received in evidence and, unless the contrary is proved, taken to be so executed.

(d) Before any building, engineering, property or capital document is sealed it must be approved and signed by the Director of Finance Director of Finance (or an Officer nominated by him/her), and authorised and countersigned by the Chief Executive (or an officer nominated by him/her who shall not be within the originating department).

8.3 Register of Sealing

(1) An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal.

(2) The Trust Board shall receive a report once the seal has been used. The report shall contain details of the seal number, the description of the document and date of sealing.

8.4 Signature of Documents

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

9. MISCELLANEOUS

9.1 Joint Finance Arrangements

(1) The Trust Board may confirm contracts to purchase from a voluntary organisation or a local authority using its powers under the National Health Services Act 2006 as amended by the Health and Social Care Act 2012 and any secondary legislation. The Trust 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 the National Health Services Act 2006 as amended by the Health and Social Care Act 2012 and any secondary legislation.

9.2 Governance Manual to be given to Directors and Officers

(1) It is the duty of the Chief Executive to ensure that existing Directors of the Trust Board, Officers and all new appointees are notified of their responsibilities within the Governance Manual. Updated copies shall be issued to staff designated by the Chief Executive and copies shall also be placed on the Trust's public folders to allow ease of access to the latest version.

(2) New designated officers shall be informed in writing and shall be made aware of, receive

copies or have access to the Governance Manual. Trust Board members and Senior Managers' will be expected to sign a declaration of receipt and intention to honour the requirements of the Governance Manual

9.3 Review of Standing Orders

(1) The Trust Board shall ensure that the Governance Manual is reviewed annually. The Governance Manual will be treated as a "Controlled Document" and updates will be communicated and distributed in accordance with the Controlled Document Policy.

STANDING FINANCIAL INSTRUCTIONS

10.0 INTRODUCTION

10.1 General

(1) The Code of Accountability requires that each NHS Trust shall give, and may vary or revoke, Standing Financial Instructions for the regulation of the conduct of members and officers in relation to all financial matters with which they are concerned. These Standing Financial Instructions (SFIs) are issued in accordance with the code. They shall have effect as if incorporated in the Standing Orders (SOs).

(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 accountability, probity, openness, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Matters Reserved to the Trust Board and Scheme of Delegation adopted by the Trust.

(3) These Standing Financial Instructions identify the financial responsibilities which apply to everyone working for the Trust and its constituent organisations including Trading Units and the Charitable Funds administered by the Trust in its role as Corporate Trustee. 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.

(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.

(5) Failure to comply with SFIs and SOs is a disciplinary matter that could result in dismissal and if fraud and/or corruption is suspected the matter may be referred to the Local Counter Fraud Specialist for investigation that may lead to a criminal investigation and criminal proceedings being commenced. .

(6) 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 Trust 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.

(7) All breaches of these regulations, including evidence of fraud or irregularity will be investigated in accordance with the Trust's People and Local Anti-Fraud Policies. All breaches of Financial Regulations will be referred to the Director of Finance and the Audit Committee. The Director of Finance will consider the necessary course of action, which may in certain circumstances include taking disciplinary action. .

(8) In the event that a staff or Board member becomes aware of an irregularity or breach of any of the SFIs, or systematic breach or abuse of the levels of delegated authority, and is concerned about the reporting or notification of such actions through the normal management channels, the Trust has a clear 'Speak Up Policy' which should be followed in such circumstances

10.2 Responsibilities and Delegation to the Trust Board

(1) The Trust 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 Trust Board and employees as indicated in the Scheme of Delegation document.

(2) The Trust Board has resolved that certain powers and decisions may only be exercised by the Trust Board in formal session. These are set out in the document entitled *Matters Reserved to the Trust Board and Scheme of Delegation.* All other powers have been delegated to Officers or such other Committees as the Trust Board has established.

(3) The Trust Board will delegate responsibility for the performance of its functions in accordance with the Matters Reserved to the Trust Board and Scheme of Delegation document adopted by the Trust Board.

10.3 The Chief Executive and Director of Finance

(1) The Chief Executive and Director of Finance will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control.

(2) Within the Standing Financial Instructions, it is acknowledged that the Chief Executive is ultimately accountable to the Trust Board, and as Accountable Officer, to the Secretary of State for Health and Social Care, for ensuring that the Trust 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 Chair and the Trust Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

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

(4) **The Director of Finance is responsible for**:
(a) implementing the Trust's financial policies and for co-ordinating 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:

(i) 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

(ii) the provision of financial advice to other members of the Trust Board and employees;
(iii) the design, implementation and supervision of systems of internal financial control;
(iv) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust Board may require for the purpose of carrying out its statutory duties.

(5) All members of the Trust Board and Employees, are responsible for:
(a) the security of the property, assets and resources 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, Matters Reserved to the Trust Board and Scheme of Delegation, and other relevant regulations.

Contractors and their employees

(1) 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.

(2) For all members of the Trust 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 Trust Board and employees discharge their duties must be to the satisfaction of the Director of Finance.

11.0 AUDIT

11.1 Audit Committee

(1) An independent Audit Committee is a central means by which a Board ensures effective internal control arrangements are in place. In addition, the Audit Committee provides a form of independent check upon the executive arm of the Board. In accordance with SOs the Board shall formally establish an Audit Committee, with clearly defined terms of reference, and in accordance with guidance from the NHS Audit Committee Handbook, to perform the following tasks. In accordance with Standing Orders, the Trust Board shall formally establish an Audit Committee, with clearly defined terms of reference, which will provide an independent and objective view of internal control by:

(a) Revising financial systems;
(b) Overseeing Internal and External Audit, and Counter Fraud Services;
(c) Reviewing the work and findings of the External Audit and considering the implications of and management's responses to their work;
(d) ensuring that the systems of financial control and reporting to the Board, including those of internal control, are subject to review as to completeness and accuracy of the information provided to the Board;
(e) Reviewing financial and information systems and monitoring the integrity of the financial statements and reviewing significant financial reporting judgments;
(f) Reviewing 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;
(g) Reviewing waivers to SFI's;
(h) Reviewing schedules of losses and compensations and making recommendations to the Board;
(i) Review the annual report and financial statements prior to submission to the Board, focusing particularly on;
The wording in the annual governance statement and other disclosures relevant to the Terms of Reference of the Committee;
    i) Changes in, and compliance with, accounting policies and practices;
    ii) Unadjusted misstatements in the financial statements;
    iii) Major judgmental areas;
    iv) Significant adjustments resulting from audit.
(j) Reviewing the external auditor's report on the financial statements and the annual audit letter;
(k) Reviewing any incident of fraud or corruption or possible breach of ethical standards or legal or statutory requirements that could have a significant impact on the Trust's published financial accounts or reputation;
(l) Reviewing 'value for money' audits reporting on the effectiveness and efficiency of the selected departments or activities;
(m) Ensure compliance and reviewing the mechanisms and levels of authority in operation (e.g.

SOs, SFIs, Delegated limits) and make recommendations to the Trust Board;
(n) Reviewing the scope of both internal and external audit, including agreement on the range of audits per year.
(o) Ensuring the adequacy of all risk and control related disclosure statements (within the Board Assurance Framework, Corporate risk register, any other disclosure).
(p) Acting as the Trust's Auditor Panel in line with the Local Audit and Accountability Act 2014

(2) As noted above, if for any reason these SFIs 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.

(3) Where the Audit Committee considers there is evidence of ultra vires transactions, improper acts, or any other important matters that the Committee wishes to raise, the Chair 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 & Social Care. (Having advised the Director of Finance in the first instance). The matter should be raised to the Director of Finance in the first instance and the Local Counter Fraud Specialist (LCFS) should be involved where issues of fraud, bribery and corruption are suspected.

(4) 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.

11.2 Director of Finance

(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 the Internal Audit is adequate and meets the NHS mandatory audit standards;
(c) ensuring that the Trust maintains adequate Counter Fraud and Corruption arrangements and deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption;
(d) ensuring that an annual internal audit report is prepared for the consideration of the Audit Committee and the Trust 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 and Social Care 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) 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 Trust Board or employees of the Trust;
(c) the production of any cash, stores or other property of the Trust under the Trust Board and an employee's control; and
(d) explanations concerning any matter under investigation.

11.3 Role of Internal Audit

(1) Internal Audit will review, appraise and report upon:

(a) the extent of compliance with, and the financial effect of, relevant establish 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) Ensure compliance with established policies (including behavioural and ethical expectations), procedures, laws and regulations;
(e) Safeguard the organisation's assets and interests from losses of all kinds, including those arising from fraud, Waste, extravagance, inefficient administration and poor value for money or other causes;
(f) Internal Audit shall also independently verify the Assurance Statements in accordance with relevant guidance;
(g) the economic acquisition and the efficient use of resources;
(h) efficient operation of systems and departments
(i) the adequacy of follow up action to audit reports;
(j) other matters as requested by directors and senior managers and agreed by the Head of Internal Audit, or considered appropriate by the Head of Internal Audit

(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.

(3) The Head of Internal Audit will provide to the Audit Committee:

(a) A risk-based annual plan of internal audit work, agreed with management for approval by the Audit Committee, based upon the management's assurance framework that will enable the auditors to collect sufficient evidence to give an opinion on the adequacy and effective operation of the organisation;
(b) Regular updates on progress against plan;
(c) Reports of management's progress on the implementation of actions agreed as a result of internal audit findings;

(4) Additional reports as requested by the Audit Committee

(5) The Head of Internal Audit will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chair and Chief Executive of the Trust.

(6) Internal audit reports will be distributed to relevant directors and managers who will be responsible for the implementation of agreed recommendations. Failure to act on audit reports within a reasonable period will be reported to relevant directors and the Audit Committee.

(7) The Head of Internal Audit 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 Head of Internal Audit. The agreement shall comply with the guidance on reporting contained in the Public Sector Internal Audit Standards (PSIAS)

(8) The appointment and termination of the Head of Internal Audit and/or the Internal Audit Service must be approved by the Audit Committee.

11.4 External Audit

(1) The External Auditors are appointed by the Trust under the powers set out in the Local Audit and Accountability Act 2014.

(2) The External Auditor should annually express an opinion on his ability to rely on the work of internal audit.

(3) The External Auditor's statutory responsibilities and powers are set out in the 'Local Audit and

Accountability Act 2014' and the Code of Audit Practice issued by the Comptroller and Auditor General of the National Audit Office.

11.5 Fraud, Bribery and Corruption

(1) In line with their responsibilities and as set out in the Anti-Fraud, Bribery and Corruption Policy**,** the Chief Executive and Director of Finance shall monitor and ensure compliance with the Government Functional Standard 013 well as NHS contractual obligations, in addition to any other requirements as may be instructed by NHS Counter Fraud Authority.

(2) The Bribery Act 2010 established corporate and individual offences as defined in 16.1 of these SFIs. All staff and contractors must be made aware of the Act to ensure compliance. Any breach of the Act may result in criminal proceedings being commenced.

(3) The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist as specified by the NHS Standard Contract.

(4) The LCFS shall report to the Director of Finance, and shall work with staff in the NHS Counter Fraud Authority and current Area Anti-Fraud Specialist (AAFS) in accordance with the NHS Standard Contract.

(5) The Director of Finance will prepare a 'Counter Fraud Policy and Corruption Strategy Policy and Procedures' that sets out the action to be taken both by persons detecting a suspected fraud and those persons responsible for investigating it.

(6) The Local Counter Fraud Specialist will provide a written report, at least annually, on counter fraud work within the Trust.

11.6 Security Management

(1) In line with their responsibilities, the Chief Executive will monitor and ensure compliance with Directions issued under the NHS Standard Contract guidance on NHS security management.

(2) The Chief Executive shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS) as specified by the NHS Standard Contract on NHS security management.

(3) The Trust shall prepare a 'Security Policy' that sets out measures to protect staff, visitors, premises and assets.

(4) The Trust shall nominate a lead Non-Executive Director to be responsible to the Board for NHS security management.

(5) The Chief Information Officer is the Trust's Senior Information Responsible Officer (SIRO) and is responsible for ensuring that the Trust has a robust Information Governance Framework in place and IM& T Support Services within the organisation is robust, resilient and supported by a comprehensive Business Continuity Plan in managing cyber security.

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

12.1 Preparation and Approval of Plans and Budgets

(1) The Chief Executive will compile and submit to the Trust Board an annual business plan which considers the Trust's financial requirements, forecast income and expenditure plans and cash resources. The annual business plan will contain;

(a) a statement of the significant assumptions on which the plan is based;

(b) details of major changes in workload, delivery of services or resources required to achieve the plan.

(2) This plan will be in line with the requirements of NHSE/I.

(3) 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 Trust Board. Such budgets will:
(a) be in accordance with the aims and objectives set out in the annual business plan;
(b) accord with workload and People plans;
(c) be produced following discussion with appropriate budget holders;
(d) be prepared within the limits of available funds; and
(e) identify potential risks.

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

(5) Budget holders must provide information as required by the Director of Finance to enable budgets to be compiled.

(6) All budget holders will sign up to their allocated budgets and ongoing compliance with the Trusts Governance Framework at the commencement of each financial year.

(7) 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 their budgets successfully.

12.2 Budgetary Delegation

(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 in accordance with the Trusts virement policy;
(e) achievement of planned levels of service; and
(f) the provision of regular reports.

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

(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 in accordance with the Trust's virement policy.

(4) Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive.

(5) Budgets shall only be used for the purpose for which they were established.

12.3 Budgetary Control and Reporting

(1) The Director of Finance will devise and maintain systems of budgetary control. These will include:
(a) monthly financial reports to the Trust Board in a form approved by the Trust Board containing:
(i) A Statement of Comprehensive Income to date showing trends and forecast year-end position;
(ii) A Statement of Financial Position showing trends and forecast year-end position;

(iii) Movements in cash and projected outturn against plan;
(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) Identification and evaluation of financial risks to the achievement of plan and their potential mitigation

(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 People budgets;
(d) monitoring of management action to correct variances; and
(e) arrangements for the authorisation of budget transfers.

(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 Director of Finance or the Chief Executive;

(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 virement policy; and
(c) no permanent or temporary employees are appointed without the approval of the Chief Executive other than those provided for within the available resources and People establishment as approved by the Trust Board.

(3) The rules and process that apply in the approval of budget virement are set out in the Trust's virement policy and include:
a) A virement is not normally permitted:
i) Between pay and non-pay;
ii) Between non-recurrent and recurrent expenditure;
iii) Where it would be in breach of the rules on earmarked or ring-fenced funding arrangements;
iv) Where it would increase management costs (unless approved in writing by the Executive Team).
b) Adjustment to reflect changes that could not have been foreseen at the start of the year.
c) Where planned actions by managers mean that resources previously allocated for one purpose are no longer required for that purpose.
d) Authority delegation levels.

(4) The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the annual business plan and a balanced budget.

(5) The Director of Finance shall keep the Chief Executive and the Trust Board informed of the financial consequences of changes in policy, pay awards and trends affecting budgets, and shall advise on the financial and economic aspects of future plans and projects.

(6) The Trust has a No PO No Pay (No Purchase Orders No Pay) policy in place, which requires Budget holders to inform suppliers to reference the Purchase Order numbers on their invoice to ensure immediate payment.

12.4 Capital Expenditure

(The general rules applying to delegation and reporting shall also apply to capital expenditure.

12.5 Monitoring Returns

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

requisite monitoring organisation e.g. NHSE/I.

13. ANNUAL ACCOUNTS AND REPORTS

13.1 Governance Process

(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 Social Care, the Trust's accounting policies, and generally accepted accounting practice;
- (b) prepare and submit annual financial reports to the Department of Health and Social Care certified in accordance with current guidelines;
- (c) submit financial returns to the Department of Health and Social Care and NHSE/I for each financial year in accordance with the timetable prescribed by the Department of Health and Social Care.

(2) The Trust's annual accounts must be audited by an auditor appointed by the Trust in accordance with the Local Audit and Accountability Act 2014. The Trust's audited annual accounts must be presented to a public meeting and made available to the public.

(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 and Social Care's Group Accounting Manual.

(4) The Trust's Annual Report and audited Annual Accounts must be presented to a public meeting on or before 30 September each year. The document will comply with the Department of Health and Social Care's Group Accounting Manual

14. BANK ACCOUNTS

14.1 General

(1) The Director of Finance is responsible for managing the Trust's banking arrangements in accordance with the Trust's Cash and Treasury Management Policy and for advising the Trust on the provision of banking services and operation of accounts.

(2) The Performance and Finance Committee will, on behalf of the Trust Board, approve the Trusts Cash and Treasury Management Policy, operational cash management procedures and the use of banking institutions.

14.2 Bank and Government Banking Service Accounts

(1) The Director of Finance is responsible for:
- a) Government Banking Service (GBS) accounts;
- b) establishing separate bank accounts for the Trust's non-exchequer funds;
- c) ensuring payments made from bank accounts do not exceed the amount credited to the account except where arrangements have been made;
- d) ensuring that GBS accounts do not become overdrawn;
- e) reporting to the Trust Board all arrangements made with the Trust's bankers for accounts to be overdrawn;
- f) monitoring compliance with Department of Health and Social Care guidance on the level of cleared funds;
- g) establishing a Working Capital Facility in the manner required by NHSE/I.

14.3 Banking Procedures

(1) The Director of Finance will prepare detailed instructions on the operation of GBS and other bank

accounts which must include:
(a) the conditions under which the GBS and other bank accounts are to be operated;
(b) those approved to sign cheques or other orders drawn on the Trust's accounts.

(2) The Director of Finance must advise the Trust's bankers in writing of the conditions under which the account will operate.

(3) All funds shall be held in accounts in the name of the Trust. No officer other than the Director of Finance shall open any bank account in the name of the Trust.

(4) The Director of Finance shall be authorised to make payments using BACS, CHAPS and Faster Payment systems and to establish appropriate procedures in accordance with locally agreed arrangements.

(5) All payment instruments shall be treated as controlled stationery, with appropriate records being maintained.

(6) Where payments are made by direct debit, each mandate shall be approved by the Director of Finance and in accordance with the bank mandate requirements.

14.4 Tendering and Review

(1) The Director of Finance will review the 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 banking business.

(2) Competitive tenders for commercial banking services should be sought at least every five years. The results of the tendering exercise should be reported to the Trust Board. This review is not necessary for GBS accounts.

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

15.1 Income Systems

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

(2) The Director of Finance is also responsible for the prompt banking of all monies received.

15.2 Raising Invoices

(1) All invoices must be raised by the Finance Directorate's Debtors Section, unless specifically agreed otherwise by the Director of Finance.

15.3 Fees and Charges

(1) The Trust shall follow the advice in the 'Approved Costing Guidance' published by NHSI in setting prices for NHS service agreements.

(2) The Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by Statute. Independent professional advice on matters of valuation shall be taken as necessary. Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered the guidance in the Department of Health and Social Care's Commercial Sponsorship – Ethical Standards in the NHS' shall be followed.

(3) The Director of Finance will lead and coordinate an executive review of fees and charges on an annual basis.

(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.

(4) No officer of the Trust, except within the boundaries of any delegated authority, is allowed to confirm or agree with a third party (whether NHS or Non-NHS), any reduction to or waiver of the Trusts normal charges, without the prior express authority of the Director of Finance if less than £100,000, the Trust Board if over £100,000.

15.4 Debt Recovery

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

(2) The Director of Finance is responsible for establishing and maintaining procedures for the issuing of credit notes and the write-off of debt, within delegated limits, the Trust must demonstrate all reasonable steps have been taken to secure payment.

(3) Income not received should be dealt with in accordance with losses procedures.

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

(5) A list of amounts written off shall be submitted for information by the Director of Finance to the Audit Committee at every meeting. Any proposed write offs over £50,000 will also require the approval of the Audit Committee.

15.5 Security of Cash, Cheques and other Negotiable Instruments

(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.

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

(3) Any loss or shortfall of cash, cheques or other negotiable instruments, however occasioned, shall be reported to the Director of Finance. Any significant trends should also be reported. Where there is prima facie evidence of fraud, bribery or corruption this should be reported in accordance with the Trust's Fraud and Corruption Reporting Arrangements and the guidance provided by NHS Counter Fraud Authority. The referral will be investigated by the Trust counter fraud specialist. Where there is no evidence of fraud or corruption the loss should be dealt with in line with the Trust's Losses and Compensations Procedures.

(4) 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.

(5) The opening of incoming post should wherever possible be undertaken by two officers, unless otherwise formally agreed by the Director of Finance. All cash, cheques, postal orders and other forms of payment received by an officer other than a cashier shall be entered immediately in an approved form of register. The remittances shall be passed to the cashier from whom a signature shall be obtained.

(6) An official receipt shall be made out by the cashier for all cash received, together with a reason for the payment. Receipts for cheque payments etc. will be issued on demand.

(7) The opening of cash tills, telephone and other coin operated machines, and the counting and recording of the takings shall be undertaken by two officers together.

(8) Any employee who has any indication that the safe custody of cash etc. on the Trust's premises or in transit may be at risk, must immediately notify the Director of Finance.

(9) 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.

16. TENDERING AND CONTRACTS PROCEDURES

16.1 General

The Trust shall use Hertfordshire and West Essex Procurement function for purchasing of all goods and services, unless the Chief Executive or nominated officer deems it inappropriate. The decision to use alternative sources must be documented. Where the Trust does not use Hertfordshire and West Procurement; the Trust shall procure goods and services in accordance with the procurement procedures approved by the Director of Finance.

16.2 Duty to comply with Standing Orders and Standing Financial Instructions

(1) The procedure for making all contracts by or on behalf of the Trust shall comply with these SOs and SFIs (except where Standing Order No. 3.13 Suspension of SOs is applied).

(2) No member of staff shall sign or enter into any contract on behalf of the Trust which may commit expenditure in excess of their authorised limit set out in the Scheme of Delegation without the prior approval of either the Chief Executive or Director of Finance. It is the responsibility of the member of staff to fully understand the legal and financial consequences of the contract signed, and to have sought the advice and approval of the Chief Executive or Director of Finance as appropriate.

(3) All personnel involved in tendering and contacting activities must be aware of the Bribery Act 2010 and must ensure that all dealings with other organisations and their staff do not bring them in breach of the Act that could leave them open to investigation by the Local Counter Fraud Specialist, and criminal proceedings being commenced.

(4) The following information has been extracted from the Bribery Act 2010, and related guidance documents, and serves to identify the main offences covered within the Act. All those involved in the tendering and contracting process should be aware that the Bribery Act 2010 broadly defines the following:

(a) Two general offences of bribery:
  i) Offering or giving a bribe to induce someone to behave, or to reward someone for behaving, improperly; and
  ii) requesting or accepting a bribe either in exchange for acting improperly, or where the request or acceptance is itself improper;

(b) The new corporate offence by a company or limited liability partnership of negligently failing to prevent bribery being given or offered by an employee or agent on behalf of that organisation.

16.3 Statutory Legislation and Guidance

(1) The Trust may only enter into contracts which align with the statutory powers delegated to it by the Secretary of State. The main legislation that applies to procurement activity are Public Contract Regulations 2015 (PCR) which govern public procurement.

(2) These regulations are supported by statutory guidance published by the Government. This includes statutory guidance published by the Department of Health and Social Care, NHS England and Improvement and Procurement Policy Notes (PPNs) published by the Cabinet Office or Crown Commercial Services. Please note that this list is not exhaustive, and any regulation or statutory guidance which is applicable to procurement and contracting shall have effect as if incorporated in these SFIs.

(3) Any changes in legislation or statutory guidance that will impact on the procedures set out within these SFIs will be reviewed by the Trust Procurement Department to ensure compliance in procurement practice.

16.3 NHS Finance Manual and other Department of Health & Social Care (DHSC) Guidance

(1) The Trust shall comply as far as is practicable with the requirements of the Department of Health & Social Care "NHS Finance Manual" and “Estate code” The efficient management of healthcare estates and facilities (HBN 00-08) - Publications - GOV.UK in respect of capital investment and estate and property transactions

16.4 Capital Investment and Business Cases

(1) The Trust shall comply as far as is practicable with the requirements of the NHSI’s *Capital Regime and Investment Business Case Approvals Guidance for NHS Trusts* in respect of capital investment and estate and property transactions. The Trust will also comply as far as is practicable with current best practice required by the Department of Health and Social Care or the Cabinet Office.

16.5 Private and Alternative Financing for Capital Procurement

(1) Private and Alternative Financing must be authorised by the Trust Board.

16.6 Formal Competitive Tendering

(1) The Trust shall ensure that competitive quotations, proposals or tender, as appropriate are invited for:

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

(b) the provision of services including all forms of management consultancy services (other than specialised services sought from or provided by the Department of Health and Social Care or NHS body, where a competitive process is prescribed when deemed necessary);

(c) for the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens);

(d) for disposals.

16.7 Waiver Process

(1) Where the Trust elects to invite tenders for the supply of goods and/or services these Standing Orders and Standing Financial Instructions shall apply as far as they are applicable to the tendering procedure. The related procurement directive, as applicable, should also be observed.

(2) The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a management consultant originally appointed through a competitive procedure.
All waivers should be approved by:
i) Director of Finance and Budget Holder, up to £25,000;
ii) Director of Finance, £25,000 to £250,000;
iii) Director of Finance and Chief Operating Officer, £251,000 to £500,000; or
iv) The Board, over £500,000

(3) Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded in an appropriate Trust record and reported to the Audit Committee at each meeting.

(4) Waivers must be documented using the standard waiver form at Appendix F and attached to the GHX procurement system maintained by the ICS procurement function. Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded in an appropriate Trust record and reported to the Audit Committee at each meeting.

(5)

a) Formal tendering procedures need not be applied where:
i) the estimated expenditure or income does not, or is not reasonably expected to, exceed £50,000 including VAT;
ii) the supply is proposed under special arrangements negotiated by the Department of Health and Social Care or its agencies (including Supply Chain Corporation Limited SCCL). in which event the said special arrangements must be complied with;
iii) national/regional public sector contracts or contract frameworks are in place;
iv) a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members;
v) the requirement is covered by an existing contract and the value of the variation is within +/- 10% of contract value, and is within originally specified scope.

b) Formal tendering procedures may be waived in the following circumstances and where supporting evidence is provided:
i) Urgency: 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;
ii) Specialist knowledge available from single source: where specialist expertise is required and is available from only one source. This provision does NOT cover management consultancy;
iii) Continuity (1): 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; However, in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering;
iv) Compatibility: where the objects of procurement forms a compatibility complex with other equipment in use, in the Trust;
v) Standardised products or equipment: where the objects of procurement forms part of standardised products or equipment formulary in the Trust. This justification MUST not be used however, if there is a clear business case to alter standard practice or change suppliers. Where appropriate, expenditure relating to standardised products MUST be reviewed if it is expected to exceed tendering threshold required by Public Contracts Regulations 2015;
vi) Extension pending conclusion of a tendering process;
vii) There is a sole supplier of the goods and/or services

16.8 List of Approved Firms

(1) The Trust shall ensure that the firms/individuals invited to tender are technically competent to undertake to fulfil the supply of goods and services. Contracts should only be awarded to firms/individuals who are financially and technically competent. To reflect requirements of Public Contracts Regulation 2015,

Contracting/Tendering Procedure, Systems and Documentation

Procurement in the Trust is facilitated by the ICS Procurement Function, which facilitate the procurement of requirements in accordance with the provisions of the section relating to 'Tendering and Contracting Procedures' in the Trusts SFI's and the Public Contract Regulations 2015 (PCR).

(1) The PCR's requires NHS Trusts to publish electronically new procurement opportunities with an aggregated whole life cost of over £50,000 on Contracts Finder and opportunities over the PCR Threshold. These opportunities must be published through the procurement eTendering system (Delta e-sourcing). This system provides a complaint and auditable system compliant with trust SFI's and the principles of the PCR's which are:

- Transparency
- Equal Treatment
- Non-discrimination
- Proportionality

Features of the system are:

- Statutory advertising of requirements in Contracts Finder and / or the Official Journal of the European Union.
- The application of mandatory minimum time periods for the submission of tenders.
- An auditable communications trail with potential suppliers.
- A sealed tender box preventing access to bids prior to the closing date and controlled access to information to only those involved in the project.
- Publication of mandatory award notices in Contracts Finder and / or the Official Journal of the European Union.
- Audit of all activity relating to the process, as every action is recorded and time and date stamped.

As set out in the schedule below, the Trust's approach is that a competitive tendering process (or requests for quotations) should be followed where the estimated spend, aggregated over the expected contract duration, exceeds £25,000.

(2) The Trust Procurement Department has created tender templates to cover all aspects of the sourcing process. This documentation sets out key information, such as: how to submit a bid, the specification, the evaluation criteria, the Conditions of Contract and a format for submitting a proposal. Further information on procurement processes are covered in the Trust SFI's and in the Smart Together Procurement Policy. The procurement department must be consulted on all requirements over the quotation threshold.

(3) The Procurement will be responsible for managing and maintaining a Contract Register indicating when contracts will expire, based on information provided by Staff

(4) Procurement are responsible for ensuring there are templates available for tender documents covering all aspects of the sourcing process.

(5) The Director of Procurement (ICS Director of Procurement) will be responsible for the publication on behalf of the Trust of all Find a Tender Service (FaTS) contract advertisement, award and other notices and statistical returns required by the Public Contract Regulations. Information kept by the Director of Procurement on procurements undertaken will be published on the E-Procurement System and Contracts Finder, including specifications, contract terms and contract expenditure (tender documents and

award notices will be published).

(6) The Director of Procurement will provide procurement support and advice on the application of these SFIs in relation to all procurements across the Trust and ensure that any advice or support is in line with current guidance and best practice

(7) The Director of Procurement will maintain a list of approved framework agreements which can be used across the Trust

16.9 Tender reports to the Director of Finance and the Trust Board

(1) Tender Reports must be submitted for ratification by the Director of Finance for all potential contracts over £100,000 to £500,000. Contracts over £250,000 are subject to approval by TME and contracts over £500,000 are subject to approval by the Trust Board.

(2) Contracts cannot be signed or Purchase Orders raised until ratification of the Tender Report has been confirmed

16.10 Financial Standing and Technical Competence of Contractors

(1) The Financial Standing and Technical Competence of contractors will initially be assessed during the tendering process by "self-certification" by the Contractor. The Use of Pre- qualification questionnaires (PQQs) are no longer permitted for contracts below the OJEU Threshold of £122,976 for Supplies and Services, or £4.733M for Works (excluding VAT). The Trust Procurement Department will formally assess these competences immediately prior to award of a contract (to the short-listed contractors). This may involve taking up formal references, and consideration of the Credit Reference agencies. E.g. Dun & Bradstreet report.

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16.11 Procurement & Supplies Management

(1) The Procurement Team will seek to ensure that all contractors who the Trust enters into a contract with are technically and financially competent to undertake to fulfil the supply of goods and services.

Quotations: Competitive and non-competitive

16.12 General Position on Quotations

(1) A minimum of three Quotations is required where formal tendering procedures are not adopted and where the intended expenditure or income does not exceed, or is reasonably expected not to exceed, £25,000 excluding VAT, in line with central government procurement guidelines

16.13 Quotations to be within Financial Limits

(1) 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.

16.14 Quotations

Competitive Quotations

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

(2) Quotations should be in writing unless the Chief Executive determines it is impractical to do so, in which case quotations may be obtained by telephone. Confirmation of telephone quotations should be obtained as soon as possible, and the reasons why the telephone

quotation was obtained should be set out in a permanent record and written quotation should be requested immediately.

(3) All quotations should be treated as confidential, and should be retained for inspection.

(4) 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.

Non-Competitive Quotations

(1) 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 Chief Executive, possible or desirable to obtain competitive quotations;
ii. The supply of goods or manufactured articles of any kind which are required urgently and are not obtainable under existing contracts; or
iii. Miscellaneous services, supplies and disposals.

(2) Instances where formal competitive tendering or competitive quotation is not required

(3) Where competitive tendering or a competitive quotation is not required, then the Trust should adopt one of the following alternatives:

i. The Trust shall use the NHS Supply Chain 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.
ii. If the Trust does not use NHS Supply Chain, and where tenders or quotations are not required because expenditure is below that stated in the Trust Scheme of Delegation, then the Trust shall procure goods and services in accordance with procurement procedures approved by the Director of Finance

16.15 Authorisation of Tenders and Competitive Quotations

(1) 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 staff to the value of agreed authorised limits, as specified in the Scheme of Delegation.

(2) These levels of authorisation may be varied or changed and need to be read in conjunction with the Scheme of Delegation.

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

16.16 Notifying Successful and Unsuccessful Bidders

(1) Successful and unsuccessful bidders are notified in accordance to the applicable standstill period.

16.17 Compliance Requirements for all Contracts

(1) The Trust 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) Statutory provisions, including any applicable Public Contract Regulations;
(c) Any applicable NHS Standard Contract conditions

(d) Any relevant NHS directions including the NHS Finance Manual, Estate code and guidance on the Procurement and Management of Consultants (which although archived and not replaced, is still considered good practice and should be followed)

(e) 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.
(f) Care Quality Commission requirements
(g) In all contracts made by the Trust, the Board shall endeavour to obtain best value for money. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust

16.18 Personnel and Agency or Temporary Staff Contracts

(1) The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.

(2) Any situations where it is proposed that agency staff should be remunerated at a rate above the agency cap rate must be approved in accordance with the Trusts Policy in this area.

(3) Any Bank staff rate variations to be approved by Chief Executive and Director of Finance.

16.19 Disposals

(1) 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 medical devices or equipment, which should be disposed of in accordance with the Management of Medical Devices & Equipment policy of the Trust;
(c) Items to be disposed of with an estimated sale value of that which is stated within the Trust's Scheme of Delegation: 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 Department of Health and Social Care guidance has been issued but subject to compliance with such guidance.

16.20 In-House Services

(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.

(2) In all cases where the Trust 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 that stated within the Trust Scheme of Delegation, a non-officer member should be a member of the evaluation team;
(d) The evaluation team shall make recommendations to the Trust Board.
(e) 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
(f) The Chief Executive shall nominate an officer to oversee and manage any resulting contract on behalf of the Trust
(g) These SFIs shall not only apply to expenditure from Exchequer funds but also to works, services and goods purchased from the Trust's charitable trust funds and private resources

16.21 Applicability of Standing Financial Instructions on Tendering and Contracting to Charitable Funds

(1) The general principles of these Standing Financial Instructions shall apply to works, services and goods purchased from the trust's Charitable Funds and private resources, including charities funding.

16.22 Determination of Contracts for Failure to Deliver Goods or Materials

(1) There shall be inserted in every written contract for the supply of goods or materials a clause to secure that, should the contractor fail to deliver the goods or materials or any portion thereof within the time or times specified in the contract, the Trust may without prejudice determine the contract either wholly or to the extent of such default and purchase other goods, or material of similar description to make good;

a) such default, or

b) in the event of the contract being wholly determined the goods or materials remaining to be delivered. The clause shall further secure that the amount by which the cost of so purchasing other goods or materials exceeds the amount which would have been payable to the contractor in respect of the goods or materials shall be recoverable from the contractor.

17. NHS SERVICE AGREEMENTS FOR PROVISION OF SERVICES

17.1 Service Agreements

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

(2) All Service Agreements should aim to implement the agreed priorities contained within the Annual Plan and wherever possible, be based upon integrated care pathways to reflect expected patient experience.

Reports to Board on Service Agreements - The Chief Executive, as the Accountable Officer, will ensure that regular reports are provided to the Board or nominated committee detailing actual and forecast income from the Service Agreements. This will include information on costing arrangements, which should be based upon divisions.

17.2 Cancellation of Contracts

(1) Except where specific provision is made in model Forms of Contracts or Standing Schedules of Conditions approved for use within the NHS, there shall be inserted in every written contract a clause empowering the Trust to cancel the contract and to receive from the contractor the amount of any loss resulting from such cancellation:

(a) if the contractor shall have offered, or given or agreed to give, any person any gift or consideration of any kind as an inducement or reward (contrary to the Bribery Act 2010) for doing or forbearing to do or having done or forborne to do any action in relation to the obtaining or execution of the contract or any other contract with the Trust; or

(b) for showing or forbearing to show favour or disfavour to any person in relation to the contracts or any other contract with the Trust; or

(c) if the like act as shall have been done by any person employed by him/her or acting on his/her behalf (whether with or without the knowledge of the contractor); or

(d) if in relation to any contract with the Trust the contractor or any person employed by him/her or acting on his/her behalf shall have committed any offence under the Bribery Act 2010 and other appropriate legislation.

17.3 Involving Partners and Jointly Managing Risk

(1) A good SLA / contract 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 / contract will apportion responsibility for handling a particular risk to the party or parties 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.

18. TERMS OF SERVICE, ALLOWANCES AND PAYMENT OF EXECUTIVE DIRECTORS OF THE TRUST BOARD

18.1 Committee dealing with Remuneration and Terms of Service

(1) In accordance with Standing Orders the Trust Board shall appoint a Remuneration Committee of Non-Executive Directors. The Remuneration Committee shall have delegated responsibility for setting the remuneration and terms of service of the Trust's Chief Executive, Executive Directors and Very Senior Managers within the overall pay framework of the Trust.

(2) The Committee will:

(a) Agree and keep under review the overall remuneration policy of the Trust

(b) Determine the broad framework and policy for the employment, remuneration and terms and conditions of service of the Trust's Chief Executive, Executive Directors and Senior Managers in accordance with all relevant Trust guidelines including:

(i) salary (including any performance-related pay or bonus);

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

(iii) allowances.

(c) Agree a performance management framework for the Chief Executive and other Executive Directors;

(d) Receive reports on performance against objectives set for the previous year and note forward objectives for the Chief Executive (prepared by the Chair) and the Executive Directors (prepared by the CEO). Performance of other Senior Managers will be monitored and evaluated by their line managers;

(e) Ensure that remuneration packages are affordable and enable people of appropriate high ability to be recruited, retained and motivated (this may require the Remuneration Committee to seek advice about pay structures and the state of the market for the role under recruitment);

(f) Undertake an annual review of Director salaries/remuneration packages;

(g) Receive reports on the Clinical Excellence Awards and other management allowances paid to medical staff;

(h) Ensure that all decisions are publicly defensible.

(3) The Remuneration Committee shall report to the Trust Board after each meeting (in private if required); if the matters discussed pertain to Executive Directors, these may be covered in the Chief Executive's report to the Trust Board.

(4) The Committee will ensure that emoluments for the Trust Board are accurately reported in the required format in the Trust's Annual Report and Accounts.

(5) The Trust will pay allowances to the Chair and non-officer members of the Trust Board in accordance with instructions issued by the Secretary of State for Health and Social Care.

18.2 Staff Appointments

(1) No employee shall engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in remuneration without Executive approval unless:

(a) It is within the limit of their approved budget and funded establishment; and

(b) It is within the structure of the NHS National Pay Frameworks (e.g. Agenda for Change) and

(c) For agency staff, the remuneration rate is within the published rate caps.

(2) The Trust Board will approve procedures presented by the Chief Executive or by delegation to the Director of People (Director responsible for People), for the determination of commencing pay rates, condition of service, etc., for employees.

(3) All time sheets and other pay records and notifications shall be in a format approved by the Director of Finance and Director of People, and shall be certified and submitted in accordance with instructions issued by the Director of Finance.

(4) A signed copy of the appointment form and other such documents as they may require shall be sent to the Director of Finance and Director of People immediately upon a new employee commencing duty.

(5) The Director of Finance and Director of People shall be notified immediately and in a prescribed format, upon the effective date of change in the state of employment or personal circumstances of an employee being known.

(6) The Trust will use the VSM National Pay Framework, to inform any local VSM reviews that are undertaken by Remuneration Committee.

18.3 Funded Establishment

(1) The People plans incorporated within the annual budget form the funded establishment.

(2) The funded establishment of any department may not be varied without the approval of the Chief Executive. Budget Holders may change bands within the funded establishment as long as the overall establishment budget is not exceeded and the Departmental Finance Manager and HR Manager have been consulted.

18.4 Off – Payroll Engagements

No Executive Director or employee may engage or re-engage any individual who is not to be paid via the Trusts payroll unless the IR35 Review process has been applied by the Trusts HR Department and a decision to engage or reengage via an off-payroll arrangement has been approved by the Director of Finance and the Director responsible for People or their nominated deputies.

18.5 Processing Payroll

(1) The Director responsible for People 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; and
(d) agreeing method of payment.

(2) The Director responsible for People 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;

(l) procedures for the recall of cheques and bank credits;
(i) pay advances and their recovery;
(j) maintenance of regular and independent reconciliation of pay control accounts;
(k) separation of duties of preparing records and handling cash; and
(l) 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.

(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) maintaining detailed and accurate records of hours worked which will result in enhanced payments (e.g. overtime, unsocial hours, call outs, etc.); and
(d) maintaining detailed absence records for all employees and completing absence returns as specified by the Director responsible for People.;
(e) submitting termination forms and other such documents as the Director responsible for People may require in the prescribed form immediately upon knowing the effective date of an employees or officer's resignation, termination or retirement;
(f) Where an employee fails to report for duty or to fulfil obligations in circumstances that suggest they have left the Trust without notice, the Director responsible for People must be informed immediately.

(4) Regardless of the arrangements for providing the payroll service, the Director responsible for People shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, 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.

(5) Overall responsibility for the determination of pay, including verification that rate of pay and relevant conditions of service is in accordance with current agreements, shall rest with the Director responsible for People. The Director of Finance shall have overall responsibility for the proper compilation of the payroll, and for payments made.

(6) All employees shall be paid by bank credit transfer, unless otherwise agreed by the Director of Finance.

(7) Overall responsibility for payment of staff expenses shall rest with the Director of Finance, or an authorised agent, in accordance with Trust policy, upon receipt of a prescribed claim form, duly completed and signed by a designated signatory. It is the duty of designated signatories to assure themselves that the claims they certify are genuine and correct.

18.6 Contracts of Employment

(1) The Trust Board shall delegate responsibility to the Director responsible for People for:
(a) ensuring that all employees are issued with a Contract of Employment in a form approved by the Trust Board and which complies with employment legislation; and
(b) dealing with variations to, or termination of, contracts of employment.

(2) The Director responsible for People will prepare detailed procedures for the preparation, variation to and termination of contracts of employment, and ensure these are notified to managers.

19. NON-PAY EXPENDITURE

19.1 Delegation of Authority

(1) The Trust 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.

(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.

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

19.2 Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services

(1) 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. Where this advice is not acceptable to the requisitioner, the Director of Finance (and/or the Chief Executive) shall be consulted.

(2) All purchases of goods, works and services must be supported by appropriately certified orders before the acquisition of those goods, works or services is contractually committed, unless the Director of Finance agrees otherwise.

(3) The Director of Finance shall be responsible for the prompt payment of accounts and claims supported by appropriately certified orders. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

(4) The Director of Finance will:
(a) advise the Trust 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 to 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 (Note: Purchase orders/requisitions must be completed for the full cost of the service and must not be split into separate elements to circumvent delegated limits);
(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 employees or holders of office (including specimens of their signatures) authorised to approve the placing of orders and/or certify invoices;
(ii) Certification that:
(iii)

1. goods have been duly received, examined and are in accordance with specification and the prices are correct;

2. 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;
3. 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;
4. where appropriate, the expenditure is in accordance with regulations and all necessary

authorisations have been obtained;
5. the account is arithmetically correct;
6. the account is in order for payment.

(iv) 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;
(v) 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, works and services are received.

19.3 Prepayments

(1) Prepayments are only permitted where exceptional circumstances apply and following approval by the Director of Finance. In such instances:

(a) Pre-payments are only permitted where the financial advantages outweigh the disadvantages (i.e. cash flows must be discounted to NPV using the National Loans Fund (NLF) rate plus 2%).
(b) The appropriate officer must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet his commitments;
(c) The Director of Finance will need to be satisfied with the proposed arrangements before contractual arrangements proceed (considering the public procurement contract 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; and
(e) In the case of contracts which require payments to be made on account during progress of the work / delivery of equipment, the Director of Finance shall make progress payments on receipt of a certificate / invoice signed by the Director of Estates & Facilities or Associate Director of Procurement. Prior to payment of the final account, the Director of Finance may arrange a financial examination of the project as he thinks appropriate.

19.4 Official Orders

(1) Official Orders must:

(a) be consecutively numbered;
(b) be in a form approved by the Director of Finance;
(c) state the Trust's terms and conditions of trade; and
(d) Only be issued to, and used by, those duly authorised by the Chief Executive. Lists of authorised officers shall be maintained and a copy of each list supplied to the Director of Finance. Such lists will be notified to Integra & GHX as specified in a service agreement with Integra & GHX.

19.5 Duties of all Staff

(1) All staff 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 inof Health;

(b) 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 to the Trust of a trivial character or inexpensive seasonal gifts to the Trust, such as calendars;

(ii) conventional hospitality, such as lunches in the course of working visits;

(c) 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;

(d) 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;

(e) 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";

(f) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

(g) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

(h) changes to the list of directors / employees authorised to certify invoices are notified to the Director of Finance;

(i) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Director of Finance; and

(j) petty cash records are maintained in a form as determined by the Director of Finance.

(2) 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 CONCODE and ESTATECODE (Health Building Note 00-08). The technical audit of these contracts shall be the responsibility of the relevant Director.

19.6 Joint Finance Arrangements with Local Authorities and Voluntary Bodies (see overlap with Standing Order No. 9.1)

(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. (See overlap with Standing Order No. 9.1)

20. EXTERNAL BORROWING

(1) The Director of Finance will advise the Trust Board concerning the Trust's ability to pay dividend on, and repay Public Dividend Capital (PDC) and any proposed new borrowing, within the limits set by the Department of Health and Social Care. The Director of Finance is also responsible for reporting periodically to the Trust Board concerning the PDC debt and all loans and overdrafts.

(2) The Trust 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.

(3) The Director of Finance must prepare detailed procedural instructions concerning

applications for loans and overdrafts.

(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 and Social Care.

(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 Trust Board must be made aware of all short-term borrowings at the next Trust Board meeting.

(6) All long-term borrowing must be consistent with the plans outlined in the current Financial Planning Return (FPR) and be approved by the Trust Board.

(7) 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

(8) 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.

(9) The Director of Finance will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained

21. INVESTMENTS

(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 Trust Board.

(2) The Director of Finance is responsible for advising the Trust Board on investments and shall report periodically to the Trust Board concerning the performance of investments held.

(3) The Director of Finance will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

22. FINANCIAL TARGETS

(1) The Director of Finance should ensure that members of the Trust Board are aware of the Trusts Financial Totals that have been agreed with NHSE/I and the Single Oversight Framework for NHS Provider Trusts which sets out the basis of assessing the level of support a Trust may require to deliver its financial responsibilities. The Director of Finance should also ensure that the Trust Board is regularly updated on the delivery of the Financial Control Total.

(2) The Director of Finance will regularly update the Trust Board on current and future NHSI regulatory requirements and/or restrictions.

23. CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

23.1 Capital Investment

(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 capital resources being in place and the availability of resources to finance all revenue consequences, including capital charges.

(2) For every capital expenditure proposal, the Chief Executive shall ensure that a business case (in line with the guidance contained within the GAM or HMT Green Book) is produced, setting out:

(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; and
  (iii) 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 and involved relevant Trust personnel and external agencies in the process.

(4) For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of CONCODE or ESTATECODE (Health Building Note 00-08).

(5) The Director of Finance shall assess on an annual basis the requirement for the operation of the construction industry tax deduction (CIS) scheme in accordance with HMRC guidance.

(6) The Director of Finance shall issue procedures for the regular reporting of capital expenditure and commitment against authorised expenditure.

(7) The approval of a capital programme shall not constitute approval for expenditure on any scheme.

(8) The Chief Executive shall issue to the manager responsible for any scheme:
(a) specific authority to commit expenditure;
(b) authority to proceed to tender;
(c) approval to accept a successful tender

(9) The Chief Executive will issue a scheme of delegation for capital investment management in accordance with ESTATE CODE (Health Building Note 00-08)/CONCODE guidance and the Trust's Standing Orders.

(10) 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 as notified to the Trust by the Department of Health & Social Care and NHS England/Improvement.

23.2 Private and Alternative Financing

(1) The Trust should normally test for Private and Alternative Financing 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 NHSI for a risk assessment and decision to approve the borrowing.
(c) The proposal must be specifically agreed by the Trust Board.
(d) Where a capital scheme is funded using Private or Alternative Financing, any variations to the contract will be dealt with under procedures for variations in capital contracts and shall be authorised by the Trust Board.

23.3 Asset Registers

(1) The Chief Executive is responsible for the maintenance of register(s) 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, and valuation of land and buildings against the asset register to be conducted once a year to reflect good practice.

(2) The Trust shall maintain an asset register f or recording fixed assets. The minimum data set to be held within this register shall be as specified in the *Department of Health and Social Care Group Accounting Manual*.

(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 lease agreements in respect of assets held under a finance lease and capitalised.

(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).

(5) The Director of Finance shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

(6) The value of each asset shall be indexed to current values in accordance with methods specified in the *Department of Health and Social Care Group Accounting Manual*.

(7) The value of each asset shall be depreciated using methods and rates as specified in the *Department of Health and Social Care Group Accounting Manual*.

(8) The Director of Finance shall calculate and pay capital charges as specified in the *Department of Health and Social Care Group Accounting Manual*.

23.4 Security of Assets

(1) The overall control of fixed assets is the responsibility of the Chief Executive.

(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.

(3) All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Director of Finance.

(4) Whilst each employee and officer has a responsibility for the security of property of the Trust, it is the responsibility of Trust Board Directors and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Trust Board. Any breach of agreed security practices must be reported in accordance with agreed procedures.

(5) Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by the Trust Board and employees in accordance with the procedure for reporting losses.

(6) Where practical, assets should be marked as Trust property.

(7) Assets valued at more than £5,000 shall be recorded in the Asset Register, and under this value should be entered in ward and department inventories.

24. SUPPLY CHAIN AND RECEIPT OF GOODS

24.1 General Position

(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.
- (d) Subject to regular product reviews to ensure value for money (VFM) and in line with current legislation and directives.

24.2 Control of par levels (stock levels on wards), Stocktaking, Condemnations and Disposal

(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 within the procurement team structure. The day-to-day responsibility is delegated to employees and stores managers and materials management staff. 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.

(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.

(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.

(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, to coincide with the financial year end (unless a continuous stock checking system is in operation). The physical check shall involve at least one officer other than the person responsible for the stock / store. Stocktaking records shall be in a format prescribed by the Director of Finance be numerically controlled and signed by the officers undertaking the check.

(5) Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Director of Finance.

(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. Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

(7) Any surpluses or deficiencies revealed on stocktaking shall be reported to the Director of Finance who may investigate if appropriate. Known losses of stock items not subject to stores control shall be reported to the Director of Finance.

(8) Stocks which have been damaged, deteriorated or are not usable for any other reason than their intended purpose, or may have become obsolete, shall be written down to their net realisable value. Managers seeking to write off such values should follow procedures for reporting losses as laid down by the Director of Finance.

(9) All goods received shall be entered onto an appropriate goods receive/stock record on the day of receipt. A delivery note shall be obtained from the supplier at the time of delivery and shall be signed by the person receiving the goods.

(10) All goods received shall be checked as regards quantity and/or weight and be inspected as to quality and specification. If goods received are unsatisfactory, the record shall be marked accordingly. Where goods received are seen to be unsatisfactory, or short delivery, they shall only be accepted on the authority of the departmental manager or the Supplies Manager, and the supplier shall be notified immediately.

The issue of stocks shall be supported by an authorised requisition note. Where a 'top up' system is used, a record shall be maintained as approved by the Director of Finance.

24.3 Goods supplied by NHS Supply Chain

(1) For goods supplied via the NHS Supply Chain, the Director of Finance shall identify those authorised to requisition and accept goods from the store if relevant. 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.

25. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

25.1 Disposals and Condemnations

(1) The Director of Finance must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers.

(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.

(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.

(c) All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Director of Finance.

(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.

25.2 Losses and Special Payments

(1) The Director of Finance must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments.

(2) Any employee or officer discovering or suspecting a loss of any kind must either immediately inform their head of department, who then must immediately inform the Chief Executive and the Director of Finance or inform an officer charged with responsibility for responding to concerns involving loss (i.e. Local Counter Fraud Service ((LCFS) and/or Local Security Management Specialist). Where a criminal offence is suspected, the Director of Finance must inform the police, following consultation with the LSMS 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 consult with the LCFS and inform the NHS Counter Fraud Authority Area Anti-Fraud Specialist (AAFS) in accordance with guidance contained within the NHS Standard Contract

(3) The Director of Finance must notify the LCFS, NHS Counter Fraud Authority, and the External Auditor of all frauds

(4) 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 Trust Board, and
(b) the External Auditor
(c) the Local Security Management Specialist.

(5) Within limits delegated to it by the Department of Health and Social Care, the Trust Board shall approve the writing-off of losses.

(6) The Director of Finance shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

(7) For any loss, the Director of Finance shall consider whether any insurance claim can be made.

(8) The Director of Finance shall maintain a Losses and Special Payments Register in which write-off action is recorded.

(9) No special payments exceeding delegated limits shall be made without the prior approval of the Department of Health and Social Care. These shall be approved by the Trust Board.

(10) All losses and special payments must be reported to the Audit Committee on a regular basis.

26.0 INFORMATION TECHNOLOGY

26.1 Responsibilities and duties of the Chief Information Officer

(1) The Chief Information Officer, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:
(a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which the Director is responsible from accidental or intentional disclosure to unauthorised persons, deletion or

modification, the Trust 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; and
(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.

(3) The Chief Information Officer shall need to ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

(4) The Director responsible for Communications and Stakeholder Engagement shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the Information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about the Trust that are made publicly available.

26.2 Responsibilities and Duties of Other Directors and Officers in relation to Computer Systems of a General Application

(1) In the case of computer systems which are proposed General Applications (i.e. normally those applications which the majority of trusts in the local health economy wish to sponsor jointly) all responsible directors and employees will send to the Chief Information Officer:
(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.

26.3 Contracts for Computer Services with Other Health Bodies or Outside Agencies

(1) The Chief Information Officer shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

(2) Where another health organisation or any other agency provides a computer service for financial applications, the Chief Information Officer shall periodically seek assurances that adequate controls are in operation.

26.4 Risk Assessment

(1) The Chief Information Officer 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.

26.5 Requirements for Computer Systems which have an Impact on Corporate Financial Systems

(1) 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; and
(d) such computer audit reviews as are considered necessary are being carried out.

27. PATIENTS' PROPERTY

(1) The Trust has a responsibility to provide safe custody for money and other personal 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.

(2) The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

(a) Notices and information booklets; (notices are subject to sensitivity guidance);
(b) Hospital admission documentation and property records;
(c) 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

(3) The Trust will not accept responsibility or liability for patients' property brought into Trust premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

(4) 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.

(5) Where Department of Health and Social Care instructions require the opening of separate accounts for patients' monies, these shall be opened and operated under arrangements agreed by the Director of Finance.

(6) 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.

(7) 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.

(8) 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.

28. CHARITABLE FUNDS

28.1 Corporate Trustee

(1) The Trust has responsibilities as a Corporate Trustee for the management of funds it holds

on Trust, and needs to comply with the Charity Commission latest guidance and best practice.

(2) The discharge of the Trust's corporate Trustee responsibilities are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. Trustee responsibilities cover both charitable and non-charitable purposes.

(3) 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.

28.2 Accountability to Charity Commission and Secretary of State for Health and Social Care

(1) The Trustee's responsibilities must be discharged separately and full recognition given to the Trust's dual accountabilities to the Charity Commission for Charitable Funds and to the Secretary of State for all Charitable Funds.

(2) The Schedule of Matters Reserved to the Trust 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 Directors and Trust officers must take account of that guidance before taking action.

28.3 Applicability of Standing Financial Instructions to Charitable Funds

(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 Charitable Funds.

(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.

29 ACCEPTANCE OF GIFTS TO TRUSTS BY STAFF AND LINK TO STANDARDS OF BUSINESS CONDUCT

(1) The Director of Finance shall ensure that all staff are made aware of the Trust's policy on acceptance of gifts, hospitality and sponsorship and other benefits in kind by staff. This policy follows the guidance contained in the Department of Health and Social Care circular HSG (93) 5 'Standards of Business Conduct for NHS Staff' and is also deemed to be an integral part of these Standing Orders and Standing Financial Instructions. The 'Code of Conduct for NHS Managers' and 'Managing Conflicts of Interest in the NHS' shall also apply.

30. RETENTION OF RECORDS

(1) The Chief Executive shall be responsible for maintaining archives for all records in line with statutory legislation and guidance issued by the Department of Health & Social Care and other regulators. The Chief Executive shall develop a policy and ensure all staff are aware of the mandatory requirements and best practice in relation to the retention of documents.

(2) The records held in archives shall be capable of retrieval by authorised persons.

(3) Records held in accordance with latest Department of Health and Social Care guidance shall only be destroyed at the express instigation of the Chief Executive. Detail shall be maintained of records so destroyed

31. RISK MANAGEMENT AND INSURANCE

31.1 Programme of Risk Management

(1) 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 Trust Board.

(2) 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; and
(g) arrangements to review the risk management programme.

(3) The existence, integration and evaluation of the above elements will assist in providing a basis to make the Annual Governance Statement within the Annual Report and Accounts as required by current Department of Health and Social Care guidance.

31.2 Insurance: Risk Pooling Schemes administered by NHS Resolution

(1) The Trust Board shall decide if the Trust will insure through the risk pooling schemes administered by the NHS Resolution or self- insure for some or all of the risks covered by the risk pooling schemes. If the Trust 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.

31.3 Insurance Arrangements with Commercial Insurers

(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:

(a) Trust's may enter commercial arrangements for insuring motor vehicles owned by the Trust including insuring third party liability arising from their use;
(b) 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
(c) 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 Director of Finance should consult the Department of Health and Social Care.

31.4 Arrangements to be followed by the Trust Board in agreeing Insurance Cover

(1) Where the Trust Board decides to use the risk pooling schemes administered by the NHS Resolution, 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 Trust Board decides not to use the risk pooling schemes administered by the NHS Resolution for one or other of the risks covered by the schemes, the Director of Finance shall ensure that the Trust 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.

MATTERS RESERVED TO THE TRUST BOARD AND SCHEME OF DELEGATION

32. INTRODUCTION

The purpose of this document is to set out how powers are reserved to the Trust Board, generally matters for which it is held accountable to the Secretary of State, while at the same time delegating to the appropriate level the detailed application of Trust policies and procedures. The Trust Board remains accountable for all of its functions, even those delegated to the Chair, individual directors or officers or committees of the Trust Board, and must therefore receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

Requirements under Other Framework Documents
Details of the reservation of powers by the Trust Board and of where powers may be delegated are laid out within several documents. These include, The Accountable Officer Memorandum and issued codes of accountability (included within the Trusts Standing Orders)

In particular, Standing Orders (S 5.1) provides that "subject to such directions as may be given by the Secretary of State, the Trust Board may make arrangements for the exercise, on behalf of the Trust Board, of any of its functions by a Committee or 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 Board thinks fit". The Code of Accountability also requires that there should be a formal schedule of matters specifically reserved to the Trust Board.

Application of Powers and Responsibilities of Officers

Role of the Chief Executive
All powers of the Trust which have not been retained as reserved by the Trust Board or delegated to an executive committee or sub-committee shall be exercised on behalf of the Trust Board by the Chief Executive. The Chief Executive has a responsibility to prepare a Scheme of Delegation identifying which functions he/she shall perform personally and which functions have been delegated to other directors and officers.

All powers delegated by the Chief Executive can be re-assumed by him/her should the need arise. As Accountable Officer the Chief Executive is accountable to the Accounting Officer of NHS Improvement for the funds entrusted to the Trust.

Caution over Use of Delegated Powers
Powers are delegated to directors and officers on the understanding that they would not exercise delegated powers in a matter which in their judgement was likely to be a cause for

public concern.

Directors' Ability to Delegate their own Delegated Powers
The Scheme of Delegation provides direction on the "top level" of delegation within the Trust and on certain detailed delegated powers. It is to be used in conjunction with the system of budgetary control and other established procedures within the Trust.

Absence of Directors of Officers to Whom Powers have been Delegated
In the absence of a director or officer to whom powers have been delegated those powers shall be exercised by the director or officer's superior unless alternative arrangements have been approved by the Trust Board. If the Chief Executive is absent powers delegated to him/her may be exercised by the Chair or Vice Chair in the Chair's absence after taking appropriate advice from the Director of Finance.

33. DETAILED SCHEME OF DELEGATION

Delegated matters in respect of decisions that 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 in accordance with Standing Financial Instructions and Standing Orders.

Delegated Matter	Authority Delegated To
A. Accountability	
a) Accountable officer to NHS England for stewardship of NHS resources	Chief Executive
b) Ensuring expenditure by Trust complies with NHS Improvement requirements is prudent, efficient, economical and effective	Chief Executive and Director of Finance
c) Advice to Trust Board on matters of probity	Chief Executive, Director of Finance and Head of Corporate Affairs
B. Strategy and Plans	
a) Approve the strategic aims and objectives of the Trust	Trust Board
b) 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 and relevant regulatory bodies	Trust Board
c) Approve the Trust's policies for the management of risk and the requirements of being a Category One Responder laid down by the Civil Contingencies Act 2004	Trust Board
d) Approve the Trust's organisational development plan including values, standards and behaviours	Trust Board
C. Regulations and Control	
a) Approve Standing Orders, Standing Financial Instructions, Schedule of Matters Reserved to the Trust Board and all other instructions for the regulation of its proceedings and business	Trust Board
b) Suspend Standing Orders and ratify any instances of failure to comply with Standing Orders	Trust Board (decisions reviewed by Audit Committee)
c) Vary or amend Standing Orders, Standing Financial Instructions or Matters Reserved to the Trust Board	Trust Board
d) Ratify urgent decisions taken outside the Trust Board cycle	Trust Board

e) Final authority in interpretation of Standing Orders	Chair and Chief Executive
f) Final authority in interpretation of Standing Financial Instructions	Director of Finance
g) Approve the Scheme of Delegation and powers from Trust Board to Committees	Trust Board
h) Consider declarations of interest and any conflicts which may arise	Chair/Meeting Chair
i) Approve arrangements for dealing with complaints	Trust Board (may be delegated to Quality and Safety Committee)
j) Establish Terms of Reference and reporting arrangements for all Committees of the Trust Board	Chair and Head of Corporate Affairs on behalf of the Trust Board
k) Receive reports from Committees and act on recommendations as required	Trust Board
l) Approve arrangements relating to the discharge of the Trust's responsibilities for acting as Corporate Trustee for Charitable Funds	Trust Board
m) Approve management policies including personnel policies	Trust Policy Group
n) Approve arrangements for arrangements relating to the discharge of the Trust's responsibilities as a bailer for patients' property	Director of Finance on behalf of the Trust Board

1. Management of Budgets	
a) Responsibility of keeping expenditure within budgets	
i) At individual budget level (Pay and Non-Pay)	Budget Holder (usually a senior manager/nurse)
ii) At Divisional Board or Corporate level	Divisional Directors /Executive Director
iii) Overall responsibility for the budgets	Chief Executive
Virement (Budget Transfer between Department) of Resource	In accordance with Trust Business Case Policy
2. Bank Accounts and Loans	
a. Opening and Closing of Bank Accounts	Director of Finance
b. Maintenance and operation of bank accounts	Director of Finance
c. Loan arrangements	Director of Finance
d. Working Capital Facility (DHSC guidance)	Trust Board
3. Non-Pay Revenue Expenditure/Requisitioning/	

Ordering/Payment of Goods & Services (Note: Purchase orders/requisitions must be completed for the full cost of the service and must not be split into separate elements to circumvent delegated limits) **a. Authorisation of Non-Stock Requisitions** **The transactions below do not require a requisition:** i) Eye vouchers, ii) Child Care Vouchers or any other deduction from staff pay that falls due to an external organisation iii) Refund of interview expenses iv) NHS Resolution v) Compensation under legal obligation vi) Individual Trust Credit card purchases vii) Volunteer Expenses Ex gratia payments for losses of Patients Personal effects	Two Executive Directors, one of whom is the Director of Finance Chief Executive and Director of Finance Agreement by Trust Board authorised by Chief Executive, Director of Finance & Chair
b. All contracts for goods & services and subsequent variations to contracts (excluding leases)	Director of Finance who may wish to take advise from the ICS Director of Procurement Trust Board with recommendation from originating department As above and to be ratified at the following Trust Board meeting **NOTE: Corporate and Divisions may not commit the Trust to contracts without authorisation from the responsible Executive Director**
c. Granting, signing and termination of lease (Operating and Finance)	Director of Finance Non-Executive Director with either the Chief Executive or the Director of Finance
d. Compensation under legal obligation (any value)	Chief Executive and Director of Finance and Director responsible for People
4. Capital Schemes a) Selection of architects, quantity surveyors, consultant engineer and other professional advisors within procurement regulations	Director of Finance and Chief Operating Officer

b) Financial monitoring and reporting on all capital scheme expenditure c) Responsibility for Projects within Capital Project Budgets	Director of Finance Director of Quality Improvement
5. **Setting of Fees and Charges** i) Private patients, overseas visitors, income generation and other patient related services ii) Pricing of NHS contracts iii) Approval of healthcare contracts and other agreements resulting in income to the Trust iv) Approval of non-healthcare contracts and other agreements resulting in income to the Trust	 Director of Finance Director of Finance Chief Executive and Director of Finance Trust Board Director of Finance Trust Board
6. **Engagement of Staff Not on the Establishment** **a) Interim staff or consultancy assignments following completion of the IR35 Review process signed off by the Director of Finance and Director responsible for People** Subject to limits outlined in section 1 a) Authorisation of Non- Stock Invoices Agencies from accredited frameworks must be used. This is in line with NHS Improvement guidance. Standard HR processes to be followed	 Responsible Executive Director Chief Executive and Director of Finance Performance & Finance Committee then to NHSE/I **NOTE: All interim staff or consultancy assignments are subject to review and approval by a committee established for that purpose.**
b) Booking of Bank, Agency and Locum Staff following completion of the IR35 Review process signed off by the Director of Finance and Director of People	Director Responsible for People and Director of People **NOTE: All use of bank, agency and locum staff is subject to review and approval by a committee established for that purpose.**

7. Charitable Funds	
a) All expenditure up to £2,500	Fund Managers
b) All expenditure up to £2,500 - £10,000	Head of Financial Services, Deputy Director of Finance or Deputy Director of People
c) All expenditure above £10,000 should be seek further approval	Charitable Fund Committee (in exceptional circumstance outside the committee meeting approval should be made by Director of People or Director of Finance Financial Representative on the Charitable Funds
b) Review/approve acceptance of restricted funds	Charitable Funds Committee
8. Agreements/Licences re Properties	
a) Preparation of all tenancy agreements/licences for all staff subject to Trust Policy and accommodation for staff	Director of Quality Improvement
b) Extension to existing property leases	Director of Finance
c) Letting of premises to outside organisations	Director of Finance
d) Approval of rent based on professional valuation	Director of Finance
9. Condemning & Disposal	Condemning Decision Condemning Officer and Head of Department with the item to be condemned or disposed of Disposal Condemning Officer and Head of Financial Services

a) Items obsolete, obsolescent, redundant, irreparable or cannot be repaired cost effectively	
10. Losses, Compensation and Write-offs **a) Losses and Special Payments (including Compensation) Register** i) Maintenance of Losses and Special Payments Register ii) Review of schedules of Losses, Special Payments and Compensations and make recommendations to the Trust Board **b) Clinical cases settled by the NHS Resolution** **c) Non-Clinical Cases** **i)** Losses and cash due to the Trust, fraud, overpayment and others **ii)** Fruitless payments **iii)** Bad debts and claims abandoned **iv)** Damages to buildings, fittings, furniture and equipment and loss of property in stores and in use **v)** Compensation payments made under legal obligation **vi)** Extra Contractual payments to contractors Ex-gratia for Patients Personal Effects (any amount)	Director of Finance Audit Committee Director of Finance and Director of Nursing and Midwifery or Chief Executive Chief Executive and Director of Finance Chief Executive and Director of Finance Chief Executive and Director of Finance in line with Trust's Bad Debt Policy Chief Executive and Director of Finance Chief Executive and Director of Finance and Director responsible for People Chief Executive and Director of Finance

d) Any debts authorised for write off **MUST** be notified to the Trust's Credit Controller **The following delegated powers will apply in respect of the authorisation of loss or special payments**: £0 - £500 £501-£1,000 £1,001 – above	Head of Financial Services, Deputy Director of Finance and Director Finance and Audit Committee Head of Financial Services Deputy Director of Finance Director of Finance or Chief Executive
11. Reporting of Incidents to the Police a) Where a criminal offence is suspected (of any type except fraud) b) Where a fraud is involved	 Chief Executive or Chief Operating Officer or Director responsible for People Director of Finance in line with the counter-fraud policy and Local Counter Fraud Specialist
12. Petty Cash Disbursements	Budget Holder (Senior Manager/Nurse) Head of Financial Services Deputy Director of Finance
13. Hospitality i) Approve procedures for declaration of hospitality ii) Maintenance of Trust's hospitality register iii) Approval of receipt of both individual and collective hospitality Approval of corporate hospitality including attendance at events (e.g. for receipt of awards)	 Trust Board Head of Corporate Affairs Executive Director Executive Team

14. Audit	
a) Internal Audit	
i) Having an effective Internal Audit Function in place	Director of Finance
ii) Approval and review of Internal Audit arrangements and service provider	Audit Committee
iii) Delivery of management actions on Internal Audit Recommendations	Trust Manager identified as Lead Manager for that Internal Audit investigation
iv) Follow-up and verification of delivery of management actions	Internal Audit Service
v) Devising an annual Internal Audit Plan	Director of Finance supported by Executive Management Board (or successor body) and Compliance Manager
vi) Approving the annual Internal Audit Plan	Audit Committee
Receiving the Head of Internal Audit Opinion	Audit Committee and Trust Board
b) External Audit	
i) Having an effective External Audit Function in place	Audit Committee & Trust Board
ii) Oversee External Audit arrangements for Trust	Audit Committee
iii) Oversee External Audit/Independent Review of Charitable Funds	Charitable Funds Committee & Trust Board
iv) Receive letter of representation from the external auditors and agree proposed actions	Audit Committee & Trust Board
v) Follow-up and verification of delivery of management actions	External Audit Service
v) Agreeing an annual External Audit Plan	Director of Finance
15. Annual Report and Accounts	
a) Receipt and approval of the Trust's Annual Report & Accounts	Director of Finance, Audit Committee and Trust Board
b) Receipt and approval of the Annual Report and Accounts for the Funds held in Trust.	Charitable Funds Committee and Trust Board
c) Ensure the accounts of the Trust are prepared in line with prevailing guidance	Director of Finance
d) Produce the narrative for the Trust's Annual Report and Accounts	Head of Corporate Affairs/ Communications Team
e) Produce the Quality Accounts	Director of Nursing and Midwifery
f) Receipt and approval of the annual Quality Accounts	Audit Committee and Trust Board

16. Investment of Funds (including Charitable Funds)	Charitable Funds Committee & Director of Finance
17. Personnel & Pay a) Authority to fill funded post on the establishment with permanent staff	Director responsible for People and subject to review at the weekly challenge meeting
b) Authority to fill unfunded posts on the establishment with permanent staff (i) With allocated funding	Responsible Executive with Director responsible for People and Director of Finance
(ii) Without Allocated Funding	Chief Executive
c) Authority to appoint staff not on the formal establishment i) With allocated funding	Responsible Executive with Director responsible for People and Director of Finance
Without Allocated Funding	Chief Executive Director responsible for People

d) Granting of Additional Increments to Staff **Note: This has to be affordable within the Departmental Establishment Pay budget**	
e) Rebanding **Note: All requests for upgrading/regrading shall be dealt with in accordance with Trust Procedure and shall only be actioned should the Departmental Establishment pay budget not be exceeded.**	Director responsible for People and in consultation with People Manager and Finance Manager
f) Pay i) Authority to complete standing data forms effecting pay, new starters, variations and leavers ii) Authority to complete and authorise Salary returns iii) Authority to authorise overtime iv) Authority to authorise Additional Duty Hours v) Authority to authorise travel & subsistence expenses vi) Authority to authorise travel & subsistence expenses in exceptional cases not submitted for over 3 months Approval of Executive expenses – (including any transactions made via Trust Purchasing Cards)	Line Manager

d) Authority to fill unfunded posts on the establishment with permanent staff	Budget Holder or Line Manager
(i) With allocated funding	Medical Director
(ii) Without Allocated Funding	Director of Finance
e) Authority to appoint staff not on the formal establishment	
ii) With allocated funding	
iii) Without Allocated Funding	
d) Granting of Additional Increments to Staff	Chief Executive (Chief Executive's expenses should be approved by the Trust Chair)
g) Arrears of Pay Where it is established that a member of staff is owed arrears of salary	Budget Holder Deputy Director of People Director responsible for People Chief Executive, Director of Finance and Director responsible for People Executive Team
h) Leave Approval of annual leave (over 2 weeks) (a) Medical Staff (b) Nursing Staff (c) Other staff	a) Medical Director b) Director of Nursing and Midwifery c) Responsible Executive and Line Manager

Annual leave – No approval to carry any leave forward except in EXCEPTIONAL circumstances.	Line Manager with approval or responsible Executive
i) Compassionate Leave	Line Manager – in accordance with Trust Policy
j) Special Leave Arrangements	
i) Paternity Leave	Line Manager – in accordance with Trust Policy
ii) Carers Leave	Line Manager – in accordance with Trust Policy
iii) Leave without Pay	Line Manager – in accordance with Trust Policy
iv) Medical Staff Leave of absence (Unpaid)	Associate Chief Medical Officer
v) Maternity Leave – Paid and Unpaid	Automatic approval with guidance
vi) Time off in Lieu	HR Manager
k) Sick Leave	Line Manager – in accordance with Trust Policy
i) Extension of sick leave on half pay up to three months	Line Manager with Director responsible for People
ii) Return to work part-time on full pay to assist recovery	
iii) Extension of sick leave on full pay	Director responsible for People or Chief Executive
l) Study Leave	
Staff study leave (UK)	Chief Executive or Executive Director
All other study leave (UK)	
Medical Staff Study Leave (UK)	Chief Medical Officer
m) Trust Car and Mobile Phone Users	
i) Post to be designated as Car Users	Director responsible for People
ii) Post to be designated as Mobile phone user	Director responsible for People
n) Grievance Procedure All grievances must be dealt with strictly in accordance with the Grievance Procedure and the advice of a People Officer must be sought as soon as is appropriate and in line with the Grievance Procedure.	Line Manager in conjunction with, and after obtaining advice from, a People Officer

o) Renewal of Fixed Term Contracts	People Department
p) Staff Retirement Policy	Director responsible for People
q) Redundancy	Chief Executive or Remuneration Committee
r) Ill Health Retirement	Director responsible for People
s) Dismissal	Nominated Dismissing Officer
18. Authorisation of Sponsorship	Relevant Authorising Officer
19. Research Projects authorisation **a) Authorisation**	Chief Executive and Director responsible for research following proposals made by the Chair of the Trust's Research Committee. Where appropriate, approval from the Trust's Research Ethics Committee may also be required Research Manager Director of Finance Trust Research Committee
20. Authorisation of:	
a) New Drugs	Chief Pharmacist and Medical Director, financial implications to be approved by the Director of Finance

b) New Technologies and Procedures	Chief Operating Officer, Director of Nursing and Midwifery and Medical Director, financial implications to be approved by the Director of Finance
21. Insurance Policies and Risk Management	Director of Finance and Director of Nursing and Midwifery
22. Contact with Press a) Non-Emergency General Enquiries i) Within Hours ii) Outside Hours b) Emergency i) Within Hours ii) Outside Hours	 Communications team On Call Manager Communications team On Call Manager or Executive Director
23. Infectious Diseases & Notifiable Outbreaks	Chief Operating Officer/Director of Nursing and Midwifery /Medical Director / Director of Strategy and Estates
24. Review of Fire Precautions	Chief Executive
25. Review of statutory compliance legislation and Health and Safety requirements including control of Substances Hazardous, Health Regulations and Major Incidents	Director of Strategy and Estates
26. Review of compliance with environmental regulations, for example those relating to clean air and waste disposal	Director of Strategy and Estates
27. Review of Trust's compliance with the Data Protection Act and The General Data Protection Regulation 2016/679	Chief Information officer

28. Review of Trust's compliance with the Access to Records Act	Chief Information officer
29. Review of the Trust's compliance code of Practice for handling confidential information in the contracting environment and the compliance with "safe haven" per EL 92/60	Chief Information officer
30. Patient's and Relatives Complaints a) Responsibility for ensuring all complaints are dealt with correctly including the completion of a thorough investigation b) Responsibility for handling medical – legal complaints with the NHS RESOLUTION	Director of Nursing and Midwifery Director of Nursing and Midwifery
31. The keeping of Declarations of Interests	Head of Corporate Affairs
32. Attestation of sealings in accordance with Standing Orders	Chair/Non-Executive Director & Chief Executive/Executive Director
33. The keeping of a register of sealing	Head of Corporate Affairs or another nominated individual
34. Retention of Corporate Records	Chief Executive
35. Clinical Audit	Medical Director
36. Review of Medicines Inspectorate Regulations	Chief Pharmacist
37. Monitor Proposal for contractual arrangements between the Trust and outside bodies	Chief Operating Officer

38. Patient Services a) Variation of operating and clinic sessions within existing numbers, including: i) Outpatients ii) Theatres iii) Other b) All proposed changes in bed allocation and use, including Temporary Change	Chief Operating Officer Chief Operating Officer
39. Facilities for staff not employed by the Trust to gain practical experience Professional Recognition, Honorary Contracts, & Insurance of Medical Staff, work experience students and apprentices	Director of People

34. Value of Order / Contract: Goods & Services and Works Contracts

Process	Goods & Services	Works	Contrcts for Social and other specific services
I written quotation	Up to £10,000	Up to £10,000	Up to £10,000
Minimum of 3 written quotations	Over £10,000 to £25,000	Over £10,000 to £25,000	Over £10,000 to £25,000
Mininmum of 3 tenders invited	Over £25,000 to £123,796	Over £25,000 to £4,733,252	Over £25,000 to £663,540
Public Contrct Regulations	Over £123,796	Over £4,733,252	Over £663,540
Full Process under Thresholds for Utilities Contract Regulations	Over £378,660	Over £4,733,252	Over £884,720

The above limits apply to standard contracts, signed in the normal order of business. Any documents that require additional certification e.g. signing under seal, additional escalation will be made to the appropriate executive directors as appropriate

Acceptance of Tenders / Quotes

Financial Limit	Opened by	Adjudicated by	Accepted by
Quotations			
£5,000 - £25,000	Originating Dept. (Estates or Supplies).	Representative from user department and senior manager from Supplies or Estates.	Supplies Services Manager or Director of Estates & Redevelopment/Head of Estates.
Tenders			
£25,001 - £50,000	Executive Director and Deputy Director of Finance	Representative from user department and senior manager from Supplies or Estates.	Supplies Services Manager or Director of Estates & Redevelopment/Head of Estates. Reported to the Chief Financial Officer.
£50,000 +	Executive Director and Deputy Director of Finance	Representative from user department and senior manager from Supplies or Estates.	Supplies Services Manager or Director of Estates & Redevelopment/Head of Estates. Reported to Board.

Waiver of Standing Financial Instructions

Financial Limit	Approved by	Reported to
Quotations		
Up to £25,000	Deputy Director of Finance or Director of Finance and Budget Holder	Audit Committee
Tenders		
£25,001 to £250,000;	Director of Finance	Audit Committee
£250,001 - £500,000	Director of Finance and Chief Executive	Audit Committee
£500,000 +	Trust Board (DoF & CEO)	N/A

Scheme of Delegation: Expenditure Approval Limits (Revenue, and Capital expenditure)

Funded revenue expenditure (including full cost of all contracts entered into)				
Description	**Approval and Requisition limit**		**Approval**	**Receipting**
Requisitioner	-	-	✓	✓
Band 7	£2,500	£2,500	✓	✓
Band 8a	£2,500	£5,000	✓	✓
Band 8b	£5,000	£7,500	✓	✓
Band 8c	£7,500	£19,999	✓	✓
Band 8d	£20,000	£49,999	✓	✓
Band 9	£50,000	£79,999	✓	✓
Exec Director	£80,000	£109,999	✓	✓
Director of Finance	£110,001	£250,000	✓	✓
Chief Executive	£250,001	£1,000,000	✓	✓
Trust Chair in approval with Trust Board	£1,000,000+	£1,000,000+	✓	✓

Business cases approval limits - Capital	Required Approval
Up to £75,000	CWG chaired by DoF
£75,000 to £500,000	SMT, with subsequent recommendation by Performance and Finance Committee & Trust Board approval
£500, 001 to £14,999,999	Trust Board (Following recommendation from Performance and Finance Committee)
£15,000,000	ICB
Any expenditure that breaches the Trust's CRL will need to be approved by the highest level which is the ICB	

Business cases approval limits - Revenue	Required Approval
Up to £250,000 and within budget	Diviisional Board, with subsequent recommendation to SMT
UP TO £250,000 and not within budget	SMT (Following recommendation by Divisional Board and EMT)
£250,000 to £500,000 whether within budget or without	SMT (Following recommendation by Divisional Board and EMT)
£500, 001 to £14,999,999	Trust Board (Following recommendation from Performance and Finance Committee)
£15,000,000	ICB – Any expenditure that is above this level will need to be approved first by the Trust Board prior to escalation to the ICB/NHSE.

STANDARDS OF BUSINESS CONDUCT

34. INTRODUCTION

34.1 The Princess Alexandra Hospital NHS Trust ("The Trust") aspires to perform to the highest standards of corporate behaviour and responsibility and operates in line with:

i. The seven principles of public life as enshrined in the Nolan Principles (1995) – attached at Appendix A
ii. Professional Standards Authority: Standards for Members of NHS Boards and Clinical Commissioning Group Governing Bodies in England – attached for reference at Appendix B
iii. The NHS Code of Conduct and Accountability in the NHS (second revision July 2004) which sets out the importance of the public service values of Accountability, Probity and Openness
iv. The Code of Conduct for NHS Managers (October 2002).

34.2 It is a long and well-established principle that public sector organisations must be impartial and honest in the conduct of their business and that their staff must remain above suspicion of corruption.

34.3 The aim of the Standards of Business Conduct is to protect the Trust and its staff from any suggestion of corruption, partiality or dishonesty by providing a clear framework through which the Trust can provide assurance that its' staff conduct themselves with honesty, integrity and probity.

35. LEGAL CONTEXT AND DEFINITIONS

35.1 Under the Bribery Act 2010, it is an offence for an employee to accept a reward for doing or refraining from doing anything in his/her official capacity or to corruptly show favour or disfavour in the handling of contracts. Any breach of the Bribery Act will render employees liable to disciplinary action and/or prosecution. Moreover, employees in the NHS are expected to ensure that the interests of patients remain paramount, that they are impartial and honest in the conduct of their business and that public funds are utilised to the best advantage of the service. In addition, employees must ensure that they do not abuse their position for personal gain to the benefit of family, friends or their private business interests. An employee abusing their position for personal gain may be committing an offence under the Fraud Act 2006.

35.2 The Fraud Act 2006 gives a statutory definition of the criminal offence of fraud under three main headings. Those found guilty under the Act are liable for a fine or imprisonment with a maximum sentence of 10 years.

Fraud by False Representation

35.3 This offence is committed by someone dishonestly making a false representation and intending, through this false representation, to make a gain for themselves or another, or to cause loss to another or to expose another to a risk of loss. In this context a "representation" is "false" if it is untrue or misleading and if the person making it knows that it is or that it might be, untrue or misleading.

Fraud by Failing to Disclose Information

35.4 This offence is committed by someone dishonestly failing to disclose to another person information which they are under a legal duty to disclose and having the intention, by failing to disclose this information, to make a gain for themselves or another, or to cause loss to another or to expose another to a risk of loss.

Fraud by Abuse of Position

35.5 This offence is committed by someone who occupies a position in which s/he is expected to safeguard, or not to act against, the financial interests of another person. In these circumstances, the person dishonestly abuses this position, and intends, by means of the abuse of that position, to make a gain for themselves or another, or to cause loss to another or to expose another to a risk of loss. Further a person may be regarded as having abused their position even though their conduct consisted of an omission rather than an act. The terms "'gain" and "loss" can be applied to money or property and the gain or loss could be temporary or permanent in nature.

Bribery and Corruption

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35.6 Bribery/Corruption is defined as the "offering, giving, soliciting or acceptance of an inducement or reward, which may influence a person to act against the interest of the organisation." (Corruption relates to rewards or inducements, such as bribes).

35.7 The Bribery Act (2010) came into force on 1 July 2011. Generally, bribery is defined as giving someone a financial or other advantage to perform their functions improperly or to reward that person for having already done so.

35.8 The general offences under the act are:

- To offer, promise or give a financial or other advantage to another individual to bring about the improper performance by another person of a relevant function or activity and to reward that improper performance. This is referred to as active bribery.
- To request, agree to receive or accept a bribe where the individual knows or believes that the acceptance of the advantage offered, promised or given constitutes the improper performance of a relevant function or activity. This is referred to as passive bribery.
- Promise, offer or give a financial or other advantage to a foreign public official, either directly or through a third party, where such an advantage is not legitimately due.
- Failure of commercial organisations to prevent bribery on their behalf. Applies to all commercial organisations which have business in the UK. Applies to the commercial organisation itself, as well as individuals and employees acting on their behalf.

35.9 Where is the Trust is engaged in commercial activity it could be considered guilty of a corporate bribery offence if an employee, agent, subsidiary or any other person acting on its behalf bribes another person intending to obtain or retain business or an advantage in the conduct of business for the Trust and it cannot demonstrate that it has adequate procedures in place to prevent such.

35.10 The Trust does not tolerate any bribery on its behalf, even if this might result in a loss of business for it. Criminal liability must be prevented at all times.

35.11 Individuals could be found guilty of the one of the three following offences and face a 10-year prison sentence and unlimited fines:

i. Bribing, or offering to bribe, another person (section 1 of the Act)
ii. Requesting, agreeing to receive, or accepting a bribe (section 2 of the Act)
iii. Bribing, or offering to bribe, a foreign public official (section 6 of the Act).

35.12 The Trust has a responsibility to ensure that all Trust staff are aware of their duties and obligations under the Act otherwise it could be found guilty of failing to prevent bribery (section 7 of the Act).

36. SCOPE

36.1 The Standards of Business Conduct applies to all persons working for the Trust, whether in a clinical or non-clinical capacity. As well as covering all employees of the Trust, this also includes the Trust Chair and Non-Executive Directors, bank, agency, locum or interim staff engaged by the Trust, students and trainees (including apprentices), staff on honorary contracts and secondees, volunteers, lay Committee members and any other third parties acting on behalf of the Trust under a contract. For the purpose of the Standards of Business Conduct, this group is referred to collectively as "Trust Staff".

36.2 It is the responsibility of all Trust staff to ensure that they:

i. have read and understood the Trust's Standards of Business Conduct
ii. do not place themselves in a position that risks or appears to risk conflict between any private interests and their Trust duties
iii. are familiar with and adhere at all times to the principles set out on this procedure and any other related documents which may be issued
iv. seek further advice if they are unsure of any aspect of the procedure
v. make declarations as the need arises, not just as part of an annual declarations process
vi. report any known or suspected deviations from the procedure to their manager, the Head of Corporate Affairs or the LCFS
vii. report any suspicions or allegations of bribery to one of the following:
   a) the Trust's Local Counter Fraud Specialist, whose contact details can be obtained via the Trust's Counter Fraud intranet pages or from the Director of Finance
   b) Director of Finance;
   c) NHS Counter Fraud Authority's NHS Fraud and Corruption Reporting Line on 0800 028 40 60 or https://cfa.nhs.uk/reportfraud.

36.3 In certain circumstances, the acceptance of a Gift, Hospitality, and Donation, Sponsorship or other benefit may be authorised and anyone who has the capacity to authorise is known as an "Authorising Officer". An Authorising Officer will be:

i. the Chief Executive
ii. the Chair for the Non-Executive Directors
iii. an Executive director or Associate Medical Director of a Healthcare group

36.4 In accordance with the Trust's Equality and Diversity policy, this procedure will not discriminate, either directly or indirectly, on the grounds of gender, race, colour, ethnic or national origin, sexual orientation, marital status, religion or belief, age, trade union membership, disability, offending background or any other personal characteristic.

37. GENERAL PRINCIPLES - GIFTS, HOSPITALITY, SPONSORSHIP

37.1 As a general rule, Trust staff must not, in their official capacity, receive Gifts, Hospitality, Sponsorship or any other benefits of any kind which might reasonably be regarded as compromising the Trust's position or the individual's judgement and integrity. In short, Trust staff should always behave in such a manner that a fair-minded member of the public, knowing the facts of the matter, would not see anything improper or suspicious in the receipt of the Gift, and/or Hospitality, and/or Sponsorship and/or any other benefit.

37.2 Particularly staff who are in contact with suppliers and contractors (including external consultants), especially those who are authorised to sign purchase requisitions or place contracts for goods and services are expected to adhere to the professional standards set out in the Ethical Code of the Institute of Purchasing and Supply (set out in NHS circular HSG(93)5.

Some staff are more likely than others to have a decision making influence on the use of taxpayers' money, because of the requirements of their role. For the purposes of this guidance these people are referred to as 'decision making staff.'
Decision making staff in this organisation are:

- Executive and non-executive directors (or equivalent roles) who have decision making roles which involve the spending of taxpayers' money
- Members of advisory groups which contribute to direct or delegated decision making on the commissioning or provision of taxpayer funded services
- Those at Agenda for Change band 8d and above
- Administrative and clinical staff who have the power to enter into contracts on behalf of their organisation
- Administrative and clinical staff involved in decision making concerning the commissioning of services, purchasing of good, medicines, medical devices or equipment, and formulary decisions

37.3 Further, to avoid any potential claim of unfair influence, collusion or canvassing, Trust staff should be especially cautious of accepting small items of value, or hospitality from organisations or individuals (potentially) concerned with supplying goods and services to the Trust, particularly during a procurement process.

37.4 Dealing with offers of Gifts, Hospitality, Sponsorship or other benefits is largely a matter of common sense. However, if ever in doubt, about the propriety of accepting them, a polite but firm refusal is the right course of action.

37.5 All offers of Gifts, Hospitality, Sponsorship or any other benefit, whether accepted or declined, must be recorded.

38. GENERAL PRINCIPLES - INTERESTS

38.1 All Trust staff, and in particular Directors, must act at all times with the utmost integrity and objectivity and in the best interests of the Trust in performing their duties. They must not use their position for personal advantage or seek to gain preferential treatment. Further they must declare any interest, whether direct, or indirect or personal, which may give rise to a conflict of interest or loyalty. They shall do this in the prescribed form (Appendix C):

i. on joining the Trust (howsoever engaged)
ii. as soon as the interest is acquired.

38.2 To assist this process, a standing item on all meetings of the Trust Board and its Committees is "Declarations of Interest". This will be managed by the Head of Corporate Affairs.

38.3 Compliance with these requirements is mandatory to ensure the Trust can identify and manage any current or potential conflicts which may arise between the interests of the Trust and the personal interests, associations and relationships of its Directors and/or staff. Failure to adhere to these arrangements may constitute a criminal offence of fraud or bribery, as an individual could be gaining unfair advantages or financial rewards for themselves or a family member/friend or associate; in the case of a Trust Board member it could result in dismissal from the Trust Board. Any suspicion that a relevant interest may not have been declared should be reported to the Head of Corporate Affairs.

38.4 The Head of Corporate Affairs will maintain registers of interests of Directors and staff and will also ensure that interests of Directors and staff are captured on joining the Trust and as any new interest arises. The register will be available on the Trust's website.

38.5 Relevant interests include:

i. directorships, including Non-Executive directorships, held in private companies or public limited companies (with the exception of dormant companies) or
ii. ownership, part ownership or directorship of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS or the Trust or
iii. Staff should declare, as a minimum, any shareholdings and other ownership interests in any publicly listed, private or not-for-profit company, business, partnership or consultancy which is doing, or might be reasonably expected to do, business with the organisation.

iv. a position of authority in a charity or voluntary organisation in the field of health or social care or
v. any connection with a voluntary or other organisation contracting for NHS or the Trust's services or commissioning NHS or the Trust's services or
vi. any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the Trust. Staff should declare patents and other intellectual property rights they hold (either individually, or by virtue of their association with a commercial or other organisation), including where applications to protect have started or are ongoing, which are, or might be reasonably expected to be, related to items to be procured or used by the organisation. Staff should seek prior permission from the organisation before entering into any agreement with bodies regarding product development, research, work on pathways etc, where this impacts on the organisation's own time, or uses its equipment, resources or intellectual property.

38.6 Such interests or potential conflicts of interest may arise through a "family interest" which is an interest of a Close Family Member of a Director or member of Trust staff which, if it were the interest of that Director or member of Trust staff, would be regarded as a personal or pecuniary interest. A "Close Family Member" means a person who is related to a Director or member of staff in any of the following ways:

i. spouse or partner (defined as someone who is married to, or has the status of "Civil Partner" to or is a co-habitee of the individual)
ii. parent or parent in law
iii. child, step child or adopted child
iv. sibling
v. grandparent or grandchild
vi. nephew, niece or first cousin
vii. aunt or uncle
viii. spouse or partner of any of above
ix. close family member (as defined above) of the spouse or partner.

38.7 Furthermore, there may be circumstances in which Trust staff receive no financial benefit but are influenced by external factors, e.g. by gaining some other intangible benefit, or awarding contracts to friends or personal business contacts.

38.8 In addition, there may be a conflict of loyalties in which Trust staff have competing loyalties between the Trust to which they owe a primary duty and some other person or entity. In this case, such a conflict of interest may present problems in the form of:
i. inhibiting free discussion
ii. resulting in decisions or actions that are not in the interests of the trust
iii. risking the impression that the trust has acted improperly.

38.9 Howsoever the conflict of interest or loyalty arises; it is necessary that it is declared and a decision taken about whether or not the individual should be excluded from discussion or consideration of the matter. In some circumstances, it may be possible to authorise a conflict of interest or loyalty, for example as it would be beneficial for the individual with the conflict to still contribute to discussions. In such circumstances, the individual may be subject to terms and conditions relating to his/her continued attendance and involvement in circumstances where the matter is considered (e.g. through meetings, correspondence or relevant documentation) and shall be obliged to conduct him or herself in accordance with these. Such an authorisation may be revoked or varied at any time. Any authorisation of a conflict of interest or loyalty will be recorded as appropriate in the register of interests including how it was authorised. The authorisation of a conflict of interest or loyalty will be granted by the forum in which the interest has arisen – e.g. if the conflict of interest or loyalty has arisen during the course of a Trust Board meeting, the Trust Board will authorise, or not, the conflict.

39. GIFTS, DONATIONS AND WILLS/LEGACIES

39.1 Trust staff should not solicit or accept Gifts, although it may be possible to accept unsolicited Gifts or tokens of gratitude of low value where to refuse may cause offence. Trust staff should always refuse gifts or other benefits which might reasonably be seen to compromise their personal judgement or integrity.
Gifts from suppliers or contractors doing business (or likely to do business) with the organisation should be declined, whatever their value.
Low cost branded promotional aids such as pens or post-it notes may, however, be accepted where they are under the value of £6 in total, and need not be declared.

Gifts from other sources (e.g. patients, families, service users):
Gifts of cash and vouchers to individuals should always be declined.
Staff should not ask for any gifts.
Gifts valued at over £50 should be treated with caution and only be accepted on behalf of the Trust and not in a personal capacity. These should be declared by staff.
Modest gifts accepted under a value of £50 do not need to be declared.
A common sense approach should be applied to the valuing of gifts (using an actual amount, if known, or an estimate that a reasonable person would make as to its value).
Multiple gifts from the same source over a 12 month period should be treated in the same way as single gifts over £50 where the cumulative value exceeds £50.

39.2 Under no circumstances should staff accept a personal Gift of cash or cash equivalents (e.g. tokens, vouchers, gift cards, lottery tickets or betting slips) regardless of value. Where a cash or cash equivalent gift has been offered to an individual, the donor should be invited to donate to the Trust's general charity fund or to a ward-based charity fund, subject to a receipt being issued and the cash banked through the cashier's office. If the donor does not wish to do this, the Gift must be refused.

39.3 Donations made by suppliers or bodies seeking to do business with the organisation should be treated with caution and not routinely accepted. In exceptional circumstances they may be accepted but should always be declared. A clear reason should be recorded as to why it was deemed acceptable, alongside the actual or estimated value.

- Staff should not actively solicit charitable donations unless this is a prescribed or expected part of their duties for the organisation, or is being pursued on behalf of the organisation's own registered charity or other charitable body and is not for their own personal gain.
- Staff must obtain permission from the organisation if in their professional role they intend to undertake fundraising activities on behalf of a pre-approved charitable campaign for a charity other than the organisation's own.
- Donations, when received, should be made to a specific charitable fund (never to an individual) and a receipt should be issued.
- Staff wishing to donate to a charitable fund in lieu of receiving a professional fee may do so, subject to ensuring that they take personal responsibility for ensuring that any tax liabilities related to such donations are properly discharged and accounted for.

39.4 All Trust staff must immediately declare and register any Gifts worth £50 or more, whether accepted or declined, using the form at Appendix C. The Head of Corporate Affairs will maintain a register of Gifts and Hospitality and ensure that staff are aware of how and when the declaration of Gifts should be made.

39.5 If there is any doubt about the appropriateness of accepting a Gift, staff should either politely decline or consult their line manager or the Head of Corporate Affairs. The Head of Corporate Affairs should be informed immediately if any unreasonably generous Gifts are received.

39.6 Where a member of staff is named as a beneficiary in the will of a patient who has been under their care, the member of staff must inform the Director of Finance and Head of

Corporate Affairs so that consideration can be given to whether or not it is appropriate for that member of staff to retain the benefit. It is the responsibility of member of staff to ensure that they are not placed in a position which risks, or appears to risk, conflict between their private interests and their NHS duties. Furthermore, it is important to avoid subsequent claims by the beneficiaries of the estate of inducement, reward or corruption.

40.0 HOSPITALITY

40.1 "Hospitality" in this context means the provision of meals and refreshments as well as invitations to functions such as award ceremonies, receptions, presentations and conferences as well as invitations to social, cultural and sporting events. Some offers may include overnight accommodation and travel to and from a venue at which an event is being held.

40.2 Trust staff should exercise discretion in accepting offers of hospitality in case it would, or might appear to:

i. place them under any obligation to the individual or organisation making the offer
ii. compromise their impartiality
iii. otherwise be improper.

40.3 This includes hospitality provided by contractors, organisations or individuals concerned with the supply of goods or services, family members or friends, or patients, their relatives, carers or friends.

40.4 Where it is necessary for staff to travel to inspect equipment for possible purchase, the Trust will consider meeting the cost itself to avoid purchasing decisions being compromised. Where contractors meet the cost it must be made clear that this does not create an obligation.

40.5 Where a meeting is funded by the pharmaceutical industry, this must be disclosed in the papers relating to the meeting and in any published minutes or actions. The Department or Directorate organising or hosting the event must ensure that the receipt of funding is approved by the Authorising Officer and recorded in the Sponsorship Register.

40.6 Modest hospitality may be accepted provided that it is normal and reasonable in the circumstances, e.g. lunch provided during the course of a working visits, provided that it does not exceed the scale of hospitality that the Trust would be likely to offer. In case of doubt, advice should be sought from the Head of Corporate Affairs. In all cases, hospitality should always be both appropriate, proportionate and exclude alcohol.

40.7 Meals and refreshments:

- Under a value of £25 - may be accepted and need not be declared.
- Of a value between £25 and £75 - may be accepted and must be declared in the form prescribed by the Head of Corporate Affairs (see Appendix C). The Head of Corporate Affairs will record this in the Gifts and Hospitality Register.
- Over a value of £75 - should be refused unless (in exceptional circumstances) senior approval is given. A clear reason should be recorded on the organisation's register(s) of interest as to why it was permissible to accept.

A common sense approach should be applied to the valuing of meals and refreshments (using an actual amount, if known, or a reasonable estimate).

Travel and accommodation:

Modest offers to pay some or all of the travel and accommodation costs related to attendance at events may be accepted and must be declared.

Offers which go beyond modest, or are of a type that the organisation itself might not usually offer, need approval by senior staff, should only be accepted in exceptional circumstances, and must be declared. A clear reason should be recorded on the organisation's register(s) of interest as to why it was permissible to accept travel and accommodation of this type. A

non-exhaustive list of examples includes:

- offers of business class or first class travel and accommodation (including domestic travel)
- offers of foreign travel and accommodation.

40.8 As well as declaring the acceptance of hospitality in the form prescribed, Trust staff are obliged to declare the hospitality on the P11D form as part of an annual tax return to HMRC.

41.0 GIFTS AND HOSPITALITY PROVIDED BY THE TRUST

41.1 Care should also be taken when providing hospitality from Charitable Funds and staff must be aware that Gifts and hospitality provided by the Trust are still sourced from public funding and the public expect these funds to be used for legitimate purposes and demonstrate value for money.

41.2 In exceptional circumstances only, and with the prior approval of the Chief Executive and Chief Financial Officer, it may be appropriate for the Trust to provide a Gift for a member of staff. However, this would be highly unusual and subject to consideration on a case by case basis.

41.3 In certain circumstances, it may be acceptable for the Trust to provide modest hospitality in the way of working lunches and/or dinners as long as this is:

i. subject to a genuine business reason, and
ii. with the prior approval of the Chief Executive and Chief Financial Officer.

41.4 As part of its staff recognition and reward initiatives, the Trust may support staff in attending an externally organised event (e.g. an awards ceremony) subject to there being a cap per head of £100 and up to a 20% contribution from each member of staff. In such circumstances, staff are required to declare the hospitality on the on the P11D form as part of an annual tax return to HMRC.

42.0 COMMERCIAL SPONSORSHIP

42.1 Commercial sponsorship refers to all funding from sources external to the NHS. This includes funding of all or part of the cost of a member of staff or project, NHS research, publications, training, pharmaceuticals, equipment, meeting rooms, costs associated with meetings, hotel and transport costs, and provision of speakers or premises. Any sponsorship over the value of £25 or more must be declared regardless of whether it is declined or accepted.

42.2 Commercial sponsorship may only be accepted in accordance with the **General Principles - Gifts, Hospitality, and Sponsorship.** Commercial sponsorship should not in any way compromise any decisions of the Trust or be dependent on the purchase or supply of goods or services.

42.3 Sponsors should not have any influence over the content of an event, meeting, seminar, publication or training event. The Trust will not endorse individual companies or their products as a result of the sponsorship.

42.4 During dealings with sponsors there must be no breach of patient or individual confidentiality or data protection legislation. As a general rule, information which is not in the public domain should not be supplied and no information should be supplied to a company for its commercial gain.

42.5 Trust staff may accept commercial sponsorship subject to:

i. seeking permission from an Authorising Officer in advance using the template at Appendix D
ii. ensuring that purchasing or other relevant decisions will not be compromised in any way.

42.6 The Head of Corporate Affairs will record details of commercial sponsorship in the Sponsorship Register.

42.7 The Trust will not enter into any arrangements regarding the commercial sponsorship of a post unless it has been made clear to the sponsor that the arrangements will have no effect on purchasing decisions. This must be recorded in writing and kept in the Sponsorship Register by the Head of Corporate Affairs.

42.8 All pharmaceutical companies entering into sponsorship agreements must comply with the Code of Practice for the Pharmaceutical Industry Second 2012 Edition10. Sponsorship agreements valued in excess of £500 must be approved by the Chief Pharmacist and the Controlled Drugs - Accountable Officer.

42.9 Should there be any doubt about the appropriateness of accepting sponsorship, staff should either politely decline or seek advice from the Director of Financeor Head of Corporate Affairs.

43.0 OUTSIDE EMPLOYMENT OR PRIVATE PRACTICE

43.1 Trust staff are required to seek approval from the Trust if they are engaged in or wish to engage in outside employment in addition to their work with the Trust using the form at Appendices C. Staff should declare any existing outside employment on appointment and any new outside employment when it arises.

43.2 Clinical consultants are permitted to carry out private practice subject to national terms and conditions and the terms of their individual contracts of employment. Non-clinical staff may undertake private practice or work provided that it is with the approval of the Trust.

43.3 In either case, outside employment or private practice must neither conflict with nor be detrimental to the NHS work of the Trust staff in question. Examples of outside employment or private practice which may give rise to a conflict of interest includes:

i. employment with another NHS body;
ii. employment with another organisation which might be in a position to supply goods/services to the Trust, and
iii. self-employment, including private practice, in a capacity which might conflict with the work of the Trust or which might be in a position to supply goods/services to the Trust.

43.4 The Trust reserves the right to refuse permission where it believes a conflict will arise.

43.5 The use of Trust equipment or resources for outside employment or private practice is strictly forbidden unless it is agreed in advance and documented in writing.

43.6 The undertaking of undeclared private practice or outside employment during contracted NHS hours may constitute an offence under the Fraud Act 2006. As such, where any such concerns are identified, the matter will be referred to the Trust's Counter Fraud Team for investigation, as appropriate, and may result in disciplinary and / or criminal action, including dismissal and / or prosecution

Initiatives

43.7 In the case of collaborative research between the Trust and any outside body, Trust staff must be fairly rewarded for their input is essential that a written contract is drawn up to cover the collaborative research project which clearly sets out how the input of the Trust and/or its staff will be recognised and/or rewarded.

43.8 Any patents, designs, trademarks or copyright resulting from work done by a member of

Trust staff carried out as part of their employment by the Trust (including working on a collaborative research project) shall be the Intellectual Property of the Trust.

43.9 Where the undertaking of external work, gaining patent or copyright or the involvement in innovative work benefits or enhances the Trust's reputation or results in financial gain for the Trust, consideration will be given to rewarding employees subject to any relevant guidance for the management of Intellectual Property in the NHS issued by the Department of Health and Social Care.

43.10 Before entering into an obligation to undertake external work connected with the business of the Trust, e.g. writing articles for publication or speaking at conferences, approval must be sought from an Authorising Officer.

44.0 SUPPLIERS AND CONTRACTORS

44.1 The Trust has legal duties to uphold under UK procurement law. All Trust staff who are in contact with suppliers and contractors (including external consultants), and in particular those who are authorised to sign purchase orders or enter into contracts for goods and services, are expected to adhere to professional standards in line with those set out in the Code of Ethics of the Chartered Institute of Procurement and Supply as well as the provisions of the Trust's Standing Orders and Standing Financial Instructions.

44.2 All Trust staff must treat prospective contractors or suppliers of services to the Trust equally and in a non-discriminatory way and act in a transparent manner. Trust staff involved in the awarding of contracts and tender processes must be excluded from all stages of the selection process if they have a relevant conflict of interest or loyalty.

Such an interest must be declared to the Head of Corporate Affairs using the form at Appendix C as soon as it becomes apparent.

44.3 No organisation of any sort that bids for Trust work can be given an advantage over competitors. This applies in all cases. All contracts are awarded on merit and in line with the Trust's Standing Orders, Standing Financial Instructions and any other procedural notes linked to specific procurement activity. In addition, no favour can be shown to the business of current or former Trust staff or their relatives or associates.

44.4 Trust staff must not at any time seek to give undue advantage to any private business or other interests in the course of their duties. Equally, Trust staff must not seek, or accept, preferential rates or benefits in kind for private transactions carried out with companies with which they have had, or may have, official dealings on behalf of the Trust. This does not apply to officers' and members' benefit schemes offered by the NHS or trade unions.

44.5 Every invitation to tender to a prospective bidder for Trust business must require each bidder to give a written undertaking, not to engage in collusive tendering or other restrictive practice and not to engage in canvassing the Trust, its employees or officers concerning the contract opportunity tendered. All invitations to potential contractors must include a notice warning of the consequences of engaging in corrupt practices.

44.6 Offers of pro bono work from prospective bidders for Trust business should be refused.

45.0 PERSONAL CONDUCT

Information Governance and Confidentiality

45.1 Trust staff must, at all times, operate in line with the Data Protection Act 1998 and maintain the confidentiality of information of any type, including but not exclusively: patient information, personal information relating to staff, commercial information. This duty of confidence remains after a member of staff (howsoever employed) leaves the Trust and this requirement applies to all individuals. The only exception is where disclosure of confidential

information is required by law; in these circumstances, advice should be sought from the Head of Corporate Affairs. Information concerning the Trust which is not in the public domain must not at any time be divulged to any unauthorised person.

45.2 All Trust staff must hold confidential information in the strictest confidence and take all reasonable precautions to prevent anyone else having unauthorised access to it. Further, confidential information should be used solely for the purpose of discharging Trust functions and responsibilities and copies should only be taken or made when strictly necessary.

45.3 Care should be taken that confidentiality is not breached inadvertently by, for instance by:

i. discussing confidential matters in public places, such as whilst travelling by train
ii. leaving patient information (e.g. hand-over notes) in a public place
iii. leaving portable IT equipment containing confidential information where it might easily be stolen, such as on full view in a parked car.

45.4 Disciplinary measures may be taken if the Trust feels that staff have not operated in line with Information Governance principles.

45.5 Trust staff should guard against providing information on the operations of the Trust which might provide a commercial advantage to any type of organisation which supplies/is seeking to supply goods or services to the Trust. In some instances, Trust staff will be required to sign a Non-Disclosure Agreement form, as set out at Appendix E.

Social Networking

45.6 Trust staff must be aware that social networking websites are public forums and should not assume that their entries will remain private. Trust staff communicating via social media outside work must not:

i. identify themselves as someone who works for the Trust
ii. conduct themselves in a way that brings the Trust into disrepute;
iii. disclose information that is confidential or related in any way to Trust business, staff or patients.

Use of Computers and Information Technology/Information Management

45.7 Trust staff must not run any unauthorised or unlicensed programs, computer games or software on any of the Trust's computers/computer architecture without prior permission. Further no unauthorised equipment should be attached or connected to any of the Trust's computer equipment without express authorisation.

45.8 The Trust's IT department will report all suspicious, inappropriate or fraudulent use of the Trust's IT, internet and/or email provision and HR/People will be informed if there is a concern that a member of Trust staff has breached the Trust's regulations.

Use of Trust Equipment and Resources

45.9 Trust staff are not permitted to use Trust equipment or resources for outside employment, private practice or personal use unless it is agreed in advance and documented in writing.

Gambling

45.10 No member of staff may bet or gamble when on duty or on Trust premises, with the exception of small lottery syndicates or sweepstakes related to national events such as the World Cup or Grand National among immediate colleagues.

Trading on Trust Premises

45.11 Trading on official premises is prohibited, whether for personal gain or on behalf of others. Canvassing within the office by, or on behalf of, outside bodies or firms (including non-Trust interests of staff or their relatives) is also prohibited. Trading does not include small tea or refreshment arrangements solely for staff.

Individual Voluntary Arrangements, County Court Judgment (CCJ), Bankruptcy/Insolvency

45.12 Any member of staff who becomes bankrupt, insolvent, has active CCJ, or made individual voluntary arrangements with organisations must inform their line manager and the People Department as soon as possible. Staff who are bankrupt or insolvent cannot be employed in posts that involve duties which might permit the misappropriation of public funds or involve the approval of orders or handling of money.

Arrest or Conviction

45.13 A member of staff who is arrested and refused bail or convicted of any criminal offence must inform their line management and the People Department as soon as possible.

Corporate Responsibility

45.14 All Trust staff, and in particular Directors, have a responsibility to respect and promote the corporate or collective decision of the Trust, even though this may conflict with their personal views. This applies particularly if the Trust has yet to decide on an issue or has decided in a way with which they personally disagree. Directors and staff may comment as they wish as individuals however, if they decide to do so, they should make it clear that they are expressing their personal view and not the view of the Trust.

When speaking as a member of the Trust, whether to the media, in a public forum or in a private or informal discussion, staff should ensure that they reflect the current policies or view of the Trust. For any public forum or media interview, approval should be sought in advance: from the Chair and/or Chief Executive (in the case of the Trust Board) or the Communications Team (in the case of all other Trust staff), or their nominated deputies, and Communications Team, but when this is not practicable, they should report their action to the Chair or Chief Executive, or their nominated deputies, as soon as possible.

45.15 All staff, and in particular Directors, must ensure their comments are well considered, sensible, well informed, made in good faith, in the public interest and without malice and that they enhance the reputation and status of the Trust.

45.16 The Trust has guidance for communication with the media which all Trust staff must follow and disciplinary action may be taken if this is not followed.

Freedom of Information

45.17 All staff will comply with the Trust's Publication Scheme and forward any Freedom of Information requests to the Freedom of Information Officer as soon as practicable. Where an individual member of staff or a Director receives a Freedom of Information request s/he must not reply without forwarding the request to the Freedom of Information Officer and obtaining their advice.

Meeting Etiquette

45.18 All Trust staff must conduct themselves in a professional manner at all times. When invited to a meeting, they are expected to attend for the full duration of the meeting – unless the invitation is for a single item or part of the meeting only – to arrive on time, having read all the relevant papers, and participate fully in the discussions.

45.19 Trust staff should be especially aware of how their actions, including non-verbal actions, may be perceived by others (particularly if meetings are held in public) and all activities which may cause a distraction to others (e.g. using mobile devices, laptops, using telephones etc.) should be avoided.

45.20 When attending meetings, it is important to be tolerant of diverse points of view, avoid giving offence (and be ready to apologise) and avoid taking offence by being open to discussion. It is important that points are made clearly and succinctly and only when they are relevant to the discussion at hand. Challenge should be constructive, not critical, all ideas should be

treated with respect and no-one should be isolated when expressing his/her views. In addition, all efforts should be made to help the Chair of the meeting run to time.

45.21 As set out in the section on Information Governance and Confidentiality, it is important to be mindful of the need for appropriate confidentiality though meetings should be candid and not secretive.

45.22 Finally, time should be set aside at each meeting to review and reflect on the effectiveness of the meeting.

46.0 MANAGEMENT ARRANGEMENTS, REQUIREMENTS AND DUTIES

46.1 The table below sets out the management arrangements, including duties and monitoring requirements, to successfully implement the Trust's Standards of Business Conduct:

MANAGEMENT ARRANGEMENT	DUTY/REQUIREMENT
Chief Executive The Chief Executive has the overall responsibility for funds entrusted to the Trust as the Accountable Officer and that adequate policies and procedures are in place to protect the Trust and the public funds entrusted to it. The Chief Executive shall ensure that arrangements are in place to record and register Interests, Gifts, Hospitality, Sponsorship or other benefits and that these registers are available for public inspection as required.	Trust Accountable Officer
Senior Management Team (SMT) Members of the SMT are required to lead by example and ensure staff are aware of their obligation to comply with the Standards of Business Conduct and make the necessary declarations in line with it. SMT members may also be Authorising Officers in relation to circumstances set out in the Standards of Business Conduct.	Authorising Officer as required
Director of Finance The Director of Finance Director of Finance is the Director responsible for the Trust's overall compliance with the NHS standards in relation to counter fraud, bribery and corruption. To this end, s/he will ensure that the Trust has an LCFS through which adherence to these standards is monitored and any deviation investigated. The Director of Finance Director of Finance will ensure that the Trust takes the required actions to limit and recover losses, apply relevant sanctions and/or manage potential reputational damage – taking advice from and consulting with any members of the EMB as required. The Director of Finance will set the scope and monitor the work of the LCFS. Should a member of Trust staff require to be interviewed or disciplined, s/he, in conjunction with the LCFS, shall consult and take advice from the Director of People. In these circumstances, the employee may be the subject of a separate investigation by the People Department.	Director responsible for Trust's compliance with NHS standards in relation to counter fraud, bribery and corruption Putting in place and managing the LCFS

People Department The People Department will ensure that all Trust staff are aware of their obligations under the Trust's Standards of Business Conduct by ensuring that this is covered at induction and details of how to make the necessary declarations are available to new starters. The People Department will also liaise with managers, the Director of Finance Director of Finance and the LCFS, where an employee is suspected of being involved in fraud and/or bribery/corruption. The People Department is responsible for ensuring the appropriate use of any disciplinary procedures operated by the Trust. The People Department manages arrangements for the appointment of	Highlighting Standards of Business Conduct at induction All relevant declarations made by new starters Coordinating annual return from staff concerning outside employment or private practice (EMB) Managing

"Fit and Proper Persons" and any steps to be taken with Trust staff who have been arrested, convicted or have become the subject of an Individual Voluntary Arrangement, CCJ, bankruptcy or insolvency. The People Department oversees the implementation of the Trust's Raising Concerns policy and provides an annual report to the Audit Committee.	arrangements for "Fit & Proper People" – including any changes in circumstances Annual report on whistleblowing
Local Counter Fraud Specialist (LCFS) The LCFS will proactively assist the encouragement of an anti-fraud and bribery culture by undertaking work that will raise fraud and bribery awareness. The LCFS will ensure that all cases of actual or suspected fraud are reported to NHS Counter Fraud Authority before any investigation or referral to the Police takes place. The LCFS will liaise with the NHS Counter Fraud Authority and, in conjunction with the Chief Financial Officer, will decide who will conduct the investigation and when / if referral to the Police is required. The LCFS will, amongst other duties: i. Ensure that the Director of Finance is kept appraised of all cases ii. In consultation with the Director of Finance and the NHS Counter Fraud Authority, report any case to the Police as necessary; iii. Report the outcome of the investigation to the Director of Finance and the NHS Counter Fraud Authority; iv. Ensure that other departments e.g. HR are informed, where necessary. HR will be informed where an employee is a suspect. (LCFS and HR to comply with the relevant protocol between both parties); and v. Ensure that any system weaknesses identified as part of an investigation are followed through with management to implement changes. vi. Manage potential reputational damage. The LCFS shall be responsible, in discussion with the Chief Financial Officer, for informing third parties such as External Audit, NHS Counter Fraud Authority or the Police at the earliest opportunity and as circumstances dictate. The LCFS will provide a regular report about his/her work to the Trust's Audit Committee, including an annual report.	Work with key colleagues and stakeholders to promote anti-fraud work and respond to system weaknesses. Investigate allegations of fraud, bribery or corruption at the Trust. Provide regular reports to Audit Committee including an annual report Comply with national regulations, including the Government Functional Standards 013. Government Functional Standard 013: Counter Fraud – annual return. Counter Fraud work plan and fraud risk assessment detailing work required to comply with Government Functional Standard 013
Internal and External Audit Through their work, Internal and External Audit will be alert to the risk of fraud and bribery. Through on-going liaison with the LCFS, Internal Audit will seek to assess the control measures in place to manage key fraud and bribery risks where these fall within the scope of their audits. Any incident or suspicion that comes to Internal or External Audit's attention will be passed immediately to the LCFS. The outcome of the investigation may necessitate further work by Internal or External Audit to review systems.	Report any concerns to LCFS

Managers Managers at all levels have a responsibility to ensure that an adequate system of internal control exists within their areas of responsibility and that controls operate effectively. They are required to remind staff of their obligation to comply with the Standards of Business Conduct and make the	Ensure staff complete all declarations required

necessary declarations in line with it, including: i. Informing staff of the Trust's Standards of Business Conduct as part of their induction process, paying particular attention to the need for accurate completion of personal records and forms ii. Ensuring that all employees for whom they are accountable for are made aware of the requirements of the policies iii. Assessing the types of risk involved in the operations for which they are responsible, and iv. Ensuring that adequate control measures are put in place to minimise the risks. This must include clear roles and responsibilities; supervisory checks; staff rotation, particularly in key posts; separation of duties wherever possible, so that control of a key function is not invested in one individual; and regular reviews. Managers have a duty to instil and encourage an anti-fraud and bribery culture within their teams, be vigilant and alert to the possibility of unusual events or transactions which could be symptoms of fraud and or/bribery and report any concerns to the LCFS. Managers will work with the LCFS to raise awareness about anti-fraud and bribery. All instances of actual or suspected fraud or bribery must be reported immediately either to the LCFS, Director of Finance Officer or via the NHS CFA's reporting line or on-line reporting tool. Under no circumstances should managers attempt to investigate allegations of fraud, bribery or corruption themselves - instead their duty is to refer the concerns to the LCFS or the Director of Finance as soon as possible.	Support LCFS in awareness-raising of fraud, bribery and corruption Report any concerns to the LCFS or Chief Financial Officer
Trust Staff All staff (howsoever engaged by the Trust) are expected to act in accordance with the Standards of Business Conduct as well acting in accordance with the standards laid down by their professional bodies where applicable. Trust staff also have a duty to protect the assets of the Trust, including information and goodwill as well as property. In addition, all employees have a responsibility to comply with all applicable laws and regulations relating to ethical business behaviour, procurement, personal expenses and confidentiality. This means, in addition to maintaining the normal standards of personal honesty and integrity, all employees should always: i. Avoid acting in any way which might cause others to allege or suspect them of dishonesty ii. Behave in a way which would not give cause for others to doubt that official matters are dealt with fairly and impartially iii. Be alert to the possibility that others might be attempting to deceive iv. Act with the highest levels of integrity and probity at all times. The Trust's Raising Concerns policy is the appropriate route for staff to raise concerns about conflicts of interest and other financial integrity or business conduct issues that cannot be dealt with satisfactorily through line-management in the first instance. All staff are responsible for reporting suspicions of fraud and/or bribery or corruption using one of the channels set out below: i. the Trust's Counter Fraud Team, whose contact details can be obtained via the Trust's Counter Fraud intranet pages or from the Director of Finance.	Declare interests: i. On appointment ii. Annually iii. As a new interest arises Declare any Gifts, Hospitality, Sponsorship or other benefits Outside employment or private practice: i. Seek approval ii. Participate in annual return Report any concerns Complete a Non-Disclosure Agreement as required

ii. the Director of Finance.	

iii. NHS Counter Fraud Authority's NHS Fraud and Corruption Reporting Line on 0800 028 40 60 or https://cfa.nhs.uk/reportfraud. Trust staff should be aware that a breach of the Trust's Standards of Business Conduct could render them liable to prosecution as well as leading to the termination of their employment or position with the Trust. Trust staff who fail to disclose any relevant interests, outside employment, private practice or receipt of Gifts, Hospitality, Sponsorship or other benefits as required by the Standards of Business Conduct, or the Trust's Standing Orders or Standing Financial Instructions may be subject to disciplinary action which could, ultimately, result in the termination of their employment or position with the Trust. Breaches of the Standards of Business Conduct will be reported to the Audit Committee. All Trust staff are required to make a declaration of interests on joining the Trust, participate in the annual declaration of interests and provide a new declaration of interest as the need arises.	
Head of Corporate Affairs The Head of Corporate Affairs will be responsible for maintaining the Registers to record interests and also Gifts, Hospitality, Sponsorship and any other benefits. S/he will keep these registers up to date by means of an annual declaration process and by recording any changes which arise in the year. S/he will produce an annual report on the Registers for consideration by the Audit Committee. The Head of Corporate Affairs will also ensure that there is an opportunity to declare interests at key corporate meetings of the Trust. The Head of Corporate Affairs is also responsible for reviewing the implementation of the Standards of Business Conduct and making changes as required.	Manage arrangements and maintain registers for: i. Interests ii. Gifts, Hospitality, Sponsorship, other benefits Coordinate annual returns for the registers and report to the Audit Committee Monitor effectiveness of the Standards of Business Conduct
Procurement Department The Procurement Department is responsible for the Trust upholding its legal duties in relation to Public Procurement Regulations 2015 and UK procurement law operating in line with the professional standards set out in the Code of Ethics of the Chartered Institute of Procurement and Supply as well as the provisions of the Trust's Standing Orders and Standing Financial Instructions. The Procurement Department will ensure that no member of staff will be involved in any stage of the selection process for a tender or contract if they have a relevant conflict of interest or loyalty. The Procurement Department will also ensure that all contracts are awarded on merit and in line with the Trust's Standing Orders, Standing Financial Instructions and any other procedural notes linked to specific procurement activity. The Procurement Department will ensure that all invitations to potential contractors must include a notice warning of the consequences of engaging in corrupt practices.	Ensuring the probity of the procurement process Including a warning notice in all invitations to potential contractors of corrupt practice

Audit Committee The Audit Committee will monitor compliance with the Standards of Business Conduct and the Trust's arrangements for raising concerns. It will also receive an annual report on the Registers of Interest, and Gifts, Hospitality, Sponsorship and other benefits. . Breaches of the Standards of Business Conduct will be reported to the Audit Committee.	Receive reports: i. from LCFS ii. Head of Corporate Affairs iii. People Department

The Princess Alexandra Hospital NHS
NHS Trust

APPENDIX A

The Seven Principles of Public Life (the Nolan Principles)

1. Selflessness
Holders of public office should act solely in terms of the public interest.

2. Integrity
Holders of public office must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions in order to gain financial or other material benefits for themselves, their family, or their friends. They must declare and resolve any interests and relationships.

3. Objectivity
Holders of public office must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias.

4. Accountability
Holders of public office are accountable to the public for their decisions and actions and must submit themselves to the scrutiny necessary to ensure this.

5. Openness
Holders of public office should act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for so doing.

6. Honesty
Holders of public office should be truthful.

7. Leadership
Holders of public office should exhibit these principles in their own behaviour. They should actively promote and robustly support the principles and be willing to challenge poor behaviour wherever it occurs.

APPENDIX B

professional standards authority

Standards for members of NHS boards and Clinical Commissioning Group governing bodies in England

All members of NHS boards and CCG governing bodies should understand and be committed to the practice of good governance and to the legal and regulatory frameworks in which they operate. As individuals they must understand both the extent and limitations of their personal responsibilities.

To justify the trust placed in me by patients, service users, and the public, I will abide by these Standards at all times when at the service of the NHS.

I understand that care, compassion and respect for others are central to quality in healthcare; and that the purpose of the NHS is to improve the health and well-being of patients and service users, supporting them to keep mentally and physically well, to get better when they are ill and, when they cannot fully recover, to stay as well as they can to the end of their lives.

I understand that I must act in the interests of patients, service users and the community I serve, and that I must uphold the law and be fair and honest in all my dealings.

Professional Standards Authority
157-197 Buckingham Palace Road, London SW1W 9SP
Telephone: 020 7389 8030 Email: info@professionalstandards.org.uk
Web: www.professionalstandards.org.uk

The Professional Standards Authority for Health and Social Care is the new name for the Council for Healthcare Regulatory Excellence.

Personal behaviour

1. **As a Member[1] I commit to:**

   The values of the NHS Constitution

   Promoting equality

   Promoting human rights

   in the treatment of patients and service users, their families and carers, the community, colleagues and staff, and in the design and delivery of services for which I am responsible.

2. **I will apply the following values in my work and relationships with others:**

- **Responsibility**: I will be fully accountable for my work and the decisions that I make, for the work and decisions of the board[2], including delegated responsibilities, and for the staff and services for which I am responsible
- **Honesty**: I will act with honesty in all my actions, transactions, communications, behaviours and decision-making, and will resolve any conflicts arising from personal, professional or financial interests that could influence or be thought to influence my decisions as a board member
- **Openness**: I will be open about the reasoning, reasons and processes underpinning my actions, transactions, communications, behaviours and decision-making and about any conflicts of interest
- **Respect**: I will treat patients and service users, their families and carers, the community, colleagues and staff with dignity and respect at all times
- **Professionalism**: I will take responsibility for ensuring that I have the relevant knowledge and skills to perform as a board member and that I reflect on and identify any gaps in my knowledge and skills, and will participate constructively in appraisal of myself and others. I will adhere to any professional or other codes by which I am bound
- **Leadership**: I will lead by example in upholding and promoting these Standards, and use them to create a culture in which their values can be adopted by all
- **Integrity**: I will act consistently and fairly by applying these values in all my actions, transactions, communications, behaviours and decision-making, and always raise concerns if I see harmful behaviour or misconduct by others.

1 The term 'Member' is used throughout this document to refer to members of NHS boards and CCG governing bodies in England.
2 The term 'board' is used throughout this document to refer collectively to NHS boards and CCG governing bodies in England.

Technical competence

3. **As a Member, for myself, my organisation, and the NHS, I will seek:**

   Excellence in clinical care, patient safety, patient experience, and the accessibility of services

   To make sound decisions individually and collectively

   Long term financial stability and the best value for the benefit of patients, service users and the community.

4. **I will do this by:**

- Always putting the safety of patients and service users, the quality of care and patient experience first, and enabling colleagues to do the same
- Demonstrating the skills, competencies, and judgement necessary to fulfil my role, and engaging in training, learning and continuing professional development
- Having a clear understanding of the business and financial aspects of my organisation's work and of the business, financial and legal contexts in which it operates
- Making the best use of my expertise and that of my colleagues while working within the limits of my competence and knowledge
- Understanding my role and powers, the legal, regulatory, and accountability frameworks and guidance within which I operate, and the boundaries between the executive and the non-executive
- Working collaboratively and constructively with others, contributing to discussions, challenging decisions, and raising concerns effectively
- Publicly upholding all decisions taken by the board under due process for as long as I am a member of the board
- Thinking strategically and developmentally
- Seeking and using evidence as the basis for decisions and actions
- Understanding the health needs of the population I serve
- Reflecting on personal, board, and organisational performance, and on how my behaviour affects those around me; and supporting colleagues to do the same
- Looking for the impact of decisions on the services we and others provide, on the people who use them, and on staff
- Listening to patients and service users, their families and carers, the community, colleagues, and staff, and making sure people are involved in decisions that affect them
- Communicating clearly, consistently and honestly with patients and service users, their families and carers, the community, colleagues, and staff, and ensuring that messages have been understood
- Respecting patients' rights to consent, privacy and confidentiality, and access to information, as enshrined in data protection and freedom of information law and guidance.

Standards for members of NHS boards and CCG governing bodies in England

professional standards authority

Business practices

5. **As a Member, for myself and my organisation, I will seek:**

   To ensure my organisation is fit to serve its patients and service users, and the community

   To be fair, transparent, measured, and thorough in decision-making and in the management of public money

   To be ready to be held publicly to account for my organisation's decisions and for its use of public money.

6. **I will do this by**:

- Declaring any personal, professional or financial interests and ensuring that they do not interfere with my actions, transactions, communications, behaviours or decision-making, and removing myself from decision-making when they might be perceived to do so
- Taking responsibility for ensuring that any harmful behaviour, misconduct, or systems weaknesses are addressed and learnt from, and taking action to raise any such concerns that I identify
- Ensuring that effective complaints and whistleblowing procedures are in place and in use
- Condemning any practices that could inhibit or prohibit the reporting of concerns by members of the public, staff, or board members about standards of care or conduct
- Ensuring that patients and service users and their families have clear and accessible information about the choices available to them so that they can make their own decisions
- Being open about the evidence, reasoning and reasons behind decisions about budget, resource, and contract allocation
- Seeking assurance that my organisation's financial, operational, and risk management frameworks are sound, effective and properly used, and that the values in these Standards are put into action in the design and delivery of services
- Ensuring that my organisation's contractual and commercial relationships are honest, legal, regularly monitored, and compliant with best practice in the management of public money
- Working in partnership and co-operating with local and national bodies to support the delivery of safe, high quality care
- Ensuring that my organisation's dealings are made public, unless there is a justifiable and properly documented reason for not doing so.

APPENDIX C

STANDARDS OF BUSINESS CONDUCT –DECLARATION FORM

Name:	
Title/Position:	
Department/Section:	

Declaration: Interests

In line with sections 5.5 – 5.9 inclusive of the Trust's Standards of Business Conduct, I have the following interests which are relevant to the work of the Trust.

Nature of Interest in Full:

Office use only:
Authorised □ YES DATE: □ NO □ NOT APPLICABLE

Nature of Interest in Full:

Office use only:
Authorised □ YES DATE: □ NO □ NOT APPLICABLE

Nature of Interest in Full:

Office use only:
Authorised □ YES DATE: □ NO □ NOT APPLICABLE

I confirm the information provided as correct and complete. I understand that knowingly providing false information and / or knowingly withholding information may constitute offences under the Fraud Act 2006 which may result in disciplinary and/or criminal investigation and prosecution.

Signature:	
Date:	

Declaration – Outside Work/Private Practice

There should be no conflict of interest between your Trust duties and any other job. If you have another job or undertake private practice and there is no conflict of interest, you must still declare it below (though you will not be prevented from keeping it). The undertaking of undeclared private practice or outside employment during contracted NHS hours may constitute an offence under the Fraud Act 2006.
Please refer to section 43.0 - Outside Employment or Private Practice for more information.

Employer:		
Post/Role:		
Date Employment Commenced:		
Hours and Time Worked:		
Authorisation Status:	**Authorised**	**Not Authorised**
Date:		

Declaration – Gifts, Hospitality, Donation and Other Benefits

All gifts, hospitality, donations or other benefits must be declared, whether accepted or declined.
I confirm the information provided as correct and complete. I understand that knowingly providing false information and / or knowingly withholding information may constitute offences under the Fraud Act 2006 which may result in disciplinary and/or criminal investigation and prosecution.

Details of Gift, Hospitality, Donation or Other Benefit:		
From whom and why: (give as much detail as possible)		
Date Offered:	**Value or Estimate: (select one and give amount)**	**Accepted or Declined: (select one)**
Details of Gift, Hospitality, Donation or Other Benefit:		
From whom and why: (give as much detail as possible)		
Date Offered:	**Value or Estimate: (select one and give amount)**	**Accepted or Declined: (select one)**
Date:		

APPENDIX D APPLICATION TO SEEK PERMISSION TO ACCEPT COMMERCIAL SPONSORSHIP FORM

Name:	
Title/Position:	
Department/Section:	

Request: To seek Commercial Sponsorship

Section 9.0 of the Trust's Standards of Business Conduct sets out the arrangements for managing commercial sponsorship.

Details of Proposed Sponsorship Opportunity: (give as much detail as possible)		
Details of Proposed Sponsor:		
Background to Offer of Sponsorship (if known):		
Date Offered:	**Value or Estimate: (select one and give amount)**	**Accepted or Declined: (select one)**
Authorising Officer:	**Name:**	**Title:**
Date Commercial Sponsorship Opportunity Authorised or Declined and Reasons Why:		
I confirm the information provided as correct and complete. I understand that knowingly providing false information and / or knowingly withholding information may constitute offences under the Fraud Act 2006 which may result in disciplinary and/or criminal investigation and prosecution.		
Signatures:	**Authorising Officer:**	**Trust Staff:**
Dates:	**Authorising Officer:**	**Trust Staff:**

APPENDIX E

NON-DISCLOSURE AGREEMENT FORM

Name:	
Title/Position:	
Department/Section:	

Declaration: Express Requirement for Confidentiality

You have been requested to be involved in [INSERT DETAILS] (the “Project”). As part of your role in respect of the Project, the Trust, or other parties participating in the Project, may provide you with access to certain confidential information relating the Project at any time before, during or after completion of the Project by any means (eg in writing, by email, verbally, through attendance at meetings), trade secrets including, without limitation, technical data and know-how relating to the Project, information that you may create, develop, receive or obtain in connection with your engagement on the Project, whether or not such information (if in anything other than oral form) is marked confidential (the "Confidential Information").

You are required to:

i. maintain the Confidential Information in the strictest confidence and not divulge any of the Confidential Information to any third party without the prior written permission of the Trust and
ii. not make use of, reproduce, copy, discuss, disclose or distribute the any information other than for use as part of your role in the Project.

By signing this form you agree to comply with these terms.

Signature:	
Date:	

APPENDIX F

PAHT WAIVER TEMPLATE

Princess Alexandra Hospital NHS Trust

Procurement use only:			
	Waiver number:	Requisition number:	Date issued:

Section A

Requesting trust	
Princess Alexandra Hospital NHS Trust	

The Requester *[The person who requires the supplies, services or works to be provided]*			
Name:	*Click or tap here to enter text.*		
Position:	*Click or tap here to enter text.*		
Email address:	*Click or tap here to enter text.*	Telephone number:	*Click or tap here to enter text.*

Please note:
All fields need to be completed
All Trust expenditure is subject to Public Sector Procurement Regulations and transparency rules.
The information detailed on this form is subject to audit and challenge.
All breaches to Trust Financial policies will be investigated and reported to the Audit Committee.

Declaration:	I confirm that I have read, considered and complied with the requirements of the trust procurement rules and standing financial instructions (SFIs) before completing this waiver.	☐

Your request for exemption	
Supplier Name:	*Click or tap here to enter text.*
Supplier quote reference:	*Click or tap here to enter text.*
Supplies, services or works required:	Please provide a brief description of the supplies, services or works required.
	Click or tap here to enter text.

Division, service area or		
	Area/function name:	*Click or tap here to enter text.*
	Person with the overall responsibility for the division	*Click or tap here to enter text.*

7.4

	Role/title:		*Click or tap here to enter text.*	
Value of this request:	Value (ex.Vat)	Aggregate Spend	*Start date:*	End date:
			dd/mm/yyyy	*dd/mm/yyyy*
	List alternative providers (if any) and reason for not considering:			
	Click or tap here to enter text.			
Consequences of non-approval of this waiver:				
	Click or tap here to enter text.			
Budget type:	Revenue: ☐	Capital: ☐	Other: ☐	Please state..
Which procurement exemption rule applies?	Please select the waiver/exemption description from the SFIs that applies to your request:			
	Select Waiver Reason			
Supporting statement:	Please explain why the above exemption/waiver rule ought to be applied in this instance including any specific financial and non-financial benefits *i.e. savings/ added value/ Free of Charge* .			
	Click or tap here to enter text.			
Evidence of best value:	Please provide evidence to demonstrate how this exemption/waiver request being granted would provide value for money.			
	Click or tap here to enter text.			
Future requirements:	Please detail the steps being taken to prevent future use of a waiver i.e. competing the future requirement.			
	Click or tap here to enter text.			
Declaration of conflict of interest:	Confirmation:		Date:	
	Yes: ☐	No: ☐	*dd/mm/yyyy*	
	Click or tap here to enter text.			

Section B: For procurement completion:

Information for Audit Committee	Date waiver approved:	P/O number:	Retrospective waiver:
			Yes: ☐ No: ☐
	Notes:		

department: department:

7.4

Previous waiver:	Please confirm if a previous waiver has been used:			Yes: ☐	No: ☐	
	Number of previous waivers:	Cumulative value:	From date of original waiver:		To end date of most recent previous waiver:	
			dd/mm/yyyy		*dd/mm/yyyy*	
Associate Director of Procurement /Director of Procurement decision: £10,000 - £49,999	Decision confirmation:				Date:	
	I have reviewed this Request for Exemption and confirm that is in accordance with the trust SFIs			☐	*dd/mm/yyyy*	
	Or				Date:	
	I have reviewed this request for exemption and find that is not in accordance with the trust SFIs for the following reasons:			☐	*dd/mm/yyyy*	
	Click or tap here to enter text.					
	Approval signature:				Date:	
					dd/mm/yyyy	
	Print name:					
Deputy Chief Financial Officer / Chief Financial Officer >£50,000	Approval signature:				Date:	
					dd/mm/yyyy	
	Print name:					
Executive Director/ Chief Executive > Find a Tender Service	Approval signature:				Date:	
					dd/mm/yyyy	
	Print name:					
Board level >£1m	Approval signature:				Date:	
					dd/mm/yyyy	
	Print name:					

7.4